

Wisconsin Department of Health Services (DHS)
Division of Medicaid Services (DMS)
HMO Quality Guide
Measurement Year (MY2022)

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

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DMS maintains an email list for monthly Quality Forum meetings as well as general quality updates. To add or remove HMO email addresses from this HMO quality list, please email DHSDMSHMO@dhs.wisconsin.gov.

Version	Date	Change Log
0.0	11/3/21	Draft guide distributed for HMO review.
1.0	11/19/21	Final guide distributed to HMOs.
2.0	12/17/21	Version 2.0 finalized, including: <ul style="list-style-type: none"> • Health disparities final PIP report templates in VI, Section 4 • WI Core Reporting (Section III) updated to incorporate CMS 2022 Adult and Child Core Set measures • Fixing a date error in VI, Section 2. • Updated header, table of contents, and change log.
3.0	12/9/2022	Version 3.0 finalized, including: <ul style="list-style-type: none"> • Correction to the Statewide Average in FUM-30 rate displayed in the table on page 11. Revised rate is 58.7% • Merged My Choice Wisconsin BC+ and My Choice Wisconsin SSI in “Participating HMOs” table on page 16. • Changed CAHPS date that was in error, page 62. • Added section on HMO Report Cards
4.0	4/17/2023	<ul style="list-style-type: none"> • Removed FVA and MSC as potential Report Card measures from table on page 23 • Revised measure names on chart “MY2022 Wisconsin Core Reporting (WICR) Measures” to align with changes by measure steward, page 18: <ul style="list-style-type: none"> ○ Revised the measure name of IET from “Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment” to “Initiation and Engagement of Substance Use Disorder Treatment” ○ Revised the measure name of FUA from “Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence” to “Follow-Up After Emergency Department Visit for Substance Use” ○ Revised measure name of “Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c)” to Hemoglobin A1c Control for Patients With Diabetes (HBD-AD) • Remove Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) from WICR measures as it is not a HEDIS measure.

I. Measurement Year 2022 (MY2022) 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. DHS submits P4P and WICR results to CMS, and CMS publishes an annual scorecard of state performance.
- The **HMO Report Card** evaluates the quality of health care that Medicaid members receive from BadgerCare Plus and Medicaid SSI HMOs based on performance data provided by the

HMOs. A 5-star rating system is used to compare HMOs on major areas of care using national and state-wide benchmarks.

- 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.
- HMOs are required to conduct two **Performance Improvement Projects (PIPs)** each year.
 - Health Disparities Reduction Performance Improvement Project (PIP) initiative focuses on reducing health disparities among Medicaid members, improving cultural and linguistic responsiveness of HMOs and providers serving Wisconsin Medicaid members, and compliance with the Managed Care Rule requirement defined in 42 CFR 438.340 (b).
 - HMOs conducting PIPs on other topics must select measures where the HMO is under-performing, as a way to improve performance in that measure.
- **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.
- The **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** survey is a survey tool used by DHS to survey both fee-for-service and HMO member experience and satisfaction with care. The survey is performed annually for children in BadgerCare Plus or CHIP populations, and data is shared with CMS.
- **OB Medical Home** is a program with an objective to improve birth outcomes and reduce birth disparities among high-risk pregnant women enrolled in BadgerCare Plus and SSI HMOs by providing enhanced care coordination services.
- **NCQA Accreditation** – DHS recognizes NCQA Health Plan Accreditation to avoid duplication of External Quality Review (EQR) activities, and will require all HMOs to be accredited for Medicaid, as well as a distinction or certification regarding culturally appropriate care, by December 31, 2023.

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. Results for all quality measures and initiatives may 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).

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.

These quality initiatives are part of the DHS Medicaid Managed Care Quality Strategy, which is a three-year strategic plan to improve quality and ensure quality assurance and compliance within managed care programs, including HMOs. HMOs can find the current Managed Care Quality Strategy online at ForwardHealth:

[https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality for BCP and Medicaid SSI/Home.htm.spage](https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality%20for%20BCP%20and%20Medicaid%20SSI/Home.htm.spage).

The 2022 tentative timeline for these quality initiatives is below.

Timeline for MY2022 Quality Initiatives

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

MY2022 Quality Timeline												
Quality Item	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
MY2021 P4P						HMO final encounter/medical record data to DHS (used for any DHS-calculated measures)	HMO audited review tables (ARTs) of 2021 data to DHS 7/31.			Prelim results from DHS	HMO feedback	Final results from DHS
MY2021-MY2022 PIP (see also additional dates PIP section pages 41-45)							MY2021 HMO final report to EQRO					MY2023 Project proposals to DHS and EQRO
MY2022 PPR									Prelim results	Final results		
MY2022 Quality Forum calls (1:00 – 2:00)	01/26	02/23	03/23	04/27	05/25	06/15	07/27	08/24	09/28	10/26	11/16	12/14
FFS extract to HMOs											FFS member list from HMOs to Gainwell	FFS extract from Gainwell to HMOs
Accreditation (NCQA accreditation &	Quarterly progress report due			Quarterly progress report due			Quarterly progress report due			Quarterly progress report due		

MY2022 Quality Timeline												
Quality Item	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
MHCD/HEA due by 12/31/2023)												
HMO Report Card		2020 Results Report Card developed for HMO review.										
CMS Core Set data reporting plan (1) – Activities by DHS	Non-HEDIS measure review	Plan to calculate non-HEDIS measures					Calculate non-HEDIS measures, as feasible			Compile and Calculate all statewide measures	DHS submits data to CMS (HEDIS & non-HEDIS)	
CAHPS survey 2022	Survey administered by Gainwell’s CAHPS vendor.						Data delivered to Gainwell for data Quality review; Data submitted to AHRQ	Final report delivery		2023 Planning: Submit new questions for NCQA consideration to SPH for Round 1 Deadline	DHS presents 2022 results to HMO; 2023 Planning: Submit new questions for NCQA consideration to SPH for Round 2 Deadline	

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.

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.

