Measurement Year (MY) 2014
Hospital Pay-for-Performance (P4P) Guide

Table of Contents

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Measurement Year (MY) 2014 Hospital P4P – Overview

1. Overview

a. **MY 2014 = April 1, 2013 through March 31, 2014**
MY 2014 and beyond will be on a 12-month cycle, from April 1 through March 31 of the next calendar year.

b. For MY 2014, DHS will implement two components of its Fee-for-Service (FFS) Hospital Pay-For-Performance (P4P) program, namely:
   i. Withhold P4P, and
   ii. Assessment P4P
   Performance for all P4P initiatives will be measured annually, not each quarter.

c. **Withhold P4P**
   i. Withhold P4P Scope: Money will be withheld from Fee-for-Service claims payments only, including inpatient and outpatient services. The scope excludes out-of-state and border-status hospitals, long term care, rehab, and nursing homes.
   ii. 1.5% will be withheld from total FFS claims payments, and earned back based on performance. In addition to earning back the 1.5% withhold, hospitals can earn a bonus up to 1.5% of their total FFS claims payments, funded entirely by forfeiture by other hospitals, and subject to caps defined by DHS, using the methodology described in Appendix 4.
   iii. Seven measures will apply in MY 2014 – Appendices 1(a), (b) and (c).
   iv. MY 2014 Timeline for Withhold P4P – Appendix 2.
   v. Withhold P4P methodology is discussed in Appendix 4.
   vi. Data submission and validation is discussed in Appendix 5.

d. **Assessment P4P**
   It will continue, with minor modifications for MY 2014 – Appendix 7.
   i. MY2014 Timeline for Assessment P4P – Appendix 3.

Appendix 1(a) – Measures for MY 2014 Hospital – Withhold P4P only

Measure	Applicable to				Data Source	Level	Error Reduction
	Acute Care (n=69)	Critical Access (n=58)	Psych (n=13)	Children's (n=2)			
1. **30-day hospital readmission** - Specifications developed by DHS. No case mix adjustment; Pre/post comparison, not across hospitals.	✓	✓	×	✓	DHS claims data	×	✓
2. **Mental health follow-up visit within 30 days** of discharge for mental health inpatient care - pre/post comparison. Specifications developed by DHS. Pre/post comparison.	✓	✓	✓	✓	DHS claims data	×	✓
3. **Asthma care for children (Home Management Plan of Care only)** – applicable to Children's Hospitals only.	×	×	×	✓	Joint Commission	✓ (national average)	✓
4. **Surgical infection index**. Move from "Assessment P4P" to "Withhold P4P"	✓	✓	×	×	CheckPoint	✓ (WI average)	✓
5. **(PN-6) – <u>Initial antibiotic</u>** – % of immunocompetent patients with **<u>community-acquired pneumonia</u>** who receive an initial antibiotic regimen during the first 24 hours that is consistent with guidelines.	✓	✓	×	×	CheckPoint	✓ (WI average)	✓
6. **Healthcare Personnel (HCP) influenza vaccination** – CMS will require it in future. Specifications developed by DHS.	✓	✓	✓	✓	Self-report via NHSN	✓ (national average)	✓
7. (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	P4R for MY2014 & MY2015	

✓ *= measure is conceptually applicable*

Appendix 1(b) – State/ National Averages for MY 2014 Hospital P4P

Hospitals can calculate their specific targets using the following state / national averages and methodology described in **Appendices 4 and 8**. Please note that these averages for MY2014 will be the same as for MY2013 due to time lags in data availability.

Withhold P4P

Measure	Numerator	Denominator	State / National Average
30-day Readmission Statewide Average n=137 hospitals	2857	16341	17.5%
30- day Mental Health Follow-up Visit Statewide Average n=49 hospitals	1175	1684	69.8%
Childhood Asthma National Average, Joint Commission Data (Oct 2010 - Sept. 2011)	Numerator / denominator data not available from The Joint Commission		82.7%
SCIP Index Statewide Average; n=125 hospitals; Data: 2010Q4 – 2011Q3	WHA does not receive the numerator / denominator for this measure from MetaStar		85.7%
Initial Antibiotic (PN-6) Statewide Average; n=125 hospitals; Data: 2010Q4 – 2011Q3	6351	6708	94.7%
Healthcare Personnel Influenza Vaccination Rate National Average (2011 – 2012 flu season); n-137	Numerator / denominator data not available from CDC		66.9%

MY2014 baselines are based on claims submitted between April 1, 2011 and March 31, 2012. Preliminary hospital-specific baselines for the readmission and mental health follow-up visit measures were posted on each facility's individual ForwardHealth portal page in late February 2013, and will be finalized by mid-April 2013.

