Wisconsin Department of Health Services
HMO Pay-For-Performance (P4P) Guide
Measurement Year (MY) 2014

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) 2014.

Table of Contents

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I. 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 2014, the Pay-For-Performance (P4P) initiative for the HMOs is currently organized as follows:
   a. BadgerCarePlus (BC+): All 6 Regions
   b. SSI: 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 will be formed by the portion of withhold not earned back (i.e., forfeited) by any HMO. This bonus pool will then be distributed, subject to certain limitations, among the HMOs that meet all their goals. The forfeited withhold will be 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 HEDIS measures, as appropriate. The DHS utilizes NCQA's Quality Compass data for Medicaid as one of the key inputs for setting targets for the P4P measures.
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.

II. Measurement Year (MY) 2014

A. BC+ and SSI P4P for all Regions

Scope:

- **BC+:** Standard plan only; excludes Core Plan members and Childless Adults.
- **SSI:** Non-dual (Medicare) eligible members only; dual-eligible members are excluded from P4P.

Features:

- The 2014 upfront **withhold rate is 2.5%**, and will apply to all capitation, including administrative payments. If the **dental** measures apply to an HMO, the withhold rate will be 2.5% of the dental capitation payment.
  Separate withhold % will apply individually to each measure. Each HMO will earn its withhold back for each measure, separately.
- **Measures**

  BC+: 13 measures (9 HEDIS, 4 HEDIS-like).
  SSI: 8 measures (6 HEDIS, 2 HEDIS-like); Plus case management P4P.
  Appendix 1 provides the list of measures and withhold % for each measure.
- **Performance measurement**

  An HMO will be deemed to have a high performance if it has either of the following: (1) a high **LEVEL** of performance, or (2) significant degree of **IMPROVEMENT** (also called Reduction In Error). CMS endorses this approach in its Value Based Purchasing program initiative.

  The **level** of performance will be measured on a "curve" by comparing MY2014 results of an HMO with MY2012 national Medicaid HEDIS percentiles for HMOs as reported in NCQA's Quality Compass. When Medicaid HEDIS results are not available, the appropriate State-wide or Region-wide averages will be used; DHS has provided baseline data to HMOs for MY 2014. BC+ and SSI could have different performance level targets for the same measures due to the differences in the two populations.

  The degree of **improvement** will be measured by comparing MY2014 results with baseline MY2012 results of an HMO using the percentage "reduction in error" approach.

  - When previous years' data are not available to calculate the "improvement" baseline for an HMO, state-wide averages will be used as that HMO's baseline.
  - HMOs that are new to Medicaid will not have their withhold at risk in their first full or partial year of P4P participation. Their withhold will be returned at the time other P4P payments are made for a particular measurement year. Such HMOs will be subject to full P4P requirements in their second year of participation.

Appendix 2 discusses P4P methodology and examples.
Appendix 3 provides P4P targets.
Appendix 4 provides specifications for the HEDIS-like or non-HEDIS measures.

- **Bonus**

  A health 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. 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:

  2.5% of the total capitation $ for that plan, OR **Total** withheld $ **forfeited** by other plans.

  Appendix 5 describes the methodology related to bonus calculations.

- **Timeline:** See *Appendix 7*
- **HMO Report Card:** The DHS will use the P4P measures data in the HMO Report Card.

Data Submission and Reporting

- **BC+:** For MY2014, all health plans are asked to report **each** of their verified HEDIS scores for all regions via **NCQA**, and to make their results available for **public reporting within the Quality Compass**. As in the past, the DHS will continue to calculate the HEDIS-like scores (e.g., for tobacco cessation, AMB-ED Visits, Dental measures for children and adults).

  SSI: The DHS will calculate the results for MY2014 for each measure, unless all HMOs submit audited HEDIS results (excluding dual-eligible members) via NCQA for a measure. Individual HMOs may submit their audited SSI HEDIS results for use in the P4P program.

