Measurement Year (MY) 2017
Hospital Pay-for-Performance (P4P) Guide

Contents

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Measurement Year (MY) 2017 Hospital P4P – Overview

The time frame for measurement year (MY) 2017 is from April 1, 2016 through March 31, 2017. There are two components to the Fee-for-Service (FFS) Hospital Pay-for-Performance (P4P) program: the Assessment P4P program and the Withhold P4P program. These components are measured independently from each other and results in one program have no bearing on results in the other. Performance for all P4P initiatives is measured annually, not each quarter. The payments for the MY 2017 P4P program will be made before December 31, 2017 per the Wisconsin Medicaid State Plan (Inpatient State Plan sections 6610 and 6620, Outpatient State Plan section 4300).

The goal of the P4P program is to promote and recognize high quality patient care at all hospitals throughout Wisconsin. The Department of Health Services (DHS) believes that through high quality patient care, it will be possible to increase positive health outcomes and improve the lives of all Wisconsin residents. Therefore, this program is an integral part of the overall quality initiative at DHS. DHS encourages all hospitals to actively participate in the P4P program and to work toward fully meeting the performance targets that are set for each measure, as well as maintaining high performance in all areas, including those not covered by this program.

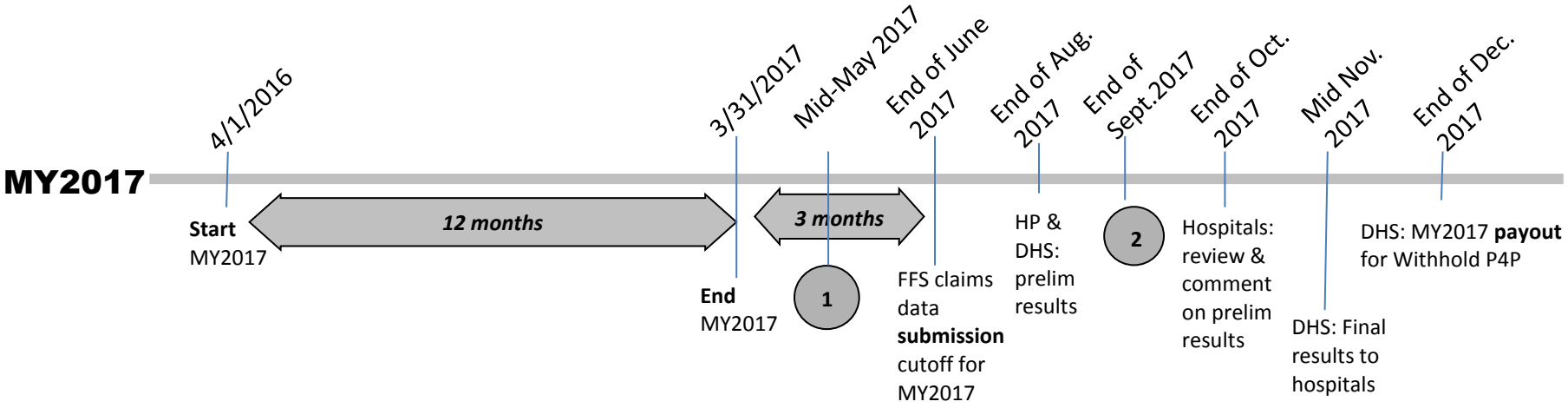
The purpose of this Guide is to provide an overview of the program, its components, the methodology, and the measures, to those who have an interest in the program. As new policies regarding the P4P program become active, this document will be updated to reflect the most current information. Additionally, with each new measurement year, this document will receive a full review to ensure that all information contained within is relevant to the given measurement year. Any questions related to the topics covered by this Guide or the P4P program in general should be directed to the DHS contacts listed on the previous page. Additionally, please sign up for the P4P mailing list by contacting one of the DHS contacts listed on the previous page and asking to be added to the list. This list will be used to keep providers up-to-date on P4P program developments.

The rest of this Guide is devoted to describing the two P4P programs in detail. This includes: a timeline for each program, an overview of each program, a description of the performance measures being used, the performance targets for each measure, and examples of the methodology that will be used to calculate the results and payments.

MY 2017 P4P Timelines

Hospital <u>Withhold</u> P4P Timeline – MY 2017

Not to scale



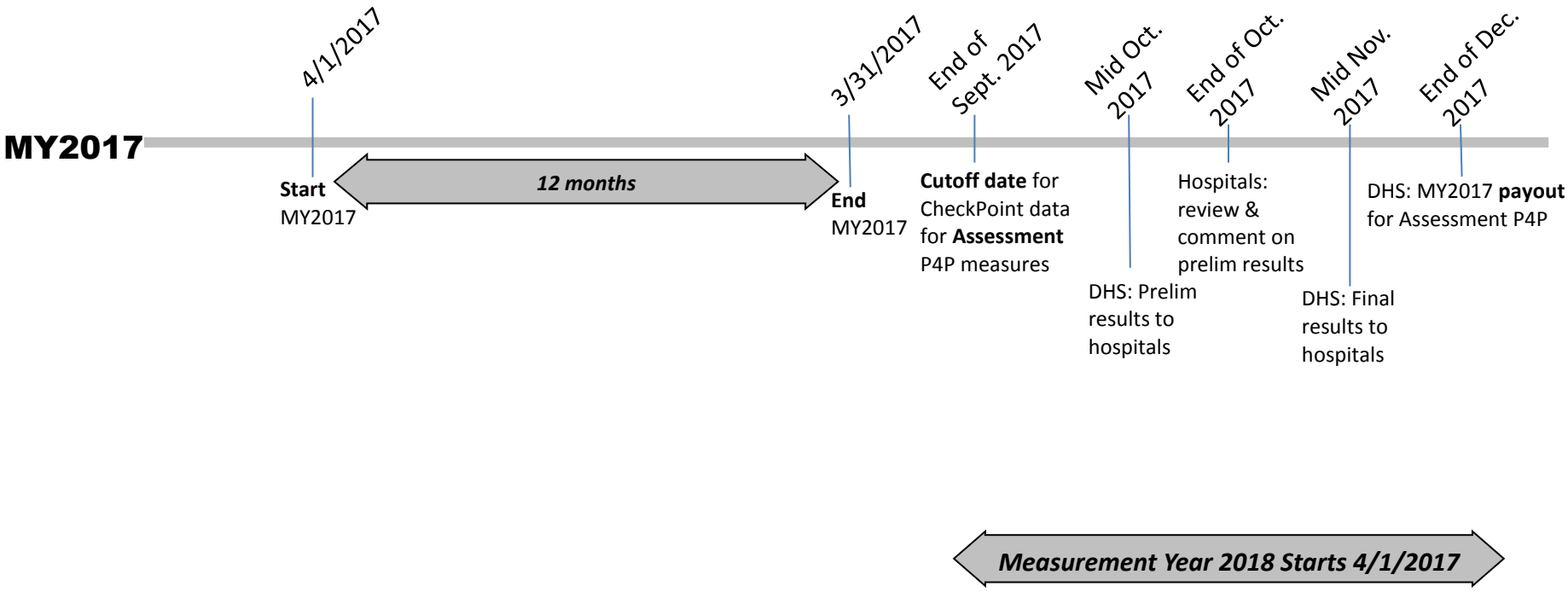
1 = *Healthcare Personnel vaccination data pull by DHS*

2 = ***Cut-off date*** *for CheckPoint data for* ***Withhold*** *P4P measures*

Measurement Year 2018 Starts 4/1/2017

Hospital <u>Assessment</u> P4P Timeline –MY 2017

Not to scale



Data Submission and Validation Process

Baselines for Measurement Years
For several measures, the baselines for MY 2017 were set using data from MY 2015 which was April 1, 2014 through March 31, 2015. The chart below shows the timeframes for using results of a previous MY as baselines for a future MY, including the time lag.

Measurement Year	MY 2014	MY 2015	MY 2016	MY 2017
Date Range	5/15/2013 – 3/31/2014	4/1/2014 – 3/31/2015	4/1/2015 – 3/31/2016	4/1/2016 – 3/31/2017
Baseline	Claims between 4/1/11-3/31/12	MY 2013	MY 2014	MY 2015

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

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

Please also see the timelines on pages 3 and 4 for additional information about the schedules for both of the P4P programs**.** The timelines provide a broad overview of each P4P program, with general timeframes for when certain aspects of the programs will be completed. Note that these timelines do not include specific dates for when items will be completed; this was done intentionally to account for possible variances in data availability. As specific dates become available, announcements will be sent to the P4P mailing list. Please see page 2 for instructions on how to sign up for the P4P mailing list.

MY 2017 Assessment P4P Program

The Assessment P4P program **only** applies to inpatient admissions. The Assessment P4P provides for payments to acute care, children's, and rehabilitation hospitals located in Wisconsin. Critical access hospitals are not included in the HAP4P program because they already receive cost-based reimbursement. Psychiatric hospitals are not included because they are paid under a different reimbursement methodology in the State Plan.

The program is funded by $5 million which is set aside from the hospital assessment levy for P4P by the State. The hospital assessment raises funds from hospitals that are then expended on this P4P program as well as access payments and other supplemental payments. The P4P funds are then split among the measures used during the MY (which will be described in detail on the next several pages).

The Department determines the payment amounts and recipients for each measure separately. The more hospitals that meet the performance targets, the less money distributed to each individual hospital. The opposite is also true; if very few hospitals meet the targets for one or more of the measures, the payouts for those measures will be higher for those hospitals that meet the targets. With the understanding that payouts to hospitals by measure may vary, the entire $5 million will be paid out regardless of how many or how few hospitals meet the performance targets. The State does not keep any funds from the Assessment P4P program.

Payment will be made by the December 31 following the conclusion of the measurement year. For MY2017 the payment will be made by December 31, 2017.

The three measures and allocation of money for MY 2017 are as follows:

Measure	MY 2017	Share Division
Pay-For-Performance		
1. **Perinatal Measures**: 2 Sub-measures as follows: a) Cesarean Section b) Newborn Screening Turnaround Time	**$ 2 million** Target = statewide average	100% = 2 of 2 75% = 1 of 2
2. Patient Experience of Care	**$1.5 million** Target = statewide average	100% = 3 of 10
3. Central-line Associated Blood Stream Infection (CLABSI)	**$1.5 million** Target = statewide average	100%= statewide avg.

Assessment P4P Measures

This chart shows the three assessment measures for MY2017, their individual components, where the data is sourced from, and what the measurement period is for each.

