

Wisconsin Department of Health Services (DHS)  
 Division of Medicaid Services (DMS)  
**HMO Quality Guide**  
**Measurement Year (MY) 2020**

This Guide provides an overview of the measures, targets, methodology and operational details supporting DMS’ HMO Quality initiatives for BadgerCare Plus and SSI.

**Table of Contents**

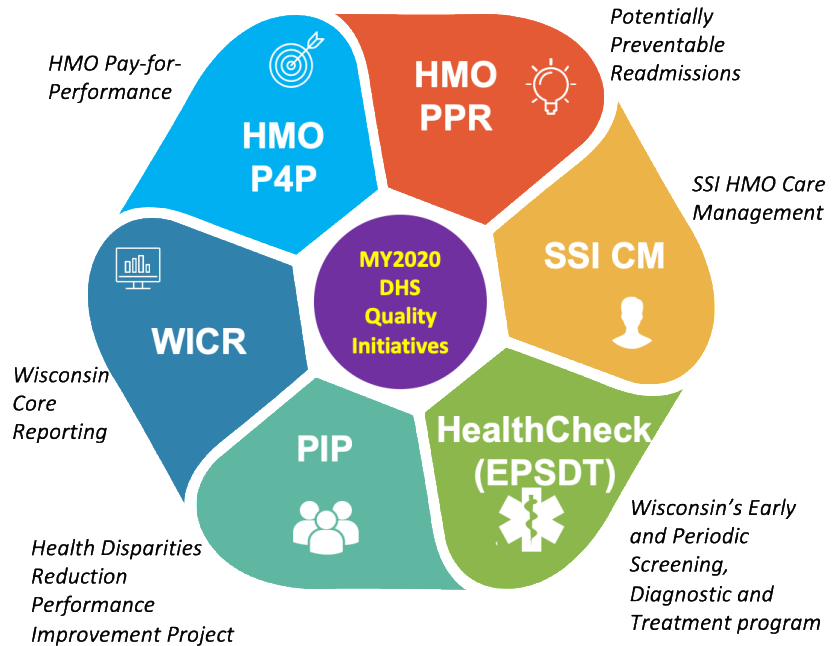
I. Measurement Year 2020 (MY2020) Overview.....	2
II. Pay-for-Performance (P4P) .....	4
Scope .....	4
Measures, Withhold and Targets .....	4
P4P Methodology .....	7
Bonus .....	9
Data Submission and Reporting for BC+ and SSI .....	10
Participating HMOs.....	12
HMO P4P Timeline for MY2020 (as of 12-20-2019) .....	13
III. Wisconsin Core Reporting (WICR).....	15
Additional Notes.....	16
IV. Potentially Preventable Readmissions (PPR) .....	19
V. SSI Care Management.....	27
G Codes & Modifiers.....	27
Qualitative EQRO Review of SSI Care Management Process Quality.....	30
VI. Health Disparities Reduction (PIP-like).....	34
Section 1: Overview of the MY2020 Health Disparities Reduction PIP-like .....	34
Section 2: MY2020 Health Disparities Reduction PIP-like Proposal Template.....	39
Check-list of PIP-like deliverables .....	45
VII. HealthCheck Specifications.....	46

**Contact:**

Susan Seibert  
 Bureau of Benefit Management / Division of Medicaid Services  
 Wisconsin Department of Health Services  
[SusanR.Seibert@dhs.wisconsin.gov](mailto:SusanR.Seibert@dhs.wisconsin.gov)

## I. Measurement Year 2020 (MY2020) Overview

The quality initiatives of the Wisconsin Department of Health Services, Division of Medicaid Services (DMS) cover a broad range of initiatives, as shown below:



- The **P4P** initiative focuses on improving the measurable quality of care for Medicaid members. Its current scope includes Managed Care Organizations (MCOs, also referred to as HMOs), with applicable capitation withholds that can be earned back by HMOs based on their performance relative to quality targets for various measures applicable to them. These measures relate to priority areas for DMS, while balancing the total number of measures in P4P. DMS continues to move from Process-only measures to a combination of Process and Outcome measures - e.g., from HbA1c testing to HbA1c Control, related to diabetes care.
- The Wisconsin Core Reporting (**WICR**) initiative focuses on providing DMS healthcare quality data for a broad set of conditions and measures which are related to Medicaid Core Sets published by CMS. It does not include a withhold but requires HMOs to report data on specific quality measures, and imposes financial penalties for not reporting results.

Results for all the above quality measures will be used as input for the DMS HMO Report Cards. The HMO Report Card is publicly available on the DMS website ([www.forwardhealth.wi.gov](http://www.forwardhealth.wi.gov)).

- The **PPR** initiative focuses on reducing preventable hospital readmissions following an initial admission. Excess readmissions compared to state-wide benchmarks suggest an opportunity to improve patient outcomes and to reduce costs through better discharge planning, better coordination of care across sites of service, and/or other improvements in the delivery of care.
- The **SSI Care Management** initiative aims to provide person-centric care through needs stratification, integration of social determinants, person-centric care plans, interdisciplinary care teams, and an on-going assessment and alignment of the SSI members' needs with their care.
- **Health Disparities Reduction Performance Improvement Project (PIP)** initiative focuses on reducing health disparities among Medicaid members, improving cultural competence of HMOs and providers serving Wisconsin Medicaid members, and compliance with the Managed Care Rule requirement defined in 42 CFR 438.340 (b).
- **HealthCheck** (Wisconsin's EPSDT Program – Early and Periodic Screening, Diagnostic and Treatment program) is a preventive health check-up program for anyone under the age of 21 who is currently eligible for Wisconsin Medicaid or BadgerCare Plus.

Depending on the specific Medicaid members it serves, an HMO might participate in multiple Quality initiatives.

DMS will publish an HMO Report Card reflecting the relative performance of HMOs for the Measurement Year. The Report Card methodology is yet to be finalized by DMS.

Measurement Year (MY) for the initiatives typically starts on January 1 and ends on December 31 of that calendar year, unless otherwise noted for specific initiatives.

## II. Pay-for-Performance (P4P)

### Scope

- **BC+**: Standard plan in all 6 Medicaid Regions
- **SSI** in all 6 Medicaid Regions

Dual (Medicare) eligible members are excluded from BC+ and SSI P4P unless they meet enrollment requirements for Medicaid only during the year. Retroactive Medicare eligibility and enrollment are accounted for if such actions occur before the cut-off date for the data used for the Measurement Year (MY).

Performance targets and results for each measure and HMO will be set and calculated for all 6 Regions collectively, unless otherwise specified.

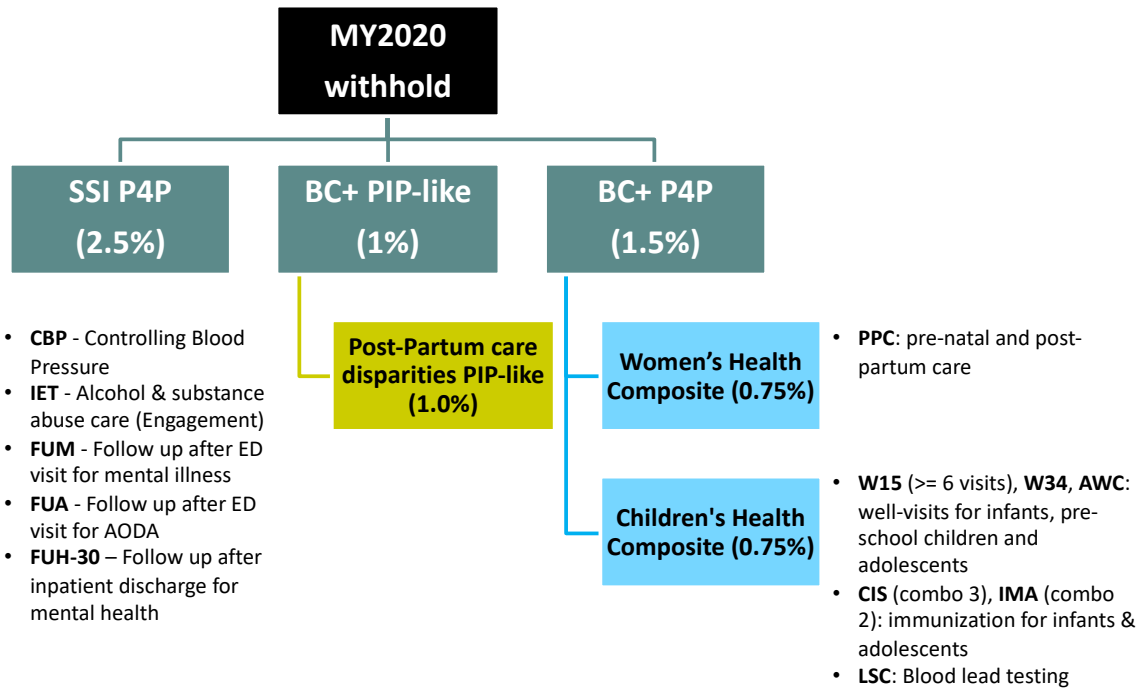
### Measures, Withhold and Targets

1. The DMS uses **HEDIS measures** for its P4P initiative.  
There will be no deviations from HEDIS specifications in MY2020. Refer to HEDIS<sup>1</sup> Technical Specifications published by NCQA<sup>2</sup> for details of specific measures.
2. The MY2020 upfront **withhold rate** is 2.5%, and will apply to capitation for BC+ and SSI, including administrative payments.
  - a. **BC+**:
    - Withhold will not apply to the childless adult (CLA) population;
    - 1% withhold will be assigned to **PIP-like** for reducing disparities in post-partum care  
A PIP-like initiative is conceptually similar to CMS' PIP (Performance Improvement Project), though with less stringent technical requirements. DMS uses the PIP-like approach for newer initiatives, which could mature over time into full PIPs.
    - 0.75% withhold will be assigned to a **women's health P4P composite**;
    - 0.75% withhold will be assigned to a **children's health P4P composite**.
  - b. **SSI**:
    - 2.5% withhold will be assigned to **SSI P4P composite**.
  - c. An HMO can also earn a bonus.

<sup>1</sup> Health Effectiveness Data and Information Set

<sup>2</sup> National Committee for Quality Assurance (<http://www.ncqa.org>), a private, 501(c)(3) not-for-profit organization

The chart below shows the withhold percentage for MY2020, and the Quality components to which it applies.



### 3. MY2020 P4P targets for BC+ and SSI

MY2020 baselines for HEDIS measures are set using the latest available MY2018 HEDIS state-wide averages and the MY2018 national HEDIS percentiles as published in the Quality Compass.

This approach provides:

- A level starting point for all HMOs
- Transparent targets shared in advance
- Consistent targets that do not change mid-year

The table below lists for each P4P measure:

- 2018 national HEDIS percentiles
- 2018 state average
- The composite applicable to the measure
- Targets for earning P4P points (further explained in the P4P Methodology section)

### MY2018 HMO P4P Measures, Composites and Targets:

Measure	2018 National HEDIS Percentiles			2018 WI Avg	MY2020 Target for:			
	50 <sup>th</sup> percentile	67 <sup>th</sup> percentile	75 <sup>th</sup> percentile		4 points	3 points	2 points	1 point
<b>BC+ Women's Health Composite</b>								
PPC - Pre-natal care	83.8%	86.4%	87.6%	<b>84%</b>	>=87.6%	>=86.4%	>=83.8%	N/A
PPC - Post-partum care	65.7%	68.4%	69.8%	<b>65.5%</b>	>=69.8%	>=68.4%	>=65.7%	>=65.5%
<b>BC+ Children's Health Composite</b>								
W15 (>=6 visits)	65.8%	68.4%	69.8%	<b>58.4%</b>	>=69.8%	>=68.4%	>=65.8%	>= 58.4%
W34	72.9%	76.2%	78.5%	<b>64.8%</b>	>=78.5%	>=76.2%	>=72.9%	>=64.8%
AWC	54.3%	60.3%	62.8%	<b>44.7%</b>	>=62.8%	>=60.3%	>=54.3%	>=44.7%
CIS –combo 3	70.7%	72.8%	74.5%	<b>71.5%</b>	>=74.5%	>=72.8%	>=70.7%	N/A
IMA – combo 2	34.4%	38.2%	40.4%	<b>39.0%</b>	>=40.4%	>=38.2%	>=34.4%	N/A
LSC	73.1%	78.8%	81.0%	<b>79.6%</b>	>=81.0%	>=78.8%	>=73.1%	N/A
<b>SSI Composite</b>								
CBP	61.0%	65.0%	66.9%	<b>64.7%</b>	>=66.9%	>=65.0%	>=61.0%	N/A
IET (Engagement)	11.2%	12.9%	13.8%	<b>10%</b>	>=13.8%	>=12.9%	>=11.2%	>=10%
FUM-30	54.3%	61.7%	64.7%	<b>55.7%</b>	>=64.7%	>=61.7%	>=54.3%	N/A
FUA-30	17.8%	22.8%	26.4%	<b>16.8%</b>	>=26.4%	>=22.8%	>=17.8%	>=16.8%
FUH-30	57.6%	62.5%	65.6%	<b>54.9%</b>	>=65.6%	>=62.5%	>=57.6%	>=54.9%

**In the table above:**

1. PPC = Prenatal and Post-partum care
2. W15 = Well-child visits in the first 15 months of life
3. W34 = Well-child visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> years of life
4. AWC = Adolescent well-care visits
5. CIS = Childhood immunization status
6. IMA = Immunizations for adolescents
7. LSC = Lead screening in children
8. CBP = Controlling blood pressure
9. IET = Initiation and engagement of alcohol and other drug abuse or dependence treatment
10. FUM-30 = Follow-up after emergency department visit for mental illness (30 days)
11. FUA-30 = Follow-up after emergency department visit for alcohol and other drug abuse or dependence (30 days)
12. FUH-30 = Follow-up after hospitalization for mental illness (30 days)

## P4P Methodology

The same methodology applies to all composites.  
All measures within a composite have equal weight.