  The following table shows who will calculate / submit results for each measure for MY2014:

Measure	BC+	SSI
Antidepressant Medication Management- Continuation	HMO	HP
Breast Cancer Screening	HMO	HP
Comprehensive Diabetes Care – HbA1c Testing	HMO	HP
Comprehensive Diabetes Care – LDL-C Screening	HP	HP
Childhood Immunizations-Combination 2	HMO	N/A
ED Visits (AMB) sans revenue code 0456 (Urgent Care)	HP	HP
Follow-Up After Mental Health Hospitalization – 30 Days	HMO	HP
Initiation and Engagement of AOD Treatment - Engagement	HMO	HP
Prenatal and Postpartum Care	HMO	N/A
Tobacco Cessation Counseling	HP	HP
Dental care for children and adults (Regions 5, 6 only)	HP	N/A

- **Data for Childless Adult members**

  For MY2014, DHS will exclude Childless Adult members from P4P, regardless of whether these members enroll anew in MY2014 or continue their enrollment from the past (previously called the Core Plan).

- **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 MY2014. 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. Therefore, HMOs are encouraged to be ready to provide the member-level details, if needed.

- **FFS data for BC+ All Regions**

  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 DHS will issue a timeline for tasks related to this data by fall 2014.

- **NCQA Data submission requirements - BC+ All Regions**

  HMOs are required to submit the following for MY2014:
  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).
     HMOs must provide to the DHS the denominators and numerators for each measure.
  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.

- **Electronic submission requirements:**
  1. Data files and documents are to be submitted to DHS via the SFTP server.
  2. All electronic data files must include the year and health plan name in the file name.
  3. 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.

Please see *Appendix 6* for medical record encounter submission.

Other P4P requirements

1. Rotation of measures is not allowed. Each measure is to be calculated each year.
2. Health plans may apply the optional exclusions for appropriate measures while submitting audited Medicaid HEDIS results to NCQA.
3. In determining continuous enrollment for specific measures, HEDIS allows a gap of 45 days for commercial plans, but only a one-month gap for Medicaid plans that enroll on a monthly

basis. Wisconsin Medicaid enrolls members on a monthly basis. The only time a member is not enrolled for the entire month is the month in which a child was born. Refer to the General Guidelines in the HEDIS Technical Specifications.

4. For measures with age stratification, HMOs are asked to 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.
6. HMOs need to submit HEDIS quality results audited by a NCQA- licensed organization only for BC+. If an HMO chooses to submit SSI results via NCQA, then those results must be audited, as well.

B. HMOs participating in MY2014 P4P

Note: The list of HMOs is updated annually.

HMO	BC+	SSI
Care Wisconsin		New for MY2014
Children's Community Health Plan	✓	
Community Connect	✓	
Compcare	✓	✓
Dean	✓	
GHC – Eau Claire	✓	✓
GHC – South Central Wisconsin	✓	
Gundersen Lutheran	✓	
Health Tradition	✓	
Independent Care	New for MY2014	✓
MercyCare	✓	
MHS	✓	✓
Molina	✓	✓
Network Health Plan	✓	✓
Physicians Plus	✓	
Security	✓	
Trilogy	New for MY2014	New for MY2014
United	✓	✓
Unity	✓	

Appendix 1: MY 2014 P4P Measures (BC+, SSI) and Withhold %

Medical Quality Measures and Withhold

Focus Area	Measure	BC+ (all Reg.)	SSI
Preventive / Screening	Breast cancer (BCS)	0.25%	0.30%
	Childhood immunization (CIS)	0.25%	N/A
Chronic	Diabetes (HbA1c & LDL)	0.25% + 0.25%	0.30% + 0.30%
Mental Health	Depression Medication (AMM2)	0.25%	0.30%
	AODA (IET2)	0.25%	0.30%
	Tobacco (Counseling only)	0.25%	0.30%
	Follow-up after inpatient discharge (FUH30)	0.25%	0.30%
Pregnancy / Birth	Prenatal and Post-partum care (PPC) – BC	0.125% + 0.125%	N/A
Emergency Dept.	ED Visits (AMB) sans revenue code 0456	0.25%	0.40%

Dental Quality Measures (Regions 5 and 6 only)

Focus Area / Measure	BC+ (Regions 5, 6 only)	SSI
Dental care		
Children (ADV + dental care provided by physicians)	1.25%	N/A
Adults (similar to ADV except for age range)	1.25%	N/A

Appendix 2: Performance Measurement Methodology

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.

Level of Performance:
High, medium and low performance for the Level and Improvement will be defined by the respective cut-off points shown in the table below for most measures. The percentiles in the 1st column below refer to the latest data available from NCQA' national HEDIS Medicaid Quality Compass. For MY2014, the latest data available pertain to MY2012. The DHS acknowledges differences across measures, and *Appendix 3* provides specific cut-off points for each measure. The table below provides a general overview of how this methodology works.

