Wisconsin Department of Health Services (DHS)
Division of Medicaid Services (DMS)

HMO Quality Guide

Measurement Year (MY2024)

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
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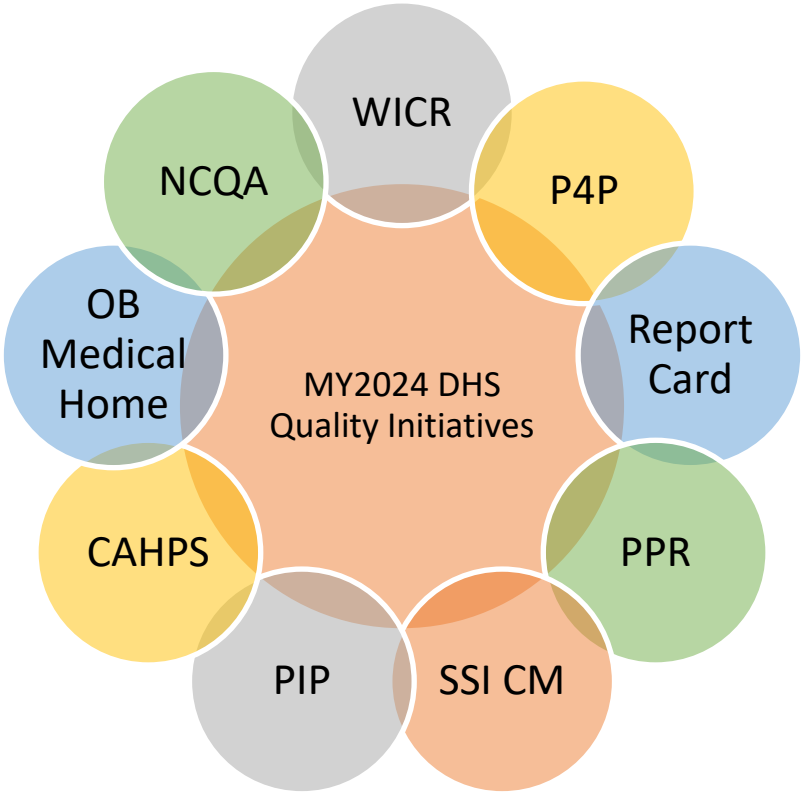
I. Measurement Year 2024 Overview

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 Wisconsin Core Reporting **(WICR)** initiative focuses on providing DMS healthcare quality data for a broad set of conditions and measures related to the Medicaid Core Sets published by CMS. WICR does not include a withhold but requires HMOs to report data on specific quality measures and imposes financial penalties for not reporting results. DMS submits Pay-for-Performance **(P4P)** and WICR results to the Centers for Medicare & Medicaid Services (CMS) and CMS publishes an annual scorecard of state performance.
- The **P4P** initiative focuses on improving the measurable quality of care for Medicaid members served by HMOs. HMOs are subject to capitation withholds that HMOs can earn back based on their performance relative to quality targets for various measures. These measures relate to DMS priorities, 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 **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 **Potentially Preventable Readmissions (PPR)** initiative supports reduction of avoidable non-value-added care as outlined in the Wisconsin Medicaid Managed Care Quality Strategy, Section 4.a.ii. HMOs must work with their public and private hospital and non-hospital providers (e.g., community-based providers, home health providers, among others) to reduce their PPR rates.
- 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 on-going assessments and alignment of the SSI members' needs with their care.
- HMOs conduct two **Performance Improvement Projects (PIPs)** each year as part of their quality assessment and performance improvement (QAPI) program. A PIP is a project conducted by the HMO that is designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction. Both PIPs must focus on reducing disparities among Medicaid members and compliance with the Managed Care Rule requirement defined in 42 CFR 438.340 (b).
- The **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** survey is a survey tool used by DMS 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 an initiative to improve birth outcomes and reduce birth disparities among high-risk pregnant members enrolled in BadgerCare Plus and Medicaid SSI HMOs by providing enhanced care coordination services.
- **National Committee for Quality Assurance (NCQA) Accreditation** is a nationally recognized review process. DMS recognizes NCQA Health Plan Accreditation to avoid duplication of External Quality Review (EQR) activities. DMS requires all HMOs to maintain accreditation for Medicaid and NCQA's Multicultural Healthcare Distinction or Health Equity Accreditation.

Measurement Year (MY) for the initiatives 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 DMS Medicaid Managed Care Quality Strategy[1], which is a three-year strategic plan to improve quality and ensure quality assurance and compliance within managed care programs, including HMOs.

Depending on the specific Medicaid members served, an HMO might participate in multiple quality initiatives.

[1] DMS Medicaid Managed Care Quality Strategy
https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage

Participating HMOs

The table below lists the BadgerCare Plus (BC+) HMOs and Supplemental Security Insurance-Related Medicaid (SSI) HMOs participating in the quality initiatives for MY2024. This list is updated annually.

	HMO	BC+	SSI
1.	Anthem Blue Cross and Blue Shield	✓	✓
2.	Chorus Community Health Plans	✓	
3.	Dean Health Plan	✓	
4.	Group Health Cooperative of Eau Claire	✓	✓
5.	Group Health Cooperative of South Central Wisconsin	✓	
6.	Independent Care (iCare)	✓	✓
7.	Mercy Care Insurance Company	✓	
8.	MHS Health Wisconsin	✓	✓
9.	Molina Healthcare	✓	✓
10.	Network Health Plan	✓	✓
11.	Quartz	✓	✓
12.	Security Health Plan of Wisc	✓	✓
13.	United Healthcare Community Plan	✓	✓

II. 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 FY 2024. While Adult Core Set measures, other than behavioral health, are not mandatory, DMS is working towards improving the number of measures from the Adult Core Set reported to CMS each year.

To improve alignment with current and future CMS requirements (e.g., CHIPRA, Managed Care Rules) and improve quality of care, DMS requires all plans to report audited Healthcare Effectiveness Data and Information Set (HEDIS) data for key measures designated as **Wisconsin Core Reporting (WICR).**

1. 2024 WICR measures are all the NCQA HEDIS measures included in either the 2024 CMS Adult or Child Core Set.
2. HMOs will be subject to a **$10,000 penalty** per measure for not reporting data for any WICR measure as applicable to BC+ and SSI, shown in the table in **Appendix E.**
3. General Submission Considerations
    - HMOs should report results using standard HEDIS specifications unless otherwise specified in **Appendix F.**
    - HMOs are asked to report all age bands, sub-populations (ex: childless adults), and any applicable totals for the measures using standard measure technical specifications.
    - HMOs should follow guidelines for denominators less than 30 for HEDIS measures.

For a full list of WICR measures, in addition to P4P measures and non-WICR measures that are to be reported to DMS, see Appendices E and F.

CMS Medicaid 2024 Adult Core Set

CMS Medicaid 2024 Child Core Set

III. Pay-for-Performance (P4P)

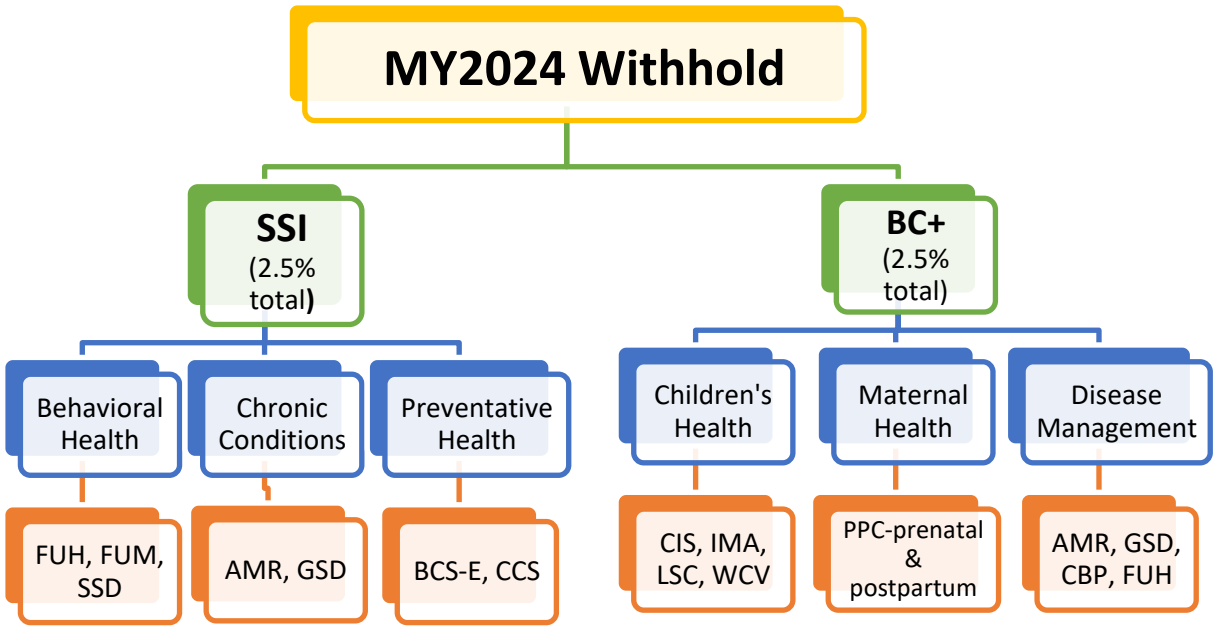
Scope

- **BC+:** All 6 Medicaid Regions
- **SSI:** All 6 Medicaid Regions

DMS will set performance targets for each measure and HMO. Results will be 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. Refer to HEDIS Technical Specifications published by NCQA for details of specific measures.
2. The MY2024 upfront **withhold rate** is 2.5%. The withhold will apply to capitation for BC+ and SSI, including administrative payments.
   a. 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).
   b. Although the scope of the P4P does not include a separate fiscal withhold for the Childless Adult (CLA) population in BC+, CLA members are to be included in the numerators and denominators for each measure.
   c. An HMO can also earn a bonus. See bonus calculation section below.



3. MY2024 P4P Level Targets
   - MY2024 baselines for HEDIS measures are set using MY2024 HEDIS statewide standardized averages and national HEDIS percentiles as published in 2025 NCQA's Quality Compass (MY2024 HEDIS data).

4. Reduction in Error (RIE) Targets
   - Also known as Degree of Improvement, RIE targets require a baseline, established from past performance data.
   - The RIE targets aim to reward HMOs that make significant improvements over time, even if their Level performance does not meet targets. RIE targets are specific to each HMO for each measure, since they are based on the past performance of each HMO.
   - RIE targets are based on MY2022 results.
   - If trending breaks occur in a P4P measure such that RIE is impacted, DMS will evaluate and communicate with HMOs what the revised methodology will be for calculating RIE for that measure.

