Wisconsin Department of Health Services
HMO Pay-For-Performance (P4P) Guide
Measurement Year (MY) 2013

This Guide provides an overview of the measures, methodology, targets and operational details that support Wisconsin Department of Health Services' HMO Pay-For-Performance (P4P) initiative. It includes information pertinent to submission of data and calculation of results for Measurement Year (MY) 2013.

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1. Overview

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

2. Measurement Year (MY) 2013

2.1. BC+ Regions 1-4 and SSI P4P

Scope:

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

Features:

- The 2013 upfront **withhold rate is 1.5%**, and will apply to all capitation, including administrative payments.
  Separate withhold % will apply individually to each measure. Each HMO will earn its withhold back for each measure, separately (see *Appendix 2013-1*).
- **Performance measurement**

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

  BC+: The **level** of performance will be measured on a "curve" by comparing MY2013 results of an HMO with MY2011 national Medicaid HEDIS percentiles as reported in the Medicaid Quality Compass. When Medicaid HEDIS results are not available the appropriate State-wide or Region-wide averages will be used; DHS has provided baseline data to HMOs for 2013.

  The degree of **improvement** will be measured by comparing MY2013 results with MY2011 results of an HMO using the percentage "reduction in error" approach.

  See *Appendix 2013-2* for steps and numerical examples. P4P targets are specified in *Appendix 2013-3*.
- **Measures**
  BC+: 11 measures (10 HEDIS), 8 conditions.

  New Measure: Prenatal and Postpartum Care (PPC).
  See *Appendix 2013-4(a)* for Blood Lead testing.

  Tobacco Cessation measure
  The Tobacco Cessation measure has different definitions for Regions 1-4, compared to Regions 5 and 6, due to the SE WI RFP. *Appendix 2013-4(b)* provides the updated tobacco cessation measure specifications for MY2013 for Regions 1-4. There is no change to the tobacco cessation measure, targets, etc. for BC+ HMOs in Regions 5 and 6.

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

Data Submission and Reporting

- **BC+ (Regions 1-4):** For MY 2013, all health plans are asked to report their verified HEDIS scores via **NCQA**, and to make their results available for **public reporting within the Quality Compass**. This includes Childhood Immunization (CIS) and Blood Lead Screening. As in the past, the DHS will continue to calculate the non-HEDIS scores (e.g., for tobacco cessation).

  SSI: The DHS will calculate the results for MY2013.

- **Data for Core Plan members**

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

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

  For MY 2013 data submission in 2014, HMOs have the option to include or exclude data for their Core plan members, as long as HMOs select to publicly report the results and the results are included in the Quality Compass and public reports.

- **Member Level Detail files**

  In order to simplify the administrative tasks associated with P4P, the DHS will not require the HMOs to submit the member level detail files for MY2013. However, if at a later date the DHS needs to verify the results reported by the HMOs, the DHS reserves the right to request member-level detail from specific HMOs, as appropriate. Therefore, HMOs are encouraged to be ready to provide the member-level details, if needed.

- **FFS data for BC+ Regions 1-4**

  The DHS will explore the possibility of providing data to HMOs for members who were enrolled in FFS prior to enrolling in an HMO, so that HMOs can get the credit for care provided while the members were enrolled in FFS.

- **NCQA Data submission requirements - BC+ Regions 1-4**

  HMOs are required to submit the following for MY2013:

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

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

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

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

- **Please see Appendix 8 for medical record encounter submission.**

Other P4P requirements

1. Rotation of measures is not allowed. Each measure is to be calculated each year.
2. Health plans have the flexibility of applying the optional exclusions for appropriate measures while submitting audited Medicaid HEDIS results to NCQA.
3. In determining continuous enrollment, HEDIS allows a gap of 45 days for commercial plans, but only a one-month gap for Medicaid plans that enroll on a monthly basis. Wisconsin Medicaid enrolls members on a monthly basis. The only time a member is not enrolled for the entire month is the month in which a child was born. Refer to the General Guidelines in the HEDIS Technical Specifications, items 27 and 28.
4. For measures with age stratification, HMOs are asked to report results in the IDSS and ART tables by age strata as well as for the overall population.
5. For HEDIS measures that can be collected using the hybrid method, inclusion of chart review data is optional. It is recommended that for hybrid measures, health plans consider using the administrative method only in order to keep administrative costs down. In order to comply with HEDIS specifications, HMOs serving all regions that want to use the hybrid method should pull different samples for the different region groups: one sample for Regions 1-4, a second sample for Region 5, and a third sample for Region 6.
6. To meet DHS' reporting requirements, HMOs need to submit HEDIS quality results audited by a NCQA- licensed organization only for the BadgerCare Plus Standard and Benchmark Plans. HMOs may choose to include Core Plan members in their HEDIS quality results, but this is optional for MY2013.