<table>
<tr><td></td><td colspan="3">Degree of IMPROVEMENT</td></tr>
<tr><td>Performance LEVEL</td><td>High (10% or higher)</td><td>Medium (5% - 9.9%)</td><td>Low (below 5%)</td></tr>
<tr><td>High (75th – 100th percentile)</td><td colspan="3">100% earn back</td></tr>
<tr><td>Medium (50th – 75th percentile)</td><td rowspan="2">100% earn back</td><td>75% earn back</td><td>50% earn back</td></tr>
<tr><td>Low (below 50th percentile)</td><td>50% earn back</td><td>No earn back*</td></tr>
</table>

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

* **1% or 10 member adjustment:** For MY2013 and beyond, if an HMO misses its LOW target for a measure by 1% or less, or by 10 or fewer members, the HMO will be deemed to have met the Low target and will be eligible to earn back 50% of its withhold for that measure. If an HMO misses its Low target for a measure by more than 1% or by more than 10 members, the HMO will not be eligible to earn back any withhold for that measure. This adjustment would not apply if an HMO misses its High or Medium targets but meets the Low target.

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 2014, compared to MY2012 baselines for that HMO.

An **example**:
If an HMO's MY2012 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 MY2014 score = 81%, then that HMO has improved its score by 1 percentage point = 5% reduction in error.
Mathematically, the reduction in error for MY2014 = $\left(\frac{(MY\,2014 - MY\,2012)}{Error = (100 - MY\,2012)} * 100\right)\%$

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

Refer to *Appendix 3* for any exceptions.

Methodology:

(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 MY2012 National Medicaid Quality Compass data for a given measure are:

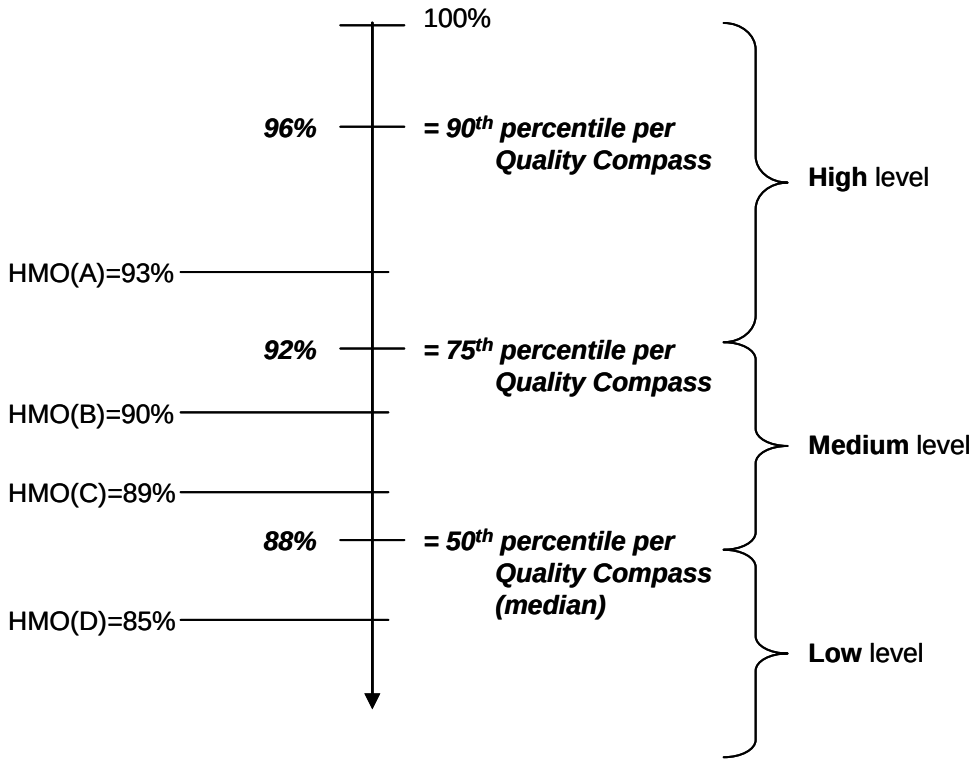
90th percentile score = 96%
75th percentile score = 92%
50th percentile score = 88%

Also assume that scores of four HMOs are:

HMO	MY2014 Score
A	93%
B	90%
C	89%
D	85%

Then, compared to the Quality Compass, determination of each HMO's level of performance is shown below in the table and the following diagram:

HMO	MY2014 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 MY2012 scores as shown below).