5. Statewide Averages
   - DHS calculates a statewide average for each measure. These averages are not used to determine P4P earnback but can be a useful tool for HMOs to see how they are performing compared to their peers.
   - Calculations will be completed using the methodology outlined in CMS's Technical Assistance Resource Calculating State-Level Rates Using Data from Multiple Reporting Units[2].

[2] https://www.medicaid.gov/sites/default/files/2023-04/state-level-rates-brief-2023.pdf

MY2024 HMO P4P Measures and Weights

BadgerCare Plus			
Measure		**Weight**	**Area of Care**
Children's Health		**1.00%**	
1.	Childhood Immunization (CIS) - Combo 3	0.25	Primary Care Access and Preventative Care
2.	Immunizations for Adolescents (IMA) - Combo 2	0.25	
3.	Lead Screening in Children (LCS)	0.25	
4.	Child and Adolescent Well-Care Visits (WCV)	0.25	
Maternal Health		**.50%**	
5.	Prenatal Care (PPC)	0.25	Maternal Health
6.	Postpartum Care (PPC)	0.25	
Disease Management		**1.00%**	
7.	Asthma Medication Ratio (AMR) - Total	0.25	Chronic Conditions
8.	*Glycemic Status Assessment for Patients with Diabetes (GSD) – Control <8%	0.25	
9.	Controlling Blood Pressure (CBP)	0.25	
10.	Follow up within 30 days after hospitalization for mental illness (FUH) – Total, 30-day follow-up	0.25	Behavioral Health

** Formerly Hemoglobin A1c Control for Patients with Diabetes (HBD)*

SSI			
Measure		**Weight**	**Area of Care**
SSI		**2.50%**	
1.	Follow up within 30 days after hospitalization for mental illness (FUH) – Total, 30-day follow-up	.4	Behavioral Health
2.	Follow up within 30 days after ED admission for mental illness (FUM)– Total, 30-day follow-up	.4	
3.	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	.4	
4.	Asthma Medication Ratio (AMR) - Ages 19 to 64	.4	Chronic Conditions
5.	*Glycemic Status Assessment for Patients with Diabetes (GSD)– Control <8%	.4	
6.	Breast Cancer Screening (BCS-E)	.1	Preventative Health
7.	Cervical Cancer Screening (CCS)	.4	

** Formerly Hemoglobin A1c Control for Patients with Diabetes (HBD)*

P4P Methodology

The same methodology applies to all measures.

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 national 67th percentile for that measure.
   - 2 points at or above the national 50th percentile for that measure.

   If an HMO does not earn points for its level of performance, it can earn 0 to 2 points based on its reduction in error.
   - 2 points if below the national 50th percentile but with a 10% or greater reduction in error from the HMO's 2022 performance.
   - 1 point if below the national 50th percentile but with a 5% or greater reduction in error from the HMO's 2022 performance.

Point Matrix			
Over 75% nationally	4		
67-74% nationally	3		
50-67% nationally	2		
RIE Point Matrix	**<5% increase over 2022 results**	**5-9.9% increase over 2022 results**	**10% ≥ increase over 2022 results**
<50% nationally	0	1	2

RIE percentage is calculated using the following formula:

$$\%\ \text{RIE for MY2024} = \left\{ \frac{\text{MY2024} - \text{MY2022}}{\text{Error}} \right\} \times 100, \text{ Where Error} = (100 - \text{MY2022})$$

2. **Earning back the withhold:**
   a. An HMO can receive between 0 and 4 points for each measure.
   b. The proportion of the earnback for the measure is equal to the points earned divided by 4 (maximum number of points) multiplied by the measure weight.

$$\text{Percentage of earnback} = \left\{ \frac{\text{Points Earned}}{\text{Maximum Points Possible}} \right\} \times \text{Measure Weight}$$

   c. The total earnback rate is the sum of the earnback proportions of all the measures in the P4P population.

3. **Small denominators:** HMOs should follow guidelines for denominators less than 30. An HMO with less than 30 observations in the denominator for a measure will receive back the full amount withheld for that measure.

4. **Example Calculation:** Table 1 below shows points and earnback calculation examples for two hypothetical HMOs using BadgerCare+.

   - **HMO A**:
     Individual measure calculation: HMO A earned 2 points for the CBP measure as the rate achieved was between the 50th and 67th national percentile. The maximum points available for CBP is 4. Using the *Percentage of Earnback* equations above, HMO A earns back 50% of the measure weight for CPB (.25), for a total of .13%.

     Total Earnback Calculation: The sum of the 10 individual measure earnback percentages for BC+ = 1.41%, therefore HMO A earns back 1.41% out of the maximum 2.5% earnback for the BC+ withhold (shown in the last row of the table).

   - **HMO B:**
     Individual measure calculation: HMO B achieved 55% for the CBP measure, which was below the 50th national percentile. Therefore, the *RIE equation* listed above was used and the HMO achieved an 8.2% reduction in error worth 1 point.

     $$\%\ RIE\ for\ CBP = (55-51)/(100-51) = 8.2\%$$

     The maximum points available for CPB is 4. Using the *Percentage of Earnback* equation above, HMO B earns back ¼ of the CBP measure weight (.25) for a total of .06.

     Total Earnback Calculation: The sum of the 10 individual measure earnback percentages for BC+ = 2.01%, therefore HMO B earns back 2.01% of the maximum 2.5% earnback for the BC+ withhold (shown in the last row of the table).

Table 1: Example Calculations

Measure (Weight)	***Hypothetical* MY2024 Level Targets**			**RIE Targets when HMO 2024 performance is below the national 50th percentile**		**Example Points and Earnback %**			
	≥75th	**≥67th**	**≥50th**						
	4 points	***3 points***	***2 points***	***2 points***	***1 point***	**HMO A Points**	**HMO A Earnback %**	**HMO B Points**	**HMO B Earnback %**
CIS Combo 3 (0.25)	≥ 69.9%	≥ 67.4%	≥ 64.0%	RIE is 10% ≥ over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results = 69.2% Points= 3	(3/4)*.25 = .19	2024 Results= 70.3% Points= 4	(4/4)*.25 = .25
IMA Combo 2 (0.25)	≥ 40.9%	≥ 38.9%	≥ 34.3%	RIE is 10% > over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results = 42.3% Points = 4	(4/4)*.25 = .25	2024 Results= 41.1% Points = 4	(4/4)*.25 = .25
LSC (0.25)	≥ 70.1%	≥ 67.1%	≥ 62.8%	RIE is 10%≥over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results =68.4% Points= 3	(3/4)*.25 = .19	2024 Results= 73.8% Points= 4	(4/4)*.25 = .25
WCV (0.25)	≥ 55.1%	≥ 51.8%	≥ 48.1%	RIE is 10% ≥ over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results =44.2% 2022 Results =38.0% *(10.0% RIE)* Points= 2	(2/4)*.25 = .13	2024 Results=38.0% 2022 Results=27.8% *(14.1% RIE)* Points= 2	(2/4)*.25 = .13
PPC – Pre (0.25)	≥ 88.3%	≥ 86.9%	≥ 84.2%	RIE is 10% ≥ over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results = 86.0% Points= 2	(2/4)*.25 = .13	2024 Results = 89.4% Points= 4	(4/4)*.25 = .25
PPC – Post (0.25)	≥ 82.0%	≥ 80.8%	≥ 78.1%	RIE is 10% ≥ over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results =79.3% Points= 2	(2/4)*.25 = .13	2024 Results =81.2% Points= 3	(3/4)*.25 = .19

Measure (Weight)	***Hypothetical* MY2024 Level Targets**			**RIE Targets when HMO 2024 performance is below the national 50th percentile**		**Points and Earnback %**			
	≥75th	**≥67th**	**≥50th**						
	4 points	***3 points***	***2 points***	***2 points***	***1 point***	**HMO A Points**	**HMO A Earnback %**	**HMO B Points**	**HMO B Earnback %**
AMR (0.25)	≥ 70.8%	≥ 69.4%	≥ 65.6%	RIE is 10% ≥ over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results =62.0% 2022 Results =6.0% *No RIE because 2024 results lower than 2022 results* Point=0	(0/4)*.25 = .00	2024 Results = 69.8% Points= 3	(3/4)*.25 = .19
GSD (0.25)	≥ 57.2%	≥ 55.7 %	≥ 52.3%	RIE is 10% ≥ over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results =53.8% Points= 2	(2/4)*.25 = .13	2024 Results = 56.1% Points= 3	(3/4)*.25 = .19
CBP (0.25)	≥ 67.3%	≥ 65.5%	≥ 61.3%	RIE is 10% ≥ over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results =62.4% Points= 2	(2/4)*.25 = .13	2024 Results=55.0% 2022 Results=51.0% *(8.2% RIE)* Points= 1	(1/4)*.25 = .06
FUH-30 (0.25)	≥ 65.4%	≥ 63.5%	≥ 57.7%	RIE is 10% ≥ over 2022 results	RIE is 5.0-9.9% increase over 2022 results	2024 Results =65.1% Points = 3	(2/4)*.25 = .13	Denominator < 30 Points=4	(4/4)*.25 = .25
Total BC+ Earnback % *(Maximum 2.50%)*							**1.41%**		**2.01%**

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.

An HMO must meet all 3 of the following requirements to be eligible for the bonus.

1. The HMO has reported data for all WICR measures, regardless of the denominator size
2. Have a minimum number of P4P measures with a denominator ≥ 30.
    - BC+ - Minimum 8 out of the 10 P4P measures
    - SSI - Minimum 5 out of the 7 P4P measures
3. HMO must earn back 100% of its BC+ withhold to be eligible for the BC+ bonus. HMO must earn back 100% of the SSI withhold to be eligible for the SSI bonus.

The total bonus earned by any plan will be the total withheld amount forfeited by other plans, capped at the total capitation P4P HEDIS withhold amount for the plan. Max bonus is = to P4P HEDIS withhold.

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 the proportion of enrolled members with specific medical conditions, which is accounted for using the denominator (not the total HMO 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**

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 Report Cards will be published in the 4th quarter of the HMO submission year (e.g., the 2024 results Report Card, using data submitted to DMS in June 2025, will be published in Q4 2025).

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, 3/4th) 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, 2/3rd) 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, 1/3rd) of all Medicaid plans in the nation.
★ = Poor	HMO performed in the lowest 1/3rd of all Medicaid plans in the nation.

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

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
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 that are part of 2024 WICR and/or P4P. The list of measures that will be selected for inclusion in the 2024 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 2024 WICR and are potential measures for the Report Card. DMS intends to publish the Report Card using the areas of care listed below.

Note: When calculating the number of stars an HMO earned, DMS uses the HEDIS rates as reported. No rounding up or down is performed for result calculations. Star ratings, however, will be rounded to 1 decimal point for publication of the overall score.

