Wisconsin Department of Health Services

HMO Pay-For-Performance (P4P) Guide – Measurement Year 2012

This Guide provides an overview of the measures, methodology, targets and operational details that support Wisconsin Department of Health Services' HMO Pay-For-Performance (P4P) initiative.
It includes information pertinent to submission of data and calculation of results for Measurement Year (MY) 2012.

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1. Overview

1. Wisconsin Department of Health Services (the DHS) defines the Measurement Year (MY) for its HMO Pay-For-Performance (P4P) initiative as follows:
   Each MY starts on January 1 and ends on December 31 of that year.
2. For MY 2012 and MY 2013, the Pay-For-Performance (P4P) initiative for the HMOs is currently organized as follows:
   a. BadgerCarePlus (BC+): Regions 1-4
   b. BadgerCarePlus (BC+): Regions 5 and 6 - measures have some similarities to Regions 1-4, but the overall methodology is separate
   c. SSI: One set of measures, targets and methodology applies across all 6 Regions.
3. Each initiative includes withholding a % of capitation payments made to each HMO; this withhold can be earned back by HMOs based on their performance relative to quality goals for various measures applicable to the HMO.
4. A bonus pool is formed by the portion of withhold not earned back (i.e., forfeited) by any HMO. This bonus pool is then distributed, subject to certain limitations, among the HMOs that meet all their goals. The forfeited withhold is the sole source of funding for the bonus pool.
5. The DHS extensively uses HEDIS measures for its P4P initiative; please see HEDIS Technical Specifications for details.
   Additional, HEDIS-like measures supplement the P4P initiative, as appropriate. The DHS utilizes NCQA's Quality Compass data for Medicaid as one of the inputs for setting targets for the measures within P4P.
6. The DHS uses the P4P measures as input for the HMO report card, which reflects the performance of each HMO on various quality measures.

2. Measurement Year (MY) 2012

2.1. BC+ Regions 1-4 and SSI P4P

Scope:

- **BC+:** Standard and Benchmark plans only.
- **SSI:** Non-dual (Medicare) eligible members only.

Features:

- The 2012 upfront **withhold rate is 1.5%**, and will apply to all capitation, including administrative payments.
  Separate withhold % will apply individually to each measure. Each HMO will earn its withhold back for each measure, separately (see *Appendix 2012-1*).

- **Performance measurement**

  HMO performance will be measured based on high **level** of performance, and/or significant **improvement**. CMS endorses this approach in Value Based Purchasing.

  BC+: The **level** of performance will be measured on a "curve" by comparing MY2012 results of an HMO with MY2010 national Medicaid HEDIS percentiles as reported in the Medicaid Quality Compass. Region-wide averages will be used for non-HEDIS measures; DHS has provided baseline data to HMOs for 2012.

  The degree of **improvement** will be measured by comparing MY2012 results with MY2010 results of an HMO using the percentage "reduction in error" approach.

  See *Appendix 2012-2* for steps and numerical examples.

  Measures:
  BC+: 9 measures, 7 conditions. In addition, HMOs are asked to **report** (BC+ only) data for **Prenatal and Postpartum Care (PPC)**, per HEDIS specifications, for MY 2012. HMOs will not have any money at risk for PPC in MY2012.

  <u>Tobacco Cessation measure</u>
  Due to delays in implementing the Striving To Quit (STQ) initiative, the tobacco cessation measure will not be applicable to any HMO for MY2012, and none of the withhold for tobacco cessation will be at risk for any HMO for MY2012 only.
  Appendices 2012-1, 2012-2 and *2012-3* have been updated to reflect this modification. There is no change to the tobacco cessation measure, targets, methodology etc. for BC+ HMOs in Regions 5 and 6.

  See *Appendix 2012-4* for Blood Lead testing.

  SSI: 8 measures (all HEDIS), 5 conditions; Plus case management P4P.

- **Data Submission and Reporting**

  BC+ (Regions 1-4): For MY 2012, all health plans are asked to report their verified HEDIS scores via **NCQA**, and to make their results available for **public reporting within the Quality Compass**. This includes Childhood Immunization (CIS) and Blood Lead Screening. Non-HEDIS scores (e.g., for tobacco cessation) will be calculated by DHS, as in the past.

  SSI: HP will calculate the results for MY2012.

  Data for Core Plan members

  The DHS wants the quality / P4P data submitted by HMOs to NCQA to be included in the Quality Compass reports and to be publicly reported. At the same time, the DHS aims to minimize the administrative burden and cost associated with data submission by the HMOs to NCQA.

  Based on recent discussions with NCQA, we understand that NCQA Medicaid accreditation procedural rules require the HMOs to submit data for all members (i.e., including Core members), and not just for the Standard and Benchmark members. Core plan members represent a very small proportion (2.8%) of all BadgerCarePlus members (as of Nov, 2012).

  For MY 2012 data submission in 2013, HMOs have the option to include or exclude data for their Core plan members, as long as HMOs select to publicly report the results and the results are included in the Quality Compass and public reports.

