Wisconsin Department of Health Services
HMO Pay-For-Performance (P4P) Guide
Measurement Year (MY) 2015

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) 2015.

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I. Overview

1. Wisconsin Department of Health Services (the DHS) defines the Measurement Year (MY) for its HMO Pay-For-Performance (P4P) initiative as follows:
   Each MY starts on January 1 and ends on December 31 of that year.
2. For MY2015, the Pay-For-Performance (P4P) initiative for the HMOs is currently organized as follows:
   a. BadgerCarePlus (BC+): All 6 Regions
   b. SSI: All 6 Regions.
3. Each initiative includes withholding a % of capitation payments made to each HMO; this withhold can be earned back by HMOs based on their performance relative to quality goals for various measures applicable to the HMO.
4. A bonus pool will be formed by the portion of withhold not earned back (i.e., forfeited) by any HMO. This bonus pool will then be distributed, subject to certain limitations, among the HMOs that meet all their goals. The forfeited withhold will be the sole source of funding for the bonus pool.
5. The DHS extensively uses HEDIS measures for its P4P initiative; please see HEDIS Technical Specifications for details. Additional HEDIS-like measures supplement the HEDIS measures, as appropriate; these additional measures are described in this Guide. The DHS utilizes NCQA's Quality Compass data for Medicaid as one of the key inputs for setting targets for the P4P measures.
6. The DHS uses the P4P measures as input for the HMO report card, which reflects the performance of each HMO on various quality measures.

II. Measurement Year (MY) 2015

A. BC+ and SSI P4P for all Regions

Scope:

- **BC+:** Standard plan, including Childless Adults.
- **SSI:** Non-dual (Medicare) eligible members only; dual-eligible members excluded from P4P.

Features:

1. The 2015 upfront **withhold rate is 2.5%**, and will apply to all capitation for BC+ and SSI, including administrative payments. If the **dental** measures apply to an HMO, the withhold rate will be 2.5% of the dental capitation payment.

2. **Measures and Withhold**
   Separate withhold % will apply individually to each measure. Each HMO will earn its withhold back for each measure, separately.
   APPENDIX 1 provides the list of measures and withhold % for each measure.
   - BC+: 14 measures (10 HEDIS, 4 HEDIS-like)
   - SSI: 9 measures (7 HEDIS, 2 HEDIS-like).

3. **Performance Measurement**
   An HMO will be deemed to have a high performance if it has either of the following:
   - A high LEVEL of performance, **OR**
   - A significant degree of IMPROVEMENT (also called Reduction In Error, or RIE).

   CMS endorses this approach in its Value Based Purchasing program initiative.

   The **level** of performance will be measured by comparing MY2015 results of an HMO with MY2013 national Medicaid HEDIS percentiles for HMOs as reported in NCQA's Quality Compass. When Medicaid HEDIS results are not available, the appropriate State-wide or Region-wide averages will be used; DHS will provide baseline data to HMOs for MY 2015. BC+ and SSI could have different performance level targets for the same measures due to the differences in the two populations.

   The degree of **improvement** will be measured by comparing MY2015 results with baseline MY2013 results of an HMO using the percentage "reduction in error" approach.

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

   APPENDIX 2 discusses P4P methodology and examples.
   APPENDIX 3 provides P4P targets.

APPENDIX 4 provides specifications for the HEDIS-like or non-HEDIS measures.

4. **Bonus**

   A health plan can potentially earn a "**bonus**" in addition to earning back its withheld amounts if it demonstrates a "**high**" level or improvement for **each** measure that applies to it. Any bonus pool will be entirely funded by withheld amounts forfeited by other plans. The total bonus earned by any plan will be the **lesser** of:

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

   APPENDIX 5 describes the methodology related to bonus calculations.

5. **Medical Record Encounter Guidance:** See APPENDIX 6

6. **Timeline:** See APPENDIX 7

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

Data Submission and Reporting for <u>both, BC+ and SSI</u>

1. For MY2015, all health plans are asked to report **each** of their verified HEDIS scores for all regions via **NCQA**, and to make their results available for **public reporting within the Quality Compass**. As in the past, the DHS (HP) will calculate the applicable HEDIS-like scores (e.g., for tobacco cessation, AMB-ED Visits, Dental measures for children and adults).