Assessment P4P

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

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

Appendix 1(c) – Specifications for MY 2014 Hospital P4P Measures

i. 30-Day Hospital Readmission

This measure applies to all hospitals with at least **30** eligible discharges in the denominator for a 12-month Measurement Year.
Measure = % of inpatient stays during the measurement year that were followed by a readmission within 30 days for all members.

Denominator = All inpatient discharges to home in MY 2014 after applying exclusions.

Numerator = All inpatient "readmissions" between 4/1/2013 – 3/31/2014 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 3/1/2013 – 3/31/2013.
- 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 plans to provide a semi-annual report for the readmission measure to each hospital. This report will include the numerator, denominator, patient identifiers for patients who comprised the numerator and the denominator, and other information. Since this report will be based on the claims data of DHS, the currency of this information will depend on the timeliness of claims submitted by hospitals.

Eligible population
- **Product line:** Medicaid FFS including BadgerCare Plus Standard, Benchmark, and Core Plan members and Wisconsin Medicaid FFS recipients.
- **Ages:** Members under 65 years of age during the measurement year.
- **Continuous enrollment:** Enrollment in Wisconsin Medicaid 30 days after the Discharge Date.
- **Benefits:** Medical.
- **Measurement Year:** April 1, 2013 to March 31, 2014.

Exclusions
- Admissions for members in HMOs for BadgerCare Plus Standard, Benchmark, and Core / Basic or Medicaid SSI. Exclude Medicare (dual eligible) members.
- Transfers to another facility; only discharges to home (discharge status =01) are included.

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

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

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

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

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

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

Calculation Steps for Baselines:

The description below is an overview of how baseline data was pulled. These dates are meant to illustrate the methodology and the associated timeframe; actual dates may vary over time.

Staging

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

new table contains those records found in the Discharge Table which show that the member was eligible for Title XIX services, excluding the BadgerCare Plus Basic Plan, 30 days after the discharge date, and therefore eligible for the measure.

Calculating Denominator

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

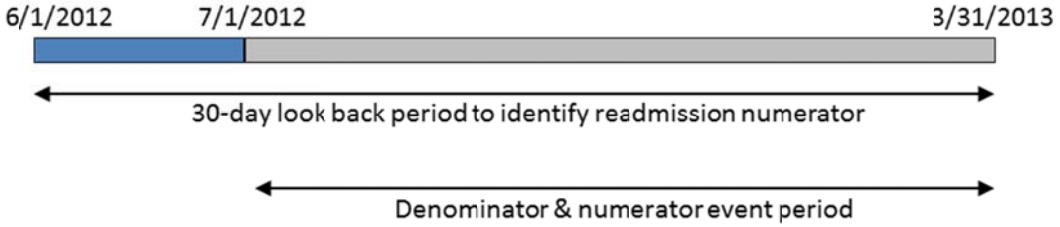
Staging

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

Calculating Numerator

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

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



The following table provides various **sample scenarios** for this measure, and is meant to be illustrative only. Actual dates may vary depending on the Measurement Year.

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

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

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

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

ii. Mental Health Follow-Up Visit Within 30 days

This measure applies to all hospitals with at least **30** eligible discharges during the Measurement Year for mental health inpatient care for a 12-month Measurement Year. The scope of the measure is broader than the HEDIS Follow-Up After Hospitalization for Mental Illness (FUH-30) definition.

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

Denominator = All patients discharged alive during the measurement year 2014, after applying exclusions, from an acute inpatient setting (including acute care psychiatric facilities) with any of the following principal mental health diagnoses during the measurement year **(aka MHF-A codes)**:
ICD-9-CM codes: 295-298.9, 299.1, 299.8, 299.9, 300 – 301.93, 307.1, 307.5, 308, 309, 311-314.