Timeline

- See Appendix 2013-7

Bonus

- A plan can potentially earn a "**bonus**" on top of its withheld amounts if it demonstrates a "**high**" level or improvement for **each** measure that applies to it. (*Appendix 2013*-5 describes the methodology related to bonus calculations).
  Any bonus pool will be entirely funded by withheld amounts forfeited by other plans. The total bonus earned by any plan will be the lesser of:
  i. **1%** of the total capitation $ for that plan, OR
  ii. **Total** withheld $ **forfeited** by other plans.

HMO Report Card:

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

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

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

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

- HMOs have the option to submit certified / audited HEDIS results for Region 5 and Region 6 for the HEDIS measures in the P4P initiative.
  By **June 15, 2014**, HMOs that plan to submit their HEDIS results for Region 5 and/or Region 6 should inform the DHS about their intent to do so. If the HMOs do not submit their intent or the actual HEDIS results, DHS will use the results compiled by HP.
- HP will calculate the results for non-HEDIS measures.
- If HMOs submit their HEDIS results, separate files should be submitted to the DHS for Region 5 and Region 6 (do not combine them), since targets vary by Region.
- HMOs must follow the data submission and reporting requirements and P4P requirements listed for BC+ Regions 1-4, as they apply to Region 5 and Region 6, including the timeline.

ED measures

- For 2013, the "no-decline" requirement will apply.
- For 2013, revenue code 0456 (urgent care) will be removed from the numerator of the results for both ED measures. The MY2013 ED targets have been updated below:
  ED 1 (average # of visits per member) target = **0.53**, and
  ED 2 (% of members with 3 or more ED visits without a PCP visit) target = **0.2%**.

Dental measures

- For MY2013, to reward positive performance among the individual dental measures, each of the four dental measures (combined 0.25% withhold) will have a separate withhold and earn-back of 0.0625% (= 0.25% split 4-ways) each.
- For MY2013, the "no-decline" requirement will apply to each of the four dental measures individually.

Methodology

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

Measure Specifications

- Please see *Appendix 2013-6* for specifications of non-HEDIS measures for Regions 5 and 6.

2.3. **HMOs** participating **in MY2013 P4P**

Note: The list of HMOs might change year to year.

HMOs	BadgerCare Plus		SSI P4P
	Reg. 1-4	Reg. 5 & 6	
Community Connect		✓	
Children's		✓	
Compcare	✓		
Dean	✓		
GHC-SCW	✓		
GHE	✓		✓
Gundersen	✓		
Health Tradition	✓		
Independent Care			✓
MercyCare	✓		
MHS	✓		✓
Molina	✓	✓	✓
NHP	✓		✓
Physicians Plus	✓		
Security	✓		
United	✓		✓
Unity	✓		

Appendix 2013-1: MY 2013 P4P Measures (BC+ Regions 1-4, SSI) and Withhold %

Focus	Measurement	BC+		SSI	
Chronic	Comprehensive diabetes care - HbA1c (CDC)	✓	0.15%	✓	0.20%
	Comprehensive diabetes care - LDL (CDC)	✓	0.15%	✓	0.20%
	Appropriate medications for people with asthma (ASM)	✓	0.10%		
	Tobacco cessation (18 & older, counseling & pharmacotherapy)	✓	0.20%		
Mental Health	Follow-up after hospitalization for mental illness with 7 days (FUH)			✓	0.20%
	Follow-up after hospitalization for mental illness within 30 days (FUH)			✓	0.20%
	Antidepressant medication management-Acute (AMM)	✓	0.10%		
	Antidepressant medication management-Continuation (AMM)	✓	0.10%		
	Initiation in AOD treatment (IET)			✓	0.15%
	Engagement in AOD treatment (IET)			✓	0.15%
Pregnancy	Pre-natal care (PPC) - ***New***	✓	0.075%		
	Post-partum care (PPC) - ***New***	✓	0.075%		
Preventive	Blood lead screening (LSC)	✓	0.20%		
	Adults' access to preventive/ambulatory health services (AAP)			✓	0.20%
	Childhood immunization status (CIS)	✓	0.20%		
	Breast cancer screening (BCS)	✓	0.15%	✓	0.20%
	Chronic Measures		**0.60%**		**0.40%**
	Mental health measures		**0.20%**		**0.70%**
	Pregnancy		**0.15%**		
	Preventive measures		**0.55%**		**0.40%**
	TOTAL		**1.5%**		**1.5%**
Maximum potential “bonus” *in addition to earning back the withhold $*			**1%**		**1%**