### 1. Points:

Based on its level of performance, an HMO can earn **0 to 4 points** for each measure (more points are better) in the following manner:

- 4 points if the HMO's rate is at or above the national 75th percentile for that measure
- 3 points at or above the 67th percentile
- 2 points at or above the 50th percentile
- No points below the 50th percentile

**Exception:** When the MY2018 State average for a measure falls below the national 50<sup>th</sup> percentile for that measure, then an HMO can earn:

- 1 point at or above the MY2018 state average
- 2, 3 or 4 points as described above

### 2. Earning back the withhold:

- a. An HMO can receive between 0 and 4 points for each measure.
- b. The maximum # of points each composite can have  
= 4 points per measure \* # of measures in the composite
- c. Each measure in a composite is weighted equally
- d. Actual total # of points for each composite for an HMO  
= Sum of HMO's points for all measures in that composite
- e. % of points earned for each composite  
= {Actual total # of points received / Maximum # of points} \* 100
- f. % of withhold earned back  
= % of points earned by the HMO for the composite

**Example:** The following **hypothetical example** using the **children's health composite** illustrates the above methodology:

- The children's health composite has 6 measures. Therefore, the maximum # of points an HMO can earn for this composite =  $6 * 4 = 24$  points.
- Assume that the table below represents the results and points for this composite:

Measure	MY2020 Target for:				Points earned based on <u>hypothetical</u> performance of:		
	4 points	3 points	2 points	1 point	HMO A	HMO B	HMO C
W15 (>=6 visits)	>=69.8%	>=68.4%	>=65.8%	>= 58.4%	72% = 4 points	71% = 4 points	66% = 2 points
W34	>=78.5%	>=76.2%	>=72.9%	>=64.8%	78.5% = 4 points	80% = 4 points	72% = 1 point
AWC	>=62.8%	>=60.3%	>=54.3%	>=44.7%	65% = 4 points	62% = 3 points	63% = 4 points
CIS –combo 3	>=74.5%	>=72.8%	>=70.7%	N/A	78% = 4 point	74% = 3 points	68% = 0 points
IMA – combo 2	>=40.4%	>=38.2%	>=34.4%	N/A	48% = 4 points	46% = 4 points	42% = 4 points
LSC	>=81.0%	>=78.8%	>=73.1%	N/A	86% = 4 points	77% = 2 points	88% = 4 points
<b>Total points earned</b>					<b>24</b>	<b>20</b>	<b>15</b>
<b>% of points earned</b>					<b>= 24/24 = 100%</b>	<b>= 20/24 = 83.3%</b>	<b>= 15/24 = 62.5%</b>

- **HMO A** earns a total of 24 points for all measures in this composite, shown in the 2<sup>nd</sup> last row of the above table. This represents  $24/24 = 100\%$  of the maximum points for this composite. Therefore, the HMO will earn back 100% of its withhold for this composite, shown in the last row of the above table.
- **HMO B** earns a total of 20 points for all measures in this composite, shown in the 2<sup>nd</sup> last row of the above table. This represents  $20/24 = 83.3\%$  of the maximum points for this composite. Therefore, the HMO will earn back 83.3% of its withhold for this composite, shown in the last row of the above table.
- **HMO C** earns a total of 15 points for all measures in this composite, shown in the 2<sup>nd</sup> last row of the above table. This represents  $15/24 = 62.5\%$  of the maximum points for this composite. Therefore, the HMO will earn back 62.5% of its withhold for this composite, shown in the last row of the above table.



## Bonus

The P4P initiative has two separate pools for withhold – one for BC+, and the other for SSI; correspondingly, there are two separate bonus pools. The bonus would reward HMOs that demonstrate high quality by meeting **all** their targets and earning back their **full** withhold for each pool, separately. An HMO must meet **all** the following requirements:

1. To earn a BC+ bonus, an HMO must earn back 100% of its BC+ withhold for all applicable composites; to earn an SSI bonus, an HMO must earn back 100% of its SSI withhold for all applicable composites.
2. It has reported data for **all** the P4P and non-P4P WICR measures, **and**,
3. A minimum # of P4P measures apply to the HMO, as shown in the table below. A measure may not apply to an HMO if that HMO's denominator is too small for that measure, per HEDIS specifications, or smaller than 30 for non-HEDIS measures.

MY2020: Minimum # of applicable P4P measures for bonus eligibility	
BC+	6 out of 8 P4P measures
SSI	4 out of 5 P4P measures

The total bonus earned by any plan will be up to the **lesser** of:

- Total capitation **withhold** \$ for that plan, OR
- Total withheld \$ **forfeited** by other plans.

**Separate** bonus pools for BC+ and for SSI will be formed by the respective portion of withhold not earned back (i.e., forfeited) by HMOs. Forfeited withhold will be the sole source of funding for the bonus pool. Eligible HMOs will share the bonus pool in proportion of the sum of their members in the **denominator** for all applicable measures, subject to the bonus limits. This approach addresses key methodological issues such as:

- Variation in the # of members enrolled, i.e., the difference between large and small HMOs, which is accounted for by the limit on bonus.
- Variations in the performance of HMOs.
- Variation in performance of HMOs due to proportion of enrolled members with specific conditions, which is accounted for by the use of denominator (not the total enrollment) in calculating the bonus.

### Example of bonus calculations

Assume the total bonus pool is worth \$2 million for the Measurement Year. Also assume that the table below represents HMOs that have met all the bonus eligibility requirements.

HMO	Total # of members in denominator for all applicable measures	% share based on denominator size	Bonus amount (assuming all are below the limits)
A	500	= (500 / 4000) = 12.5%	= 12.5% of \$2 million = \$250,000
D	400	= (400 / 4000) = 10%	= 10% of \$2 million = \$200,000
F	2000	= (2000 / 4000) = 50%	= 50% of \$2 million = \$1 million
H	1100	= (1100 / 4000) = 27.5%	= 27.5% of \$2 million = \$550,000
<b>Total</b>	<b>4000</b>	<b>100%</b>	<b>\$2 million</b>

## Data Submission and Reporting for BC+ and SSI

### 1. NCQA Data submission requirements - BC+ and SSI - All Regions

HMOs are required to submit the following for MY2020:

- a. Data from the NCQA Interactive Data Submission System (IDSS) site containing the required data elements and the denominator and numerators for each measure in the Data-filled Workbook (export), filled copy of this workbook in Excel format for local copy and for printing.  
HMOs must provide to the DMS the **denominators and numerators for each measure**.
- b. **Data Filled Workbook, including Audit Review Table (ART) format** downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied).
- c. The Audit Report produced by a NCQA Licensed HEDIS Auditor.
- d. For HEDIS measures with age stratification and other sub-populations, HMOs are asked to report results in the IDSS and ART tables by age strata and other sub-populations as well as for the overall population.

### 2. Electronic submission requirements:

- a. Data files and documents are to be submitted to DMS via the SFTP server.
- b. All electronic data files must include the year and health plan name in the file name.
- c. Send an email to [Jose.Bocanegra@dhs.wisconsin.gov](mailto:Jose.Bocanegra@dhs.wisconsin.gov) and to [VEDSHMOSupport@wisconsin.gov](mailto:VEDSHMOSupport@wisconsin.gov) notifying them when the files (test files or production files) have been placed on the SFTP server.

### 3. Public Reporting

For MY2020, all health plans are required to report each of their HEDIS scores verified by their HEDIS auditor for all regions, and to make their results available for public reporting within the Quality Compass.

### 4. Member Level Detail files are required

Although NCQA requires only Medicare plans to submit member-level data for HEDIS measures that are calculated and submitted by HMOs, HMOs are to be ready to submit Medicaid member-level data for HEDIS measures calculated by HMOs' HEDIS vendors. The purpose of such member-level files is to allow DMS and HMOs to conduct various analyses, e.g., health disparities, at a future time.

DMS does not currently have a formal template for such data. However, the Department recommends that HMOs create files for each measure that include:

- Member's Medicaid id # and available demographic data such as age, gender, race, ethnicity, preferred language, disability status, and location of residence.
- Applicable dates and types of services (e.g. inpatient, out-patient, office, ED, urgent care, medications, imaging, histology, etc.), including applicable encounter identification.
- Relevant diagnoses and procedures.

In creating these files, HMOs can apply the same HEDIS value sets for diagnosis, procedure and other codes used by their HEDIS vendors to calculate the measure results. HMOs have the discretion to retain additional information they might use in future analyses.

#### **5. Fee-For-Service (FFS) data for BC+ All Regions**

At the end of each year, DMS provides data to HMOs for members who received care under FFS during the MY, when they were not enrolled in an HMO, so that HMOs can get the credit for care provided while the members were enrolled in FFS. *In prior years, HMOs have preferred to receive this data by December, so these FFS files will not reflect the full Measurement Year data due to the associated time lags.*

HMOs must submit to DMS a file with member ids for whom HMOs would like to receive FFS data. This file should be submitted to DMS no later than Nov 15, 2020.

#### **6. Other P4P requirements:**

- a. Rotation of measures is not allowed. Each measure is to be calculated each year.
- b. Health plans may apply the optional exclusions per HEDIS specifications for appropriate measures while submitting audited Medicaid HEDIS results to NCQA.
- c. In determining continuous enrollment for specific measures, HEDIS allows a gap of 45 days for commercial plans, but only a one-month gap for Medicaid plans that enroll on a monthly basis. Wisconsin Medicaid enrolls members on a monthly basis. The only time a member is not enrolled for the entire month is the month in which a child was born. Refer to the General Guidelines in the HEDIS Technical Specifications.
- d. For HEDIS measures that can be collected using the hybrid method, inclusion of chart review data is optional.
- e. HMOs may use the sample approach to calculate their results when permitted by HEDIS.

## Participating HMOs

The table below lists the BC+ HMOs and SSI HMOs participating in the P4P and Core Reporting initiatives for MY2020. This list is updated annually.

HMO	BC+	SSI
1. Care Wisconsin Health Plan		✓
2. Children's Community Health Plan	✓	
3. Anthem	✓	✓
4. Dean Health Plan	✓	
5. Group Health Cooperative of Eau Claire	✓	✓
6. Group Health Cooperative of South Central WI	✓	
7. Independent Care Health Plan (iCare)	✓	✓
8. MercyCare Insurance Company	✓	
9. Managed Health Services	✓	✓
10. Molina Health Care WI	✓	✓
11. Network Health Plan	✓	✓
12. Quartz	✓	
13. Security Health Plan of WI	✓	
14. Trilogy Health Insurance	✓	
15. UnitedHealthcare of Wisconsin	✓	✓

## HMO P4P Timeline for MY2020 (as of 12-20-2019)

This timeline is not intended to cover all events; it will be periodically updated and shared with HMOs.