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-E)	Applicable	Applicable
	Childhood Immunization (CIS)	Applicable	N/A
	Cervical cancer screening (CCS)	Applicable	Applicable
	Chlamydia screening (CHL)	Applicable	Applicable
	Colorectal Cancer Screening (COL-E)	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

Potential Measures for HMO Report Card			
Area of Care	**Quality Measure**	BC+	**SSI**
	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
	Glycemic Status Assessment for Patients with Diabetes (GSD)	Applicable	Applicable
	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Applicable	Applicable
Mental Health Care	Anti-Depressant Medication Management – Continuation (AMM)	Applicable	Applicable
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)	Applicable	N/A
	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	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 with schizophrenia (SAA)	Applicable	Applicable
Hospital and ED Care	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 Readmissions	Living with Illness	Mental Health	Pregnancy & Birth	Staying Healthy	Overall Score (out of 5)
HMO B	★★★★★	★★★★½	★★★★½	★★★★★	★★★★½	4.0
HMO C	★★★★★	★★★	★★★★½	★★★★★	★★★	3.5
HMO A	★	★★½	★★★★½	★★½	★★★	2.8
HMO D	★	★★	★★★★	★½	★★★★½	2.8
HMO E	★	★★★	★★★	★★½	★★	2.5
HMO G	★★★	★½	★★★	★	★★	2.2
HMO F	★★	★	★★★	★	★	1.8
All Wisconsin BC+ HMOs	★★★	★★	★★★★½	★★½	★★	2.8

Example of SSI Report Card

Medicaid SSI HMO	Hospital and ED Readmissions	Living with Illness	Mental Health	Staying Healthy	Overall Score (out of 5)
HMO E	★★★★★	★★★★	★★★★½	★★★★★½	3.9
HMO B	★★★★	★★★★½	★★★★½	★★	3.3
HMO C	★	★★½	★★★★	★★★★½	3.1
HMO A	★	★★★★	★★★	★★½	2.9
HMO D	★	★★★	★★★	★★	2.6
All Wisconsin SSI HMOs	★★	★★★	★★★★	★★½	3.2

V. Potentially Preventable Readmissions (PPR)

1. Overview of the HMO PPR Initiative

This incentive supports reduction of avoidable non-value-added care as outlined in the Wisconsin Medicaid Managed Care Quality Strategy, Section 4.a.ii. HMOs must work with their public and private hospital and non-hospital providers (e.g., community-based providers, home health providers, among others) to reduce their PPR rates.

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 DMS's focus is on the impact of HMO-specific initiatives with their providers, recognizing that there will be variation across providers and HMOs.

d. 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.

e. **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 DMS's vendor, Milliman, has not shown a variation in the ABRs across the Medicaid rate regions.

f. 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.

g. 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.

h. PPR calculations for an HMO are based on all providers serving the Medicaid members of that HMO. There are no minimum thresholds for the number of Qualifying Admissions for HMOs.

i. **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 (like recipients switching hospitals for hospital PPR chain).

j. **Transfer of patients across facilities**: All transfers across facilities are handled in a similar manner, regardless of diagnoses (e.g., behavioral health, others).

k. **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 DMS.

4. HMO PPR Initiative

a. **Population in scope:**
MY 2024 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.

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

HMO ABR value used for baseline is shown in row *K* in the HMO BC+ PPR Summary

report shared by DMS with the HMOs.
Numerator = QAs with associated PPR (Initial Admissions), shown in row *E1* in the HMO BC+ Summary PPR report
Denominator = Benchmark PPR Chains, shown in row *I* in the HMO BC+ PPR Summary 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 2024:**
MY 2022 HMO-specific ABR performance results will be used to establish the baselines for MY2024, 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. **Incentive**
For MY 2024, HMOs will have an upside incentive only, with no PPR-related penalties. DMS will set aside a pool of funds as upside incentive, to be distributed among HMOs that meet their targets for percentage % reduction in their ABR, as value-based payments. HMOs that do not meet the target will not receive any PPR incentive funds.

e. **DMS guidance to HMOs:**
DMS expects HMOs to identify how best to work with their providers. DMS would like to see HMOs develop their plans to reduce PPRs jointly with their providers; DMS also encourages HMOs to collaborate with other HMOs to identify joint focus areas to reduce PPRs with common providers.

f. **Methodology for targets and incentives:**
Each HMO will be eligible to earn a prorated 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.

DMS 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):
DMS 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**, DMS 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.

BadgerCare Plus 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)**		
	Tier 1 - High performance HMOs	***Tier 2 - Middle performance HMOs***	***Tier 3 - Low performance HMOs***
100%	5% or more	7% or more	10% or more
75%	3% to 4.9%	4% to 6.9%	7% to 9.9%
50%	1% to 2.9%	2% to 3.9%	4% to 6.9%
25%	0.25% to 0.9%	0.5% to 1.9%	1.5% to 3.9%

Interpreting the "PPR Reduction Targets" table:

1. Identify the tier in which an HMO was placed, based on its baseline year ABR.
2. 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."
3. 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 / 158,000 = 25.3% share.
- Assume DMS sets aside $5 million as the total incentive pool (shown in the last row for Column 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 25.3% of $5 million = $1,265,823.
- 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.

PPR incentive payments for MY 2024 will be disbursed in 2025, after data for the full MY 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 their specific incentive sharing ideas with DMS.
   - HMOs have flexibility in negotiating how they share incentive dollars with their providers. DMS believes that the HMOs' interest in ensuring a hospital is not penalized by one HMO while being rewarded by another will 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 MY2024, 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 MY2024. HMOs are required to maintain supporting documentation of time and expenses to share with DMS upon request. HMOs will be asked to attest to the accuracy of such expenses. HMOs are welcome to discuss their plans for establishing internal teams with DMS.

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 DMS from sharing grouped PPR claims with plans. PPR software can be purchased from 3M using default settings. DMS intends to share **three types of PPR reports** with HMOs, to balance the timeliness and completeness of such reports (also see the table below):

i. **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.

j. **Preliminary annual reports:** HMOs will receive "preliminary" annual reports about5.5 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.

k. **Final annual reports:** HMOs will receive the "final" annual reports about 9.5 months after the end of the MY. HMOs will have the opportunity to provide feedback to DMS 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:
2023			
1/1 – 3/31	5/15/2023	5/15/2023 (data for MY2022)	N/A
4/1 – 6/30	8/15/2023	N/A	N/A
7/1 – 9/30	11/15/2023	N/A	N/A
10/1 – 12/31	2/15/2024	N/A	N/A
2024			
1/1 – 3/31	5/15/2024	5/15/2024 (data for MY2023)	N/A
4/1 – 6/30	8/15/2024	N/A	N/A
7/1 – 9/30	11/15/2024	N/A	9/15/2024 (data for MY2023)
10/1 – 12/31	2/15/2025	N/A	N/A

VI. SSI Care Management

The SSI Care Management Initiative is designed to improve overall quality of life for medically complex SSI members, incorporating high-touch, high-intensity interventions. HMOs are responsible for establishing a team-based care management model. The care structure and care management model must assure coordination and integration of all aspects of all SSI members' health care needs. The HMO must also promote effective communication and shared decision-making between care management team and the member regarding the member's care.

DMS 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. Performance results on either mechanism may be included in the HMO Report Card or other publicly available quality reports (e.g., Annual EQR Technical Report, Managed Care Quality Strategy).

Utilization Analysis

DMS will analyze the encounter data with G codes submitted by the HMOs to evaluate how well the care management services delivered by the HMOs meet the program objectives. Data reported will be analyzed to compare HMOs performance and to evaluate overall effectiveness of the initiative.

DMS will share G-code utilization data with HMOs.

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

HMO performance will be calculated using the following points and measures:

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 the Wisconsin Interdisciplinary Care Team (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	**<u>New members</u>** *(enrolled after 1/1/2024; not enrolled in the same HMO for the past 6 months or longer):* **(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 ***Calculated quarterly*** *by DMS using code G9001* DMS will track timeliness of care planning, from date of enrollment; Calculated quarterly by DMS using code G9001; Histograms for 90 days, 120 days, 150 days and beyond.
Needs Stratification	Use Care Management (G) codes 9002, 9006, 9007 or 9012; ***Calculated by month*** *by DMS after data submission deadline:* **<u>WICT (up to 5% of SSI membership)</u>** *Data point 1: # of unique members each month with any <u>G code + TG modifier</u> (= WICT stratum)* **(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) **(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 **(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 *Create a histogram for NS3 (# of months and corresponding # of members)* **<u>Medium stratum (next highest after WICT)</u>** *Data point 2: # of unique members each month with any G code + TF modifier (= Medium stratum). There is no payment difference between TF modifier*

Step	Data Reporting Description
	and no modifier. **(NS4): % enrollment in Medium stratum for each month** = Data point 2 / total # of members enrolled for that month **(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 **<u>Lower stratum (all combined after Medium)</u>** *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.* **(NS6): % enrollment in Lower stratum for each month** = Data point 3 / total # of members enrolled for that month **(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
Transition Care	**Calculation annually** by DMS *Data point 4: Total # of discharges from inpatient stay during the reporting period* *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* *Create a frequency distribution / histogram for data point 5 (# of days for follow-up)* **(TC1): % of all discharges from inpatient stay with a follow-up Transition Care service** = Sum of Data point 5 / Data point 4 **(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

Qualitative EQRO Review of SSI Care Management Process Quality

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*. For its review, the EQRO will use MMIS enrollment data to create samples for each HMO to identify members in WICT (Wisconsin Interdisciplinary Care Team), medium, and low strata. The sample size will be an 80% confidence rate based on the HMO's entire enrollment.

Reviews will be spread out throughout the year with one to two HMOs reviewed per month. The 2024 reviews will measure the 12 months preceding the review.

