

Measurement Year (MY) 2015 Hospital Pay-for-Performance (P4P) Guide

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Measurement Year (MY) 2015 Hospital P4P – Overview

1. Overview

- a. **MY 2015 = April 1, 2014 through March 31, 2015**

- b. For MY 2015, DHS will implement two components of its Fee-for-Service (FFS) Hospital Pay-For-Performance (P4P) program, namely:
 - i. Withhold P4P and
 - ii. Assessment P4PPerformance 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, funded entirely by forfeiture by other hospitals, using the methodology described in Appendix 4.
 - iii. Eight measures will apply in MY 2015 – Appendices 1(a), (b) and (c).
 - iv. MY 2015 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.
 - vii. Methodology for sharing Withhold P4P bonus – Appendix 8.

- d. **Assessment P4P**
 - i. Three measures will apply in MY 2015 – Appendix 1(a) and 1(d).
 - ii. State averages for Assessment measures – Appendix 1(b).
 - iii. It will continue, with minor modifications for MY 2015 – Appendix 7.
 - iv. MY 2015 Timeline for Assessment P4P – Appendix 3.
 - v. Data submission and validation – Appendix 5.

Appendix 1(a) – Measures for MY 2015 Hospital – Withhold P4P

Measure	Applicable to				Data Source	Level	Reduction in Error (RIE)	Baseline Period	Measurement Period
	Acute Care	Critical Access	Psych	Children's					
1. 30-day hospital readmission - Specifications developed by DHS. No case mix adjustment; Pre/post comparison, not across hospitals.	✓	✓	✗	✓	DHS fee-for-service claims data	✓ (WI average)	✓	MY 2013 results	MY 2015
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 fee-for-service claims data	✗	✓	MY 2013 results	MY 2015
3. Asthma care for children (Home Management Plan of Care only) – applicable to Children’s Hospitals only.	✗	✗	✗	✓	Joint Commission	✓ (nat’l average)	✓	2012 data from 2013 Annual Report	MY 2015
4. Surgical Care Improvement Index	✓	✓	✗	✗	CheckPoint	✓ (WI average)	✓	MY 2013 results	1/1/2014 to 12/31/2014*
5. (PN-6) – Initial antibiotic – % of immunocompetent patients with community-acquired pneumonia who receive an initial antibiotic regimen during the first 24 hours that is consistent with guidelines.	✓	✓	✗	✗	CheckPoint	✓ (WI average)	✓	MY 2013 results	1/1/2014 to 12/31/2014*
6. Healthcare Personnel (HCP) influenza vaccination – as reported to NHSN	✓	✓	✓	✓	Self-report via NHSN	✓ (nat’l average)	✓	MY 2013 results	10/1/2014 to 3/31/2015*

Measure	Applicable to				Data Source	Level	Reduction in Error (RIE)	Baseline Period	Measurement Period
	Acute Care	Critical Access	Psych	Children's					
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	Pay for Reporting	NA	4/1/2014 to 3/31/2015*	
8. CAUTI – Catheter Associated Urinary Tract Infections	✓	✓	✗	✗	CheckPoint	Pay for Reporting	NA	4/1/2014 to 3/31/2015*	

✓ = measure is conceptually applicable

*Dates reflect the data scheduled to be available on CheckPoint on 9/30/2015. These dates are subject to change if the data for these timeframes is not available to WHA.

Measures for MY 2015 Hospital – Assessment P4P

Measure	Data Source	Measurement Period
1. Perinatal Measures a. Birth Trauma-Injury to Neonate (AHRQ PSI-17) b. Obstetric Trauma –Vaginal Delivery With Instrument (AHRQ PSI-18) c. Obstetric Trauma –Vaginal Delivery Without Instrument (AHRQ PSI-19)	WHA Information Center	1/1/2013 to 12/31/2014**
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	CheckPoint	10/1/2013 to 9/30/2014*

<ul style="list-style-type: none"> h. Always Quiet at Night i. Room Was Always Clean j. Staff Provided Discharge Instructions 		
<p>3. CLABSI – Central Line Blood Stream Infections</p>	<p>CheckPoint</p>	<p>4/1/2014 to 3/31/2015*</p>

**Dates reflect the data scheduled to be available on CheckPoint on 9/30/2015. These dates are subject to change if the data for these timeframes is not available to WHA.*

***Dates reflect the data scheduled to be available from WHA-Information Center on 9/30/2015. These dates are subject to change if AHRQ does not release their software update in a timely manner*

Appendix 1(b) – State/ National Averages for MY 2015 Hospital P4P

Hospitals can calculate their specific targets using the following state / national averages and methodology described in **Appendices 4 and 8**.