  Member Level Detail files

  In order to simplify the administrative tasks associated with P4P, the DHS will not require the HMOs to submit the member level detail files for MY2012. However, if at a later date the DHS needs to verify the results reported by the HMOs, the DHS reserves the right to request member-level detail from specific HMOs, as appropriate.

  FFS data for BC+ Regions 1-4

  The DHS will provide data to HMOs for members who were enrolled in FFS prior to enrolling in an HMO, so that HMOs can get the credit for care provided while the members were enrolled in FFS. The data will be pulled by HP in accordance with the HEDIS specifications in effect for the MY.

  NCQA Data submission requirements - BC+ Regions 1-4

  HMOs are required to submit the following for MY2012:

  1. Data from the NCQA Interactive Data Submission System (IDSS) site containing the required data elements for each measure, downloaded as a comma separated value (CSV) text file (other options such as XML will not be accepted).
  2. Data Filled Workbook, including Audit Review Table (ART) format downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied).
  3. The Audit Report produced by a NCQA Licensed HEDIS Auditor.

  For HMOs that serve members in multiple regions, submission should include data for only Regions 1-4 in the file, and not for Regions 5 or 6 (please see the section re: Regions 5 and 6 for further clarification). Region should be determined in the following way:

- Anchor date based measures (per HEDIS Technical Specifications) —Assign members to regions based on region of residence as of the anchor date for each measure. Some measures use December 31 as the anchor date, while others use a different set date.
- Episodes of care measures—For measures without a set anchor date but an initial episode date, determine the region as of the most recent episode date.

Electronic submission requirements:

- Data files and documents are to be submitted to DHS via the SFTP server.
- All electronic data files must include the year and health plan name in the file name.
- Send an email to Mitzi.Melendez@wi.gov, and to VEDSHMOSupport@wisconsin.gov notifying them when the files (test files or production files) have been placed on the SFTP server with the number of records in each file.

Other P4P requirements:

1. Rotation of measures is not allowed. Each measure is to be calculated each year.
2. Health plans have the flexibility of applying the optional exclusions while submitting audited Medicaid HEDIS results to NCQA.
3. In determining continuous enrollment, HEDIS allows a gap of 45 days for commercial plans, but only a one-month gap for Medicaid plans that enroll on a monthly basis. Wisconsin Medicaid enrolls members on a monthly basis. The only time a member is not enrolled for the entire month is the month in which a child was born. Refer to the General Guidelines in the HEDIS Technical Specifications, items 27 and 28.
4. For measures with age stratification, HMOs will report results in the IDSS and ART tables by age strata as well as for the overall population.
5. For HEDIS measures that can be collected using the hybrid method, inclusion of chart review data is optional. It is recommended that for hybrid measures, health plans consider using the administrative method only in order to keep administrative costs down. In order to comply with HEDIS specifications, HMOs serving all regions that want to use the hybrid method should pull different samples for the different region groups: one sample for Regions 1-4, a second sample for Region 5, and a third sample for Region 6.
6. To meet DHS' reporting requirements, HMOs need to submit HEDIS quality results audited by a NCQA- licensed organization only for the BadgerCare Plus Standard and Benchmark Plans. HMOs may choose to include Core Plan members in their HEDIS quality results, but this is optional for MY2012.

Timeline: See *Appendix 2012-7*

- **Bonus**

A plan can potentially earn a "**bonus**" on top of its withheld amounts if it demonstrates a "high" level or improvement for **each** measure that applies to it. (see *Appendix 2012-5*). Any bonus pool will be entirely funded by withheld amounts forfeited by other plans. The total bonus earned by any plan will be the lesser of:

i. **1%** of the total capitation $ for that plan, OR

ii. **Total** withheld $ **forfeited** by other plans.

- **HMO Report Card:** The DHS will use the P4P measures.

2.2. BC+ Regions 5 and 6 (SE WI RFP) P4P

Please note the following updates to the P4P initiatives for BC+ Regions 5 and 6.

NCQA Data submission requirements - BC+ Region 5 and Region 6

- HMOs have the option to submit certified / audited HEDIS results for Region 5 and Region 6 for the HEDIS measures in the P4P initiative. By **June 15, 2013**, HMOs that plan to submit their HEDIS results for Region 5 and/or Region 6 should inform the DHS about their intent to do so. If the HMOs do not submit their intent, or the actual HEDIS results, HP will calculate them.
- HP will calculate the results for non-HEDIS measures.
- If HMOs submit their HEDIS results, separate files should be submitted to the DHS for Region 5 and Region 6 (do not combine them), since targets vary by Region.
- HMOs must follow the data submission and reporting requirements and P4P requirements listed for BC+ Regions 1-4, as they apply to Region 5 and Region 6, including the timeline.

ED measures

- For 2012 only, the "no-decline" requirement will be removed.
- For 2012 and 2013, revenue code 0456 (urgent care) will be removed from the numerator of the results for both ED measures, though the targets 2012 will remain unchanged.