EQRO Review
Care Plan Development - *EQRO will focus on assessing whether HMOs are complying with the Care Plan development requirements in the HMO Contract.* a. Is the Care Plan developed based on a screening conducted within 60 days of new member's enrollment in the HMO or at least every 12 months for current members? The HMO should not use screening data greater than 30 days old. b. Is the screening comprehensive as identified in the BC+ and SSI HMO Contract? This includes: i. The member's chronic physical health needs (including dental) ii. The member's chronic mental and behavioral health needs (including substance abuse) iii. The member's perception of their strengths and general well-being iv. If the member has a usual source of care v. Any indirect supports the member may have vi. Any relationships the member may have with community resources vii. Any immediate and/or long-term member concerns about their overall well-being (including SDOH) viii. Activities of daily living assistance needs ix. Instrumental activities of daily living assistance needs c. Is the Care Plan an evidence-based plan of care that: i. Identifies the member's needs, including a) Formal and informal supports b) Chronic conditions and acute illnesses c) Mental and behavioral health conditions d) Dental care needs e) Medications taken by the member; any concerns with member's understanding and use of medications f) Additional supports needed to conduct activities of daily living or instrumental activities of daily living g) Social determinants of health ii. Defines specific goals that the member wants to achieve and that are appropriate to address his/her needs? (Yes/No)

EQRO Review
iii. 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) iv. Describes the interventions that will be implemented to address the member's needs and their sequence? (Yes/No)
WICT –*To answer the questions below, the EQRO will request the HMO's WICT policies and procedures, care management records for the members in the sample, and WICT meeting minutes. EQRO will focus on assessing whether HMOs are complying with the Care Plan development requirements in the BC+ and SSI HMO Contract.* a. Well-functioning WICT - Is there evidence of a well-functioning interdisciplinary team: i. A minimum of two licensed health care professionals with adequate expertise across medical, mental, and behavioral health, and social determinants of health, with access to resources such as pharmacists, physicians, psychiatrists, dieticians, rehabilitation therapists, and substance abuse specialists as needed? ii. A Core Team meets weekly to discuss their entire shared case load? (Yes/No) iii. A 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) *The EQRO will look for evidence in the member's care plan and care management notes. 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).* b. Face-to-face requirement – Is there evidence in the member's Care Plan that at least one member of the WICT Core Team meets at least once a month face-to-face with the member to discuss a need identified in his/her care plan? (Yes/No) *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. The face-to-face visit must be documented as a care coordination and monitoring activity in the member's care plan.* c. Graduation i. Does the member's Care Plan clearly identify the criteria for the member to graduate from the WICT? (Yes/No) ii. Is there evidence of the WICT being a short-term (i.e., less than 12 months) intensive intervention? (Yes/No) iii. 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)

EQRO Review
Care Management Service Delivery – *EQRO will look for evidence in the care management records of members in the sample to address the questions below.* a. Compliance with the Care Plan - Are services, including any planned follow-ups with members, delivered according to the Care Plan? b. Member-centric Care i. 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) ii. 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." iii. Is there evidence that the HMO is asking members if their needs are being addressed? (Yes/No) c. Social Determinants (SD): i. Is follow-up on SD documented in the Care Plan? (Yes/No) ii. Did the HMO go beyond simple referrals and sharing phone numbers to provide community resources with the member? (Yes/No) *EQRO will describe HMO efforts to address social determinants including how they are working collaboratively with community resources or utilizing Community Health Workers* d. Behavioral Health i. Does the HMO follow-up to address the member's behavioral health needs identified in the Care Plan? (Yes/No)
Care Plan Review & Update –*The EQRO will 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.* a. Is the HMO reviewing and updating the Care Plan based on the criteria defined in the BC+ and SSI HMO Contract? (Yes/No) b. At least once per 12 months? (Yes/No) c. According to the HMO's policies and procedures for reviewing Care Plans and re-stratifying members? (Yes/No) d. Whenever the member is not responsive to the Care Plan or whenever the member frequently transitions between care settings? (Yes/No) e. Does the HMO re-stratify members after a change in the level of care or critical events such as a discharge from emergency departments, hospitals and nursing homes or rehabilitation facilities, as appropriate? (Yes/No)

EQRO Review
Discharge Follow-up / Transitional Care – *EQRO will review member care management records to determine compliance with the transitional care contract requirements.* a. Did the HMO's transitional care follow-up meet the transitional care requirements in the applicable *BC+ and SSI HMO* Contract? b. How was the HMO notified of the member's hospital admission? c. Was the follow-up in-person, via interactive video, or over the phone? d. Is there evidence that the transitional care follow-up included: 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? e. Did the HMO assist members with scheduling appointments with other health care providers after discharge? (Yes/No) f. Did the follow-up occur within five business days of hospital discharge? (Yes/No) *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 schedule follow-up appointments, understand their medication schedule, and implement their treatment plan.*

VII. Performance Improvement Projects

HMOs must conduct two Performance Improvement Projects (PIP) each year. See the current HMO contract for the PIP requirements. HMOs must work with DMS's EQRO to meet specific, CMS-defined project requirements. CMS's External Quality Review (EQR) Protocols[4] may be a helpful reference in developing the PIP and completing the template.

- PIP proposals and final reports must be submitted using the template provided in Appendix J. Due dates for submissions are provided in Appendix D.
- The EQRO PIP Standards and Scoring and the PIP Scoring Aggregate Report Example may be useful tools for HMOs in developing their PIP proposals and final reports. See Appendices H and I.
- Additional guidance on PIPs is available through the HMO PIP Trainings[5] on proposals (PIP 101 Training) and validation (PIP 102 Training).
- In addition to validating PIPs for sound methodology, the EQRO will evaluate PIPs for significant improvement as required by the CMS EQR Protocols. Starting with PIPs conducted during calendar year 2023 and reviewed in 2024, the EQRO will request the following data to determine this rating:
    - The raw numbers the HMO used to calculate the baseline and repeat measures (final measure) for each aim statement of each PIP, e.g., numerators and denominators.
    - The monitoring data the HMO reviewed during the PIP that correlates with the aim statements, such as monthly administrative data.
    - HMOs should submit raw numbers, not percentages.
    - If HMOs include this data in their final reports, a separate submission will not be needed.
    - The EQRO will utilize the rating scale below to validate these measures.

Rating 1: EQRO's Overall Confidence that the PIP Adhered to Acceptable Methodology for All Phases		Rating 2: EQRO's Overall Confidence that the PIP Produced Evidence of Significant Improvement	
Validation Results	**Percentage of Scoring Elements Met**	**Validation Results**	**Confidence Level**
High Confidence	90.0% - 100.0%	High Confidence	90.0% - 100.0%
Moderate Confidence	80.0% - 89.9%	Moderate Confidence	80.0% - 89.9%
Low Confidence	70.0% - 79.9%	Low Confidence	70.0% - 79.9%
No Confidence	<70.0%	No Confidence	<70.0%

[4] CMS External Quality Review (EQR) Protocols: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf

[5] HMO PIP Trainings: https://vimeo.com/showcase/9388305

PIPs as a Strategic Initiative

To align with Federal and State priorities and to further improvements in health outcomes for all Medicaid members in Wisconsin, HMOs must focus on reducing health disparities in the populations the HMOs serve for both PIPs.

Wisconsin DMS recognizes that improving health equity is a foundational strategy for 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[6]. CMS also specifically requires reduction in health disparities to be a part of the State's quality strategy[7].

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."[8] 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 is foundational to any effort to eliminate disparities.

PIP Structure

Per federal requirements, HMOs must complete one clinical project and one non-clinical project. HMOs that serve both BC+ and SSI populations can include both populations in their PIPs. HMOs that choose this option must include separate baseline and target data for each population in their proposal (with two separate aim statements) and report data separately in their final PIP reports.

Options for HMOs serving BC+ **and** SSI Populations:

Option	Clinical Topic	Non-Clinical Topic
1	BC+ Population	SSI Population
2	SSI Population	BC+ Population
3	BC+ **AND** SSI Populations	BC+ Population **OR** SSI Population
4	BC+ Population **OR** SSI Population	BC+ **AND** SSI Populations
5	BC+ Population **AND** SSI Population	BC+ Population **AND** SSI Population

[6] https://www.dhs.wisconsin.gov/publications/p0/p00187.pdf
[7] https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html
[8] Health Care Steps Up to Social Determinants: Current Context

Topic Selection

HMOs must select a topic for each PIP where there is an identified disparity in the target population, based on rural/urban residence, race, ethnicity, sex, gender, age, primary language, disability, etc., regardless of overall performance in the measure. This is not limited to P4P measures but could include any performance measure (including a HEDIS measure, a care management measure, or CAHPS result).

HMOs should consider how partnerships with community-based organizations (CBOs) and providers can address the identified disparity when selecting a topic. HMOs may continue to partner with CBOs or providers from prior PIPs or are encouraged to develop new partnerships based on the PIP topic, target population, and intervention strategies selected. If HMOs partner with CBOs or providers, they should describe how these partnerships addressed the identified disparity in their final reports.

Suggested Topics

DMS has identified some suggested PIP topics. HMOs may propose alternative performance improvement topics during the preliminary topic selection summary process, but topic selection is subject to DMS approval.

Suggested Clinical Topics

1. Adolescent immunizations
2. Antidepressant medication management
3. Asthma management
4. Blood lead testing
5. Breast cancer screening
6. Cardiovascular care
7. Childhood immunizations
8. Childhood obesity interventions
9. Dental care
10. Diabetes management
11. Emergency department utilization
12. Well Child Visits
13. Medication reconciliation upon discharge
14. Behavioral health and substance abuse screenings and management
15. Tobacco cessation
16. Hypertension management
17. Preventable hospital readmissions

Suggested Non-Clinical Topics

1. Access and availability of services
2. Member satisfaction and experience of care
3. Social Determinants of Health
4. Implementation of Culturally and Linguistically Appropriate Services (CLAS Standards)
5. Care coordination
6. SSI Care Management

VIII. 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 survey children in the Children's Health Insurance Program (CHIP) program annually via CAHPS.

DMS 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 the BadgerCare Plus and 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 12/31/2023
  - No more than one-month enrollment gap.
- Using mixed survey outreach methodology by survey vendor:
  - Questionnaire mailings
  - Reminder mailings
  - Multiple follow-up call attempts

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

IX. OB Medical Home

The HMO contract requires HMOs serving Milwaukee, Kenosha, Ozaukee, Racine, Washington, Waukesha, Dane, and Rock Counties to implement Obstetric Medical Home (OBMH) care models. This initiative 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, DMS 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.

The HMO must submit a report evaluating its OB Medical Home initiative to DMS upon request using a survey link provided by DMS.

EQRO Review

- The focus of the EQRO OB Medical Home Review process is to ensure HMO and clinic compliance with OBMH requirements defined in the BC+ and Medicaid SSI HMO contract.
- On a quarterly basis, EQRO identifies members enrolled in the OBMH with delivery dates occurring three to six months prior to the review occurring. HMOs are required to provide the EQRO with the member's medical records, and the EQRO uses a review tool and review guidelines to evaluate compliance with OBMH requirements.
- For questions on the OBMH registry, which is a tool used by participating HMOs and OBMH provider sites, contact DMS's EQRO. The OBMH registry log-in, user guides, and help desk are available on the EQRO website: https://apps.metastar.com/apps40/commercial/OBMH/OBMH/Login.aspx

HMOs are paid an incentive of $1,000 (to pass through to the OB medical home site) per enrolled OBMH member whose care was in compliance with OBMH requirements. An additional $1,000 bonus is paid for those members who met the OBMH requirements and the person giving birth had a healthy birth outcome.

