Measurement Year (MY) 2013
Hospital Pay-for-Performance (P4P) Guide

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Measurement Year (MY) 2013 Hospital P4P – Overview

1. Overview

a. **MY 2013 = July 1, 2012 through March 31, 2013**
The 9-month duration will apply only to MY 2013. MY 2014 and beyond will be on a 12-month cycle, from April 1 through March 31 of the next calendar year.

b. For MY 2013, DHS will implement two components of its Fee-for-Service (FFS) Hospital Pay-For-Performance (P4P) program, namely:
   i. Withhold P4P, and
   ii. Assessment P4P

c. **Withhold P4P** is new for **MY 2013**, beginning **July 1, 2012**.
Performance for all P4P initiatives will be measured annually, not each quarter.
   i. **Withhold P4P Scope**: Money will be withheld from Fee-for-Service claims payments only, including inpatient and outpatient services. The scope excludes out-of-state and border-status hospitals, long term care, rehab, and nursing homes.
   ii. **1.5%** will be **withheld** from total FFS claims payments, and earned back based on performance. In addition to earning back the 1.5% withhold, hospitals can earn a **bonus** up to 1.5% of their total FFS claims payments, funded entirely by forfeiture by other hospitals, and subject to caps defined by DHS, using the methodology described in Appendix 4.
   iii. **Six measures** will apply in MY 2013 – Appendices 1(a), (b) and (c).
   iv. Withhold P4P **methodology** is discussed in Appendix 4.
   v. Data submission and validation is discussed in Appendix 5.
   vi. **MY 2013 Timeline** – Appendix 3.

d. **Assessment P4P** will continue, with minor modifications for MY 2013 – Appendix 8.

e. For **MY 2014 and beyond**, DHS will form work groups including DHS Divisions and other stakeholders – Appendix 2.

2. Communication and hospital engagement

DHS has conducted the following activities:

a. Sent two Provider Updates
a. Held multiple conference calls and work sessions with hospitals, other stakeholders
b. Sent Hospital P4P Guide and updates via email and secure portal.
c. Provided answers to FAQs – Appendix 6
d. Received hospital feedback following the February 9, 2012 conference call and draft, and responded to it – Appendix 7

Appendix 1(a) – Measures for MY 2013 Hospital P4P

Measure	Applicable to				Data Source	Level	Error Reduction
	Acute Care (n=69)	Critical Access (n=58)	Psych (n=13)	Children's (n=2)			
1. **30-day hospital readmission** - Specifications developed by DHS. No case mix adjustment; Pre/post comparison, not across hospitals.	✓ (n~55)	✓ (n~9)	×	✓ (n~1)	DHS claims data	×	✓
2. **Mental health follow-up visit within 30 days** of discharge for mental health inpatient care - pre/post comparison. Specifications developed by DHS. Pre/post comparison.	✓ (n~19)	✓ (n~2)	✓ (n~10)	✓ (n~0)	DHS claims data	×	✓
3. **Asthma care for children (Home Management Plan of Care only)** – applicable to Children's Hospitals only.	×	×	×	✓ (n~1)	Joint Commission	✓ (national average)	✓
4. **Surgical infection index**. Move from "Assessment P4P" to "Withhold P4P"	✓ (n=62)	✓ (n=27)	×	×	CheckPoint	✓ (WI average)	✓
5. **(PN-6) – <u>Initial antibiotic</u>** – % of immunocompetent patients with **<u>community-acquired pneumonia</u>** who receive an initial antibiotic regimen during the first 24 hours that is consistent with guidelines.	✓ (n=57)	✓ (n=19)	×	×	CheckPoint	✓ (WI average)	✓
6. **Healthcare Personnel (HCP) influenza vaccination** – CMS will require it in future. Specifications developed by DHS.	✓	✓	✓	✓	Self-report via DPH survey	P4R only for MY 2013	P4R only for MY 2013

✓ = measure is conceptually applicable; n = # of hospitals with sufficient discharges for the measure in 2010.

Appendix 1(b) – Baseline Averages for MY 2013 Hospital P4P

Hospitals can calculate their specific targets using the following baselines and methodology described in **Appendices 4 and 8**.

Withhold P4P

Measure	Numerator	Denominator	Average
30-day Readmission Statewide Average n=137 hospitals	2857	16341	17.5%
30- day Mental Health Follow-up Visit Statewide Average n=49 hospitals	1175	1684	69.8%
Childhood Asthma National Average, Joint Commission Data (Oct 2010 - Sept. 2011)	Numerator / denominator data not available from Joint Commission		82.7%
SCIP Index Statewide Average; n=125 hospitals; Data: 2010Q4 – 2011Q3	WHA does not receive the numerator / denominator for this measure from MetaStar		85.7%
Initial Antibiotic (PN-6) Statewide Average; n=125 hospitals; Data: 2010Q4 – 2011Q3	6351	6708	94.7%

Assessment P4P

Measure	Numerator	Denominator	Average
Perinatal Measures			
Pre-Birth Steroids Statewide Average; n=49*	719	869	82.7%
Infant Composite Statewide Average; n=49*	766	41377	1.9%
Breast feeding Statewide Average; n=49*	30822	40832	75.5%
CHF Discharge Instructions Statewide Average; n=66*	7471	8305	90.0%
HCAHPS (Patient Experience of Care)		**Statewide Average (n=64 hospitals)**	
Patients Ranked Hospital High		70.9%	
Definitely Recommend Hospital		73.4%	
Doctors Always Communicated Well		80.4%	
Nurses always communicated well		78.6%	
Patients always received help as soon as they wanted		65.8%	
Staff always explained medications		64.1%	
Pain always well controlled		69.8%	
Always quiet at night		59.5%	
Room was always clean		75.2%	
Staff Provided Discharge Instructions		86.5%	

*= including all hospitals with >0 in the denominator.

Appendix 1(c) – Specifications for MY 2013 Hospital P4P Measures

Please also refer to Appendix 7.

i. 30-Day Hospital Readmission

This measure applies to all hospitals with at least **30** eligible discharges in the denominator for a 12-month Measurement Year. For MY 2013, which has been reduced from 12 to 9 months, hospitals must have at least 23 observations for this measure to apply.

Measure = % of inpatient stays during the measurement year that were followed by a readmission within 30 days for all members.

Denominator = All inpatient discharges to home in MY 2013 after applying exclusions.

Numerator = All inpatient "readmissions" between 7/1/2012 – 3/31/2013 after exclusions
Readmission = Any admission with a discharge in the previous 30 days, after exclusions
- This includes discharges between 6/1/2012 – 6/30/2012.
- FFS members that are re-admitted within 30 days post-discharge and have by then (after discharge) enrolled in an HMO, are included in the numerator.

If a FFS member discharged initially by a hospital enrolls in a Managed Care plan of Wisconsin Medicaid within 30 days of the initial discharge, it does not affect the accountability of the initial hospital for the readmission measure during the 30 days following the initial discharge. Similarly, readmission at a different hospital does not affect the accountability of the initial hospital.

DHS plans to provide a quarterly report for the readmission measure to each hospital. This report will include the numerator, denominator, patient identifiers for patients who comprised the numerator and the denominator, and other information. Since this report will be based on the claims data of DHS, the currency of this information will depend on the timeliness of claims submitted by hospitals.

Eligible population
- **Product line:** Medicaid FFS including BadgerCare Plus Standard, Benchmark, and Core Plan members and Wisconsin Medicaid FFS recipients.
- **Ages:** Members under 65 years of age during the measurement year.
- **Continuous enrollment:** Enrollment in Wisconsin Medicaid 30 days after the Discharge Date.
- **Benefits:** Medical.
- **Measurement Year:** July 1, 2012 to March 31, 2013.

Exclusions
- Admissions for BadgerCare Plus Standard, Benchmark, and Core / Basic or Medicaid SSI members in HMOs. Exclude Medicare (dual eligible) members.

- Transfers to another facility; only discharges to home (discharge status =01) are included.
- Observation status.
- Inpatient stays with the following codes as primary diagnosis:
  - Maternity ICD-9-CM codes: 630-679, V21.3,V22,V23, V24.0, V28
  - Conditions in the perinatal period (i.e., within 28 days of birth), ICD-9-CM: 760 – 779.99
  - UB Revenue: 0112, 0122, 0132, 0142, 0152, 0720-0722, 0724.
- Discharge of infants after birth, ICD-9-CM codes V30 – V39.
- Maintenance chemotherapy identified by UB-revenue codes 0331, 0332 and 0335.
- Mental health / substance abuse inpatient care **(aka MH/SA Exclusions for Readmissions)**
  - Mental health:
    - ICD-9-CM diagnosis codes: 290, 293-302, 306-316.
    - MS-DRG codes to identify inpatient services: 876, 880-887.
  - Chemical Dependency
    - ICD-9-CM Diagnosis: 291-292, 303-304, 305, 535.3, 571.1.
    - Codes to identify inpatient services: ICD-9-CM Procedure Codes 94.6x with an inpatient facility code of MS-DRG 894-897.
- Inpatient stays with discharges for death or Left against medical advice (AMA)
- A length of stay (discharge day minus admission date) of more than 120 days
- CMS draft list of exclusions (Tables 1 and 2) from August 2011.
  URL: https://www.cms.gov/MMS/Downloads/MMSHospital-WideAll-ConditionReadmissionRate.pdf
  When CMS finalizes the definition for readmissions, Wisconsin DHS will adopt that definition for subsequent measurement years.
  Steps: If Table 2 does NOT apply (i.e., the discharge category is not acute or a complication of care), and the procedures are in Table 1, then that readmission is considered planned and is excluded.

Table 1 – Planned Procedure	
AHRQ Procedure CC	**Procedure**
45	Percutaneous transluminal coronary angioplasty (PTCA)
84	Cholecystectomy and common duct exploration
Condition CCS 45	Maintenance chemotherapy
157	Amputation of lower extremity
51	Endarterectomy; vessel of head and neck
78	Colorectal resection
44	Coronary artery bypass graft (CABG)
152	Arthroplasty knee
113	Transurethral resection of prostate (TURP)
153	Hip replacement; total and partial
211	Therapeutic radiology for cancer treatment
158	Spinal fusion
48	Insertion; revision; replacement; removal of cardiac pacemaker or cardioverter / defibrillator
3	Laminectomy; excision intervertebral disc

36	Lobectomy or pneumonectomy
55	Peripheral vascular bypass
43	Heart valve procedures
52	Aortic resection; replacement or anastomosis
104	Nephrectomy; partial or complete
60	Embolectomy and endarterectomy of lower limbs
85	Inguinal and femoral hernia repair
124	Hysterectomy; abdominal and vaginal
167	Mastectomy
154	Arthroplasty other than hip or knee
74	Gastrectomy; partial and total
114	Open prostatectomy
119	Oophorectomy; unilateral and bilateral
10	Thyroidectomy; partial or complete
64	Bone marrow transplant
166	Lumpectomy; quadrantectomy of breast
105	Kidney transplant
176	Other organ transplantation
ICD-9 94.26, 94.27	Electroshock therapy

Table 2 – Discharge condition categories considered acute or complications of care

AHRQ CC	**Discharge condition categories that are acute or complications of care and are associated with planned procedures**
100	Acute myocardial infarction
237	Complication of device; implant or graft
106	Cardiac dysrhythmias
108	Congestive heart failure; nonhypertensive
105	Conduction disorders
146	Diverticulosis and diverticulitis
2	Septicemia (except in labor)
238	Complications of surgical procedures or medical care
116	Aortic and peripheral arterial embolism or thrombosis
	Fracture (207, 225, 226, 227, 229, 230, 231, 232)
145	Intestinal obstruction without hernia
201	Infective arthritis and osteomyelitis (except that caused by TB or sexually transmitted disease)
109	Acute cerebrovascular disease
97	Peri-, endo-, and myocarditis; cardiomyopathy
122	Pneumonia (except that caused by TB or sexually transmitted disease)
245	Syncope
127	Chronic obstructive pulmonary disease and bronchiectasis

131	Respiratory failure; insufficiency; arrest (adult)
55	Fluid and electrolyte disorders
159	Urinary tract infections
130	Pleurisy; pneumothorax; pulmonary collapse
157	Acute and unspecified renal failure
139	Gastroduodenal ulcer (except hemorrhage)
153	Gastrointestinal hemorrhage
160	Calculus of urinary tract
112	Transient cerebral ischemia