Measure	Data Source	Measurement Period
1. Perinatal Measures a. Cesarean Section b. Newborn Screening Turnaround Time	CheckPoint	4/1/2016 to 3/31/2017*
2. HCAHPS a. Patients Ranked Hospital High b. Definitely Recommend Hospital c. Doctors Always Communicated Well d. Nurses Always Communicated Well e. Patients Always Received Help As Soon as They Wanted f. Staff Always Explained Medications g. Pain Always Well Controlled h. Always Quiet at Night i. Room Was Always Clean j. Staff Provided Discharge Instructions	CheckPoint	10/1/2015 to 9/30/2016*
3. Central Line Blood Stream Infections- CLABSI	CheckPoint	4/1/2016 to 3/31/2017*

**Dates reflect the data scheduled to be available on CheckPoint on 9/30/2017. These dates are subject to change if the data for these timeframes is not available to WHA.*

Assessment P4P State Averages

This chart shows what the baseline statewide averages are for each of the three assessment measures, and their component measures in the case of the perinatal measures and HCAHPS. These averages are what a hospital's performance will be compared to for a given measure and these averages serve as a guideline for what a hospital should target. In order to receive a payment for the given Assessment P4P program measure, a hospital must equal or outperform the averages published on this page, on a sufficient number of measures.

Measure	Numerator	Denominator	State Average	Positive or Negative Measure
Perinatal Measures				
Cesarean Section (PC-02)	Not available from CheckPoint	Not available from CheckPoint	22%	Negative**
New Born Screening Turnaround Time	Not available from CheckPoint	Not available from CheckPoint	99%	Positive
HCAHPS (Patient Experience of Care)		**Statewide Average (n=55 hospitals)**		All Sub-measures are positive.
Patients Ranked Hospital High		76%		
Definitely Recommend Hospital		75%		
Doctors Always Communicated Well		82%		
Nurses always communicated well		82%		
Patients always received help as soon as they wanted		70%		
Staff always explained medications		68%		
Pain always well controlled		71%		
Always quiet at night		63%		
Room was always clean		77%		
Staff Provided Discharge Instructions		89%		
Central Line Associated Blood Stream Infections (CLABSI): Statewide Average Data:10/1/2014- 9/30/2015	Numerator data not available from Checkpoint	Denominator data not available from Checkpoint	0.381	Negative**

*= including all hospitals with > 0 in the denominator

**= Negative means that a hospital must score lower than the published average.

Assessment P4P Measures Detail

This page provides a more detailed description of the Assessment P4P program measures.

1. Perinatal Measures ($2 million):

There are two components to this measure, as shown below:

a. Cesarean Section (PC-02)
b. Newborn Screening Turnaround Time

Both components for this measure are reported through the WHA (Wisconsin Hospital Association)CheckPoint website. For this measure the goal is to score better than the published statewide average. State baseline averages were calculated using data reported on CheckPoint as of March 14, 2016 which covered the time period 10/1/2014 through 9/30/2015. A hospital can earn a 100% "full share" of the $2 million by equaling or outperforming the statewide average on both of the sub-measures, or a 75% "partial share" of the $2 million by equaling or outperforming the statewide average on one of the sub-measures.

2. Patient Experience of Care Survey (HCAHPS) ($1.5 million):

This measure is made up of 27 survey questions from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) that cover the entire hospitalization experience. These are grouped into the ten components of the measure. The data is reported to CheckPoint. For this measure the goal is to score equal to or greater than the published statewide average. State baseline averages were calculated using measurement year 2015 data (MY2015 results). A hospital can earn a 100% "full share" of the $1.5 million by scoring at or above the statewide average on at least three of the ten sub-measures.

3. Central Line Associated Blood Stream Infections (CLABSI) ($1.5 million):

The CLABSI surveillance protocol (http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf) within the National Healthcare Safety Network (NHSN) provides the definitions and reporting structure for this measure. This measure uses a standardized infection ratio to compare a hospital's results against the state average. Data for this measure is reported to CheckPoint. For this measure the goal is to score equal to or less than the published statewide average. The State baseline average was calculated using data reported on CheckPoint as of March 14, 2016 which covered the time period 10/1/2014 through 9/30/2015. A hospital can earn a 100% "full share" of the $1.5 million by equaling or outperforming the statewide average for this measure.

Reporting notes/resources:

- Data must be entered into NHSN and rights conferred to the WHA group (ID 27080) for measure compliance. Data are then loaded onto CheckPoint for evaluation.
- All NHSN reporting rules should be followed, including but not limited to, indicating CLABSI surveillance in monthly reporting plans, entering monthly numerators and denominators (device days and patient days) in all eligible units, and reporting only primary BSIs as CLABSIs.
- The SIR is only calculated when the number of predicted CLABSIs is ≥ 1 to help enforce a minimum precision criterion. In cases where the SIR is not calculated, a + will be indicated on CheckPoint.
- Surveillance protocol: http://www.cdc.gov/nhsn/pdfs/pscmanual/4psc_clabscurrent.pdf

- Surveillance resources: http://www.cdc.gov/nhsn/acute-care-hospital/clabsi/index.html
- Contact Jill Hanson, Quality Improvement Manager at the Wisconsin Hospital Association, at 608-268-1842 or jhanson@wha.org for CheckPoint questions.
- Contact Ashlie Dowdell, HAI Surveillance Coordinator at the Wisconsin Division of Public Health, at 608-266-1122 or ashlie.dowdell@wi.gov for NHSN questions.

Assessment P4P Methodology

This paragraph describes the Assessment P4P program methodology.

The Department determines the payment amounts and recipients for each measure separately. The Department calculates the "full share" payment amount for a measure by dividing the budget for the measure by the sum of ("partial" and "full") shares earned by hospitals; the "partial share" payment amount is the "full share" payment amount multiplied by the "partial share" percentage. For example, if, for the Perinatal Measure, 25 hospitals qualify for "full shares" and 20 hospitals qualify for 75% "partial shares," the sum of the shares is (25 +(0.75 x 20)) = 40, so the 25 hospitals each earn $50,000 ($2 million /40) while the 20 hospitals each earn $37,500 ($50,000 x 0.75).

Please see the following page for another detailed example of the methodology.

Assessment P4P Methodology Example

This chart shows an example of the Assessment P4P methodology, using the perinatal measures.

Step	Example

• Set the **targets** for each of the performance-based Birth Measures:
  • Cesarean Section
  • Newborn Screening Turnaround Time
	Assume beginning with **70** hospitals in scope for this measure.

• At the end of the MY, determine the number of hospitals **reporting** all required perinatal measures. Hospitals reporting all required perinatal measures will be eligible to participate in the perinatal P4P fund distribution.	**Assume 50** out of 70 hospitals report all required perinatal measures. Only these 50 hospitals are eligible to participate in the perinatal P4P incentive.

• Determine how many hospitals from Step 2 **meet** exactly:
  • Zero perinatal targets = not eligible for perinatal P4P money
  • 1 perinatal target= 75% share
  • 2 perinatal targets= 100% share
	Assume: of the 50 hospitals reporting all perinatal measures:
	• 20 hospitals meet 0 targets
	• 10 hospitals meet 1 target
	• 20 hospitals meet 2 targets

• Calculate individual hospital **points** and total points for hospitals meeting:
  • Zero perinatal targets = $0 from perinatal P4P = 0 points each
  • Exactly 1 target = 75% of incentive = 0.75 points each
  • 2 targets = 100% of incentive = 1 point each
	• 20 hospitals get 0 points = $0 for perinatal; total points for this group = 20*0 = 0;
	• 10 hospitals get 0.75 points; total points = 10*0.75 = 7.5;
	• 20 hospitals get 1 point; total points = 20*1 = 20.
	
	Total points for all hospitals
	= (20*0) + (10*0.75) + (20*1) = 27.5 points

• Determine percent **share** in incentive money for hospitals earning 75% of the incentive, and those earning 100% of the incentive. Calculate the incentive money for each hospital.	• **Share** of the 10 hospitals that get 0.75 points each, in the total perinatal $ = $\frac{7.5\,\text{points}}{27.5\,\text{points}} = 27.27\%$ of $2 million = $545, 454. Divided equally among the 10 hospitals, each gets $54,545. • **Share** of the 20 hospitals that get 1 point each = $\frac{20}{27.5} = 72.72\%$ of $2 million = $1,454,546. Divided equally among the 20 hospitals, each gets $72,727.

MY 2017 Withhold P4P Program

The Withhold P4P program applies to **both** inpatient and outpatient claims. The Withhold P4P program applies to acute care, children's, critical access, and psychiatric hospitals. Unlike the Assessment P4P program, critical access and psychiatric hospitals do participate in this P4P program but rehabilitation and long term care hospitals do not.

Hospital Type	Assessment P4P	Withhold P4P
Acute Care	Yes	Yes
Children's	Yes	Yes
Critical Access	No	Yes
Psychiatric	No	Yes
Rehabilitation	Yes	No
Long Term Care	Yes	No

The withhold program is funded by a 1.5% withhold on all fee-for-service FFS claims. This means that hospitals receive 98.5% of the payment they would otherwise expect and the other 1.5% is put into the Withhold P4P pool. The total withhold pool amount varies from year to year, given that each year has a unique number of claims subject to the withhold. All withheld funds are paid out through the Withhold P4P program; the state does not retain any withheld funds. All funds collected via the withhold are distributed through the methodology described later in this Guide.

There are ten measures being used for the Withhold P4P program in MY 2017. There are eight Pay-for-Performance measures. There are two Pay-for-Reporting measures. The measures will be described in detail on the following pages.

Each measure is weighted equally when it comes to earning back funds. For example, a hospital with four measures could receive up to 25% of their withheld funds for each measure. Individual measures can yield 0%, 50%, 75%, or 100% earn-back. Earn-back can be achieved in two ways: outperforming the average ("performance level") and improving over past performance ("degree of improvement"). Some measures use one or the other of these methods; others use a combination of the two. Any money not earned back is placed into a bonus pool that is paid out to high performing hospitals. Complete methodology for the withhold P4P program, both for the earn-back and the bonus, is described later in this Guide.

Claims data is used to calculate the total withhold pool. Claims with inpatient dates of discharge and outpatient dates of service April 1, 2016 through March 31, 2017 are used to calculate the pool for MY 2017.

Payments will be made by the December 31 following the conclusion of the measurement year. For MY 2017 the payment will be made by December 31, 2017.

Withhold P4P Measures

This chart shows: the 10 measures, what types of hospitals they are applicable to, the data source, whether performance level and/or degree of improvement methodology applies to the measure, the baseline period, and the measurement period.

