

Wisconsin Department of Health Services (DHS) HMO Pay-For-Performance (P4P) Guide Measurement Year (MY) 2016

This Guide provides an overview of the measures, targets, methodology and operational details supporting DHS' HMO Pay-For-Performance (P4P) initiative.

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Contact:

Raj Kamal

Bureau of Benefit Management / Division of Health Care Access and Accountability

Wisconsin Department of Health Services

raj.kamal@wisconsin.gov / 608.576.0442

Overview

1. The Measurement Year (MY) for the HMO Pay-for-Performance (P4P) initiative of the Wisconsin Department of Health Services (the DHS) starts on January 1 and ends on December 31 of that year.
2. For MY2016, the Pay-For-Performance (P4P) initiative for the HMOs has two components:
 - a. BadgerCarePlus (BC+): All 6 Regions
 - b. SSI: All 6 Regions.

Performance targets and results for each measure and HMO will be set / calculated for all 6 Regions collectively, unless otherwise specified (e.g., for Dental measures).

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 targets 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 targets. 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 of specific measures. Additional HEDIS-like measures supplement the HEDIS measures, as appropriate, and 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 one of the inputs for the HMO report card, which reflects the performance of each HMO on various quality measures.

Measurement Year (MY) 2016

A. P4P Scope and Key Features

Scope

- **BC+:** Standard plan, including Childless Adults.
- **SSI**

Dual (Medicare) eligible members are excluded from BC+ and SSI P4P unless they meet enrollment requirements for Medicaid only during the year. Retroactive Medicare eligibility and enrollment are accounted for if such actions occur before the cut-off date for the data used for the MY.

Key Features

a. Withhold rate and Measures

The 2016 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.

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). Two are Pay-for-Report (P4R) measures, i.e., HMOs will earnback their withhold for these two measures for MY2016 for simply reporting their verified HEDIS results, regardless of their performance.
- SSI: 9 measures (7 HEDIS, 2 HEDIS-like). Two are Pay-for-Report (P4R) measures.

b. Additional HEDIS data reporting

In order to improve alignment with current and future CMS requirements (e.g., CHIPRA, Managed Care Rules) and as input to a broader picture of Quality of Care and for the HMO Report Card, the DHS is requesting all plans to report audited HEDIS data for the following 9 HEDIS measures for MY2016:

1. Immunization for adolescents (IMA)
2. Adult BMI (ABA)
3. Adults' access to preventive ambulatory care (AAP)
4. Children and adolescents access to primary care (CAP)
5. Frequency of ongoing prenatal care (FPC)
6. Well-child visits in first 15 months (W15)
7. Well-child visits in the Third, Fourth, Fifth and Sixth years (W34)
8. Adolescent well care visits (AWC)
9. Mental Health Utilization (HPT)

Many HMOs already report this data through their annual HEDIS submission to the DHS. The above nine measures are not part of P4P or any bonus / incentives for MY2016.

c. Performance Measurement

The proportion of the withhold that an HMO earns back for any measure is related to how well the HMO performs for that measure. Performance is rated as “high”, “medium” or “low” for each measure along two dimensions:

- The Level of performance, and
- The Reduction In Error (RIE), also known as degree of improvement.

An HMO will be deemed to have a high performance if it has either:

- A high **LEVEL** of performance, **OR**
- A significant Reduction In Error (**RIE**), also known as Degree of Improvement.

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

The **Level** of performance will be measured by comparing MY2016 results of an HMO with MY2014 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. BC+ and SSI could have different performance level targets for the same measures due to the differences in the two populations.

The **RIE** will be measured by comparing MY2016 results with baseline MY2014 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.
- DHS will specify and/or provide baseline data to HMOs for MY2016, as appropriate.
- HMOs that are new to Medicaid will not have their withhold at risk in their first full 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 starting in their second year of participation.

Appendix 2 discusses P4P methodology and examples, and also discusses the adjustment to methodology due to the potential impact of ICD-10 in MY2016 and MY2017.

Appendix 3 provides P4P targets (both, Level and RIE) for specific measures for BC+ and SSI.

Appendix 4 provides specifications for the HEDIS-like / non-HEDIS measures.

d. 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.

e. Submitting Supplemental Chart Data

For the P4P measures that are calculated by HP, HMOs may submit chart data in addition to administrative data when the latter do not fully capture the true performance of an HMO.

There are two separate processes for such submissions:

- i. Submission of medical / chart data through the encounter submission process, and
- ii. Submission of chart data directly to the DHS Quality team.

Appendix 6 provides further guidance on these processes.

f. Timeline

Timely completion of the P4P initiative requires close coordination between multiple entities (the DHS, DHS' analytics vendor, EQRO, HMOs, HEDIS auditors of HMOs, NCQA, etc.). Appendix 7 provides a high-level timeline with key dates affecting the P4P initiative.

B. Data Submission and Reporting

Unless otherwise stated, the following section applies to both, BC+ and SSI.

1. Public Reporting

For MY2016, all health plans are asked to report **each** of their HEDIS scores verified by their HEDIS auditor for all regions, 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).

2. Submitting / calculating results

The following table shows who will calculate / submit results for each measure for MY2016:

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 for MY2016)	HMO	HMO
Controlling Blood Pressure < 140/90 mmHg (NQF 0018); (P4R for MY2016)	HMO	HMO
Childhood Immunizations-Combination 2	HMO	N/A
ED Visits (AMB) <i>sans revenue code 0456 (Urgent Care)</i>	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

HP will utilize the latest version of HEDIS specifications available at the time the calculations are made.

3. 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 MY2016. 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. This supplemental data may pertain only to that collected through chart review or other means, and not to encounter data. Please see [Appendix 6](#) for details.

4. Fee-For-Service (FFS) data for BC+ All Regions

By December 2016, the DHS plans to provide data to HMOs for members who received care under FFS during the MY while they were not enrolled in an HMO. This would allow HMOs to get credit for care provided while the members were enrolled in FFS. In prior years, HMOs have preferred to receive this data by December, so these FFS files will not reflect the full MY2016 data due to the associated time lags.