Appendix 2013-2: Performance Measurement & Numerical Examples

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

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

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

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

Degree of Improvement:
The degree of improvement achieved by an HMO is defined as the percentage "reduction in error" for a given measure in MY 2013, compared to MY2011 for that HMO.

An **example**:

If an HMO's MY2011 score for a measure = 80%, then its "error" = 100% - 80% = 20%.
An HMO can achieve a 10% reduction in error by improving its past score by = $\left(\frac{10}{100} * 20\right)$ = 2 percentage points, by attaining a score of 82%.

If the MY2013 score = 81%, then that HMO has improved its score by 1 percentage point = 5% reduction in error.

Mathematically, the reduction in error for MY2013 = $\left(\frac{(MY2013 - MY2011)}{Error = (100 - MY2011)} * 100 \right)\%$

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

Refer to *Appendix 2013-3* for any exceptions.

Methodology Steps:

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

Assume MY2011 National Medicaid Quality Compass data for a given measure are:

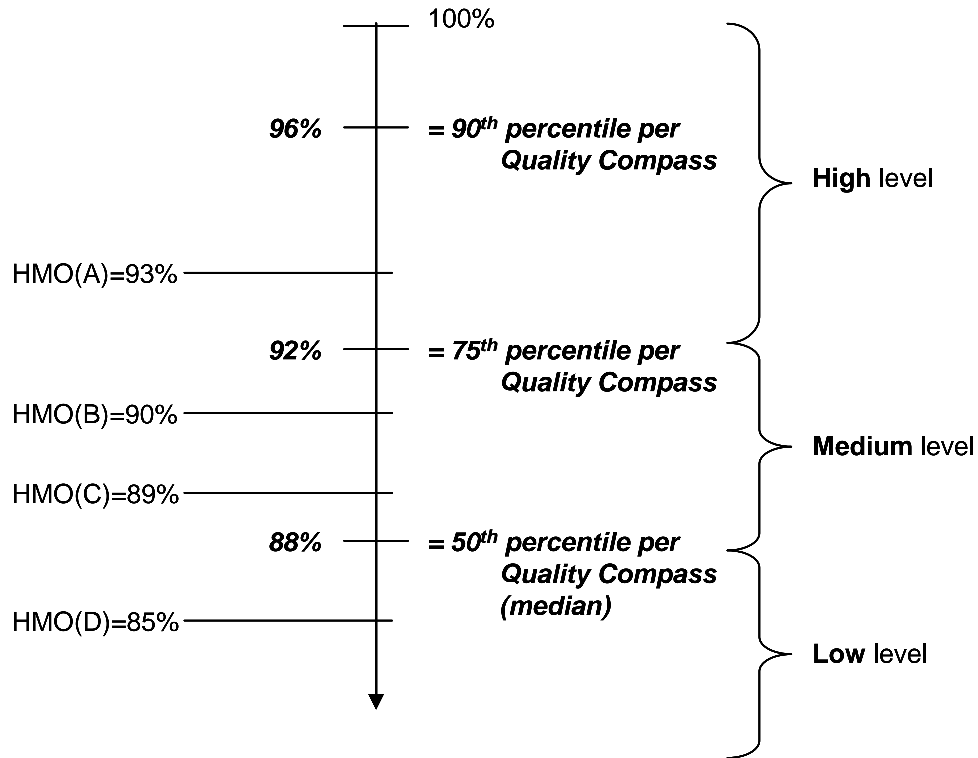
90th percentile score = 96% 75th percentile score = 92% 50th percentile score = 88%

Also assume that scores of four HMOs are:

HMO	MY2013 Score
A	93%
B	90%
C	89%
D	85%

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

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



(b) Calculate the % reduction in error for each HMO for that measure (assume the MY2011 scores as shown below).