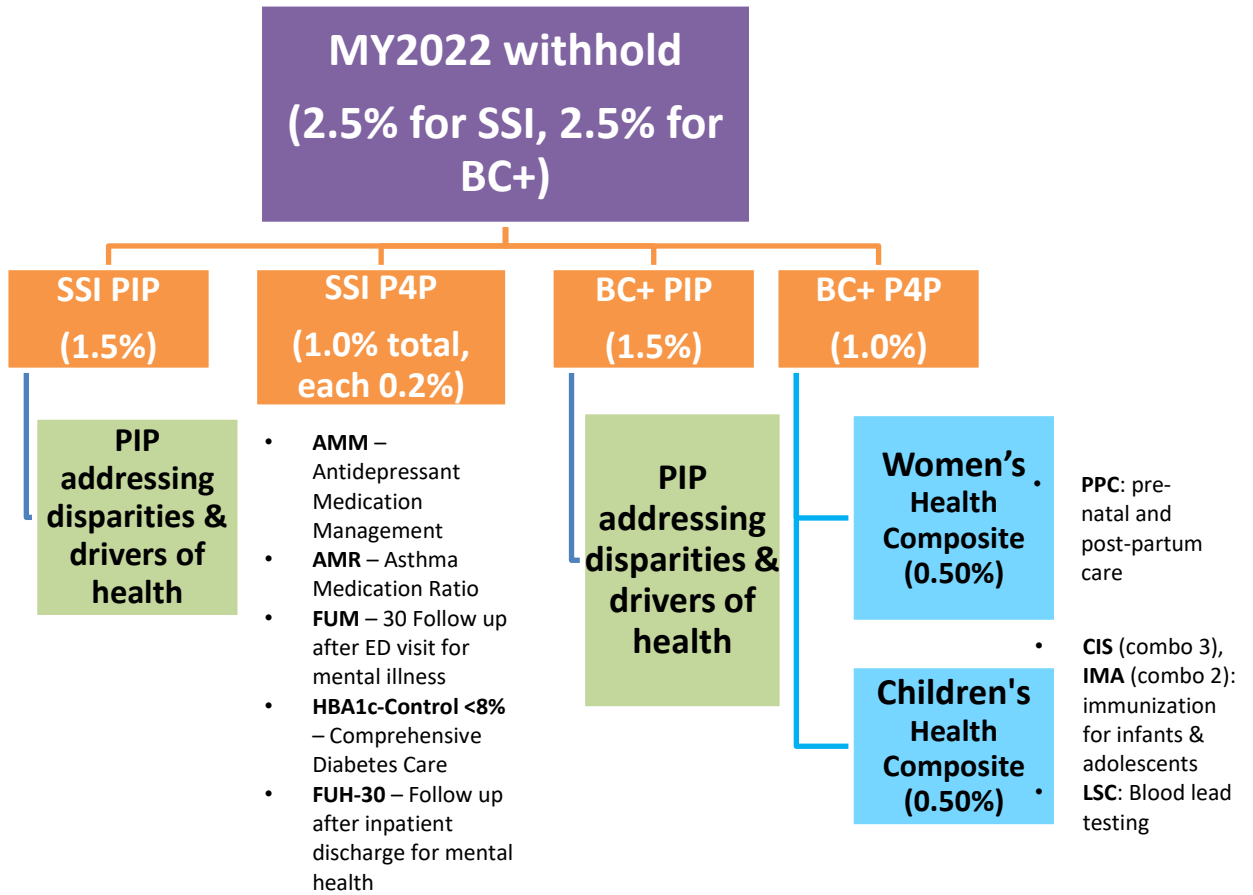
Measures, Withhold and Targets

1. The DMS uses **HEDIS measures** for its P4P initiative.
There will be no deviations from HEDIS specifications in MY2022. Refer to HEDIS¹ Technical Specifications published by NCQA² for details of specific measures.
2. The MY2022 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;
 - 1.5% withhold will be assigned to a **PIP** for reducing disparities in post-partum care
 - 0.5% withhold will be assigned to a **women’s health P4P composite**;
 - 0.5% withhold will be assigned to a **children’s health P4P composite**.
 - b. **SSI:**
 - 1.5% withhold will be assigned to a PIP for reducing disparities in a selected performance measure
 - 1.0% withhold will be assigned to a **SSI P4P composite**.
 - c. An HMO can also earn a bonus.

¹ Health Effectiveness Data and Information Set

² 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 MY2022, and the Quality components to which it applies.



3. MY2022 P4P targets for BC+ and SSI

MY2022 baselines for HEDIS measures are set using the latest available MY2020 HEDIS state-wide averages and the MY2020 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:

- 2020 national HEDIS percentiles
- 2020 state average
- The composite applicable to the measure
- Targets for earning P4P points (further explained in the P4P Methodology section)

MY2022 HMO P4P Measures, Composites and Targets:

Measure	NCQA Percentiles (CY2020 aka HEDIS 2021)			2020 WI Avg	MY2022 Target for:			
	50th percentile	67th percentile	75th percentile		4 points	3 points	2 points	1 point
BC+ Women's Health Composite								
PPC - Pre-natal care	85.9%	88.3%	89.3%	85.9%	89.3%	88.3%	85.9%	N/A
PPC - Post-partum care	76.4%	78.4%	79.6%	74.7%	79.6%	78.4%	76.4%	74.7%
BC+ Children's Health Composite								
CIS - Combo 3	67.9%	71.3%	72.8%	66.3%	72.8%	71.3%	67.9%	66.3%
IMA - Combo 2	36.7%	41.8%	43.6%	38.8%	43.6%	41.8%	36.7%	N/A
LSC	71.5%	74.7%	77.9%	76.9%	77.9%	74.7%	71.5%	N/A
SSI Composite								
AMM - Continuation	40.3%	43.0%	45.6%	51.2%	45.6%	43.0%	40.3%	N/A
FUM-30 (Total)	53.5%	60.9%	64.6%	58.7%	64.6%	60.9%	53.5%	N/A
FUH-30 (Total)	60.1%	64.4%	67.5%	61.7%	67.5%	64.4%	60.1%	N/A
AMR - Asthma Medication Ratio (Total)	64.8%	68.2%	70.7%	58.0%	70.7%	68.2%	64.8%	58.0%
CDC- Control (<8%)	46.8%	49.6%	51.3%	46.5%	51.3%	49.6%	46.8%	46.5%

In the table above:

1. PPC = Prenatal and Post-partum care
2. CIS = Childhood immunization status
3. IMA = Immunizations for adolescents
4. LSC = Lead screening in children
5. AMM = Antidepressant Medication Management
6. FUM-30 = Follow-up after emergency department visit for mental illness (30 days)
7. FUH-30 = Follow-up after hospitalization for mental illness (30 days)
8. AMR = Asthma Medication Ratio
9. CDC - HBA1c-control (<8%) = Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)

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 MY2020 State average for a measure falls below the national 50th percentile for that measure, then an HMO can earn:

- 1 point at or above the MY2020 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 3 measures. Therefore, the maximum # of points a HMO can earn for this composite = 3*4 = 12 points.
- Assume that the table below represents the results and points for this composite:

Measure	MY2022 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
CIS - Combo 3	>=75.2%	>=73.2%	>=71.1%	N/A	78% = 4 points	74% = 3 points	68% = 0 points
IMA - Combo 2	>=43.1%	>=40.9%	>=36.9%	N/A	48% = 4 points	45% = 4 points	44% = 4 points
LSC	>=81.0%	>=79.2%	>=73.1%	N/A	86% = 4 points	77% = 2 points	88% = 4 points
Total points earned					12	9	8
% of points earned					= 12 / 12 = 100%	= 9 / 12 = 75%	= 8 / 12 = 66.7%

- **HMO A** earns a total of 12 points for all measures in this composite, shown in the 2nd – to-last row of the above table. This represents $12/12 = 100\%$ 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 9 points for all measures in this composite, shown in the 2nd - to-last row of the above table. This represents $9/12 = 75\%$ of the maximum points for this composite. Therefore, the HMO will earn back 75% of its withhold for this composite, shown in the last row of the above table.
- **HMO C** earns a total of 8 points for all measures in this composite, shown in the 2nd –to-last row of the above table. This represents $8/12 = 66.7\%$ of the maximum points for this composite. Therefore, the HMO will earn back 66.7% of its withhold for this composite, shown in the last row of the above table.

3. Small denominators:

An HMO with insufficient observations (i.e., less than 30 observations in the denominator for a measure) will receive back the amount withheld for that measure.

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.

MY2022: Minimum # of applicable P4P measures for bonus eligibility

BC+	4 out of 5 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
Total	4000	100%	\$2 million

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 MY2022:

- 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 and to VEDSHMOSupport@wisconsin.gov notifying them when the files (test files or production files) have been placed on the SFTP server.

3. Public Reporting

For MY2022, 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 must 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, including identification of health disparities.

DMS will provide HMOs with a template for data submission to include member-level measure data that details member's Medicaid ID # and available demographic data such as age, gender, race, ethnicity, preferred language, disability status, and location of residence.