Calculation Steps for Baselines:

Staging

1. HP created a staging table of all Title XIX inpatient stays, excluding members in the BadgerCare Plus Basic Plan, paid as a fee-for-service claim with a last date of service between December 1, 2009 and December 31, 2010. This table is referred to herein as the FFS Inpatient Table. Claims included in this table must be Inpatient claim type with a billing provider type of either hospital or inpatient psychiatric facility.
2. From records compiled in the FFS Inpatient Table, HP created a table containing only those FFS inpatient stays which were assigned a patient status code indicating discharge to home or other self-care (discharge status code 01). This table is referred to herein as the Discharge Table:
   a. When multiple inpatient records with the same recipient ID, hospital ID, patient status code, and date of admission have different discharge dates, the latest date was assigned the true date of discharge.
   b. When multiple inpatient records with the same recipient ID, hospital ID, patient status code, and date of discharge have different admission dates, the earliest date was assigned the true date of admission.
3. In the Discharge Table, HP created condition flags to indicate 'Y' if the inpatient stay met any of the exclusion criteria (please see Appendix 1, page 4-7 of the Hospital P4P Guide for a full list of exclusions)
   a. In cases where multiple inpatient records with the same recipient ID, date of admission, and date of discharge, have different values (both 'Y' and 'N') in a given condition flag, the value 'Y' was assigned.
4. **QUALITY CHECK** was done to verify that all discharge records in the Discharge Table are represented by only one distinct record. This check was done to ensure that there would not be two records with the same recipient ID, date of admission, and date of discharge.
5. HP created an additional staging table of all members eligible for Title XIX services, excluding members in the BadgerCare Plus Basic Plan, from January 1, 2010 through January 30, 2011, for use in determining whether a member maintained at least 30 days of continuous eligibility following a qualifying discharge. This table is referred to herein as the Eligibility Table.
6. HP compared the Discharge Table (see Step 2) to the records in the Eligibility Table (see Step 5), and created a new table, referred to herein as the Eligible Discharges Table. This new table contains those records found in the Discharge Table which show that the

member was eligible for Title XIX services, excluding the BadgerCare Plus Basic Plan, 30 days after the discharge date, and therefore eligible for the measure.

Calculating Denominator

7. HP created an additional table of those records from the Eligible Discharges Table (see Step 6) where the time between dates of admission and discharge was less than or equal to 120 days (stays of over 120 days are excluded). Every discharge in this table that occurred between January 1, 2010 and December 31, 2010 will be counted in each respective hospital's denominator for measurement year 2010.

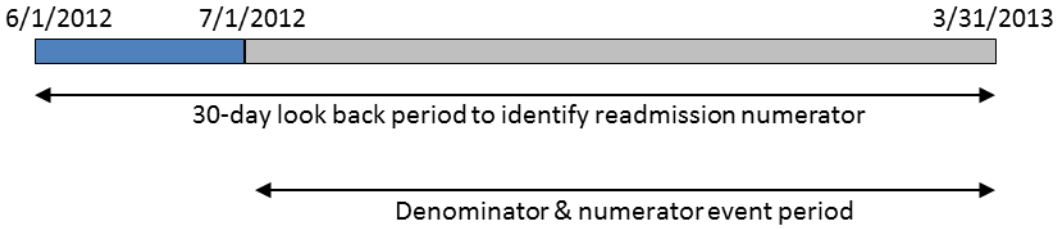
Staging

8. HP created a staging table of all Title XIX inpatient stays reported as an HMO Encounter with a date of admission, excluding members in the BadgerCare Plus Basic Plan, between January 1, 2010 and December 31, 2010. This table is referred to herein as the HMO Inpatient Table. Encounters included in this table must be of the Inpatient encounter type with a billing provider type of either hospital or inpatient psychiatric facility, and must have a length of stay at the facility of no more than 120 days between the reported date of admission and discharge.
9. HP then compared all records found in both the FFS Inpatient Table (see Step 1) and HMO Inpatient Table (see Step 8) to the discharges in the Denominator Table, and created a new table of all inpatient admissions that occurred within 30 days of qualifying discharge. This table is referred to herein as the Readmission Table:
    a. In cases where multiple readmission records with the same recipient ID, hospital ID, patient status code, and date of discharge have different readmission dates, HP assigned the earliest date as the date of readmission.
10. In the Readmission Table (see Step 9), HP created condition flags to indicate 'Y' if the inpatient stay meet any of the exclusion criteria.
    a. In cases where multiple inpatient records with the same recipient ID, date of readmission, and date of discharge have different values (both 'Y' and 'N') in a given condition flag, HP assigned a value of 'Y'.
11. **QUALITY CHECK**: HP verified that all readmission records in the Discharge Table (see Step 2) are represented by only one distinct record. This check was done to ensure that there would not be two records with the same recipient ID, date of discharge, and date of readmission.

Calculating Numerator

12. The Readmission Table (see Step 9) may contain multiple records with the same recipient ID and date of denominator discharge, indicating that the member was readmitted multiple times within the 30 day period post-discharge. HP created a new table composed of records from the Readmission Table but selected only the earliest date of readmission for each given discharge in the denominator. This table is a record of all numerator readmissions and is referred to herein as the Numerator Table. Every readmission in this table that occurred between January 1, 2010 and December 31, 2010 will be counted in each respective hospital's numerator for measurement year 2010.

The following diagram illustrates the timeline used for determining the numerator and the denominator.



The following table provides various **sample scenarios** for this measure:

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)				
Scenario	**Event date**		**Include in:**	
	Admission	**Discharge**	**Numerator**	**Denominator**
1. Patient admitted 6/3/12 and discharged 6/30/12; readmitted 7/3/12 and discharged 7/6/12.	6/3/12		No - admitted pre-MY2013	
		6/30/12		No - discharged pre-MY2013
	7/3/12		Yes - admitted within 30 days of previous discharge	
		7/6/12		Yes, for MY2013
2. Patient admitted 6/3/12 and discharged 7/1/12 but readmitted 7/3/12 then discharged 7/5/12.	6/3/12		No - admitted pre-MY2013	
		7/1/12		Yes, for MY2013
	7/3/12		Yes, admitted within 30 days of previous discharge	
		7/5/12		Yes, for MY2013
3. Patient admitted on 3/1/13 then discharged3/5/13 and admitted3/10/13 and discharged 4/1/13.	3/1/13		No – if no record of previous discharge within 30 days	
		3/5/13		Yes, for MY2013
	3/10/13		Yes - admitted within 30 days of previous discharge	
		4/1/13		Yes, for MY2014
4. Patient admitted 3/2/13 then discharged 3/5/13 and admitted 3/10/13 and discharged 3/30/13.	3/2/13		No – if no record of previous discharge within 30 days	
		3/5/13		Yes, for MY2013
	3/10/13		Yes - admitted within 30 days of previous discharge	
		3/30/13		Yes, for MY2013
5. **Rapid readmission at the same facility**: Patient admitted on 5/12/12. Patient is then discharged to home on the morning of 7/1/12 but readmitted 12 hours later on the same day (7/1/12) to the same facility and discharged	5/12/12		No - admitted pre-MY2013	
		7/1/12		Yes, for MY2013
	7/1/12		Yes - admitted within 30 days of previous discharge	
		7/4/12		Yes, for MY2013

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)				
Scenario	**Event date**		**Include in:**	
	Admission	**Discharge**	**Numerator**	**Denominator**
7/4/12.				
6. **Transfer to another facility**: Patient is admitted to Hospital A on 7/2/12 and transferred to Hospital B on the same day. The patient is then discharged to home from Hospital B on 7/7/12.	7/2/12		No - if no record of previous discharge within 30 days of either admission to A, or transfer to B.	
		7/7/12		Yes - only for Hospital B since only B discharged the patient to home. *Transfers to another facility <u>DO NOT</u> count as discharges*
7. **Readmissions after more than 30 days**: patient is admitted on 7/2/12 then discharged 7/3/12 and admitted on 8/6/12 then discharged 8/9/12.	7/2/12		No – if no record of previous discharge within 30 days	
		7/3/12		Yes, for MY2013
	8/6/12		No - 2nd admission was more than 30 days past the previous discharge	
		8/9/12		Yes, for MY2013
8. **Multiple readmissions**: patient admitted on 7/1/12 then discharged on 7/3/12 and admitted on 7/5/12. The same patient gets discharged on 7/7/12 and gets admitted again on 7/9/12 and discharged 7/12/12.	7/1/12		No – if no record of previous discharge within 30 days	
		7/3/12		Yes, for MY2013
	7/5/12		Yes - admitted within 30 days of previous discharge	
		7/7/12		Yes, for MY2013
	7/9/12		Yes - admitted within 30 days of previous discharge	
		7/12/12		Yes, for MY2013
9. **Expired patients**: A patient is admitted 8/1/12 and discharged 8/10/12. Then readmitted 8/15/12 but discharged "Expired" on 8/17/12.	8/1/12		No – if no record of previous discharge within 30 days of 8/1/12	
		8/10/12		Yes, for MY2013
	8/15/12		No - discharged expired not counted	
		8/17/12		No - discharged expired not counted
10. **Transition from FFS to MCO**: A FFS patient is admitted 8/1/12 and discharged 8/10/12. This	8/1/12		No – if no record of previous discharge within 30 days of 8/1/12	
		8/10/12		Yes, for MY2013

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)				
Scenario	**Event date**		**Include in:**	
	Admission	**Discharge**	**Numerator**	**Denominator**
patient is readmitted on 8/25/12 but had enrolled in WI Medicaid (BC+, SSI) managed care organization (MCO) before 8/25/12. The member is then discharged on 8/27/12	8/25/12		Yes - admitted within 30 days of previous discharge. *All readmissions within 30 days of a FFS discharge will be counted in the numerator as long as the member maintains continuous eligibility in WI Medicaid for 30 days post discharge, regardless of subsequent enrollment in an MCO.*	
		8/27/2012		Yes, for MY2013
11. **Maternity**: Patient is 7-months pregnant, admitted on 7/5/12 for a non-pregnancy issue, discharged on 7/9/12. She is admitted for delivery on 8/4/12 and discharged on 8/7/12. She is admitted for non-pregnancy related issue on 9/1/12 and discharged on 9/3/12.	7/5/12		No – if no record of previous discharge within 30 days	
		7/9/12		Yes, for MY2013
	8/4/12		No – maternity related admissions are excluded	
		8/7/12		No – maternity related discharges are excluded
	9/1/12		No – no non-maternity related discharge within the previous 30 days	
		9/3/12		Yes, for MY2013
12. **Maintenance chemotherapy**: Patient is admitted on 8/1/12 for chemo treatment and discharged on 8/3/12. He is admitted for a non-chemo issue on 8/7/12 and discharged on 8/9/12. He is again admitted for chemo on 9/1/12 and discharged on 9/2/12.	8/1/12		No – maintenance chemo related admissions are excluded	
		8/3/12		No – maintenance chemo discharges are excluded
	8/7/12		No – no maintenance chemo related discharge within the previous 30 days	
		8/9/12		Yes, for MY2013
	9/1/12		No – maintenance chemo related admissions are excluded	
		9/2/12		No – maintenance chemo discharges are excluded
13. **Left against medical advice**: Patient is admitted on 7/5/12 and discharged to home on 7/7/12. He is then admitted on 8/1/12 and leaves against medical advice on 8/3/12. The patient is admitted again on	7/5/12		No – if no record of previous discharge within 30 days	
		7/7/12		Yes, for MY2013
	8/1/12		No – admissions resulting in discharges against medical advice	

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)				
Scenario	**Event date**		**Include in:**	
	Admission	**Discharge**	**Numerator**	**Denominator**
8/5/12 and discharged on 8/12/12.			are excluded	
		8/3/12		No – discharges against medical advice are excluded
	8/5/12		Yes – admitted within 30 days of previous discharge on 7/7/12	
		8/12/12		Yes, for MY 2013

ii. Mental Health Follow-Up Visit Within 30 days

This measure applies to all hospitals with at least **30** eligible discharges during the Measurement Year for mental health inpatient care for a 12-month Measurement Year. For MY 2013, which has been reduced from 12 to 9 months, hospitals must have at least 23 observations for this measure to apply. The scope of the measure will be broader than the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH-30) definition.