   The following table shows who will calculate / submit results for each measure for MY2015:

Measure	BC+	SSI
Antidepressant Medication Management- Continuation	HMO	HMO
Breast Cancer Screening	HMO	HMO
Comprehensive Diabetes Care – HbA1c Testing	HMO	HMO
Comprehensive Diabetes Care – HbA1c Control < 8% (NQF 0575); (P4R – pay for reporting only for MY2015)	HMO	HMO
Controlling Blood Pressure < 140/90 mmHg (NQF 0018); (P4R – pay for reporting only for MY2015)	HMO	HMO
Childhood Immunizations-Combination 2	HMO	N/A
ED Visits (AMB) *sans revenue code 0456 (Urgent Care)*	HP	HP
Follow-Up After Mental Health Hospitalization – 30 Days	HMO	HMO
Initiation and Engagement of AOD Treatment - Engagement	HMO	HMO
Prenatal and Postpartum Care	HMO	N/A
Tobacco Cessation Counseling	HP	HP
Dental care for children and adults (Regions 5, 6 only)	HP	N/A

2. **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 MY2015. 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.
   HMOs may submit **additional / supplemental data (member level detail is required)** to augment results calculated by HP.

3. **FFS data for BC+ All Regions**
   By December 2015, the DHS plans to provide data to HMOs for members who were enrolled in FFS prior to enrolling in an HMO, so that HMOs can get the credit for care provided while the members were enrolled in FFS. HMOs have preferred to receive this data by December, so these FFS files will not reflect the full MY2015 data due to associated time lags. Please see APPENDIX 8 for specifications to request the FFS data from the DHS' Fiscal Agent (HP).

4. **NCQA Data submission requirements - BC+ and SSI - All Regions**
   HMOs are required to submit the following for MY2015:
   1. Data from the NCQA Interactive Data Submission System (IDSS) site containing the required data elements and the denominator and numerators for each measure. HMOs must provide to the DHS the **denominators and numerators for each measure**.
   2. **Data-filled Workbook (export)** – filled copy (with data entered into the workbook) in Excel (for local copy and for printing)
   3. **Data-filled workbook including Audit Review Table (ART) format** downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied).
   4. The Audit Report produced by a NCQA Licensed HEDIS Auditor.

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

Please see APPENDIX 6 for medical record encounter submission.

Other P4P requirements

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

not enrolled for the entire month is the month in which a child was born. Refer to the General Guidelines in the HEDIS Technical Specifications.

4. For measures with age stratification, HMOs are asked to report results in the IDSS and ART tables by age strata as well as for the overall population.
5. For HEDIS measures that can be collected using the hybrid method, inclusion of chart review data is optional.
6. HMOs may use the sample approach to calculate their results when permitted by HEDIS.

B. HMOs participating in MY2015 P4P

Note: The list of HMOs is updated annually.

HMO	BC+	SSI
1. Anthem	✓	
2. Care Wisconsin Health Plan		✓
3. Children's Community Health Plan	✓	
4. Compcare	✓	✓
5. Dean Health Plan	✓	
6. Group Health Cooperative of Eau Claire	✓	✓
7. Group Health Cooperative of South Central WI	✓	
8. Gundersen Health Plan	✓	
9. Health Tradition Health Plan	✓	
10. Independent Care Health Plan (iCare)	✓	✓
11. Managed Health Services	✓	✓
12. MercyCare Insurance Company	✓	
13. Molina Health Care WI	✓	✓
14. Network Health Plan	✓	✓
15. Physicians Plus Insurance Corporation	✓	
16. Security Health Plan of WI	✓	
17. Trilogy Health Insurance	✓	✓
18. UnitedHealthcare of Wisconsin	✓	✓
19. Unity Health Plans Insurance Corporation	✓	

APPENDIX 1: MY 2015 P4P Measures and Withhold %

Medical Quality Measures and Withhold – 2.5% of medical capitation

Focus Area	MY2015 Measures	BC+ Withhold	SSI Withhold
Preventive / Screening	Breast Cancer Screen (BCS)	0.25%	0.30%
	Childhood Immunization (CIS)	0.25%	N/A
Chronic	HbA1c Test	0.25%	0.30%
	HbA1c Control (Pay for Reporting) NQF 0575	0.125%	0.15%
	Controlling BP (Pay for Reporting) NQF 0018	0.125%	0.15%
Mental Health	Depression Medication (AMM2)	0.25%	0.30%
	AODA (IET2)	0.25%	0.30%
	Tobacco (Counseling only)	0.25%	0.30%
	Follow-up after inpatient discharge (FUH30)	0.25%	0.30%
Pregnancy / Birth	Prenatal and Post-partum care (PPC)	0.125% + 0.125%	N/A
Emergency Dept.	ED Visits (AMB) sans revenue code 0456	0.25%	0.40%
	TOTAL	**2.5%**	**2.5%**

Dental Quality Measures (Regions 5 and 6 only) – 2.5% of dental capitation

Focus Area	MY2015 Measures	BC+ Withhold	SSI Withhold
Dental Care	Children (ADV + dental care provided by physicians)	1.25%	N/A
	Adults (similar to children's measure except for age range)	1.25%	N/A

APPENDIX 2: Performance Measurement Methodology

Each HMO's performance for each measure will be based on a combination of the **level** (high / medium / low), compared to Medicaid Quality Compass data, and the degree of **improvement, or Reduction In Error, RIE** (high / medium / low). The withhold earned back will depend on that combination, as shown below.