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, 2022.

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 MY2022. This list is updated annually.

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

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. In addition, section 5001 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) 2018 made state reporting of the Behavioral Health Core Set for adults mandatory starting in FFY 2024. While Adult Core Set measures, other than behavioral health, are not mandatory, DHS is working towards improving the number of measures reported each year. To support DHS in our reporting of Adult Core Set measures and Child Core Set measures, including the mandatory measures, HMOs are required to provide results for **specific** WI Core Reporting measures. The WICR measures chosen as WI Core Reporting measures are those from either the 2022 CMS Adult or Child Core Set that are not otherwise reported as part of P4P.

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 MY2022, WI Medicaid HMOs are required to report:
 - a. All **MY2022** P4P measures, and
 - b. **WICR** = all remaining **HEDIS** measures from the **2022** Medicaid Adult and Child Core Sets, as applicable to BC+ and SSI, shown in the table below.

Reference documents:

- i. CMS Medicaid **2022 Adult** Core Set:
<https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-adult-core-set.pdf>
- ii. CMS Medicaid **2022 Child** Core Set:
<https://www.medicaid.gov/medicaid/quality-of-care/downloads/2022-child-core-set.pdf>

MY2022 Wisconsin Core Reporting (WICR) Measures

BC+		SSI
Adult Core Set		
1. Breast cancer screening (BCS-AD)	1. Breast cancer screening (BCS-AD)	
2. Cervical cancer screening (CCS-AD)	2. Cervical cancer screening (CCS-AD)	
3. Chlamydia screening, ages 21-24 (CHL-AD)	3. Chlamydia screening, ages 21-24 (CHL-AD)	
4. Colorectal Cancer Screening (COL-AD)	4. Colorectal Cancer Screening (COL-AD)	
5. Controlling high blood pressure (CBP-AD)	5. Comprehensive diabetes care: Hemoglobin A1c (HbA1c) poor control (>9.0%) (HPC-AD)	
6. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-AD)	6. Prenatal and Postpartum Care: (PPC-AD) *	

MY2022 Wisconsin Core Reporting (WICR) Measures

BC+

7. Hemoglobin A1c Control for Patients with Diabetes (HBD-AD)
8. Plan all-cause readmissions (PCR-AD)
9. Asthma medication ratio, ages 19-64 (AMR-AD)
10. Initiation and engagement of substance use disorder treatment (IET-AD)
11. Antidepressant medication management (AMM-AD)
12. Follow-up after hospitalization for mental illness, age 18 and older (FUH-AD)
13. Follow-up after ED visit for substance use (FUA-AD)
14. Follow-up after ED visit for mental illness (FUM-AD)
15. Diabetes screening for people with schizophrenia or bipolar disorder, using antipsychotics (SSD-AD)
16. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD)

PPC-AD is a BC+ P4P measure, therefore is not repeated in this list.

SSI

7. Controlling high blood pressure (CBP-AD)
8. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-AD)
9. Plan all-cause readmissions (PCR-AD)
10. Initiation and engagement of substance use disorder treatment (IET-AD)
11. Follow-up after hospitalization for mental illness, age 18 and older (FUH-AD)
12. Follow-up after ED visit for substance use (FUA-AD)
13. Follow-up after ED visit for mental illness (FUM-AD) - 7 days only
14. Diabetes screening for people with schizophrenia or bipolar disorder, using antipsychotics (SSD-AD)
15. Adherence to antipsychotic medications for individuals with schizophrenia (SAA-AD)

AMM, AMR, FUH-AD (30 days), and FUM-AD (30 days) are SSI P4P measures, therefore not repeated in this list.

*See Additional Notes Section for further information

Child Core Set

1. Adolescent immunization (IMA-CH) – all except combo 2
2. Well-child visits in the first 30 months of life (W30-CH)
3. Child and adolescent well-care visits (WCV-CH)
4. Childhood immunization status (CIS-CH) – all except combo 3
5. Weight assessment and counseling (WCC-CH)
6. Chlamydia screening, ages 16-20(CHL-CH)
7. Asthma Medication Ratio (AMR-CH)
8. Ambulatory care: ED visits (AMB-CH)
9. Follow-up care for children prescribed attention deficit / hyperactivity disorder (ADHD) medication (ADD-CH)
10. Follow-up after hospitalization for mental illness, ages 6-17 (FUH-CH)
11. Metabolic monitoring for children and adolescents on antipsychotics (APM-CH)
12. Use of first-line psychosocial care for children / adolescents on antipsychotics (APP-CH)

MY2022 Wisconsin Core Reporting (WICR) Measures

BC+

13. Follow-Up After Emergency Department Visit for Substance Abuse: Ages 12 to 17 (FUA-CH)
14. Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)

SSI

PPC-CH, CIS-CH (combo 3), IMA-CH (combo 2) are BC+ P4P measures, therefore not repeated in this list.

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. Additionally, HMOs providing dental services should report the HEDIS ADV measure for children. DHS will also calculate non-HEDIS dental performance for children and adults.

3. Retired measures

Any HEDIS performance measures retired or modified by NCQA that impact the HMO initiatives during the MY2022 will be discussed and documented in a Quality Guide amendment.

HEDIS Measures from the **2022** Medicaid Adult and Child Core Sets, retired between the 2021 guide and 2022 guide: No retired measures impacting HMO initiatives have been noted.

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

- This measure is listed in the **2022 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 health plan accreditation. If an HMO is not accredited or seeking accreditation in MY2021 or MY2022 by NCQA, it is not required to report this measure, and will not be subject to the non-reporting penalty.

- The measure is not listed as a required MY2022 Wisconsin Core Reporting (WICR) Measure, but will be an expectation in the future with NCQA health plan accreditation required by December 31, 2023.
- 5. Medical assistance with smoking and tobacco use cessation (MSC-AD), NQF 0027**
- This measure is listed in the **2022 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 health plan accreditation. If an HMO is not accredited or seeking accreditation in MY2021 or MY2022 by NCQA, it is not required to report this measure, and will not be subject to the non-reporting penalty.
 - The measure is not listed as a required MY2022 Wisconsin Core Reporting (WICR) Measure, but will be an expectation in the future with NCQA health plan accreditation required by December 31, 2023.
- 6. Diabetes care for people with serious mental illness; HbA1c poor control >9.0% (HPCMI-AD), NQF 2607:**
- This measure is listed in the **2022 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.
 - 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 **2022 Medicaid Core Set for Children**, and has been designated by WI DMS as part of its WICR list for **BC+** for MY2022.
 - 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. Prenatal and Postpartum Care: (PPC-AD); NQF 1517:**
- This measure is listed in the **2022 Medicaid Core Set for Adults**
 - HMOs are expected to report the measure to WI DMS regardless of the denominator amount.
 - Denominators less than 30 will not be reported to CMS

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

- This measure is listed in the **2022 Medicaid Core Set for Children**, and has been designated by WI DMS as part of its Core Reporting list for **BC+** for MY2022.
- 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 CMS reporting tools.

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

- This measure is listed in the **2022 Medicaid Core Set for Children**, and has been designated by WI DMS as part of its Core Reporting list for **BC+** for MY2022.
- HMOs must use the standard HEDIS technical specifications to report only the BMI Assessment for children and adolescents.

IV. HMO Report Card

DMS intends to publish two separate Report Cards; one for SSI and one for BadgerCare Plus.