Measure = % of discharges for members 18 years and older who were hospitalized for treatment of selected mental health disorders and who had a mental health diagnosis related outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner or a primary care provider within 30 days of discharge.

Denominator = All patients discharged alive during the measurement year 2013, after applying exclusions, from an acute inpatient setting (including acute care psychiatric facilities) with any of the following principal mental health diagnoses during the measurement year **(aka MHF-A codes)**:
ICD-9-CM codes: 295-298.9, 299.1, 299.8, 299.9, 300 – 301.93, 307.1, 307.5, 308, 309, 311-314.

Numerator = A mental health diagnosis related outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner or primary care provider within 30 days after discharge, applying the same ICD-9-CM codes as the denominator, with the following codes **(aka MHF-B codes)**:

- Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner or a primary care provider
  - CPT: 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510.
  - HCPCS: G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485.
- Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner or a primary care provider

  - CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876 *WITH* POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72.
  - CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255 *WITH* POS: 52, 53.
- UB Revenue Codes:
  - 0513, 0900-0905, 0907, 0911-0917, 0919; a practitioner type for follow-up visits does not have to be identified with these revenue codes.
  - 0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983; visits identified by these revenue codes must be with a mental health practitioner or a primary care provider or in conjunction with an ICD-9-CM code defined for the denominator.

Eligible population

- **Product line:** Medicaid FFS including BadgerCare Plus Standard, Benchmark, and Core / Basic Plan members and Wisconsin Medicaid FFS recipients.
- **Ages:** Members 18 years and older as of the date of discharge.
- **Continuous enrollment:** Enrollment in Wisconsin Medicaid 30 days after the Discharge Date.
- **Benefits:** Medical and mental health (inpatient and outpatient).
- **Measurement Year:**
  Denominator: Dates of initial discharge or readmission / direct transfer from July 1, 2012 to March 31, 2013.
  Numerator: 30-day mental health follow-up visits between July 1, 2012 and April 31, 2013 (10 months), in order to account for the 30-day post-discharge period.

Exclusions

- AODA inpatient care
- ***Mental Health readmission or direct transfer:***
  - If the discharge is followed by a readmission or direct transfer to an acute facility for a mental health principal diagnosis within the 30 day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. In other words, readmission or a transfer for a mental health principal diagnosis will start the 30-day clock again.
  - Exclude discharges followed by a readmission or direct transfer to a non-acute facility for a mental health principal diagnosis **(namely, the MH/SA Exclusions for Readmissions)** within the 30 day follow-up period.
  - Non-acute care:
    - Hospice: UB revenue codes 0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659; UB type of bill 81x, 82x; POS 34.
    - SNF: UB revenue codes 019x; UB type of bill codes 21x, 22x, 28x; POS 31, 32.
    - Hospital transitional care, swing bed or rehabilitation: UB Type of bill codes 18x.
    - Rehabilitation: UB revenue codes 0118, 0128, 0138, 0148, 0158.
    - Respite: UB revenue code 0655.
    - Intermediate Care Facility: POS 54.
    - Residential substance abuse treatment facility: UB revenue code 1002; POS 55.

  - Psychiatric residential treatment center: HCPCS codes T2048, H0017, H0019; UB revenue codes 1001; POS 56.
  - Comprehensive inpatient rehabilitation facility: POS 61.
  - Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g. ICF, SNF).
- ***Non-mental health readmission or direct transfer:*** Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or non-acute facility for a non-mental health principal diagnosis **(namely, the MH/SA Exclusions for Readmissions)**.

Mental health practitioner: A practitioner who provides mental health services and meets any of the following criteria:
- MD or Doctor of Osteopathy (DO) certified as a psychiatrist.
- Licensed Psychologist
- Licensed clinical social worker
- Registered nurse certified as a psychiatric nurse or mental health clinical nurse specialist (AP / NP)
- Licensed marriage / family therapist
- Licensed professional counselor.

Primary care provider: A physician or non-physician who offers primary care medical services such as:
- General or family practice physicians
- Geriatricians
- General internal medicine physicians
- Obstetricians/gynecologists
- Certified nurse practitioners

Inclusion of the above providers is subject to Medicaid billing rules.

The following table provides **sample scenarios** for the Mental Health Follow-up measure.

<table>
<tr><th colspan="6">Measurement Year MY 2013 (7/1/2012 – 3/31/2013)</th></tr>
<tr><th rowspan="2">Scenario</th><th colspan="3">Event Date</th><th colspan="2">Include in:</th></tr>
<tr><th>Admission</th><th>Discharge / Transfer</th><th>Follow-up Visit</th><th>Numerator</th><th>Denominator</th></tr>
<tr><td rowspan="2">1. Member is admitted to Hospital A on July 3 and discharged to home on July 5, 2012 with a MHF-A diagnosis. The member subsequently receives a MHF-B visit from a mental health practitioner / primary care provider on July 20.</td><td>at A on 7/3/2012</td><td></td><td></td><td>No, admissions are not counted for this measure</td><td></td></tr>
<tr><td></td><td>from A on 7/5/2012</td><td></td><td></td><td>Yes, for Hospital A (30 day clock starts)</td></tr>
</table>

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)					
Scenario	**Event Date**			**Include in:**	
	Admission	**Discharge / Transfer**	**Follow-up Visit**	**Numerator**	**Denominator**
			7/20/2012	Yes, follow-up occurred within 30 days of MHF-A discharge	
2. Member is admitted to Hospital A on July 3 and discharged to home on July 5, 2012 with a MHF-A diagnosis. The member subsequently fails to receive a MHF-B follow-up visit from a mental health practitioner / primary care provider within 30 days.	at A on 7/3/2012			No, Admissions are not counted for this measure	
		from A on7/5/2012			Yes, for Hospital A (30 day clock starts)
			None within 30 days of qualifying discharge	No, follow-up did not occurred within 30 days of MHF-A discharge	
3. Member is admitted to Hospital A on July 2, 2012 and transferred to Hospital B on July 5. The member is then discharged from Hospital B with a MHF-A diagnosis on July 8th. The member subsequently receives a MHF-B follow-up visit from a mental health practitioner / primary care provider on July 14.	at A on 7/2/2012			No, admissions are not counted for this measure	
		from A on 7/5/2012			No - transfers are not included in the denominator
		from B on 7/8/2012			Yes, for Hospital B (30 day clock starts)
			7/14/2012	Yes, follow-up occurred within 30 days of MHF-A discharge	
4. Member is admitted to Hospital A on July 2, 2012 and is discharged from to home with a MHF-A diagnosis on July 8. The member was	at A on 7/2/2012			No, admissions are not counted for this measure	

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)					
Scenario	**Event Date**			**Include in:**	
	Admission	**Discharge / Transfer**	**Follow-up Visit**	**Numerator**	**Denominator**
admitted with a non-mental health related inpatient event (i.e. broken arm) at Hospital A on July 20 and was discharged to home on July 21. The member subsequently receives a MHF-B follow-up visit from a mental health practitioner / primary care provider on August 1.		from A on 7/8/2012			Tentatively count in the denominator for Hospital A pending activity within the next 30 days (clock starts). In this scenario, the denominator would be eliminated because of the non-mental health admission on 7/20/12 (clock is abolished)
	at A on 7/20/2012			No, admissions are not counted for this measure	
		from A on 7/21/2012			No, the discharge was not for a MHF-A condition
			8/1/2012	No, event is excluded because a non-mental health related readmission occurred within 30 days of MHF-A diagnosis	
5. Member is admitted to Hospital A on July 2, 2012 and discharged to home with a MHF-A diagnosis on July 8th.	at A on 7/2/2012			Admissions are not counted for this measure	

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)					
Scenario	**Event Date**			**Include in:**	
	Admission	**Discharge / Transfer**	**Follow-up Visit**	**Numerator**	**Denominator**
The member is subsequently readmitted to Hospital A with a MHF-A diagnosis on July 14. The member is then discharged to home on July 20. The member then receives a MHF-B follow-up visit from a mental health practitioner / primary care provider on August 17.		from A on 7/8/2012			No, discharge is followed by a mental health related readmission within the 30 day follow-up period (30 day clock is reset pending subsequent discharge)
	at A on 7/14/2012			No, admissions are not counted for this measure	
		from A on 7/20/2012			Yes, for Hospital A (30 day clock starts)
			8/17/2012	Yes, follow-up occurred within 30 days of MHF-A discharge	
6. Member is admitted to Hospital A on August 9 and discharged to home with a MHF-A diagnosis on August 15. The member is then admitted to Hospital B's AODA inpatient care on Sept. 1 and remains in the care facility until Oct. 2.	at A on 8/9/2012			No, admissions are not counted for this measure	
		from A on 8/15/2012			Tentatively count in the denominator for Hospital A pending activity in the next 30 days (clock starts). Since there was an AODA inpatient hospitalization within 30 days of discharge, the denominator is removed (clock abolished)

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)					
Scenario	Event Date			Include in:	
	Admission	Discharge / Transfer	Follow-up Visit	Numerator	Denominator
	at B on 9/1/2012			No, admissions are not counted for this measure	
		from B on 10/2/2012			No, the discharge was from an AODA inpatient care facility, therefore the entire event is excluded

iii. Asthma Care for Children

This measure applies to Children's Hospitals only. The Joint Commission has 3 separate components to this measure:

a. **Use of systemic corticosteroids for inpatient asthma:**
The national average for this component for children 2 – 17 years of age is close to 99.5%. Wisconsin children's hospitals to which this measure applies demonstrate a similar performance. Therefore, this is ***not*** applicable to DHS' P4P initiative.

b. **Use of relievers for inpatient asthma**
The national average for this component for children 2 – 17 years of age is close to 99.5%. Wisconsin children's hospitals to which this measure applies demonstrate a similar performance. Therefore, this is ***not*** applicable to DHS' P4P initiative.

c. **Home Management Plan of care (HMPC)**
The national average for this component is close to 82%, and the Wisconsin children's hospitals to which this measure applies have an average of 76.5%. This component ***will be applicable*** to DHS' P4P initiative.

iv. Surgical Care Improvement Project (SCIP) Index

Data are for all payers for each hospital.
DHS will use the Index published on the CheckPoint website. The Index consists of the following measures:

- Start antibiotics
- Appropriate antibiotics
- Stop antibiotics
- Urinary catheter removal
- Temperature management
- Clot prevention ordered

- Clot prevention given
- Peri-operative beta blockers (to be added to CheckPoint in the 2nd quarter of 2012).

The baseline for this measure is based on the latest 12-month data available on CheckPoint, as of July 23, 2012. Performance will be based on the latest 12-month data available on CheckPoint, as of September 15, 2013.

v. Initial Antibiotic for Community-Acquired Pneumonia (PN-6)

Data are for all payers for each hospital.
DHS will use the data published on the CheckPoint website.

The baseline for this measure is based on the latest 12-month data available on CheckPoint, as of July 23, 2012. Performance will be based on the latest 12-month data available on CheckPoint, as of September 15, 2013.

vi. Healthcare Personnel (HCP) Influenza Vaccination

CMS plans to require this measure for payment in 2016, and will likely require reporting before then. In order to minimize reporting burden on hospitals, DHS plans to use the CMS specifications and data submission guidelines and tools (e.g., NHSN).

Approximately 90% of hospitals in Wisconsin already report this data in some form to Division of Public Health (DPH) via a survey. For MY 2013:

- DHCAA will use the DPH data as the sole source for calculating P4P results for individual hospitals for this measure, and will utilize the definition in use by DPH. Currently, DPH publishes aggregate data only, and individual hospital results are not released. DHCAA has already received consent forms from all hospitals subject to Withhold P4P that allow DPH to release individual hospital data to DHCAA.
- DHCAA will use CMS' specifications for the Healthcare Personnel (HCP) Influenza Vaccination measure. CDC recently published a module on the National Healthcare Safety Network (NHSN) that hospitals should utilize when submitting data on this measure. An example of this module can be found in Table 2 on the next page.
- Each healthcare personnel will be counted only once for each employer. If a healthcare personnel is employed by multiple employers, that personnel will be counted multiple times, since the measure focuses on hospitals, not individual employees.
- This is a Pay-for-Reporting measure only for MY 2013, and the data will be used to set baselines for the subsequent years.
- Although CMS requires only Inpatient Prospective Payment Systems (IPPS) to report HCP influenza vaccination rates, in order to meet the DHS 2013 Hospital P4P reporting requirement, **all hospitals to which P4P applies** are encouraged to submit data to NHSN. However, DPH will accept paper copies for MY 2013. The data must be submitted to **NHSN or DPH by August 14, 2013**, since the DHS will pull the data from NHSN on August 15, 2013.