Level of Performance:
High, medium and low performance for the Level and Improvement will be defined by the respective cut-off points shown in the table below for most measures. The percentiles in the 1st column below refer to the latest data available from NCQA' national HEDIS Medicaid Quality Compass. For MY2015, the latest data available pertain to MY2013. The DHS acknowledges differences across measures, and APPENDIX 3 provides specific cut-off points for each measure. The table below provides a general overview of how this methodology works.

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

- As shown above, an HMO with "high" performance **level** will get 100% of its withhold back, regardless of improvement shown.
- An HMO with a "high" **improvement** will get 100% of its withhold back, regardless of level.
- An HMO with insufficient observations (i.e., less than 30 observations in the denominator) for a measure will receive back the amount withheld for that measure.

* **1% or 10 member adjustment:** For MY2014 and beyond, if an HMO receives a **LOW** rating for a measure for both, Level and RIE, AND it misses its Medium target for Level for that measure by 1% or less, or by 10 or fewer members, the HMO will be eligible to earn back 50% of its withhold for that measure. This adjustment will not be applicable when an HMO shows a decline in performance for that measure from the previous year.

Degree of Improvement:
The degree of improvement achieved by an HMO is defined as the percentage "reduction in error" (RIE) for a given measure in MY2015, compared to its baselines for that HMO.

An **example**:
If an HMO's MY2012 score for a measure = 80%, then its "error" = 100% - 80% = 20%.
An HMO can achieve a 10% reduction in error by improving its past score (baseline) by = $\left(\frac{10}{100} * 20\right)$ = 2 percentage points, by attaining a score of 82%.

If the MY2014 score = 81%, then that HMO has improved its score by 1 percentage point = 5% reduction in error.

Mathematically, the reduction in error for MY2014 = $\left(\frac{(MY\,2014 - MY\,2012)}{Error = (100 - MY\,2012)} * 100\right)\%$

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

Refer to APPENDIX 3 for any exceptions.

Methodology:

(a) First determine the level of performance of an HMO for each measure, as shown in the following **example**. Assume no exceptions apply in this example to the cut-off points for level or degree of improvement. Assume MY2012 National Medicaid Quality Compass data for a given measure are:

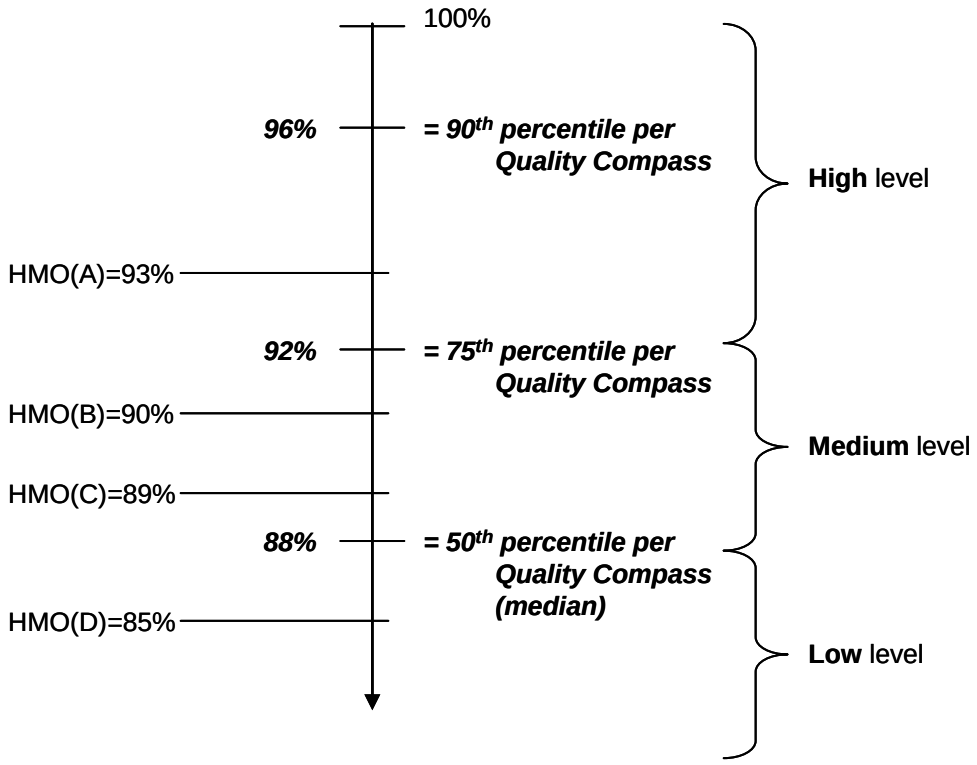
90th percentile score = 96%
75th percentile score = 92%
50th percentile score = 88%