Measure	Applicable to				Data Source	Performance Level	Degree of Improvement (DOI)	Baseline Period	Measurement Period
	Acute Care	Critical Access	Psych	Children's					
1. **30-day hospital readmission** - Specifications developed by DHS. No case mix adjustment.	✓	✓	×	✓	DHS fee-for-service claims data	✓ (WI average)	✓	MY 2015 results	MY 2017
2. **Mental health follow-up visit within 30 days** of discharge for mental health inpatient care. Specifications developed by DHS. No case mix adjustment. Pre/post comparison only.	✓	✓	✓	✓	DHS fee-for-service claims data	✓	✓	MY 2015 results	MY 2017
3. **Asthma care for children (Home Management Plan of Care only).**	×	×	×	✓	Joint Commission	✓ (nat'l average)	✓	2014 data from 2015 Annual Report	MY 2017
4. **Healthcare Personnel (HCP) influenza vaccination** – as reported to NHSN	✓	✓	✓	✓	Self-report via NHSN	✓ (nat'l average)	✓	MY 2015 results	10/1/2015 to 3/31/2016
5. **(PC-01) - Early Elective Induced Delivery** – % of patients with elective vaginal deliveries or elective cesarean sections at >=37 and < 39 weeks of gestation completed	✓	✓	×	×	CheckPoint	✓	✓	MY 2015 Results	4/1/2016 to 3/31/2017*
6. **CAUTI – Catheter Associated Urinary Tract Infections**	✓	✓	×	✓	CheckPoint	✓	✓	10/1/2014 to 9/30/2015	4/1/2016 to 3/31/2017*

Measure	Applicable to				Data Source	Performance Level	Degree of Improvement (DOI)	Baseline Period	Measurement Period
	Acute Care	Critical Access	Psych	Children's					
7. **CDI - Clostridium Difficile Infection**	✓	✓	✗	✓	CheckPoint	P4R		4/1/2015 to 3/31/2016	4/1/2016 to 3/31/2017*
8. **MRSA - Methicillin-resistant *Staphylococcus Aureus* Infection**	✓	✓	✗	✓	CheckPoint	P4R		4/1/2015 to 3/31/2016	4/1/2016 to 3/31/2017*
9. **Surgical Site Infection (SSI) – Colon Surgery**	✓	✓	✗	✗	CheckPoint	✓	✓	4/1/2015 to 3/31/2016	4/1/2016 to 3/31/2017*
10. **Surgical Site Infection (SSI) – Abdominal Hysterectomy**	✓	✓	✗	✗	CheckPoint	✓	✓	4/1/2015 to 3/31/2016	4/1/2016 to 3/31/2017*

✓ = measure is conceptually applicable
**Dates reflect the data scheduled to be available on CheckPoint on 9/30/2017. These dates are subject to change if the data for these timeframes is not available to WHA.*

Withhold P4P State/National Averages

This chart shows the baseline statewide averages are for the eight of the withhold P4P measures. These averages are what a hospital's performance will be compared to for a given measure. These averages serve as a guideline for what a hospital should target. In order to receive payment for a given Withhold P4P program measure, a hospital must equal or outperform these published averages.

Measure	Numerator	Denominator	State / National Average	Positive or Negative Measure
30-day Readmission Statewide Average n=136 hospitals Data: MY 2015 results	3724	20689	18.00%	Negative*
30- day Mental Health Follow-up Visit Statewide Average n=47 hospitals Data: MY 2015 results	1976	3355	58.90%	Positive
Childhood Asthma National Average, Joint Commission Data (2015 Annual Report (2014 Data))	Numerator / denominator data not available from The Joint Commission		91%	Positive
Healthcare Personnel Influenza Vaccination Rate National Average (2014-2015 flu season); n=137	Numerator / denominator data not available from CDC		84.5%	Positive
(PC-01) - Early Elective Induced Delivery Data:MY2015 Results	Numerator data not available from CheckPoint	Denominator data not available from CheckPoint	4.26%	Positive
CAUTI – Catheter Associated Urinary Tract Infections (Standardized Infection Ratio) Data: 10/1/2014 – 9/30/2015	Numerator data not available from CheckPoint	Denominator data not available from CheckPoint	0.528	Negative*
SSI- Colon Surgery (Standardized Infection Ratio) Data: 10/1/2014 – 9/30/2015	Numerator data not available from CheckPoint	Denominator data not available from CheckPoint	0.987	Negative*
SSI- Abdominal Hysterectomy (Standardized Infection Ratio) Data: 10/1/2014 – 9/30/2015	Numerator data not available from CheckPoint	Denominator data not available from CheckPoint	0.981	Negative*

*= Negative measures mean that the hospital must score lower than the published average.

Withhold P4P Measures Detail

The following pages contain detailed descriptions of each of the Withhold P4P measures.

1. 30-Day Hospital Readmission

This measure applies to all hospitals with at least **30** eligible discharges in the denominator.

Measure = Percentage of inpatient admissions with a discharge in the previous 30 days during the MY.

Denominator = All inpatient discharges to home in MY 2017 after applying exclusions.

Numerator = All inpatient admissions with a discharge in the previous 30 days, between 4/1/2016 – 3/31/2017 after exclusions.

In order to identify "readmissions", DHS will consider any admission with a discharge in the previous 30 days, after exclusions.

- This includes discharges between 3/1/2016 – 3/31/2016.
- FFS members that are re-admitted within 30 days post-discharge and have, by then (after discharge), enrolled in an HMO, are included in the numerator.
- Readmission could occur at any hospital.

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

DHS provides an annual report for the readmission measure to each hospital. This report includes the numerator, denominator, patient identifiers for patients who comprised the numerator and the denominator, and other information. Since this report is based on the claims data of DHS, the currency of this information depends on the timeliness of claims submitted by hospitals.

Eligible population

- **Product line:** Medicaid FFS including BadgerCare Plus Standard and Wisconsin Medicaid FFS recipients.
- **Ages:** Members under 65 years of age during the measurement year.
- **Continuous enrollment:** Enrollment in Wisconsin Medicaid (FFS and HMO) 30 days after the Discharge Date.
- **Benefits:** Medical.
- **Measurement Year:** April 1, 2016 to March 31, 2017.

Exclusions

1. Original admissions for members in HMOs for BadgerCare Plus Standard or Medicaid SSI.

2. Medicare (dual eligible) members.

3. Transfers to another facility; only discharges to home (discharge status =01) are included.

4. Observation status.

5. Inpatient stays with the following codes as primary diagnosis:
   a) Pregnancy:
      i) ICD-10 codes: O000 through O9A53.

   b) Conditions pertaining to infants in the perinatal period (i.e., within 28 days of birth):
      i) ICD-10 codes: P000 through P969, Q860 through Q868.
      ii) UB Revenue: 0112, 0122, 0132, 0142, 0152, 0720-0722, 0724.

   c) Discharge of infants after birth:
      i) ICD-10 Codes: Z3800-Z388**

   d) Maintenance chemotherapy identified by UB-revenue codes 0331, 0332 and 0335.

   e) Mental health /substance abuse inpatient care **(aka MH/SA Exclusions for Readmissions)**
      i) Mental health:
         (1) ICD-10 codes: F0150-F09, F20-F63.9, F65-F69, and F800-F99.
         (2) MS-DRG codes to identify inpatient services: 876, 880-887.

      ii) Chemical abuse, use, and dependency:
         (1) ICD-10 codes: F101-F1999, K2920-K2921, K700-K709, K852, and K860.
         (2) Codes to identify inpatient services: ICD-10 procedure codes HZ2ZZZZ-HZ99ZZZ, with an inpatient facility code of MS-DRG 894-897.

6. Inpatient stays with discharges for death or left against medical advice (AMA).

7. A length of stay (discharge day minus admission date) of more than 120 days.

8. CMS list of exclusions from March 2015[1]:
   a) Psychiatric Discharge Diagnosis Categories (Table D.1)
   b) Cancer Discharge Diagnosis Categories (Table D.3)

[1] Horwitz L, Grady J, Dorsey K, et al. 2015 Measure Updates and Specifications Report Hospital-Wide All-Cause Unplanned Readmission (Version 4.0). 2015; prepared for Centers for Medicare & Medicaid Services (CMS); https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Downloads/Hospital-Wide-All-Cause-Readmission-Updates.zip; Accessed March 28, 2016.

c) Admissions identified using the Planned Admission Algorithm Version 3.0 (Appendix E)

Table D.1 – Psychiatric Discharge Diagnosis Categories Excluded from the Measure

AHRQ Diagnosis CCS	Description
650	Adjustment disorders
651	Anxiety disorders
652	Attention-deficit, conduct, and disruptive behavior disorders
654	Developmental disorders
655	Disorders usually diagnosed in infancy, childhood, or adolescence
656	Impulse control disorders, not elsewhere classified
657	Mood disorders
658	Personality disorders
659	Schizophrenia and other psychotic disorders
662	Suicide and intentional self-inflicted injury
670	Miscellaneous disorders

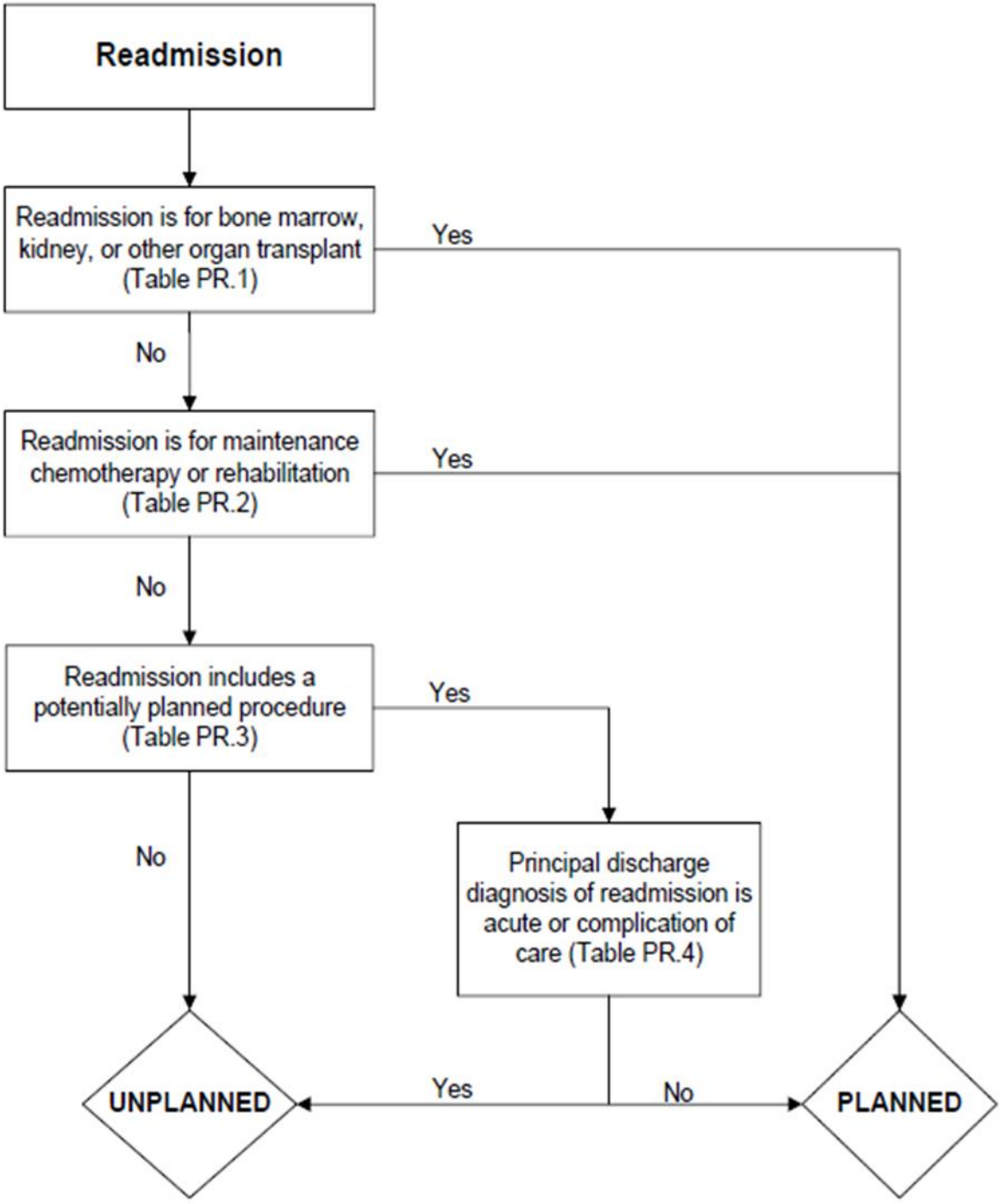
Table D.3 – Cancer Discharge Diagnosis Categories Excluded from the Measure for Admissions not Included in the Surgical Cohort