Any questions regarding enrollment in or use of NHSN should be directed to Ashlie Dowdell (ashlie.dowdell@wi.gov or 608-266-1122) in the Division of Public Health.

Methodology

Denominator: # of hospital employees, licensed independent practitioners and adult students / trainees and volunteers that have worked in a hospital for 30 days between January 1 and March 31, 2013. The definitions for each category of HCP are listed in **Table 1**.

Reporting data on "Other Contractors" to CMS and the DHCAA for P4P purposes is voluntary.

Numerator: # of hospital employees, licensed independent practitioners and adult students / trainees and volunteers that have worked in a hospital for 30 days between January 1 and March 31, that receive a flu vaccination during the vaccination season.

Overall Rate: The HCP vaccination rate will be calculated for each hospital using the following data and Row numbers from **Table 2**:

$$\frac{\text{Row 2} + \text{Row 3}}{\text{Row 1} - \text{Row 4}}$$

*Note - Even though a hospital's overall rate is calculated using rows 1 – 4, hospitals must report data for **all rows**, in order to be deemed in compliance with the P4R requirements. Hospitals are not required to complete the Other Contractors column*

Table 1 HCP Influenza Vaccination Denominators

Employees	• All persons who receive a direct paycheck from the reporting facility (i.e. on payroll)
Licensed independent practitioners	• Physicians (MD, DO), advanced practice nurses, and physician assistants • Affiliated with the facility but not receiving a direct paycheck from the facility
Adult students/trainees and volunteers	• Students, trainees, and volunteers • Aged ≥18 years • Affiliated with the facility but not receiving a direct paycheck from the facility
Contractors **(optional for CMS and DHCAA P4P Program)**	• Examples: agency or registry nurses (not advanced practice nurses), environmental services personnel, maintenance workers

Table 2 NHSN Healthcare Personnel Influenza Vaccination Summary

Record the number of HCP for each category below for the influenza season being tracked			
Facility ID #:			
Vaccination type: influenza	Influenza subtype:	Influenza season:	Date Last Modified:

	□ seasonal □ non-seasonal			
	Employee HCP	**Non-employee HCP**		
	Employees (staff on facility payroll)	Licensed independent practitioners (physicians, advanced practice nurses, and physician assistants)	Adult students/trainees/volunteers	Other contract personnel **(optional for CMS and DHCAA P4P Program)**
1. Number of HCP who worked at this facility for at least 30 days between January 1, 2013 and March 31, 2013				
2. Number of HCP who received an influenza vaccination at this facility since influenza vaccine became available this season				
3. Number of HCP who provided a written report or documentation of influenza vaccination outside this facility since influenza vaccine became available this season				
4. Number of HCP who have a medical contraindication to the influenza vaccine				
5. Number of HCP who declined to receive the influenza vaccine				
6. Number of HCP with unknown vaccination status (or criteria not met for questions 2-5 above)				

Appendix 2 – Potential focus areas for MY 2014 and beyond

A preliminary list includes:

- Transition care planning, including medication reconciliation at discharge
- Drug measures – e.g., narcotics / pain medication in ER
- Elective early induced births
- Venous Thromboembolism
- Other?
    a. Children's measure?
    b. Measures specific to critical access hospitals?
    c. Outpatient (in addition to HCP vaccination)?
    d. Expand beyond FFS to include MCO, to align with HMO P4P where feasible?
    e. Align with CMS core quality measures, clinical quality and meaningful use measures.

Appendix 3 – Time Line

Updated: 7/23/2012

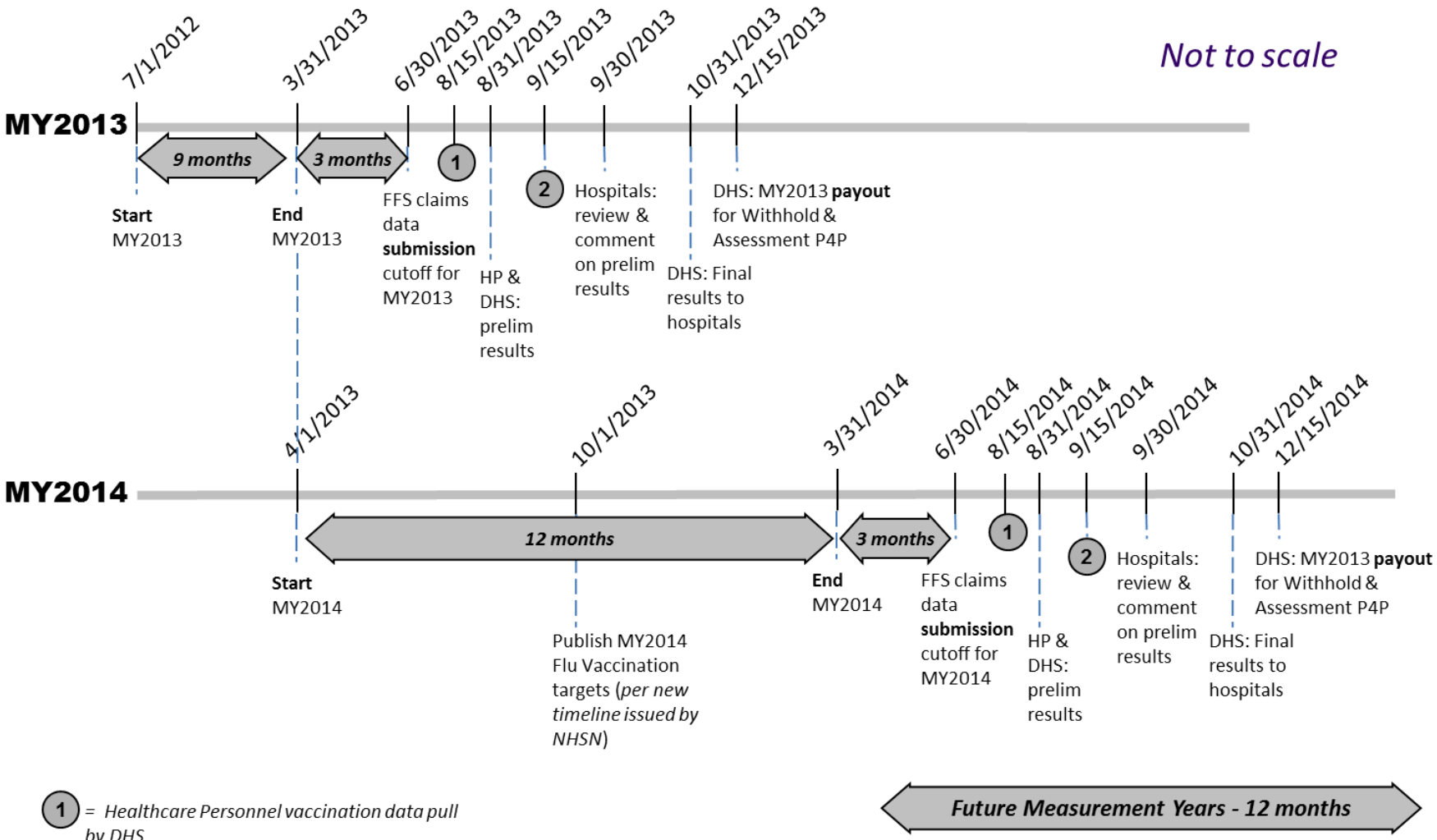
Note: The timeline for MY 2013 covers 9 months only. MY 2014 and beyond will cover a full 12-month period, from April 1 of a year to March 31 of the next calendar year. This change was made to enable hospitals to receive the P4P payout closer to the end of the MY.

Major Tasks	Date	Status	Ownership
1. Finalize measures			DHS
a. Initial list	1/31/2012	Completed	
b. Hospital feedback	2/21/2012	Completed	
c. Final list	2/28/2012	Completed	
2. Finalize methodology / measures etc.			DHS
a. Hospital feedback	2/29/2012	Completed	
b. Finalize	3/9/2012	Completed	
3. Set baselines for MY 2013			DHS, HP,
a. Preliminary baselines	4/9/2012	Completed	hospitals
b. Receive hospital feedback via the portal	4/30/2012	Completed	
c. Revised Withhold baselines to hospitals	6/29/2012	Completed	
d. Final Assessment P4P baseline from DHS to hospitals	6/29/2012	Completed	
e. Comments from hospitals re: Withhold baselines	7/16/2012	Completed	
f. Final Withhold baseline from DHS	Mid-Aug 2012	In progress	
4. Communications			
a. Meeting / conference call	2/9/2012	Completed	DHS,
b. Conference calls	3/9/2012	Completed	hospitals,
	3/29/2012	Completed	other stake
	4/23/2012	Completed	holders
	4/27/2012	Completed	
	5/29/12	Completed	
	6/26/2012		
c. First Provider Update (2012-15)	4/1/2012	Completed	
d. Second Provider Update (2012-20)	6/1/2012	Completed	
5. Implementation planning and execution	Jan – June 2012		
a. Consent forms for HCP Immunization measure from Hospitals	6/30/12	Completed	DHS
b. Progress update spreadsheet from DHS	6/1/2012	Completed	
c. Updated definition of the measure and included staff	6/18/2012	Completed	
	7/19/2012	Completed	DPH
6. Make systems modifications	April-June 2012		DHS, HP
a. Operational updates		Completed	
b. Data exchange process, tools		Completed	
c. Result reconciliation process		Completed	
7. Submit State Plan Amendments	Summer 2012	Completed	DHS, HP