<b>MY2020 Quality Timeline</b>												
<b>Quality Item</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>
<b>MY2019 P4P</b>						HMO encounter /medical record data to DHS	HMO audited 2019 data to DHS		Prelim results from DHS	HMO feedback, additional data to DHS	Final results from DHS	
<b>MY2019 PIP</b>							HMO final report to EQRO					
<b>MY2019 PPR</b>								Prelim results		Final results		
<b>MY2020 PIP (Disparities)</b> LC = Learning Collaborative	2019 PIP-like proposal due 1/10; calls w/ EQRO, DMS	Calls w/ EQRO, DMS	LC (3/27, 9:00 AM-11:00 AM); Quarterly progress report			LC (6/23; 1:00 PM-3:00 PM); Quarterly progress report	Mid-year check w/ EQRO		LC (9/24; 1:00 PM – 3:00 PM); Quarterly progress report			LC (12/17; 1:00 PM – 3:00 PM); Quarterly progress report
<b>MY2020 Quality Forum calls</b> (1:00 – 2:00)	Jan 22	Feb 26	Mar 25	Apr 22	May 27	Jun 24	Jul 22	Aug 26	Sep 23	Oct 28	Nov 25	Dec 16
<b>MY2021 Quality Plans</b>						2021 quality discussions			Draft 2021	Final 2021	2021 Quality	2021 PIP proposals

<b>MY2020 Quality Timeline</b>												
<b>Quality Item</b>	<b>Jan</b>	<b>Feb</b>	<b>Mar</b>	<b>Apr</b>	<b>May</b>	<b>Jun</b>	<b>Jul</b>	<b>Aug</b>	<b>Sep</b>	<b>Oct</b>	<b>Nov</b>	<b>Dec</b>
									quality plan	quality plan	Guide to HMOs	to EQRO, DMS
<b>FFS extract to HMOs</b>											FFS member list from HMOs to DXC	FFS extract from DXC to HMOs
<b>HMO Report Card</b>		2018 Report Card										2019 Report Card?
<b>CMS Core Set data reporting plan (1)</b>	Non-HEDIS measure review	Plan to calculate non-HEDIS measures					Calculate non-HEDIS measures, as feasible			MACPro data entry (HEDIS & non-HEDIS)		
<b>Health home quality reporting (2)</b>										Plan	Execute	
<b>HMO Contract Admin Mtgs</b>	Date TBD	Date TBD	Date TBD	Date TBD	Date TBD	Date TBD	Date TBD	Date TBD	Date TBD	Date TBD	Date TBD	Date TBD
<b>CAHPS survey (dates TBD)</b>												

**Notes:**

- (1) This activity pertains to DMS’ plans to report non-HEDIS measures in the CMS core sets; HMOs are not required to report this data to DMS.
- (2) Health Home quality reporting pertains to data DMS submits to CMS for the OB Medical Home and HIV Health Home

### III. Wisconsin Core Reporting (WICR)

The Bipartisan Budget Act of 2018 (P.L. 115-123) requires states to report on the child core set for Medicaid and CHIP beginning with reports for fiscal year (FY) 2024.

1. As part of its initiatives to improve alignment with current and future CMS requirements (e.g., CHIPRA, Managed Care Rules) and as input to a broader picture of Quality of Care, DMS requires all plans to report audited HEDIS data for key measures designated as **Wisconsin Core Reporting (WICR)**.
  - a. The WICR measures are not part of P4P withhold or bonus.
  - b. HMOs will be subject to a \$10,000 penalty per measure for not reporting HEDIS data for the measures discussed below.
2. For MY2020, WI Medicaid HMOs are required to report:
  - a. All **MY2020** P4P measures, and
  - b. **WICR** = all remaining **HEDIS** measures from the **2020** Medicaid Adult and Child Core Sets, as applicable to BC+ and SSI, shown in the table below.

Reference documents:

- i. CMS Medicaid **2020 Adult** Core Set:  
<https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-adult-core-set.pdf>
- ii. CMS Medicaid **2020 Child** Core Set:  
<https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2020-child-core-set.pdf>

MY2020 Wisconsin Core Reporting (WICR) Measures	
BC+	SSI
Adult Core Set	
<ol style="list-style-type: none"> <li>1. Adult BMI (ABA-AD)</li> <li>2. Breast cancer screening (BCS-AD)</li> <li>3. Cervical cancer screening (CCS-AD)</li> <li>4. Chlamydia screening, ages 21-24 (CHL-AD)</li> <li>5. Controlling high blood pressure (CBP-AD)</li> <li>6. Comprehensive diabetes care: Hemoglobin A1c (HbA1c) poor control (&gt;9.0%) (HPC-AD; this label is used by CMS in the 2020 Medicaid Adult Core Set)</li> <li>7. Plan all-cause readmissions (PCR-AD)</li> <li>8. Asthma medication ratio, ages 19-64 (AMR-AD)</li> <li>9. Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET-AD)</li> <li>10. Antidepressant medication management (AMM-AD)</li> </ol>	<ol style="list-style-type: none"> <li>1. Adult BMI (ABA-AD)</li> <li>2. Breast cancer screening (BCS-AD)</li> <li>3. Cervical cancer screening (CCS-AD)</li> <li>4. Chlamydia screening, ages 21-24 (CHL-AD)</li> <li>5. Comprehensive diabetes care: Hemoglobin A1c (HbA1c) poor control (&gt;9.0%) (HPC-AD)</li> <li>6. Plan all-cause readmissions (PCR-AD)</li> <li>7. Asthma medication ratio, ages 19-64 (AMR-AD)</li> <li>8. Initiation and engagement of alcohol and other drug abuse or dependence treatment (IET-AD) – initiation only</li> <li>9. Antidepressant medication management (AMM-AD)</li> <li>10. Follow-up after hospitalization for mental illness, age 18 and older (FUH-AD) – 7 days only</li> </ol>

<b>MY2020 Wisconsin Core Reporting (WICR) Measures</b>	
<b>BC+</b>	<b>SSI</b>
<ol style="list-style-type: none"> <li>11. Follow-up after hospitalization for mental illness, age 18 and older (FUH-AD)</li> <li>12. Diabetes screening for people with schizophrenia or bipolar disorder, using antipsychotics (SSD-AD)</li> <li>13. Follow-up after ED visit for alcohol and other drug abuse or dependence (FUA-AD)</li> <li>14. Follow-up after ED visit for mental illness (FUM-AD)</li> <li>15. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD)</li> </ol> <p><i>W-15-CH, AWC-CH, PPC are P4P measures, and not listed here again.</i></p>	<ol style="list-style-type: none"> <li>11. Diabetes screening for people with schizophrenia or bipolar disorder, using antipsychotics (SSD-AD)</li> <li>12. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD)</li> </ol> <p><i>CBP, IET (engagement), FUA-AD, FUM-AD and FUH-AD (30 days) are P4P measures, and not listed here again.</i></p>
<b>Child Core Set</b>	
<ol style="list-style-type: none"> <li>1. Adolescent immunization (IMA-CH) – all except combo 2</li> <li>2. Well-child visits in first 15 months (W15-CH)</li> <li>3. Well-child visits in the Third, Fourth, Fifth and Sixth years (W34-CH) – all except 6 or more visits</li> <li>4. Childhood immunization status (CIS-CH) – all except combo 3</li> <li>5. Adolescent well care visits (AWC-CH)</li> <li>6. Weight assessment and counseling (WCC-CH)</li> <li>7. Chlamydia screening, ages 16-20(CHL-CH)</li> <li>8. Asthma Medication Ratio (AMR-CH)</li> <li>9. Ambulatory care: ED visits (AMB-CH)</li> <li>10. Follow-up care for children prescribed attention deficit / hyperactivity disorder (ADHD) medication (ADD-CH)</li> <li>11. Follow-up after hospitalization for mental illness, ages 6-17 (FUH-CH)</li> <li>12. Metabolic monitoring for children and adolescents on antipsychotics (APM-CH)</li> <li>13. Use of first-line psychosocial care for children / adolescents on antipsychotics (APP-CH)</li> </ol> <p><i>Prenatal and postpartum care (PPC) is a P4P measure, and is not listed here again.</i></p>	<p>Not applicable</p>

### Additional Notes

In response to questions posed by HMOs, the Department has provided the following clarifications pertaining to P4P and WICR measures.



**1. Measures with CH (children) and AD (adult) designations:**

- HMOs are asked to report all age bands, sub-populations and any applicable totals for the measures, using standard HEDIS technical specifications.
- DMS will analyze the data submitted by HMOs to determine future use including, e.g., setting applicable targets for future years, or as components of the HMO Report Card.

**2. Two lists of measures – P4P and WICR:**

Medicaid Core Set measures that are already included in the P4P measures are not listed again in the WICR measures list. The two lists, P4P and WICR, should be reviewed together to see a full list of HEDIS measures to be reported by HMOs.

**3. Retired measures:**

NCQA recently announced the **retirement** of **APC** (Use of multiple concurrent antipsychotics in children and adolescents) and **MPM** (Annual monitoring for patients on persistent medications) and **HPCMI** (measures for HEDIS 2020 (which applies to 2019 dates of service)). These two measures are on the 2019 Medicaid Core Set for Children, and for Adults, respectively and were also part of the WI Core Reporting set for MY2019. Due to retirement, these two measures will not be included in IDSS, and therefore, HMOs will not be able to report these measures as part of the standard set for 2019 dates of service. Therefore, HMOs would **NOT** be required to report these two measures for MY2019 dates of service, in summer 2020.

**4. Flu vaccinations for adults (FVA-AD), NQF 0039:**

- This measure is listed in the **2020 Medicaid Core Set for Adults**.
- It is administered by NCQA, and data are collected through CAHPS survey. Many Wisconsin HMOs conduct their own CAHPS survey, usually as part of their NCQA certification. If an HMO is not certified or seeking certification in MY2019 or MY2020 by NCQA, it is not required to report this measure, and will not be subject to the non-reporting penalty.

**5. Medical assistance with smoking and tobacco use cessation (MSC-AD), NQF 0027**

- This measure is listed in the **2020 Medicaid Core Set for Adults**.
- It is administered by NCQA, and data are collected through CAHPS survey. Many Wisconsin HMOs conduct their own CAHPS survey, usually as part of their NCQA certification. If an HMO is not certified or seeking certification in MY2019 or MY2020 by NCQA, it is not required to report this measure, and will not be subject to the non-reporting penalty.

**6. Diabetes care for people with serious mental illness; HbA1c poor control >9.0% (HPCMI-AD), NQF 2607:**

- This measure is listed in the **2020 Medicaid Core Set for Adults**.
- According to the latest information from HEDIS experts from MetaStar (DMS' EQRO):

- i. This measure is owned by NCQA, and has been altered to meet the needs of the Medicaid Core Set program;  
<https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement>.
  - ii. CMS provides technical assistance for the Core Set Technical Specifications;  
[MACQualityTA@cms.hhs.gov](mailto:MACQualityTA@cms.hhs.gov).
  - iii. NCQA does not plan to incorporate this measure into IDSS. Therefore, plans and their software vendor have the option to program the software to generate measure data using the CMS Core Set value sets for numerator and denominator identification.
- If an HMO is unable to generate this measure, the HMO must submit a letter to DMS clearly stating the reason(s) for its inability to generate this measure along with its regular HEDIS data submission to DMS. HMOs submitting such letter will not be subject to the non-reporting penalty, and will not be disqualified from potentially earning a bonus based on its performance for other measures.

#### **7. Follow-up After Hospitalization for Mental Illness (FUH-CH); NQF 0576:**

- This measure is listed in the **2020 Medicaid Core Set for Children**, and has been designated by WI DMS as part of its WICR list for **BC+** for MY2020.
- DMS recognizes that at times, HEDIS and CMS use slightly different technical specifications. In order to minimize the reporting burden, HMOs should report results using **standard HEDIS specifications** for this measure.

#### **8. Asthma Medication Ratio (AMR-CH, AMR-AD); NQF 1800:**

- This measure is listed in the **2020 Medicaid Core Set for Children** and for **Adults**, and has been designated by WI DMS as a Core Reporting measure: AMR-CH and AMR-AD for **BC+**, and AMR-AD for **SSI** in MY2020.
- HMOs are asked to report all HEDIS age bands and any applicable totals for this measure.

#### **9. Ambulatory Care: Emergency Department (ED) Visits (AMB-CH):**

- This measure is listed in the **2020 Medicaid Core Set for Children**, and has been designated by WI DMS as part of its Core Reporting list for **BC+** for MY2020.
- HMOs must use the standard HEDIS technical specifications to report only the ED Visits portion for this measure.
- Urgent Care exclusion (code 0456) should not be excluded by HMOs, since this data will be reported to CMS through MACPro.

#### **10. Weight Assessment and Counseling (WCC-CH); NQF 0024:**

- This measure is listed in the **2020 Medicaid Core Set for Children**, and has been designated by WI DMS as part of its Core Reporting list for **BC+** for MY2020.
- HMOs must use the standard HEDIS technical specifications to report only the BMI Assessment for children and adolescents.

## IV. Potentially Preventable Readmissions (PPR)

### 1. Goal of the HMO PPR Initiative

To reduce Potentially Preventable Readmissions (PPRs) for Wisconsin Medicaid members served by HMOs.

Excess readmission chains relative to benchmarks suggest an opportunity to improve patient outcomes and to reduce costs through discharge planning, coordination of care across sites of service, and/or other improvements in the delivery of care.

### 2. PPR Software

PPR calculation is based upon a clinical algorithm created by 3M. Many items are evaluated when determining clinical relationships such as DRGs, diagnosis codes, procedure codes and duration between discharge and admission. Certain conditions are excluded when classified as “intrinsically clinically complex.” 3M provides a detailed User Guide documenting the algorithm to hospitals and plans who purchase the software.