5. NCQA Data submission requirements - BC+ and SSI - All Regions

HMOs are required to submit the following for MY2016:

- a. Data from the NCQA Interactive Data Submission System (IDSS) site containing the required data elements and the denominator and numerators for each measure in the Data-filled Workbook (export), filled copy of this workbook in Excel format for local copy and for printing. HMOs must provide to the DHS the **denominators and numerators for each measure**.
- b. **Data Filled Workbook, including Audit Review Table (ART) format** downloaded from the NCQA IDSS site (with evidence that the auditor lock has been applied).
- c. The Audit Report produced by a NCQA Licensed HEDIS Auditor.
- d. 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.

6. Electronic submission requirements:

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

Other P4P requirements

1. Rotation of measures is not allowed. Each measure is to be calculated each year.
2. Health plans may apply the optional exclusions per HEDIS specifications for appropriate measures while submitting audited Medicaid HEDIS results to NCQA. HMOs have the option to include chart review data for HEIS measures that permit using the hybrid method.

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. HMOs may use the sample approach to calculate their results when permitted by HEDIS.
5. HMOs are asked to submit their final version of the encounter data for the Measurement Year by late June of the following year (the exact date will be specified separately). These data will be used by the DHS and its analytics vendor to calculate the results for HEDIS-like measures. Once the encounter data have been extracted for P4P results (aka “snapshot”), further changes to that data will not be feasible.

C. List of Participating HMOs

The following HMOs (18 in BC+, 10 in SSI) are participating in the MY2016 P4P initiative. This list is updated annually.

HMO	BC+	SSI
1. Care Wisconsin Health Plan		✓
2. Children’s Community Health Plan	✓	
3. Anthem	✓	✓
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. MercyCare Insurance Company	✓	
12. Managed Health Services	✓	✓
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 2016 P4P Measures and Withhold %

Medical Quality Measures and Withhold – 2.5% of medical capitation

Focus Area	MY2016 Measures	BC+ Withhold	SSI Withhold
Preventive / Screening	Breast Cancer Screen (BCS)	0.25%	0.30%
	Childhood Immunization (CIS)	0.25%	N/A
Chronic Illness	Comprehensive Diabetes Care - HbA1c Test	0.25%	0.30%
	HbA1c Control (<8.0%) - Pay for Reporting. This is a HEDIS measure, and its NQF # is 0575	0.125%	0.15%
	Controlling BP (CBP) - Pay for Reporting. This is a HEDIS measure, and its NQF # is 0018	0.125%	0.15%
Mental Health & Substance Abuse	Depression Medication (AMM - Continuation)	0.25%	0.30%
	AODA (IET - Engagement)	0.25%	0.30%
	Tobacco (Counseling only)	0.25%	0.30%
	Follow-up after inpatient discharge (FUH-q30)	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 and relevant codes)	1.25%	N/A

Appendix 2: Performance Measurement Methodology

The DHS utilizes two types of targets to determine P4P performance of HMOs:

- **Level Targets**
 - Level targets are based on NCQA’s Quality Compass (national Medicaid) percentiles, or State-wide averages, as applicable.
 - The Level targets aim to reward HMOs that perform at high average levels.
 - All HMOs have the same Level target for a measure.
- **Reduction in Error (RIE) Targets**
 - Also known as Degree of Improvement. The RIE targets require a baseline, established from past performance data.
 - The RIE targets aim to reward HMOs that make significant improvements over time, even if their levels do not meet targets.
 - The RIE methodology recognizes “diminishing returns” as performance improves. For example, moving 5 percentage points from 65% to 70% is not the same as moving 5% percentage points from 85% to 90%.
 - RIE targets are specific to each HMO for each measure, since they are based on the past performance of each HMO.

High / Medium / Low Performance Grid:

Each HMO’s earn-back for each measure will be based on a combination of its performance for the **Level** (high / medium / low), and **RIE** (high / medium / low), as shown below.

Appendix 3 provides specific cut-off points for the high/medium/low performance for Level and RIE for each applicable measure. The table below offers an overview of this methodology.

	Degree of IMPROVEMENT (RIE)		
Performance LEVEL	High	Medium	Low
High	100% earnback		
Medium	100% earnback	75% earnback	50% earnback
Low		50% earnback	No earnback*

- An HMO with “high” performance **Level** will get 100% of its withhold back, regardless of RIE.
- An HMO with a “high” **RIE** 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% Adjustment to “No Earn Back”**: For MY2016 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 by 1% or less, the HMO will be deemed to have met the lower threshold of the Medium target and will be eligible to earn back 50% of its withhold for that measure. This 1% adjustment does not apply to RIE targets. This adjustment will not be applicable when an HMO shows a decline in performance for that measure from the previous year.

Reduction in Error (RIE) Example:

The degree of improvement achieved by an HMO is defined as the percentage “Reduction In Error” (RIE) for a given measure in MY2016, compared to its baselines for that HMO. Consider the following example:

1. Assume an HMO’s score for a measure for MY2014 was 80%. This forms the RIE baseline, and its MY2014 “error” = 100% - 80% = 20 percentage points.
2. If an HMO attains a score of 82% in MY2016, then it would have achieved a 10% RIE, calculated as:
 - Percentage point increase from last year = 82% - 80% = 2 percentage points
 - This 2% represents one-tenth (or 10%) of the error in MY2014, which was calculate to be 20 percentage points, above.
3. Looking at the same data from a different point, if an HMO attains a score of 80% in MY2014, it can demonstrate a 10% RIE in MY2016 by attaining a score of 82% in MY2016, because:
 - MY2014 “error” = 100% - 80% = 20 percentage points.
 - 10% reduction in this error = (10% * 20%) = 2 percentage points.
 - 80% + 2% = 82%.
4. If the MY2016 score = 81%, then that HMO has improved its score by 1 percentage point, which is equal to a 5% reduction in error.