The HMO Report Card serves multiple purposes:

- Informational tool for Medicaid members to select an HMO. The Report Card is included in the HMO Enrollment Selection Tool.
- Comparisons of HMO performance compared to state and national benchmarks

The HMO Report Card is publicly available on [ForwardHealth](#)³. DMS anticipates that Reports cards will be published in the 4th quarter of the HMO submission year (e.g., the 2022 results Report Card, using data submitted to DMS in June 2023, will be published in Q4 2023).

Star Rating System and Methodology

1. Each HMO will receive 1 to 5 stars for each quality measure in each area of care based on how well it performed compared to NCQA's Quality Compass - National Medicaid HEDIS percentiles.

# of Stars	Explanation
★★★★★ = Excellent	HMO was among the top 25 percent of all Medicaid HMOs in the nation; it performed better than 75 percent (or, 3/4 th) of all Medicaid plans.
★★★★☆ = Very Good	HMO was among the top 33 percent of all Medicaid HMOs in the nation; it performed better than 67 percent (or, 2/3 rd) of all Medicaid plans.
★★★☆☆ = Good	HMO was among the top 50 percent of all Medicaid HMOs in the nation; it performed better than 50 percent (or, half) of all Medicaid plans.
★★☆☆☆ = Fair	HMO was below the national average; it performed better than 33 percent (or, 1/3 rd) of all Medicaid plans in the nation.
★☆☆☆☆ = Poor	HMO performed in the lowest 1/3 rd of all Medicaid plans in the nation.

2. Areas of care are assigned a star rating in ½ star increments based on the **average star rating for each quality measure within that Area of Care.**

From	To	Number of stars assigned
4.75	5	5
4.25	4.74	4.5
3.75	4.24	4
3.25	3.74	3.5
2.75	3.24	3

³https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage

From	To	Number of stars assigned
2.25	2.74	2.5
1.75	2.24	2
1.25	1.74	1.5
0.75	1.24	1
0	0.74	0.5

The Report Card may include any or all HEDIS measures and stratifications, unless specifically indicated, that are part of 2022 WICR and/or P4P. The list of measures that will be selected for inclusion in the 2022 results HMO Report Card may be revised due to changes in priority areas, revisions to the measure specifications from the measure stewards (e.g., NCQA), member feedback, and HMO results such that the information included in the HMO Report Card is helpful for members in their HMO selection process.

The measures listed in the table below are from 2022 WICR and are potential measures for the Report Card. DMS intends to publish the Report Card using the areas of care listed below.

Potential Measures for HMO Report Card			
Area of Care	Quality Measure	BC+	SSI
Staying Healthy	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Applicable	Applicable
	Breast Cancer Screening (BCS)	Applicable	Applicable
	Childhood Immunization (CIS)	Applicable	N/A
	Cervical cancer screening (CCS)	Applicable	Applicable
	Chlamydia screening (CHL)	Applicable	Applicable
	Colorectal Cancer Screening (COL)	Applicable	Applicable
	Immunizations for Adolescents immunization (IMA)	Applicable	N/A
	Lead screening in children (LSC)	Applicable	N/A
	Well-Child Visits in the First 30 Months of Life (W30)	Applicable	N/A
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Applicable	N/A
	Child and Adolescent Well-Care Visits (WCV)	Applicable	N/A
Living With Illness	Asthma Medication Ratio (AMR)	Applicable	Applicable
	Controlling Blood Pressure (CBP)	Applicable	Applicable
	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Applicable	Applicable
	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI)	Applicable	Applicable
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Applicable	Applicable

Potential Measures for HMO Report Card			
Area of Care	Quality Measure	BC+	SSI
Mental Health Care	Anti-depressant Medication Management – Continuation (AMM)	Applicable	Applicable
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	Applicable	N/A
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Applicable	N/A
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Applicable	N/A
	Follow-up after ED visit for alcohol and other drug abuse or dependence (FUA)	Applicable	Applicable
	Follow-up after Hospitalization for Mental Illness (FUH)	Applicable	Applicable
	Follow-up after ED visit for mental illness (FUM)	Applicable	Applicable
	Alcohol and Other Drug Dependence – Engagement (IET)	Applicable	Applicable
	Adherence to antipsychotic medications for individuals w/ schizophrenia (SAA)	Applicable	Applicable
Hospital and ED Care	Ambulatory Care: Emergency Department (ED) Visits (AMB)	Applicable	N/A
	Plan all-cause readmissions (PCR)	Applicable	Applicable
Pregnancy & Birth-related Care	Prenatal Care & Postpartum Care (PPC)	Applicable	N/A

3. Overall numerical quality score is calculated as an average score, calculated as **the total sum of each individual measure divided by the total number of individual measures.**

Example of BadgerCare + Report Card

BadgerCare Plus HMO	Hospital and ED	Living with Illness	Mental Health	Pregnancy & Birth	Staying Healthy	Overall (out of 5)
HMO a	★★★★★	★★★★★	★★★★☆	★★★	★★★	3.4
HMO b	★★	★★★	★★★★★	★★★	★★★★★	3.8
HMO c	★★★★★	★★★★	★★★	★★	★★★	2.8
HMO d	★★★★★	★★★★	★★★★☆	★★★★★	★★★★	4
HMO e	★	★★	★★★	★	★★★★	2.4
All Wisconsin BC+ HMOs	★★★★☆	★★★★☆	★★★★☆	★★★	★★★★	3.2

Example of SSI Report Card

Medicaid SSI HMO	Hospital and ED	Living with Illness	Mental Health	Staying Healthy	Overall (out of 5)
HMO a	★★★★★	★★★★☆	★★★	★★	2.7
HMO b	★	★★★★★	★★★★★	★★★★★	3.7
HMO c	★	★★	★★★	★★★	2.7
HMO d	★	★★★	★★★★★	★★★★★	3.3
HMO e	★★★★★	★★★★★	★★★★★	★★★	3.6
All Wisconsin SSI HMOs	★★★	★★★★☆	★★★★★	★★★	3.2

V. 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.
- 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).
- 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 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 Programs & Policy, 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:

MY2022 HMO PPR initiative will focus on BadgerCare Plus 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 2022:

MY2020 HMO-specific ABR performance results will be used to establish the baselines for MY2022, 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 MY2022, 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 ≤ 0.95 ;
- Tier 2 = Middle performance HMOs, with baseline ABR ≥ 0.96 but ≤ 1.05 ;
- Tier 3 = Low performance HMOs, with baseline ABR ≥ 1.06 .

The Tiers above also create confidence intervals for the methodology.

HMOs with low ABR (≤ 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 ≤ 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>
1.00	5% or more	7% or more	10% or more
0.75	3% to 4.9%	4% to 6.9%	7% to 9.9%
0.50	1% to 2.9%	2% to 3.9%	4% to 6.9%
0.25	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
State-wide	158,000	100.00%	\$5,000,000	1.000			3.14%	60%	\$ 3,022,152

- 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 MY2022 will occur in 2022, 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 MY2022, 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 MY2022. 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. 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.