Dental measures

- For MY2012 and MY2013, to reward positive performance among the individual dental measures, the four dental measures (combined 0.25% withhold) will have separate withhold and earn-back of 0.0625% each.
- The “no-decline” requirement will apply to MY2012.

Methodology

- For all measures for Regions 5 and 6, the same methodology as used in the Regions 1-4 will apply when results are below a target: if an HMO is within 1 percentage point of its target, or misses a target by 10 or fewer members, the HMO will be deemed to have met the target.

Specifications

- Please see *Appendix 2012-6* for specifications of non-HEDIS measures.

Appendix 2012-1:
MY 2012 P4P Measures (BC+ Regions 1-4, SSI) and Withhold %

Focus	Measurement	BC+			SSI	
			% withhold			% withhold
			~~Non-STQ~~	~~STQ~~		
Chronic	Comprehensive diabetes care - HbA1c (HEDIS - CDC)	✓	0.15%	~~0.15%~~	✓	0.20%
	Comprehensive diabetes care - LDL (HEDIS - CDC)	✓	0.15%	~~0.15%~~	✓	0.20%
	Appropriate medications for people with asthma (HEDIS - ASM)	✓	0.25%	~~0.25%~~		
	Blood lead screening (HEDIS - LSC) - ***Appendix 2012-4***	✓	0.20%	~~0.20%~~		
	Tobacco cessation (18 & older, counseling & pharmacotherapy) - ***Appendix 2012-3***	✓	0.20% ***Not at risk***	~~0.20%~~ ~~***Not at risk***~~		
Mental Health	Follow-up after hospitalization for mental illness with 7 days (HEDIS - FUH)				✓	0.20%
	Follow-up after hospitalization for mental illness within 30 days (HEDIS - FUH)				✓	0.20%
	Antidepressant medication management-Acute (HEDIS - AMM) - ***New***	✓	0.10%	~~0.10%~~		
	Antidepressant medication management-Continuation (HEDIS - AMM) - ***New***	✓	0.10%	~~0.10%~~		
	Initiation in AOD treatment (HEDIS - IET) - ***New***				✓	0.15%
	Engagement in AOD treatment (HEDIS - IET) - ***New***				✓	0.15%
Preventive	Adults' access to preventive/ambulatory health services (HEDIS - AAP)				✓	0.20%
	Childhood immunization status (HEDIS - CIS)	✓	0.20%	~~0.20%~~		
	Breast cancer screening (HEDIS - BCS) - ***New***	✓	0.15%	~~0.15%~~	✓	0.20%
Chronic Measures			**0.95%**	~~**0.75%**~~		**0.40%**
Mental health measures			**0.20%**	~~**0.20%**~~		**0.70%**
Preventive measures			**0.35%**	~~**0.35%**~~		**0.40%**
Total			**1.5%**	~~**1.5%**~~		**1.5%**
Max potential "bonus" in addition to earning back the withhold $			**1%**	~~**0.867%**~~		**1%**

Appendix 2012-2:
Performance Measurement & Numerical Examples

Level of Performance:

Each HMO's performance for each measure will be based on a combination of the **level** ((high / medium / low),) compared to Medicaid Quality Compass data, and the degree of **improvement** (high / medium / low); the withhold earned back will depend on that combination, as shown below.
High, medium and low for the Level and Improvement will be defined by the respective cut-off points shown in the table below for most measures, with **exceptions** noted each year, as appropriate.

	Degree of **IMPROVEMENT**		
Performance **LEVEL**	High (10% or higher)	Medium (5% - 9.9%)	Low (below 5%)
High (75^{th} – 100th percentile)	100% earn back		
Medium (50^{th} – 75^{th} percentile)	100% earn back	75% earn back	50% earn back
Low (below 50^{th} percentile)		50% earn back	No earn back

- As shown above, an HMO with "high" performance level will get 100% of its withhold back, regardless of improvement shown.
- An HMO with a "high" improvement will get 100% of its withhold back, regardless of level.

An HMO with insufficient observations for a measure will receive back the amount withheld for that measure.

Degree of Improvement:

The degree of improvement achieved by an HMO is defined as the percentage "reduction in error" for a given measure in MY 2012, compared to MY2010 for that HMO.

An **example**:

If an HMO's MY2010 score for a measure = 80%, then its "error" = 100% - 80% = 20%.

An HMO can achieve a 10% reduction in error by improving its past score by = $\left(\frac{10}{100} * 20\right) = 2$

percentage points, by attaining a score of 82%.

If the MY2012 score = 81%, then that HMO has improved its score by 1 percentage point = 5% reduction in error.

Mathematically, the reduction in error for MY2012 = $\left(\frac{(MY2012 - MY2010)}{Error = (100 - MY2010)} * 100\right)\%$

Exceptions to the High / Medium / Low cut off points:

Please refer to the letters issued by the DHS in December 2011 to each individual HMO regarding HMO P4P.