Also assume that scores of four HMOs are:

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

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

HMO	MY2014 Score	Level	Rationale
A	93%	High	Higher than 75th percentile
B	90%	Medium	Between 50th and 75th percentile
C	89%	Medium	Between 50th and 75th percentile
D	85%	Low	Below 50th percentile



(b) Calculate the % reduction in error for each HMO for that measure (assume the MY2012 scores as shown below).

HMO	MY2014 Score	MY2012 Score	MY2014 – MY2012	MY2012 Error	% reduction in Error	
A	93%	93%	0% points	7% points	=(0/7)*100 = 0%	Low
B	90%	89%	1% points	11% points	= (1/11)*100 = 9.1%	Medium
C	89%	89%	0% points	11% points	=(0/11)*100 = 0%	Low
D	85%	83%	2% points	17% points	=(2/17)*100 = 11.8%	High

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

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

Examples for AMB Measure:

The five **scenarios** below illustrate how to determine AMB performance (**lower score is better**). Note that AMB is a utilization measure (ED visits / 1000 member months), and does not have a % value.

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX 3: MY2015 HMO P4P Targets for BC+ and SSI

December 2, 2014

MY2015 HMO P4P – BadgerCarePlus											
MY2015 Measures	**2013 State Avg**	**Quality Compass 2014 (2013 data) percentiles**				**LEVEL Target**			**Reduction In Error Target**		
		25th	*50th*	*75th*	*90th*	*High*	*Med*	*Low*	*High*	*Med*	*Low*
AMB - ED Visits sans revenue code 0456 [1]	45.7 visits	N/A				**<=45**	45.1 – 49.0	>=49.1	>=5%	3%-4.9%	<3%
AMM (continuation) - Depression Rx	46.5	30	34	**38.2**	44	>=75th *	50th – 75th *	<50th *	>=7%	5%-6.9%	<5%
Breast Cancer Screen (BCS)	69	51.2	57.4	**65.1**	71.4	>=75th *	50th – 75th *	<50th *	>=10%	5%-9.9%	<5%
CDC-HbA1c Test (Diabetes)	88.7	80.2	83.9	**87.6**	91.7	>=75th *	50th – 75th *	<50th *	>=10%	5%-9.9%	<5%
CIS - Childhood Immunization	78.6	70.6	75.2	**79.7**	83.3	>=75th *	50th – 75th *	<50th *	>=10%	5%-9.9%	<5%
FUH-30 - Follow-up after MH inpatient discharge [2]	57.6	51.4	**64.6**	74.1	80.3	>=50th *	25th – 50th *	<25th *	>=10%	5%-9.9%	<5%
IET Engagement - AODA	12.9	5.4	10.3	**15**	19.1	>=75th *	50th – 75th *	<50th *	>=5%	2%-4.9%	<2%
PPC – Timely Prenatal care	77	77.8	**84.3**	89.6	93.1	>=50th *	25th – 50th *	<25th *	>=10%	5%-9.9%	<5%
PPC - Post-partum care	64.8	56.2	62.8	**69.5**	74.0	>=75th *	50th – 75th *	<50th *	>=10%	5%-9.9%	<5%
Tobacco (Counseling) [3]	65.7	N/A				**>= 69%**	68.9 – 65	<=64.9	>=10%	5%-9.9%	<5%
ADV - Children (+ dental care by physicians) [4]	36.8	**43.3**	52.6	61.1	66.8	>= 43.3%	33.6 – 43.2	<=33.5	>=7%	5%-6.9%	<5%
ADV - Adults (+dental care by physicians) [5]	28.5	N/A				**>=32%**	27 – 31.9%	<=26.9	>=7%	5%-6.9%	<5%

*=percentile as reported in Quality Compass based on 2015 data.

P4R measures (no targets for MY2015): HbA1c Control - NQF 0575; Controlling BP - NQF 0018

[1] There was large variation across the State; HMO size did not affect variation in results

[2] FUH 30 specifications have changed from HEDIS 2013 to HEDIS 2015. The 2015 baselines were calculated by HP using HEDIS 2015 specs.