HMO	MY2014 Score	MY2012 Score	MY2014 – MY2012	MY2012 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; example below:

HMO	MY2014 level	MY2014 % reduction in error	Withhold earned back
A	High	Low	100%
B	Medium	Medium	75%
C	Medium	Low	50%
D	Low	High	100%

Examples for AMB Measure:

The five **scenarios** below illustrate how to determine AMB performance (lower score is better).

- MY2012 BC+ State average score (base) = 49.3 ED visits/1000 member months.
- MY2014 BC+ **Level** =
  High when HMO score = 50.5 ED visits / 1000 member months or lower;
  Medium when HMO score = between 50.6 and 55;
  Low when HMO score = 55.1 or higher.
- MY2014 BC+ **Reduction in Error (RIE)** =
  High when HMO achieves a 5% or higher reduction of its base;
  Medium when HMO achieves 3% to 4.9% reduction;
  Low when HMO achieves 2.9% or lesser reduction.

1. Assume an HMO's MY2012 score for AMB (calculated by HP) is 55 (= base), and the MY2014 score is 50.

RIE	Level	Earnback
(55-50)/55 = 9.1% = HIGH	HIGH	100%

2. Assume an HMO's MY2012 score for AMB (calculated by HP) is 56 (= base), and the MY2014 score is 53.

RIE	Level	Earnback
(56-53)/56 = 5.4% = HIGH	MEDIUM	100%

3. Assume an HMO's MY2012 score for AMB (calculated by HP) is 53 (= base), and the MY2014 score is 51.

RIE	Level	Earnback
(53-51)/53 = 3.8% = MEDIUM	MEDIUM	75%

4. Assume an HMO's MY2012 score for AMB (calculated by HP) is 54 (= base), and the MY2014 score is 53.

RIE	Level	Earnback
(54-53)/54 = 1.9% = LOW	MEDIUM	50%

5. Assume an HMO's MY2012 score for AMB (calculated by HP) is 58 (= base), and the MY2014 score is 57.

RIE	Level	Earnback
(58-57)/58 = 1.7% = LOW	LOW	0% (Zero) *

* Unless the "1% or 10 member adjustment" applies, as discussed earlier in this Appendix.