Withhold P4P

Measure	Numerator	Denominator	State / National Average
30-day Readmission Statewide Average n=137 hospitals	2173	11693	18.58%
30- day Mental Health Follow-up Visit Statewide Average n=47 hospitals	928	1386	66.9%
Childhood Asthma National Average, Joint Commission Data (2013 Annual Report (2012 Data))	Numerator / denominator data not available from The Joint Commission		86.7%
SCIP Index Statewide Average; n=101 hospitals; Data: 7/1/2012- 3/31/2013	WHA does not receive the numerator / denominator for this measure from MetaStar		89.9%
Initial Antibiotic (PN-6) Statewide Average; n=124 hospitals; Data: 7/1/2012- 3/31/2013	6126	6340	96.62%
Healthcare Personnel Influenza Vaccination Rate National Average (2011 – 2012 flu season); n=137	Numerator / denominator data not available from CDC		(2012-2013 data to be filled in when available) 66.9%

MY 2015 baselines are based on MY 2013 results for 30-day Readmission, 30-day Mental Health Follow-up Visit, SCIP index and PN-6 measures.

Assessment P4P State Averages

Measure	Numerator	Denominator	State Average
Perinatal Measures			
Birth Trauma (AHRQ PSI 17) Statewide Average; n=62*	411	174029	.236%
Obstetric Trauma (AHRQ PSI 18) Statewide Average; n=55*	1546	9800	15.78%
Obstetric Trauma (AHRQ PSI 19) Statewide Average; n=62*	2592	120369	2.15%
HCAHPS (Patient Experience of Care)		Statewide Average (n=55 hospitals)	
Patients Ranked Hospital High		73.62%	
Definitely Recommend Hospital		75.15%	
Doctors Always Communicated Well		81.77%	
Nurses always communicated well		80.55%	
Patients always received help as soon as they wanted		68.62%	
Staff always explained medications		66.12%	
Pain always well controlled		71.25%	
Always quiet at night		62%	
Room was always clean		76.54%	
Staff Provided Discharge Instructions		87.55%	
CLABSI: (Central Line Associated Blood Stream Infections) n=68 Data:10/1/12-9/30/13	Numerator data not available from Checkpoint	Denominator data not available from Checkpoint	.477

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

Appendix 1(c) – Specifications for MY 2015 Withhold 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 2015 after applying exclusions.

Numerator = All inpatient “readmissions” between 4/1/2014 – 3/31/2015 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 3/1/2014 – 3/31/2014.
- 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, 2014 to March 31, 2015.

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

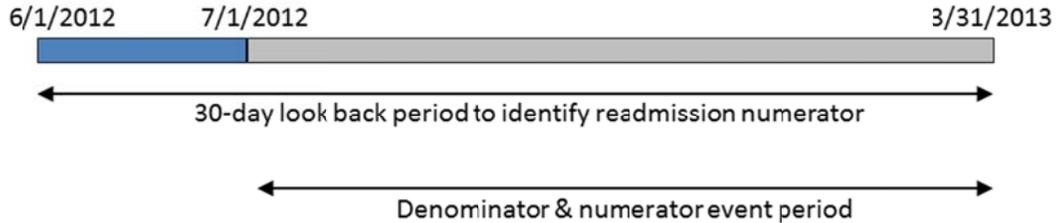
Table 2 – Discharge condition categories considered acute or complications of care

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

The Department of Health Services created these examples for MY2013, and the dates have not been modified for future MY. These are examples to illustrate the concepts and not specific to any particular year.