~~(a) AMM Exception (MY 2012 only)~~

~~For MY 2012 only, due to the timeframe of dates of service included in the AMM measure, the level of performance will be defined as:~~

- ~~High = above the 50th percentile from Medicaid Quality Compass~~
- ~~Medium = between 25th and 50th percentile~~
- ~~Low = below 25th percentile.~~

~~(b) IET Exception (MY 2012 only)~~

~~The average level for IET is quite low, and using the error reduction approach will result in a target that might be unachievable. Therefore, for MY 2012 only, the degree of improvement will be defined as:~~

- ~~High = more than 4% reduction in error~~
- ~~Medium = between 2% and 3.9% reduction in error~~
- ~~Low = less than 2% reduction in error.~~

~~(c) Tobacco Cessation (non-STQ) Exception (MY 2012 only)~~

~~Please also see *Appendix 3* for this measure. The average level for Tobacco Cessation, as defined for MY 2012, is quite low, and using the error reduction approach will result in a target that might be unachievable. Therefore, for MY 2012 only, the degree of improvement will be defined as:~~

- ~~High = more than 4% reduction in error~~
- ~~Medium = between 2% and 3.9% reduction in error~~
- ~~Low = less than 2% reduction in error.~~

Methodology Steps:

(a) First determine the level of performance of an HMO for each measure, as shown in the following **example**. Assume no exceptions apply in this example to the cut-off points for level or degree of improvement.

Assume MY2010 National Medicaid Quality Compass data for a given measure are:

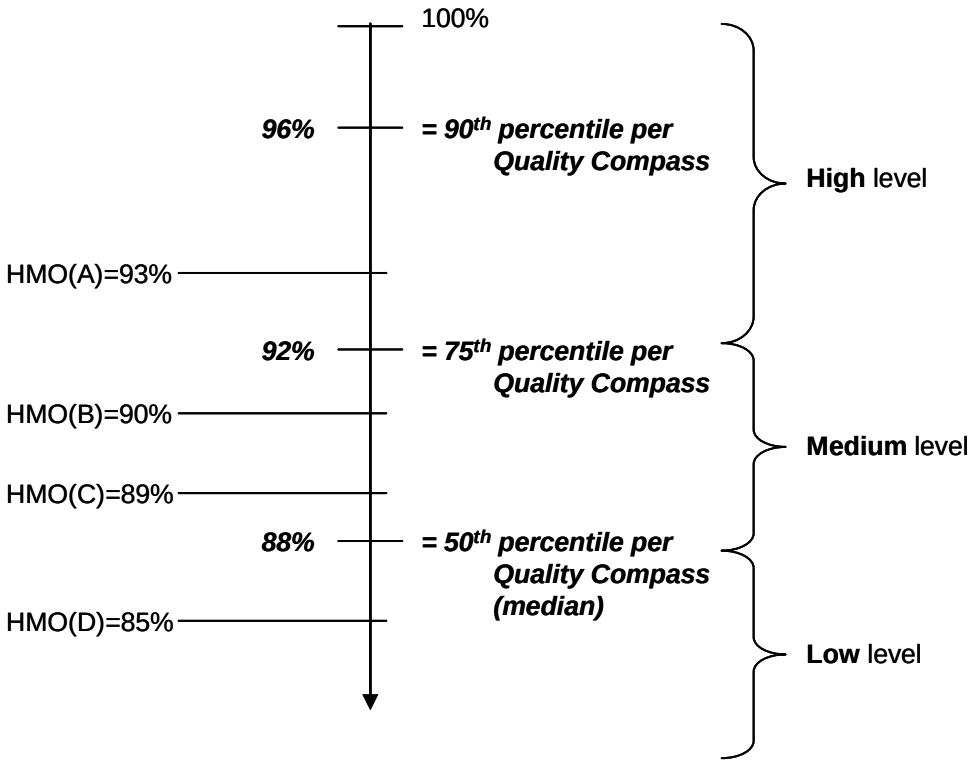
90th percentile score = 96%
75th percentile score = 92%
50th percentile score = 88%

Also assume that scores of four HMOs are:

HMO	MY2012 Score
A	93%
B	90%
C	89%
D	85%

Then, compared to the Quality Compass, each HMO's level of performance is shown below:

HMO	MY2012 Score	Level	Rationale
A	93%	High	Higher than 75th percentile
B	90%	Medium	Between 50th and 75th percentile
C	89%	Medium	Between 50th and 75th percentile
D	85%	Low	Below 50th percentile



(b) Calculate the % reduction in error for each HMO for that measure (assume the MY2010 scores as shown below).