Table: Schedule of PPR reports for HMOs

Measurement period	Working data available on:	Preliminary annual report available on:	Final annual report available on:
2021			
1/1 – 3/31	5/15/2021	5/15/2021 (data for MY2020)	N/A
4/1 – 6/30	8/15/2021	N/A	N/A
7/1 – 9/30	11/15/2021	N/A	N/A
10/1 – 12/31	2/15/2022	N/A	N/A
2022			
1/1 – 3/31	5/15/2022	5/15/2022 (data for MY2021)	N/A
4/1 – 6/30	8/15/2022	N/A	N/A
7/1 – 9/30	11/15/2022	N/A	9/15/2022 (data for MY2021)
10/1 – 12/31	2/15/2023	N/A	N/A

VI. 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

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
Care Planning	<p><u>New members</u> <i>(enrolled after 1/1/2022; not enrolled in the same HMO for the past 6 months or longer):</i></p> <p>(CP1): % of new members with care plans within 90 days of enrollment = # of new members with care plans within 90 days of enrollment / # of new members with 90+ days of continuous enrollment <i>Calculated quarterly by DMS/Gainwell using code G9001</i></p> <p><u>Annual Target = 75% of new members should have care plan within 90 days</u></p> <p>Also track timeliness of care planning, from date of enrollment; Calculated quarterly by DMS/Gainwell using code G9001; Histograms for 90 days, 120 days, 150 days and beyond.</p>
Needs Stratification	<p>Use Care Management (G) codes 9002, 9006, 9007 or 9012; <i>Calculated by month by DMS/Gainwell after data submission deadline:</i></p> <p><u>WICT (up to 5% of SSI membership)</u> <i>Data point 1: # of unique members each month with any <u>G code + TG modifier</u> (= WICT stratum)</i></p> <p>(NS1): % enrollment in WICT for each month = 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>(NS2): Average % enrollment in WICT over last 12 months = Sum of Data point 1 over last 12 months / # of total member months over last 12 months</p> <p>(NS3): Average # of months in WICT over last 12 months = 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><u>Medium stratum (next highest after WICT)</u> <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>(NS4): % enrollment in Medium stratum for each month = Data point 2 / total # of members enrolled for that month</p> <p>(NS5): Average % enrollment in Medium stratum over last 12 months = Sum of Data point 2 over last 12 months / total # of member months over last 12 months</p>

Step	Data Reporting Description
	<p>months</p> <p>Lower stratum (all combined after Medium) <i>Data point 3: # of unique members each month with any <u>G code + no modifier</u> (= all combined Lower stratum). There is no payment difference between TF modifier and no modifier.</i></p> <p>(NS6): % enrollment in Lower stratum for each month = Data point 3 / total # of members enrolled for that month</p> <p>(NS7): Average % enrollment in Medium stratum over last 12 months = Sum of Data point 3 over last 12 months / total # of member months over last 12 months</p>
<p>Transition Care</p>	<p>Calculation annually by DMS / Gainwell</p> <p><i>Data point 4: Total # of discharges from inpatient stay during the reporting period (from Gainwell)</i></p> <p><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>(TC1): % of all discharges from inpatient stay with a follow-up Transition Care service = Sum of Data point 5 / Data point 4</p> <p>(TC2): Timeliness of Transition Care (within 5 days of discharge) = % 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>Care Plan Development - 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 2021 Care Plan development requirements in the BC+ and SSI HMO Contract.</p>	
<ul style="list-style-type: none"> a. Is the Care Plan developed based on a screening conducted within 60 days of the member’s enrollment in the HMO or 30 days prior to the care plan? b. Is the screening comprehensive as identified in the 2020-2021 BC+ and SSI HMO Contract, including? <ul style="list-style-type: none"> • The member’s chronic physical health needs (including dental) • member’s chronic mental and behavioral health needs (including substance abuse). • The member’s perception of their strengths and general well-being • If the member has a usual source of care. • Any indirect supports the member may have. • Any relationships the member may have with community resources. • Any immediate and/or long-term member concerns about their overall well-being (including SDOH). • Activities of daily living assistance needs. • Instrumental activities of daily living assistance needs. c. Is the Care Plan an evidence-based plan of care that: <ul style="list-style-type: none"> • Identifies the member’s needs including: <ul style="list-style-type: none"> i. Formal and informal supports ii. Chronic conditions and acute illnesses iii. Mental and behavioral health conditions iv. Dental care needs v. Medications taken by the member; any concerns with member’s understanding and use of medications vi. Additional supports needed to conduct activities of daily living or instrumental activities of daily living vii. Social determinants of health (Yes/No). • Defines specific goals that the member wants to achieve and that are appropriate to address his/her needs (Yes/No). 	Annual

EQRO Review	EQRO frequency
<ul style="list-style-type: none"> • 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). • Describes the interventions that will be implemented to address the member’s needs and their sequence (Yes/No). 	
<p>WICT – 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 2021 Care Plan development requirements in the BC+ and SSI HMO Contract.</p>	
<p>a. Well-functioning WICT - Is there evidence of a well-functioning interdisciplinary team:</p> <ul style="list-style-type: none"> • 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) • With a WICT Core Team that meets weekly to discuss their entire shared case load? (Yes/No) • 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) 	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>	Annual
<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>During the public health emergency, the face-to-face member meeting may occur via telehealth (phone or video) visit. If the member did not have access to telehealth visits, the care management notes and/or care plan must reflect the cancellation or inability to meet face-to-face.</i></p>	

EQRO Review	EQRO frequency
<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). Alternate format visits (telehealth, telephonic, etc.) in lieu of the required face-to-face visits during the public health emergency will be scored as “met with waiver” as long as all other requirements (care plan need discussed, who from the core team led the visit) are met.</i></p>	
<p>c. Graduation –</p> <ul style="list-style-type: none"> • Does the member’s Care Plan clearly identify the criteria for the member to graduate from the WICT? (Yes/No) • Is there evidence of the WICT being a short-term (i.e., less than 12 months) intensive intervention? (Yes/No) • 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) 	Annual
<p>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, medium, high using the TG and TF modifiers. EQRO will look for evidence in the care management records of members in the sample to address the questions below.</p>	
<p>a. Compliance with the Care Plan - Are services, including any planned follow-ups with members, delivered according to the Care Plan?</p>	Annual
<p>i. Member-centric Care</p> <ul style="list-style-type: none"> ○ 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) ○ 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? Member contacts or attempts using alternate formats in lieu of a HMO-required face-to-face will be scored as “met with waiver”. ○ Is there evidence that the HMO is asking members if their needs are being addressed? (Yes/No) 	Annual
<p>ii. Social Determinants (SD):</p> <ul style="list-style-type: none"> ○ Is follow-up on SD documented in the Care Plan? (Yes/No) ○ Did the HMO go beyond simple referrals and beyond sharing phone numbers for community resources with the member? (Yes/No) <p><i>EQRO will describe HMO efforts to address social determinants including how they are working</i></p>	Annual

EQRO Review	EQRO frequency
<p><i>collaboratively with community resources or utilizing Community Health Workers.</i></p>	
<p>iii. Behavioral Health</p> <ul style="list-style-type: none"> o Does the HMO follow-up to address the member’s behavioral health needs identified in the Care Plan? (Yes/No) 	Annual
<p>Care Plan Review & Update – <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></p>	
<p>a. Is the HMO reviewing and updating the Care Plan based on the criteria defined in the 2021-2022 BC+ and SSI HMO Contract?</p> <ul style="list-style-type: none"> • At least once per calendar year (Yes/No) • According to the HMO’s policies and procedures for reviewing Care Plans and re-stratifying members (Yes/No) • Whenever the member is not responsive to the Care Plan or whenever the member frequently transitions between care settings (Yes/No) 	Annual
<p>b. Does the HMO re-stratify members after critical events, as appropriate? (Yes/No)</p>	Annual
<p>Discharge Follow-up / Transitional Care – <i>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.</i></p>	
<p>a. Did the HMO’s transitional care follow-up meet the transitional care requirements in the applicable BC+ and SSI HMO Contract?</p> <ul style="list-style-type: none"> • How was the HMO notified of the member’s hospital admission? • Was the follow-up in-person, via interactive video, or over the phone? • Is there evidence that the transitional care follow-up included: <ul style="list-style-type: none"> i. Medication reconciliation, documented in the member’s care management notes, conducted either by the hospital or the HMO. ii. A review with members of (a) the discharge information prepared by the hospital and (b) the member’s medications and their medication schedule. • Did the HMO assist members with scheduling appointments with other health care providers after discharge? (Yes/No) • Did the follow-up occur within five business days of hospital discharge? (Yes/No) 	Annual
<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</i></p>	

EQRO Review	EQRO frequency
<i>appointments, understand their medication schedule and their treatment plan.</i>	

Additional note:

- The EQRO, MetaStar, recommends that HMOs document events such as sharing care plans through mail and/or secure portal (upon confirming the member has an accessible account), 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.