The 3M PPR software analyzes all admissions for HMO members, and classifies each admission into one of the following categories:

- Only Admission (OA): A claim that is not a potentially preventable readmission and is not followed by a potentially preventable readmission (at any hospital) within 30 days;
- Initial Admission (IA): A claim that is not a potentially preventable readmission and is followed by a potentially preventable readmission (at any hospital) within 30 days;
- Readmission (RA): A claim that is a potentially preventable readmission associated with an initial admission within 30 previous days;
- Exclusion: A claim that is excluded from measurement under 3M’s clinically-based algorithm exclusions (example: clinically complex cases).

**Qualifying Admissions are defined as OAs + IAs.**

### 3. PPR Calculation Methodology

- a. All Wisconsin Medicaid recipients for whom an HMO receives a capitated payment are included in the PPR model.
- b. Actual IAs and benchmark IAs (readmission chains) are aggregated for each HMO to determine risk adjusted readmission chain rates for each HMO.
- c. Readmission chain rates for HMOs will be calculated using only the HMO data from all providers, since the Department’s focus is on the impact of HMO-specific initiatives with their providers, recognizing that there will be variation across providers and HMOs. Readmission chain rates for Fee-for-Service (FFS) hospitals will be calculated using only the FFS data. All FFS hospitals are included in FFS PPR calculations, though only providers with over 25 qualifying admissions are eligible to participate in the FFS incentive program.

- d. Benchmark IAs are risked adjusted and calculated for each HMO based on the statewide managed care average rate of IAs by APR-DRG and Severity of Illness combination. Further adjustments to benchmark IAs are made to account for differences in patient age and secondary mental health diagnosis. Benchmark IAs by HMO are aggregated based on the HMO's mix of services (based on APR-DRG and patient age) and volume. Analysis by the Department's vendor, Navigant, has not shown a variation in the ABRs across the Medicaid rate regions.
- e. Benchmark IAs are compared to actual IAs for each HMO. "Excess" IAs are actual IAs exceeding benchmark IAs. Measuring HMO performance based on actual vs. risk adjusted benchmark IAs (readmission chains) enables DMS to compare HMO performance even when there are differences in enrollment, population morbidity, inpatient volume, and inpatient case mix. Examples of risk adjustment were shared with the HMOs via email on November 14, 2017.
- f. Providers who are paid on a per diem basis are included in the development of statewide managed care average rate of IAs by APR-DRG and Severity of Illness, though these providers are exempted from PPR-based incentives / penalties. Behavioral admissions are included in calculations of PPRs.
- g. PPR calculations for an HMO are based on all providers serving the Medicaid members of that HMO. There are no minimum thresholds re: the number of Qualifying Admissions for HMOs.
- h. Attribution of PPR chains to an HMO: HMO PPR analyses are based on encounter data only, which eliminates the impact of mid-chain switching between HMO and FFS eligibility. Similar to the hospital PPR initiative, the HMO that is assigned the start of a PPR chain is also assigned the PPR if a recipient changes HMOs within a PPR chain (similar to recipients switching hospitals for hospital PPR chain). However, such instances are rare - a Department analysis found that less than 0.5% of HMO PPR chains involved a switch between HMOs by a member.
- i. Transfer of patients across facilities: All transfers across facilities are handled in a similar manner, regardless of diagnoses (e.g., behavioral health, others). Please refer to the PPR training slides (#12-16) from the May 4, 2017 HMO Technical Call.
- j. Social determinants: There are no current adjustments for social determinants in PPR calculations. HMOs have the flexibility to collect social determinants data using ICD-10 codes, and report the data to the Department. The Department will be open to reviewing at a later date how social determinants data submitted by HMOs can be used in PPR calculations.
- k. For PPR related to SSI Care Management PIPs only: When a patient who has previously not had an upfront screening (i.e., no G9001 code billed yet for that year) is so identified while being admitted for inpatient care, it presents an opportunity to conduct the upfront screening (G9001 billing code) and to provide transition care services (G9012 code). Both the codes cannot be billed in the same month even though both services can be provided in the same month in this scenario. The Department will track such

service events. The HMOs are also expected to track such service events separately, and to bring them to the Department's attention in a timely manner. HMOs will have an opportunity to review the preliminary results from the Department, and provide feedback to the Department if such services are missed in the calculations.

- I. An HMO may dispute the Department's PPR calculations by sending a written communication to the Department's Quality team within the Bureau of Benefits Management, no later than 30 days after receiving the Department's PPR calculations. After 30 days, the HMO waives the right to dispute the PPR calculations. Any dispute communication should be accompanied by supporting documentary evidence that shows how the HMO's PPR calculations are different than the Department's calculations.

#### 4. HMO PPR Initiative

##### a. Population in scope:

MY2020 HMO PPR initiative will focus on BadgerCarePlus readmissions only.

##### b. PPR measure:

= % reduction in Actual to Benchmark Ratio (ABR) in the Measurement Year (MY) ABR compared to the Baseline ABR.

$$\% \text{ reduction in ABR} = \frac{[\text{Baseline ABR} - \text{MY ABR}]}{[\text{Baseline ABR}]}$$

HMO ABR value used for baseline is shown in row *N* in the HMO PPR report shared by the Department with the HMOs.

Numerator = Readmission rate, shown in row *I* in the HMO PPR report

Denominator = Benchmark readmission rate, shown in row *M* in the HMO PPR report.

Note: The Wisconsin Medicaid PPR measure is different than the CMS All-Cause Readmission measure in that the PPR measure is based on actual Wisconsin Medicaid utilization; its exclusions for clinically complex conditions such as neonatal births and certain malignancies make it more relevant and actionable for Wisconsin Medicaid HMOs and providers. The CMS measure is aligned with Medicare utilization data.

##### c. Baseline for 2020:

MY2018 HMO-specific ABR performance results will be used to establish the baselines for MY2020, reflecting each HMO's actual # of PPRs as a ratio of its expected # of PPRs:

- Baseline ABR = 1 means that in the baseline year, the HMO's PPR performance was the same as the state-wide average PPR performance;
- Baseline ABR < 1 means that in the baseline year, the HMO's PPR performance was below (i.e., better than) the state-wide average PPR performance;
- Baseline ABR > 1 means that in the baseline year, the HMO's PPR performance was above (i.e., worse than) the state-wide average PPR performance.

**d. Upside incentive**

For MY2020, HMOs will have an up-side incentive only, with no PPR-related penalties. The Department will set aside a pool of funds as up-side only incentive, to be distributed among HMOs that meet their targets for % reduction in their ABR, as value-based payments. HMOs that do not meet the target will not receive any PPR incentive funds.

There is no PPR withhold currently for HMOs. In future years the initiative may include an up-side (bonus) and down-side (penalties) arrangements, in alignment with the FFS PPR initiative for hospitals.

Note: **Per 42 CFR 438.6(b)(2)**, "...Contracts with incentive arrangements may not provide for payment in excess of 105 percent of the approved capitation payments attributable to the enrollees or services covered by the incentive arrangement, since such total payments will not be considered to be actuarially sound...". The 105% limitation will be applicable cumulatively across various incentives such as P4P and PPRs.

**e. Departmental guidance to HMOs:**

- The Department expects HMOs to identify how best to work with their providers. The Department would like to see HMOs develop their plans to reduce PPRs jointly with their providers; HMOs may also choose to collaborate with other HMOs to identify joint focus areas to reduce PPRs with common providers.
- Throughout the state, no health plan holds a majority (over 50%) of the state Medicaid market share. The Department believes this incents larger HMOs to work with smaller HMOs so that together, the relative market share encompasses a greater share of the population for plans pursuing statewide approaches.

**f. Methodology for targets and incentives:**

Each HMO will be eligible to earn a pro-rated share of the incentive pool based on two factors - its relative share of the total qualifying admissions in the baseline year, and its % reduction in ABR. The Department will publish the # of qualifying admissions in the baseline year for each HMO.

The Department has established three tiers of HMOs, based on their baseline ABRs:

- Tier 1 = High performance HMOs, with baseline ABR  $\leq 0.95$ ;
- Tier 2 = Middle performance HMOs, with baseline ABR  $\geq 0.96$  but  $\leq 1.05$ ;
- Tier 3 = Low performance HMOs, with baseline ABR  $\geq 1.06$ .

The Tiers above also create confidence intervals for the methodology.

**HMOs with low ABR ( $\leq 0.85$ ):**

The Department recognizes that HMOs which already have low ABRs might face a limited ability to improve their performance year over year. Therefore, if an HMO’s ABR is  $\leq 0.85$  in both, the baseline year and the Measurement Year, the Department will deem that HMO eligible to participate in the incentive even if it does not show any % improvement in PPR in the MY over the baseline year. Such an HMO will be eligible for 100% of its potential incentive share. There will be no graduated scale for this adjustment.

All HMOs are expected to improve their PPR performance over time, as reflected in the reduction in their ABR in the MY compared to their baseline year. However, in recognition of a potentially different starting point for each HMO, each tier will have different targets for earning the Potential Incentive Share, as shown in the table below:

**Table: PPR Reduction Targets**

Proportion of Potential Incentive Share that is earned by the HMO	Baseline Tier (based on ABR)		
	<i>Tier 1 - High performance HMOs</i>	<i>Tier 2 - Middle performance HMOs</i>	<i>Tier 3 - Low performance HMOs</i>
<b>1.00</b>	5% or more	7% or more	10% or more
<b>0.75</b>	3% to 4.9%	4% to 6.9%	7% to 9.9%
<b>0.50</b>	1% to 2.9%	2% to 3.9%	4% to 6.9%
<b>0.25</b>	0.25% to 0.9%	0.5% to 1.9%	1.5% to 3.9%

Interpreting the “PPR Reduction Targets” table:

- First, identify the tier in which an HMO was placed, based on its baseline year ABR.
- Next, calculate the % reduction in ABR and find the cell (in white, in the table above) that corresponds to that % reduction.

For example, the relevant cell for a Tier 1 HMO with a 6% reduction in ABR is the top left cell (in white) in the above table, which reads “5% or more”.

- Next, identify the proportion of the Potential Incentive Share that is earned by the HMO based on its % reduction in ABR, by looking left in the first column.

Example: A Tier 1 HMO with a 6% reduction in ABR would earn its full potential incentive share (earned proportion = 1.00, or 100%).

Alternatively, if that HMO reduced its ABR by, e.g., 3.5% instead of 6%, it would earn 0.75 proportion (=75%) of its potential incentive share; if that HMO reduced its ABR by, e.g., 0.7%, it would earn 0.25 proportion (=25%) of its potential incentive share.

**Illustrative example - HMO PPR methodology (hypothetical data)**

- Assume there are 5 HMOs as shown in Column 1 of the table below, each with the total number of qualifying admissions in the baseline year shown in Column 2.

HMO PPR - HYPOTHETICAL EXAMPLE									
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8	Col. 9	Col. 10
HMO	Qualifying admissions in Baseline Year	Share of qualifying admissions	Potential Incentive share	Baseline ABR	Tier in baseline year	MY ABR	% reduction from baseline	Potential Incentive earned	\$ Incentive earned
A	40,000	25.3%	\$1,265,823	1.090	Low	0.940	13.76%	100%	\$ 1,265,823
B	20,000	12.7%	\$632,911	1.030	Middle	0.980	4.85%	75%	\$ 474,684
C	50,000	31.6%	\$1,582,278	1.040	Middle	1.070	-2.88%	0%	\$ -
D	15,000	9.5%	\$474,684	0.940	High	0.920	2.13%	50%	\$ 237,342
E	33,000	20.9%	\$1,044,304	0.840	High	0.850	-1.19%	100%	\$ 1,044,304
<b>State-wide</b>	<b>158,000</b>	<b>100.00%</b>	<b>\$5,000,000</b>	<b>1.000</b>			<b>3.14%</b>	<b>60%</b>	<b>\$ 3,022,152</b>

- Column 3 shows the relative share of each HMO in the total qualifying admissions in the baseline year. E.g., HMO A has 40,000 / 215,000 = 18.6% share.
- Assume the Department sets aside \$5 million as the total incentive pool (shown in the last row for Col. 4). Column 4 shows the potential share of the incentive pool each HMO could earn, based on its share of qualifying admissions. For example, HMO A could earn up to 32.6% of \$5 million = \$1,627,907.
- Hypothetical baseline ABR for each of the 5 HMOs are shown in Column 5.
- Column 6 shows the tier in which each HMO is placed, based on its baseline ABR.
- Column 7 shows the ABR achieved in the Measurement Year (MY).
- Column 8 shows each HMO’s % ABR reduction = (Column 5 – Column 7) / Column 5.
- Column 9 shows the % of the Potential Incentive earned, based on the “PPR Reduction Targets” table, discussed above.  
For example, HMO A earned 100% of its Potential Incentive \$, while HMO D earned 50% of its Potential Incentive. HMO E earned 100% of its potential share because its ABR was <= 0.85 for both, the baseline year and the MY, regardless of its reduction in ABR.
- Column 10 shows the \$ value of incentive earned (= Column 9 \* Column 4).