HMO	MY2012 Score	MY2010 Score	MY2012 – MY2010	MY2010 Error	% reduction in Error	
A	93%	93%	0% points	7% points	=(0/7)*100 = 0%	Low
B	90%	89%	1% points	11% points	= (1/11)*100 = 9.1%	Medium
C	89%	89%	0% points	11% points	=(0/11)*100 = 0%	Low
D	85%	83%	2% points	17% points	=(2/17)*100 = 11.8%	High

(c) Earn-back - An HMO will earn back 100% of its withhold for a measure if it demonstrates "high" performance either for the level or the % reduction in error, as shown in the example below:

HMO	MY2012 level	% reduction in error	Withhold earned back
A	High	Low	100%
B	Medium	Medium	75%
C	Medium	Low	50%
D	Low	High	100%

Appendix 2012-3:
Tobacco Cessation – Striving To Quit (STQ)

The DHS has not yet implemented the Striving To Quit (STQ) initiative, so the **tobacco cessation** measure will not be applicable to any HMO for MY2012, and none of the withhold for tobacco cessation will be at risk for any HMO for MY2012 only. *Appendices 2012-1, 2012-2* and *2012-3* have been updated to reflect this modification. There is no change to the tobacco cessation measure, targets, methodology etc. for HMOs in Regions 5 and 6.

~~Wisconsin has been awarded the STQ grant to help Medicaid members quit smoking. An overview of STQ is available in a separate set of documents. The STQ initiative is still being planned and has yet to be fully implemented.~~

~~The 0.20% withhold will apply to all HMOs, though the at-risk amount will vary, as described below.~~

~~1. HMOs participating in STQ~~

- ~~At the end of the measurement year, if at least 50% of the Regions 1-4 members of an HMO participating in STQ are in Regions 2 and 4, then the entire 0.20% withhold for tobacco cessation measure will not be at risk. This "risk-free" withhold applies only to Measurement Year 2012.~~
- ~~Alternatively, if an HMO has at least 200 members participating in STQ during MY 2012, **regardless** of its proportion of members in Regions 2 and 4, that HMO's entire 0.20% withhold for tobacco cessation will not be at risk. This "risk-free" withhold applies only to Measurement Year 2012, and could change in MY 2013 and beyond.~~
- ~~If neither of the above two conditions apply, then the amount at risk will depend on the relative proportion of members in Regions 2 and 4 vs. in Regions 1 and 3. The following **example** illustrates this concept.~~
  ~~Assume an HMO's enrollment across Regions is shown below, and less than 200 of its members participated in STQ. Then, the amount at risk will be based on a weighted proportion of that HMO's members in Regions 1 and 3, Regions 2 and 4, as shown in the example below.~~

~~EXAMPLE~~			
~~Region(s)~~	**~~% of HMO enrollment~~**	**~~Withhold %~~**	**~~At Risk~~**
~~1 and/or 3~~	~~25%~~	~~0.20%~~	~~(25% / 65%) * 0.2% = 0.077%~~
~~2 and/or 4~~	~~40%~~	~~0.20%~~	~~Not at risk~~
~~5 and/or 6 (SE contract)~~	~~35%~~	~~Per SE contract terms~~	

~~Therefore, an HMO participating in STQ with all its members only in Regions 2 and 4 will have no money at risk for Tobacco Cessation.~~

~~2. HMOs NOT participating in STQ~~

- ~~The conventional tobacco cessation measure (modified for MY 2012 to include both, counseling and pharmacology) will apply to HMOs not participating in STQ for any reason, and full 0.20% of their capitation rate will be withheld and at risk. DHS is developing specific definition and baseline for this measure. Performance will be measured using a combination of level and degree of improvement (also see *Appendix 2*), as shown below.~~

	~~Degree of **IMPROVEMENT**~~		
~~Performance **LEVEL**~~	~~High (4% or higher)~~	~~Medium (2% - 3.9%)~~	~~Low (below 2%)~~
~~High (>110% of average of Regions 1 – 4)~~	~~100% earn back~~		
~~Medium (between 90% and 110% of average of Regions 1 – 4)~~	~~100% earn back~~	~~75% earn back~~	~~50% earn back~~
~~Low (below 90% of average of Regions 1 – 4)~~		~~50% earn back~~	~~No earn back~~

3. HMOs operating in Regions 5 and/or 6 (SE contract Regions)

- There is no change to the tobacco cessation measure, targets, methodology etc. for the RFP Region. ~~HMOs will receive credit towards their P4P goals for counseling received by their members through STQ in this area.~~

Appendix 2012-4:
Blood Lead Screening Measure

For **BC+ Regions 1-4** in 2012, Wisconsin DHS will use the **HEDIS** measure for measuring HMO performance. In addition, DHS will continue to calculate performance using Blood Lead 1 and Blood Lead 2 measures since:

- CMS requires DHS to report performance for Blood Lead 1 and 2 measures, and
- DHS wants to ensure that the change to HEDIS does not negatively affect performance for blood lead testing at age 2, when children are most vulnerable. Internal data analyses indicate that Medicaid rates for children testing positive are still twice those of non-Medicaid rates.

If performance on Blood Lead 1 and 2 deteriorates significantly in 2012, DHS may decide to revert back to those measures, instead of HEDIS, in future.

There is **no change** in blood lead measure for **BC+ Regions 5 and 6**.