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

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

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

Eligible population

- **Product line:** Medicaid FFS including BadgerCare Plus Standard, Benchmark, and Core / Basic Plan members and Wisconsin Medicaid FFS recipients.
- **Ages:** Members 18 years and older as of the date of discharge.
- **Continuous enrollment:** Enrollment in Wisconsin Medicaid 30 days after the Discharge Date.
- **Benefits:** Medical and mental health (inpatient and outpatient).
- **Measurement Year:**
  Denominator: Dates of initial discharge or readmission / direct transfer from April 1, 2013 to March 31, 2014.
  Numerator: 30-day mental health follow-up visits between April 1, 2013 and April 30, 2014 (13 months), in order to account for the 30-day post-discharge period.

Exclusions

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

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

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

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

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

The following table provides **sample scenarios** for the Mental Health Follow-up measure, and is meant to be illustrative only. Actual dates may vary depending on the Measurement Year.

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

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

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

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

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

iii. Asthma Care for Children

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

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

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

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

iv. Surgical Care Improvement Project (SCIP) Index

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

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

- Clot prevention given
- Peri-operative beta blockers.

The baseline for this measure is based on the latest 12-month data available on CheckPoint, as of July 23, 2012. Performance will be based on the latest 12-month data available on CheckPoint, as of September 15, 2014.

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

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

The baseline for this measure is based on the latest 12-month data available on CheckPoint, as of July 23, 2012. Performance will be based on the latest 12-month data available on CheckPoint, as of September 15, 2014.

vi. Healthcare Personnel (HCP) Influenza Vaccination

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

Approximately 90% of hospitals in Wisconsin already report this data in some form to Division of Public Health (DPH) via a survey. For MY 2014:

- DHCAA will 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. An example of this module can be found in Table 2, ahead.
- Each healthcare personnel will be counted only once for each employer. If a healthcare personnel is employed by multiple employers, that personnel will be counted multiple times, since the measure focuses on hospitals, not individual employees.
- Although CMS requires only Inpatient Prospective Payment Systems (IPPS) to report HCP influenza vaccination rates, in order to meet the DHS 2014 Hospital P4P requirements, **all hospitals to which P4P applies** must submit data to NHSN. The data must be submitted to **NHSN by May 14, 2014**, since the DHS will pull the data from NHSN on May 15, 2014. 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 (see Appendix 1(b)) as published by the CDC for flu season 2011 – 2012 will be used for calculating hospital specific performance levels.

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

Methodology

Denominator: # of hospital employees, licensed independent practitioners and adult students / trainees and volunteers that have worked in a hospital for 30 days between October 1, 2013 and March 31, 2014. The definitions for each category of HCP are listed in **Table 1**.

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

Numerator: # of hospital employees, licensed independent practitioners and adult students / trainees and volunteers that have worked in a hospital for 30 days between October 1, 2013 and March 31, 2014 that receive a flu vaccination during the vaccination season.

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

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

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

Table 1 HCP Influenza Vaccination Denominators

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

Table 2 NHSN Healthcare Personnel Influenza Vaccination Summary

Record the number of HCP for each category below for the influenza season being tracked				
Facility ID #:				
Vaccination type: influenza	Influenza subtype: □ 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)**
1. Number of HCP who worked at this facility for at least 30 days between October 1, 2013 and March 31, 2014				
2. Number of HCP who received an influenza vaccination at this facility since influenza vaccine became available this season				
3. Number of HCP who provided a written report or documentation of influenza vaccination outside this facility since influenza vaccine became available this season				
4. Number of HCP who have a medical contraindication to the influenza vaccine				
5. Number of HCP who declined to receive the influenza vaccine				
6. Number of HCP with unknown vaccination status (or criteria not met for questions 2-5 above)				

vii. Early Elective Induced Deliveries (PC-01)