[3] Mid-point of 2013 range (50% - 88%); 8 HMOs above 69 in 2013; 2015 target represents <10% RIE

[4] Wisconsin measure gives HMOs additional credit for dental care provided by physicians.

[5] Target = 3.5 percentage point improvement, and is < 5% RIE overall

MY2015 HMO P4P – SSI											
MY2015 Measures	**2013 State Avg**	**Quality Compass 2014 (2013 data) percentiles**				**LEVEL Target**			**Reduction In Error Target**		
		25th	*50th*	*75th*	*90th*	*High*	*Med*	*Low*	*High*	*Med*	*Low*
AMB - ED Visits sans revenue code 0456 [6]	125 visits	N/A				**<=125**	125.1 – 130	>=130.1	>=5%	3%-4.9%	<3%
AMM (continuation) - Depression Rx	23.3	**30**	34	38.2	44	>=25th *	10th – 25th *	<10th *	>=7%	5%-6.9%	<5%
Breast Cancer Screen (BCS)	61.9	51.2	57.4	**65.1**	71.4	>=75th *	50th – 75th *	<50th *	>=10%	5%-9.9%	<5%
CDC-HbA1c Test (Diabetes)	84.9	80.2	83.9	**87.6**	91.7	>=75th *	50th – 75th *	<50th *	>=10%	5%-9.9%	<5%
FUH-30 - Follow-up after MH inpatient discharge [7]	65.1	51.4	64.6	74.1	80.3	**>=68.5**	65 - 68.4	<=64.9	>=10%	5%-9.9%	<5%
IET Engagement - AODA	15.2	5.4	10.3	**15**	19.1	>=75th *	50th – 75th *	<50th *	>=5%	2%-4.9%	<2%
Tobacco (Counseling) [8]	66.5	N/A				**>= 70%**	69.9 – 66	<=65.9	>=10%	5%-9.9%	<5%

*=percentile as reported in Quality Compass based on 2015 data

P4R measures (no targets for MY2015): HbA1c Control - NQF 0575; Controlling BP - NQF 0018

[6] MY2013 range was 92 – 143 visits per 1000 member months. Target represents <5% RIE

[7] FUH 30 specifications have changed from HEDIS 2013 to HEDIS 2015. The 2015 baselines were calculated by HP using HEDIS 2015 specs. Target represents a mid-point between 50th and 75th percentile, and a 10% RIE

[8] 2013 range was wide (65% - 94%); Most HMOs were between 65% and 67%; 2015 target represents a 10% RIE from 2013.

APPENDIX 4: HEDIS-Like and Non-HEDIS Measures

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

- **Measure description:** The % of members 2-21 years of age who had at least one dental visit during the measurement year with a dental practitioner.
- **Specifications:** The DHS will use the 2015 HEDIS specifications for Annual Dental Visits (ADV). A dental practitioner, for this measure, is defined as follows:
  - Per HEDIS, only services rendered by a practitioner who holds a **Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (DMD)** degree from an accredited school of dentistry and is licensed to practice dentistry by a state board of dental examiners.
  - Per HEDIS, **certified and licensed dental hygienists** are considered dental practitioners.
  - Per DHS definitions, dental services (included in the codes above) provided by a **physician** would also count.

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

- **Measure description:** The % of members 22-64 years of age who had at least one dental visit during the measurement year.
- **Denominator:**
  - Age: from 22 to 64 years of age.
  - Continuous Enrollment: The member needs to be enrolled in the same HMO continuously for 11 months of the measurement year.
  - Anchor Date: the member needs to be enrolled in the HMO as of Dec. 31 of the measurement year.
- **Numerator:** One or more dental visits with a dental practitioner (see definition above) during the measurement year. A member had a dental visit if a claim or encounter submit contains any code listed below:
  - CPT Codes: 70300, 70310, 70320, 70350, 70355.
  - CDT Codes: D0120-D0999; D1110; D1120; D1204-D2999; D3110-D3999; D4210-D4999; D5110-D5899; D5994; D6010-D6205; D 7111-D7999; D8010-D8999; D9110-D9999.

C. Emergency Room Utilization (AMB)

- **Measure description:** Number of Emergency Department visits per 1000 member months; this is a utilization measure.
- **Specifications**: The DHS will use the 2015 HEDIS specifications and value sets for Ambulatory Care – ED Visits (AMB), excluding revenue code 0456 (Urgent Care).
- **Denominator:** Number of member months during measurement year 2015.
- **Numerator:** Number of Emergency Department visits during the measurement year that do not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.
  - Codes to identify Emergency Department Visits