Mathematically, the % RIE for MY2016 = $\left\{ \frac{(MY2016 - MY2014)}{Error = (100 - MY2014)} * 100 \right\} \%$

A. Current Methodology Example – Level and RIE

The steps below demonstrate how Level and RIE ratings are calculated under the current methodology.

(a) Set the **MY2016 performance targets** for Level and RIE. Assume MY2014 National Medicaid Quality Compass¹ data for a given measure are:

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

Then, the MY2016 Level targets are:

- High Level target = 75th percentile score = 92%;
- Medium Level target between the 50th and 75th percentiles = 88% to 91.9%; and,
- Low Level cut-off is below 50th percentile = 87.9% or lower.

Also assume that the MY2016 RIE targets are:

- High target = 10% or more RIE
- Medium target = Between 5% and 9.9% RIE; and,
- Low RIE cut-off is 4.8% or lower RIE.

(b) When MY2016 performance data are available, first determine the **Level ratings** for each HMO for each measure, as shown in the following example.

Assume that the MY2014 and MY2016 scores of four HMOs for the measure being studied are:

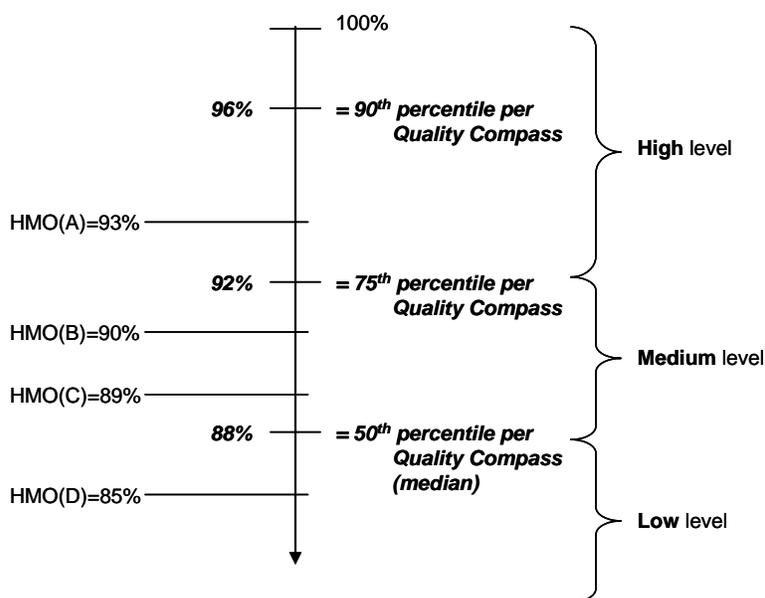
HMO	MY2014 Score	MY2016 Score
A	93%	93%
B	89%	90%
C	89%	89%
D	83%	85%

Then, compared to the MY2014 Quality Compass percentiles, each HMO's level of performance is rated as follows:

HMO	MY2016 Score	Level rating	Rationale
A	93%	High	Higher than 75 th percentile score
B	90%	Medium	Between 50 th and 75 th percentile
C	89%	Medium	Between 50 th and 75 th percentile
D	85%	Low	Below 50 th percentile

The diagram below provides a graphical representation of the above discussion.

¹ Quality Compass data for MY2014 refers to data reported by NCQA for Calendar Year 2014. NCQA released this data in 2015, and labeled it HEDIS 2015.



(c) Calculate the **% RIE** for each HMO for that measure (based on MY2014 scores).

HMO	MY2014 Score	MY2016 Score	MY2016 – MY2014	MY2014 Error	RIE rating	
A	93%	93%	0% points	7% points	$= (0/7) * 100 = 0\%$	Low
B	89%	90%	1% points	11% points	$= (1/11) * 100 = 9.1\%$	Medium
C	89%	89%	0% points	11% points	$= (0/11) * 100 = 0\%$	Low
D	83%	85%	2% points	17% points	$= (2/17) * 100 = 11.8\%$	High

(d) **Earn-back:** An HMO will earn back its withhold for a measure depending on the combination of its Level and RIE performance ratings, as shown in the example below:

HMO	MY2016 Level rating	MY2016 RIE rating	Withhold earned back
A	High	Low	100%
B	Medium	Medium	75%
C	Medium	Low	50%
D	Low	High	100%

Examples for AMB (ED visits) Measure:

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

Data for the following examples are hypothetical.

- MY2014 BC+ State average score (base) = 49.3 ED visits/1000 member months.
 - MY2016 BC+ **Level** targets =
High: HMO score \leq 50.5 ED visits / 1000 member months;
Medium: HMO score between 50.6 and 55;
Low: HMO score \geq 55.1 visits.
 - MY2016 BC+ **Reduction in Error (RIE)** =
High: HMO achieves a 5% or higher reduction of its base;
Medium: HMO achieves 3% to 4.9% reduction;
Low: HMO achieves 2.9% or lesser reduction.
1. Assume an HMO's MY2014 score for AMB (calculated by HP) is 55 (= baseline), and the MY2016 score is 50 visits.

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

2. Assume an HMO's MY2014 score is 56 (=baseline), and the MY2016 score is 53.

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

3. Assume an HMO's MY2014 score is 53 (=baseline), and the MY2016 score is 51.

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

4. Assume an HMO's MY2014 score is 54 (=baseline), and the MY2016 score is 53.

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

5. Assume an HMO's MY2014 score is 58 (=baseline), and the MY2016 score is 57.

RIE	Level	Earnback
$(58-57)/58 = 1.7\%$ = LOW	LOW	0% (zero) *

* Unless the "1% adjustment" applies.

B. Modifications related to ICD-10

ICD-10 has the potential to influence the results for P4P measures because the MY2016 results will be based on ICD-10, while the baselines and targets will be set using ICD-9 based MY2014 results. The table below shows which P4P measures are susceptible to ICD-10 implementation (based on advice from the DHS' HEDIS expert from MetaStar, the EQRO).