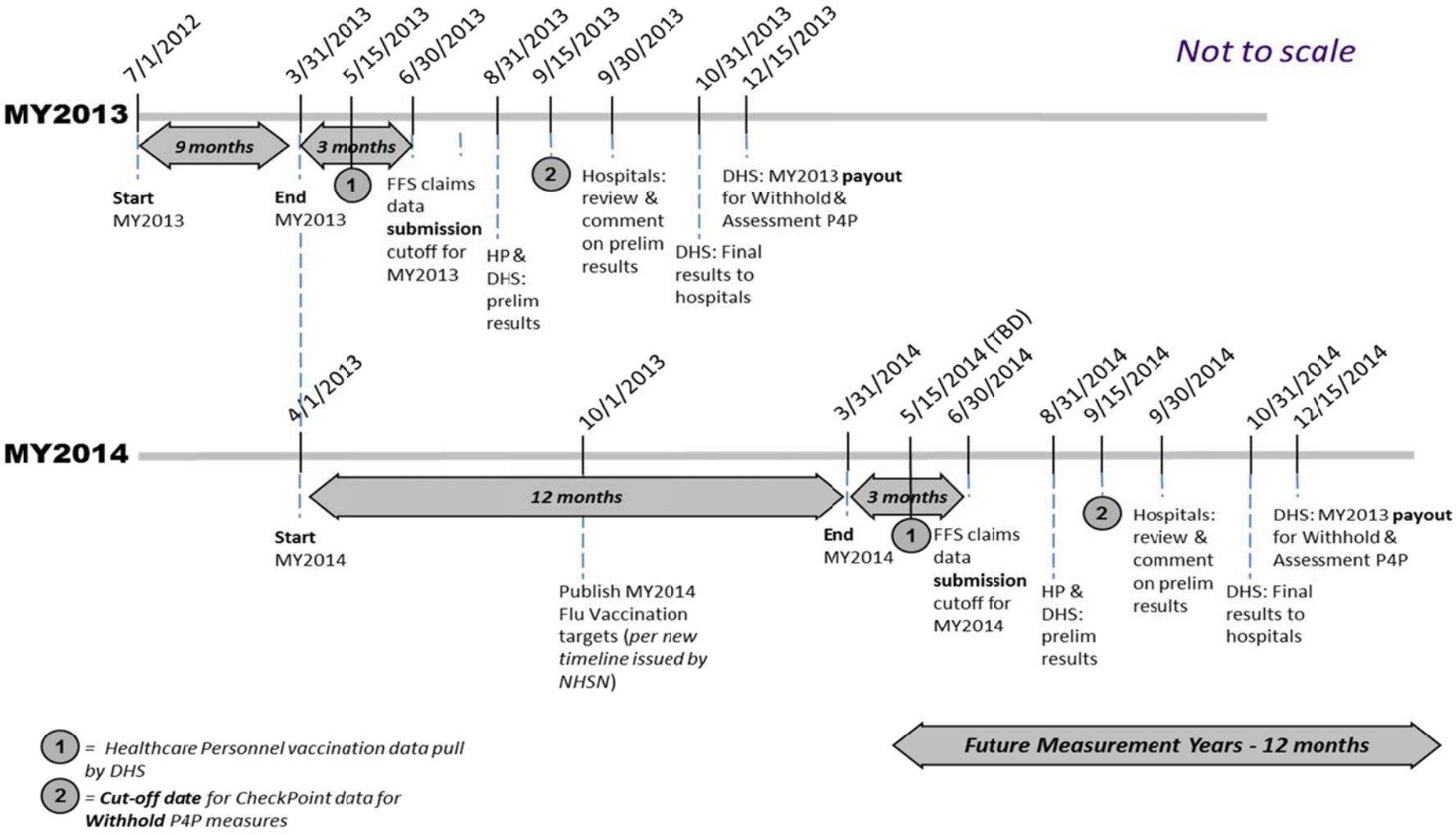
Data are for all payers for each hospital.
DHS will use the data published on the CheckPoint website for:

- Patients with elective vaginal deliveries or elective cesarean sections at >= 37 weeks and < 39 weeks of gestation.