Appendix 2012-5:
Bonus (BC+ Regions 1-4 and SSI only)

An HMO can earn a bonus on top of receiving its withhold if it receives a rating of "high" for each measure that is applicable to it, as shown in the example below:

HMO	# of applicable measures	# of measures with "high" rating	Eligible for bonus?
A	9	9	Yes
B	9	8 or fewer	No
C	7	7	Yes
D	6	5 or fewer	No

A measure may not apply to an HMO if that HMO's denominator is too small for that measure, per HEDIS specifications, or smaller than 30 for non-HEDIS measures.

Calculations

- Any bonus pool will be entirely funded through forfeitures by HMOs.
- The bonus pool will be shared among HMOs eligible for bonus in proportion of the sum of the number of members in the **denominator** for all applicable measure, subject to the limits discussed earlier in Section 2.1 of this document.

  Rationale:
  - Variations in the # of members enrolled, i.e., the difference between large and small HMOs, is accounted for by the 1% limitation on bonus.
  - Variations in the performance of HMOs are accounted for by the high / medium / low ratings for level and reduction in error.
  - Variation in performance of HMOs due to proportion of members with specific conditions is accounted for by the use of denominator (and not the total enrollment) in calculating the bonus.

  Illustrative question:

  Consider 2 HMOs, A and B. A has 30,000 members and B has 10,000 members. Each has the same # of members in the denominator (7,000) for all measures combined. Each achieves identical ratings for level and reduction in error. Should A get 3 times the bonus as B because A has 3 times the enrollment?

Example

Assume the total bonus pool is worth $2 million for MY2012, and the following plans have achieved a "high" rating for each applicable measure. Also assume the following:

HMO	# of members in denominator, summed for all applicable measures	% share based on denominator size	Bonus amount
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**

Appendix 2012-6:
Specifications for non-HEDIS measures for BC+ Regions 5 and 6

- **HEDIS-Like Measure: Lead Testing for One Year Olds:** The percentage of one year olds that had a lead screen performed between 6 to 16 months of age.

  Measurement Year (MY) - Dates of service January 1, 2012 to December 31, 2012.

  Denominator - Members that met the following eligibility criteria:
  Children who turn one year of age during the MY.
  Enrolled in the same HMO for 11 months of the MY
  Enrolled in the same HMO on the member's first birthday.

  Numerator - Members in the denominator that had at least one blood lead test (using CPT code 83655) between 6 to 16 months of age.

  Data Sources - To identify members in the denominator, DHS' eligibility information is used. To define the numerator, data from encounters, FFS claims, and STELLAR are used.

- **HEDIS-Like Measure: Lead Testing for Two Year Olds:** The percentage of two year olds that had a lead screen performed between 17 to 28 months of age.

  Measurement Year (MY) - Dates of service January 1, 2012 to December 31, 2012.

  Denominator - Members that met the following eligibility criteria:
  - Children who turn two years of age during the MY.
  - Enrolled in the same HMO for 11 months of the MY.
  - Enrolled in the same HMO on the member's second birthday.
  - Same criteria as CIS-Combination 2 denominator.

  Numerator - Members in the denominator that had at least one blood lead test (using CPT code 83655) between 17 to 28 months of age.

  Data Sources - To identify members in the denominator, DHS' eligibility information is used. To define the numerator, data from encounters, FFS claims, and STELLAR is used.

- **MEDDIC - Tobacco Cessation (Counseling Only):** The percentage of members 11 years of age and older who were identified as tobacco users and received counseling to quit smoking during the MY.
  Measurement Year (MY) - Dates of service January 1, 2012 to December 31, 2012.

  Denominator - Members that met the following eligibility criteria:
  - Enrolled in the same HMO for 11 months of the MY.
  - Enrolled in the same HMO as of December 31st of the MY.

- Members who were 11 years of age or older as of December 31 of the MY.
- Members were diagnosed as tobacco users (via ICD-9-CM codes 305.1 or V15.82).

Numerator - Members in the denominator that received counseling to quit smoking as defined by table TBC-A

CPT	HCPCS	ICD-9-CM
96150-96154, 99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397, 99401 -99404, 99406, 99407, 90804-90815, 90845, 90846, 90847, 90849, 90875, 90876, 90880, 90899	~~G0375, G0376,~~ G0436, G0467, G9016, ~~S9445, S9446,~~ S9453, ~~S9075~~	305.1

Data Sources - To identify members in the denominator, DHS' eligibility information and encounter data are used. To define the numerator, data from encounters and FFS claims (including pharmacy claims) are used.

Dental Measures

- **Overall dental utilization by continuously enrolled children:** Percent of members 18 years and younger who were enrolled in the HMO for at least 11 months that year and had a D-code encounter.

  Measurement Year (MY)-Dates of service January 1, 2012 to December 31, 2012.