  - An ED Visit in the HEDIS ED Value Set for ED
  - CPT 99281-99285 ***OR*** UB Revenue Codes 450, 451, 452, 459, 981 **excluding** revenue code 456.
  - A procedure code in the HEDIS ED Procedure Code Value Set with an ED place of service code (In HEDIS ED POS Value Set)
  - CPT 10030, 10040-69979 ***WITH*** Place of Service 23.
- **Exclusions:** The measure does not include mental health or chemical dependency services. The exclusions are defined in the HEDIS 2015 Volume 2 Value Set Directory which include the following:
  - Electroconvulsive Therapy Value Set
  - Mental and Behavioral Disorders Value Set
  - AOD Rehab and Detox Value Set
  - Psychiatry Value Set

D. Tobacco Cessation – Counseling

- **Measure Description:** For BC+, members 12 years of age or older during the measurement year. For SSI Managed Care, members 19 years of age or older during the measurement year.
- **Denominator:** The eligible population:
  - Age: Members 12 years of age or older during the measurement year for BC+ members. Member 19 years of age or older during the measurement year for SSI Managed Care members.
  - Continuous Enrollment: The measurement year.
  - Allowable Gap: No More than a 1-month gap in coverage (i.e. a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
  - Anchor Date: December 31 of the measurement year.
  - Benefits: Medical during the measurement year.
  - Event/Diagnosis: Members are part of the eligible population if they are identified as tobacco users by having at least one encounter or claim in the measurement year with the following codes:
    - ICD-9-CM 305.1 (tobacco use disorder) as a primary, secondary, tertiary or fourth diagnosis code.
    - ICD-10-CM F17200, F17201, F17203, F17208, F17209, F17210, F17211, F17213, F17218, F17219, F17220, F17221, F17223, F17228, F17229, F17290, F17291, F17293, F17298, F17299, Z720.
    - 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 and ICD-10-CM code Z87891.
  - Pregnancy Diagnosis:
  - ICD-9-CM codes 630-679, V22, V23, V28.

  - ICD-10-CM codes in MY2015 Tobacco Measure – ICD-10 Pregnancy Status Codes. Please see **APPENDIX 9**, the enclosed file (MY2015 Tobacco Cessation - ICD-10 Pregnancy Codes) for details.
  - Tobacco Use Disorder Complicating Pregnancy: ICD-9-CM Diagnosis: 649.01 and ICD-10-CM codes O99330, O99331, O99332, O99333.
- **Numerator:** The member is numerator compliant if he or she received counseling to quit smoking either face-to-face or by phone as identified by any claim or encounter with at least one of the codes listed in Table TBC-A during the measurement year and with the following codes in the same encounter as a primary, secondary, tertiary or fourth diagnosis code:
  - ICD-9-CM code 305.1
  - ICD-10-CM F17200, F17201, F17203, F17208, F17209, F17210, F17211, F17213, F17218, F17219, F17220, F17221, F17223, F17228, F17229, F17290, F17291, F17293, F17298, F17299, Z720.
  - Striving to Quit- Members that received tobacco cessation treatment through the Quit Line would be added to the numerator of the measure.

Table TBC-A: Codes to Identify Tobacco Cessation Counseling

CPT	HCPCS	ICD-9-CM	ICD-10-CM
96150-96154, 99201-99205, 99211-99215, 99241-99245, 99384-99387, 99394-99397, 99401 -99404, 99406, 99407, 90832-90834, 90836-90838, 90845, 90847, 90849, 90875, 90876, 90880, 90899, 98967-98968.	G0436, G0437, G9016 S9453	305.1	F17200, F17201, F17203, F17208, F17209, F17210, F17211, F17213, F17218, F17219, F17220, F17221, F17223, F17228, F17229, F17290, F17291, F17293, F17298, F17299, Z720.

Please see APPENDIX 6 for further information re: medical record encounter data submission.

APPENDIX 5: Bonus (BC+ and SSI)

The DHS would like to reward HMOs demonstrating high quality by meeting all their targets and earning back their full withhold. An HMO can earn a bonus on top of 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.
- When an HMO receives its full withhold back because none of the measures applied to it (e.g., due to small denominator size), that HMO will not be eligible for the bonus.
- Any bonus pool will be entirely funded through forfeitures by HMOs.