MY2016 measures potentially impacted by ICD-10	MY2016 measures not impacted by ICD-10
<ul style="list-style-type: none"> • AMB (ED visits) • HbA1c testing (diabetes) • FUH-30 (follow-up after discharge for mental health inpatient care) • IET – engagement (substance abuse) • PPC (2 measures - prenatal & postpartum care) • Tobacco cessation counseling 	<ul style="list-style-type: none"> • AMM (antidepressant medication management) • BCS (breast cancer screening) • CIS (childhood immunization) • ADV (2 measures - dental care for children & adults)

Reimbursement for the 2 P4R measures will not be affected by ICD-10 implementation.

After multiple discussions, the DHS and HMOs agreed to apply the following modifications to the P4P methodology in MY2016 and MY2017, in order to account for the potential impact of change from ICD-9 to ICD-10.

In order to avoid any confusion due to the way NCQA labels the Quality Compass data, the discussion below utilizes "CY201x" to denote the calendar year (Jan 1 – Dec 31) to which the baselines, results, targets, etc. pertain.

Step 1: Use the data from CY2014 HEDIS percentiles to set the Level targets (High, Medium and Low) for CY2016. This follows the current P4P methodology.

Step 2: When CY2016 HEDIS percentiles are published by NCQA in Fall 2017, compare the value of the CY2016 High Level target percentile (e.g., 75th) to the value of the next lower (e.g., 67th) percentile from CY2014. This comparison will help determine if the percentile curve has shifted between CY2014 and CY2016.

Decision Rule:

IF the value of the CY2016 **High** Level target percentile (e.g., 75th) is **at or below** the CY2014 value of the next lower percentile (e.g., 67th), it suggests a significant shift in the percentile curve between CY2014 and CY2016, and CY2016 targets should be **revised**. Otherwise, continue to use the targets based on CY2014 HEDIS percentiles.

Revised Target:

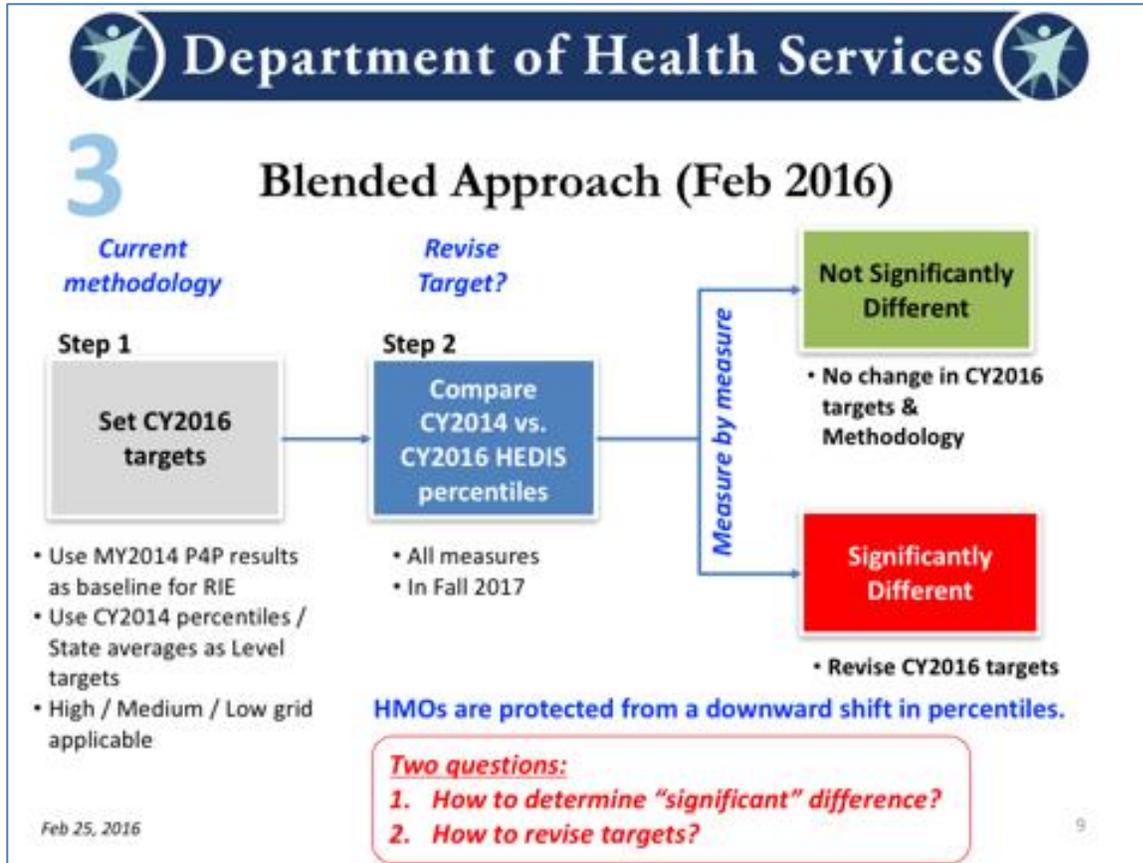
If there is a significant shift in the percentile curve, replace the original (CY2014) value of the Level target (e.g., 75th percentile) with CY2016 value of the same target percentile (e.g., 75th). In other words, the target percentile does not change due to a significant shift, but the the target value changes from that in CY2014 to the one from CY2016.

Additional notes

1. The above methodology protects HMOs from any significant downward shift of the percentile curves. Upward shifts in the percentile curves will not lead to revision of targets.
2. The High / Medium / Low performance grid will apply to Level and RIE targets in all situations.
3. Comparisons between CY2014 and CY2016 percentiles will focus only on the value of the High Level target, because the other targets and cut-off points cascade from it.
4. RIE baseline and targets remain unchanged (CY2014 data).
5. The 1% adjustment will continue, though the 10-member adjustment has been eliminated for MY2016 and beyond.

Presentation Slides

The following slides describe the methodology for identifying and making any needed adjustments to MY2016 Level targets due to the potential impact of ICD-10 implementation. They are excerpted from a larger presentation shared with HMOs on February 25, 2016.