Appendix 3: MY2014 HMO P4P Targets for BC+ and SSI

Measure	BadgerCare Plus (Regions 1-6)									2014 Targets					
	BC+ (Reg. 1-6)		MY2012 HEDIS Medicaid Quality Compass Percentile - All HMOs						Rationale	Level (NCQA percentile)			Reduction in Error		
	BC+ State		2012 Avg	10th	25th	50th	75th	90th		High	Med	Low	High	Med	Low
AMB- ED Visits per 1000 MbrMnths (not %)	49.30	*HP*	AMB has been altered (0456 removed) so only state average will be used;						REVERSE measure - Lower score is better. **Target = 50.5 or lower**	Score = 50.5 or lower	Score = 50.6 to 55	Score - 55.1 or higher	5% or higher reduction of Base	3%-4.9% reduction of Base	2.9% or lower reduction of Base
AMM-Continuation	39.64%		36.65%	28.13%	32.07%	35.26%	**40.06%**	45.86%		>75th	50th - 75th	<50th	7% or higher	3% - 6.9%	2.9% or lower
BCS	59.58%		51.82%	41.72%	46.51%	51.32%	**57.71%**	62.88%		>75th	50th - 75th	<50th	10% or higher	5% - 9.9%	4.9% or lower
CDC-HbA1c	87.61%		82.98%	75.75%	79.21%	83.16%	**87.33%**	91.11%		>75th	50th - 75th	<50th	10% or higher	5% - 9.9%	4.9% or lower
CDC-LDL	75.79%		75.56%	66.71%	71.05%	76.28%	**80.54%**	83.52%		>75th	50th - 75th	<50th	10% or higher	5% - 9.9%	4.9% or lower
CIS- Combo 2	78.96%		75.74%	65.97%	70.44%	76.89%	**81.74%**	85.40%		>75th	50th - 75th	<50th	10% or higher	5% - 9.9%	4.9% or lower
FUH-30	62.33%	*HP*	63.75%	38.13%	57.21%	**65.85%**	75.68%	82.01%		>50th	50th - 25th	<25th	10% or higher	5% - 9.9%	4.9% or lower
IET- Engagement	14.87%	*HP*	10.84%	2.85%	5.14%	10.19%	**16.17%**	19.84%		>75th	50th - 75th	<50th	5% or higher	3% - 4.9%	2.9% or lower
PPC-Prenatal	85.50%		82.93%	70.59%	79.85%	**85.88%**	89.72%	92.82%	2012 hybrid average ~ 85.5%.	>50th	25th - 50th	<25th	10% or higher	5% - 9.9%	4.9% or lower
PPC-Postpartum	63.30%		63.05%	50.69%	57.91%	**63.99%**	70.20%	73.83%		>50th	26th - 50th	<25th	10% or higher	5% - 9.9%	4.9% or lower
TOBACCO (Counsel)	63.54%	*HP*	TOB - only state average will be used						**Target = 66%**	Score=66% or higher	Score = 63% - 65.9%	Score = 62.9% or lower	10% or higher	5% - 9.9%	4.9% or lower
ADV-Children	37.88%	*HP*	ADV has been altered so only Region 5&6 average will be used						**Target = 40%**	Score = 40% or higher	Score = 37.5% - 39.9%	Score - 37.4% or lower	7% or higher	3% - 6.9%	2.9% or lower
ADV-Adults	27.40%	*HP*	ADV has been altered so only Region 5&6 average will be used						**Target = 30%**	Score = 30% or higher	Score = 27% - 29.9%	Score - 26.9% or lower	5% or higher	3% - 4.9%	2.9% or lower
	SSI (Regions 1-6)									2014 Targets					
Measure	SSI		MY2012 HEDIS Medicaid Quality Compass Percentile - All HMOs						Comments	Level (NCQA percentile)			Reduction in Error		
	SSI State		2012 Avg	10th	25th	50th	75th	90th		High	Med	Low	High	Med	Low
AMB- ED Visits per 1000 MbrMnths (not %)	113.58	*HP*	AMB has been altered (0456 removed) so only state average will be used;						REVERSE measure - Lower score is better. **Target = 113 or lower**	Score = 113 or lower	Score = 113.1 and 120	Score - 120.1 or higher	5% or higher reduction of Base	3%-4.9% reduction of Base	2.9% or lower reduction of Base
AMM-Continuation	19.32%	*HP*	36.65%	28.13%	32.07%	35.26%	40.06%	45.86%	**Target = 23%**	Score = 23% or higher	Score = 20% - 22.9%	Score = 19.9% or lower	5% or higher	3% - 4.9%	2.9% or lower
BCS	60.16%	*HP*	51.82%	41.72%	46.51%	51.32%	**57.71%**	62.88%		>75th	50th - 75th	<50th	10% or higher	5% - 9.9%	4.9% or lower
CDC-HbA1c	84.88%	*HP*	82.98%	75.75%	79.21%	83.16%	87.33%	91.11%	**Target = 86%**	Score = 86% or higher	Score = 84% - 85.9%	Score = 83.9% or lower	10% or higher	5% - 9.9%	4.9% or lower
CDC-LDL	74.62%	*HP*	75.56%	66.71%	71.05%	**76.28%**	80.54%	83.52%		>50th	25th-50th	<25th	10% or higher	5% - 9.9%	4.9% or lower
FUH-30	53.92%	*HP*	63.75%	38.13%	**57.21%**	65.85%	75.68%	82.01%		>25th	25th percentile - 48%	Below 48%	10% or higher	5% - 9.9%	4.9% or lower
IET-Engagement	12.77%	*HP*	10.84%	2.85%	5.14%	10.19%	16.17%	19.84%	**Target = 14%**	Score = 14% or higher	Score = 12% - 13.9%	Score = 11.9% or lower	5% or higher	3% - 4.9%	2.9% or lower
TOBACCO (Counsel)	65.10%	*HP*	TOB - only state average will be used						**Target = 68%**	Score=68% or higher	Score =65% - 67.9%	Score =64.9% or lower	10% or higher	5% - 9.9%	4.9% or lower
Please do not compare BC+ and SSI results based on Quality Compass percentiles; SSI data are not included in Quality Compass.															

Appendix 4: HEDIS-Like and Non-HEDIS Measures

A. Annual Dental Visit – Children (BC+ Regions 5 and 6 Only)

- **Measure description:** The % of members 2-21 years of age who had at least one dental visit during the measurement year.
- **Specifications:** The DHS will use the 2014 HEDIS specifications for Annual Dental Visits (ADV).
  - Per HEDIS, only services rendered by a practitioner who holds a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners.
  - Per DHS definitions, dental services (included in the codes above) provided by a physician would also count.