For the next cycle, the MY ABR (Column 7) would become the baseline for the HMO, so that HMOs could move across tiers. In the above example, HMO A started in the Low tier (ABR = 1.09) in the baseline year, but would be classified in the High tier (ABR = 0.95) in the next cycle.

Any PPR incentive payments for MY2020 will occur in 2021, after data for the full MY are available and have been analyzed.

**g. Sharing the incentives with Providers:**

- HMOs may keep up to 15% of PPR incentive earned for their administrative expenses. The remaining incentives must be shared with their providers, including hospital and non-hospital providers.  
HMOs are welcome to discuss with the Department their specific ideas re: gain sharing with their providers.



- HMOs will have flexibility in negotiating how they share incentive dollars with their providers. The Department believes that the HMOs’ interest in ensuring a hospital is not penalized by one HMO while being rewarded by another, would encourage HMOs to coordinate and collaborate in their approach for designing the incentive program for hospitals.
- HMOs may set up their own staff teams (clinical and non-clinical) to work on PPR reduction, and such related expenses will be counted as “provider sharing” for MY2020, provided the HMOs can demonstrate that infrastructure spending on such internal teams is directly related to and relevant for PPR reductions. Examples of such activities include discharge planning, medication reconciliation on discharge, follow-up in out-patient settings following discharge, home visits, etc. HMOs can count the actual hours (and related dollars) worked by their internal teams on PPR reduction, as provider sharing for MY2020. HMOs will be required to maintain adequate supporting documentation for such time and dollars, and share it with the Department if requested. HMOs will be asked to attest to the accuracy of such dollars. HMOs are welcome to discuss their plans for establishing internal teams with the Department.

**h. Data reports:**

HMOs will receive quarterly PDF summary reports for the HMO and associated hospitals, a list of members with PPRs, and a data dashboard for their members for their providers; HMOs will not receive data for patients not enrolled in that HMO.

HMOs will receive a summary PPR report comparing their performance to other plans, a list of recipients with one or more PPR within their claims dataset and one PDF per hospital in the claims dataset that had a PPR attributed to the plan. 3M licensing contract prohibits the Department from sharing grouped PPR claims with plans. PPR software can be purchased from 3M using default settings, grouper version 32.

The Department intends to share three types of PPR reports with HMOs, to balance the timeliness and completeness of such reports (also see the table below):

1. **Working data reports:** HMOs will receive “working data” reports about 6 weeks after the end of a measurement period (e.g., a quarter). Working data reports are meant to provide recent information to HMOs, while recognizing that such reports will have incomplete data because not enough “claims run-out” time would have passed since the end of the measurement period.
2. **Preliminary annual reports:** HMOs will receive “preliminary” annual reports about 4.5 months after the end of the measurement year. These reports will have most of the full measurement year’s data, though there might be minor additions before the final annual reports are issued.
3. **Final annual reports:** HMOs will receive the “final” annual reports about 7.5 months after the end of the MY. HMOs will have the opportunity to provide feedback to the Department between receiving the preliminary annual reports and the final annual

reports. Any PPR-related incentives will be calculated based on the final annual reports.

<b>Table: Schedule of PPR reports for HMOs</b>			
<b>Measurement period</b>	<b>Working data available on:</b>	<b>Preliminary annual report available on:</b>	<b>Final annual report available on:</b>
<b>2019</b>			
1/1 – 3/31	5/15/2019	5/15/2019 (data for MY2018)	N/A
4/1 – 6/30	8/15/2019	N/A	N/A
7/1 – 9/30	11/15/2019	N/A	N/A
10/1 – 12/31	2/15/2020	N/A	N/A
<b>2020</b>			
1/1 – 3/31	5/15/2020	5/15/2020 (data for MY2019)	N/A
4/1 – 6/30	8/15/2020	N/A	N/A
7/1 – 9/30	11/15/2020	N/A	8/15/2020 (data for MY2019)
10/1 – 12/31	2/15/2021	N/A	N/A

## V. SSI Care Management

The Department will employ the following mechanisms for monitoring its SSI Care Management initiative.

- Utilization analysis of specific care management services (**G codes and modifiers related to needs assessment tiers**);
- **Qualitative External Quality Review Organization (EQRO) Review** of SSI Care Management Process Quality.

Each of the above are described in further detail, below.

### G Codes & Modifiers

The SSI Care Management Billing Guide is available on the ForwardHealth Portal at:

[https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement\\_and\\_Capitation/Home.htm.spage#ssicmbg](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Reimbursement_and_Capitation/Home.htm.spage#ssicmbg)

The Department will calculate the following data points and measures using G Codes and appropriate Modifiers (TG, TF and none):

1. Care Planning (CP1) = % of new members had a care plan within 90 days of enrollment
2. Needs Stratification (NS1) = % of members enrolled each month assigned to WICT
3. Needs Stratification (NS2) = % of members enrolled over the year assigned to WICT
4. Needs Stratification (NS3) = average # of months a member assigned to WICT
5. Needs Stratification (NS4) = % of members enrolled each month assigned to Medium stratum
6. Needs Stratification (NS5) = % of members enrolled over the year assigned to Medium stratum
7. Needs Stratification (NS6) = % of members enrolled each month assigned to Low stratum (=combining all strata below Medium)
8. Needs Stratification (NS7) = % of members enrolled over the year assigned to Low stratum (=combining all strata below Medium)
9. Transition Care (TC1) = % of discharges who received transition care follow-up
10. Transition Care (TC2) = % of discharges who received transition care follow-up within 5 days

Step	Data Reporting Description
<p><b>Care Planning</b></p>	<p><b><u>New members</u></b>  <i>(enrolled after 1/1/2020; not enrolled in the same HMO for the past 6 months or longer):</i></p> <p><b>(CP1): % of new members with care plans within 90 days of enrollment</b>            = # of new members with care plans within 90 days of enrollment / # of new members with 90+ days of continuous enrollment  <b>Calculated quarterly</b> by DMS/DXC using code G9001</p> <p><b><u>Annual Target = 75% of new members should have care plan within 90 days</u></b></p> <p>Also track timeliness of care planning, from date of enrollment; Calculated quarterly by DMS/DXC using code G9001; Histograms for 90 days, 120 days, 150 days and beyond.</p>
<p><b>Needs Stratification</b></p>	<p>Use Care Management (G) codes 9002, 9006, 9007 or 9012;  <b>Calculated by month</b> by DMS/DXC after data submission deadline:</p> <p><b><u>WICT (up to 5% of SSI membership)</u></b>  <i>Data point 1: # of unique members each month with any <u>G code + TG modifier</u> (= WICT stratum)</i></p> <p><b>(NS1): % enrollment in WICT for each month</b>            = Data point 1 / total # of members enrolled for that month            (Assumption: each member in WICT receives at least one WICT related service each month)</p> <p><b>(NS2): Average % enrollment in WICT over last 12 months</b>            = Sum of Data point 1 over last 12 months / # of total member months over last 12 months</p> <p><b>(NS3): Average # of months in WICT over last 12 months</b>            = Sum of # of months each unique member had a WICT code over 12 months / # of unique members with WICT services at any time over last 12 months  <i>Create a histogram for NS3 (# of months and corresponding # of members)</i></p> <p><b><u>Medium stratum (next highest after WICT)</u></b>  <i>Data point 2: # of unique members each month with any <u>G code + TF modifier</u> (= Medium stratum). There is no payment difference between TF modifier and no modifier.</i></p> <p><b>(NS4): % enrollment in Medium stratum for each month</b>            = Data point 2 / total # of members enrolled for that month</p> <p><b>(NS5): Average % enrollment in Medium stratum over last 12 months</b>            = Sum of Data point 2 over last 12 months / total # of member months over last 12 months</p>

Step	Data Reporting Description
	<p><b><u>Lower stratum (all combined after Medium)</u></b>  <i>Data point 3: # of unique members each month with any G code + no modifier (= all combined Lower stratum). There is no payment difference between TF modifier and no modifier.</i></p> <p><b>(NS6): % enrollment in Lower stratum for each month</b>                      = Data point 3 / total # of members enrolled for that month</p> <p><b>(NS7): Average % enrollment in Medium stratum over last 12 months</b>                      = Sum of Data point 3 over last 12 months / total # of member months over last 12 months</p>
<p><b>Transition Care</b></p>	<p><b>Calculation annually</b> by DMS / DXC</p> <p><i>Data point 4: Total # of discharges from inpatient stay during the reporting period (from DXC)</i>  <i>Data point 5: Total # of discharges during the reporting period with an associated follow-up Transition of Care encounter measures by the presence of procedure code G9012 or in its absence, G9001; respective # of days between discharge and follow-up</i>  <i>Create a frequency distribution / histogram for data point 5 (# of days for follow-up)</i></p> <p><b>(TC1): % of all discharges from inpatient stay with a follow-up Transition Care service</b>                      = Sum of Data point 5 / Data point 4</p> <p><b>(TC2): Timeliness of Transition Care (within 5 days of discharge)</b>                      = % of all discharges from inpatient stay with a follow-up Transition Care service within 5 days of discharge                      = Data point 5 within 5 days / Data point 4</p>

## Qualitative EQRO Review of SSI Care Management Process Quality

**Overview:** For its review, the EQRO will use MMIS data to create samples for each HMO to identify members in WICT (Wisconsin Interdisciplinary Care Team), medium, and low strata. The focus of the EQRO SSI Care Management Review process is to ensure HMO compliance with the SSI Care Management requirements defined in the BC+ and Medicaid SSI HMO Contract.

EQRO Review	EQRO frequency
<p><b>Care Plan Development</b> - EQRO will create a sample per HMO of members with the G9001 code in the CY and request care management records for the members in the sample. EQRO will focus on assessing whether or not HMOs are complying with the Care Plan development requirements in the 2020 BC+ and SSI HMO Contract.</p>	
<ul style="list-style-type: none"> <li>a. Is the Care Plan developed based on a screening conducted within 60 days of the member’s enrollment in the HMO?</li> <li>b. Is the Care Plan an evidence-based plan of care that:                             <ul style="list-style-type: none"> <li>• Identifies the member’s needs including:                                     <ul style="list-style-type: none"> <li>i. Formal and informal supports</li> <li>ii. Chronic conditions and acute illnesses</li> <li>iii. Mental and behavioral health conditions</li> <li>iv. Dental care needs</li> <li>v. Medications taken by the member; any concerns with member’s understanding and use of medications</li> <li>vi. Additional supports needed to conduct activities of daily living or instrumental activities of daily living</li> <li>vii. Social determinants of health (Yes/No).</li> </ul> </li> <li>• Defines specific goals that the member wants to achieve and that are appropriate to address his/her needs (Yes/No).</li> <li>• Evidence that HMO has a system to prioritize member’s goals appropriately, based on urgency, member’s engagement and the ability to lead to positive outcomes and impact for the member (Yes/No).</li> <li>• Describes the interventions that will be implemented to address the member’s needs and their sequence (Yes/No).</li> </ul> </li> </ul>	<p>Annual</p>
<p><b>WICT</b> – EQRO will pull a sample per HMO of members with TG modifier from codes G9002, G9006, G9007 and G9012 billed during the CY. To answer the questions below, the EQRO will request the HMO’s WICT policies and procedures, care management records for the member’s in the sample, and WICT meeting minutes. EQRO will focus on assessing whether or not HMOs are complying with the Care Plan development requirements in the 2020 BC+ and SSI HMO Contract.</p>	