Department of Health Services

Step 1: Set CY2016 targets using CY2014 data

DIFFERENT EXAMPLE: Start with CY2014 data for a measure

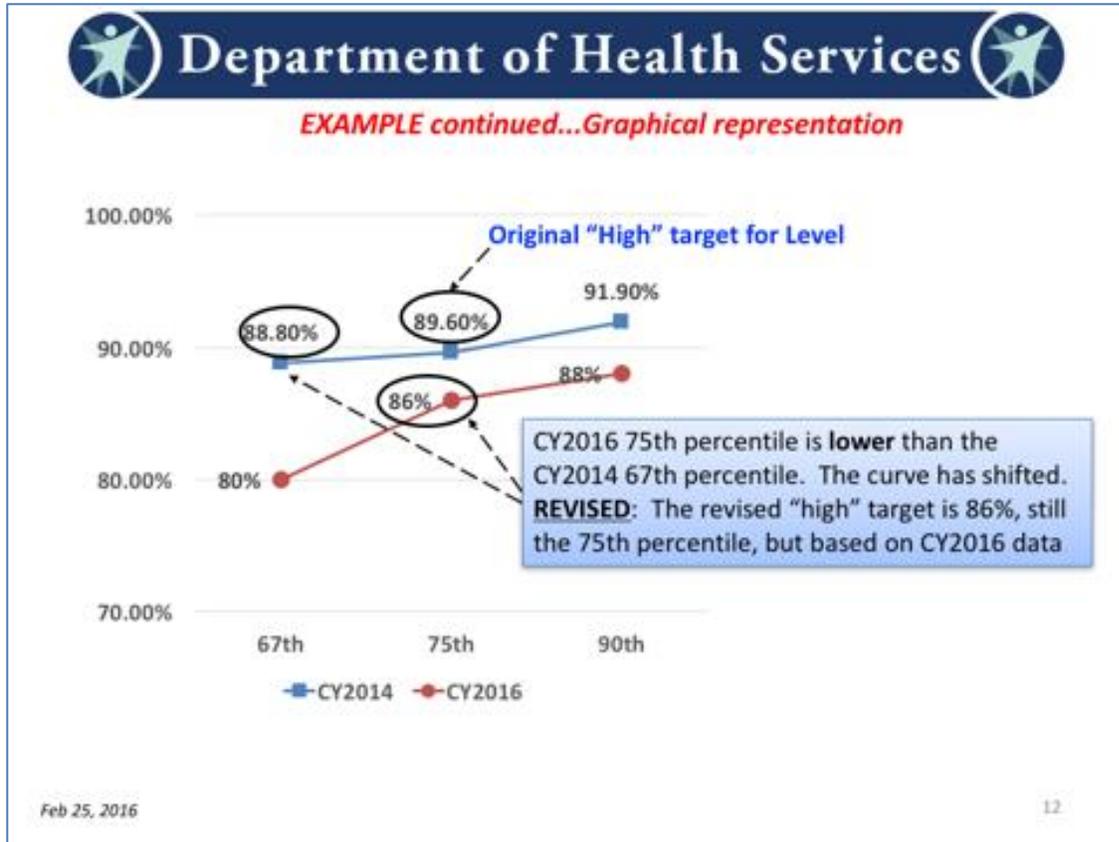
	State-wide Avg	50 th	67 th	75 th	90 th
CY2014	89.4%	86.2%	88.8%	89.6%	91.9%

Level: High target for CY2016 = CY2014 75th percentile value = 89.6%
 Medium target = 86.2% to 89.5%
 Low cut-off = 86.1% or lower

RIE: Assume an HMO's CY2014 performance = 79% (= baseline)
 "Error" = 100% - 79% = 21%
 High RIE target (@ 10% reduction) = 79% + (10% of 21%) = 81.1% or higher
 Medium target (@ 5% to 9.9% reduction) = 80.1% to 81%
 Low cut-off (@ below 5% reduction) = 80% or lower

This is the current methodology

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EXAMPLE continued...

Step 2: Compare CY2014 & CY2016 percentiles

Original "High" target

	State-wide Avg	50 th	67 th	75 th	90 th
CY2014	89.4%	86.2%	88.8%	89.6%	91.9%
CY2016	84%	79%	80%	86%	88%

Defining Significant Shift:

- Is CY2016 75th percentile value (e.g., 86%) at or below CY2014 67th percentile value (e.g., 88.8%)?
 - **Yes.** This suggests a "**significant shift**" in the percentiles curve.
 - **Revised** CY2016 Level target = CY2016 75th percentile value = **86%** instead of 89.6%.

This adjustment protects HMOs from a downward shift in CY2014 vs. CY2016 percentile curves. Upward shifts will not lead to modified targets.

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Example #2: IET

Original "High" target

	State-wide Avg	50 th	67 th	75 th	90 th
CY2014	13.5%	10.1%	13.1%	14.9%	18.9%
CY2016	16%	12%	15%	17%	21%

- In this example, the percentile curve has significantly shifted **Upwards**.
- There will be no change in CY2016 targets, to the HMOs' benefit.



Example #3: AMB (lower is better)

Original "High" target

	State-wide Avg	25 th	33 rd	50 th	67 th
CY2014	51.7 visits	50.7	55.2	61.9	68.4
CY2016	55.7 visits	55.2	58	63	70

- CY2016 25th percentile value (e.g., 55.2 visits) is "at or above" the CY2014 33rd percentile value (e.g., 55.2)
- This suggests a "significant shift" in the percentiles curve.
 - Revised High Level target = 55.2 visits instead of 50.7 visits.