B. Annual Dental Visit – Adults (BC+ Regions 5 and 6 Only)

- **Measure description:** The % of members 22-64 years of age who had at least one dental visit during the measurement year.
- **Denominator:**
  - Age: from 22 to 64 years of age.
  - Continuous Enrollment: The member needs to be enrolled in the same HMO continuously for 11 months of the measurement year.
  - Anchor Date: the member needs to be enrolled in the HMO as of Dec. 31 of the measurement year.
- **Numerator:** One or more dental visits with a dental practitioner during the measurement year. A member had a dental visit if a claim or encounter submit contains any code listed below:
  - CPT Codes: 70300, 70310, 70320, 70350, 70355.
  - CDT Codes: D0120-D0999; D1110; D1120; D1204-D2999; D3110-D3999; D4210-D4999; D5110-D5899; D6010-D6205; D 7111-D7999; D8010-D8999; D9110-D9999.
  - Per HEDIS, only services rendered by a practitioner who holds a Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD) degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners.
  - Per DHS definitions, dental services (included in the codes above) provided by a physician would also count.

C. Emergency Room Utilization

- **Measure description:** Number of Emergency Department visits per 1000 member months; this is a utilization measure.
- **Specifications**: The DHS will use the 2014 HEDIS specifications for Ambulatory Care – ED Visits (AMB), excluding revenue code 0456 (Urgent Care).
- **Denominator:** Number of member months during measurement year 2014.

- **Numerator:** Number of Emergency Department visits during the measurement year that do not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.
  - Codes to identify Emergency Department Visits
    - CPT 99281-99285 ***OR*** UB Revenue Codes 450, 451, 452, 459, 981 **excluding** revenue code 456.
    - CPT 10040-69979 ***WITH*** Place of Service 23.
- **Exclusions:** The measure does not include mental health or chemical dependency services. The exclusions are defined in the HEDIS 2015 Volume 2 Value Set Directory which include the following:
  - Electroconvulsive Therapy Value Set
  - Mental and Behavioral Disorders Value Set
  - AOD Rehab and Detox Value Set
  - Psychiatry Value Set

D. Tobacco Cessation – Counseling

- **Measure Description:** The percentage of members 12 years of age or older who were identified as tobacco users and who received tobacco cessation counseling during the measurement year.
- **Denominator:** The eligible population:
  - Age: Members 12 years of age or older during the measurement year.
  - Continuous Enrollment: The measurement year.
  - Allowable Gap: No More than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
  - Anchor Date: December 31 of the measurement year.
  - Benefits: Medical during the measurement year.
  - Event/Diagnosis: Members are part of the eligible population if they are identified as tobacco users by having at least one encounter or claim in the measurement year with the following codes:
    - ICD-9-CM 305.1 (tobacco use disorder) as a primary, secondary, tertiary or fourth diagnosis code.
    - All CPT codes are included even from professional, inpatient, or outpatient claims.
- **Exclusions:** Members who have a diagnosis of history of tobacco use, pregnancy, or tobacco use disorder complicating pregnancy during the measurement year:
  - History of Tobacco Use: ICD-9-CM Diagnosis V15.82.
  - Pregnancy Diagnosis: ICD-9-CM codes 630-679, V22, V23, V28.
  - Tobacco Use Disorder Complicating Pregnancy: ICD-9-CM Diagnosis: 649.01.
- **Numerator:** The member is numerator compliant if he or she received counseling to quit smoking either face-to-face or by phone as identified by any claim or encounter with at least one of the codes listed in Table TBC-A during the measurement year and with the following codes in the same encounter as a primary, secondary, tertiary or fourth diagnosis code:
  - ICD-9-CM code 305.1

- Striving to Quit- Members that received tobacco cessation treatment through the Quit Line or First Breath would count in the measure.

Table TBC-A: Codes to Identify Tobacco Cessation Counseling

CPT	HCPCS	ICD-9-CM
96150-96154, 99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397, 99401 -99404, 99406, 99407, 90832-90834, 90836-90838, 90845, 90847, 90849, 90875, 90876, 90880, 90899, 98967-98968	G0436, G0437, G9016 S9453	305.1

Please see *Appendix 6* for further information re: medical record encounter data submission

Appendix 5: Bonus (BC+ and SSI)

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.
- Any bonus pool will be entirely funded through forfeitures by HMOs.