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. **Actual dates will 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 discharged 3/5/13 and admitted 3/10/13 and discharged 4/1/13.	3/1/13		No – if no record of previous discharge within 30 days	
		3/5/13		Yes, for MY2013

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)				
Scenario	Event date		Include in:	
	Admission	Discharge	Numerator	Denominator
	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 <u>to home</u> on the morning of 7/1/12 but readmitted 12 hours later on the same day (7/1/12) to the same facility and discharged 7/4/12.	5/12/12		No - admitted pre-MY2013	
		7/1/12		Yes, for MY2013
	7/1/12		Yes - admitted within 30 days of previous 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. <i>Transfers to another facility DO NOT count as discharges</i>
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	

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)				
Scenario	Event date		Include in:	
	Admission	Discharge	Numerator	Denominator
		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 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	8/1/12		No – if no record of previous discharge within 30 days of 8/1/12	
		8/10/12		Yes, for MY2013
	8/25/12		Yes - admitted within 30 days of previous discharge. <i>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.</i>	
		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	

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)				
Scenario	Event date		Include in:	
	Admission	Discharge	Numerator	Denominator
		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 8/5/12 and discharged on 8/12/12.	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 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 2015, 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
 - o 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.
 - o 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
 - o 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.
 - o CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255 *WITH* POS: 52, 53.
- UB Revenue Codes:
 - o 0513, 0900-0905, 0907, 0911-0917, 0919; a practitioner type for follow-up visits does not have to be identified with these revenue codes.
 - o 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, 2014 to March 31, 2015.
Numerator: 30-day mental health follow-up visits between April 1, 2014 and April 30, 2015 (11.5 months), in order to account for the 30-day post-discharge period.

Exclusions

- AODA inpatient care
- **Mental Health readmission or direct transfer:**
 - o 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.
 - o 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.
 - o 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 Department of Health Services created these examples for MY2013, and the dates have not been modified for future MY. These are examples to illustrate the concepts and not specific to any particular year.

The following table provides **sample scenarios** for the Mental Health Follow-up measure, and is meant to be illustrative only. **Actual dates will 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)
			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 on 7/5/2012			Yes, for Hospital A (30 day clock starts)
			None within 30 days of qualifying discharge	No, follow-up did not occur 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	

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)						
Scenario	Event Date			Include in:		
	Admission	Discharge / Transfer	Follow-up Visit	Numerator	Denominator	
				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 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 7/2/2012			No, admissions are not counted for this measure		
		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	

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)					
Scenario	Event Date			Include in:	
	Admission	Discharge / Transfer	Follow-up Visit	Numerator	Denominator
<p>5. Member is admitted to Hospital A on July 2, 2012 and discharged to home with a MHF-A diagnosis on July 8th. 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.</p>	at A on 7/2/2012			Admissions are not counted for this measure	
		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	
<p>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.</p>	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,

Measurement Year MY 2013 (7/1/2012 – 3/31/2013)					
Scenario	Event Date			Include in:	
	Admission	Discharge / Transfer	Follow-up Visit	Numerator	Denominator
					the denominator is removed (clock abolished)
	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 99.7%. 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 86.7%, 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 results from measurement year 2013 (7/1/2012-3/31/2013). Performance will be based on the latest 12-month data available on CheckPoint, as of September 30, 2015.

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 results from measurement year 2013 (7/1/2012-3/31/2013). Performance will be based on the latest 12-month data available on CheckPoint, as of September 30, 2015.

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 2015:

- 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/forms/57-214-HCP-Influenza-Vaccination-Summary-Form.pdf>. 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 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 2015 Hospital P4P requirements, **all hospitals to which P4P applies** must submit data to NHSN. The

data must be submitted to **NHSN by dates specified by CMS**. 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 2012-13 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: # of hospital employees, licensed independent practitioners and adult students / trainees and volunteers that have worked in a hospital for 30 days between October 1, 2014 and March 31, 2015. 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, 2014 and March 31, 2015 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	<ul style="list-style-type: none"> All persons who receive a direct paycheck from the reporting facility (i.e. on payroll)
Licensed independent practitioners	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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: <input type="checkbox"/> seasonal <input type="checkbox"/> 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 9/30/2015) will be deemed to have met the requirement for this measure.

viii. Catheter Associated Urinary Tract Infections (CAUTI)

This is a **Pay-For-Reporting (P4R)** measure for MY2015. Data is submitted to Checkpoint.

Hospitals that submit data to CheckPoint in a timely manner (so that data are available on CheckPoint by 9/30/2015) will be deemed to have met the requirement for this measure.