EQRO Review	EQRO frequency
<p>a. Well-functioning WICT - Is there evidence of a well-functioning interdisciplinary team:</p> <ul style="list-style-type: none"> <li>• With at least 2 health care professionals with access to expertise across multiple areas (MD, pharmacist, BH, social work, social determinants of health etc.)? (Yes/No)</li> <li>• With a WICT Core Team that meets weekly to discuss their entire shared case load? (Yes/No)</li> <li>• With a WICT Core Team that coordinates regularly with the member’s PCP, medical specialists, behavioral health specialists, dental providers, and other community resources as driven by the member’s care plan? (Yes/No)</li> </ul>	Annual
<p>b. Face-to-face requirement – Is there evidence in the member’s Care Plan that the WICT Core Team (a licensed healthcare professional or other WICT team member meeting weekly and sharing a caseload) or the member’s community-based care manager, that is also a WICT team member (e.g., community health worker), meet at least once a month face-to-face with the member to discuss a need identified in his/her care plan? (Yes/No)</p> <p><i>Note: A WICT member’s face-to-face meeting with their community based case manager (e.g., Comprehensive Community Services or Community Support Programs case manager) may meet the face-to-face requirement if the community based case manager has a close, collaborative relationship with the WICT Core Team that is demonstrated in the member’s care plan and includes reciprocal communication between the WICT Core Team and the community based case manager.</i></p> <p><i>The face-to-face visit must be documented as a care coordination and monitoring activity in the member’s care plan to be deemed as met.</i></p> <p><i>The EQRO will look for evidence in the member’s care plan and care management notes.</i></p> <p><i>The EQRO will also describe who within the WICT is conducting the meetings and the meeting location (i.e., meeting at the member’s home or meeting the member elsewhere).</i></p>	Annual
<p>c. Graduation –</p> <ul style="list-style-type: none"> <li>• Does the member’s Care Plan clearly identify the criteria for the member to graduate from the WICT? (Yes/No)</li> <li>• Is there evidence of the WICT being a short-term (i.e., less than 12 months) intensive intervention? (Yes/No)</li> <li>• Once the member is ready to graduate from the WICT, is there evidence that the WICT is coordinating the transition of members to a lower intensity of care management? (Yes/No)</li> </ul>	Annual
<p><b>Care Management Service Delivery – EQRO will create a sample per HMO of members with the G9001 and G9002 codes billed during the CY which will be stratified by low,</b></p>	

EQRO Review	EQRO frequency
<i>medium, high using the TG and TF modifiers. EQRO will look for evidence in the care management records of member's in the sample to address the questions below.</i>	
a. Compliance with the Care Plan - Are services, including any planned follow-ups with members, delivered according to the Care Plan?	Annual
i. Member-centric Care <ul style="list-style-type: none"> <li>○ When implementing the Care Plan, does the HMO regularly assess the member's readiness to change and their level of engagement in meeting their Care Plan goals? (Yes/No)</li> <li>○ As part of Care Plan implementation, is there evidence that the HMO is adhering to its own policies and procedures regarding frequency of contact with members per strata?</li> <li>○ Is there evidence that the HMO is asking members if their needs are being addressed? (Yes/No)</li> </ul>	Annual
ii. Social Determinants (SD): <ul style="list-style-type: none"> <li>○ Is follow-up on SD documented in the Care Plan? (Yes/No)</li> <li>○ Did the HMO go beyond simple referrals and beyond sharing phone numbers for community resources with the member? (Yes/No)</li> </ul> <i>EQRO will describe HMO efforts to address social determinants including how they are working collaboratively with community resources or utilizing Community Health Workers.</i>	Annual
iii. Behavioral Health <ul style="list-style-type: none"> <li>○ Does the HMO follow-up to address the member's behavioral health needs identified in the Care Plan? (Yes/No)</li> </ul>	Annual
<b>Care Plan Review &amp; Update</b> – <i>EQRO will create a sample per HMO of members with G9001 and G9002 codes billed during the CY. The EQRO will also review the HMO's care management policies and procedures as well as the member's care management records to assess compliance with the review and updates to the Care Plan requirements defined in the current BC+ and SSI HMO Contract.</i>	
a. Is the HMO reviewing and updating the Care Plan based on the criteria defined in the 2020 BC+ and SSI HMO Contract? <ul style="list-style-type: none"> <li>● At least once per calendar year (Yes/No)</li> <li>● According to the HMO's policies and procedures for reviewing Care Plans and re-stratifying members (Yes/No)</li> <li>● Whenever the member is not responsive to the Care Plan or whenever the member frequently transitions between care settings (Yes/No)</li> </ul>	Annual
b. Does the HMO re-stratify members after critical events, as appropriate? (Yes/No)	Annual



EQRO Review	EQRO frequency
<p><b>Discharge Follow-up / Transitional Care</b> – EQRO will create a sample per HMO of SSI members with G9012 code billed during the CY and review their care management records to determine compliance with the transitional care contract requirements.</p>	
<p>a. Did the HMO’s transitional care follow-up meet the transitional care requirements in the 2020 BC+ and SSI HMO Contract?</p> <ul style="list-style-type: none"> <li>• How was the HMO notified of the member’s hospital admission?</li> <li>• Was the follow-up in-person, via interactive video, or over the phone?</li> <li>• Is there evidence that the transitional care follow-up included: <ul style="list-style-type: none"> <li>i. Medication reconciliation, documented in the member’s care management notes, conducted either by the hospital or the HMO.</li> <li>ii. A review with members of (a) the discharge information prepared by the hospital and (b) the member’s medications and their medication schedule.</li> </ul> </li> <li>• Did the HMO assist members with scheduling appointments with other health care providers after discharge? (Yes/No)</li> </ul> <p><i>The EQRO will describe if the HMO is receiving real-time notifications about the member’s hospital admission and if the HMO is using WISHIN or EPIC Care Everywhere for transitional care. The EQRO will also describe how the HMO is conducting the follow-up and assess whether the HMO is helping members scheduling follow-up appointments, understand their medication schedule and their treatment plan.</i></p>	<p>Annual</p>

**Additional note:**

- MetaStar recommends that HMOs document events such as mailing care plans, completing medication reconciliation, and conducting follow-up activities in their systems. Without documentation, MetaStar will be unable to confirm that such activities took place.
- MetaStar also recommends that in addition to reviewing a medication list with the member, HMO’s medication reconciliation should include the following: review of pre and post discharge medications and dosages, confirmation of absence of duplication of medications, confirmation of absence of drug interactions / contraindications, and correctness of all continued, discontinued and new medications and dosages.

## VI. Health Disparities Reduction (PIP-like)

In order to comply with Health Disparities Reduction requirement per the Managed Care Rule (42 CFR 438.340 (b)), DMS will employ a phased approach.

### **Purpose**

This document provides guidance on the **PIP-like** proposal on Health Disparities for **BC+ HMOs**. Reducing health disparities is a key component of the CMS Medicaid and CHIP Managed Care Rule and the WI Division of Medicaid Services (DMS) Quality Roadmap.

Each HMO is required to submit two PIP (performance improvement project) proposals each year to DMS, and work with DMS' EQRO (MetaStar) to meet specific proposal requirements defined by CMS.

This document addresses one of the two PIPs that each HMO is required to pursue. It provides background and requirements related to **PIP-like** initiative for health disparities reduction. Though the PIP-like initiative has less stringent formal validation requirements as compared to a full PIP, it still requires HMOs to complete all required interventions.

HMOs must work directly with DMS' EQRO (MetaStar) to develop and submit the proposals for their other PIP.

#### **There are 2 Sections in this document:**

- **Section 1: Overview** of the MY2020 Health Disparities Reduction PIP-like
- **Section 2: Template** HMOs must use for submitting their MY2020 Health Disparities Reduction PIP-like proposal to MetaStar and DMS by **January 10, 2020**.

## Section 1: Overview of the MY2020 Health Disparities Reduction PIP-like

### **Background**

Health disparities are documented in numerous areas:

#### 1. Managed Care Rule

42 CFR 438.340 (b): **Elements of the State quality strategy**, requires that:

At a minimum, the State's quality strategy must include the following: (6) The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability.

#### 2. Wisconsin data confirming some of the highest health disparities related to births in the nation:

<https://www.cdc.gov/nchs/data/databriefs/db295.pdf>.

3. Wisconsin DMS has multiple initiatives focused on health disparities. Examples include the OB Medical Home, Prenatal Care Coordination (PNCC), Maternal and Child Health (MCH, Title V), Home Visiting, WIC coordination, [Healthy Wisconsin five-year plan](#), among others.
4. The 2019 and 2020 HMO contracts require HMOs to conduct a cultural-competence self-assessment of their organization at all levels, including the providers and staff who directly contact and/or serve their members. DMS will continue emphasizing cultural competence and reducing health disparities.

### ***Principles for PIP-like design***

1. As a means of reducing health disparities, the MY2020 health disparities reduction PIP-like aims to improve cultural competence at the HMO-level and at the level of individual provider clinics.
2. DMS has aligned the MY2020 PIP-like topic with its larger Quality program focus on reducing disparities in women's and children's health, as seen in pre-natal and post-partum care, immunizations, preventive screenings, etc.
3. Over time, DMS plans to include a judicious balance of process and outcome measures as input to and evaluation of PIP-like initiatives.
4. Over time, health disparities reductions will be addressed through full PIPs (and not PIP-like) that meet CMS requirements (e.g., annual proposals) and continue over multiple years in order to meaningfully impact complex issues.
5. M2020 PIP-like is aligned with the MY2020 P4P initiative which requires HMOs to perform at a high level of post-partum care.

### **The initial priority is to reduce disparities in post-partum care for Wisconsin BadgerCare Plus members while improving overall post-partum care rates.**

- **MY2017** state-wide Medicaid HMO average for post-partum care (part of HEDIS measure PPC) was 67.3%, below the 2017 national 75<sup>th</sup> percentile (69.3%).
- **MY2018** state-wide average for post-partum care was 65.5%, below the 2018 national 75<sup>th</sup> percentile (69.8%).

As a result, approximately 1 out of 3 **WI Medicaid members** eligible to receive post-partum care did not receive the requisite care.

### ***Design elements:***

1. MY2020 PIP-like **metric:** Overall rate of **post-partum care (HEDIS)** for each HMO.
2. Each HMO will be required to undertake initiatives at its **own organizational level and** also at **one provider location (clinic)** that serves a significant number (50 or more preferred) of its under-represented Medicaid pregnant women, including migrants, refugees, and others.
  - a. Multiple HMOs may not choose the same provider clinic.
  - b. DMS recommends not choosing an **FQHC** for this PIP-like, since many FQHCs have already begun work on disparity reduction initiatives.
  - c. However, if an HMO is unable to find a suitable non-FQHC clinic, it should discuss its other alternatives, potentially including an FQHC, with the **DMS Quality team**.

3. DMS will continue to emphasize disparity reduction initiatives over **multiple years**, though each year will require HMOs to submit a new PIP proposal in accordance with CMS requirements.
4. DMS will designate **1%** from the 2.5% HMO quality withhold to PIP-like for reducing disparities in post-partum care. Earning back this 1% withhold for the PIP-like is not dependent on an HMO's overall HEDIS post-partum care rate, which will be addressed through the P4P initiative.
5. The 1% PIP-like withhold does not apply to the CLA population.

### **Requirements:**

Each MY2020 HMO PIP-like proposal must address the "MY2020 PIP-like Requirements" shown in the **PIP-like Template** (in Section 2 of this document):

- a. **All** components (#1 - #4) of **Part A**, HMO-level cultural competence plan which goes beyond just post-partum care (0.5% withhold)
- b. **All** components (#5 - #7) of **Part B**, Provider clinic-level cultural competence initiatives focused on post-partum care (0.5% withhold)

DMS has developed a **PIP-like proposal template** (*in Section 2 of this document*) for HMOs. HMOs will need to identify the following items in the proposal template and return to MetaStar and DMS by **January 10, 2020**:

1. Their baseline (MY2018) overall post-partum care rate using HEDIS PPC measure;
2. The overall PPC (post-partum care) goal HMOs want to achieve for their PIP-like initiative by the end of MY2020;
3. Brief description of how the PPC rate and effectiveness of interventions will be monitored throughout the year;
4. A brief description of the planned data collection process (what data will be collected, by whom, and how often) as well as a summary of the prospective data analysis plan.

### **Earn-back:**

**HMOs will earn back their withhold by completing the listed requirements and submitting appropriate documents / reports by due dates listed in the PIP-like Template (Section 2 of this document).**

While Parts A and B discussed in Section 2 below are connected, HMOs are expected to pursue them simultaneously, and not wait for one part to be completed before starting the other.

HMOs may collaborate and share resources in completing the earn-back requirements. For example, they could use similar self-assessment tools, work with the same external cultural competency advisors, and participate and share joint learnings / ideas in the Learning Collaborative.

***Additional notes:***

1. Definition of “under-represented”: In MY2020, HMOs can define “under-represented” in the manner that works best for them, based on their current data availability. For example, HMOs could begin with an analysis of “white” vs. “non-white” members. As more granular data become available, HMOs and DMS will collaborate to finetune this definitions. Managed Care rule specifies 6 disparity factors – race, ethnicity, age, gender, language and disability status. Since income plays a key role in Medicaid eligibility, the Department would prefer not to use income as a Medicaid disparity factor at this time. Therefore, low income Caucasian Medicaid members should not be counted as “under-represented” for this requirement.
2. Disparities between under-represented and non-under-represented members will be calculated at the overall HMO level only, and not at the provider clinic level.
3. If multiple HMOs choose the same provider clinic for Part B of the 2020 PIP-like, DMS will collaborate with them to resolve the overlap.
4. HMOs can meet PIP-like requirements #3 and #7 for MY2020 by working with employee and/or non-employee providers of non-traditional culturally-competent maternity services.
5. Learning Collaborative will include discussion of qualifications, proven benefits, etc. of non-traditional maternity services and their providers not covered by Medicaid.