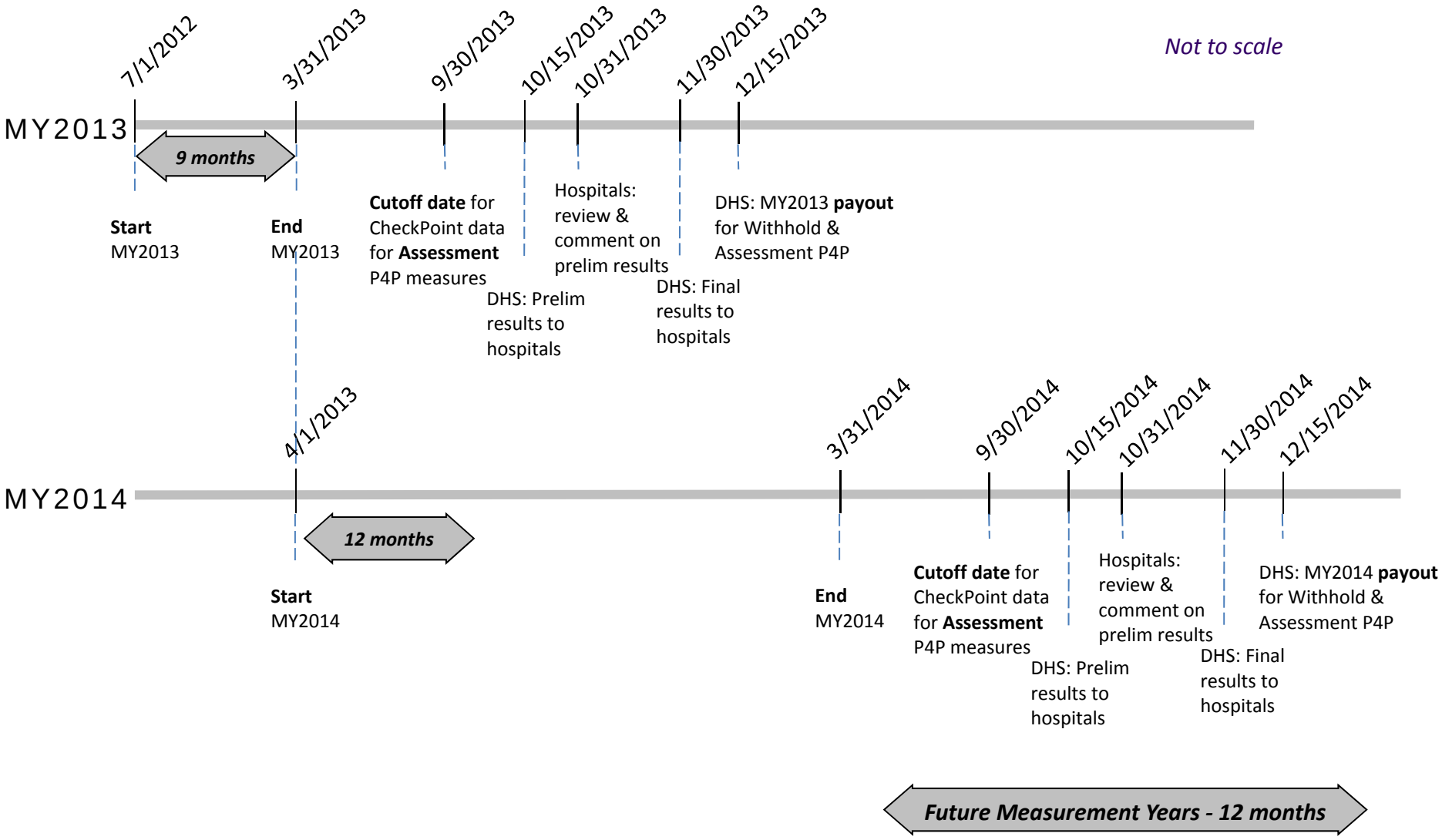
This is a **Pay-For-Reporting (P4R)** measure for MY2014 and MY2015.

Hospitals that submit data to CheckPoint in a timely manner (so that data are available on CheckPoint by 9/15/2014) will be deemed to have met the requirement for this measure.