Calculations

The bonus pool will be shared among HMOs eligible for bonus in proportion of the sum of the number of members in the **denominator** for all applicable measure, subject to the limits discussed earlier in this document. **Rationale:**

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

Bonus Example

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

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

APPENDIX 6: Medical Record Encounter Guidance (X12 837)

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

Background

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

Required 837 Detail Fields for Medical Record/Chart Review

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

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

Required Field Differences from Pre-837 Encounter Submission Process

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

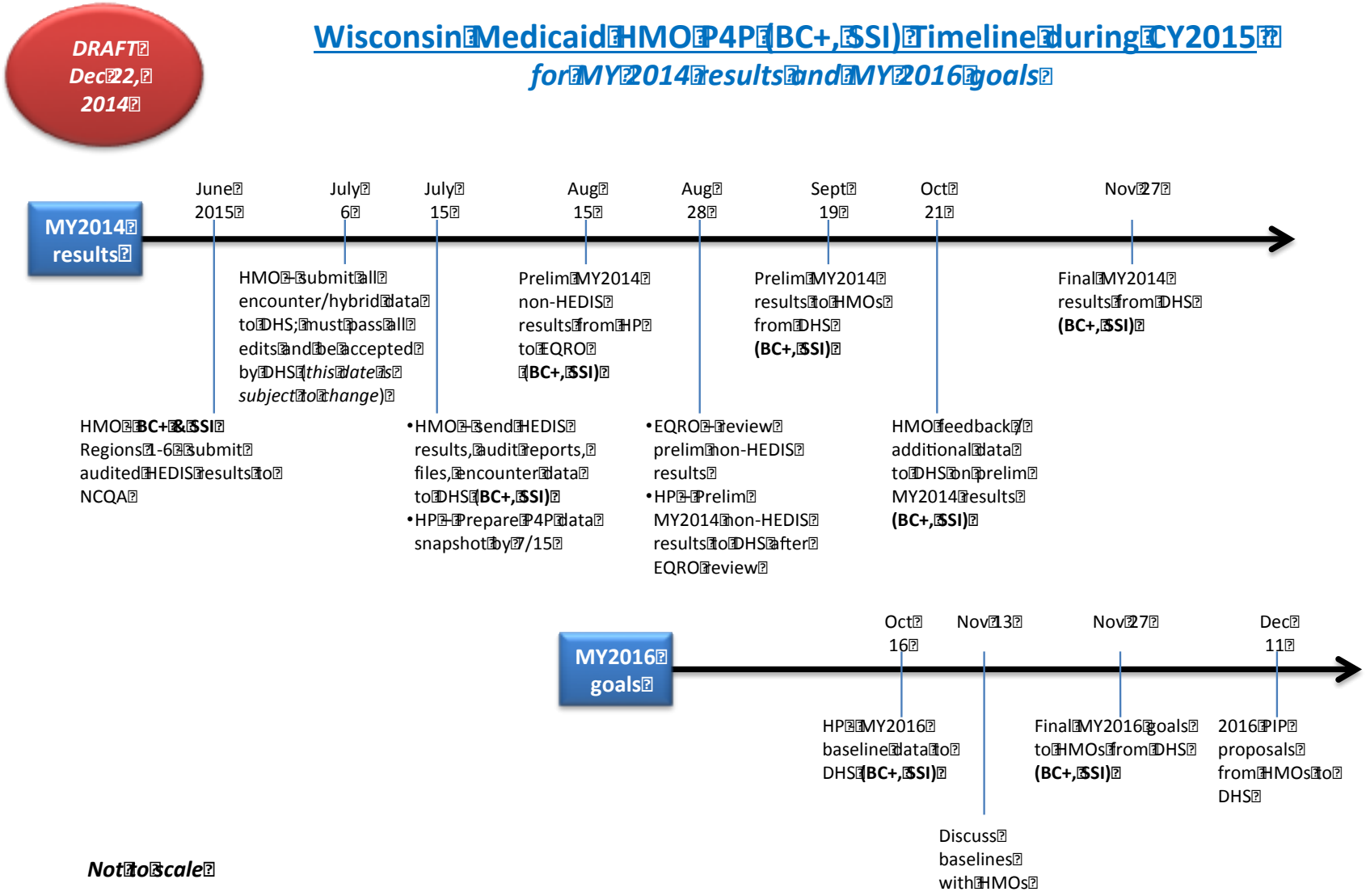
- Encounter type – This is not used as a data field in the new format. Encounters are grouped as O, I, P, D.
- HMO ID: HMO ForwardHealth ID number is used as a data field.
- Data Source- Not used as a data field.
- Record Type – Not used as a data field.
- RIN – Not used as a data field.
- Process Date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