Appendix 3: MY2016 HMO P4P Targets for BC+ and SSI

BC+ MY2016 P4P Targets													
MY2016 P4P Measures	2014 WI Avg	NCQA percentiles (CY2014)						Level Target			RIE Target		
		25 th	33 rd	50 th	67 th	75 th	90 th	High (shaded)	Med	Low	High	Med	Low
AMB - ED Visits (sans revenue code 0456) ²	51.7 visits	50.7	55.2	61.9	68.4	72.4	83.7	<= 50.7 (25 th p'tile)	50.8 – 55.2	>=55.3	>= 5%	2%-4.9%	<=1.9%
AMM (continuation) - Depression Rx	41.4%	31	32.4	34	38.3	40.5	48.4	>=40.5% (75 th p'tile)	34% – 40.4%	<=33.9%	>=5%	2%-4.9%	<=1.9%
Breast Cancer Screen (BCS)	66.9%	51.6	53.5	58.3	63.3	66	71.4	>=66% (75 th p'tile)	58.3% -65.9%	<=58.2%	>=10%	5%-9.9%	<=4.9%
CDC-HbA1c Test (Diabetes)	89.4%	83.2	84.3	86.2	88.8	89.6	91.9	>=89.6% (75 th p'tile)	86.2% - 89.5%	<=86.1%	>=10%	5%-9.9%	<=4.9%
CIS - Childhood Immunization	77.1%	70.1	71.9	75.5	78.5	79.4	82.8	>=79.4% (75 th p'tile)	75.5% – 79.3%	<=75.4%	>=10%	5%-9.9%	<=4.9%
FUH-30	75.5%	53.2	59.2	66.6	72.6	75.3	80.2	>=75.3% (75 th p'tile)	66.6% - 75.2%	<=66.5%	>=10%	5%-9.9%	<=4.9%
IET Engagement - AODA	13.5%	7.1	8.6	10.1	13.1	15	19	>=15% (75 th p'tile)	10.1% - 14.9%	<=10%	>= 5%	2% - 4.9%	<=1.9%
PPC – Prenatal care	82.7%	77.4	80.7	85.2	87.4	88.7	91.7	>=87.4% (67 th p'tile)	80.7% - 87.3%	<=80.6%	>=10%	5%-9.9%	<=4.9%
PPC - Post-partum care	67%	55.5	58.8	62.8	66.7	68.9	72.4	>=68.9% (75 th p'tile)	62.8% - 68.8%	<=62.7%	>=10%	5%-9.9%	<=4.9%
Tobacco (Counseling) ³	63.8%	N/A	N/A	N/A	N/A	N/A	N/A	>=67%	62% - 66.9%	<=61.9%	>=10%	5%-9.9%	<=4.9%
Dental – Children	40.2%	40.2	45.6	54.7	57.5	60.3	66.6	>= 45.6% (33 rd p'tile)	40.2% -45.5%	<=40.1%	>=7%	4%-6.9%	<=3.9%
Dental - Adults ⁴	27.7%	N/A	N/A	N/A	N/A	N/A	N/A	>=31%	25% -30.9%	<=24.9%	>=7%	2%-4.9%	<=1.9%

² AMB is a “reverse” measure – lower numbers are better than higher numbers

³ Tobacco – Level: High = 2014 average + (~10% of RIE); Medium = 2014 average – (~5% of RIE)

⁴ Dental – Adults – Level: High = 2014 average + (~4% of RIE); Medium = 2014 average – (~4% of RIE)

SSI MY2016 P4P Targets													
MY2016 P4P Measures	2014 WI Avg	NCQA percentiles (CY2014)						Level Target			RIE Target		
		25 th	33 rd	50 th	67 th	75 th	90 th	High (shaded)	Med	Low	High	Med	Low
AMB - ED Visits (sans revenue code 0456) ⁵	106.2 visits	N/A	N/A	N/A	N/A	N/A	N/A	<= 101	101.1 - 111	>=111.1	>= 5%	2% - 4.9%	<=1.9%
AMM (continuation) - Depression Rx	41.1%	31	32.4	34	38.3	40.5	48.4	>=40.5% (75 th p'tile)	34% - 40.4%	<= 33.9%	>=5%	2%-4.9%	<=1.9%
Breast Cancer Screen (BCS)	62.1%	51.6	53.5	58.3	63.3	66	71.4	>=66% (75 th p'tile)	58.3% - 65.9%	<=58.2%	>=10%	5%-9.9%	<=4.9%
CDC-HbA1c Test (Diabetes)	86.3%	83.2	84.3	86.2	88.8	89.6	91.9	>=88.8% (67 th p'tile)	86.2% - 88.7%	<=86.1%	>=10%	5%-9.9%	<=4.9%
FUH-30	63.2%	53.2	59.2	66.6	72.6	75.3	80.2	>=66.6% (50 th p'tile)	59.2% - 66.5%	<=59.1%	>=10%	5%-9.9%	<=4.9%
IET Engagement - AODA	18.3%	7.1	8.6	10.1	13.1	15	19	>=15% (75 th p'tile)	13.1% - 14.9%	<=13%	>=5%	2%-4.9%	<=1.9%
Tobacco (Counseling) ⁶	69.8%	N/A	N/A	N/A	N/A	N/A	N/A	>= 72.8%	68.3% - 72.7%	<=68.2%	>=10%	5%-9.9%	<=4.9%

Note:

P4R HEDIS measures (no targets for MY2016) for both, BC+ and SSI:

1. HbA1c Control (<8.0%)
2. Controlling BP (CBP)

⁵ AMB is a "reverse" measure – lower numbers are better than higher numbers. Level: High = ~0.95*MY2014 average; Medium = ~1.05*MY2014 average

⁶ Tobacco – Level: High = 2014 average + (~10% of RIE); Medium = 2014 average – (~5% of RIE)

Appendix 4: HEDIS-Like and Non-HEDIS Measures

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

- **Measure description:** The % of members 2-20 years of age who had at least one dental visit during the measurement year.
- **Specifications:** The DHS will use the 2017 HEDIS specifications for Annual Dental Visits (ADV). Dental services can be provided by a dental practitioner or a physician. For this measure, a dental practitioner 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 – Adults (BC+ Regions 5 and 6 Only)

- **Measure description:** The % of members 21-64 years of age who had at least one dental visit during the measurement year.
- **Denominator:**
 - Age: from 21 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) or a physician during the measurement year. A member had a dental visit if a claim or encounter submitted contains any code listed below:
 - CPT Codes: 70300, 70310, 70320, 70350, 70355, 99188.
 - CDT Codes: D0120-D0999; D1110-D1999; D2140-D2999; D3110-D3999; D4210-D4999; D5110-D5899; D6010-D61999; D6205-D6999; D7111-D7999; D8010-D8999; D9110-D9975, D9999.
 - CDT Codes Excluded: D0145, D1353, D5900-D5999, D9985-D9987.
 - CDT Codes removed from the 2016 Dental Procedure Code Set will not be included in the numerator.