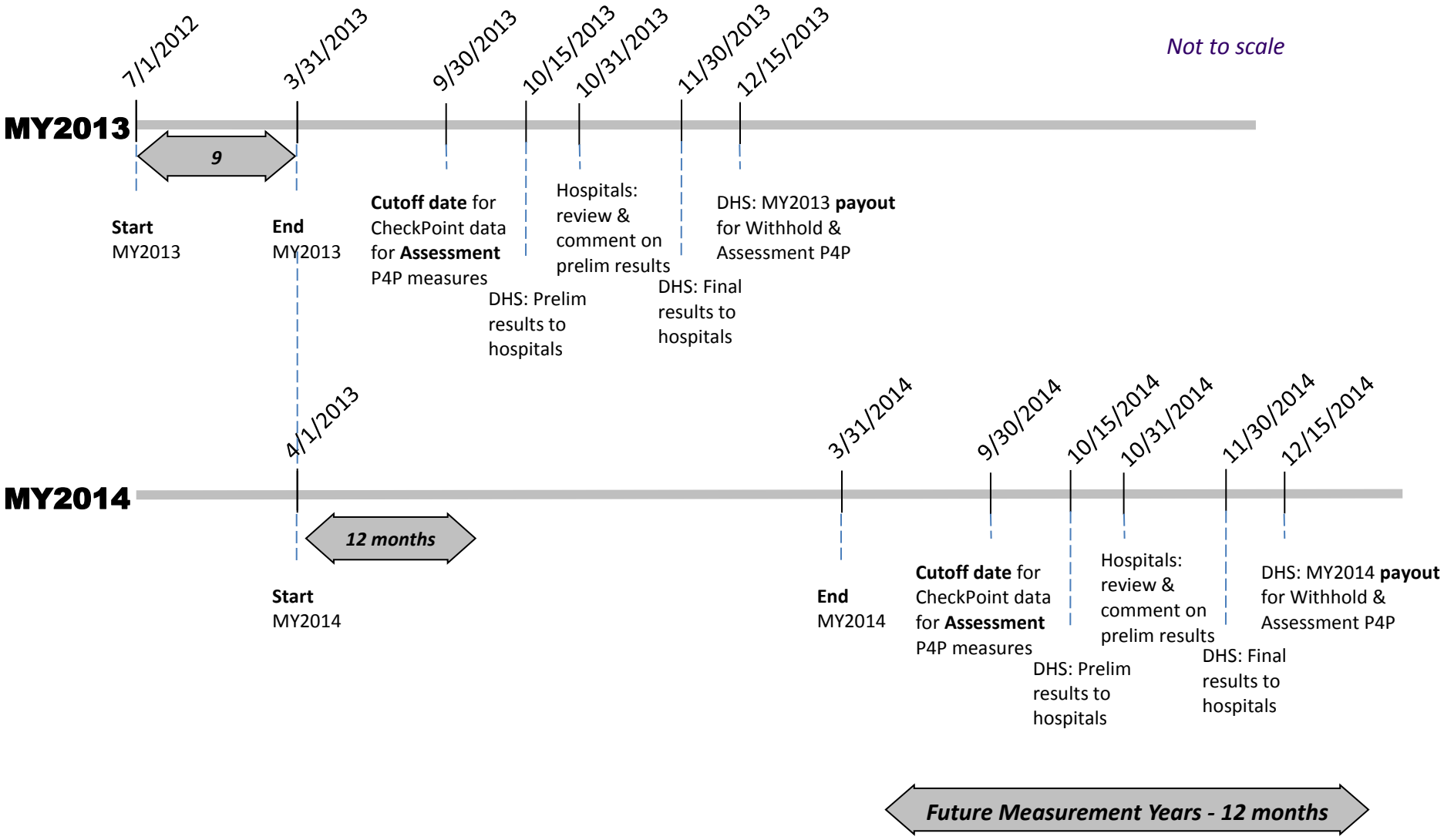
Major Tasks	Date	Status	Ownership
8. Begin MY 2013 P4P	7/1/2012	Completed	
9. End MY 2013 P4P	3/31/2013		
10. Cutoff date for claims submission for **Withhold** P4P for MY 2013	6/30/2013		Hospitals
11. Healthcare Personnel **Vaccination** data report due from Hospitals to NHSN, or to DPH	8/14/2013		Hospitals
12. Healthcare Personnel **Vaccination** data pull by DHS from NHSN	8/15/2013		DHS
13. Preliminary **Withhold** P4P results from DHS to hospitals	8/31/2013		DHS
14. Cutoff date for Checkpoint data for **Withhold** P4P for MY 2013	9/15/2013		Hospitals, WHA
15. Cutoff date for Checkpoint data for **Assessment** P4P for MY 2013	9/30/2013		Hospitals, WHA
16. Review of preliminary **Withhold** P4P results and comments by hospitals due to DHS	9/30/2013		Hospitals
17. Preliminary **Assessment** P4P results from DHS to hospitals	10/15/2013		DHS
18. Final **Withhold** P4P results from DHS to hospitals	10/31/2013		DHS
19. Review of preliminary **Assessment** P4P results and comments by hospitals due to DHS	10/31/2013		Hospitals
20. Final **Assessment** P4P results from DHS to hospitals	11/30/2013		DHS
21. MY 2013 payout for **Withhold** and **Assessment** P4P	12/15/2013		DHS
22. MY 2014 measures: a. Identify measures, update methodology b. Set targets	3/31/2013		DHS, hospitals, other stake holders

Please see the following diagrams for clarity.

Hospital WITHHOLD P4P Timeline – MY 2013 and MY 2014



Hospital ASSESSMENT P4P Timeline – MY 2013 and MY 2014



Appendix 4 – Withhold P4P Methodology for MY 2013

a. Withhold period = Measurement period = **MY 2013** (July 1, 2012 – March 31, 2013).
b. Measurement will take place on an **annual** basis, and not each quarter.
c. A priori, it is impractical to predict which measures will apply to each hospital, since there must be a minimum # of cases for each measure for a given hospital. The applicability of each measure will be determined when the results are calculated, i.e., at the end of MY 2013. Hospitals with insufficient cases for any measure will not be subject to that measure.
   For each hospital, **each applicable measure will have an equal weight** in the withheld $. Example: If only 4 measures are applicable to a hospital, then each of those 4 measures will have a $1/4^{th}$ weight in determining the earnback for the 1.5% withhold. Although case-mix adjustments are not applied for MY 2013, DHS intends to explore applying them in the future.
   If a measure is applicable to a hospital but **no baseline** data are available, then the baseline would be assumed to be equal to the **state-wide average** for that measure, unless clear data suggesting otherwise are available.
d. This is not an "all-or-nothing" approach. Hospitals will earn back their withhold separately for each applicable measure. As an example, if 3 measures apply to a hospital, it is possible that the hospital earns back full withhold for one measure, 75% of withhold for the 2^{nd} measure, and none for the 3^{rd} measure.
e. Depending on the measure (see Appendix 1), a combination of two criteria might be applied for earning back the withhold, as shown in the table below:
   i. Relative **level** of performance is defined by comparison with the designated (e.g., national or State-wide) average for all hospitals.
   ii. **Improvement** shown is defined by, e.g., % reduction in "error" rates for each measure.

<table>
<tr><th></th><th colspan="3">Degree of IMPROVEMENT</th></tr>
<tr><th>Performance LEVEL</th><th>High (10% or higher)</th><th>Medium (5% - 10%)</th><th>Low (below 5%)</th></tr>
<tr><td>High (greater than 1.10 times the designated average)</td><td colspan="3">100% earn back</td></tr>
<tr><td>Medium (between 0.90 and 1.10 times the designated average)</td><td rowspan="2">100% earn back</td><td>75% earn back</td><td>50% earn back</td></tr>
<tr><td>Low (less than 0.90 times the designated average)</td><td>50% earn back</td><td>No earn back</td></tr>
</table>

   iii. As shown above, a hospital with "high" performance level for a measure will get back 100% of its withhold for that measure, regardless of improvement shown.
   iv. A hospital showing "high" improvement for a measure will get back 100% of its withhold for that measure, regardless of its level.

Example: Degree of Improvement - "Reduction in Error"

The degree of improvement achieved by a hospital is defined as the percentage "reduction in error" for a given measure in MY 2013, compared to Calendar Year 2010 for that hospital. Calendar Year 2010 results will be used as baseline due to the time lag in obtaining final data.

An example:

If a hospital's MY 2010 score for a measure = 80%, then its MY 2010 "error" = 100% - 80% = 20%.
A hospital 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 MY2013 score = 81%, then that hospital would have improved its score by 1 percentage point = 5% reduction in error.

Mathematically, the reduction in error for MY 2013 = $\left(\frac{(MY2013 - MY2010)}{Error = (100 - MY2010)} * 100\right)\%$

The following table provides various sample scenarios for calculating the % reduction in error.

Hospital	MY 2013 Score	MY 2010 Score	MY 2010 Error	MY 2013 – MY 2010	% reduction in Error	
A	93%	93%	7% points	0% points	=(0/7)*100 = 0%	Low
B	90%	89%	11% points	1% points	= (1/11)*100 = 9.1%	Medium
C	89%	89%	11% points	0% points	=(0/11)*100 = 0%	Low
D	85%	83%	17% points	2% points	=(2/17)*100 = 11.8%	High

f. Specific methodology for the 30-day Readmission Measure and the Mental Health Follow-up Visit Measure

i. Due to the shortening of MY 2013 from 12 to 9 months, the minimum # of denominator observations for a measure to apply to a hospital has been commensurately adjusted from 30 to 23 for MY 2013 only. In subsequent years, the minimum number of observations in the denominator will be 30 for a 12 month Measurement Year.

ii. Since DHS is not applying risk-adjustment to these two measures for MY 2013, only **Degree of Improvement** will apply, and comparisons across hospitals will not be made. The following table shows how the % of earn back will be determined for these two measures for MY 2013:

Degree of **Improvement**			
High (10% or higher)	Medium (5- 10%)	Low (1 - 5%)	No improvement (<1%)
100% earn back	75% earn back	50% earn back	No earn back

g. Specific Withhold P4P methodology for CheckPoint Measures

i. Set baseline at statewide average, calculated using most recent four quarters of data available on 6/30/2012
ii. Hospitals with less than 25 observations in the Measurement Year (MY) are exempt from the measure.
iii. For hospitals with more than 25 observations in the MY, the methodology from Section "e" of this Appendix applies. Both, Degree of Improvement and Performance Level, apply.

h. **Minimum # of applicable measures:**
The 1.5% **withhold** will apply to all hospitals. Any hospital with at least one measure applicable to it (including Pay for Reporting measures) will have its withhold at risk. For MY 2013, hospitals to which only pay for reporting measures (e.g., HCP vaccination) apply can earn their entire withhold by meeting the reporting requirements, though they would not be eligible for the bonus pool.

i. Hospitals can earn a **bonus** in addition to their withheld amounts. Any bonus will be entirely funded by one or more hospitals forfeiting part or all of their withhold, due to performance or other factors.

To be eligible for the bonus pool**,** hospitals must have at least 1 pay-for-performance measure applicable to them, in order to maintain fairness for hospitals that are subject to pay-for-performance measures.

DHS will employ a Four Tier Methodology for bonus sharing. Please see **Appendix 9** for details.

Each eligible hospital can earn a bonus up to lesser of the following two:
the applicable tier-specific percentage of its total FFS claims payments, OR, the size of the bonus pool.

Example: Earnback Bonus
For an individual hospital, assume that:

- Total FFS claims payments from Wisconsin Medicaid = $20 million.
- Then, P4P withhold = 1.5% of $20 million = $300,000.
- If Tier 1 applies, i.e., the hospital meets all its P4P goals and earns back the full $300,000 withhold, it will also be eligible for a bonus, subject to the 1.5% cap,
  = 1.5% of $20 million = up to $300,000.
- If the bonus pool is large enough, and depending on the relative performance of other hospitals, a hospital could earn a maximum of $300,000 (earnback) + $300,000 (1.5% bonus for Tier 1) = $600,000.

The bonus pool cannot exceed the forfeited withheld amounts.

Example: Total Bonus Pool Size

Assume that:

- Total forfeiture = bonus pool = $500,000.
- Five hospitals are eligible for bonus.

If 1.5% of the total FFS claims payments of the 5 eligible hospitals = $400,000, then, the total bonus paid out = $400,000, which is smaller than the bonus pool. If 1.5% = $600,000, then the total bonus paid out = $500,000, up to the funds available in the bonus pool.

j. **Sharing the Bonus Pool**:
DHS utilized the following guiding principles for its policy re: bonus payments:

- Budget neutrality – DHS intends to pay out all the withheld amounts;
- Bonus should be distributed among high performing hospitals, and,
- Bonus $ should be allocated equitably, taking into account the total $ value of the withheld amount and the # of applicable measures.

The bonus pool $ will be shared proportionally, based on the relative amounts withheld for all hospitals qualifying for the bonus. Each measure in the P4P initiative has an equal weight. This methodology helps distribute the bonus pool based on the relative performance for the P4P measures, while accounting for the size of the hospitals (larger hospitals will likely have a larger number of applicable measures).

Appendix 9 explains the methodology that the DHS plans to implement for distributing bonus $. The Appendix also provides an example.

If any small sums are still left in the bonus pool after paying out in Step C as explained in Appendix 9, those funds might be redistributed among hospitals, or rolled over to the next year's bonus pool.

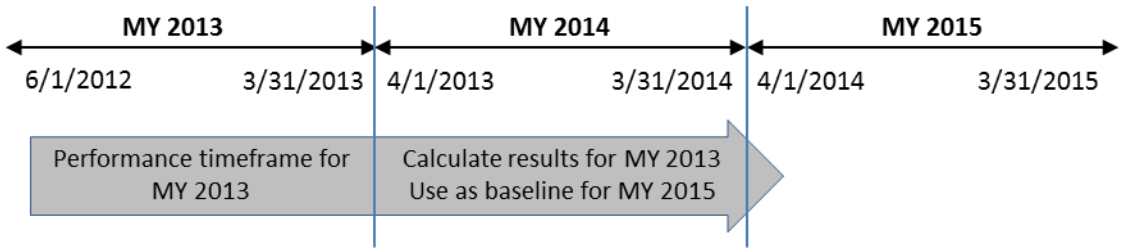
k. For applicable **CheckPoint measures**, DHS will use data available from CheckPoint as the sole source for calculating the P4P results for all hospitals. All hospitals must submit data to CheckPoint **even if they have no eligible observations**, so that DHS can correctly determine applicability of measures to each hospital. If no data are reported to CheckPoint for a particular measure by a hospital, that hospital could forfeit its withhold for that measure, and, consequently, not be eligible for any bonus payments.

l. DHS may, at its discretion, utilize other sources such as DHS claims data and Hospital Compare to review how well hospitals have reported the data, and how they have performed.