Appendix 2: Hospital Withhold P4P Timeline – MY 2013 and MY 2014



Appendix 3: Hospital Assessment P4P Timeline – MY 2013 and MY 2014



Appendix 4 – Withhold P4P Methodology for MY 2014

a. Withhold period = Measurement period = **MY 2014** (April 1, 2013 – March 31, 2014).
b. Measurement will take place on an **annual** basis, and not each quarter.
c. A priori, it is impractical to predict which measures will apply to each hospital, since there must be a minimum # of cases for each measure for a given hospital. The applicability of each measure will be determined when the results are calculated, i.e., at the end of MY 2014. Hospitals with insufficient cases for any measure will not be subject to that measure.
   For each hospital, **each applicable measure will have an equal weight** in the withheld $. Example: If only 4 measures are applicable to a hospital, then each of those 4 measures will have a $1/4^{th}$ weight in determining the earn back for the 1.5% withhold. Although case-mix adjustments are not applied for MY 2014, DHS intends to explore applying them in the future.
   If a measure is applicable to a hospital but **no baseline** data are available, then the baseline would be assumed to be equal to the **state-wide average** for that measure, unless clear data suggesting otherwise are available.
d. This is not an "all-or-nothing" approach. Hospitals will earn back their withhold separately for each applicable measure. As an example, if 3 measures apply to a hospital, it is possible that the hospital earns back full withhold for one measure, 75% of withhold for the 2^{nd} measure, and none for the 3^{rd} measure.
e. Depending on the measure (see Appendix 1(a)), a combination of two criteria might be applied for earning back the withhold, as shown in the table below:
   i. Relative **level** of performance is defined by comparison with the designated (e.g., national or State-wide) average for all hospitals.
   ii. **Improvement** shown is defined by, e.g., % reduction in "error" rates for each measure.

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

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

Example: Degree of Improvement - "Reduction in Error"

The degree of improvement achieved by a hospital is defined as the percentage "reduction in error" for a given measure in MY 2014, compared to that hospital's MY2014 baseline, as discussed in Appendix 1(b).

An example:

If a hospital's MY 2014 baseline for a measure = 80%, then its MY 2014 "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 2014 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 2014 = $\left(\frac{(MY\,2014\,score - MY\,2014\,baseline)}{Error = (100 - MY\,2014\,baseline)} * 100\right)\%$

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

Hospital	MY 2014 Baseline	MY 2014 Error	MY 2014 Score	MY 2014 score – MY 2014 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

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

Since DHS is not applying risk-adjustment to these two measures for MY 2014, only **Degree of Improvement** will apply, and comparisons across hospitals will not be made. The following table shows how the % of earn back will be determined for these two measures for MY 2014:

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

g. Specific Withhold P4P methodology for CheckPoint Measures

i. Set baseline at statewide average, calculated using most recent four quarters of data available on 7/23/2012.

ii. Hospitals with less than 25 observations in the Measurement Year (MY) are exempt from the measure.
iii. For hospitals with more than 25 observations in the MY, the methodology from Section "e" of this Appendix applies. Both, Degree of Improvement and Performance Level, apply.

For those measures where it is mathematically impossible to reach a High Performance Level (i.e. 1.1 times the designated average for a particular measure), hospitals will be evaluated solely on their reduction in error. Situations where use of the Degree of Improvement or Performance Level methodology cannot be applied will be reviewed on a case-by-case basis by the DHS.

h. **Minimum # of applicable measures:**
The 1.5% **withhold** will apply to all hospitals. Any hospital with at least one measure applicable to it (including Pay for Reporting measures) will have its withhold at risk. For MY 2014, hospitals to which only pay for reporting measures apply can earn their entire withhold by meeting the reporting requirements, though they would not be eligible for the bonus pool.

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

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

DHS will employ a Four Tier Methodology for bonus sharing. Please see **Appendix 8** for details.

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

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

The bonus pool cannot exceed the forfeited withheld amounts.

Example: Total Bonus Pool Size
Assume that:
- Total forfeiture = bonus pool = $500,000.
- Five hospitals are eligible for bonus.

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

j. **Sharing the Bonus Pool**:
DHS utilized the following guiding principles for its policy re: bonus payments:
- Budget neutrality – DHS intends to pay out all the withheld amounts;
- Bonus should be distributed among high performing hospitals, and,
- Bonus $ should be allocated equitably, taking into account the total $ value of the withheld amount and the # of applicable measures.

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

Appendix 8 explains the methodology that the DHS plans to implement for distributing bonus $. The Appendix also provides an example.