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

X. NCQA Accreditation Desk Review

DMS and its EQRO complete an accreditation deeming plan as part of DMS' Medicaid Managed Care Quality Strategy. The deeming plan includes a crosswalk between federal requirements, NCQA accreditation requirements, DMS oversight, and EQRO oversight.[9]

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

[9] HMO Accreditation Deeming Plan can be accessed on the ForwardHealth Portal here: https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Quality_for_BCP_and_Medicaid_SSI/Home.htm.spage

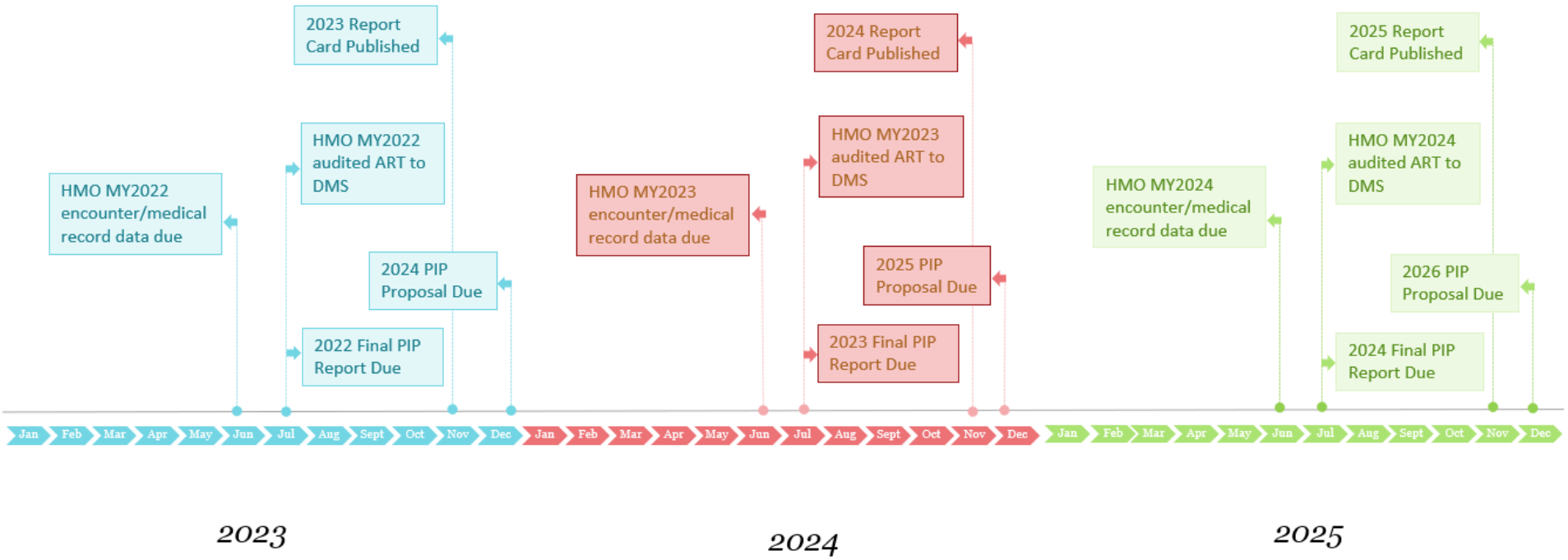
Appendix A: Timeline of Quality Initiative

Timelines for 2024 Quality Initiatives	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
WICR												
HMO 2023 final encounter/medical record data to DMS (used for any DMS-calculated measures)												
HMO audited review tables (ARTs) of 2023 data to DMS												
Patient-Level files for 2023 data to DMS												
DMS calculates and submits Core Set measures to CMS												
2025 WICR measure selection process (CMS Core Set published December)												
P4P												
HMO 2023 final encounter/medical record data to DMS (used for any DMS-calculated measures)												
HMO audited review tables (ARTs) of 2023 data to DMS												
Prelim results from DMS												
HMO validation of results												
Final results from DMS												
Report Card												
HMO audited review tables (ARTs) of 2023 data to DMS												
DMS calculates star ratings and shares with HMOs												
DMS publishes 2023 report card												
PPR												
Prelim results												
Final results												
PIP												
MY2023 HMO final report to EQRO												
MY2025 HMO PIP proposal due												
CAHPS												
DMS's vendor delivers CAHPS survey												
Vendor receives results data; Data submitted to AHRQ												
Final report delivery to DMS												
DMS presents 2024 results to HMO; 2025 Planning												
Other												
Fee-For-Service (FFS) Data Extract Request												

Appendix B: Yearly Quality Initiative and Data Reporting Cycle

Yearly Cycle

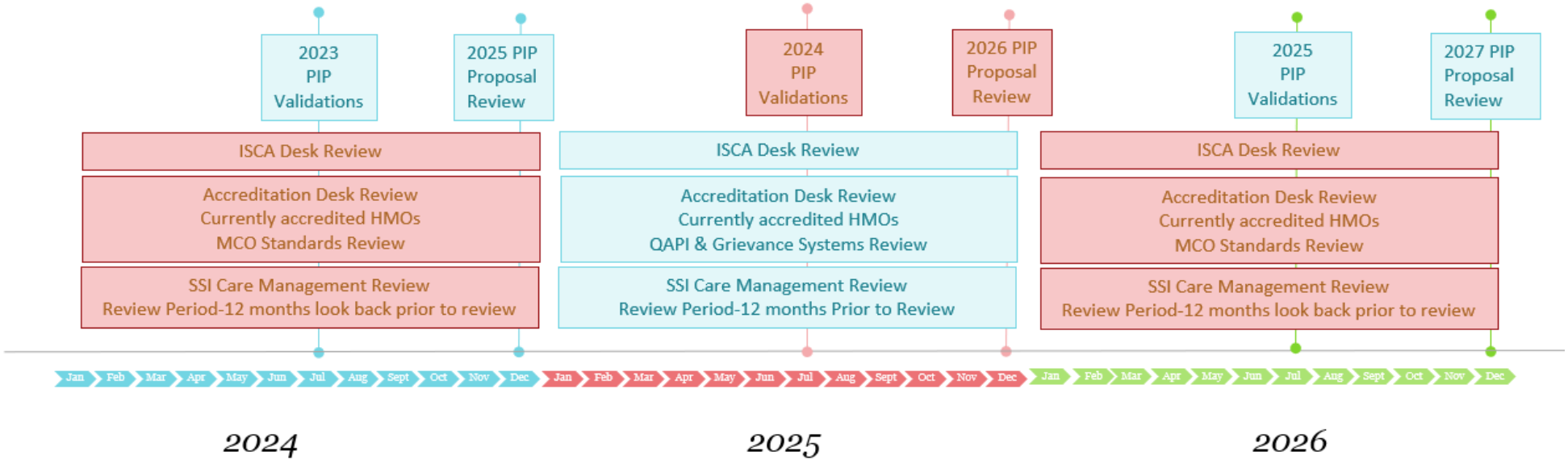
Quality Initiative and Data Reporting



Appendix C: 3 Year EQRO Review Cycle

3 Year EQRO Review Cycle

- The Accreditation Desk Review and SSI Care Management Review will occur concurrently for each HMO. All HMO reviews will be scheduled throughout calendar year 2024.
- Each year one third of HMOs will have Information System Capabilities Assessment (ISCA) review each year starting in 2024



Appendix D: Deliverables Due Dates & Submission Instructions

Frequency	Report/Deliverable	Due Date	Template
Patient Level Detail Report	• Email to DHSDMSHMO@dhs.wisconsin.gov and to VEDSHMOSupport@wisconsin.gov notifying them when the files have been placed on the SFTP server	7/31/2024 for MY2023	File layout for the Patient Level Detail *(to be posted at later date)*
Performance Improvement Project (PIP) Final Project Report	• Email to DHSDMSHMO@dhs.wisconsin.gov and EQRO contact by password protected email attachment. • Report is due on the 1st business day of July for the prior calendar year's PIP.	7/3/2024 For 2023 projects 7/1/2025 for 2024 projects	Appendix J
HMO audited review tables (ARTs) of 2023 data to DHS	• Data files and documents are to be submitted to DMS via the SFTP server • See Appendix F for instructions.	7/31/2024	
Fee-For-Service (FFS) Data Extract Request (HEDIS Supplemental File)	• HMOs must submit to DMS a file with member IDs for whom HMOs would like to receive FFS data	11/15/2024	
Initial Performance Improvement Project (PIP) Proposal	• Email to DHSDMSHMO@dhs.wisconsin.gov and EQRO contact by password protected email attachment. • Initial proposal is due on the first business day of December for the next calendar year.	12/1/2023 for 2024 projects 12/1/2024 for 2025 projects	Appendix J
Quality Work Plan	• Email to DHSDMSHMO@dhs.wisconsin.gov	4th Monday in January 2024	No template requirement, HMOs may use same format as NCQA submission
Annual Evaluation	• Email first evaluation of the Quality Workplan to DHSDMSHMO@dhs.wisconsin.gov	July 15, 2025	
SSI Care Management	N/A		
PPR	N/A		
CAHPS	N/A		

Appendix E: Table of Measures: WICR, P4P, and Report Card

BadgerCare Plus			
	WICR	**P4P**	**Report Card**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	✓		✓
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)	✓		✓
Ambulatory Care: Emergency Department (ED) Visits (AMB)			
Antidepressant Medication Management (AMM-AD)	✓		✓
Asthma Medication Ratio: Ages 19 to 64 (AMR-AD), Ages 5 to 18 (AMR-CH)	✓	✓ Total	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	✓		✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	✓		✓
Breast Cancer Screening (BCS-E)	✓		✓
Controlling High Blood Pressure (CBP-AD)	✓	✓	✓
Cervical Cancer Screening (CCS-AD)	✓		✓
Chlamydia Screening in Women (CHL)	✓		✓
Childhood Immunization Status (CIS-CH)	✓	✓ Combo 3	✓
Colorectal Cancer Screening (COL-E)	✓		✓
Follow-Up After ED Visit for Substance Use (FUA-AD), Ages 13 to 17 (FUA-CH)	✓		✓
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD), Ages 6 to 17 (FUH-CH)	✓	✓ Total, 30- day	✓
Follow-Up After ED Visit for Mental Illness (FUM-AD), Ages 6 to 17 (FUM-CH)	✓		✓
Glycemic Status Assessment for Patients with Diabetes (GSD)	✓	✓ <8.0% Control	✓
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) **(Core Set Measure, not HEDIS)**			
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	✓		✓
Immunizations for Adolescents (IMA-CH)	✓	✓ Combo 2	✓
Lead Screening in Children (LSC)	✓	✓	✓
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) (**Core Set Hybrid Measure)**			
Plan All-Cause Readmissions (PCR-AD)	✓		✓
Prenatal and Postpartum Care (PPC)	✓	✓ pre- & post-partum	✓

BadgerCare Plus continued	WICR	P4P	Report Card
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	✓		✓
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	✓		✓
Well-Child Visits in the First 30 Months of Life (W30-CH)	✓		✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	✓		✓
Child and Adolescent Well-Care Visits (WCV-CH)	✓	✓	✓

SSI			
	WICR	**P4P**	**Report Card**
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-AD)	✓		✓
Antidepressant Medication Management (AMM-AD)	✓		✓
Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	✓	✓	✓
Breast Cancer Screening (BCS-E)	✓	✓	✓
Controlling High Blood Pressure (CBP-AD)	✓		✓
Cervical Cancer Screening (CCS-AD)	✓	✓	✓
Glycemic Status Assessment for Patients with Diabetes (GSD**)**	✓	✓ <8.0% Control	✓
Chlamydia Screening in Women Ages 16 to 20 (CHL-AD)	✓		✓
Colorectal Cancer Screening (COL-E)	✓		✓
Follow-Up After ED Visit for Substance Use (FUA-AD)	✓		✓
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	✓	✓ 30 days	✓
Follow-Up After ED Visit for Mental Illness (FUM-AD)	✓ 7 days	✓ 30 days	✓
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD) **(Core Set Measure, not HEDIS)**			
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	✓		✓
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) **(Core Set Hybrid Measure)**			
Plan All-Cause Readmissions (PCR-AD)	✓		✓
Prenatal and Postpartum Care (PPC-AD)	✓		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	✓		✓
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	✓	✓	✓

Appendix F: Data Reporting Specifications

In addition to the WICR initiatives, HMOs shall submit all other NCQA HEDIS measures results to DMS. Results will be used for potential future baseline measurements.