C. Emergency Room Utilization

- **Measure description:** Number of Emergency Department visits per 1000 member months; this is a utilization measure.
- **Specifications:** The DHS will use the 2017 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.
- **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 **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.
- **Exclusions:** The measure does not include mental health or chemical dependency services. The exclusions are defined in the HEDIS 2017 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:** Members diagnosed as tobacco users that received tobacco cessation counseling during the measurement year.
- **Denominator:** The eligible population:
 - Age: Members 12 years of age or older during the measurement year for BC+ members. Members 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, including sub-codes of any specified code.
 - ICD-10-CM codes in MY2015 Tobacco Measure – ICD-10 Pregnancy Status Codes.

Please click on the enclosed Excel file below (MY2016 Tobacco Cessation ICD-10 Codes) for details.



MY2016 P4P Tobacco
Cessation ICD-10 Codes

- Tobacco Use Disorder Complicating Pregnancy: ICD-9-CM Diagnosis: 649.01 (including sub-codes) 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:
 - ICD-9-CM code 305.1 (including sub-codes) 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.

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 (and subcodes) as primary, secondary, tertiary or fourth diagnosis code	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 Methodology

The DHS would like to reward BC+ and SSI HMOs that demonstrate high quality performance 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 Level or RIE 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 (i.e., excluding members in the denominators of measures that were not applicable), 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 four HMOs 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: Submitting Supplemental Data

This Appendix provides guidance to the HMO staff for submitting supplemental chart review and / or administrative data only for the P4P measures that are calculated by HP. The table below shows the method that an HMO must follow to submit different types and volumes of data.

	Type of Data	
	Chart / Medical review data	Administrative data
50 or fewer records for a measure	Direct submission to DHS Quality Team (see #A below)	
More than 50 records for a measure	Medical record encounter submission process (see #B below)	Regular encounter submission process (not described in this Guide)

Each method is described in further detail below.

A. Direct Data Submission to DHS Quality Staff

This section outlines the process for HMOs to submit member-level data directly to the Quality Staff at DHS, to supplement the preliminary P4P results calculated by HP (AMB, Tobacco, Dental care for Adults and Children in MY2016). Supplemental data are not accepted for HEDIS measures reported by HMOs' HEDIS auditors.

Volume

This Appendix pertains only to submission of **50 or fewer supplemental records for a measure** by an HMO. If an HMO plans to submit more than 50 records for a measure, the HMO is asked to contact DHS as soon as possible; such a large # of records should be submitted directly through the encounter data system, and not using the process outlined in this Appendix.

Intent to submit

HMOs intending to submit supplemental member-level data should notify DHS via email (to mitzi.melendez@wi.gov) **within 1 week of receiving the preliminary results calculated by HP**.

The email should include:

- A list of the measures for which the HMO intends to submit supplemental data
- Target populations (BC+ and/or SSI)
- Estimated # of records the HMO plans to submit for each measure.

Specific submission requirements

HMOs submitting member-level data to supplement their P4P results **must** comply with all of the following requirements:

1. Submit member-level data saved as separate Excel 2010 worksheets for BC+ and SSI populations. An HMO submitting data for multiple measures for both populations must submit one excel file with different worksheets clearly labeling the measure and the population, e.g., AMB for BC+, AMB for SSI, Tobacco for SSI, Dental-Children, Dental-Adult, etc.
2. Place all member-level excel files in each HMO's SFTP folder and send an email to VEDSHMOSupport@wi.gov and mitzi.melendez@wi.gov to notify DHS that the files have been uploaded with the name(s) of the files.
3. Send all member-level files to DHS **by the date specified in Appendix 7**. DHS will not be able to review files submitted after the due date.
4. Provide electronic copies of the chart data included in the supplemental member-level files made available to DHS.
 - HMOs submitting chart data to DHS must post the data in the SFTP folder at the same time as the member-level data spreadsheet and also include the name of the file in the email to VEDS HMO Support and Mitzi Melendez, notifying them that the files are available for download.
 - HMOs need to submit separate files with chart data for the different measures and populations following the same naming convention as the member-level detail files (see above).

The following section lists the required **data elements** for each measure for which supplemental data can be submitted:

AMB – Emergency Department Utilization

1. Member's Medicaid ID
2. Member's Date of Birth - MM/DD/YYYY
3. Whether the member is already included in HP's denominator? – Yes or No
4. Should member be removed from the denominator? – Yes or No
5. Does the HMO have different member months for this member than HP? – Yes or No
6. Number of months the member was enrolled in the HMO during the measurement year - MM (member months)
 - Example: If a member was enrolled for four months as a BadgerCare Managed Care member and eight months as a SSI Managed Care member, please include "04" in the BadgerCare Plus AMB spreadsheet and "08" in the SSI AMB spreadsheet for your HMO.
7. Procedure code for the Emergency Department (ED) visit (if applicable) – In the HEDIS AMB ED value set or in the ED procedure code value set
8. Place of service for the ED visit (if applicable) – In the HEDIS AMB ED place of service value set
9. Revenue code for the ED visit (if applicable) – In the HEDIS AMB ED value set
10. Date of ED visit – MM/DD/YYYY
11. Is the ED visit In HP's numerator? – Yes or No
12. Should ED visit be removed from the numerator? – Yes or No
13. Principal diagnosis code for mental health of chemical dependency during ED visit - In the HEDIS mental and behavioral disorders value set; if not applicable, write "NA".