Calculations

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:**

- Variation in the # of members enrolled, i.e., the difference between large and small HMOs, is accounted for by the limit 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.

Bonus Example

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

HMO	Total # of members in denominator 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 6: Medical Record Encounter Guidance (X12 837)

This Appendix provides guidance to the HMO staff for submitting chart reviewed data for the P4P measures, e.g., when creating an encounter from medical record information. The review guidelines should first be discussed with the HMO technical staff, which can assist them with submitting the information in the required format. All HMOs are expected to follow the X12 837 standards when submitting encounters.

Background

- An encounter record may be created from data acquired through medical record or chart review, or other non-claim sources.
- This is done when the HMO wishes to supplement its encounter data set, **but no claim was received for the service provided. Examples include: HealthCheck services, medical records transferred from another state.**
- The only medical record/chart reviewed data that may be submitted is information obtained from a provider or clinician, **and must meet the following criteria:**
  - The information is in the record within the time period the information will be used.
  - When a test result is needed, the medical record includes a note indicating the date of service and the result.
  - Electronic supplemental data may be used if the information is related to the disease being managed, the reported value was measured by a health care provider, and the information is either in the member's medical record or the HMO has the ability to access the information (example: WIR)
- Member reported biometric values from self-administered tests are not acceptable.
- Member survey information may not be used.
- If the review supplements an existing encounter record, do not submit the additional data as a medical record reviewed encounter. Adjust or void and resubmit the original encounter.
- DHCAA Required Fields for Medical Record/Chart Review Data (Please work with your technical staff to get the appropriate information from the companion guide).

Required 837 Detail Fields for Medical Record/Chart Review

- All HMOs are expected to follow the X12 837 standards when submitting encounter data, even when it comes in by chart review. Included in the 837 standards are instructions for identifying the encounter as a chart review. The list below identifies the fields that are specific to chart reviewed data. Keep in mind that your data submissions should begin with the 837 standards. Please work with your technical staff to utilize the appropriate information from the companion guide.
- Loop 2330 NM 109 – Other Payer Primary Identifier (This is the HMO ForwardHealth ID)
- Inner Envelope BHT06 – Encounter ID. Use Loop 2300 with PWK01 = 09. Any encounter submitted with 09 in the PWK01 segment will be labeled as a chart review. (Data source 1, 2, 3 is no longer used). These services will not be used for encounter pricing.

- Loop 2300 with PWK – Use this segment when it is necessary to indicate an encounter chart review.
- Loop 2300 PWK 01 – Report Type Code = 09 (Encounter). Added element. Element will designate a chart review encounter.
- Loop 2300 PWK02 – Attachment Transmission Code AA. This means that the attachment is available by request at provider site.

Required Field Differences From Last Year

As a point of reference, this section shows which fields from last year are included in the 837 format and which data fields are excluded or identified differently in the new format. This is an informational item only and does not reflect how chart reviewed data should be submitted. Please refer to the companion guide for submission instructions.