In the Attachment below, DMS has provided Cultural Competence references that the HMOs could use for their PIP-like initiative.

## **ATTACHMENT: Cultural Competence Resources**

### **Cultural Competence Plans**

- 2019 – Sunshine Health, Florida  
<https://www.sunshinehealth.com/content/dam/centene/Sunshine/pdfs/SUN201806SA18CCP.AA.pdf>
- 2015 – PHC, Florida <http://positivehealthcare.net/wp-content/uploads/2014/06/2015-PHC-FL-CLAS-Program-Description.pdf>
- 2013 - Alliance Behavioral Healthcare, North Carolina  
<https://www.alliancebhc.org/wp-content/uploads/Alliance-Cultural-Competency-Plan.pdf>

### **Department of Health and Human Services**

- <https://thinkculturalhealth.hhs.gov>
- CLAS standards: <https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53>
- Video-based CLAS training resources: <https://thinkculturalhealth.hhs.gov/resources/videos>
- <https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol>
- SAMHSA [https://www.samhsa.gov/sites/default/files/programs\\_campaigns/samhsa\\_hrsa/cultural-competence-self-assessment.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/cultural-competence-self-assessment.pdf)
- HRSA <https://www.hrsa.gov/sites/default/files/culturalcompetence/healthdlvr.pdf>

### **Georgetown University**

- Health Policy Institute <https://hpi.georgetown.edu/cultural/>
- Self-assessment focused on family organizations concerned with children and youth with behavioral-emotional disorders, special health care needs, and disabilities:  
[https://nccc.georgetown.edu/documents/FIMR\\_Assessment.pdf](https://nccc.georgetown.edu/documents/FIMR_Assessment.pdf)
- Cultural and Linguistic Competence Organizational Assessment Instrument for Fetal and Infant Mortality Review Programs [https://nccc.georgetown.edu/documents/FIMR\\_Assessment.pdf](https://nccc.georgetown.edu/documents/FIMR_Assessment.pdf)

### **MCH (maternal and child health)**

- Cultural competence self-assessment for individual providers:  
[https://www.mchnavigator.org/assessment/v4/competency\\_07.php](https://www.mchnavigator.org/assessment/v4/competency_07.php)

### **American Hospital Association**

- Cultural competence self-assessment for individual providers:  
[http://www.hpoe.org/Reports-HPOE/becoming\\_culturally\\_competent\\_health\\_care\\_organization.PDF](http://www.hpoe.org/Reports-HPOE/becoming_culturally_competent_health_care_organization.PDF)

### **Culture Care Connections**

- <http://www.culturecareconnection.org/navigating/assessment.html>

### **Other**

- Background on cultural competence  
<https://www.magellanprovider.com/media/11875/intro.pdf>
- Cultural Competence awareness and importance  
<https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol>

## Section 2: MY2020 Health Disparities Reduction PIP-like Proposal Template

Reference: EQR Protocol 3, Version 2.0  
 Validating Performance Improvement Projects (PIPs):  
 A Mandatory Protocol for External Quality Reviewers (EQR)

<b>Organization:</b>		<b>Report Prepared by:</b>	
<b>Project Title:</b>			
<b>Date Project Initiated:</b>		<b>Date of DMS Approval:</b>	<b>Date Report Submitted:</b>
<b>Project Team:</b>	<b>Names</b>	<b>Title/Department</b>	

**Directions:** HMOs will fill in the following areas in this template (Section 2) and return to MetaStar and DMS by **January 10, 2020**.

1. Their baseline (MY2018) overall post-partum care rate using HEDIS PPC measure;
2. The overall PPC (post-partum care) goal HMOs want to achieve for their PIP-like initiative by the end of MY2020;
3. Brief description of how the PPC rate and effectiveness of interventions\* will be monitored throughout the year;
4. A brief description of the planned data collection process (what data will be collected, by whom, and how often) as well as a summary of the prospective data analysis plan.

\*Technical Assistance will be available to HMOs from DMS and MetaStar on this PIP-like during 2020. Please contact [SusanR.Seibert@dhs.wisconsin.gov](mailto:SusanR.Seibert@dhs.wisconsin.gov) for any questions.

### Study Topic – Reduction in Health Disparities

Reduction in health disparities is one of the key components of DMS’ Quality Roadmap, and of the Managed Care Rule Requirements. Wisconsin has one of the highest health disparities related to births in the nation. According to the CDC data for births 2013-2015, Wisconsin’s overall infant mortality rate was slightly above the national average (5.92 per 1,000 live births). However, Wisconsin also has the highest state mortality rate for infants of non-Hispanic black women at 14.28 per 1,000 live births; 1.7 times as high as the lowest rate of 8.27 in Massachusetts.

Wisconsin DMS has multiple initiatives focused on health disparities, including, e.g., OB Medical Home, PNCC, Maternal and Child Health (MCH, Title V), Home Visiting, alignment with WIC, and Healthy Wisconsin five-year plan, among others. DMS has aligned the MY 2020 PIP-like topic with the larger

quality program’s focus on reducing disparities in women’s and children’s health, by focusing on Post-Partum Care (PPC) for under-represented BadgerCarePlus Members.

This is a multi-year topic, with the MY2020 PIP-like focusing on improving cultural competence at the HMO-level and at the level of individual provider clinics, as a means of reducing health disparities. “Cultural competence is widely seen as a foundational pillar for reducing disparities through culturally sensitive and unbiased quality care.” <https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol>

Post-Partum Care (a component of HEDIS PPC) is a DMS pay for performance (P4P) measure and it is also the metric for this PIP-like. Post-Partum Care (PPC) is a Healthcare Effectiveness Data and Information Set (HEDIS®)<sup>3</sup> measure already collected by the HMOs and reported annually to DMS.

DMS has identified PPC as a priority topic since a high percentage of BC+ recipients are women and children. Additionally, almost half of the births in Wisconsin occur to Medicaid recipients.

**1. Directions: Below, insert HMO’s MY2018 PPC (post-partum care) Rate**

(Insert HMO Name) [redacted] PPC rate for MY2018 was (insert 2018 PPC rate) [redacted], which is {choose one: Higher, Equal to, or Lower} than the MY2018 state average of 65.5%. The 2018 national Medicaid 75<sup>th</sup> percentile for this measure was 69.8%.

**2. Directions: Below, insert HMO targeted goal for post-partum care**

**Study Question/Project Aim**

(Insert HMO name) [redacted] will improve overall post-partum care rates for Wisconsin BadgerCare Plus members from [redacted] in MY2018 to [redacted] in MY2020.

- 3. Directions: Below, briefly describe how the HMO plans to monitor the PPC rate and effectiveness of interventions during the year. This includes any other data and measurable indicators that the HMO plans to monitor to reach the PPC goal.**

**Study Indicators**

Overall project success will be measured by the MY2020 final HEDIS result for PPC, compared to the HMO’s baseline from MY2018.

[redacted]

**Study Population**

The study population includes all members meeting the HEDIS 2020 specifications denominator criteria.

**Sampling**

HMOs should use the **standard HEDIS specifications** for the PPC measure.

<sup>3</sup> “HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).”



**4. Directions: Below, briefly discuss, for PIP-like Requirements # 3, 4, 6 and 7 from the table:**

- Data sources (e.g., claims/administrative data, member files) the HMO plans to use;
- How data will be collected and by whom;
- How data will be stored and aggregated (e.g., registry, database); and
- How data will be analyzed and by whom;
- How frequently the data will be collected and analyzed.

Include examples of any existing data collection tools or instruments (e.g., surveys, system reports, any others) the HMO plans to use, as an attachment to this report. If no examples are available yet, briefly discuss any tools the HMO plans to use to collect the data.

<b>Data Collection</b>
------------------------



**Improvement Strategies (7) to be completed/operationalized during MY2020.**

- DMS will collaborate with HMOs to develop a reporting template in 2020.
- The final PIP-like report is due by HMOs to MetaStar and DMS by 7/1/2021.

MY2020 PIP-like Requirement	Deliverable (Earn-back criteria) for HMOs
<i>Part A: HMO-level cultural competence plan</i>	
<p>1. Complete <b>Cultural Competence Self-Assessment and Plan</b> at the <b>HMO/organization level</b>, and report results to DMS.</p> <p><i>Scope, content and format of the self-assessment report will be discussed by DMS and HMOs in 2020.</i></p> <p><i>HMOs may consider working with an external consultant for this assessment and to develop a plan based on the results.</i></p>	<p>A. Submit completed organization-level <b>self-assessment report</b> – tool used, dates, # of different staff / providers assessed, results broken out by type of staff (member-facing, administrative, executive, etc.). This assessment would cover the whole organization, and not be limited to post-partum care only.</p> <p>B. Use the organizational self-assessment results to develop and submit a <b>health disparities plan</b> identifying 2-3 focus areas the HMO plans to pursue, key related initiatives, timeline, etc. Two examples of focus areas are:</p> <p><b>Example:</b> Incorporate culture-specific attitudes and values into health promotion tools as they relate to post-partum health promotion. The HMO must submit description of active initiatives, including sources of subject matter expertise, intended populations, timing, number of staff engaged, expected results / outcomes, data sources, etc.</p> <p><b>Example:</b> Recruit and retain under-represented staff in member-facing positions at the HMO. The HMO must submit its recruitment and retention plan, and the # of under-represented staff employed, ratios of staff to patients served, etc.</p> <p><b>Resources:</b> <a href="https://nccc.georgetown.edu/assessments/">https://nccc.georgetown.edu/assessments/</a>. Also see “<b>Cultural Competence Resources</b>” in Section 1, above.</p>
<p>2. Participate in a <b>Learning Collaborative</b> to be convened by the Department - share experiences, develop the <b>PIP menu</b> (to be further discussed in 2020). The Collaborative will include other HMOs, DPH, DMS staff, NEMT, EQRO, other experts / stakeholders</p>	<p>Regular and active participation** in DMS quarterly collaborative meetings to develop the PIP menu and share lessons learned from engaging in various cultural competence and disparities reduction initiatives.</p> <p>**HMOs will be asked to provide quarterly progress updates on this PIP-like. HMOs will also have an opportunity at mid-year to discuss their PIP-like progress with MetaStar and receive relevant technical assistance.</p> <p><b>Example/potential PIP menu item:</b> Improve referrals to WIC program. HMOs will share ideas with DMS about how they would improve WIC referrals.</p>

MY2020 PIP-like Requirement	Deliverable (Earn-back criteria) for HMOs
<p>3. Offer <b>non-traditional culturally-competent maternity provider</b> services <b>across the HMO for Medicaid members</b> through, e.g.,:</p> <ul style="list-style-type: none"> <li>• Community health workers (CHW)</li> <li>• Traditional healers</li> <li>• Doula services</li> <li>• Peer support</li> </ul>	<p>While there are no specific targets for 2020, HMOs can get credit for this requirement by submitting to DMS <u>any one</u> of the following:</p> <ul style="list-style-type: none"> <li>• Documentation showing HMOs <u>continued</u> use in MY2020 of non-traditional culturally-competent maternity provider services for Medicaid members; Submit # of non-traditional providers deployed, their location, qualifications, type of member education and support provided, # of members assisted; or,</li> <li>• Documentation showing HMOs <u>started</u> using non-traditional culturally-competent maternity provider services for Medicaid members; Submit # of non-traditional providers deployed, their location, qualifications, type of member education and support provided, # of members assisted; or,</li> <li>• HMO's <u>plan to offer</u> non-traditional culturally-competent maternity provider services for Medicaid members in 2021.</li> </ul>
<p>4. Calculate <b>post-partum care disparities baselines</b>: Using the list of members in the denominator and numerator of the overall MY2020 HEDIS PPC (post-partum care) measure, and the members' race/ethnicity data provided by DMS, calculate:</p> <ul style="list-style-type: none"> <li>• The rate of post-partum care for the HMO's Medicaid non-under-represented sub-population, as identifiable;</li> <li>• The rate of post-partum care for the HMO's Medicaid under-represented sub-population, as identifiable.</li> </ul>	<p>Submit:</p> <ol style="list-style-type: none"> <li>A. The <b>overall MY2020 HEDIS PPC</b> (post-partum care) rate for Medicaid members of the HMO – HMOs already calculate this for the P4P initiative;</li> <li>B. Post-partum care rate for the HMO's <b>non- under-represented sub-population</b>.</li> <li>C. Post-partum care rate for the HMO's <b>under-represented sub-population</b>.</li> </ol> <p>Comparison of B and C will identify the MY2020 disparities baselines, which will be input for the MY2022 PIP.</p>
<p><b>Part B: Provider clinic-level cultural competence initiatives – HMO to choose one clinic or FQHC to work with during the MY</b></p>	
<p>5. Conduct <b>Cultural Competence Self-Assessment and Plan</b> at the <b>chosen provider clinic</b>.</p> <p>Scope, content and format of the self-assessment report will be discussed by DMS and HMOs in 2020.</p> <p><i>HMOs / clinics may consider working with an external consultant for this assessment and to develop a cultural competence plan based on the results.</i></p>	<ol style="list-style-type: none"> <li>A. Submit completed clinic-level <b>self-assessment report</b> – tool used, dates, # of different staff / providers assessed, results broken out by type of staff (member-facing, administrative, executive, etc.) This assessment would cover the provider clinic in the context of post-partum care.</li> <li>B. Submit a <b>health disparities plan</b> identifying 2-3 focus areas to pursue at the provider clinic, key related initiatives, timeline, etc. Examples of focus areas are:</li> </ol> <p><b>Example:</b> Monitor and ensure adequacy of <b>translation and interpretation services at the provider site</b>. The plan should include how the HMO will collaborate with the provider to ensure linguistic competence, including all other CMS and</p>