Appendix 1d: Assessment P4P Measures

i. Perinatal Measures

This measure is comprised of the three sub-measures listed below:

1. Birth Trauma
2. Obstetric Trauma with Instrument
3. Obstetric Trauma without Instrument

The baseline for this measure is based on WHA Information Center data from 2010-2012. Performance will be based on the latest 12-month data available from the WHA Information Center, as of September 30, 2015.

ii. Patient Experience of Care (HCAHPS)

This measure is a survey conducted annually by WHA and results are reported on CheckPoint. There are ten categories in the survey as follows:

1. Overall hospital rating
2. Would the patient recommend the hospital
3. Doctors communicated well
4. Nurses communicated well
5. Patient received help in a timely manner
6. Medications are explained well
7. Pain controlled well
8. Quietness at night
9. Room cleanliness
10. Discharge instructions

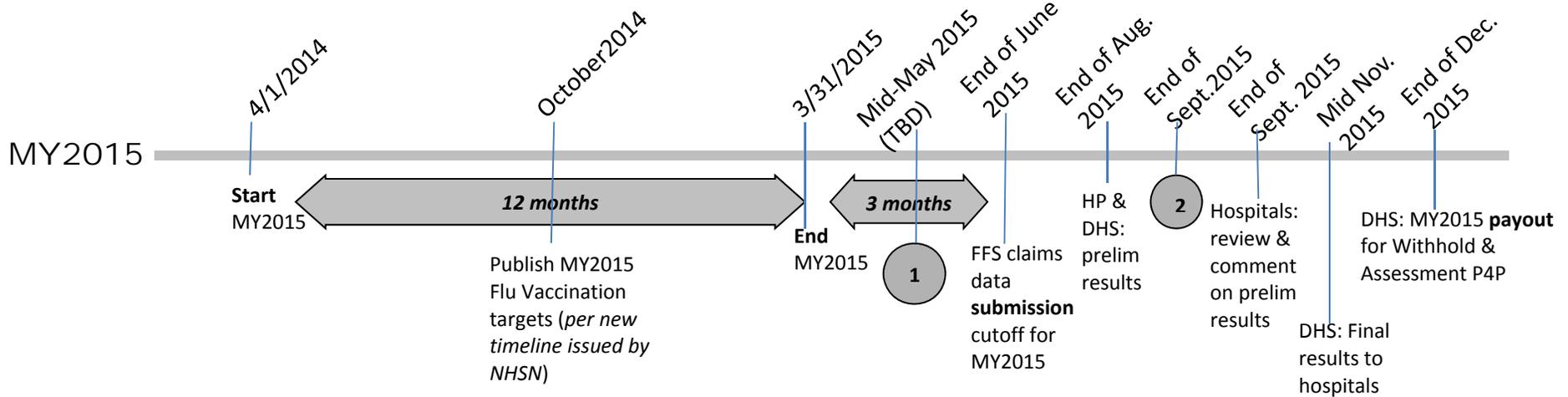
The baseline for this measure is based on the results from measurement year 2013 (7/1/2012- 3/31/2013). Performance will be based on the latest 12-month data available on CheckPoint, as of September 30, 2015.

iii. Central-line Associated Blood Stream Infection

This measure is reported to CheckPoint and represents a standardized infection ratio. Checkpoint reports an individual hospital's ratio and both the national standard and the Wisconsin standard. For this measure the Wisconsin standard will be used. The baseline data reported on CheckPoint (10/1/2012 – 9/30/2013) shows the Wisconsin standard to be 0.477. This is the number that will be used by DHS as the baseline when calculating the results of this measure. Performance will be measured based on the latest 12-month data available on Checkpoint, as of September 30, 2015.