AHRQ Diagnosis CCS	Description
11	Cancer of head and neck
12	Cancer of esophagus
13	Cancer of stomach
14	Cancer of colon
15	Cancer of rectum and anus
16	Cancer of liver and intrahepatic bile duct
17	Cancer of pancreas
18	Cancer of other GI organs; peritoneum
19	Cancer of bronchus; lung
20	Cancer; other respiratory and intrathoracic
21	Cancer of bone and connective tissue
22	Melanomas of skin
23	Other non-epithelial cancer of skin
24	Cancer of breast
25	Cancer of uterus
26	Cancer of cervix
27	Cancer of ovary
28	Cancer of other female genital organs
29	Cancer of prostate
30	Cancer of testis

31	Cancer of other male genital organs
32	Cancer of bladder
33	Cancer of kidney and renal pelvis
34	Cancer of other urinary organs
35	Cancer of brain and nervous system
36	Cancer of thyroid
37	Hodgkin`s disease
38	Non-Hodgkin`s lymphoma
39	Leukemias
40	Multiple myeloma
41	Cancer; other and unspecified primary
42	Secondary malignancies
43	Malignant neoplasm without specification of site
44	Neoplasms of unspecified nature or uncertain behavior
45	Maintenance chemotherapy

Appendix E. Planned Readmission Algorithm

Figure PR.1 – Planned Readmission Algorithm Version 3.0 Flowchart



Planned Readmission Algorithm Version 3.0 Tables – HWR Measure

Table PR.1 – Procedure Categories That are Always Planned (Version 3.0)

Procedure CCS	Description
64	Bone marrow transplant
105	Kidney transplant
134	Cesarean section (Included only in all-payer population, not Medicare)
135	Forceps; vacuum; and breech delivery (Included only in all-payer population, not Medicare)
176	Other organ transplantation

Table PR.2 – Diagnosis Categories That are Always Planned (Version 3.0)

Diagnosis CCS	Description
45	Maintenance chemotherapy
194	Forceps delivery (Included only in all-payer population, not Medicare)
196	Normal pregnancy and/or delivery (Included only in all-payer population, not Medicare)
254	Rehabilitation (Includes only V52.0, V52.1, V52.4, V52.8, V52.9, V53.8, and V58.82 -Refer to Appendix C for more detail)

Table PR.3 – Potentially Planned Procedure Categories (Version 3.0)

Diagnosis CCS	Description
3	Laminectomy; excision intervertebral disc
5	Insertion of catheter or spinal stimulator and injection into spinal
9	Other OR therapeutic nervous system procedures
10	Thyroidectomy; partial or complete
12	Other therapeutic endocrine procedures
33	Other OR therapeutic procedures on nose; mouth and pharynx
36	Lobectomy or pneumonectomy
38	Other diagnostic procedures on lung and bronchus
40	Other diagnostic procedures of respiratory tract and mediastinum
43	Heart valve procedures
44	Coronary artery bypass graft (CABG)
45	Percutaneous transluminal coronary angioplasty (PTCA)
47	Diagnostic cardiac catheterization; coronary arteriography
48	Insertion; revision; replacement; removal of cardiac pacemaker or cardioverter/defibrillator
49	Other OR heart procedures
51	Endarterectomy; vessel of head and neck
52	Aortic resection; replacement or anastomosis
53	Varicose vein stripping; lower limb
55	Peripheral vascular bypass

56	Other vascular bypass and shunt; not heart
59	Other OR procedures on vessels of head and neck
62	Other diagnostic cardiovascular procedures
66	Procedures on spleen
67	Other therapeutic procedures; hemic and lymphatic system
74	Gastrectomy; partial and total
78	Colorectal resection
79	Local excision of large intestine lesion (not endoscopic)
84	Cholecystectomy and common duct exploration
85	Inguinal and femoral hernia repair
86	Other hernia repair
99	Other OR gastrointestinal therapeutic procedures
104	Nephrectomy; partial or complete
106	Genitourinary incontinence procedures
107	Extracorporeal lithotripsy; urinary
109	Procedures on the urethra
112	Other OR therapeutic procedures of urinary tract
113	Transurethral resection of prostate (TURP)
114	Open prostatectomy
119	Oophorectomy; unilateral and bilateral
120	Other operations on ovary
124	Hysterectomy; abdominal and vaginal
129	Repair of cystocele and rectocele; obliteration of vaginal vault
132	Other OR therapeutic procedures; female organs
142	Partial excision bone
152	Arthroplasty knee
153	Hip replacement; total and partial
154	Arthroplasty other than hip or knee
157	Amputation of lower extremity
158	Spinal fusion
159	Other diagnostic procedures on musculoskeletal system
166	Lumpectomy; quadrantectomy of breast
167	Mastectomy
169	Debridement of wound; infection or burn
170	Excision of skin lesion
172	Skin graft
ICD-9 Codes	**Description**
30.1, 30.29, 30.3, 30.4, 31.74, 34.6	Laryngectomy, revision of tracheostomy, scarification of pleura (from Procedure CCS 42-Other OR Rx procedures on respiratory system and mediastinum)
38.18	Endarterectomy leg vessel (from Procedure CCS 60-Embolectomy and endarterectomy of lower limbs)

55.03, 55.04	Percutaneous nephrostomy with and without fragmentation (from Procedure CCS 103-Nephrotomy and nephrostomy)
94.26, 94.27	Electroshock therapy (from Procedure CCS 218-Psychological and psychiatric evaluation and therapy)

Earn-Back Methodology

1. Relative **level** of performance is defined by comparison with the designated (e.g., national or statewide) average for all hospitals.

2. **Improvement** shown is defined by percent reduction in error rates for each measure.

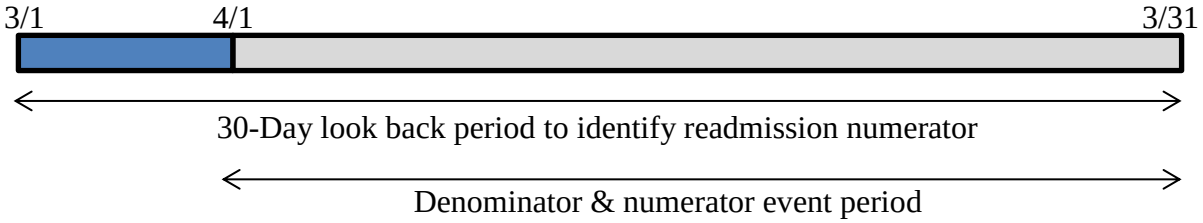
	Degree of **IMPROVEMENT**		
Performance **LEVEL**	High (10% or higher)	Medium (5% - 10%)	Low (0% - 5%)
High (greater than 1.10 times the designated average)	100% earn-back		
Medium (between 0.90 and 1.10 times the designated average)	100% earn-back	75% earn-back	50% earn-back
Low (less than 0.90 times the designated average)		50% earn-back	No earn-back

3. As shown above, a hospital with "high" performance level for this measure will earn back 100% of its withhold for this measure, regardless of improvement shown.

4. A hospital showing "high" improvement for this measure will earn back 100% of its withhold for this measure, regardless of its level.

5. When high achievement is not possible for either level or degree of improvement (e.g. the baseline scores are already at 100%), DHS may make adjustments to the methodology so that high performance is possible (e.g. continued performance at 100% for a measure may constitute high performance). Any such modifications will be communicated via the P4P mailing list.

The following diagram is an example of the timeline used for determining the numerator and the denominator.



The following table provides various **sample scenarios** for this measure, and is meant to be illustrative only.

Scenario	Event date		Include in:	
	Admission	**Discharge**	**Numerator**	**Denominator**
1. Patient admitted 2/28 and discharged 3/28; readmitted 4/3 and discharged 4/6.	2/28		No - admitted pre-MY	
		3/28		No - discharged pre-current MY
	4/3		Yes - admitted within 30 days of previous discharge	
		4/6		Yes, for current MY
2. Patient admitted 2/28 and discharged 4/1 but readmitted 4/3 then discharged 4/5.	2/28		No - admitted pre-MY	
		4/1		Yes, for current MY
	4/3		Yes, admitted within 30 days of previous discharge	
		4/5		Yes, for current MY
3. Patient admitted on 3/1 current MY then discharged 3/5 and admitted 3/10 and discharged 4/1 next MY.	3/1		No – if no record of previous discharge within 30 days	
		3/5		Yes, for current MY
	3/10		Yes - admitted within 30 days of previous discharge	
		4/1 next MY		Yes, for next MY
4. Patient admitted 3/2 then discharged 3/5 and admitted 3/10 and discharged 3/30.	3/2		No – if no record of previous discharge within 30 days	
		3/5		Yes, for current MY
	3/10		Yes - admitted within 30 days of previous discharge	
		3/30		Yes, for current MY
5. **Rapid readmission at the same facility**: Patient admitted on 5/12. Patient is then discharged <u>to home</u> on the morning of 7/1 but readmitted 12 hours later on the same day (7/1) to the same facility and discharged 7/4.	5/12		No – if no record of previous discharge within 30 days	
		7/1		Yes, for current MY
	7/1		Yes - admitted within 30 days of previous discharge	
		7/4		Yes, for current MY
6. **Transfer to another facility**: Patient is admitted to Hospital A on 7/2 and transferred to Hospital B on the same day. The patient is then discharged to home from Hospital B on 7/7.	7/2		No - if no record of previous discharge within 30 days of either admission to A, or transfer to B.	
		7/7		Yes - only for Hospital B since only B discharged the patient to home. *Transfers to another*