- Those measures where the primary collection method is a survey are not included in WICR; however, HMOs are still responsible for reporting.
- There is not a fiscal penalty if HMOs fail to submit a non-WICR measure.

Any HEDIS performance measures retired or modified by NCQA that impact the HMO initiatives during MY2024 will be discussed and documented in a Quality Guide amendment.

HMOs should report results using **standard HEDIS specifications** for all measures.

Data Submission and Reporting for BC+ and SSI

1. **NCQA Data submission requirements for HEDIS data- BC+ and SSI – All Regions**

   HMOs are required to submit the following for MY2024:

   a. **Data Filled Workbook, including Audit Review Table (ART) format** downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied) as an CSV file. HMOs must provide to DMS the **denominators and numerator for each measure**.

   b. The Audit Report produced by a NCQA Licensed HEDIS Auditor.

   c. 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.

   d. **Submit files Electronically.**

   - Data files (including ARTs) and documents are submitted to DMS via the Secure File Transfer Protocol (SFTP) server.
   - All electronic data files must be in csv format submitted using the following file naming convention:

   <MY>_<PG>_<HMOID>_<custom part>.csv

   - MY must be a 4-digit year
   - PG must be “BC” or “SSI”
   - HMOID must be from table below
   - “Custom Part” is for HMO to add HMO name and additional info they need for file identification
   - No special characters (except underscores "_") in filename, no whitespace character in the entire filename.

   - Do not ZIP files together, upload the files separately.

HMO	PG	HMO ID
Anthem Blue Cross and Blue Shield	BC	69009026
Anthem Blue Cross and Blue Shield	SSI	69009134
Chorus Community Health Plans	BC	69006500
Dean Health Plan	BC	69000200
Group Health Cooperative of Eau Claire	BC	69001600
Group Health Cooperative of Eau Claire	SSI	69007700
Group Health Cooperative of South Central Wisconsin	BC	69000100
Independent Care (iCare)	BC	69009000
Independent Care (iCare)	SSI	69002600
MHS Health Wisconsin	BC	69002400
MHS Health Wisconsin	SSI	69006000
Mercy Care Insurance Company	BC	69004700
Molina Healthcare	BC	69004600
Molina Healthcare	SSI	69006200
My Choice Wisconsin Health Plan Inc	SSI	69009103
My Choice Wisconsin Health Plan Inc	BC	69009117
Network Health Plan	BC	69004800
Network Health Plan	SSI	69006300
Quartz	BC	69009146
Quartz	SSI	69009169
Security Health Plan of Wisc	BC	69004300
Security Health Plan of Wisc	SSI	69009165
United Healthcare Community Plan	BC	69000900
United Healthcare Community Plan	SSI	69006100

2. Public Reporting

For MY2024, 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.

3. Patient Level Detail files are required

Although NCQA requires only Medicare plans to submit patient-level data for HEDIS measures that are calculated and submitted by HMOs, HMOs must submit Medicaid patient-level data for HEDIS measures calculated by HMOs' HEDIS vendors. The purpose of such patient-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 patient-level measure data that details patient's Medicaid ID # and available demographic data such as age, gender, race, ethnicity, 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.

4. Supplemental HEDIS 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 measurement year, so that HMOs can get the credit for measures that rely on FFS data. 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.

DMS will provide HMOs instructions on how to submit requests for supplemental data file extracts in October 2025. HMOs must submit their request to DMS between November 1st and November 15th, 2025.

Appendix G: Flow Chart on HEDIS and Data Alignment

DMS will be revising the Data Flow Chart for 2024 and adding it back in a later version of the Quality Guide. If HMOs have questions about how P4P, WICR, Report Card, HEDIS and Quality Compass are connected, send questions to dhsdmshmo@dhs.wisconsin.gov.

Appendix H: PIP Standards and Scoring

PIP Standards and Scoring

Reference: Department of Health and Human Services. Centers for Medicare and Medicaid Services. (February 2023). *EQR Protocol 1. Validation of Performance Improvement Projects; A Mandatory EQR-Related Activity.* Retrieved from https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf.

#	Standards
1	**PIP Topic** 1.1 The PIP topic was selected through a comprehensive analysis of MCO enrollee needs, care, and services. 1.2 The PIP topic considered performance on the CMS Child and Adult Core Set measures (if applicable). 1.3 The selection of the PIP topic considered input from enrollees or providers who are users of, or concerned with, specific service areas. 1.4 The PIP topic addressed care of special populations or high priority services. 1.5 The PIP topic aligned with priority areas identified by DHS and/or CMS.
2	**PIP Aim Statement** 2.1 The PIP aim statement clearly specified the improvement strategy. 2.2 The PIP aim statement clearly specified the population for the PIP. 2.3 The PIP aim statement clearly specified the time period for the PIP. 2.4 The PIP aim statement was concise. 2.5 The PIP aim statement was answerable. 2.6 The PIP aim statement was measurable.
3	**PIP Population** 3.1 The project population was clearly defined in terms of the identified PIP question. 3.2 If the entire MCO population was included in the PIP, the data collection approach captured all enrollees to whom the PIP question applied.
4	**Sampling Method** 4.1 The sampling frame contained a complete, recent, and accurate list of the target PIP population. (The sampling frame is the list from which the sample is drawn.) 4.2 The sampling method considered and specified the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error. 4.3 The sample contained a sufficient number of enrollees taking into account non-response.

#	Standards
	4.4 The method assessed the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status. 4.5 Valid sampling techniques were used to protect against bias.
5	**PIP Variables and Performance Measures** 5.1 The variables were adequate to answer the PIP question. 5.2 The performance measure assessed an important aspect of care that will make a difference to enrollees' health or functional status. 5.3 The performance measures were appropriate based on the availability of data and resources to collect the data. 5.4 The measures were based on current clinical knowledge or health services research. 5.5 The performance measures monitored, tracked, and compared performance over time; and informed the selection and evaluation of quality improvement activities. 5.6 The MCO considered existing measures such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures. 5.7 The MCO developed new measures based on current clinical practice guidelines or health services research if there were gaps in existing measures. 5.8 The measures captured changes in enrollee satisfaction or experience of care. 5.9 The measures included a strategy to ensure inter-rater reliability (if applicable). 5.10 The process measure is meaningfully associated with outcomes (if applicable).
6	**Data Collection Procedures** *General* 6.1 The PIP design specified a systematic method for collecting valid and reliable data that represents the population in the PIP. 6.2 The PIP design specified the frequency of data collection. 6.3 The PIP design clearly specified the data sources. 6.4 The PIP design clearly defined the data elements to be collected. 6.5 A list of data collection personnel and their relevant qualifications was provided. 6.6 The data collection plan linked to the data analysis plan to ensure that appropriate data would be available for the PIP. 6.7 The data collection instruments allowed for consistent and accurate data collection over the time periods studied.

#	Standards
	6.8 Qualitative data collection methods were well-defined and designed to collect meaningful and useful information from respondents (if applicable). *Administrative Data Sources (if applicable)* 6.9 If inpatient data was used, the data system captured all inpatient admissions/discharges. 6.10 If primary care data was used, primary care providers submitted encounter or utilization data for all encounters. 6.11 If specialty care data was used, specialty care providers submitted encounter or utilization data for all encounters. 6.12 If ancillary data was used, ancillary service providers submitted encounter or utilization data for all services provided. 6.13 If LTSS data was used, all relevant LTSS provider services were included. 6.14 If EHR data was used, patient, clinical, service, or quality metrics were validated for accuracy and completeness as well as comparability across systems. *Medical Record Review (if applicable)* 6.15 A list of data collection personnel and their relevant qualifications was provided. 6.16 For medical record review, interrater and intra-rater reliability was described. 6.17 For medical record review, guidelines for obtaining and recording the data were developed.
7	**Data Analysis and Interpretation of PIP Results** 7.1 The analysis was conducted in accordance with the data analysis plan. 7.2 The analysis included baseline and repeat measurements of project outcomes. 7.3 The analysis assessed the statistical significance of any differences between the initial and repeat measurements. 7.4 The analysis accounted for factors that may influence the comparability of initial and repeat measurements. 7.5 The analysis accounted for factors that may threaten the internal or external validity of the findings. 7.6 The PIP compared the results across multiple entities, such as different patient subgroups, provider sites, or MCOs. 7.7 PIP results and findings were presented in a concise and easily understood manner. 7.8 To foster continuous quality improvement, the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance.

#	Standards
8	**Improvement Strategies** 8.1 The selected improvement strategy was evidence-based, that is, there was existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables). 8.2 The strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes. 8.3 The rapid-cycle PDSA approach was used to test the selected improvement strategy. 8.4 The strategy was culturally and linguistically appropriate. 8.5 The implementation of the strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices). 8.6 Building on the findings from the data analysis and interpretation of PIP results, the PIP assessed the extent to which the improvement strategy was successful and identify potential follow-up activities.
9	**Significant and Sustained Improvement** 9.1 The same methodology was used for baseline and repeat measurements. 9.2 There was quantitative evidence of improvement in processes or outcomes of care. 9.3 The reported improvement in performance was likely to be a result of the selected intervention. 9.4 There is statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention. 9.5 Sustained improvement was demonstrated through repeated measurements over time.