HMO	MY2013 Score	MY2011 Score	MY2013 – MY2011	MY2011 Error	% reduction in Error	
A	93%	93%	0% points	7% points	=(0/7)*100 = 0%	Low
B	90%	89%	1% points	11% points	= (1/11)*100 = 9.1%	Medium
C	89%	89%	0% points	11% points	=(0/11)*100 = 0%	Low
D	85%	83%	2% points	17% points	=(2/17)*100 = 11.8%	High

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

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

Appendix 2013-3: MY2013 HMO P4P Targets for BC+ (Reg. 1-4) and SSI

	BadgerCare Plus (Regions 1-4)									2013 Targets					
Measure	BC+ (Reg. 1-4)		MY2011 HEDIS Medicaid Quality Compass- All HMOs						Rationale	Level (NCQA percentile)			Reduction in Error		
	2013 State Avg Target	**Higher of HMO or HP 2011 Avg**	2011 Avg	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile		High	Med	Low	High	Med	Low
AMM- Acute	53%		51.11%	43.40%	46.98%	49.42%	**52.74%**	61.58%	2011 range = 47% to 60%	>75th	50th - 75th	<50th	>10%	5% - 10%	<5%
AMM-Continuation	37%		34.43%	26.73%	29.96%	32.42%	**37.31%**	42.94%	2011 range = 29% to 41%	>75th	50th - 75th	<50th	>7%	3% - 7%	<3%
ASM	89%	88.9%	84.99%	79.72%	82.54%	85.87%	**88.19%**	**90.56%**		>75th	50th - 75th	<50th	>10%	5% - 10%	<5%
BCS	57%	54.0%	50.43%	36.80%	44.82%	50.46%	**56.58%**	62.76%		>75th	50th - 75th	<50th	>10%	5% - 10%	<5%
CIS	81%	78.1%	74.48%	64.23%	69.10%	75.35%	**80.79%**	84.18%		>75th	50th - 75th	<50th	>10%	5% - 10%	<5%
HbA1c	87%		82.53%	74.90%	78.54%	82.38%	**87.01%**	91.13%		>75th	50th - 75th	<50th	>10%	5% - 10%	<5%
LDL	81%	76.8%	75%	64.38%	70.34%	76.16%	**80.88%**	83.45%		>75th	50th - 75th	<50th	>10%	5% - 10%	<5%
LSC	86%	84.3%	67.81%	39.23%	57.52%	71.41%	81.86%	**86.56%**	2011 range = 81% to 87% (above 90th percentile); one HMO at 67%.	>90th	75th - 90th	<75th	>10%	5% - 10%	<5%
PPC-Prenatal	86%		82.75%	72.02%	80.54%	**86.13%**	90.39%	93.33%	2011 hybrid average ~ 84%.	>50th	25th - 50th	<25th	>10%	5% - 10%	<5%
PPC-Postpartum	65%	~65%	64.12%	52.43%	58.70%	**64.98%**	71.05%	74.73%	2011 hyrbid average using hybrid data reported by HMOs ~ 65%.	>50th	26th - 50th	<25th	>10%	5% - 10%	<5%
TOB (Counsel & Rx)	30%	27.6%							Target based on about 10% average improvement.	**Score**>31%	**Score** 27% - 31%	**Score** <27%	>7%	3% - 7%	<3%