Scenario	Event date		Include in:	
	Admission	Discharge	Numerator	Denominator
				facility DO NOT count as discharges
7. **Readmissions after more than 30 days**: patient is admitted on 7/2 then discharged 7/3 and admitted on 8/6 then discharged 8/9.	7/2		No – if no record of previous discharge within 30 days	
		7/3		Yes, for current MY
	8/6		No - 2nd admission was more than 30 days past the previous discharge	
		8/9		Yes, for current MY
8. **Multiple readmissions**: patient admitted on 7/1 then discharged on 7/3 and admitted on 7/5. The same patient gets discharged on 7/7 and gets admitted again on 7/9 and discharged 7/12.	7/1		No – if no record of previous discharge within 30 days	
		7/3		Yes, for current MY
	7/5		Yes - admitted within 30 days of previous discharge	
		7/7		Yes, for current MY
	7/9		Yes - admitted within 30 days of previous discharge	
		7/12		Yes, for current MY
9. **Expired patients**: A patient is admitted 8/1 and discharged 8/10.Then readmitted 8/15 but discharged "Expired" on 8/17.	8/1		No – if no record of previous discharge within 30 days of 8/1	
		8/10		Yes, for current MY
	8/15		No - discharged expired not counted	
		8/17		No - discharged expired not counted
10. **Transition from FFS to MCO**: A FFS patient is admitted 8/1 and discharged 8/10.This patient is readmitted on 8/25 but had enrolled in WI Medicaid (BC+, SSI) managed care organization (MCO) before 8/25. The member is then discharged on 8/27	8/1		No – if no record of previous discharge within 30 days of 8/1	
		8/10		Yes, for current MY
	8/25		Yes - admitted within 30 days of previous discharge. *All readmissions within 30 days of a FFS discharge will be counted in the numerator as long as the member maintains continuous eligibility in WI Medicaid for 30 days post discharge, regardless of subsequent enrollment in an MCO.*	

Scenario	Event date		Include in:	
	Admission	Discharge	Numerator	Denominator
		8/27		Yes, for current MY
11. **Maternity**: Patient is 7-months pregnant, admitted on 7/5 for a non-pregnancy issue, discharged on 7/9. She is admitted for delivery on 8/4 and discharged on 8/7. She is admitted for non-pregnancy related issue on 9/1 and discharged on 9/3.	7/5		No – if no record of previous discharge within 30 days	
		7/9		Yes, for current MY
	8/4		No – maternity related admissions are excluded	
		8/7		No – maternity related discharges are excluded
	9/1		No – no non-maternity related discharge within the previous 30 days	
		9/3		Yes, for current MY
12. **Maintenance chemotherapy**: Patient is admitted on 8/1 for chemo treatment and discharged on 8/3. He is admitted for a non-chemo issue on 8/7 and discharged on 8/9. He is again admitted for chemo on 9/1 and discharged on 9/2.	8/1		No – maintenance chemo related admissions are excluded	
		8/3		No – maintenance chemo discharges are excluded
	8/7		No – no maintenance chemo related discharge within the previous 30 days	
		8/9		Yes, for current MY
	9/1		No – maintenance chemo related admissions are excluded	
		9/2		No – maintenance chemo discharges are excluded

2. Mental Health Follow-Up Visit within 30 days

This measure applies to all hospitals with at least **30** eligible discharges during the Measurement Year for mental health inpatient care. The scope of the measure is broader than the HEDIS Follow-Up after Hospitalization for Mental Illness (FUH-30) definition.

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

Denominator = All patients discharged alive during measurement year 2017, after applying exclusions, from an acute inpatient setting (including acute care psychiatric facilities) with any of the principal mental health diagnoses found in HEDIS 2015 FUH-30 during the measurement year.

Numerator = A mental health diagnosis related outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner or primary care provider within 30 days after discharge, applying the same codes as the denominator, with the codes found in HEDIS 2015 FUH-30.

Eligible population

- **Product line:** Medicaid FFS including BadgerCare Plus Standard Plan members and Wisconsin Medicaid FFS recipients.
- **Ages:** Members 18 years and older as of the date of discharge.
- **Continuous enrollment:** Enrollment in Wisconsin Medicaid (FFS or HMO) 30 days after the discharge date.
- **Benefits:** Medical and mental health (inpatient and outpatient).
- **Measurement Year:** April 1, 2015 through March 31, 2016.
- **Denominator**: Dates of initial discharge or readmission /direct transfer from April 1, 2015 to March 31, 2016.
- **Numerator**: 30-day mental health follow-up visits between April 1, 2015 and April 30, 2016 (13 months), in order to account for the 30 post discharge period.

Exclusions

- AODA inpatient care.
- Exclude Medicare (dual eligible) members.
- ***Mental Health readmission or direct transfer:***
    - If the discharge is followed by a readmission or direct transfer to an acute facility for a mental health principal diagnosis within the 30 day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. In other words, readmission or a transfer for a mental health principal diagnosis will start the 30-day clock again.
    - Exclude discharges followed by a readmission or direct transfer to a non-acute facility within the 30 day follow-up period.
    - Non-acute care:
        - Hospice: UB revenue codes 0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659; UB type of bill 81x, 82x; POS 34.
        - SNF: UB revenue codes 019x; UB type of bill codes 21x, 22x, 28x; POS 31, 32.
        - Hospital transitional care, swing bed, or rehabilitation: UB type of bill codes 18x.
        - Rehabilitation: UB revenue codes 0118, 0128, 0138, 0148, 0158.
        - Respite: UB revenue code 0655.
        - Intermediate care facility: POS 54.
        - Residential substance abuse treatment facility: UB revenue code 1002; POS 55.
        - Psychiatric residential treatment center: HCPCS codes T2048, H0017, H0019; UB revenue codes 1001; POS 56.
        - Comprehensive inpatient rehabilitation facility: POS 61.
        - Other non-acute care facilities that do not use the UB revenue or type of bill codes for billing (e.g. ICF, SNF).
- ***Non-mental health readmission or direct transfer:*** Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or non-acute

facility for a non-mental health principal diagnosis **(namely, the MH/SA Exclusions for Readmissions)**.
- Initial mental health treatment provided at out of state or border status hospitals are excluded from the denominator.

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

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

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

Earn-Back Methodology

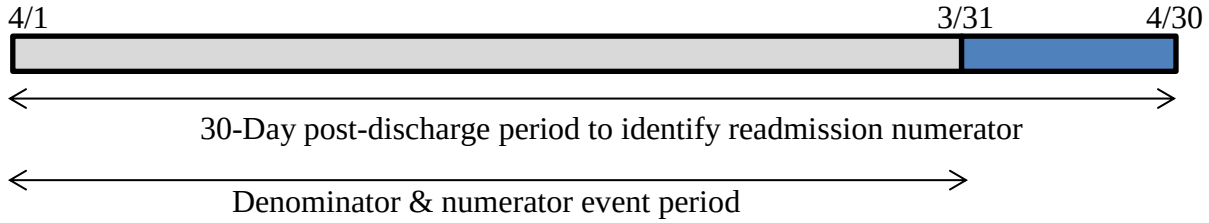
i. Relative **level** of performance is defined by comparison with the designated (e.g., national or statewide) average for all hospitals.
ii. **Improvement** shown is defined by percent reduction in error rates for each measure.

<table>
<tr><td></td><td colspan="3">Degree of IMPROVEMENT</td></tr>
<tr><td>Performance LEVEL</td><td>High (10% or higher)</td><td>Medium (5% - 10%)</td><td>Low (0% - 5%)</td></tr>
<tr><td>High (greater than 1.10 times the designated average)</td><td colspan="3">100% earn-back</td></tr>
<tr><td>Medium (between 0.90 and 1.10 times the designated average)</td><td rowspan="2">100% earn-back</td><td>75% earn-back</td><td>50% earn-back</td></tr>
<tr><td>Low (less than 0.90 times the designated average)</td><td>50% earn-back</td><td>No earn-back</td></tr>
</table>

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

When high achievement is not possible for either level or degree of improvement (e.g. the baseline scores are already at 100%), DHS may make adjustments to the methodology so that high performance is possible (e.g. continued performance at 100% for a measure may constitute high performance). Any such modifications will be communicated via the P4P mailing list.

The following diagram is an example of the timeline used for determining the numerator and the denominator.



The following table provides **sample scenarios** for the Mental Health Follow-up measure, and is meant to be illustrative only.

Scenario	Event Date			Include in:	
	Admission	Discharge / Transfer	Follow-up Visit	Numerator	Denominator
1. Member is admitted to Hospital A on April 3 and discharged to home on April 5 with a MHF-A diagnosis. The member subsequently receives a MHF-B visit from a mental health practitioner /primary care provider on April 20.	at A on 4/3			No, admissions are not counted for this measure	
		from A on 4/5			Yes, for Hospital A (30 day clock starts)
			4/20	Yes, follow-up occurred within 30 days of MHF-A discharge	
2. Member is admitted to Hospital A on July 3 and discharged to home on July 5 with a MHF-A diagnosis. The member subsequently fails to receive a MHF-B follow-up visit from a mental	at A on 7/3			No, Admissions are not counted for this measure	
		from A on 7/5			Yes, for Hospital A (30 day clock starts)

Scenario	Event Date			Include in:	
	Admission	**Discharge / Transfer**	**Follow-up Visit**	**Numerator**	**Denominator**
health practitioner / primary care provider within 30 days.			None within 30 days of qualifying discharge	No, follow-up did not occurred within 30 days of MHF-A discharge	
3. Member is admitted to Hospital A on July 2 and transferred to Hospital B on July 5. The member is then discharged from Hospital B with a MHF-A diagnosis on July 8th. The member subsequently receives a MHF-B follow-up visit from a mental health practitioner/primary care provider on July 14.	at A on 7/2			No, admissions are not counted for this measure	
		from A on 7/5			No - transfers are not included in the denominator
		from B on 7/8			Yes, for Hospital B (30 day clock starts)
			7/14	Yes, follow-up occurred within 30 days of MHF-A discharge	
4. Member is admitted to Hospital A on July 2 and is discharged from to home with a MHF-A diagnosis on July 8. The member was admitted with a non-mental health related inpatient event (i.e. broken arm) at Hospital A on July 20 and was discharged to home on July 21. The member subsequently receives a MHF-B follow-up visit from a mental health practitioner/primary care provider on August 1.	at A on 7/2			No, admissions are not counted for this measure	
		from A on 7/8			Tentatively count in the denominator for Hospital A pending activity within the next 30 days (clock starts). In this scenario, the denominator would be eliminated because of the non-mental health admission on 7/20 (clock is abolished)
	at A on 7/20			No, admissions are not counted for	

Scenario	Event Date			Include in:	
	Admission	Discharge / Transfer	Follow-up Visit	Numerator	Denominator
				this measure	
		from A on 7/21			No, the discharge was not for a MHF-A condition
			8/1	No, event is excluded because a non-mental health related readmission occurred within 30 days of MHF-A diagnosis	
5. Member is admitted to Hospital A on July 2 and discharged to home with a MHF-A diagnosis on July 8. The member is subsequently readmitted to Hospital A with a MHF-A diagnosis on July 14. The member is then discharged to home on July 20. The member then receives a MHF-B follow-up visit from a mental health practitioner /primary care provider on August 17.	at A on 7/2			Admissions are not counted for this measure	
		from A on 7/8			No, discharge is followed by a mental health related readmission within the 30 day follow-up period (30 day clock is reset pending subsequent discharge)
	at A on 7/14			No, admissions are not counted for this measure	
		from A on 7/20			Yes, for Hospital A (30 day clock starts)
			8/17	Yes, follow-up occurred within 30 days of MHF-A discharge	