If any small sums are still left in the bonus pool after paying out in Step C as explained in Appendix 8, those funds might be redistributed among hospitals, or rolled over to the next year's bonus pool.

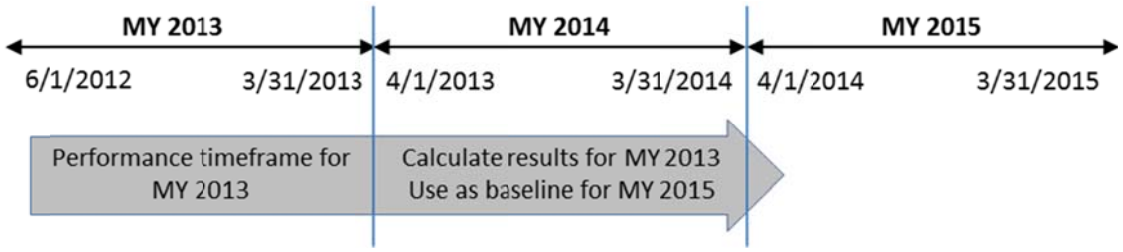
k. For applicable **CheckPoint measures**, DHS will use data available from CheckPoint as the sole source for calculating the P4P results for all hospitals. All hospitals that have eligible observations must submit data to CheckPoint, so that DHS can correctly determine applicability of measures to each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

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

Appendix 5 – Data Submission and Validation Process

Baselines for Measurement Years

For the Readmission and the Mental Health Follow-up Visit measures, baseline for MY 2014 were set using data from April 1, 2011 through March 31, 2012, due to time lag in data submission. The diagram below shows the timeframes for using results of a previous MY as baselines for future Measurement Years, including the time lag.



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

Reviewing preliminary results with hospitals

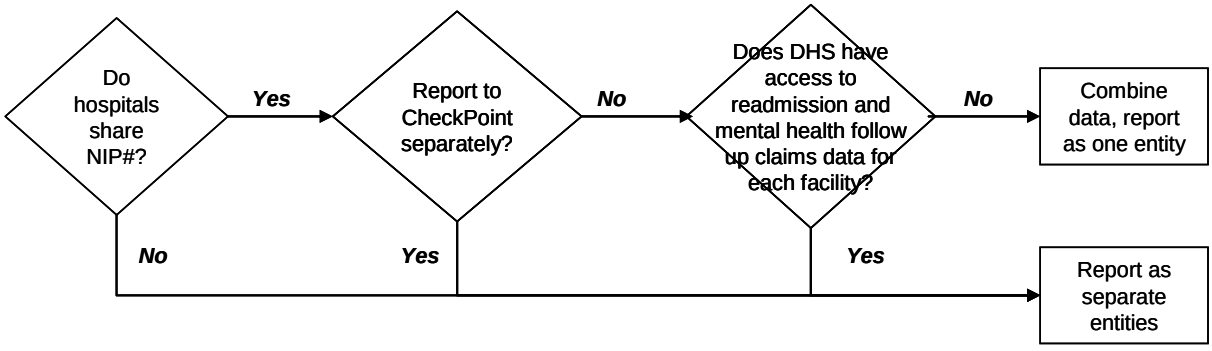
After the data submission cut-off date, DHS will calculate and compile the results, and share them with the hospitals. Hospitals are expected to review the results, and respond to DHS with comments and supporting data in case there are discrepancies between the results calculated by DHS and those by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

Please also see **timelines in Appendices 2 and 3.**

Appendix 6 – FAQ

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

1. Will the measures be reported every quarter, similar to CheckPoint?
   Answer: Measures will be reported and calculated annually, though DHS will provide quarterly results and supporting data for the hospital re-admission and mental health follow-up measures, subject to compliance with HIPAA and Wisconsin statutes.
2. What exclusions apply to various measures?
   Answer: See Appendix 1(c).
3. How will HIPAA / Wisconsin statutory privacy requirements be met for follow-up visit within 30 days?
   Answer: A "yes / no" answer about the member making a follow-up answer can be released for quality improvement activity, per DHS' Privacy Officer.
4. How will the HCP influenza vaccination data be validated?
   Answer: Please see Appendix 1(c).
5. How will DHS publish the results?
   Answer: Via ForwardHealth portal. Please see April 2012 Provider Update (2012-15).
6. Will hospitals be required to submit chart data?
   Answer: The MY 2014 measures do not require chart data. Hospitals will have the option to submit chart data to DHS as part of the process to reconcile any differences between the results calculated by DHS and hospitals' internal results.
7. How is a hospital identified as Acute Care, Critical Access, Psych or Childrens? How will satellite facilities be treated – as part of a larger organization or as separate entities for P4P?
   Answer: The following chart explains the process:



8. What are the claim submission cut-off dates for hospitals for data to be included in P4P for MY2014?
   Answer: June 30, 2014 for Withhold P4P.
9. Does the initiative include Long Term Acute Care (LTAC) Hospitals?
   Answer: No, it does not include LTAC for MY 2014. DHS may consider LTACs for future inclusion in the P4P initiative.

Appendix 7 – MY 2014 Modifications to the Assessment P4P

Measurement Year (MY) 2014 = 4/1/2013 – 3/31/2014.

- DHS will continue reserving $5 million (all funds) for the Assessment P4P program. The Assessment P4P applies only to Acute Care, Children's and Rehab hospitals.
- Targets for Assessment P4P are provided in **Appendix 1(b)**.
- The measures and allocation of money will change for MY 2014 as follows:

Measure	MY 2014
Pay-For-Reporting	
1. Pre-birth Steroids	No money associated with reporting on these measures. Hospitals must report on all these measures to be eligible for the Perinatal P4P $ (see below).
2. Forceps Delivery	
3. Vacuum Delivery	
4. Breast Feeding	
5. Infant Composite	
Pay-For-Performance	
1. Perinatal measures	**$2.0 million;** 3 measures - pre-birth steroids, breast feeding, infant composite($0.667 million per measure) See methodology and example, below.
2. Patient Experience of Care	**$1.5 million** Target = state-wide average
3. Discharge Instructions for heart-related care	**$1.5 million** Target = state-wide average

Methodology and example for the perinatal measure:

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

Appendix 8 – Methodology for Sharing Withhold P4P bonus

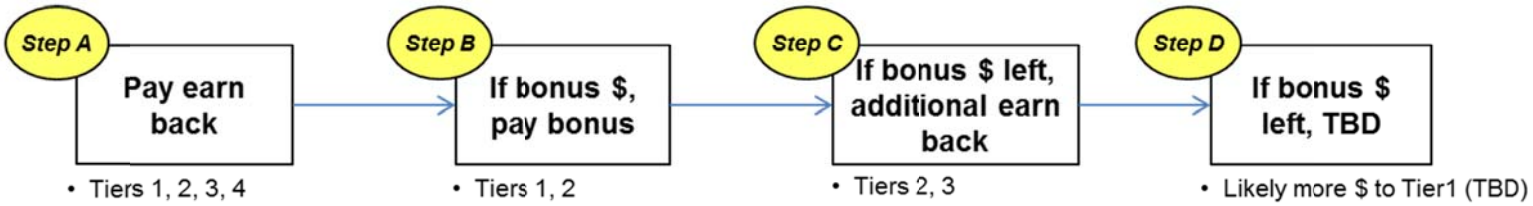
DHS will use a Four Tier Bonus Methodology to distribute any bonus $ as part of the Withhold P4P for MY 2014. This methodology provides multiple opportunities for hospitals to earn back their withhold, and to earn any bonuses. It includes 4 tiers and 4 steps, as explained below.
Tier 1 denotes the highest performance, and Tier 4, the lowest. Depending on the Tier applicable to a given hospital, the hospital will earn a bonus on top of earning back its 1.5% withhold, earn back full or partial withhold, or forfeit its withhold.

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

The following diagram shows the Four Tier Bonus Sharing Methodology.

Four Tier Bonus Sharing Methodology

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



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

Example: Four Tier Bonus Sharing Methodology (Withhold P4P)

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

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

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

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

Step A

The following table shows calculations for Step A.

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

Steps B & C

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

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

Summary Bonus Distribution Table

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

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

Distribution and Sources of Withheld $

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

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

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

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