VII. Performance Improvement Projects

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. CMS' protocol worksheets are available [here](#), and may be a helpful reference in developing the PIP and completing the templates provided below. MetaStar's PIP standards and PIP Scoring Example files below may be useful tools for HMOs in developing their PIP proposals and final reports.



PIP
Standards_111921.doc



PIP Scoring Example
111921.xlsx

For 2022, HMOs may have performance improvement projects (PIPs) related to reducing health disparities and/or other topics. The health disparities reduction PIPs are part of the 2022 P4P withhold, while other projects do not have an incentive structure.

HMO serves	PIP 1	PIP 2
BadgerCare Plus only	Health disparities for PPC – Year 3	PIP of choice on a measure where the HMO is underperforming
SSI only	Health disparities for other clinical topic – Year 2	PIP of choice on a measure where the HMO is underperforming
Both BadgerCare Plus and SSI	BC+: Health disparities for PPC – Year 3	SSI: Health disparities for other clinical topic – Year 2

A. PIPs (topics other than the required health disparities reduction projects under part B)

See the 2022-2023 BadgerCare Plus and Medicaid SSI HMO contract requirements for PIPs in Article X, (J). HMOs should select a topic where it is underperforming, such as not meeting a DHS-specified target, or where the HMO is below a state or national average. This is not limited to P4P measures, but could include any performance measure (including a HEDIS measure, a care management measure, or CAHPS result). In its selection of an underperforming measure to address through a PIP, the HMO should consider the availability of sociodemographic data about the population to determine if there are disparities within the baseline that should be targeted in an appropriate intervention, and re-measured throughout the PIP.

The PIP proposal template is due to DHS December 1, 2021. After DHS approval, the HMO's project will operate for CY 2022. The final PIP report is due to DHS and the EQRO by July 1, 2023, and must be submitted using the provided final report template.

PIP proposal template:



PIPProposalFormatGuideline_Dec2021_1101

PIP final report template:



PIPReportFormatGuideline_July2022_110121

B. Health Disparities Reduction PIPs

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

Purpose

This document provides guidance on the **PIP** proposal on Health Disparities for **BC+ and SSI 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 Strategy.

Part B provides background and requirements related to **PIP(s)** for health disparities reduction, which includes a drivers of health (DOH) component.

There are four sections for the Part B: Health Disparities Reduction PIP:

- **Section 1: Overview** of the MY2022 Health Disparities Reduction PIP
- **Section 2: Requirements** of and **Checklist** for the MY2022 Health Disparities PIP
- **Section 3: Resources and References** for HMOs developing 2022 PIPs
- **Section 4: Templates** HMOs must use for submitting their MY2022 Health Disparities Reduction PIP proposal and final report to MetaStar and DMS.

Section 1: Overview of the MY2022 Health Disparities Reduction PIP

Background

Wisconsin DMS recognizes that improving health equity is a foundational strategy for achieving the triple aim: improving the health of Wisconsin's residents, improving the experience of care for Wisconsinites, and containing costs of care to ensure affordability. Persistent and systematic differences in health outcomes for different Wisconsin populations are well documented, and a

key component of Healthiest Wisconsin 2020.⁴ CMS also specifically requires reduction in health disparities to be a part of a state’s quality strategy.⁵ To align with federal and state priorities and to further improvements in health outcomes for all Medicaid members in Wisconsin, the MY2022 health disparities reduction PIP aims to reduce health disparities, improve cultural and linguistic responsiveness among HMOs and providers, and encourage cross-sector partnership to improve drivers of health.

Health disparities are often related to the conditions in which people are born, live, grow, work, and age – also called the drivers of health (DOH). In fact, “upwards of 70% of health outcomes are driven by factors beyond health care.”⁶ Economic resources and geographical location have a proven sizable impact on health outcomes, and so partnerships between communities and the health care system are critical for improving health across the lifespan and reducing disparities in health outcomes. Having data on the unmet social needs of individuals, and using that data to connect to existing community resources and strengthen evidence-based partnerships that improve whole-person health, will be foundational to any effort to eliminate disparities.

Example: postpartum care

Across the United States and in Wisconsin, Black and Hispanic women (as compared to White women) experience greater maternal mortality, pregnancy complications, and higher rates of chronic illness such as hypertension that are particularly dangerous during pregnancy and which frequently lead to post-partum hospitalizations. Disparities in appropriate follow-up postpartum care also put women from racial and ethnic minorities at higher short-and long-term health risk after pregnancy. Medicaid covers almost half of all births in Wisconsin, yet in 2017 and 2018 approximately 1 out of 3 WI Medicaid members eligible to receive post-partum care did not receive the requisite care, both years falling below the national 75th percentile.

HMOs can contribute to reducing disparities in postpartum care in a number of creative ways, such as employing community health workers, expanding provider training in trauma-informed and culturally and linguistically competent ways, partnering with evidence-based models like the Pathways HUBs to address whole-person health needs for moms and babies, or partnering with trusted community-based organizations who support new mothers by addressing drivers of health.

Example: diabetes control

In 2001-2005, the age-adjusted mortality rate for diabetes was 3.3 times higher among American Indians, 2.3 times higher among African Americans, 1.4 times higher among Hispanics/Latinos, and 1.2 times higher among Asians compared to Whites (Wisconsin

⁴ <https://www.dhs.wisconsin.gov/hw2020/report.htm>

⁵ Managed Care Rule 42 CFR 438.340 (b)

⁶ [Health Care Steps Up to Social Determinants: Current Context](#)

Department of Health Services, 2008). SSI HMOs could work with diabetic populations to identify what the key cultural, environmental, and economic barriers are faced that disproportionately impact minority populations, work directly with provider offices to establish team-based care management approaches to supporting individuals with poorly controlled diabetes, or identify/offer peer-led diabetes programs that promote lifestyle changes to help reduce disparities in diabetes management and improve overall outcomes.