Scenario	Event Date			Include in:	
	Admission	**Discharge / Transfer**	**Follow-up Visit**	**Numerator**	**Denominator**
6. Member is admitted to Hospital A on August 9 and discharged to home with a MHF-A diagnosis on August 15. The member is then admitted to Hospital B's AODA inpatient care on Sept. 1 and remains in the care facility until Oct. 2.	at A on 8/9			No, admissions are not counted for this measure	
		from A on 8/15			Tentatively count in the denominator for Hospital A pending activity in the next 30 days (clock starts). Since there was an AODA inpatient hospitalization within 30 days of discharge, the denominator is removed (clock abolished)
	at B on 9/1			No, admissions are not counted for this measure	
		from B on 10/2			No, the discharge was from an AODA inpatient care facility, therefore the entire event is excluded

3. Asthma Care for Children

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

a. **Use of systemic corticosteroids for inpatient asthma**
The national average for this component for children 2 – 17 years of age is close to 99.7%. Wisconsin children's hospitals to which this measure applies demonstrate a similar performance. Therefore, this is ***not*** applicable to DHS' P4P initiative.

b. **Use of relievers for inpatient asthma**
The national average for this component for children 2 – 17 years of age is close to 100%. Wisconsin children's hospitals to which this measure applies demonstrate a similar performance. Therefore, this is ***not*** applicable to DHS' P4P initiative.

c. **Home Management Plan of care (HMPC)**
The national average for this component is close to 91%, and the Wisconsin children's hospitals to which this measure applies have an average of 98.6%. This component ***will be applicable*** to DHS' P4P initiative.

Minimum number of observations:
At least 25 observations are required for this measure to be applicable to a hospital.

Earn-Back Methodology:

i. Relative **level** of performance is defined by comparison with the designated (e.g., national or statewide) average for all hospitals.
ii. **Improvement** shown is defined by percent reduction in error rates for each measure.

	Degree of **IMPROVEMENT**		
Performance **LEVEL**	High (10% or higher)	Medium (5% - 10%)	Low (0% - 5%)
High (greater than 1.10 times the designated average)	100% earn-back		
Medium (between 0.90 and 1.10 times the designated average)	100% earn-back	75% earn-back	50% earn-back
Low (less than 0.90 times the designated average)		50% earn-back	No earn-back

iii. As shown above, a hospital with "high" performance level for this measure will earn back 100% of its withhold for this measure, regardless of improvement shown.
iv. A hospital showing "high" improvement for this measure will earn back 100% of its withhold for this measure, regardless of its level.
v. When high achievement is not possible for either level or degree of improvement (e.g. the base line scores are already at 100%), DHS may make adjustments to the methodology so that high performance is possible (e.g. continued performance at 100% for a measure may constitute high performance). Any such modifications will be communicated via the P4P mailing list.

4. Healthcare Personnel (HCP) Influenza Vaccination

CMS has required this measure for specific hospital types since 2013 as part of its quality reporting program. In order to minimize reporting burden on hospitals, DHS uses CMS specifications and data submission guidelines and tools (e.g., NHSN).

For MY 2017:

- DHCAA will continue to use CMS' specifications for the Healthcare Personnel (HCP) Influenza Vaccination measure. CDC has published a module on the National Healthcare Safety Network (NHSN) that hospitals should utilize when submitting data on this measure. Please see the NHSN website for details, at http://www.cdc.gov/nhsn/acute-care-hospital/hcp-vaccination/index.html. The NHSN reporting protocol for this module can be found at http://www.cdc.gov/nhsn/PDFs/HPS-manual/vaccination/HPS-flu-vaccine-protocol.pdf.

- Each healthcare personnel will be counted only once for each employer. If healthcare personnel are employed by multiple employers, those personnel will be counted multiple times, since the measure focuses on hospitals, not individual employees.
- In order to meet the DHS 2017 Hospital P4P requirements, **all hospitals to which the withold P4P applies** must submit data to NHSN. The data must be submitted to **NHSN by May 15 following the flu season in question (i.e. 2015 -16 flu season data are due on May 15, 2016)**. Hospital specific baselines for this measure are based on the vaccination rate the hospital submitted as part of the MY2013 Withhold Hospital P4R requirement for this measure. The national average as published by the CDC for flu season 2014-15 will be used for calculating hospital specific performance levels, when available. If the results are not available from NHSN data, DHS will use other sources, e.g., overall WI vaccination rate with percentiles.

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

Methodology
Denominator: number of hospital employees, licensed independent practitioners and adult students / trainees and volunteers that have worked in a hospital for 1 day between October 1, 2015 and March 31, 2016. The definitions for each category of HCP are listed in **Table 1**.

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

Numerator: number of hospital employees, licensed independent practitioners and adult students / trainees and volunteers that have worked in a hospital for 1 day between October 1, 2015 and March 31, 2016 that receive a flu vaccination during the vaccination season.

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

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

*Note - Even though a hospital's overall rate is calculated using rows 1 – 4, hospitals must report data for **all rows**, in order to be deemed in compliance with the P4P requirements. Hospitals are not required to complete the Other Contractors column*

Table 1 HCP Influenza Vaccination Denominators

Employees	• All persons who receive a direct paycheck from the reporting facility (i.e. on payroll)
Licensed independent practitioners	• Physicians (MD, DO), advanced practice nurses, and physician assistants • Affiliated with the facility but not receiving a direct paycheck from the facility

Adult students/trainees and volunteers	• Students, trainees, and volunteers • Aged ≥18 years • Affiliated with the facility but not receiving a direct paycheck from the facility
Contractors **(optional for CMS and DHCAA P4P Program)**	• Examples: agency or registry nurses (not advanced practice nurses), environmental services personnel, maintenance workers

Minimum number of observations:

At least 25 observations are required for this measure to be applicable to a hospital.

Earn-back Methodology:

i. Relative **level** of performance is defined by comparison with the designated (e.g., national or statewide) average for all hospitals.
ii. **Improvement** shown is defined by percent reduction in error rates for each measure.

	Degree of **IMPROVEMENT**		
Performance **LEVEL**	High (10% or higher)	Medium (5% - 10%)	Low (0% - 5%)
High (greater than 1.10 times the designated average)	100% earn-back		
Medium (between 0.90 and 1.10 times the designated average)	100% earn-back	75% earn-back	50% earn-back
Low (less than 0.90 times the designated average)		50% earn-back	No earn-back

iii. As shown above, a hospital with "high" performance level for this measure will earn back 100% of its withhold for this measure, regardless of improvement shown.
iv. A hospital showing "high" improvement for a measure will earn back 100% of its withhold for this measure, regardless of its level.
v. When high achievement is not possible for either level or degree of improvement (e.g. the base line scores are already at 100%), DHS may make adjustments to the methodology so that high performance is possible (e.g. continued performance at 100% for a measure may constitute high performance). Any such modifications will be communicated via the P4P mailing list.

NHSN Healthcare Personnel Influenza Vaccination Summary

Record the number of HCP for each category below for the influenza season being tracked				
Facility ID #:				
Vaccination type: influenza	Influenza subtype: □ seasonal □ non-seasonal	Influenza season:	Date Last Modified:	
	Employee HCP	**Non-employee HCP**		
	Employees (staff on facility payroll)	Licensed independent practitioners (physicians, advanced practice nurses, and physician assistants)	Adult students/trainees/volunteers	Other contract personnel **(optional for CMS and DHCAA P4P Program)**
• Number of HCP who worked at this facility for at least 1 day between October 1, 2015 and March 31, 2016				
• Number of HCP who received an influenza vaccination at this facility since influenza vaccine became available this season				
• Number of HCP who provided a written report or documentation of influenza vaccination outside this facility since influenza vaccine became available this season				
• Number of HCP who have a medical contraindication to the influenza vaccine				
• Number of HCP who declined to receive the influenza vaccine				
• Number of HCP with unknown vaccination status (or criteria not met for questions 2-5 above)				

5. Early Elective Induced Deliveries (PC-01)

Data are for all payers for each hospital.
DHS will use the data published on the CheckPoint website for: Patients with elective vaginal deliveries or elective cesarean sections at greater than or equal to 37 weeks and less than 39 weeks of gestation.

Minimum number of observations:

At least 25 observations are required for this measure to be applicable to a hospital.

Earn-Back Methodology:

i. Relative **level** of performance is defined by comparison with the designated (e.g., national or statewide) average for all hospitals. For this measure in MY 2017, the performance level will be considered "high" if a hospital's performance outperforms the state average by 10% OR a hospital has a score of less than 4%.

ii. **Improvement** shown is defined by percent reduction in error rates for each measure.

<table>
<tr><th></th><th colspan="3">Degree of IMPROVEMENT</th></tr>
<tr><th>Performance LEVEL</th><th>High (10% or higher)</th><th>Medium (5% - 10%)</th><th>Low (0% - 5%)</th></tr>
<tr><td>High (greater than 1.10 times the designated average, or less than 4%)</td><td colspan="3">100% earn-back</td></tr>
<tr><td>Medium (between 0.90 and 1.10 times the designated average)</td><td rowspan="2">100% earn-back</td><td>75% earn-back</td><td>50% earn-back</td></tr>
<tr><td>Low (less than 0.90 times the designated average)</td><td>50% earn-back</td><td>No earn-back</td></tr>
</table>

iii. As shown above, a hospital with "high" performance level for this measure will earn back 100% of its withhold for this measure, regardless of improvement shown.

iv. A hospital showing "high" improvement for this measure will earn back 100% of its withhold for this measure, regardless of its level.

v. When high achievement is not possible for either level or degree of improvement (e.g. the base line scores are already at 100%), DHS may make adjustments to the methodology so that high performance is possible (e.g. continued performance at 100% for a measure may constitute high performance). Any such modifications will be communicated via the P4P mailing list.

6. Catheter Associated Urinary Tract Infections (CAUTI)

This measure uses a standardized infection ratio to compare a hospital's results against the statewide ratio. Data is submitted to CheckPoint. The CAUTI surveillance protocol (http://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf) within NHSN provides the definitions and reporting structure for this measure.

Minimum number of observations:

At least 25 observations are required for this measure to be applicable to a hospital.

Reporting notes/resources:

- Data must be entered into NHSN and rights conferred to the WHA group (ID 27080)

for measure compliance. Data are then loaded onto CheckPoint for evaluation.

- All NHSN reporting rules should be followed, including but not limited to, indicating CAUTI surveillance in monthly reporting plans and entering monthly numerators and denominators (device days and patient days) in all eligible units.
- The SIR is only calculated when the number of predicted CAUTIs is ≥ 1 to help enforce a minimum precision criterion. In cases where the SIR is not calculated, a + will be indicated on CheckPoint.
- Surveillance protocol: http://www.cdc.gov/nhsn/pdfs/pscmanual/7psccauticurrent.pdf
- Surveillance resources: http://www.cdc.gov/nhsn/acute-care-hospital/cauti/index.html
- Contact Jill Hanson, Quality Improvement Manager at the Wisconsin Hospital Association, at 608-268-1842 or jhanson@wha.org for CheckPoint questions.
- Contact Ashlie Dowdell, HAI Surveillance Coordinator at the Wisconsin Division of Public Health, at 608-266-1122 or ashlie.dowdell@wi.gov for NHSN questions.