Appendix 2: Hospital Withhold P4P Timeline - MY 2015

Not to scale

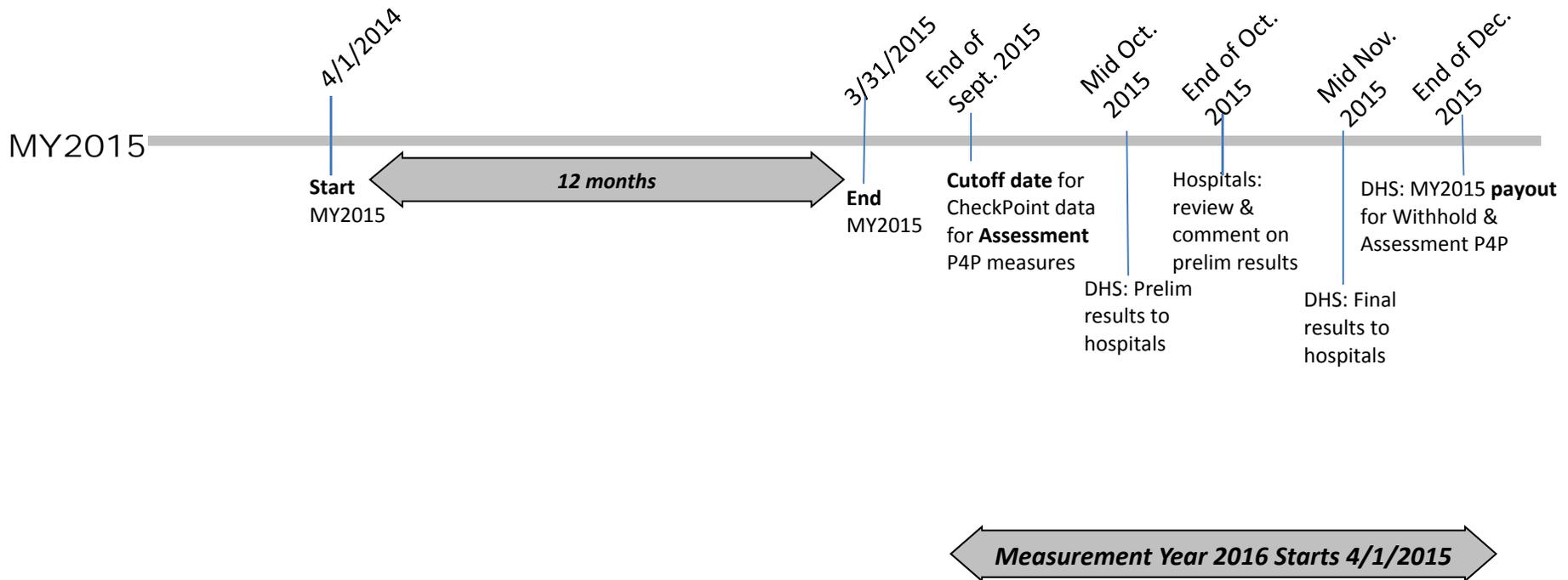


1 = Healthcare Personnel vaccination data pull by DHS

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

Appendix 3: Hospital Assessment P4P Timeline –MY 2015

Not to scale



Appendix 4 – Withhold P4P Methodology for MY 2015

- a. Withhold period = Measurement period = **MY 2015** (April 1, 2014– March 31, 2015).
- 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 2015. Hospitals with insufficient cases in the denominator 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 1/4th weight in determining the earn-back for the 1.5% withhold. Although case-mix adjustments are not applied for MY 2015, 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 2nd measure, and none for the 3rd 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.

	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 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 2015, compared to that hospital’s MY2015 baseline, as discussed in Appendix 1(b).

An example:

If a hospital’s MY 2015 baseline for a measure = 80%, then its MY 2015 “error” = 100% - 80% = 20%.

A hospital can achieve a 10% reduction in error by improving its past score by =

$$\left(\frac{10}{100} * 20 \right) = 2 \text{ percentage points, by attaining a score of 82\%.$$

If the MY 2015 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 2015 =

$$\left(\frac{(MY\ 2015\ score - MY\ 2015\ baseline)}{Error = (100 - MY\ 2015\ baseline)} * 100 \right)$$

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

Hospital	MY 2015 Baseline	MY 2015 Error	MY 2015 Score	MY 2015 score – MY 2015 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

DHS is not applying risk-adjustment to these two measures for MY 2015. Both **Level of Performance** and **Degree of Improvement** will apply to the 30-day readmission measure, and only Degree of Improvement will apply to the mental health follow-up visit measure. The same methodology described above will apply for the 30-day readmission measure. The following table shows how the % of earn-back will be determined for the mental health follow-up measure for MY 2015:

Degree of Improvement			
High (10% or higher)	Medium (5- 10%)	Low (0% - 5%)	No improvement (<0%)
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, based on MY2013 results.
- 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. 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. All hospitals must report data for both P4R measures to earn back the withhold for those two P4R measures. If the hospital does not achieve 100% on at least one measure, it would not be eligible for any bonus payment. If the hospital does not meet at P4R requirements, it would not be eligible for any bonus payment. Any hospital with at least one measure applicable to it (including Pay for Reporting measures) will have its withhold at risk. For MY 2015, 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. Bonus:

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. The goal of the methodology is to ensure that a hospital’s bonus is proportional to that hospital’s share in the total dollar withheld across all hospitals, and that hospital’s performance.