  Denominator- Members that met the following eligibility criteria:
  - Members who were 18 years of age or younger as of December 31 of the MY.
  - Enrolled in the same HMO for 11 months of the MY.
  - Enrolled in the same HMO as of December 31st of the MY.

  Numerator- Members that had at least one D-code encounter during the MY.

  Exclusion- Exclude the following CDT codes: D5911 – D5999 (maxillofacial prosthetics), D6210 – D6999 (fixed partial denture pontics, retainers – inlays/onlays, crowns).

  Data Sources- To identify members in the denominator, DHS' eligibility information is used. To define the numerator, data from encounters and FFS claims are used.

- **Overall dental utilization by continuously enrolled adults:** Percent of members 19 years or older who were enrolled in the HMO for at least 11 months that year and received a D-code encounter.

  Measurement Year (MY) - Dates of service January 1, 2012 to December 31, 2012.

Denominator - Members that met the following eligibility criteria:
- Members who were 19 years of age or older as of December 31 of the MY.
- Enrolled in the same HMO for 11 months of the MY
- Enrolled in the same HMO as of December 31st of the MY

Numerator - Members that had at least one D-code encounter during the MY.

Exclusion - Exclude the following CDT codes: D5911 – D5999 (maxillofacial prosthetics), D6210 – D6999 (fixed partial denture pontics, retainers – inlays/onlays, crowns).

Data Sources - To identify members in the denominator, DHS' eligibility information is used. To define the numerator, data from encounters and FFS claims are used.

- **Comprehensive dental exam utilization by continuously enrolled children:** Percent of members 18 years and younger who were enrolled in the HMO for at least 11 months that year who received comprehensive dental exam services using either codes D0120 (periodic oral evaluation) or D0150 (comprehensive oral evaluation).

  Measurement Year (MY) - Dates of service January 1, 2012 to December 31, 2012.

  Denominator - Members that met the following eligibility criteria:
  - Enrolled in the same HMO for 11 months of the MY.
  - Enrolled in the same HMO as of December 31st of the MY.
  - Members who were 18 years of age or younger as of December 31 of the MY.

  Numerator - Members that had at least one D-code encounter with codes D0120 (periodic oral evaluation) or D0150 (comprehensive oral evaluation) during the MY.

  Data Sources - To identify members in the denominator, DHS' eligibility information is used. To define the numerator, data from encounters and FFS claims are used.

- **Comprehensive dental exam utilization by continuously enrolled adults:** Percent of members 19 years or older (as of December 31 of the MY) who were enrolled in the HMO for at least 11 months that year who received either codes D0120 or D0150.

  Measurement Year (MY) - Dates of service January 1, 2012 to December 31, 2012.

  Denominator - Members that met the following eligibility criteria:
  - Continuously enrolled in the same HMO for 11 months of the MY
  - Enrolled in the same HMO as of December 31st of the MY
  - Members who were 18 years of age or younger as of December 31 of the MY.

  Numerator - Members that had at least one D-code encounter with codes D0120 (periodic oral evaluation) or D0150 (comprehensive oral evaluation) during the MY.

Data Sources - To identify members in the denominator, DHS' eligibility information is used. To define the numerator, data from encounters and FFS claims is used.

Emergency Department Measures

- **Number of Emergency Department (ED) visits per continuously enrolled member:** Number of total Emergency Department (ED) visits that members who were continuously enrolled in a HMO for 11 months had during the MY.

  Measurement Year (MY) - Dates of service January 1, 2012 to December 31, 2012.

  Denominator - Members that met the following eligibility criteria:
  - Enrolled in the same HMO for 11 months of the MY.
  - Enrolled in the same HMO as of December 31st of the MY.

  Numerator - Number of Emergency Department visits (NOT members) during the MY.
  - Only outpatient hospital encounter records are included.
  - Revenue codes: 0450, 0451, 0452, ~~0456~~, 0459.
  - Professional claims were not included.
  - Distinct visits are identified using first date of service.

  Data Sources - To identify members in the denominator, DHS' eligibility information is used. To define the numerator, data from encounters and FFS claims are used.

- **Members with 3 or more ED visits and no primary care visit:** Percentage of continuously enrolled members with 3 or more ED visits and no primary care visits during the measurement year.

  Measurement Year (MY) - Dates of service January 1, 2012 to December 31, 2012.

  Denominator - Members that met the following eligibility criteria:
  - Enrolled in the same HMO for 11 months of the MY.
  - Enrolled in the same HMO as of December 31st of the MY.