Earn-Back Methodology:

i. Relative **level** of performance is defined by comparison with the designated (e.g., national or statewide) average for all hospitals.

ii. **Improvement** shown is defined by percent reduction in error rates for each measure.

<table>
<tr><th></th><th colspan="3">Degree of IMPROVEMENT</th></tr>
<tr><th>Performance LEVEL</th><th>High (10% or higher)</th><th>Medium (5% - 10%)</th><th>Low (0% - 5%)</th></tr>
<tr><td>High (greater than 1.10 times the designated average)</td><td colspan="3">100% earn-back</td></tr>
<tr><td>Medium (between 0.90 and 1.10 times the designated average)</td><td rowspan="2">100% earn-back</td><td>75% earn-back</td><td>50% earn-back</td></tr>
<tr><td>Low (less than 0.90 times the designated average)</td><td>50% earn-back</td><td>No earn-back</td></tr>
</table>

iii. As shown above, a hospital with "high" performance level for this measure will earn back 100% of its withhold for this measure, regardless of improvement shown.

iv. A hospital showing "high" improvement for this measure will earn back 100% of its withhold for this measure, regardless of its level.

v. When high achievement is not possible for either level or degree of improvement (e.g. the base line scores are already at 100%), DHS may make adjustments to the methodology so that high performance is possible (e.g. continued performance at 100% for a measure may constitute high performance). Any such modifications will be communicated via the P4P mailing list.

7. CDI- Clostridium Difficile Infection

This measure uses National Quality Forum (NQF) 1717 specifications. Data is submitted to CheckPoint in the form of a standardized infection ratio to compare a hospital's results against the statewide ratio. The CDI laboratory-identified (LabID) event surveillance protocol (http://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf) within NHSN provides the definitions and reporting structure for this measure.

This is a Pay-for-Reporting measure for MY2017.
Hospitals that submit data to CheckPoint in a timely manner (so that the data is available on CheckPoint by 9/30/2017) will be deemed to have met the requirement for this measure.
Reporting notes/resources:

- Data must be entered into NHSN and rights conferred to the WHA group (ID 27080) for measure compliance. Data are then loaded onto CheckPoint for evaluation.
- All NHSN reporting rules should be followed, including but not limited to, indicating CDI LabID surveillance in monthly reporting plans and entering monthly numerators and denominators (admissions, patient days and encounters) in all eligible units.
- CDI LabID event surveillance should not be performed in NICUs, specialty care nurseries, on babies in labor delivery recovery postpartum (LDRP) units, well-baby nurseries or well-baby clinics. If LDRP locations are being monitored, baby counts should be removed from denominator totals.
- The SIR is only calculated when the number of predicted CDI LabID events is ≥ 1 to help enforce a minimum precision criterion. In cases where the SIR is not calculated, a + will be indicated on CheckPoint.
- Surveillance protocol: http://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf
- Surveillance resources: http://www.cdc.gov/nhsn/acute-care-hospital/cdiff-mrsa/index.html
- Contact Jill Hanson, Quality Improvement Manager at the Wisconsin Hospital Association, at 608-268-1842 or jhanson@wha.org for CheckPoint questions.
- Contact Ashlie Dowdell, HAI Surveillance Coordinator at the Wisconsin Division of Public Health, at 608-266-1122 or ashlie.dowdell@wi.gov for NHSN questions.

8. MRSA- Methicillin-resistant *Staphylococcus aureus* Infection

This measure uses National Quality Forum (NQF) 1716 specifications. Data is submitted to CheckPoint in the form of a standardized infection ratio to compare a hospital's results against the statewide ratio. The MRSA bacteremia (LabID) event surveillance protocol (http://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf) within NHSN provides the definitions and reporting structure for this measure.
This is a Pay-for-Reporting measure for MY2017.
Hospitals that submit data to CheckPoint in a timely manner (so that the data is available on CheckPoint by 9/30/2017) will be deemed to have met the requirement for this measure.
Reporting notes/resources:

- Data must be entered into NHSN and rights conferred to the WHA group (ID 27080) for measure compliance. Data are then loaded onto CheckPoint for evaluation.
- All NHSN reporting rules should be followed, including but not limited to, indicating MRSA blood LabID surveillance in monthly reporting plans and entering monthly numerators and denominators (admissions, patient days and encounters) in all eligible units.
- The SIR is only calculated when the number of predicted MRSA blood LabID events is ≥ 1 to help enforce a minimum precision criterion. In cases where the SIR is not calculated, a + will be indicated on CheckPoint.
- Surveillance protocol: http://www.cdc.gov/nhsn/pdfs/pscmanual/12pscmdro_cdadcurrent.pdf

- Surveillance resources: http://www.cdc.gov/nhsn/acute-care-hospital/cdiff-mrsa/index.html
- Contact Jill Hanson, Quality Improvement Manager at the Wisconsin Hospital Association, at 608-268-1842 or jhanson@wha.org for CheckPoint questions.
- Contact Ashlie Dowdell, HAI Surveillance Coordinator at the Wisconsin Division of Public Health, at 608-266-1122 or ashlie.dowdell@wi.gov for NHSN questions.

9. Surgical Site Infection (SSI) Colon Surgery

This measure uses a standardized infection ratio to compare a hospital's results against the statewide ratio. Data is submitted to CheckPoint. The SSI surveillance protocol (http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf) within NHSN provides the definitions and reporting structure for this measure.

Minimum number of observations:

At least 25 observations are required for this measure to be applicable to a hospital.

Reporting notes/resources:

- Data must be entered into NHSN and rights conferred to the WHA group (ID 27080) for measure compliance. Data are then loaded onto CheckPoint for evaluation.
- All NHSN reporting rules should be followed, including but not limited to, indicating COLO SSI inpatient surveillance in monthly reporting plans and entering monthly numerators and denominators for all eligible surgeries.
- The SIR is only calculated when the number of predicted COLO SSIs is ≥ 1 to help enforce a minimum precision criterion. In cases where the SIR is not calculated, a + will be indicated on CheckPoint.
- SSIs are included in the numerator of a SIR based on the month of the procedure date, not the event date.
- If it is possible for your facility to perform a COLO surgery, COLO SSIs should be entered into monthly reporting plans each month. If COLO procedures are not an option at your facility, please contact Jill Hanson so the appropriate notation of NA can be made on CheckPoint.
- Surveillance protocol: http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- Surveillance resources: http://www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html
- Contact Jill Hanson, Quality Improvement Manager at the Wisconsin Hospital Association, at 608-268-1842 or jhanson@wha.org for CheckPoint questions.
- Contact Ashlie Dowdell, HAI Surveillance Coordinator at the Wisconsin Division of Public Health, at 608-266-1122 or ashlie.dowdell@wi.gov for NHSN questions.

Earn-Back Methodology:

i. Relative **level** of performance is defined by comparison with the designated (e.g., national or statewide) average for all hospitals.

ii. **Improvement** shown is defined by percent reduction in error rates for each measure.

	Degree of **IMPROVEMENT**		
Performance **LEVEL**	High (10% or higher)	Medium (5% - 10%)	Low (0% - 5%)
High (greater than 1.10 times the designated average)	100% earn-back		
Medium (between 0.90 and 1.10 times the designated average)	100% earn-back	75% earn-back	50% earn-back
Low (less than 0.90 times the designated average)		50% earn-back	No earn-back

iii. As shown above, a hospital with "high" performance level for this measure will earn back 100% of its withhold for this measure, regardless of improvement shown.
iv. A hospital showing "high" improvement for this measure will earn back 100% of its withhold for this measure, regardless of its level.
v. When high achievement is not possible for either level or degree of improvement (e.g. the base line scores are already at 100%), DHS may make adjustments to the methodology so that high performance is possible (e.g. continued performance at 100% for a measure may constitute high performance). Any such modifications will be communicated via the P4P mailing list.

10.Surgical Site Infection (SSI) Abdominal Hysterectomy

This measure uses a standardized infection ratio to compare a hospital's results against the statewide ratio. Data is submitted to CheckPoint. The SSI surveillance protocol (http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf) within NHSN provides the definitions and reporting structure for this measure.

Minimum number of observations:

At least 25 observations are required for this measure to be applicable to a hospital.

Reporting notes/resources:

- Data must be entered into NHSN and rights conferred to the WHA group (ID 27080) for measure compliance. Data are then loaded onto CheckPoint for evaluation.
- All NHSN reporting rules should be followed, including but not limited to, indicating HYST SSI inpatient surveillance in monthly reporting plans and entering monthly numerators and denominators for all eligible surgeries.
- The SIR is only calculated when the number of predicted HYST SSIs is ≥ 1 to help enforce a minimum precision criterion. In cases where the SIR is not calculated, a + will be indicated on CheckPoint.
- SSIs are included in the numerator of a SIR based on the month of the procedure date, not the event date.
- If it is possible for your facility to perform a HYST surgery, HYST SSIs should be entered into monthly reporting plans each month. If HYST procedures are not an option at your facility, please contact Jill Hanson so the appropriate notation of NA can be made on CheckPoint.
- Surveillance protocol: http://www.cdc.gov/nhsn/pdfs/pscmanual/9pscssicurrent.pdf
- Surveillance resources: http://www.cdc.gov/nhsn/acute-care-hospital/ssi/index.html

- Contact Jill Hanson, Quality Improvement Manager at the Wisconsin Hospital Association, at 608-268-1842 or jhanson@wha.org for CheckPoint questions.
- Contact Ashlie Dowdell, HAI Surveillance Coordinator at the Wisconsin Division of Public Health, at 608-266-1122 or ashlie.dowdell@wi.gov for NHSN questions.

Earn-Back Methodology:

i. Relative **level** of performance is defined by comparison with the designated (e.g., national or statewide) average for all hospitals.

ii. **Improvement** shown is defined by percent reduction in error rates for each measure.

<table>
<tr><th></th><th colspan="3">Degree of IMPROVEMENT</th></tr>
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</table>

iii. As shown above, a hospital with “high” performance level for this measure will earn back 100% of its withhold for this measure, regardless of improvement shown.

iv. A hospital showing “high” improvement for this measure will earn back 100% of its withhold for this measure, regardless of its level.

v. When high achievement is not possible for either level or degree of improvement (e.g. the base line scores are already at 100%), DHS may make adjustments to the methodology so that high performance is possible (e.g. continued performance at 100% for a measure may constitute high performance). Any such modifications will be communicated via the P4P mailing list.