Design elements:

1. MY2022 Health Disparities PIP **metrics:**
 - a. BC+: Disparities in **post-partum care (HEDIS)** for each HMO across race/ethnicity
 - b. SSI: Disparities in any of the following topics:
 - i. Adult immunization status (AIS)
 - ii. Chronic condition management
 1. Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
 2. Controlling High Blood Pressure
 3. Other HEDIS measure related to effective management of a chronic condition
 - iii. Behavioral Health measures in P4P
 - c. Each SSI HMO will be required to select a measure from 1.b for their PIP based on their health disparities baseline data across any of the 6 elements in the Medicaid Managed Care Rule (42 CFR 438.340 (b)): race, ethnicity, age, gender, language and disability status.
2. The HMO will be required to report findings to DMS, along with a target reduction in disparities for the 2022 measurement year in their PIP proposal and final PIP Report.
3. Each HMO will be required to undertake initiatives at its **own organizational level and** also at **two provider locations (clinics)** that serves a significant number (50 or more preferred) of its under-represented Medicaid members for whom the measure is applicable (i.e. pregnant women for BC+ or the population of focus for SSI selected in 1b). This reflects ongoing work with the current clinic partner and expansion of efforts to an additional clinic partner by the end of 2022.
 - a. Multiple HMOs may not choose the same provider clinic for the same project.
4. In 2022, each HMO will expand their clinic partnerships to a second clinic, and work with a community-based organization to address highest priority drivers of health needs for the target population.
5. 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.
6. DMS will designate 1.5% from the 2.5% HMO quality withhold to the PIP for Reducing Health Disparities for BC+ and SSI. Earning back this 1.5% withhold for the Health Disparities PIP is not dependent on an HMO's overall HEDIS performance on their selected metrics (e.g., post-partum care for BC+).

7. The 1.5% PIP withhold does not apply to the BadgerCare Plus CLA population, as the BadgerCare Plus focus is on postpartum care.
8. All member materials regarding interventions in this PIP distributed by the HMO and/or the provider clinic, should be tailored to the target population, culturally-responsive, and comply with DHS' member communications and outreach guide. As an example, a letter to members regarding resources for food insecurity should be tailored to address the unique needs of the BadgerCare Plus pregnant/post-partum population and separately tailored for the SSI target population.

Earn-back:

HMOs will earn back their withhold by completing the listed requirements and submitting appropriate documents / reports by due dates listed in Section 2 of this document.

While Parts A, B, and C 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 conduct trainings for providers in a local area, 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 MY2022, 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 data that are granular become available, HMOs and DMS will collaborate to refine this definition. The Medicaid 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 will not use income as a sole 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. This will be done at the HMO level based on HEDIS measures. HMOs may choose to share provider clinic level demographics and disparities in utilization data with the clinic.

Section 2: Requirements of the MY2022 Health Disparities Reduction PIP

Requirements

The EQRO has developed a **PIP proposal template** (*in Section 4 of this document*) for HMOs, which is compliant with 2022 federal requirements for PIPs. HMOs will need to identify the

	31, 2022. (0.05%)	beginning of collaboration/PIP project and submitted with 12/31/22 deliverables.	
	Final assessment submitted with final PIP report July 1, 2023. (0.05%)	The second assessment is done at the end of the PIP project, and can include reflection from both parties on what partnership aspects were successful and what lessons were learned; this second assessment is submitted with the final PIP report by 7/1/23. The goal is to identify effective collaborations between health plans and CBOs during this quality improvement PIP that could be expanded to other partnerships serving mutual populations.	

The below table provides additional details on some of the above components as it relates to expansion of current provider partnership efforts to additional clinics, the CBO partnership, or how the HMO can submit documentation of completion.

Requirement from above table	Description of Deliverable / Data and documentation
<p>HMOs must offer non-traditional culturally competent provider services across the HMO for Medicaid members.</p> <p>BC+ and SSI partner clinics can offer non-traditional culturally competent provider services at the provider site for targeted HMO members.</p> <ul style="list-style-type: none"> • Community health workers (CHW) • Peer support specialists • Traditional healers • Doula services (BC+ PIP only) <p><i>HMOs can meet this requirement by working with employee and/or non-employee providers of non-traditional culturally-competent services.</i></p> <p>SSI HMOs and SSI partner clinics may propose services or interventions as an alternative to the above provider types that will assist with drivers of health for members in the target population.</p>	<p>While there are no specific targets for 2022, HMOs can get credit for this requirement by submitting to DMS <u>any one</u> of the following for the HMO and for each partner clinic:</p> <ul style="list-style-type: none"> • Documentation showing HMO and provider clinic’s use in MY2022 of non-traditional culturally-competent 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, • SSI HMOs and partner clinics opting to provide services or other interventions that address drivers of health instead of the above provider types will be required to submit data about the services offered, including # of members assisted and types of support provided by whom.

<p>Each organization completes a cultural competence self-assessment and creates a disparities reduction plan.</p> <p>New partner clinics must conduct a cultural competence self-assessment and create a disparities reduction plan.</p> <p>HMOs / clinics may consider working with an external consultant for this assessment and to develop a disparities reduction plan based on the results.</p>	<p>HMOs and current partner clinics report progress updates on existing disparities reduction plan (created in 2020 or 2021).</p> <p>New clinics: Submit completed clinic-level self-assessment report – 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 for BC+ members or the clinical measure and disparity focus for SSI members.</p> <p>New clinics: Submit completed clinic-level disparities reduction plan. The plan should focus on 2-3 goals for improvement based on the findings of the self-assessment.</p> <ul style="list-style-type: none"> • Example: Monitor and ensure adequacy of translation and interpretation services at the provider site. The plan should include how the HMO will collaborate with the provider to ensure linguistic competence, including all other CMS and 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. • Example: Include family and community members 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. • Example: Recruit and retain under-represented staff 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>Resources: https://nccc.georgetown.edu/assessments/. Also see “Cultural Competence Resources” at the end of this section.</p>
<p>Conduct provider training in CY 2022 at the selected clinic / site on cultural competence to improve, e.g.:</p>	<p>In the Final Report (7/1/2023), include:</p> <ul style="list-style-type: none"> • Discussion of how provider training was aligned with self-assessment findings.

<ul style="list-style-type: none"> • Awareness, attitudes, beliefs, stereotypes for under-represented members • Specific knowledge of health needs unique to LGBTQ community • Skills in providing culturally competent health care: affect clinical decision making, communication and clinical behavior <p>The training must be performed by culturally-competent trainers, and ideally representative of the population. General trainings, such as an hour-long webinar on cultural competence, should be considered foundational with the goal to deliver trainings to directly improve the identified disparities within the project. Training on culturally responsive and linguistically appropriate care is meant to be an ongoing activity, with training conducted each year.</p>	<ul style="list-style-type: none"> • Documentation on type / dates / location of provider training, description of trainers and content, # of providers trained, broad provider type profiles, # of CME credits awarded
<p>HMO and Partner Clinic DOH Needs Analysis (Part E)</p>	<p>This may be done at the partner clinic level for the HMO’s PIP target population or across the clinic’s entire membership if data is available.</p> <p>The HMO should consider DOH needs data for the entire HMO’s target population (e.g. African American pregnant women for PPC projects). Analyses at both the clinic-level and HMO-level for the target population’s greatest needs may assist in selecting the most culturally and linguistically appropriate CBO to address the DOH intervention in Part F.</p> <p>Both the clinic and HMO should stratify those DOH needs by race, ethnicity, age, sex, language, and disability status in their analysis, where member sociodemographic data is available, to determine the CBO intervention</p>
<p>HMO and CBO DOH intervention (Part F)</p>	<p>HMOs would complete documentation (a template may be provided) that shows consideration for the following in the selection, implementation, and evaluation of the DOH service intervention:</p> <ul style="list-style-type: none"> • Driver of health priority • PIP Intervention(s) to address DOH priority (description of service, number of members served, date launched, description of outreach to members about intervention) • Geographic area • Partner CBO name

	<ul style="list-style-type: none">• Metric(s)• Intervention(s) Cost• Anticipated or Actual Health Outcome(s)• Resource(s) that can be leveraged• Availability of Resource(s) that can be leveraged• Health Disparities Objective(s)• Social impact(s)
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Section 3: MY2022 PIP Resources and References

In this section, DMS has provided resources and references that the HMOs could use for their Health Disparities PIP initiative.