	SSI (Regions 1-6)									2013 Targets					
Measure	SSI		MY2011 HEDIS Medicaid Quality Compass- All HMOs						Comments	Level (NCQA percentile)			Reduction in Error		
	2013 State Avg Target	**2011 HP Avg**	2011 Avg	10th Percentile	25th Percentile	50th Percentile	75th Percentile	90th Percentile		High	Med	Low	High	Med	Low
AAP	87%	84.3%	81.92%	70.66%	79.85%	83.90%	**86.67%**	89.41%	75th percentile > 2011 result.	>75th	50th - 75th	<50th	>10%	5% - 10%	<5%
BCS	57%	53.6%	50.43%	36.80%	44.82%	50.46%	**56.58%**	62.76%	75th percentile > 2011 result.	>75th	50th - 75th	<50th	>10%	5% - 10%	<5%
FUH-7	32%	28.7%	46.50%	24.03%	**32.20%**	46.06%	57.68%	69.57%	25th percentile > 2011 result.	>25th	10th - 25th	<10th	>7%	3% - 7%	<3%
FUH-30	57%	53.6%	64.99%	36.04%	**57.29%**	67.65%	77.47%	84.28%	25th percentile > 2011 result.	>25th	10th - 25th	<10th	>10%	5% - 10%	<5%
HbA1c	82%	81.2%	82.53%	74.90%	78.54%	**82.38%**	87.01%	91.13%	50th percentile > 2011 result.	>50th	25th - 50th	<25th	>10%	5% - 10%	<5%
LDL	70%	65.8%	75%	64.38%	**70.34%**	76.16%	80.88%	83.45%	25th percentile > 2011 result.	>25th	10th - 25th	<10th	>10%	5% - 10%	<5%
IET-Initiation	49%	49.0%	39.19%	29.93%	34.30%	38.80%	43.62%	**49.44%**	90th percentile > 2011 result.	>90th	75th - 90th	<75th	>10%	5% - 10%	<5%
IET-Engagement	13%	11.6%	11.93%	2.41%	5.84%	**11.72%**	**18.56%**	21.24%	Target based on about 10% average improvement.	>75th	50th - 75th	<50th	>5%	3% - 5%	<3%

Please do not compare BC+ and SSI results based on Quality Compass percentiles; SSI data are not included in Quality Compass.

Appendix 2013-4(a): Blood Lead Screening Measure

For **BC+ Regions 1-4** in 2013, Wisconsin DHS will use the **HEDIS** measure for measuring HMO performance. In addition, DHS will continue to calculate performance using Blood Lead 1 and Blood Lead 2 measures since:

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

If performance on Blood Lead 1 and 2 deteriorates significantly in 2013, DHS may decide to revert back to those measures, instead of HEDIS, in future.

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

Appendix 2013-4(b): Tobacco Cessation Measure for BC+ Regions 1-4 only

The Tobacco Cessation measure has different definitions for BC+ Regions 1-4, compared to Regions 5 and 6.

This appendix provides the updated tobacco cessation measure specifications for MY2013 for BC+ Regions 1-4. There is no change to the tobacco cessation measure, targets, methodology etc. for BC+ HMOs in Regions 5 and 6.

Measure Description: The percentage of members between 18 years and 64 years of age who were identified as tobacco users and who received the following during the measurement year:

- Counseling and tobacco cessation medication (Counseling and Pharmacotherapy Numerator).

Tobacco Cessation Measure - Specifications

Ages: between 18 years of age to 64 years of age during the measurement year.

Continuous Enrollment: The measurement year.

Allowable Gap: No More than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor Date: December 31 of the measurement year.

Benefits: Medical and Pharmacy during the measurement year.

Event/Diagnosis: Members are part of the eligible population if they are identified as tobacco users by having at least one encounter or claim in the measurement year with the following codes:

- ICD-9-CM 305.1 (tobacco use disorder) as a primary, secondary, tertiary or fourth diagnosis code.
- All CPT codes are included even from professional, inpatient, or outpatient claims.

Exclusions: Members who have a diagnosis of history of tobacco use, pregnancy, or tobacco use disorder complicating pregnancy during the measurement year:

- History of Tobacco Use ICD-9-CM Diagnosis: V15.82.
- Pregnancy ICD-9-CM Diagnosis: 630-679, V22, V23, V28.
- Tobacco Use Disorder Complicating Pregnancy ICD-9-CM Diagnosis: 649.01.

ADMINISTRATIVE SPECIFICATION

Denominator: The eligible population.

Numerator:

Counseling Only — The member is numerator compliant if he or she received counseling to quit smoking either face-to-face or by phone as identified by any claim or encounter with at least one of the codes listed in Table TBC-A during the measurement year and with ICD-9-CM code 305.1 in the same encounter as a primary, secondary, tertiary or fourth diagnosis code:

Table TBC-A: Codes to Identify Tobacco Cessation Counseling

CPT	HCPCS	ICD-9-CM
96150-96154, 99201-99205, 99211-99215, 99241-99245, 99385-99386, 99395-99396, 99401 -99404, 99406, 99407, 90832-90834, 90836-90838, 90845, 90847, 90849, 90875, 90876, 90880, 90899, 98967-98968,	G0436, G0437, G9016 S9453	305.1

Counseling and Pharmacotherapy— The member is numerator compliant if during the measurement year he or she received counseling to quit smoking (as identified by any claim or encounter with at least one of the one of the codes in Table TBC-A) and the member filled one of the tobacco cessation medications listed in Table TBC-B:

Table TBC-B: Pharmacotherapy Medications

Brand Name	Generic Name
Zyban	Bupropion
Wellbutrin	Bupropion
Nicotine patch	
Nicotine gum	
Nicotrol Nasal Spray	
Nicotrol Inhaler	
Chantix	Varenicline Tartrate

Pharmacotherapy Only—The member is numerator compliant if during the measurement year he or she was prescribed one of the tobacco cessation medications listed in Table TBC-B.