Appendix I: PIP Scoring Aggregate Report Example

	Section Description	Met #	Met %	Not Met #	Not Met %	NA #	a	b	c	d	e
PIP Topic											
1.1	The PIP topic was selected through a comprehensive analysis of MCO enrollee needs, care, and services.	0	NA	0	NA	1	0	0	0		
1.2	The PIP topic considered performance on the CMS Child and Adult Core Set measures (if applicable).	0	NA	0	NA	1					
1.3	The selection of the PIP topic considered input from enrollees or providers who are users of, or concerned with, specific services areas.	0	NA	0	NA	1	0				
1.4	The PIP topic addressed areas of special populations or high priority services.	1	100.0%	0	0.0%	0	0				
1.5	The PIP topic aligned with priority areas identified by DHS and/or CMS.	1	100.0%	0	0.0%	0	0				
Section 1 Total		2	100.0%	0	NA	3					
PIP Aim Statement											
2.1	The PIP aim statement clearly specified the improvement strategy.	1	100.0%	0	0.0%	0	0				
2.2	The PIP aim statement clearly specified the population for the PIP.	1	100.0%	0	0.0%	0	0				
2.3	The PIP aim statement clearly specified the time period for the PIP.	1	100.0%	0	0.0%	0	0				
2.4	The PIP aim statement was concise.	1	100.0%	0	0.0%	0	0				
2.5	The PIP aim statement was answerable.	1	100.0%	0	0.0%	0	0	0	0	0	
2.6	The PIP aim statement was measurable.	1	100.0%	0	0.0%	0	0	0			
Section 2 Total		6	100.0%	0	NA	0					
PIP Population											
3.1	The project population was clearly defined in terms of the identified PIP question.	1	100.0%	0	0.0%	0	0	0			

3.2	If the entire MCO population was included in the PIP, the data collection approach captured all enrollees to whom the PIP question applied.	1	100.0%	0	0.0%	0	0				
Section 3 Total		2	100.0%	0	NA	0					
PIP Variables and Performance Measures											
5.1	The variables were adequate to answer the PIP question.	1	100.0%	0	0.0%	0	0	0			
5.2	The performance measure assessed an important aspect of care that will make a difference to enrollees' health or functional status.	1	100.0%	0	0.0%	0	0	0			
5.3	The performance measures were appropriate based on the availability of data and resources to collect the data.	1	100.0%	0	0.0%	0	0				
5.4	The measures were based on current clinical knowledge or health services research.	1	100.0%	0	0.0%	0	0				
5.5	The performance measures monitored, tracked, and compared performance over time; and informed the selection and evaluation of quality improvement activities.	1	100.0%	0	0.0%	0	0				
5.6	The MCO considered existing measures such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures.	1	100.0%	0	0.0%	0					
5.7	The MCO developed new measures based on current clinical practice guidelines or health services research if there were gaps in existing measures.	0	NA	0	NA	1	0				
5.8	The measures captured changes in enrollee satisfaction or experience of care.	0	NA	0	NA	1	0				
5.9	The measures included a strategy to ensure inter-rater reliability (if applicable).	0	NA	0	NA	1	0				
5.10	The process measure is meaningfully associated with outcomes (if applicable).	0	NA	0	NA	1	0				
Section 5 Total		6	100.0%	0	NA	4					

Data Collection Procedures											
6.1	The PIP design specified a systematic method for collecting valid and reliable data that represents the population in the PIP.	1	100.0%	0	0.0%	0	0	0	0		
6.2	The PIP design specified the frequency of data collection.	1	100.0%	0	0.0%	0	0				
6.3	The PIP design clearly specified the data sources.	1	100.0%	0	0.0%	0	0				
6.4	The PIP design clearly defined the data elements to be collected.	1	100.0%	0	0.0%	0	0				
6.5	The data collection plan linked to the data analysis plan to ensure that appropriate data would be available for the PIP.	1	100.0%	0	0.0%	0	0	0	0		
6.6	The data collection instruments allowed for consistent and accurate data collection over the time periods studied.	1	100.0%	0	0.0%	0	0				
6.7	Qualitative data collection methods were well-defined and designed to collect meaningful and useful information from respondents (if applicable).	0	NA	0	NA	1	0				
6.8	If inpatient data was used, the data system captured all inpatient admissions/discharges.	0	NA	0	NA	1	0	0			
6.9	If primary care data was used, primary care providers submitted encounter or utilization data for all encounters.	1	100.0%	0	0.0%	0	0				
6.10	If specialty care data was used, specialty care providers submitted encounter or utilization data for all services provided.	1	100.0%	0	0.0%	0	0				
6.11	If ancillary data was used, ancillary service providers submitted encounter or utilization data for all services provided.	1	100.0%	0	0.0%	0	0				
6.12	If LTSS data was used, all relevant LTSS provider services were included.	0	NA	0	NA	1	0				
6.13	If Electronic Health Record data was used, patient, clinical, service, or quality metrics were validated for accuracy and completeness as well as comparability across systems.	0	NA	0	NA	1	0				
6.14	A list of data collection personnel and their relevant qualifications was provided.	1	100.0%	0	0.0%	0	0				
6.15	Inter-rater and intra-rater reliability was described.	1	100.0%	0	0.0%	0	0				
6.16	Guidelines for obtaining and recording the data were developed.	1	100.0%	0	0.0%	0	0				
Section 6 Total		12	100.0%	0	NA	4					

Data Analysis and Interpretation of PIP Results											
7.1	The analysis was conducted in accordance with the data analysis plan.	1	100.0%	0	0.0%	0	0	0			
7.2	The analysis included baseline and repeat measurements of project outcomes.	1	100.0%	0	0.0%	0	0				
7.3	The analysis assessed the statistical significance of any differences between the initial and repeat measurements.	1	100.0%	0	0.0%	0	0				
7.4	The analysis accounted for factors that may influence the comparability of initial and repeat measurements.	0	NA	0	NA	1	0				
7.5	The analysis accounted for factors that may threaten the internal or external validity of the findings.	1	100.0%	0	0.0%	0	0				
7.6	The PIP compared the results across multiple entities, such as different patient subgroups, provider sites, or MCOs.	1	100.0%	0	0.0%	0	0				
7.7	PIP results and findings were presented in a concise and easily understood manner.	1	100.0%	0	0.0%	0	0				
7.8	To foster continuous quality improvement, the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance.	0	NA	0	NA	1	0				
Section 7 Total		6	100.0%	0	NA	2					
Improvement Strategies											
8.1	The selected improvement strategy was evidence-based, that is, there was existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables).	1	100.0%	0	0.0%	0	0				
8.2	The strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes.	1	100.0%	0	0.0%	0	0				
8.3	The rapid-cycle PDSA approach was used to test the selected improvement strategy.	1	100.0%	0	0.0%	0	0				
8.4	The strategy was culturally and linguistically appropriate.	1	100.0%	0	0.0%	0	0				

8.5	The implementation of the strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., patient risk factors, Medicaid program changes, provider education, clinic policies or practices).	1	100.0%	0	0.0%	0	0	0			
8.6	Building on the findings from the data analysis and interpretation of PIP results, the PIP assessed the extent to which the improvement strategy was successful and identify potential follow-up activities.	1	100.0%	0	0.0%	0	0	0			
Section 8 Total		6	100.0%	0	NA	0					
Significant and Sustained Improvement											
9.1	The same methodology was used for baseline and repeat measurements.	1	100.0%	0	0.0%	0	0				
9.2	There was quantitative evidence of improvement in processes or outcomes of care.	1	100.0%	0	0.0%	0	0	0			
9.3	The reported improvement in performance was likely to be a result of the selected intervention.	1	100.0%	0	0.0%	0	0	0			
9.4	There is statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention.	0	NA	0	NA	1	0	0	0		
9.5	Sustained improvement was demonstrated through repeated measurements over time.	0	0.0%	1	100.0%	0	1	0			
Section 9 Total		3	75.0%	1	25.0%	1					
Overall Totals		**43**	**97.7%**	**1**	**2.3%**	**14**					

Appendix J: PIP Template

Performance Improvement Project (PIP)

Proposal and Final Report Format Template

Instructions:

- Reference the PIP section of the Quality Guide for additional information.
- PIP Proposal: Complete standards 1-6 and 8 in this template.
- Final PIP Report Validation: Complete standards 7 and 9 in this template. Make any updates to standards 1-6 and 8 if changes were made after the proposal was approved, including changes made as a result or EQRO recommendations or changes made to facilitate project implementation.

HMO Name: Click here to enter text.	**Report Prepared by:** Click here to enter text.
Date Proposal Submitted: Click here to enter a date.	**Date Final Report Submitted:** Click here to enter a date.
Project Title: Click here to enter text.	
Project Implementation Date: Click here to enter a date.	
Please check the following items as applicable to this PIP report	
PIP Proposal Type: ☐ Clinical ☐ Nonclinical	
Population: ☐ SSI ☐ BC+ ☐ Both SSI and BC+	
Primary HMO Contact Regarding PIP Project Click or tap here to enter text.	
Email: Click or tap here to enter text.	**Phone:** Click or tap here to enter text.
HMO Project Team	
Name	**Title/Department**
STANDARD 1: PIP Topic ***Standard 1 applies to PROPOSAL and VALIDATION*** 1.1 The PIP topic was selected through a comprehensive analysis of HMO member needs, care and services.	

1.2 The PIP topic considered performance on the CMS Child and Adult Core Set measures (if applicable).
1.3 The selection of the PIP topic considered input from members or providers who are users or concerned with specific service areas.
1.4 The PIP topic addresses care of special populations or high priority services.
1.5 The PIP topic aligns with priority areas identified by DHS and/or CMS.

1a. Describe the process or analysis used to prioritize and select this topic as an area or opportunity for improvement related to **reducing health inequities**. HMOs must consider stratification of any or all target populations by rural/urban, sex, age, primary language, race, and/or ethnicity (encouraged to select at least two stratifications) in order to identify health equity quality improvement opportunities.

Information should include:

- Discussion of the member needs assessment or source data that helped identify baseline performance
- Baseline data and the timeframe of the baseline data
- Address any performance measures considered in the selection of the topic

1b. Describe the relevance of this topic to the HMO's membership

- Identify how the topic relates to the member health status and/or member experience. Address consideration of health inequities, care of special populations, and/or high priority services as applicable
- Identify why the topic is important to members, giving consideration to members' social determinants of health.

1c. Describe any member and provider input obtained in considering this topic.

Standard 1 PIP Topic:

Click or tap here to enter text.