2021 HMO PIP Activities

For further details on the 2021 HMO and partner clinic PIP activities, some of which may be continued into 2022 or throughout 2022, please see the 2021 HMO Quality Guide on the [ForwardHealth Portal](#).

DOH Screening and Additional Resources



PIP_DoH_Workbook_0
32021.docx

- DHS Drivers of Health Workbook:
- DHS Drivers of Health Improvement Plan Template (required for new partner clinics):



2021 PIP DoH Action
Plan template Octobe

- The 2022-2023 BadgerCare Plus and Medicaid SSI HMO Contract also includes requirements for HMOs to conduct drivers of health screenings on adult members for four domains, starting in 2022.
- UCSF SIREN Screening Tool Comparison Table⁷
- Center for Health Care Strategies: Screening for Drivers of health in Populations with Complex Needs: Implementation Considerations⁸
- Institute for Medicaid Innovation: Innovation and Opportunities to Address Drivers of health in Medicaid Managed Care⁹
- [American Hospital Association: Screening for Social Needs: Guiding Care Teams to Engage Patients.](#)
- [National Alliance to Impact the Drivers of health: Identifying Social Risk and Needs in Health Care.](#)
- [Health Leads: Action Plan for a Social Needs Program.](#)
- [The National Association of Community Health The National Association of Community Health Centers \(NACHC\): PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences](#)
- [Centers for Medicaid and Medicare \(CMS\): The Accountable Health Communities Health-Related Social Needs Screening Tool](#)

Cultural Competence

Cultural Competence Plans

- 2019 – Sunshine Health, Florida
<https://www.sunshinehealth.com/content/dam/centene/Sunshine/pdfs/SUN201806SA18CCP.AA.pdf>

⁷ <https://sirennetwork.ucsf.edu/siren-resources/screening-tool-comparison-table-0>

⁸ <https://www.chcs.org/resource/screening-social-determinants-health-populations-complex-needs-implementation-considerations/>

⁹ <https://www.medicaidinnovation.org/images/content/2019-IMI-Social-Determinants-of-Health-in-Medicaid-Report.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
- HRSA <https://www.hrsa.gov/sites/default/files/culturalcompetence/healthdlvr.pdf>
- National Institute on Minority Health & Health Disparities: <https://nimhd.nih.gov/>

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
- Cultural and Linguistic Competence Organizational Assessment Instrument for Fetal and Infant Mortality Review Programs https://nccc.georgetown.edu/documents/FIMR_Assessment.pdf

Maternal and child health

- Cultural competence self-assessment for individual providers:
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

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 4: MY2022 Health Disparities Reduction PIP Templates

- A. BadgerCare Plus PIP Proposal Template for Health Disparities Reduction Projects



PIPDIsparitiesPropo
alFormatGuideline_BC

- B. SSI PIP Proposal Template for Health Disparities Reduction Projects



PIPDIsparitiesPropo
alFormatGuideline_SSI

- C. BadgerCare Plus PIP Final Report Template for Health Disparities Reduction Projects
This file will be provided in Version 2.0 of the Quality Guide.



PIPDIsparitiesRepo
rtFormatGuideline_E

- D. SSI PIP Final Report Template for Health Disparities Reduction Projects
This file will be provided in Version 2.0 of the Quality Guide.



PIPDIsparitiesRepo
rtFormatGuideline_S

VIII. 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 also require the use of a specific diagnosis, 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 a specific diagnosis:

- ICD-10-CM “Z” 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-Z00.01 – 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):

			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)						
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

IX. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey

The **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** survey was developed by the Agency of Health Research and Quality (AHRQ) to capture information from members about their experiences with their health plan and health care providers. Per the Children's Health Insurance Program Reauthorization Act (CHIPRA), CMS requires states to annually survey children in the Children's Health Insurance Program (CHIP) program via CAHPS.

DHS uses the CAHPS to survey both fee-for-service and HMO member experience and satisfaction with care. The survey is performed annually for children in BadgerCare Plus or CHIP populations. The CAHPS survey is used as part of HEDIS reporting and survey data is shared with CMS.

DMS administers CAHPS through a certified vendor, surveying approximately 1,650 fee-for-service members, and 1,650 members from each HMO. Results are stratified by language (English, Spanish, and Hmong), and CHIP, Medicaid, HMO, and FFS populations. DMS follows NCQA protocols for the survey, including:

- Using current CAHPS version 5.1 child questionnaire.
- Eligibility criteria for sampling:
 - Continuous enrollment for the last 6 months prior to 12/31/2021
 - No more than one-month enrollment gap.
- Using mixed survey outreach methodology by survey vendor:
 - questionnaire mailings;
 - reminder mailings;
 - Multiple follow-up call attempts.

DMS will evaluate options to survey adults in 2023, which may include surveying HMO members about their experience of care and satisfaction for 2022 dates of service.

Please note that HMOs are not prohibited from administering the CAHPS survey to their membership. Although DHS is not requiring collection of HMO-administered CAHPS results at this time, DHS may request information in the future.

X. OB Medical Home

Under Article IV, D of the current HMO contract, HMOs serving Regions 5, 6, and Dane and Rock Counties are required to implement Obstetric Medical Home (OBMH) care models. This model has a goal of improved care management and service delivery for high-risk pregnant HMO members in geographic areas with high and disparate rates of poor birth and maternal outcomes.

In addition to the contract language, DHS maintains OBMH resources for HMOs and providers on the ForwardHealth Portal here:

https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Managed_Care_Medical_Homes/Home.htm.spage.

HMOs may contact DHSOBMH@wi.gov with questions on the OBMH requirements.

For questions on the OBMH registry, which is a tool used by participating HMOs and OBMH provider sites, contact MetaStar. The OBMH registry log-in, user guides, and help desk are available on MetaStar's website here:

<https://apps.metastar.com/apps40/commercial/OBMH/OBMH/Login.aspx>

XI. NCQA Accreditation

A. Accreditation Requirements

In March 2021, DMS issued the below policy memo to HMOs. This memo indicates that all HMOs must receive NCQA Health Plan Accreditation (HPA) by December 31, 2023. Additionally, all HMOs must achieve either Multicultural Health Care Distinction (MHCD) or Health Equity Accreditation (HEA) by December 31, 2023, as part of DMS' goals to improve members' access to culturally and linguistically appropriate care.



NCQA Accreditation
Memo 20210325.pdf

HMOs must submit quarterly progress reports on their work towards accreditation using the below template. Once the HMO has achieved HPA and either MHCD or HEA, the HMO is not required to submit quarterly progress reports.



NCQA Quarterly
Progress Report - [HE

B. Accreditation Deeming

As part of DMS' Medicaid Managed Care Quality Strategy ([link to ForwardHealth](#)), DMS and the EQRO complete an accreditation deeming plan and crosswalk of federal requirements to DMS oversight, EQR oversight, and NCQA accreditation.

HMOs with NCQA accreditation are deemed as having met specific federal requirements, and additional DMS or EQRO review is waived as being duplicative. These HMOs are not subject to a comprehensive compliance with standards review by the EQRO. For federal requirements that are not met via accreditation, the EQR conducts a focused accreditation review to bridge the gap for specific standards.

Accreditation status of HMOs is included on the Department's public website, and accreditation review activities are described in the EQRO's annual report, which is published on DMS's public website and submitted to CMS annually, per federal requirements.