To be eligible for the bonus pool, hospitals must have at least 1 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.

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 (see example in Appendix 8).

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

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.

- 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 2015 were set using data from July 1, 2012 through March 31, 2013, this was measurement year 2013. The chart below shows the timeframes for using results of a previous MY as baselines for future Measurement Years, including the time lag.

MY 2013		MY 2014		MY 2015	
7/1/2012	3/31/2013	5/15/2013	3/31/2014	4/1/2014	3/31/2015
Performance timeframe for MY 2013		Calculate results for MY 2013 Use MY 2013 results as baseline for MY 2015		Calculate results for MY 2014 Use MY 2014 results as baseline for MY 2016	

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

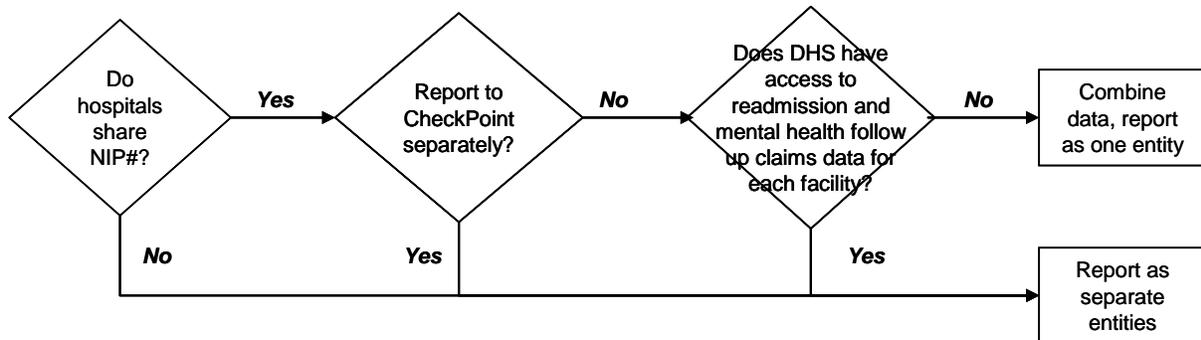
After the data submission cut-off date, DHS will calculate and compile the results, and share them with the hospitals. Hospitals are expected to review the results, and respond to DHS with comments and supporting data in case there are discrepancies between the results calculated by DHS and those by 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 2015 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 Children’s? 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 MY2015?
Answer: June 30, 2015 for Withhold P4P.
9. Does the initiative include Long Term Acute Care (LTAC) Hospitals?
Answer: No, it does not include LTAC for MY 2015. DHS may consider LTACs for future inclusion in the P4P initiative.

Appendix 7 – MY 2015 Modifications to the Assessment P4P

Measurement Year (MY) 2015 =4/1/2014– 3/31/2015.

- 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 2015 as follows:

Measure	MY 2015
Pay-For-Performance	
1. Perinatal measures	\$2.0 million; 3 measures – Birth Trauma, Obstetric trauma with instrument, Obstetric trauma without instrument(\$0.667 million per measure) See methodology and example, below.
2. Patient Experience of Care	\$1.5 million Target = state-wide average
3. Central-line Associated Blood Stream Infection (CLABSI)	\$1.5 million Target = state-wide average

Methodology and example for the perinatal measure:

Step	Example
<p>1. Set the targets for each of the performance-based Birth Measures:</p> <ul style="list-style-type: none"> • Birth Trauma (AHRQ PSI 17) • Obstetric Trauma (AHRQ PSI 18) • Obstetric Trauma (AHRQ PSI 19) 	<p>Assume beginning with 70 hospitals in scope for this measure.</p>
<p>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 \$.</p>	<p>Assume 50 out of 70 hospitals report all required perinatal measures. Only these 50 hospitals are eligible to participate in the perinatal P4P incentive.</p>
<p>3. Determine how many hospitals from Step 2 meet exactly:</p> <ul style="list-style-type: none"> • zero perinatal targets = not eligible for perinatal P4P \$. • 1 perinatal target • 2 or more perinatal targets. 	<p>Assume: of the 50 hospitals reporting all perinatal measures:</p> <ul style="list-style-type: none"> • 20 hospitals meet 0 targets • 10 hospitals meet 1 target • 20 hospitals meet 2 or more targets.
<p>4. Calculate individual hospital points and total points for hospitals meeting:</p> <ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 20 hospitals get 0 points = \$0 for perinatal; total points for this group = $20 \times 0 = 0$; • 10 hospitals get 0.75 points; total points = $10 \times 0.75 = 7.5$; • 20 hospitals get 1 point; total points = $20 \times 1 = 20$. <p>Total points for all hospitals = $(20 \times 0) + (10 \times 0.75) + (20 \times 1) = 27.5$ points</p>
<p>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.</p>	<ul style="list-style-type: none"> • 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.