STANDARD 2: PIP Aim Statement

Standard 2 applies to PROPOSAL and VALIDATION

2.1 The PIP aim statement clearly specifies the improvement strategy *(relevant to Standards 8.1 -8.4)*
2.2 The PIP aim statement clearly specifies the population for the PIP
2.3 The PIP aim statement clearly specifies the time period for the PIP
2.4 The PIP aim statement is concise
2.5 The PIP aim statement is answerable
2.6 The PIP aim statement is measurable

2a. State each PIP aim or question in a concise, answerable, and measurable format, including:

- Specific numerical goal(s) and target date(s)
- Intervention or improvement strategy that will be implemented
- Rate of desired improvement (from what to what) in each aim or question
- Population that will be involved in the PIP

Standard 2 PIP Aim Statement:

Click or tap here to enter text.

STANDARD 3: PIP Population

Standard 3 applies to PROPOSAL and VALIDATION

3.1 The project population is clearly defined in terms of the identified PIP question

3.2 If the entire HMO population is included in the PIP, the data collection approach captures all members to whom the PIP aim or question applies

3a. Describe the relevant population (all members to whom the study question and indicators apply), including:

- Target populations by rural/urban, race, ethnicity, sex, gender, age, primary language, disability, etc.
- Any inclusion or exclusion criteria
- Any enrollment/eligibility criteria (e.g., requirements for how long members had to be enrolled)

3b. If data for the entire HMO population will be studied, describe how the data collection approach will capture all members to whom the study question applied

Standard 3 PIP Population:

Click or tap here to enter text.

STANDARD 4: Sampling Method

Standard 4 applies to PROPOSAL and VALIDATION

4.1 The sampling frame contains a complete, recent, and accurate list of the target PIP population.

4.2 The sampling method considers and specifies the true or estimated frequency of the event, the confidence interval to be used, and the acceptable margin of error

4.3 The sample contains a sufficient number of members taking into account non-response

4.4 The method assesses the representativeness of the sample according to subgroups, such as those defined by age, geographic location, or health status

4.5 Valid sampling techniques were used to protect against bias

4a. If sampling will be utilized (i.e., data for a sample of the population will be studied and findings generalized to the entire population), provide a detailed explanation of the sampling methods to be used (e.g., sample size/population size, sampling technique used, confidence intervals, acceptable margin of error).

If 4a. is not applicable to this project, enter "N/A" here

Standard 4 Sampling Method:

Click or tap here to enter text.

STANDARD 5: PIP Variables and Performance Measures

Standard 5 applies to PROPOSAL and VALIDATION

5.1 The variables are adequate to answer the PIP question
5.2 The performance measures assess an important aspect of care that will make a difference to members' health or functional status
5.3 The performance measures are appropriate based on the availability of data and resources to collect the data
5.4 The measures are based on current clinical knowledge or health services research
5.5 The performance measures will monitor, track, and compare performance over time; and inform the selection and evaluation of quality improvement activities
5.6 The HMO considered existing measures such as CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, or AHRQ measures
5.7 The HMO developed new measures based on current clinical practice guidelines or health services research if there were gaps in existing measures
5.8 The measures captured changes in member satisfaction or experience of care
5.9 The measures include a strategy to ensure inter-rater reliability (if applicable)
5.10 The process measure is meaningfully associated with outcomes (if applicable)

5a. List and define all study indicators/performance measures.
- Clearly define each numerator and denominator
- Ensure the indicators are concise, measurable, and adequately answer the PIP aim(s) or questions(s)

5b. Briefly summarize how the performance measure(s):
- Assess an important aspect of care that will make a difference to members' health or experience
- Are appropriate based on the availability of data and resources to collect the data
- Are based on current clinical knowledge or health services research
- Will monitor, track, and compare performance over time and inform the selection and evaluation of quality improvement activities
- Address any gaps in existing measures, if applicable

5c. If CMS Child and Adult Core Set, Core Quality Measure Collaborative, certified community behavioral health clinics (CCBHC) measures, HEDIS®, AHRQ or other existing measures are used, include the relevant specifications

Standard 5 PIP Variables and Performance Measures:

Click or tap here to enter text.

STANDARD 6. Data Collection Procedures

Standard 6 applies to PROPOSAL and VALIDATION

6.1 The PIP design specifies a systematic method for collecting valid and reliable data that represents the population in the PIP
6.2 The PIP design specifies the frequency of data collection
6.3 The PIP design clearly specifies the data sources
6.4 The PIP design clearly defines the data elements to be collected

6.5 The data collection plan links to the data analysis plan to ensure that appropriate data would be available for the PIP
6.6 The data collection instruments will allow for consistent and accurate data collection over the time periods studied
6.7 Qualitative data collection methods are well-defined and designed to collect meaningful and useful information from respondents (if applicable)

Administrative Data Sources (if applicable)
6.8 If inpatient data will be used, the data system captures all inpatient admissions/discharges
6.9 If primary care data will be used, primary care providers submit encounter or utilization data for all encounters
6.10 If specialty care data will be used, specialty care providers submit encounter or utilization data for all encounters
6.11 If ancillary data will be used, ancillary service providers submit encounter or utilization data for all services provided
6.12 If LTSS data will be used, all relevant LTSS provider services are included
6.13 If EHR data will be used, patient, clinical, service, or quality metrics are validated for accuracy and completeness as well as comparability across systems

Medical Record Review (if applicable)
6.14 A list of data collection personnel and their relevant qualifications is provided
6.15 For medical record review, interrater and intra-rater reliability is described
6.16 For medical record review, guidelines for obtaining and recording the data were developed

Study results are dependent on accurate and valid data that are collected appropriately. Clearly describe the data collection components for all PIP indicators.
6a. Identify all data sources (e.g., claims/administrative data, member files)
6b. Describe how data was collected
6c. Provide a list of data collection personnel and their relevant qualifications
6d. Describe how the data was stored and aggregated (e.g., registry, database)
6e. Describe how the data was analyzed and by whom
6f. Describe the frequency of data collection and analysis

For continuing projects, include the data from the previous year(s) in addition to any data from the current year. Include samples of any data collection tools or instruments as an attachment.

Standard 6 Data Collection Procedures:
Click or tap here to enter text.

STANDARD 7. Data Analysis and Interpretation of PIP Results
Standard 7 applies to VALIDATION. HMOs do not need to address this in the PIP Proposal.
7.1 The analysis was conducted in accordance with the data analysis plan.
7.2 The analysis included baseline and repeat measurements of project outcomes.

7.3 The analysis assessed the statistical significance of any differences between the initial and repeat measurements
7.4 The analysis accounted for factors that may influence the comparability of initial and repeat measurements
7.5 The analysis accounted for factors that may threaten the internal or external validity of the findings
7.6 The PIP compared the results across multiple entities, such as different patient subgroups, provider sites, or HMOs
7.7 PIP results and findings were presented in a concise and easily understood manner
7.8 To foster continuous quality improvement, the analysis and interpretation of the PIP data included lessons learned about less-than-optimal performance

In a concise and easily understood manner:
7a. Describe how the data analysis was conducted and aligned with the data analysis plan
7b. Identify the baseline and repeat measurements of the project outcomes
7c. Identify the statistical significance of any differences between the initial and repeat measurements and account for any factors that may influence the comparability of initial and repeat measurements
7d. Discuss any factors that may threaten the internal or external validity of the findings
7e. As applicable, discuss comparison of the results across multiple entities, such as different member subgroups, provider sites, or HMOs
7f. Identify and discuss any lessons learned about less-than-optimal performance

- Include baseline, interim data, and repeat measurement(s)
    - Was the same methodology used for the baseline and repeat measurements? (Note Standard 9.1)
    - Are the numerical results accurate and clear?
- Effectiveness and/or accuracy of the numerators and denominators used in data analysis
- Discussion of ongoing data review in accordance with the data analysis plan.
- Include any tables, charts, and/or graphs as applicable

For continuing projects, include any data and analysis from both the current year and previous year(s).

Standard 7 Data Analysis and Interpretation of PIP Results:
Click or tap here to enter text.

STANDARD 8. Improvement Strategies
Standard 8 applies to PROPOSAL and VALIDATION
8.1 The selected improvement strategy was evidence-based, that is, there was existing evidence (published or unpublished) suggesting that the test of change would be likely to lead to the desired improvement in processes or outcomes (as measured by the PIP variables)

8.2 The strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes
8.3 The rapid-cycle PDSA approach was used to test the selected improvement strategy.
8.4 The strategy was culturally and linguistically appropriate
8.5 The implementation of the strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., member risk factors, Medicaid program changes, provider education, clinic policies or practices)
8.6 Building on the findings from the data analysis and interpretation of PIP results, the PIP assessed the extent to which the improvement strategy was successful and identify potential follow-up activities

8a. Describe how the improvement strategy was selected with respect to available evidence from the literature, data, root cause analysis, or barrier analysis
8b. Explain how the improvement strategy was determined to be likely to lead to the desired improvement in processes or outcomes
8c. Discuss how the improvement strategy was designed to address root causes or barriers identified through data analysis and quality improvement processes, including how the Plan-Do-Study-Act (PDSA) approach was utilized
8d. Discuss how the improvement strategy was culturally and linguistically appropriate
8e. Describe how implementation of the strategy was designed to account or adjust for any major confounding variables that could have an obvious impact on PIP outcomes (e.g., member risk factors, Medicaid program changes, provider education, clinic policies or practices)
8f. With respect to the PIP data analysis and interpretation of the results, explain how the PIP assessed the extent to which the improvement strategy was successful; identify potential follow-up activities (note Standard 9.2 and 9.3)

Include any materials that were developed and/or used for interventions, such as, member educational materials, practice guidelines, etc., as attachments to this report.

For continuing projects, provide documentation that focuses on interventions implemented during the current project period.

Standard 8 Improvement Strategies:
Click or tap here to enter text.

STANDARD 9. Significant and Sustained Improvement
Standard 9 applies to VALIDATION. HMOs do not need to address this in the PIP Proposal.
9.1 The same methodology was used for baseline and repeat measurements.
9.2 There was quantitative evidence of improvement in processes or outcomes of care.
9.3 The reported improvement in performance was likely to be a result of the selected intervention.
9.4 There is statistical evidence (e.g., significance tests) that any observed improvement is the result of the intervention.
9.5 Sustained improvement was demonstrated through repeated measurements over time.

9a. Clearly describe how the same methodology was used for baseline and repeat measurements

9b. Specify the quantitative evidence of improvement in processes or outcomes of care 9c. Discuss the extent to which reported improvement in performance was likely to be a result of the selected intervention(s), including any statistical evidence 9d. If applicable, identify any sustained improvement demonstrated through repeated measurements over time For continuing projects, include the relevant data from previous year(s) and any analysis of the data from the current year to previous year(s).
Standard 9 Significant and Sustained Improvement: Click or tap here to enter text.

In the space below:

- **Please list any references relevant to this PIP final report.**
- **Attach any relevant documents (or include attachments in the report submission packet)**

Click or tap here to enter text.