14. Procedure code of psychiatry during ED visit - In the HEDIS psychiatry value set; if not applicable, write "NA".
15. Procedure code of electroconvulsive therapy during ED visit - In the HEDIS electroconvulsive therapy value set; if not applicable, write "NA".
16. Procedure code of alcohol or drug rehabilitation or detoxification during ED Visit – In the HEDIS AOD rehab and detox value set; if not applicable, write "NA".
17. ICN# for ED visit - If this information comes from chart data, please write "Chart" and send electronic copies of the chart data in a separate file.
 - Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.

Tobacco

1. Member's Medicaid ID
2. Member's date of birth - MM/DD/YYYY
3. Member's age in Measurement Year – YY
 - Note: For example, if a member turned 50 in the measurement year, please send 50.
4. Is the Member in HP's denominator? – Yes or No
5. Date the Member enrolled in the HMO - MM/DD/YYYY
6. If Member disenrolled from HMO during the Measurement Year (MY), submit the HMO disenrollment date – MM/DD/YYYY; if not applicable, write "NA".
7. Months of continuous BadgerCare Plus or SSI eligibility in MY - MM
8. Was the Member enrolled in the HMO on Dec. 31, 2014? - Yes or No
9. Diagnosis code that identifies Member as tobacco user – ICD-9 CM or ICD-10 tobacco addiction diagnosis code
 - Note: See tobacco cessation specifications in Appendix 4 for a list of qualifying diagnosis codes.
10. Date of tobacco diagnosis - MM/DD/YYYY
11. ICN # for encounter with tobacco cessation diagnosis – If this information comes from chart data, please write "Chart" and send electronic copies of the chart data in a separate file.
 - Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.
12. Should the member be removed from the denominator? – Yes or No.
13. Diagnosis of history of tobacco use – ICD-9-CM or ICD-10-CM codes. If not applicable, write "NA".
 - Note: See tobacco cessation specifications in Appendix 4 for a list of qualifying diagnosis codes.
14. Pregnancy diagnosis – ICD-9-CM or ICD-10-CM codes. If not applicable, write "NA".
 - Note: See tobacco cessation specifications in Appendix 4 for a list of qualifying diagnosis codes.
15. ICN # for tobacco exclusion diagnosis – If this information comes from chart data, please write "Chart" and send electronic copies of the chart data in a separate file.

- Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.
16. Procedure code for the encounter in which tobacco cessation counseling was provided – If not applicable, write “NA”.
 - Note: See tobacco cessation specifications in Appendix 4 for a list of qualifying procedure codes.
 17. Diagnosis code to identify that tobacco cessation counseling was addressed by provider during the encounter referenced in #15 – ICD-9 CM or ICD-10 tobacco addiction diagnosis code.
 - Note: See tobacco cessation specifications in Appendix 4 for a list of qualifying diagnosis codes.
 18. HCPCS code for the encounter in which tobacco cessation counseling was provided – If not applicable, write “NA”.
 - Note: See tobacco cessation specifications in Appendix 4 for a list of qualifying HCPCS codes.
 19. Date of service when tobacco cessation counseling was provided - MM/DD/YYYY
 20. ICN # for tobacco cessation counseling encounter – If this information comes from chart data, please write “Chart” and send electronic copies of the chart data in a separate file.
 - Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.

Annual Dental Visit for Children

1. Member’s Medicaid id
2. Member’s date of birth - MM/DD/YYYY
3. Member’s age in Measurement Year – YY
 - Note: For example, if a member turned 5 in the measurement year, please send 5.
4. Is the Member in HP’s denominator? – Yes or No
5. Date the Member enrolled in the HMO - MM/DD/YYYY
6. If Member disenrolled from HMO in MY, submit the HMO disenrollment date – MM/DD/YYYY; if not applicable, write “NA”.
7. Months of continuous BadgerCare Plus eligibility in MY - MM
8. Was the Member enrolled in the HMO on Dec. 31, 2014? - Yes or No
9. Procedure code to identify qualifying dental encounter in MY– From HEDIS dental visits value set; if not applicable, write “NA”.
10. Dental code to identify qualifying dental encounter in MY– From HEDIS dental visits value set; if not applicable, write “NA”.
11. Date of service for qualifying dental encounter in MY - MM/DD/YYYY
12. ICN # for qualifying dental encounter – If this information comes from chart data, please write “Chart” and send electronic copies of the chart data in a separate file.

13. Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.

Annual Dental Visit for Adults

1. Member's Medicaid ID
2. Member's date of birth - MM/DD/YYYY
3. Member's age in Measurement Year – YY
 - Note: For example, if a member turned 50 in the measurement year, please send 50.
4. Is the Member in HP's denominator? – Yes or No
5. Date the Member enrolled in the HMO - MM/DD/YYYY
6. If Member disenrolled from HMO in MY, submit the HMO disenrollment date – MM/DD/YYYY; if not applicable, write "NA".
7. Months of continuous BadgerCare Plus eligibility in MY - MM
8. Was the Member enrolled in the HMO on Dec. 31, 2014? - Yes or No
9. Procedure code to identify qualifying dental encounter in MY– If not applicable, write "NA".
 - Note: See Annual Dental Visit for Adults specifications in Appendix 4 for a list of qualifying procedure codes.
10. Dental code to identify qualifying dental encounter in MY– If not applicable, write "NA".
11. Note: See Annual Dental Visit for Adults specifications in Appendix 4 for a list of qualifying dental codes.
12. Date of service for qualifying dental encounter in MY - MM/DD/YYYY
13. ICN # for qualifying dental encounter – If this information comes from chart data, please write "Chart" and send electronic copies of the chart data in a separate file.
 - Note: ICN numbers are provided by DHS to HMOs in the weekly encounter response file for every encounter that was processed by HP. Please do not submit your own internal claim number.

B. Medical Record Encounter Guidance (X12 837)

This section provides guidance for 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. This supplemental data may pertain only to that collected through chart review or other means, and not encounter data.

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 2016

Updated 3-15-2016

Wisconsin Medicaid HMO P4P (BC+, SSI) Timeline During CY2016 for MY2015 results and MY2017 targets