Tobacco Cessation Measure - Codes

Primary Care CPT Codes

- **Evaluation and Management Codes**
  - ***New Patient***
    99201-99205: Office or other outpatient visit for the evaluation and management of a new patient; 10 to 60 minutes.

  - ***Established Patient***
    99211-99215: Office or other outpatient visit for the evaluation and management of an established patient; 10 to 40 minutes.

  - ***Office or Other Outpatient Consultations- New or Established Patient***
    99241-99245: Office consultation for a new or established patient which requires coordination of care with other physicians or providers; patient present problems that are self-limited or minor. 15 mins to 80 mins.

  - ***Counseling Risk Factor Reduction and Behavior Change Intervention***
    - ***Preventive Medicine, Individual Counseling***
      99401-99404: Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual; 15 to 60 mins.
    - ***Behavior Change Interventions, Individual***
      99406: Smoking and tobacco use cessation counseling visit; 3 to 10 mins
      99407: Same but greater than 10 mins.

- **Preventive Medicine Services**
  - ***New Patient***
    99385-99386: Initial comprehensive preventive medicine evaluation and management of a new patient, ages 18 to 64 years

  - ***Established Patient***
    99395-99396: Periodic comprehensive preventive medicine evaluation and management of an established patient, ages 18-64

- **Health and Behavior Assessment Intervention**
  96150-96154: Health and behavior assessment (eg. Health-focused clinical interview, behavioral observations, psychophysicological monitoring, health-oriented questionnaires)

Mental Health CPT Codes

- **Psychotherapy**
  90832, 90834, 90837: Psychotherapy with patient and/or family member; 30, 45 or 60 mins.
  90833, 90836, 90838: Same as above when performed with an evaluation and management service; 30, 45 or 60 mins.

- **Other Psychotherapy**
  - ***Psychotherapy for Crisis***
    90845: Psychoanalysis
    90847: Family psychotherapy (conjoint psychotherapy) with patient present
    90849: Multiple-family group psychotherapy

  - ***Other Psychiatric Services or Procedures***
    90875, 90876: Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy; 30 to 45 mins
    90880: Hypnotherapy
    90899: Unlisted psychiatric service or procedure.

Telephone Services CPT Codes Provided by Non-Physician Providers

98967: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

98968: 21-30 minutes of medical discussion.

Note: CPT codes 98967-98968 cannot be reported during the same month with cpt codes 99487-99489 for complex chronic care coordination services.

MY2013 HCPCS Codes in Tobacco Cessation Specs

- *G0436:* Smoking and tobacco cessation counseling visit for the asymptomatic patient; between 3 to 10 mins.
- *G0437:* Same as above but greater than 10 mins.
- *G9016:* Smoking cessation counseling, individual, per session (6-10 mins)
- *S9453:* Smoking cessation classes, non-physician provider, per session.

MY2013 ICD-9-CM Code in Tobacco Cessation Specs

305.1: Tobacco use disorder; excludes history of tobacco use (*V15.82),* smoking complicating pregnancy *(649.0)*, and tobacco use disorder complicating pregnancy *(649.0).*

Please see Appendix 8 for further information re: medical record encounter data submission

Appendix 2013-5: Bonus (BC+ Regions 1-4 and SSI only)

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

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

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

Calculations

- Any bonus pool will be entirely funded through forfeitures by HMOs.
- The bonus pool will be shared among HMOs eligible for bonus in proportion of the sum of the number of members in the **denominator** for all applicable measure, subject to the limits discussed earlier in Section 2.1 of this document.
  Rationale:
  - Variations in the # of members enrolled, i.e., the difference between large and small HMOs, is accounted for by the 1% limitation on bonus.
  - Variations in the performance of HMOs are accounted for by the high / medium / low ratings for level and reduction in error.
  - Variation in performance of HMOs due to proportion of members with specific conditions is accounted for by the use of denominator (and not the total enrollment) in calculating the bonus.