Withhold P4P Methodology

Withhold methodology overview:

Hospitals that meet both reporting requirements and performance-based targets, for the measures described earlier in this Guide, are eligible to receive payments from the hospital withhold P4P (HWP4P) pool as follows:

a. DHS calculates individual HWP4P pool amounts for each eligible hospital. At the end of the MY, DHS divides each individual HWP4P pool amount by the number of measures applicable to the respective hospital to determine the value of each measure. (E.g., if a hospital's individual pool equals $100,000 and it qualifies to participate in four measures, then each measure is worth $25,000.) As a result, the value of a given measure will vary from hospital to hospital, impacted by both the size of the individual hospital's HWP4P pool amount and the number of measures for which the hospital qualified.
b. If a hospital meets all of its performance targets for all applicable measures, it receives a payment equal to its individual HWP4P pool amount.
c. If a hospital does not meet all of its performance targets, it earns dollars for those measures where the targets were met, in a graduated manner (0%, 50%, 75%, or 100%).
d. If all participating hospitals meet all of their individually applicable targets, no additional HWP4P pool funds are available and thus no payments beyond those described above can be made to any hospital (i.e. no bonus payments could be made).
e. If at least one participating hospital does not receive its full HWP4P pool amount, DHS aggregates all remaining HWP4P pool funds and distributes them as additional bonus payments to hospitals that met their performance targets.

DHS ensures that all HWP4P pool dollars are paid back to hospitals by providing bonus payments. If a hospital meets all reporting requirements and performs in the highest tier on at least one applicable pay-for-performance (as opposed to pay-for-reporting) measure, it qualifies to receive a bonus payment. Bonus dollars are shared proportionally among hospitals weighted by two factors: the relative magnitudes of the individual HWP4P pool amounts for all hospitals that qualified for the additional bonus and the percentage of applicable measures for which the hospitals performed in the highest performance tier. Therefore, hospitals with a larger HWP4P pool amount receive a larger portion of the additional bonus dollars available, while high-performing hospitals are also rewarded. The University of Wisconsin Medical Center and CAHs are only eligible for P4P payments up to cost.

Specific Methodology for Degree of Improvement "Reduction in Error"

The degree of improvement achieved by a hospital is defined as the percentage "reduction in error" for a given measure in MY 2017, compared to a hospital's MY2017 baseline.

The following shows an example of how the degree of improvement methodology is implemented.

If a hospital's MY 2017 baseline for a measure = 80%, then its MY 2017 "error" = 100% - 80% = 20%.
A hospital can achieve a 10% reduction in error by improving its past score by = $\left(\frac{10}{100} * 20\right)$ = 2 percentage points, by attaining a score of 82%.

If the MY 2017 score = 81%, then that hospital would have improved its score by 1 percentage point = 5% reduction in error.

Mathematically, the reduction in error for MY 2017 = $\left(\frac{(MY\,2017 score - MY\,2017 baseline)}{Error = (100 - MY\,2017 baseline)} * 100\right)$

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

Hospital	MY 2017 Baseline	MY 2017 Error	MY 2017 Score	MY 2017 score – MY 2017 baseline	% Reduction in Error	
A	93%	7% points	93%	0% points	=(0/7)*100 = 0%	Low
B	89%	11% points	90%	1% points	= (1/11)*100 = 9.1%	Medium
C	89%	11% points	89%	0% points	=(0/11)*100 = 0%	Low
D	83%	17% points	85%	2% points	=(2/17)*100 = 11.8%	High

Specific Methodology for Withhold Data
The data (data = dollars withheld) for a given MY will be pulled on or shortly after November 1 following the conclusion of the MY. The data will never be pulled before November 1 to allow for completeness of the data.

Specific Withhold P4P Methodology for Individual Measures
For those measures where it is mathematically impossible to reach high performance for either level or degree of improvement (e.g. the base line scores are already at 100%), DHS may make adjustments to the methodology so that high performance is possible (e.g. continued performance at 100% for a measure may constitute high performance). Any such modifications will be communicated via the P4P mailing list.

For applicable **CheckPoint** measures, DHS will use data available from CheckPoint as the sole source for calculating the P4P results for all hospitals. All hospitals that have eligible observations must submit data to CheckPoint, so that DHS can correctly determine applicability of measures to each hospital. DHS may review claims of those hospitals that did not report any data to CheckPoint for a particular measure. If DHS determines that a hospital had eligible observations for a measure but did not report data to CheckPoint, DHS reserves the right to recoup both earn-back and bonus money that was paid out during that measurement year. Therefore it is important for hospitals to ensure that all data is properly reported so as to avoid possible recoupment.

Earn-Back Methodology
Any hospital with at least one measure applicable to it (including Pay-for-Reporting measures) will have its entire withhold at risk. Hospitals with more than one applicable will have each applicable measure carry an equal share of the withhold risk. All hospitals must report data for both P4R measures to earn back the withhold for those two P4R measures.

Bonus Methodology
Hospitals can earn a bonus in addition to their withheld amounts. The bonus pool will be entirely funded by one or more hospitals forfeiting part or all of their withheld amounts, due to performance or other factors. The goal of the methodology is to ensure that a hospital's bonus is proportional to both that hospital's share in the total dollars withheld across all hospitals and that hospital's performance—bonus funding is intended to recognize high-performing hospitals. DHS pays out all remaining withheld funds as bonus payments; DHS does not retain any of the withhold P4P funds.

To be eligible for the bonus pool**,** hospitals must have at least one pay-for-performance measure applicable to them and meet 100% performance on at least one pay-for-performance measure, in order to maintain fairness for hospitals that are subject to pay-for-performance measures. A hospital with only pay-for-reporting (P4R) measures applicable to it will not be eligible for any bonus, but could earn back 100% of the withhold if it meets both P4R requirements. If a hospital does not meet all applicable P4R requirements, it will not be eligible for any bonus payment.

Bonus funding is weighted on the percentage of applicable measures for which the hospital achieved the highest performance (100%) and the amount of funds withheld from the hospital. In this way, bonus money is allocated equitably, taking into account the total dollar value of the withheld amount and the number of applicable measures. Weighting in this manner ensures that a hospital with a smaller withheld amount will not receive an excessively large bonus payment.

There is no cap on the amount of bonus money a hospital can receive.

The example on the following pages illustrates the earn-back and bonus methodologies.

Withhold P4P Methodology Example

This example is used for illustrating the Hospital Withhold P4P Methodology. The worksheet can help a hospital understand the underlying calculations that are used to determine the withhold earn-back and bonus.

Legend for Tables	
P4R = Pay for Reporting; P4P = Pay for Performance	
Column 1	Hospital Name
Column 2	$ withheld, = 1.5% of FFS claims payments
Column 3	# of applicable measures, including P4R; Col. 3 = sum (Columns 5,6, 7, 8, and 9)
Column 4	Weight per applicable measure = 1 / Col. 3
Column 5 – 8	# of measures with various earn-back %, based on High, Medium, Low ratings
Column 9	# of P4R measures that apply– applies to each hospital
Column 10	P4R measures met
Column 11	Earn-back % = (Column 4 * ((Column 5 * 100%) + (Column 6 * 75%) + (Column 7 * 50%) + (Column 8 * 0%) + (Column 10/ 9 * 100%))
Column 12	Earn-back $ = (Column 11 * Column 2) **(STEP A)**
Column 13	Same as column 1 (hospital name)
Column 14	Same as column 3
Column 15	Did the hospital report on all applicable P4R measures? “Yes (1)” if the hospital reported on P4R measures. “No (0)” if the hospital did *not* report on P4R measures.
Column 16	Applicable measures minus the applicable P4R measures
Column 17	Same as column 2
Column 18	Same as column 12
Column 19	Amount of money remaining for the bonus pool (Column 17- Column 18)
Column 20	Number of applicable measures at 100% (excluding P4R)
Column 21	Percent of applicable measures at 100% (excludes P4R) (Column 20 divided by Column 16)
Column 22	Withhold dollars scaled to performance (column 21 x column 17 x column 15)
Column 23	Same as columns 1 and 12
Column 24	Weighted bonus distribution (individual column 22 number divided by the total of that same column)
Column 25	Bonus earned (column 24 x total bonus pool (total of column 19))
Column 26	Total payout (column 25 plus column 18)
Column 27	Percent of withhold paid back (column 26 divided by column 17)

Earn-Back

The following table shows example calculations for earn-back. Five hospitals using MY2013 data, totals represent MY13 data for all 137 hospitals in the Withhold P4P program.

col. 1	*col. 2*	*col. 3*	*col. 4*	*col. 5*	*col. 6*	*col. 7*	*col. 8*	*col. 9*	*col. 10*	*col. 11*	*col. 12*
				P4P Earn-back							
Hospital	**Withhold $***	**# of applicable measures**	**Weight per measure**	**100%***	**75%***	**50%***	**0%***	**P4R***	**P4R Met**	**Earn-back %**	**Earn-back $**
A	$25,534.84	1	100%					1	1	100.0%	$25,534.84
B	$19,516.96	4	25%	2		1		1	1	87.5%	$17,077.34
C	$7,208.90	4	25%	1		1	1	1	1	62.5%	$4,505.56
D	$24,317.74	4	25%			2	1	1	1	50%	$12,158.87
E	$19,516.96	4	25%	2		1		0	0	87.5%	$17,077.34
Total (N=137) **$4,834,156.57**											**$3,581,335.89**

Bonus Distribution

Here are five examples of the bonus methodology in action using MY2013 data: (Total represents MY2013 data from all 137 hospitals in the Withhold P4P program.)

Col. 13	Col. 14	Col. 15	Col. 16	Col. 17	Col.18	Col. 19	Col. 20	Col. 21	Col. 22
Name	Total Applicable Measures	Reported on applicable P4R	Applicable Measures less P4R	Total Withheld	Total Earn-back	Amount left for Bonus Pool	Number of Measures at 100% excluding P4R	% of Applicable Measures at 100% (excluding P4R)	Withhold $ scaled by Performance (% of 100% measures*total withheld*reported on P4R)
A	1	Yes(1)	0	$25,534.84	$25,534.84	$0	0	0%	$0
B	4	Yes(1)	3	$19,516.96	$17,077.34	$2,439.62	2	66.67%	$13,011.31
C	4	Yes(1)	3	$7,208.90	$4,505.56	$2,703.34	1	33.33%	$2,402.97
D	4	Yes(1)	3	$24,317.74	$12,158.87	$12,158.87	0	0%	$0
E	4	No(0)	3	$19,516.96	$17,077.34	$2,439.62	2	66.67%	$0
Total for all Hospitals (137):				**$4,834,156.57**	**$3,581,335.89**	**$1,252,820.68**			**$2,361,961.19**

Col. 23	Col. 24	Col. 25	Col. 26	Col. 27
Name	Weighted Bonus Distribution (Withhold $ scaled by performance/ total of same col.)	Bonus (weighted share*Total bonus pool)	Total Payout	% of withhold earned back
A	0%	$0	$25,534.84	100%
B	.5509%	$6,901.40	$23,978.74	123%
C	.1017%	$1,274.57	$5,780.13	80%
D	0%	$0	$12,158,87	50%
E	0%	$0	$17,077.34	88%
		$1,252,820.68	**$4,834,156.57**	