Chart Review FAQ's

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

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

APPENDIX 7: HMO P4P Timeline during 2015



APPENDIX 8: Fee For Service (FFS) data to HMOs

FIELD	SOURCE	FORMAT	POPULATED
recipient_id	**mco**	**VARCHAR2(12 BYTE)**	**MCO FILE**
date_of_birth	**mco**	**DATE**	**MCO FILE**
gender	**mco**	**VARCHAR2(1 BYTE)**	**MCO FILE**
mco_abbreviation	**mco**	**VARCHAR2(3 BYTE)**	**MCO FILE**
recipient_age	claim_analysis	NUMBER(3,0)	
icn	claim_analysis	VARCHAR2(17 BYTE)	
detail_line_num	claim_analysis	VARCHAR2(3 BYTE)	
first_date_of_service	claim_analysis	DATE	
last_date_of_service	claim_analysis	DATE	
claim_type_code	claim_analysis	VARCHAR2(1 BYTE)	
active_ind	claim_analysis	VARCHAR2(1 BYTE)	Y
claim_status_code	claim_analysis	VARCHAR2(1 BYTE)	P
detail_status_code	claim_analysis	VARCHAR2(1 BYTE)	P
financial_payer	claim_analysis	VARCHAR2(4 BYTE)	TXIX
paid_date	claim_analysis	DATE	
procedure_code	claim_analysis	VARCHAR2(6 BYTE)	
revenue_code	claim_analysis	VARCHAR2(4 BYTE)	
header_diagnosis_code_primary	claim_analysis	VARCHAR2(7 BYTE)	
header_diagnosis_code_2	claim_analysis	VARCHAR2(7 BYTE)	
header_diagnosis_code_3	claim_analysis	VARCHAR2(7 BYTE)	
header_diagnosis_code_4	claim_analysis	VARCHAR2(7 BYTE)	
header_diagnosis_code_5	claim_analysis	VARCHAR2(7 BYTE)	
header_diagnosis_code_6	claim_analysis	VARCHAR2(7 BYTE)	
header_diagnosis_code_7	claim_analysis	VARCHAR2(7 BYTE)	
header_diagnosis_code_8	claim_analysis	VARCHAR2(7 BYTE)	
header_diagnosis_code_9	claim_analysis	VARCHAR2(7 BYTE)	
diagnosis_code	claim_diagnosis	VARCHAR2(7 BYTE)	
sequence_num	claim_diagnosis	VARCHAR2(2 BYTE)	
detail_diagnosis_code_1	claim_analysis	VARCHAR2(7 BYTE)	
detail_diagnosis_code_2	claim_analysis	VARCHAR2(7 BYTE)	
detail_diagnosis_code_3	claim_analysis	VARCHAR2(7 BYTE)	
detail_diagnosis_code_4	claim_analysis	VARCHAR2(7 BYTE)	
diagnosis_code_emergency	claim_analysis	VARCHAR2(7 BYTE)	
diagnosis_code_admit	claim_analysis	VARCHAR2(7 BYTE)	
drug_code	claim_analysis	VARCHAR2(11 BYTE)	
total_days_supply	claim header	NUMBER(9,0)	
icd9_procedure_code_1	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_2	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_3	claim_analysis	VARCHAR2(7 BYTE)	

FIELD	SOURCE	FORMAT	POPULATED
icd9_procedure_code_4	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_5	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_6	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_7	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_8	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_9	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_10	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_11	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_12	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_13	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_14	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_15	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_16	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_17	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_18	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_19	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_20	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_21	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_22	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_23	claim_analysis	VARCHAR2(7 BYTE)	
icd9_procedure_code_24	claim_analysis	VARCHAR2(7 BYTE)	
patient_status_code	claim_analysis	VARCHAR2(2 BYTE)	
place_of_service	claim_analysis	VARCHAR2(2 BYTE)	
type_of_bill_code	claim_analysis	VARCHAR2(3 BYTE)	
sak_prov_loc_rend	claim_analysis	VARCHAR2(9 BYTE)	
rendering_prov_id	claim_analysis	VARCHAR2(15 BYTE)	
rendering_prov_npi	claim_analysis	VARCHAR2(10 BYTE)	
rendering_prov_type	claim_analysis	VARCHAR2(3 BYTE)	
rendering_prov_specialty	claim_analysis	VARCHAR2(4 BYTE)	
provider_specialty_desc	dss.prov_specialty_code	VARCHAR2(50 BYTE)	
sak_prov_loc_bill	claim_analysis	VARCHAR2(9 BYTE)	
billing_prov_id	claim_analysis	VARCHAR2(15 BYTE)	
billing_prov_npi	claim_analysis	VARCHAR2(10 BYTE)	
billing_prov_type	claim_analysis	VARCHAR2(3 BYTE)	
billing_prov_specialty	claim_analysis	VARCHAR2(4 BYTE)	
admit_date_time	claim_analysis	DATE	
admit_type_code	claim_analysis	VARCHAR2(1 BYTE)	

APPENDIX 9: Tobacco Cessation – ICD-10 Pregnancy Codes

Please refer to APPENDIX 4, (D).

Click on the icon below to open the file.

MY2015 Tobacco Measure - ICD-10 Pregnan