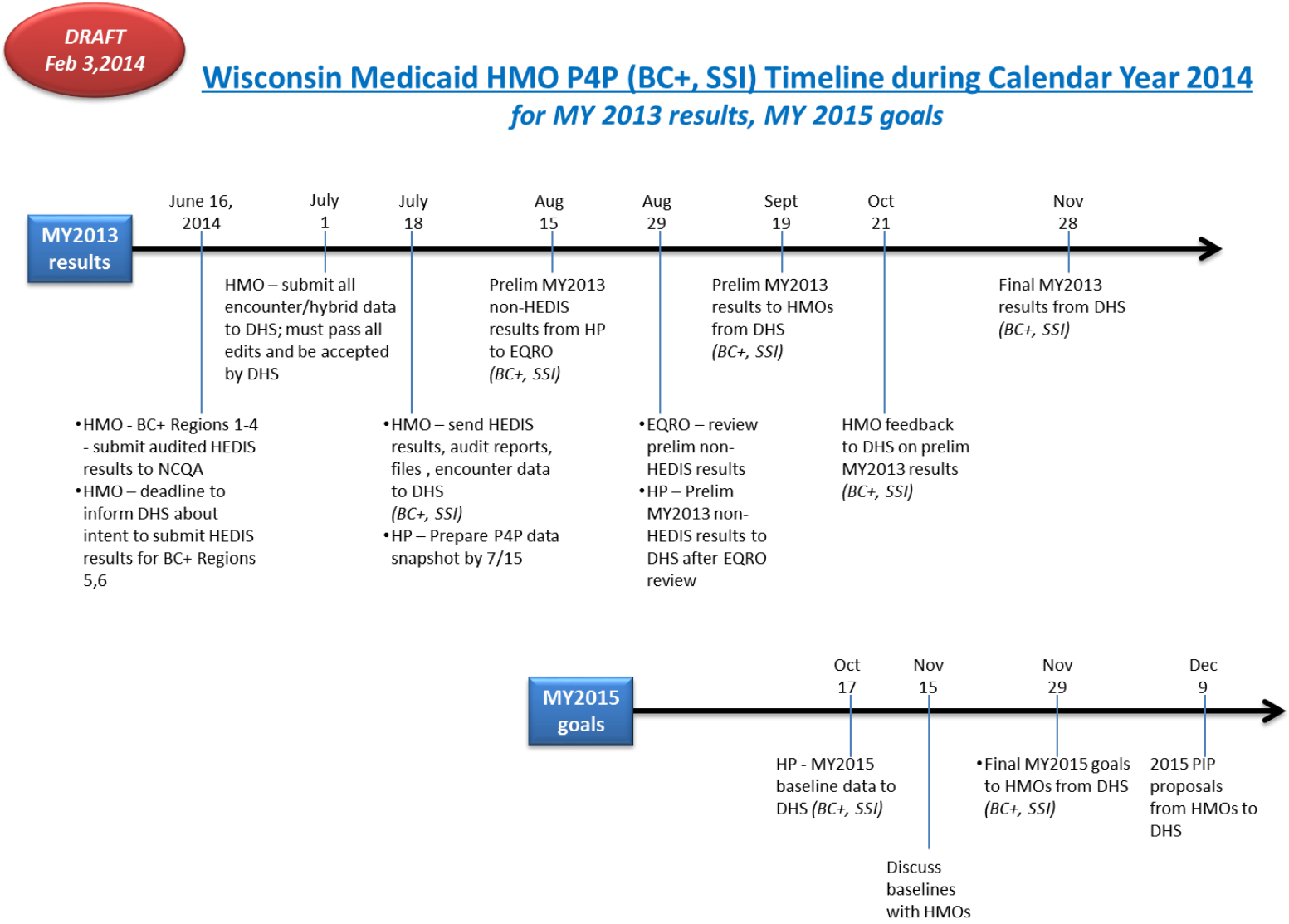
- Encounter type – This is not used as a data field in the new format. Encounters are grouped as O, I, P, D.
- HMO ID: HMO ForwardHealth ID number is used as a data field.
- Data Source- Not used as a data field.
- Record Type – Not used as a data field.
- RIN – Not used as a data field.
- Process Date – Not used as a data field.
- Rendering Provider NPI – Used as a data field. If rendering provider NPI is unavailable, use the HMO ID number.
- Rendering Provider Taxonomy – Used as a data field, but can be sent blank.
- Rendering Provider Zip + Four – Not used as a data field.
- Member ID – Used as a data field.
- Member Last Name – Used as a data field.
- Member First Name – Used as a data field.
- Facility Name – Not used as a data field.
- Diagnosis Code #1 – Used as a data field.
- From Date of Service – Used as a data field.
- Procedure Code – Used as a data field.
- Quantity – Used as a data field.

Chart Review FAQ's

- Will the Department accept the clinic as the rendering provider?
  - Data pulled from the medical record must comply with the guidelines concerning HEDIS data element requirements and audit review. Supplemental data may be used if the information is related to the disease being managed, the reported value was measured by a health care provider and the information is either in the member's medical record or the HMO has the ability to access the information. If the rendering provider number is not available, the HMO may use their HMO ID number.

- Will the department accept reviewed medical records with the clinic NPI when the rendering NPI is not available. Also can the department populate the diagnosis or procedure code fields?
  - The department will accept reviewed records with the HMO ID number when the rendering NPI is not available. The data will not be used to calculate HMO rates.
  - The department will not accept medical record reviewed data without the diagnosis or procedure codes. This is consistent with HEDIS requirements.

Appendix 7: HMO P4P Timeline during 2014



Not to scale