  Numerator - Number of continuously enrolled members in the HMO with 3 or more ED visits and no primary care visit during the measurement year.
  - The criteria to identify ED visits will be the same as the first measure.
  - The criteria to identify primary care visits are listed below:

    Primary Care Visit includes the following CPT codes:
    1. 99201-99205
    2. 99211-99215
    3. 99304-99310
    4. 99315-99316
    5. 99318
    6. 99324-99328

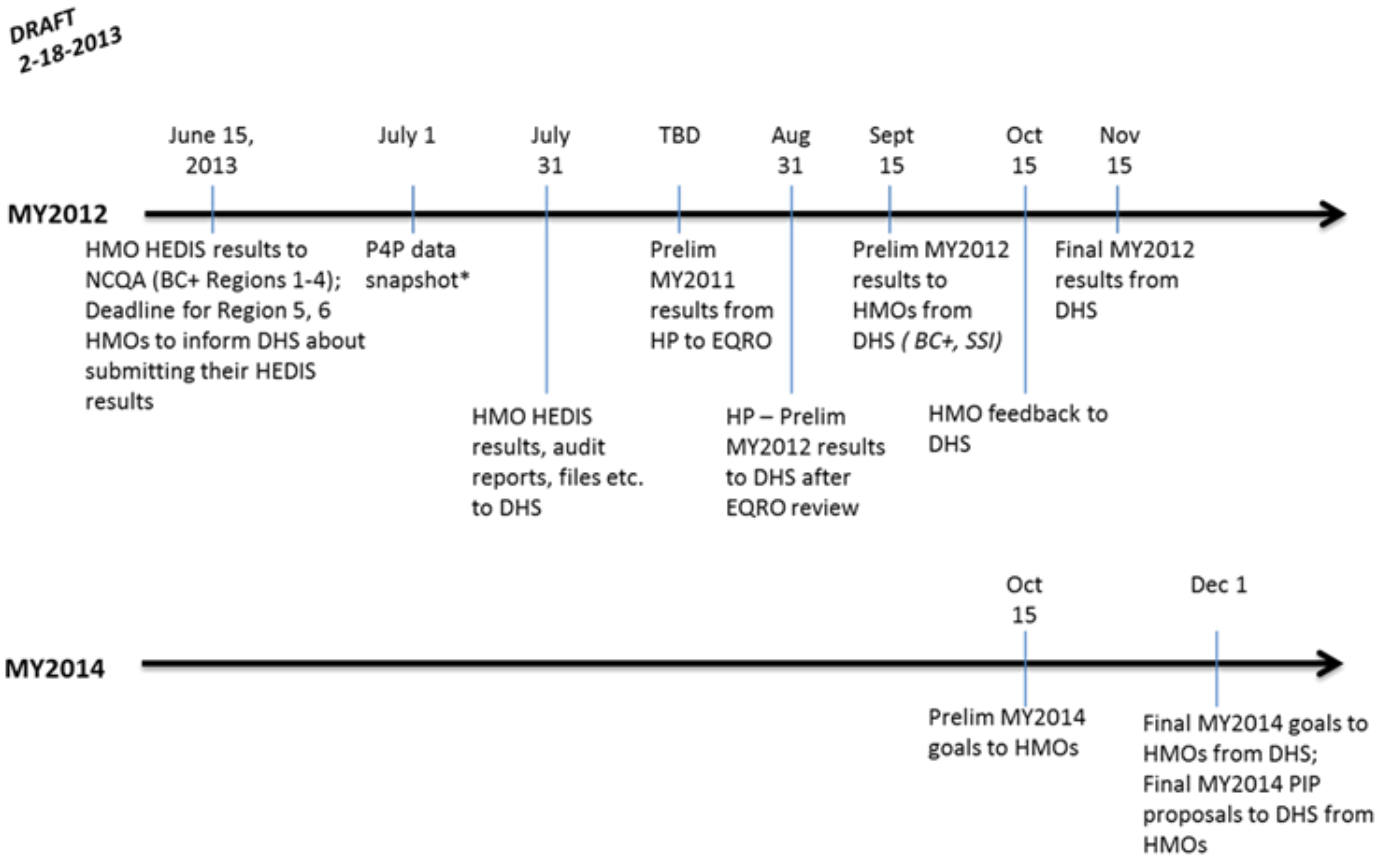
7. 99334-99337
8. 99339-99340
9. 99341-99345
10. 99347-99350
11. 99381 – 99387
12. 99391 – 99397
13. 99401 – 99409
14. 99411 – 99412
15. 99420
16. 99429

Primary Care Visit includes the following rendering provider codes:

17. 93 - Other Nurse Practitioner
18. 316 - Family Practice
19. 345 – Pediatrician
20. 90 - Certified Pediatric Nurse Practitioner
21. 271 - General Practice
22. 92 - Certified Family Nurse Practitioner
23. 212 - Nurse Midwife
24. 322 - Internal Medicine
25. 95 - Nurse Practitioner/Nurse Midwife
26. 318 - General Practice
27. 328 - Obstetrics and Gynecology
28. 100 - Physician Assistant

Data Sources - To identify members in the denominator, DHS' eligibility information is used. To define the numerator, data from encounters and FFS claims are used.

Appendix 2012-7:
HMO P4P Timeline during 2013



** By **July 1, 2013**, HMOs are responsible for ensuring that they have submitted all encounter and/or hybrid data, and that the data have passed the edits and been accepted by DHS. HP will create a snapshot from encounters, relevant FFS claims, STELLAR and WIR data.*