MY2020 PIP-like Requirement	Deliverable (Earn-back criteria) for HMOs
	<p>contractual requirements regarding large print, Braille, audio recordings, ASL, etc., and extend beyond the clinical encounter to the appointment desk, customer service, advice lines, medical billing, signs on the walls, and other written materials. The HMO must submit evidence of monitoring and ensuring adequacy – baselines, procedures / processes used, source / type / # of staff providing linguistic services.</p> <p><b>Example:</b> Include <b>family and community members</b> in health care decision-making at the provider site. The HMO must submit documentation / evidence of procedures / processes at the provider site used to ensure inclusion of family and community members.</p> <p><b>Example:</b> Recruit and retain <b>under-represented staff</b> in member-facing positions at the provider site. The HMO/clinic must submit its recruitment and retention plan, # of under-represented staff deployed, their location, qualifications, patient/staff ratios, etc.</p> <p><b>Resources:</b> <a href="https://nccc.georgetown.edu/assessments/">https://nccc.georgetown.edu/assessments/</a>. Also see “<b>Cultural Competence Resources</b>” in Section 1, above.</p>
<p>6. Conduct <b>provider training</b> at the selected clinic / site on cultural competence to improve, e.g.:</p> <ul style="list-style-type: none"> <li>• Awareness, attitudes, beliefs, stereotypes for under-represented members</li> <li>• Specific knowledge of health needs unique to LGBTQ community</li> <li>• Skills in providing culturally competent health care: affect clinical decision making, communication and clinical behavior</li> </ul>	<p>Submit a brief report including:</p> <ul style="list-style-type: none"> <li>• Discussion of how provider training was aligned with self-assessment findings.</li> <li>• Documentation on type / dates / location of provider training, description of trainers and content, # of providers trained, broad provider type profiles, # of CME credits awarded</li> </ul>
<p>7. Offer <b>non-traditional culturally-competent maternity provider services at the provider site</b> through, e.g.,:</p> <ul style="list-style-type: none"> <li>• Community health workers (CHW)</li> <li>• Traditional healers</li> <li>• Doula services</li> <li>• Peer support</li> </ul>	<p>While there are no specific targets for 2020, HMOs can get credit for this requirement by submitting to DMS <u>any one</u> of the following:</p> <ul style="list-style-type: none"> <li>• Documentation showing HMOs/providers <u>continued</u> use in MY2020 of non-traditional culturally-competent maternity provider services for Medicaid members; Submit # of non-traditional providers deployed, their location, qualifications, type of member education and support provided, # of members assisted; or,</li> <li>• Documentation showing HMOs/providers <u>started</u> using non-traditional culturally-competent maternity provider services for Medicaid members; Submit # of non-traditional providers deployed, their location, qualifications, type of</li> </ul>

MY2020 PIP-like Requirement	Deliverable (Earn-back criteria) for HMOs
	member education and support provided, # of members assisted; or, <ul style="list-style-type: none"> <li>• HMO’s/provider’s <u>plan to offer</u> non-traditional culturally-competent maternity provider services for Medicaid members in 2021.</li> </ul>

## Check-list of PIP-like deliverables

### Due by 12/31/2020:

- #1A Submit an organization-level Cultural Competence self-assessment report
- #1B Submit an organization-level health disparities reduction plan
- #2 Regular and active participation in DMS quarterly collaborative meetings
- #5A Submit a clinic-level Cultural Competence self-assessment report
- #5B Submit a clinic-level health disparities reduction plan

### Due by 7/1/2021 (to be included in the final PIP-like report; template TBD in 2020):

- #3 Submit documentation of non-traditional culturally-competent maternity provider services at the HMO level that is an explanation of what will continue to be provided or what was started or a plan to address this requirement in 2021.
- #4 Submit disparities baselines using MY2020 results for post-partum care
- #6 Submit documentation of provider training
- #7 Submit documentation of non-traditional culturally-competent maternity provider services at the provider site that is an explanation of what will continue to be provided or what was started or a plan to address this requirement in 2021.

## VII. HealthCheck Specifications

DMS plans to include HealthCheck results in the HMO Report Card, and to issue Corrective Action Plans to HMOs not meeting the HealthCheck targets.

An HMO gets credit for HealthCheck services that are performed during the time a member is enrolled in that HMO.

### Measure Description:

The percentage of the required age-appropriate comprehensive screenings for members under 21 years of age conducted in the measurement year.

To be considered a comprehensive HealthCheck screen, the provider must conduct and document the following assessments:

- A complete health and developmental history (including anticipatory guidance).
- A comprehensive unclothed physical examination.
- An age-appropriate vision screening exam.
- An age-appropriate hearing screening exam.
- An oral assessment plus referral to a dentist beginning at one year of age.
- The appropriate immunizations (according to age and health history).
- The appropriate laboratory tests (including blood lead level testing when appropriate for age).

### Codes

Number of comprehensive screenings completed by age group is identified by the following:

- Procedure Codes:

#### CPT – 4 Codes: Preventive Medicine Services \*

- 99381 – New patient under one year
- 99382 – New patient (ages 1 – 4 years)
- 99383 – New patient (ages 5 – 11 years)
- 99384 – New patient (ages 12 – 17 years)
- 99385 – New patient (ages 18 – 39 years)
- 99391 – Established patient under one year
- 99392 – Established patient (ages 1 – 4 years)
- 99393 – Established patient (ages 5 – 11 years)
- 99394 – Established patient (ages 12 – 17 years)
- 99395 – Established patient (ages 18 – 39 years)
- 99460 – Initial hospital or birthing center care for normal newborn infant
- 99461 – Initial care in other than a hospital or birthing center for normal newborn infant

- 99463 – Initial hospital or birthing center care of normal newborn infant (admitted/discharged same date)

\* These CPT codes do not require use of an ICD-9-CM “V” code or an ICD-10-CM “Z” code.

CPT – 4 codes: Evaluation and Management Codes\*\*

- 99202-99205: New patient
- 99213-99215: Established patient

\*\* These CPT-4 codes must be used in conjunction with:

- ICD-10-CM codes:
  - o Z76.2 – Encounter for health supervision and care of other healthy infant and child,
  - o Z00.121 – Encounter for routine child health examination with abnormal findings,
  - o Z00.129 – Encounter for routine child health examination without abnormal findings.
  - o Z00.110 – Health examination for newborn under 8 days old and
  - o Z00.111 – Health examination for newborn 8 to 28 days old and/or
  - o Z00.00-01 – Encounter for general adult medical examination without/with abnormal findings and/or
  - o Z02.0 – Encounter for examination for admission to educational institution,
  - o Z02.1 – Encounter or pre-employment examination,
  - o Z02.2 – Encounter for examination for admission to residential institution,
  - o Z02.3 – Encounter for examination for recruitment to armed forces,
  - o Z02.4 – Encounter for examination for driving license,
  - o Z02.5 – Encounter for examination for participation in sport,
  - o Z02.6 – Encounter for insurance purposes,
  - o Z02.81 – Encounter for paternity testing,
  - o Z02.82 – Encounter for adoption services,
  - o Z02.83 – Encounter for blood-alcohol and blood-drug test,
  - o Z02.89 – Encounter for other administrative examinations,
  - o Z00.8 – Encounter for other general examination,
  - o Z00.6 – Encounter for examination for normal comparison and control in clinical research program,
  - o Z00.5 – Encounter for examination of potential donor of organ and tissue,
  - o Z00.70 – Encounter for examination for period of delayed growth in childhood without abnormal findings,
  - o Z00.71 - Encounter for examination for period of delayed growth in childhood with abnormal findings.

**Work Sheet:**

DMS will use the HealthCheck worksheet below to measure compliance with the 80% target of HealthCheck comprehensive visits in the current BadgerCare Plus and Medicaid SSI HMO

Contract. An HMO that does not meet the target will be subject to one penalty, combined, for BadgerCare Plus and SSI contracts.

The results for this measure are calculated by DMS using the following HealthCheck Worksheet (also see the example later in this section):

		Calculation	Age Groups					Total
			< 1	1 – 2	3 – 5	6 – 14	15 – 20	
1	# of eligible months for members under age 21	Entered (Total is sum across all age groups)						
2	# of unduplicated members under age 21	Entered						
3	# of recommended screens per age group	Per CMS / State specifications	5	1.5	1	0.5	0.5	
4	Average period of eligibility in years	=Line 1 ÷ Line 2 ÷ 12						
5	Adjusted # of recommended screens per age group	=Line 3 x Line 4						
6	Expected # of screens (100% of required screens for ages and months of eligibility)	=Line 2 x Line 5 (Total is sum of age groups)						
7	# of screens required to meet the 80% goal	=Line 6 x 0.80						
8	Actual # of screens completed	Entered						
9	Did the HMO meet the goal?	=Line 8 – Line 7 (If negative, goal was not met)						
10	Penalty	\$10,000 if “Total” for line 9 is negative						

**Explanation of the HealthCheck Worksheet**

- Row #1: Member months for members in the eligible population, under 21 years of age during the measurement year, broken out by:
  - < 1 year
  - 1 – 2 years
  - 3 – 5 years
  - 6 – 14 years
  - 15 – 20 years
  - Each member will be assigned to an age group based on their age on December 31 of the measurement year.

Anchor Date for the measure: December 31 of the measurement year.

- Row #2: # of unique, unduplicated members in the eligible population.



- Row #3: Expected # of screens for an individual member in each age group, based on CMS recommendations / specifications.
- Row #4: Average period of eligibility during the Measurement Year (MY), expressed as a proportion of the year (not in months)  
= # of member months / (# of unique members / 12 months)
- Row #5: # of expected screens for an average member in each age group, adjusted for the average period of eligibility in that age group.
- Row #6: # of expected screens for all members in the HMO in each age group, adjusted for the average period of eligibility.
- Row #7: # of screens that the HMO is required to have for each age group in order to meet the 80% goal, after adjustment for the # of unique members and their average eligibility period within each age group.
- Row #8: Actual # of HealthCheck screens completed by the HMO during the MY for each age group.
- Row #9: This is equal to the difference between Row #8 and Row #7 (=Row #8 – Row #7), aggregated across all age groups. A negative value in the “Total” cell indicates the HMO failed to meet the 80% HealthCheck goal during the MY.
- Row #10: If the HMO failed to meet the 80% HealthCheck goal during the MY, a penalty of \$10,000 is applied.

**HealthCheck Worksheet EXAMPLE:**

DMS will use the HealthCheck worksheet below to measure compliance with the 80% target of HealthCheck comprehensive visits in the current BadgerCare Plus and Medicaid SSI HMO Contract.

Assume the numbers in Rows #1, 2 and 3 are given.

			Age Groups					
		Calculation	< 1	1 – 2	3 – 5	6 – 14	15 – 20	Total
1	# of eligible months for members under age 21	Entered (Total is sum across all age groups)	1,200	1,200	1,200	1,200	1,200	6,000
2	# of unduplicated members under age 21	Entered	120	120	120	120	120	600
3	# of recommended screens per age group	Per CMS / State specifications	5	1.5	1	0.5	0.5	
4	Average period of eligibility in years	=Line 1 ÷ Line 2 ÷ 12	0.833	0.833	0.833	0.833	0.833	

		Age Groups						
		Calculation	< 1	1 – 2	3 – 5	6 – 14	15 – 20	Total
5	Adjusted # of recommended screens per age group	=Line 3 x Line 4	4.167	1.250	0.833	0.417	0.417	
6	Expected # of screens (100% of required screens for ages and months of eligibility)	=Line 2 x Line 5 (Total is sum of age groups)	500	150	100	50	50	850
7	# of screens required to meet the 80% goal	=Line 6 x 0.80	400	120	80	40	40	680
8	Actual # of screens completed	Entered	350	98	86	38	43	615
9	Did the HMO meet the goal?	=Line 8 – Line 7 (If negative, goal was not met)						-65
10	Penalty	\$10,000 if "Total" for line 9 is negative						\$10,000