Appendix 5 – Data Submission and Validation Process

Baselines for Measurement Years
For the Readmission and the Mental Health Follow-up Visit measures, baseline for MY 2013 will be set using data from Calendar Year 2010, due to time lag in data submission.

In subsequent years, the baseline will be set using the same time frame as the Measurement Year. For example, baseline for MY 2015 (April 1, 2014 – March 31, 2015) will be based on data from April 1, 2012 through March 31, 2013, as shown below:



When specific hospital information is either not available or there are insufficient observations for a given measure (e.g., the hospital did not report that information to CheckPoint, or claims data are insufficient), the baselines will be set using state-wide averages as reported on CheckPoint, or as calculated by DHS based on past claims data.

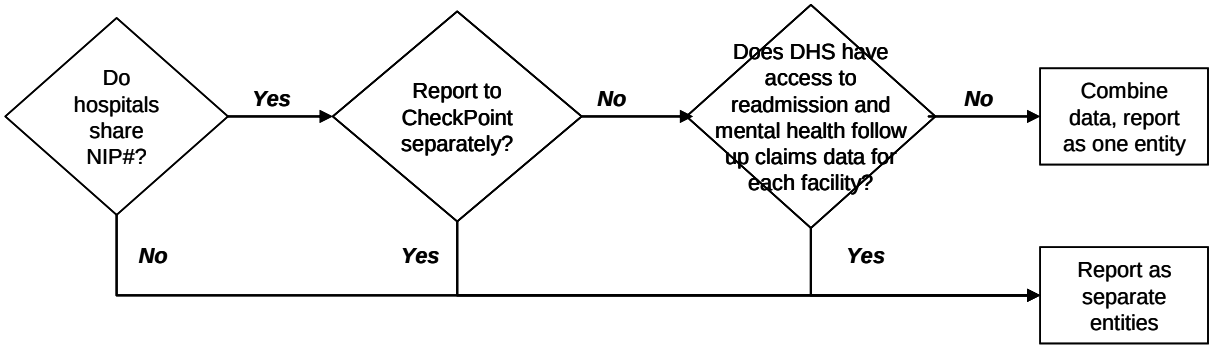
Reviewing preliminary results with hospitals
After the data submission cut-off date, DHS will calculate and compile the results, and share them with the hospitals. Hospitals are expected to review the results, and respond to DHS with comments and supporting data in case there are discrepancies between the results calculated by DHS and those by the hospitals. DHS will then review the data submitted by hospitals.

Please also see **Appendix 3**.

Appendix 6 – FAQ

This document will be periodically updated and shared with all hospitals and stakeholders.

1. Will the measures be reported every quarter, similar to CheckPoint?
   Answer: Measures will be reported and calculated annually, though DHS will provide quarterly results and supporting data for the hospital re-admission and mental health follow-up measures, subject to compliance with HIPAA and Wisconsin statutes.
2. What exclusions apply to various measures?
   Answer: See Appendix 1(c).
3. How will HIPAA / Wisconsin statutory privacy requirements be met for follow-up visit within 30 days?
   Answer: A "yes / no" answer about the member making a follow-up answer can be released for quality improvement activity, per DHS' Privacy Officer.
4. How will the HCP influenza vaccination data be validated?
   Answer: Through the DPH survey. Please see Appendix 1(c).
5. How will DHS publish the results?
   Answer: Via ForwardHealth portal. Please see April 2012 Provider Update (2012-15).
6. Will hospitals be required to submit chart data?
   Answer: The MY 2013 measures do not require chart data. Hospitals will have the option to submit chart data to DHS as part of the process to reconcile any differences between the results calculated by DHS and hospitals' internal results.
7. How is a hospital identified as Acute Care, Critical Access, Psych or Childrens? How will satellite facilities be treated – as part of a larger organization or as separate entities for P4P?
   Answer: The following chart explains the process:



8. What are the claim submission cut-off dates for hospitals for data to be included in P4P?
   Answer: June 30, 2013 for Withhold P4P.
9. Does the initiative include Long Term Acute Care Hospitals?
   Answer: No, it does not include LTAC for MY 2013. DHS may consider LTACs for future inclusion in the P4P initiative.

Appendix 7 – Updated Hospital Feedback & DHS Response

This appendix summarizes the feedback from hospitals on the draft shared by DHS on February 9, 2012, and the subsequent response from DHS, including updates from DHS as of June 20, 2012.

Hospitals' Comment	DHS' Response
30-Day Readmission Measure	
1. It is our recommendation that this measure not include readmissions at a different hospital unless DHS can provide hospitals with an at least quarterly report of numerator information. Hospitals currently do not know if one of their past patients is subsequently admitted at another hospital and without a regular report of such activity there will be limited opportunity to improve performance. It is our recommendation that at a minimum the report include information regarding the DRG, diagnoses and procedures from both admissions. It is also important to ensure that index admissions do not include patients who were cared for under Observation status. We agree with all of the exclusions you have included in the measure specification circulated on 2/9/2012. We suggest the CMS Tables mentioned in the last bullet point be incorporated into the measure specification to ensure everyone has all of the information. (WHA, RWHC)	DHS plans to provide a quarterly report for the readmission measure. Subject to approval by the Privacy Officer of DHS and the feasibility of extracting this data, this report will include the numerator, denominator, patient identifiers for patients who comprised the numerator and the denominator, and other information requested by WHA. Since this report will be based on the claims data of DHS, the currency of this information will depend on the timeliness of claims submitted by hospitals. The measure does not include Observation status. The CMS Tables have been incorporated in the measure specification (See Appendix 1(c)). When CMS finalizes the readmission specifications, WI DHS will adopt those specifications for subsequent measurement years. **Update (Jun 20, 2012):** The DHS Privacy Officer has approved the creation and dissemination of quarterly readmissions and mental health follow up reports via the Secure Provider Portal. These reports will contain the same information and will be in the same format as that used in the preliminary baseline reports. Since this report will be based on the claims data of DHS, the currency of this information will depend on the timeliness of claims submitted by

Hospitals' Comment	DHS' Response
	hospitals.
2. Aurora does not agree with the inclusion of patients that transition from Fee for Service to Managed care in the 30 day readmission window. If this is a Fee for Service measure, it should be a clean measure and not blend the two populations. (Aurora Health Care)	This measure holds the initial discharging hospital accountable for the quality of health care provided, for a period of 30 days after the initial discharge. That accountability does not change, regardless of the hospital where the readmission occurs, or a change in payer in the next 30 days.
3. Only readmissions to the same facility should be counted as readmissions since it is impossible for hospitals to obtain any data on readmission statistics when patients are readmitted to other facilities. Readmissions within our facility can be monitored and studied to reduce these rates. (St Clare Hospital, Baraboo, WI)	Addressed in other responses for this measure.
Mental Health Follow-Up Visits	
4. We agree with the observation in the document that the "30 day follow up" should include primary care as well as mental health providers. Some of our lesser acute mental health patients are being managed by primary care on their psychotropic drugs. Also, we experience longer than 30 days for appointments for county providers whose schedules we don't influence, particularly county psychiatrists but sometimes even therapists. We are at risk for our county funded patients in this area, unless we can set follow up with primary care at the free clinic. We would also recommend this measure only include follow up to Mental health and not AODA patients. (ThedaCare, Appleton, WI)	The specifications for this measure have been updated to include Primary Care Providers. Please see measure specifications in Appendix 1(c). AODA has already been excluded from this measure.
5. Do not limit a patient's follow-up care to a mental health practitioner. (RWHC)	Addressed in other responses for this measure.
6. Publish a list of principal diagnosis codes for the denominator in advance. (RWHC)	Please see specifications in Appendix 1(c).
7. Aurora has no concerns with the measure concept. However, we do have concerns that the details regarding the definition of a mental health patient has not been communicated to providers. Aurora is unable to take a position with regard to this	Please see specifications in Appendix 1(c).

Hospitals' Comment	DHS' Response
measure, as we currently do not have the detailed specifications. (Aurora Health Care)	
8. We are concerned that the shortage of Mental Health providers could result in waits longer than 30 days for patients to be seen post-discharge that are out of the control of the hospital. Suggested options to address: a. Allow a longer timeframe for the visit to occur, such as 60 days. Consider adding additional time for patients residing in a HPSA/MUA b. Include primary care provider follow-up for Mental Health as meeting the requirement for follow-up care (Ministry Saint Joseph's Hospital, Marshfield, WI; Sacred Heart Hospital (Tomahawk); Saint Mary's Hospital (Rhinelander); Ministry Our Lady of Victory Hospital, Stanley, WI; Ministry Eagle River Memorial Hospital)	DHS will continue to use HEDIS specifications of 30 days post-discharge. Primary care providers - Addressed in other responses for this measure.
9. We recommend that a follow-up visit, with any provider visit in which a mental health diagnosis is coded be considered compliant. (WHA)	Addressed in other responses for this measure.
Surgical Care Improvement Project Composite	
10. The measures encompass standards of care broader than infection prevention. We recommend this measure be appropriately re-titled to Surgical Care Improvement Project Composite to match the national title. CheckPoint will continue to report nine measures of surgical care improvement; however the existing Surgical Infection Prevention Index will likely be retired in October 2012. Data collection for the existing measure for Hair Removal was retired on 12/31/2011. The measure related to "6 a.m. Blood Sugar Control" only applies to cardiac surgery, therefore we recommend it not be included. We recommend the composite score be calculated using the "All Procedure" data, for eight measures, based on the (Sum of all Numerator)/(Sum of all Denominators) for the following eight measures: a. Start antibiotics b. Appropriate antibiotics c. Stop antibiotics	DHS accepts WHA's recommendation to rename the measure. DHS will consider WHA's recommendations re: composite score algorithm and calculations. SCIP measures have been removed from the Assessment P4P, to prevent duplication. **Update (Jun 20, 2012):** The DHS will use the SCIP Index as published on the WHA CheckPoint website. For a full list of the measures that comprise this Index, please see Appendix 1(c).