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

Bonus Example

Assume the total bonus pool is worth $2 million for MY2013, and the following plans have achieved a "high" rating for each applicable measure. Also assume the following:

HMO	Total # of members in denominator for all applicable measures	% share based on denominator size	Bonus amount
A	500	= (500 / 4000) = 12.5%	= 12.5% of $2 million = $250,000
D	400	= (400 / 4000) = 10%	= 10% of $2 million = $200,000
F	2000	= (2000 / 4000) = 50%	= 50% of $2 million = $1 million
H	1100	= (1100 / 4000) = 27.5%	= 27.5% of $2 million = $550,000
Total	**4000**	**100%**	**$2 million**

Appendix 2013-6: Non-HEDIS Specifications for BC+ Regions 5 and 6

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

  Measurement Year (MY) - Dates of service January 1, 2013 to April 30, 2014.

  Denominator - Members that met the following eligibility criteria:
  Children with a date of birth from Jan. 1, 2012 to Dec. 31, 2012.
  Enrolled in the same HMO for 11 months of calendar year 2013.
  Enrolled in the same HMO on the member's first birthday.

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

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

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

  Measurement Year (MY) - Dates of service January 1, 2013 to April 30, 2014.

  Denominator - Members that met the following eligibility criteria:
    - Children with a date of birth from Jan. 1, 2011 to Dec. 31, 2011.
    - Enrolled in the same HMO for 11 months of calendar year 2013.
    - Enrolled in the same HMO on the member's second birthday.
    - Same criteria as CIS-Combination 2 denominator.

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

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

- **MEDDIC - Tobacco Cessation (Counseling Only):** The percentage of members 11 years of age and older who were identified as tobacco users and received counseling to quit smoking during the MY.
  Measurement Year (MY) - Dates of service January 1, 2013 to December 31, 2013.

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

- Enrolled in the same HMO as of December 31st of the MY.
- Members who were 11 years of age or older as of December 31 of the MY.
- Members were diagnosed as tobacco users (via ICD-9-CM codes 305.1).

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

CPT	HCPCS	ICD-9-CM
96150-96154, 99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397, 99401 -99404, 99406, 99407, 90832-90834, 90836-90838, 90845, 90847, 90849, 90875, 90876, 90880, 90899	~~G0375,~~ ~~G0376,~~ G0436, G0437, G9016, ~~S9445, S9446,~~ S9453~~S9075~~	305.1

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

Dental Measures

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

  Measurement Year (MY)-Dates of service January 1, 2013 to December 31, 2013.

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

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

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

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

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

  Measurement Year (MY) - Dates of service January 1, 2013 to December 31, 2013.

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

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

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

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

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

  Measurement Year (MY) - Dates of service January 1, 2013 to December 31, 2013.

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

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

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

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

  Measurement Year (MY) - Dates of service January 1, 2013 to December 31, 2013.

  Denominator - Members that met the following eligibility criteria:

- Continuously enrolled in the same HMO for 11 months of the MY
- Enrolled in the same HMO as of December 31st of the MY
- Members who were 18 years of age or younger as of December 31 of the MY.

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

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

Emergency Department Measures

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

  Measurement Year (MY) - Dates of service January 1, 2013 to December 31, 2013.

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

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

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

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

  Measurement Year (MY) - Dates of service January 1, 2013 to December 31, 2013.

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

  Numerator - Number of continuously enrolled members in the HMO with 3 or more ED visits and no primary care visit during the measurement year.

- The criteria to identify ED visits will be the same as the first measure.
- The criteria to identify primary care visits are listed below:

Primary Care Visit includes the following CPT codes:

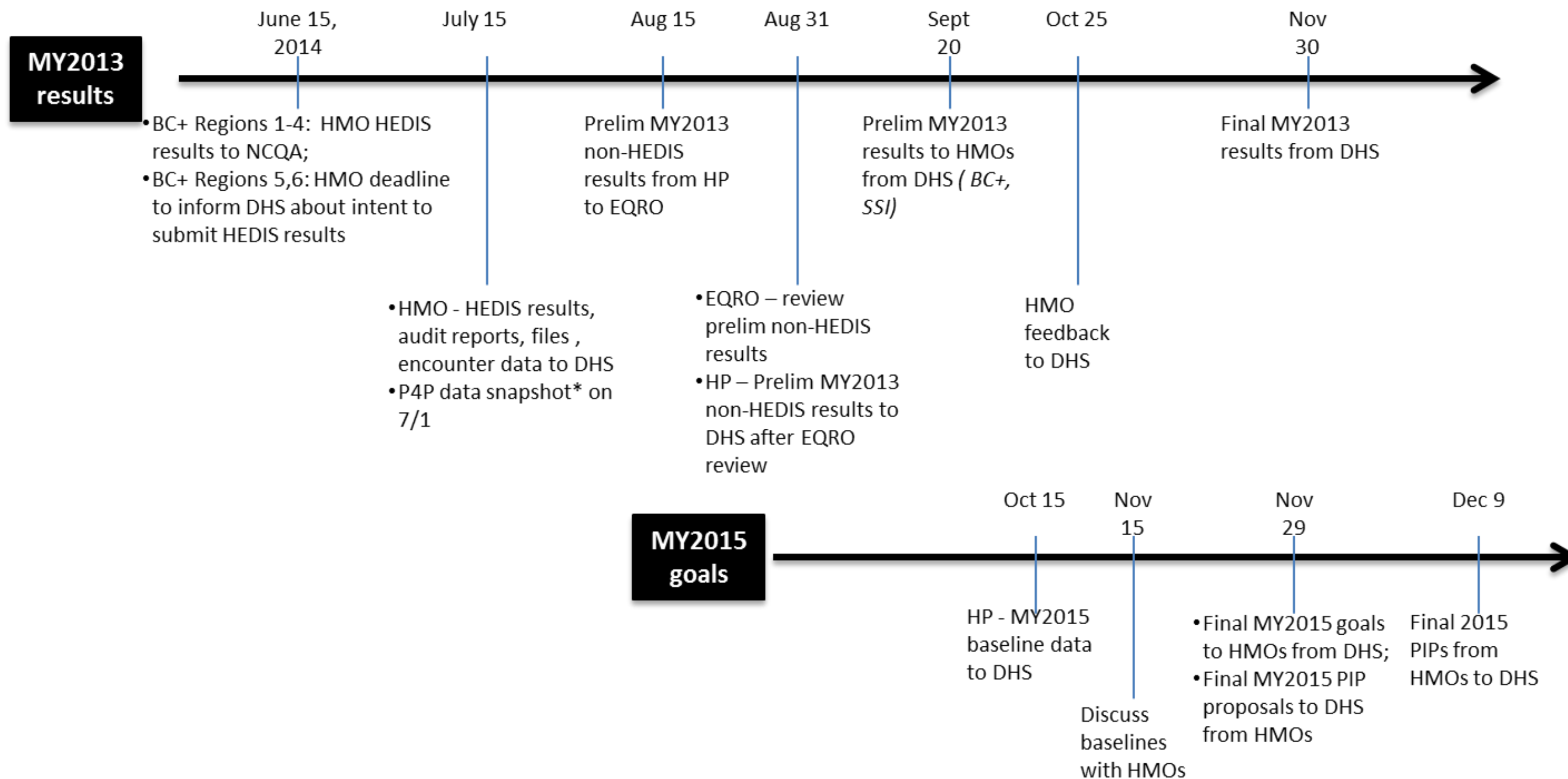
1. 99201-99205
2. 99211-99215
3. 99304-99310
4. 99315-99316
5. 99318
6. 99324-99328
7. 99334-99337
8. 99339-99340
9. 99341-99345
10. 99347-99350
11. 99381 – 99387
12. 99391 – 99397
13. 99401 – 99409
14. 99411 – 99412
15. 99420
16. 99429

Primary Care Visit includes the following rendering provider codes:

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

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

Appendix 2013-7: HMO P4P Timeline during 2014



* By **July 1, 2014**, HMOs are responsible for ensuring that they have submitted all encounter and/or hybrid data, and that the data have passed the edits and been accepted by DHS. HP will create a snapshot from encounters, relevant FFS claims, STELLAR and WIR data.

Appendix 2013-8: Medical Record Encounter Guidance (X12 837)

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

Background

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

Required 837 Detail Fields for Medical Record/Chart Review

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

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

<u>Required Field Differences From Last Year</u>

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

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

<u>Chart Review FAQ's</u>

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

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