Appendix 8 – Methodology for Sharing Withhold P4P bonus

1. A hospital with only pay for reporting (P4R) measures applicable would not be eligible for any bonus, but could receive 100% earn-back if the P4R measures were all fulfilled.
2. If the hospital does not achieve 100% on at least one P4P measure, it would not be eligible for any bonus payment.
3. If the hospital does not meet all P4R requirements, it would not be eligible for any bonus payment. This is consistent with the previous methodology.
4. Bonus funding is weighted based by the percentage of applicable measures for which the hospital achieved the highest performance (100%) and the amount of funds withheld from the hospital (see examples starting on next page). Weighting in this manner helps to ensure that a hospital with a smaller withheld amount could not receive an excessively large bonus payment.
5. Note that there is no inherent cap in the amount of bonus money a hospital can receive. However, there is a fundamental tension between having a cap and paying out all the withheld funds, as became apparent with “step D” this past year.

Example: Withhold P4P Methodology

This example is used for illustrating the Hospital Withhold P4P Methodology. The work sheet can help a hospital estimate its likely earn-back and bonus amounts given different performance scenarios.

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	Earn-back % = (Column 4 * ((Column 5 * 100%) + (Column 6 * 75%) + (Column 7 * 50%) + (Column 8 * 0%) + (Column 9 * 100%))
Column 11	Earn-back \$ = (Column 11 * Column 2) (STEP A)
Column 12	Same as column 1 (hospital name)
Column 13	Same as column 3
Column 14	Did the hospital report on P4R measures? “Yes (1)” if the hospital reported on P4R measures. “No (0)” if the hospital did <i>not</i> report on P4R measures.
Column 15	Applicable measures minus the P4R measures
Column 16	Same as column 2
Column 17	Same as column 11
Column 18	Amount of money remaining for the bonus pool (Column 16- Column 17)
Column 19	Number of applicable measures at 100% (excluding P4R)
Column 20	Percent of applicable measures at 100% (excludes P4R) (Column 19 divided by Column 15)
Column 21	Withhold dollars scaled to performance (column 20 x column 16 x column 14)
Column 22	Same as columns 1 and 12
Column 23	Weighted bonus distribution (individual column 21 number divided by the total of that same column)
Column 24	Bonus earned (column 23 x total bonus pool (total of column 18))
Column 25	Total payout (column 24 plus column 17)
Column 26	Percent of withhold paid back (column 25 divided by column 16)

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 P4P program.

<i>col. 1</i>	<i>col. 2</i>	<i>col. 3</i>	<i>col. 4</i>	<i>col. 5</i>	<i>col. 6</i>	<i>col. 7</i>	<i>col. 8</i>	<i>col. 9</i>	<i>col. 10</i>	<i>col. 11</i>	
			P4P Earn-back								
Hospital	Withhold \$*	# of applicable measures	Weight per measure	100%*	75%*	50%*	0%*	P4R*	Earn-back %	Earn-back \$	
A	\$25,534.84	1	100%					1	100.0%	\$25,534.84	
B	\$19,516.96	4	25%	2		1		1	87.5%	\$17,077.34	
C	\$7,208.90	4	25%	1		1	1	1	62.5%	\$4,505.56	
D	\$24,317.74	4	25%			2	1	1	50%	\$12,158.87	
E	\$19,516.96	4	25%	2		1		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 P4P program.)

Col. 12	Col. 13	Col. 14	Col. 15	Col. 16	Col.17	Col. 18	Col. 19	Col. 20	Col. 21
Name	Total Applicable Measures	Reported on 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. 22	Col. 23	Col. 24	Col. 25	Col. 26
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**