Hospitals' Comment	DHS' Response
d. Urinary catheter removal e. Temperature management f. Clot prevention ordered g. Clot prevention given Peri-operative beta blockers (to be added to CheckPoint in the 2nd quarter of 2012) All SCIP measures should be removed from the Medicaid Assessment Pay for Performance program to prevent duplication. This would include the current SIP Index and Clot Prevention Medication Given (WHA, RWHC)	
11. The attachment states that calendar year 2010 will be used as a baseline. What does this mean for hospitals that did not report SCIP data in 2010 to CMS and Checkpoint? (Mayo Clinic Health System, Eau Claire, WI)	When specific hospital information is not available for a given measure, the baselines will be set using state-wide averages as reported on CheckPoint, or as calculated by DHS based on past claims data.
12. While Aurora has no concerns with the measure concept, we are concerned that the measure may be retired from Checkpoint during Fiscal Year 2013. Aurora recommends that a new algorithm be created if Checkpoint will no longer be available to track progress on the measure. Aurora recommends that if the state determines that a new algorithm is needed, that it be developed soon so that all sites can monitor their performance for Fiscal Year 2013. (Aurora Health Care)	Addressed in other responses for this measure.
HCP Vaccination Measure	
13. We recommend this measure be maintained as Pay for Reporting and that it be limited to the definition currently used by DPH, which limits it to "employees". Expanding this measure to other individuals creates administrative burden in trying to calculate an accurate denominator. It is also outside of the hospitals control to influence individuals who are not employees. If this measures moves to a Pay for Performance status then additional measures should be added to the program to eliminate the potential for a relatively large number of hospitals who will only have one applicable measure. (WHA, RWHC)	This will be a Pay For Reporting measure for MY 2013. DHS will use the definition employed by Division of Public Health for collecting this information for MY 2013. DHS has invited WHA to propose additional measures for the P4P initiative.
14. HCP immunization is important but it should not	Addressed in other responses for

Hospitals' Comment	DHS' Response
be tied to reimbursement. Patient length of stay is short, their (patient) contact within community may well be the source of influenza. Mandating immunization infringes on employees freedom of choice and may have negative impact. Generalizing populations, geographics, demographics, in WI is an easy way to decrease payments to the rural, poorer communities serving the elderly. (Indianhead Medical Center, Shell Lake, WI)	this measure.
15. Apply only to hospital employees, and not to non-employees, contractors, etc. Hospitals can enforce disciplinary measures with their own employees and hold them accountable to hospital policy, however would not have the same control over other proposed groups. (St Clare Hospital, Baraboo, WI)	Addressed in other responses for this measure.
16. Since this data on contracted staff is not collected right now, will there be a baseline, and if so, how will it be determined? Also, many physicians that are attending physicians at our hospital are also attending physicians at other hospitals. Will these physicians potentially be reported on by more than one hospital? We have the same question as it relates to the residents who rotate to more than one organization. Also, will this only include physicians who actually saw patients – they may be on staff, but for whatever reason have not have had any patients admitted during the time period reported on, and therefore were not physically in our Hospital – how would these be handled? (Children's Hospital of Wisconsin)	Each healthcare personnel will be counted only once for each employer. If a healthcare personnel is employed by multiple employers, that professional will be counted multiple times, since the measure focuses on individual employers, not individual employees. This measure is a Pay-for-Reporting measure only for MY 2013, and the data will be used to set baselines for the subsequent years.
17. Related to reporting influenza vaccine outcomes, the critical access hospital would be best to report employee results and in-patient only results. We would ask that this be considered. (Vernon Memorial Healthcare, Viroqua, WI)	The definition used by Division of Public Health will be employed for this measure.
18. Flu shot should be limited to how we currently reported the data to the Department of Public health - paid employees only. We are concerned that if we need to track contracted staff, non-employed medical staff, volunteers, etc. the methodology has not been determined by CMS	Addressed in other responses for this measure.

Hospitals' Comment	DHS' Response
yet. To include this prematurely will add administrative burden to trying to collect an accurate denominator and may need to change when CMS has determined the measurement methodology for this measure (as suggested in bullet two of the recommendation on page 9). We would recommend only including the data that is currently reported at this time. (ThedaCare, Appleton, WI)	
Methodology / Reporting / Payment	
19. Will hospitals that don't perform surgery be losing the ability to earn back a portion of the withhold because they do not perform surgery? Would there be any point in reporting something even if just zero qualifying cases? (Mayo Clinic Health System, Eau Claire, WI)	As discussed in Appendix 4, item (c), a measure would not be applicable to a hospital if there were insufficient observations (e.g., less than 30 for the Measurement Year) in the denominator for that measure. For the CheckPoint measures, DHS will use CheckPoint definitions for determining sufficiency (e.g., at least 25 for the measurement year). Please see specific measures for the minimum number of observations in the denominator.
20. To ensure this program is "budget neutral" and that all money withheld is paid back to hospitals it is our recommendation that the "bonus pool" be eliminated until there is experience with the measures. If the bonus pool is not eliminated and remains capped at 1% we recommend DHS works with WHA to create a methodology in which all money is distributed to the hospitals. (WHA)	DHS is open to discussing various suggestions re: budget neutrality, bonus pool, etc.
21. We recommend that each hospital receive a detailed report of their performance and how it relates to their withhold and payout. The report should include measure time frames, data source, numerators, denominators, calculated rates and any applicable benchmark used for each measure. (WHA)	DHS already plans to do this.
22. We are concerned on how the Bonus Pool criteria would work for Critical Access hospitals. Are there enough measures that are applicable to Critical Access Hospitals to use this for Bonus Pay? (Vernon Memorial Healthcare, Viroqua, WI)	Please see Appendix 4.
23. Availability of clinical outcomes data based on similar size organizations. Having comparisons	This issue focuses on stratification of hospitals by criteria such as size,

Hospitals' Comment	DHS' Response
with similar likes is essential for creating by-in and engagement into the program. (Vernon Memorial Healthcare, Viroqua, WI)	type, etc. DHS is open to suggestions re: stratification in subsequent years.
24. Reporting data for Critical Access Hospitals and small Rural Hospitals that has statistical significance for that size of organization is important. Public reporting needs to be done according to size and metrics with appropriate indicators for Critical Access and Rural Hospitals. (Vernon Memorial Healthcare, Viroqua, WI)	Addressed in other responses for this measure.
25. We are concerned that small hospitals would not have a fair chance to earn back their withhold if there is only one applicable measure that is Pay for Performance. Since the Influenza measure is Pay for Reporting, this will not be an issue. Once the Influenza measure is moved to Pay for Performance then we need to consider other measures. (WHA)	Please see Appendix 4.
26. We are concerned that many Critical Access Hospitals will not have enough volume in 5 of the 6 proposed metrics, resulting in their entire 1.5% withhold being dependent on performance in one metric (Healthcare personnel influenza vaccination). We would suggest two options to address this: a. Proportionally reduce the withhold based on the number of metrics the hospital is able to participate in. For example, if a hospital can only participate in 1 of 6 measures, their withhold would to 1/6th of the total 1.5%. b. Add additional measures that would broaden the number of Critical Access Hospitals that could participate. Potential additional measures could be drawn from the current Assessment initiative, or consider Heart Failure measures. (Ministry Saint Joseph's Hospital, Marshfield, WI; Sacred Heart Hospital (Tomahawk); Saint Mary's Hospital (Rhinelander); Ministry Our Lady of Victory Hospital, Stanley, WI; Ministry Eagle River Memorial Hospital)	The withhold will continue to be set at 1.5%. DHS has asked hospitals and WHA to suggest additional measures. DHS has taken an extensive look at the available CheckPoint measures, and has already transferred measures from the Assessment P4P to the Withhold P4P. DHS' analysis suggests that at this moment, there are no other viable candidates. The Heart Failure measures are more appropriate for the Medicare population.
27. Aurora is concerned with the long six month time frame of the withhold recoupment as well as the time frame for receiving bonus payments. Programmatic funding will be provided through	Please see Appendix 3 for an updated timeline. DHS' analysis suggests that quarterly calculations of all measures for the Withhold

Hospitals' Comment	DHS' Response
the withholding of 1.5% of Medicaid hospital fee for service payments. The proposed six month wait period to recoup those funds following the state's fiscal year puts hospitals at a financial disadvantage, especially hospitals that provide care to a disproportionate share of Medicaid patients. Aurora recommends estimated quarterly payments with a reconciliation based upon the year's performance following the close of the State's fiscal year. (Aurora Health Care)	P4P are not feasible, given the # of observations available for hospitals.
28. Appendix 4 seems to allude that performance and improvement measures would apply to all measures. Could the State please clarify how the provider will be measured when they are already performing at a high level for readmissions and mental health measures? (Aurora Health Care)	Please see Appendix 4.
29. Appendix 3 indicates that baselines will be set on 3-15-2012. Does this mean that the data on Checkpoint as of 3-15-12 will be used as the baseline for the Fiscal Year 2013 measures? (Aurora Health Care)	**Update (Jun 20, 2012):** The baselines for CheckPoint measures were calculated using the most recent four quarters of data available on 6/30/2012. The baseline for the Asthma Care for Children measure was calculated using Joint Commission data (October 2010 – September 2011). The baselines for the readmission and 30 day mental health follow-up measures were calculated using calendar year 2010 data.
30. RWHC recommends the suspension of the Bonus Pool methodology until there is more time to look at current measure methodology and develop more measures that are applicable to Critical Access Hospitals and small hospitals with low volume data. (RWHC)	Addressed in other responses for this measure.

Appendix 8 – MY 2013 Modifications to the Assessment P4P

Measurement Year (MY) 2013 = 7/1/2-12 – 3/31/2013.

- DHS will continue reserving $5 million (all funds) for the Assessment P4P program. The Assessment P4P applies only to Acute Care, Children's and Rehab hospitals.
- Targets for Assessment P4P are provided in **Appendix 1(b)**.
- The measures and allocation of money will change for MY 2013 as follows:

Measure	MY 2012	MY 2013
Pay-for-Reporting		
1. Pre-birth Steroids 2. Forceps Delivery 3. Vacuum Delivery 4. C-section with Labor 5. C-section without Labor 6. Breast Feeding 7. Infant Composite	$0.5 million out of $5 million allocated to Pay-for-Reporting	No money associated with reporting on these measures. Hospitals must report on all these measures to be <u>eligible</u> for the Perinatal P4P $ (see below).
Pay-for-Performance		
1. Perinatal measures	$0.5 million; 3 measures - pre-birth steroids, breast feeding, infant composite	**$2.0 million;** 3 measures - pre-birth steroids, breast feeding, infant composite($0.667 million per measure) See methodology and example, below.
2. Patient Experience of Care	$1 million; 10 measures (HCAHPS),	**$1.5 million;** No change in measures Target = state-wide average
3. Surgical Infection Prevention Index	$1 million	**<u>Moved</u>** to Withhold P4P; not part of Assessment P4P.
4. Flu Vaccine for Pneumonia Patients	$1 million; 1 measure	**<u>Dropped</u>** by WHA
5. Surgical Care Improvement, Clot Prevention Medication Given	$1 million	**<u>Moved</u>** to Withhold P4P; not part of Assessment P4P.
6. Discharge Instructions for heart-related care	-	**<u>Added</u>: $1.5 million** Target = state-wide average

Methodology and example for the perinatal measure:

Step	Example
1. Set the **targets** for each of the performance-based Perinatal Measures: • Pre-Birth Steroids (greater than or = 82.7%) • Breast Feeding (greater than or = 75.5%) • Infant Composite (less than or = 1.9%).	**Assume** beginning with **70** hospitals in scope for this measure.
2. At the end of MY2013, determine the # of hospitals **reporting** all seven perinatal measures. Hospitals reporting all seven perinatal measures will be eligible to participate in the perinatal P4P $.	**Assume 50** out of 70 hospitals report all 7 perinatal measures. Only these 50 hospitals are eligible to participate in the perinatal P4P incentive.
3. Determine how many hospitals from Step 2 **meet** exactly: • zero perinatal targets = not eligible for perinatal P4P $. • 1 perinatal target • 2 or more perinatal targets.	**Assume**: of the 50 hospitals reporting all 7 perinatal measures: • 20 hospitals meet 0 targets • 10 hospitals meet 1 target • 20 hospitals meet 2 or more targets.
4. Calculate individual hospital **points** and total points for hospitals meeting: • zero perinatal targets = $0 from perinatal P4P = 0 points each • Exactly 1 target = 75% of incentive = 0.75 points each • 2 or more targets = 100% of incentive = 1 point each	• 20 hospitals get 0 points = $0 for perinatal; total points for this group = 20*0 = 0; • 10 hospitals get 0.75 points; total points = 10*0.75 = 7.5; • 20 hospitals get 1 point; total points = 20*1 = 20. **Total points for all hospitals** = (20*0) + (10*0.75) + (20*1) = 27.5 points
5. Determine % **share** in incentive $ for hospitals earning 75% of the incentive, and those earning 100% of the incentive Calculate the incentive $ for each hospital.	• **Share** of the10 hospitals that get 0.75 points each, in the total perinatal $ = $\frac{7.5\,\text{points}}{27.5\,\text{points}} = 27.27\%$ of $2 million = $545, 454. Divided equally among the10 hospitals, each gets $54,545. • **Share** of the 20 hospitals that get 1 point each = $\frac{20}{27.5} = 72.72\%$ of $2 million = $1,454,546. Divided equally among the 20 hospitals, each gets $72,727.

Appendix 9 – Methodology for Sharing Withhold P4P bonus

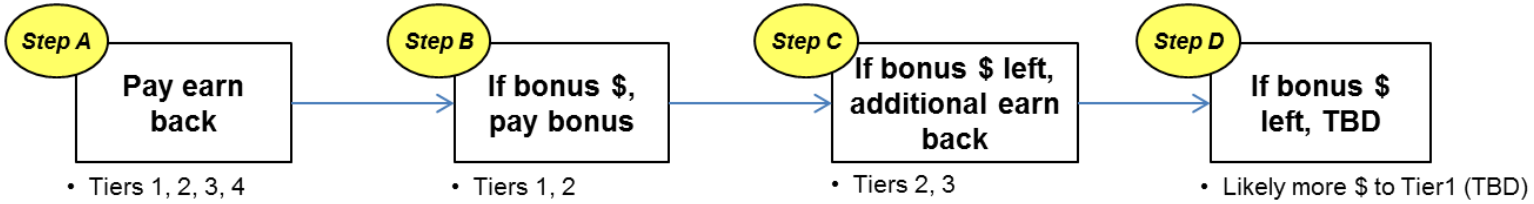
DHS will use a Four Tier Bonus Methodology to distribute any bonus $ as part of the Withhold P4P for MY 2013. This methodology provides multiple opportunities for hospitals to earn back their withhold, and to earn any bonuses. It includes 4 tiers and 4 steps, as explained below.
Tier 1 denotes the highest performance, and Tier 4, the lowest. Depending on the Tier applicable to a given hospital, the hospital will earn a bonus on top of earning back its 1.5% withhold, earn back full or partial withhold, or forfeit its withhold.

DHS has prepared a sample Excel worksheet to assist hospitals in better understanding the methodology, and has shared it with the hospitals. This Appendix provides the background information to use that work sheet more effectively.

The following diagram shows the Four Tier Bonus Sharing Methodology.

Four Tier Bonus Sharing Methodology

- **Intent:** DHS does not not aim to achieve any savings through forfeiture. If any forfeited money is left at the end of the measurement year after applying the methodology below (Steps A through C), DHS will develop ways to distribute the remaining funds (Step D).



	Eligibility	Earn back	Bonus
Tier 1	• 100% earn back for all applicable P4P measures • Meet all P4R requirements	• Full earn back, no forfeiture (***Step A***)	• Must have at least one applicable P4P measure • Up to 1.5% of FFS payments (***Step B***), proportional to withhold $ in Tier 1 • TBD – (***Step D***)
Tier 2	• Not in Tier 1 • At least 75% earn back for all, AND 100% earn back for at least one of the applicable P4P measures • Meet all P4R requirements	• Earn back based on applicable % achieved (***Step A***); Limited forfeiture possible • Eligible for additional earn back (up to withhold $), proportional to withhold $ in Tier 2 (***Step C***)	• Must have at least one applicable P4P measure • Up to 0.75% of FFS payments per measure, only for measures where 100% earn back achieved, proportional to withhold $ in Tier 2 (***Step B***)
Tier 3	• Not in Tiers 1 or 2 • At least 75% earn back for all measures • Meet all P4R requirements	• Earn back based on applicable % achieved (***Step A***); Some forfeiture possible • Eligible for additional earn back (up to withhold $), proportional to withhold $ in Tier 3 (***Step C***)	• None
Tier 4	• Not in Tiers 1, 2 or 3	• Earn back based on applicable % achieved (***Step A***)	• None

Example: Four Tier Bonus Sharing Methodology (Withhold P4P)

This example uses the Excel work sheet provided by DHS for the Hospital Withhold P4P Four Tier Bonus Methodology. The work sheet can help a hospital estimate its likely earn back and bonus amounts given different performance scenarios.

- Assume a total of 12 hospitals, A, B, C,…, K, L.
- Assume total $ withheld = $3,050,000 for the 12 hospitals, combined.

Legend for Tables	
P4R = Pay for Reporting; P4P = Pay for Performance	
Column 2*	$ withheld, = 1.5% of FFS claims payments
Column 3	# of applicable measures, including P4R; Col. 2 = sum (Columns 5,6, 7 and 8) + 1 (for Column 9)
Column 4	Weight per applicable measure = 1 / Col. 3
Column 5 – 8*	# of measures with various earn back %, based on High, Medium, Low ratings
Column 9*	# of P4R measures met – applies to each hospital
Column 10	Applicable bonus tier (based on performance in Columns 5-9
Column 11	Earn back % = (Column 4 * ((Column 5 * 100%) + (Column 6 * 75%) + (Column 7 * 50%) + (Column 8 * 0%) + (Column 9 * 100%))
Column 12	Earn back $ = (Column 11 * Column 2) **(STEP A)**
Column 13	Same as Column 10
Column 14	Maximum possible bonus that could be paid to hospitals in Tiers 1and 2 (this is **not** the actual bonus $ paid) -Tier 1 eligible hospitals can earn a bonus up to 1.5% of FFS payments, proportional to withhold $ available for Tier 1 -Tier 2 eligible hospitals can earn a bonus up to 0.75% of FFS payments for those measures where their performance was 100%, proportional to withhold $ available for Tier 2.
Column 15	Actual bonus $ to hospitals in Tier 1 **(STEP B)**
Column 16	Actual bonus $ to hospitals in Tier 2 **(STEP B)**
Column 17	$ to Tier 2 hospitals that are eligible for additional earn back up to their withhold, proportional to withhold $ for Tier 2 **(STEP C) –** *step only applies if there are $ remaining after Steps A and B*
Column 18	$ to Tier 3 hospitals that eligible for additional earn back up to their withhold, proportional to withhold $ for Tier 3 **(STEP C) –** *step only applies if there are $ remaining after Steps A and B*
Column 19	Total P4P payments after Steps A, B and C= Column 12 + (Columns 15 + 16 + 17 + 18)
Column 20	Total P4P $ earned as % of withhold = Column 19/ Column 2 - result includes both earn back and bonus $ from Steps A, B and C
Column 21	Total forfeited = Column 2 - Column 19; Positive $ = forfeited, Negative $ = P4P bonus

NOTE: Columns with an * are open for editing (in the Excel document, "input" cells are shaded tan, all other cells have been locked).

Step A

The following table shows calculations for Step A.

col. 1	*col. 2*	*col. 3*	*col. 4*	*col. 5*	*col. 6*	*col. 7*	*col. 8*	*col. 9*	*col. 10*	*col. 11*	*col. 12*
				Step A: P4P Earnback							
Hospital	**Withhold $***	**# of applicable measures**	**Weight per measure**	**100%***	**75%***	**50%***	**0%***	**P4R***	**Applicable Tier**	**Earnback %**	**Earnback $**
A	$ 200,000	4	25%	3				1	T1	100.0%	$ 200,000
B	$ 500,000	3	33%	1		1		1	T4	83.3%	$ 416,667
C	$ 150,000	3	33%	1	1			1	T2	91.7%	$ 137,500
D	$ 300,000	3	33%		2			1	T3	83.3%	$ 250,000
E	$ 700,000	4	25%	1	1	1		1	T4	81.3%	$ 568,750
F	$ 150,000	3	33%		2			1	T3	83.3%	$ 125,000
G	$ 150,000	2	50%		1			1	T3	87.5%	$ 131,250
H	$ 150,000	3	33%	2				0	T4	100.0%	$ 150,000
I	$ 150,000	1	100%					1	T1	100.0%	$ 150,000
J	$ 500,000	3	33%	1	1			1	T2	91.7%	$ 458,333
K	$ 50,000	2	50%		1			1	T3	87.5%	$ 43,750
L	$ 50,000	2	50%	1				1	T1	100.0%	$ 50,000
Total	**$ 3,050,000**	**33**		**10**	**9**	**2**	**-**	**11**		**87.91%**	**$ 2,681,250**

Steps B & C

The following table shows calculations for Steps B & C. Columns 1 through 4 have been repeated for ease of reference.

col. 1	*col. 2*	*col. 3*	*col. 4*	*col. 13*	*col. 14*	*col. 15*	*col. 16*	*col. 17*	*col. 18*
					Step B: Bonus (Tiers 1, 2)			**Step C: Additional Earnback (Tiers 2, 3)**	
Hospital	**Withhold $***	**# of applicable measures**	**Weight per measure**	**Applicable Tier**	**Max Possible Bonus**	**Tier 1**	**Tier 2**	**Tier 2**	**Tier 3**
A	$ 200,000	4	25%	T1	$ 200,000	$ 200,000	$ -	$ -	$ -
B	$ 500,000	3	33%	T4	$ -	$ -	$ -	$ -	$ -
C	$ 150,000	3	33%	T2	$ 25,000	$ -	$ 25,000	$ 2,404	$ -
D	$ 300,000	3	33%	T3	$ -	$ -	$ -	$ -	$ -
E	$ 700,000	4	25%	T4	$ -	$ -	$ -	$ -	$ -
F	$ 150,000	3	33%	T3	$ -	$ -	$ -	$ -	$ -
G	$ 150,000	2	50%	T3	$ -	$ -	$ -	$ -	$ -
H	$ 150,000	3	33%	T4	$ -	$ -	$ -	$ -	$ -
I	$ 150,000	1	100%	T1	$ -	$ -	$ -	$ -	$ -
J	$ 500,000	3	33%	T2	$ 83,333	$ -	$ 83,333	$ 8,013	$ -
K	$ 50,000	2	50%	T3	$ -	$ -	$ -	$ -	$ -
L	$ 50,000	2	50%	T1	$ 50,000	$ 50,000	$ -	$ -	$ -
Total	**$ 3,050,000**	**33**			**$ 358,333**	**$ 250,000**	**$ 108,333**	**$ 10,417**	**$ -**

Summary Bonus Distribution Table

The following table shows summary for Steps A through C. Columns 1 through 4 have been repeated for ease of reference.

col. 1	*col. 2*	*col. 3*	*col. 4*	*col. 19*	*col. 20*	*col. 21*
				Steps A-C:		
Hospital	**Withhold $***	**# of applicable measures**	**Weight per measure**	**Total earned**	**Total earned as % of withhold**	**Forfeiture**
A	$ 200,000	4	25%	$ 400,000	200%	$ (200,000)
B	$ 500,000	3	33%	$ 416,667	83%	$ 83,333
C	$ 150,000	3	33%	$ 164,904	110%	$ (14,904)
D	$ 300,000	3	33%	$ 250,000	83%	$ 50,000
E	$ 700,000	4	25%	$ 568,750	81%	$ 131,250
F	$ 150,000	3	33%	$ 125,000	83%	$ 25,000
G	$ 150,000	2	50%	$ 131,250	88%	$ 18,750
H	$ 150,000	3	33%	$ 150,000	100%	$ -
I	$ 150,000	1	100%	$ 150,000	100%	$ -
J	$ 500,000	3	33%	$ 549,679	110%	$ (49,679)
K	$ 50,000	2	50%	$ 43,750	88%	$ 6,250
L	$ 50,000	2	50%	$ 100,000	200%	$ (50,000)
Total	**$ 3,050,000**	**33**		**$ 3,050,000**		**$ 0**

Distribution and Sources of Withheld $

The following table shows how the withheld $ were distributed by each step and tiers, and where they came from.
For example:

- Of the total $3,050,000 withheld, 88%, or $2,681,250 were paid out in Step A for Tiers 1 and 2, leaving $368,750 for Step B.
- Of the $368,750 available for Step B, $250,000 were paid out to Tier 1, and $108,333 to Tier 2, leaving $10,417 for Step C.
- All the remaining $ available for Step C were paid out in Step C.
- Hospitals qualifying for Tier 1 contributed 13% of total $3,050,000 withheld.
  Hospitals qualifying for Tier 2 contributed 21% of total $ withheld.
  Hospitals qualifying for Tier 3 contributed 21% of total $ withheld.
  Hospitals qualifying for Tier 4 contributed 44% of total $ withheld.

Distribution of Withheld $			
	$ available for payout	**Paid**	**Remaining**
Step A, Tiers 1& 2	$ 3,050,000 (= original withhold)	$ 2,681,250	$ 368,750
Step B, Tier 1	$ 368,750	$ 250,000	$ 118,750
Step B, Tier 2	$ 118,750	$ 108,333	$ 10,417
Step C, Tier 2	$ 10,417	$ 10,417	$ -
Step C, Tier 3	$ -	$ -	$ -
Step D	$ -	TBD	TBD

Source of Withheld $	
Tier 1	13%
Tier 2	21%
Tier 3	21%
Tier 4	44%
Total	100%