

# **Minnesota Department of Human Services**

**2012**

## **Managed Care Withhold Technical Specifications**

**November, 2011**

**Updated July 6, 2012\***

**2012 Family and Children Contract Section 4.6**

**2012 MSHO/MSO+ Contract Section 4.6 (Treating, Pay-to & PCA Provider)**

**2012 SNBC Contract Section 4.7 (Treating & Pay-to Provider)**

\* Updating of the 2012 Managed Care Withhold Technical Specifications is necessary due to DHS' request of the 2012 Minnesota Legislature to amend the 2011 First Special Session legislation requirement to use of CY 2011 as the baseline and replace with a baseline of calendar year 2009 for the ED Utilization Reduction measures. DHS' request was granted to amend subdivision 5g. The 2012 Minnesota Legislature also provided for the return of withheld funds commensurate with achieved reductions less than the targeted amount for the ED utilization, Hospital Admission and 30 Day Readmission measures.

# Valid Treating Provider Measure Managed Care Withhold Technical Specifications

## Contract Year 2012

**Purpose.** Hold MCOs accountable for submission of valid NPI and UMPI (as appropriate) treating provider information. If the MCO achieves the annual NPI (UMPI) treating provider performance target points will be awarded. The performance target is based on the annual percent of valid NPI (UMPI) treating provider numbers for service dates within the Contract year for the defined procedure codes.

**Withhold Performance Target Computation.** The MCO is determined to have achieved the NPI treating provider target if the percent of CMS-1500 encounter lines submitted with valid NPI individual treating provider numbers is equal to or greater than 95%.

Annual Performance Target is achieved **IF:**  $R_{Cy}$  is equal to or greater than 95%  
 $R_{Cy}$  : The Contract year rate.

### Rates ( $R_{Cy}$ ).

- Formula: Rate = (N / D) computed to the second decimal.
- The Denominator (D) is the number of CMS-1500 encounter lines submitted by the MCO with service dates during the Contract year with one of the evaluation and management (E&M) or mental health procedure codes found on the list shown below (Treating Provider Withhold Codes and Descriptions). To be “eligible” for the denominator, the encounter lines must meet the criteria listed in the Denominator Detail section below.
- The Numerator (N) is the number of CMS-1500 encounter lines with valid individual NPI treating provider numbers. Appropriate individual NPIs are those found in DHS Provider File which is updated monthly. To be “eligible” for the numerator, the encounter lines must meet the criteria listed in the Numerator Detail section below.
- The rates are calculated by dividing the numerator by the denominator. The result will be calculated to the second decimal (e.g. 45.63).

### Denominator Detail:

- Denominator is a count of encounter lines.
- Encounters with dates of service within the Contract year, received prior to May 31<sup>st</sup> of the year following the contract year.
- Encounters having procedure codes from the list below (NPI Treating Provider Withhold Codes and Descriptions) are included in the denominator.
- Only CMS-1500 (DHS Claim.Type = ‘A’) are included.
- Encounters are included only for those individuals enrolled in Families and Children Medical Assistance, or MinnesotaCare. DHS Fee for Service claims are not included.
- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation. Denied claims that are not a result of the implementation of the

True Denial Project may be counted unless the line is denied as a duplicate or is a failed replacement.

- Voided and replaced encounters are excluded.
- MSHO/MSCH+ Home and Community Based Services (HCBS) encounters and MSHO/MSCH+ and SNBC Nursing Facility (NF) encounters will be excluded.

**Numerator Detail:** Valid and Invalid treating provider numbers are determined as follows:

- Valid = Individual NPI (UMPI) treating provider numbers registered in DHS' provider file.
- Invalid = Group provider numbers.
- Invalid = Provider numbers not registered in DHS' NPI file
- Invalid = pseudo numbers
- Invalid = Encounters where MMIS has placed the MCO UMPI in the treating provider field. This occurs when the MCO has left both the Pay-To and the treating provider fields blanks.

Encounters included in the numerator must meet all criteria defined above for the denominator.

**Data Sources.**

- DHS Claims Database

Data used to determine treating provider withhold are from records received by the STATE no later than May 31<sup>st</sup> of the year following the Contract year.

**Example. R<sub>cy</sub>:**

	Denominator	Numerator	(N \ D)
<b>MCO</b>	<b>Count of encounter lines in CY that meet denominator criteria above.</b>	<b>Number of valid individual provider NPIs or UMPIs in CY that meet denominator criteria above.</b>	<b>Rate: Percent of encounter lines with valid treating provider NPIs or UMPIs in CY</b>
GoodCare	2,000	1,900	95.00%

- **95.00% target met - withhold returned**

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### Treating Provider Withhold Codes and Descriptions

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90801 - PSYCHIATRIC INTERVIEW - 30 MIN UNIT  
90802 - Intac psy dx interview  
90804 - Psytx, office (20-30)  
90805 - Psytx, office (20-30) w/e&m  
90806 - Psytx, office (45-50)  
90807 - Psytx, office (45-50) w/e&m  
90808 - Psytx, office (75-80)  
90809 - Psytx, office (75-80) w/e&m  
90810 - Intac psytx, office (20-30)  
90811 - Intac psytx, off 20-30 w/e&m  
90812 - Intac psytx, office (45-50)  
90813 - Intac psytx, off 45-50 w/e&m  
90814 - Intac psytx, office (75-80)  
90815 - Intac psytx, off 75-80 w/e&m  
90846 - FAMILY PSYCHOTHERAPY (WITHOUT PATIENT)  
90847 - FAMILY PSYCHOTHERAPY (WITH PT PRESENT)  
90853 - GROUP PSYCHOTHERAPY  
90857 - INTERACTIVE GROUP PSYCHOTHERAPY  
90862 - MEDICATION MANAGEMENT  
99201 - OFFICE/OUTPATIENT VISIT, NEW  
99202 - OFFICE/OUTPATIENT VISIT, NEW  
99203 - OFFICE/OUTPATIENT VISIT, NEW  
99204 - OFFICE/OUTPATIENT VISIT, NEW  
99205 - OFFICE/OUTPATIENT VISIT, NEW  
99211 - OFFICE/OUTPATIENT VISIT, EST  
99212 - OFFICE/OUTPATIENT VISIT, EST  
99213 - OFFICE/OUTPATIENT VISIT, EST  
99214 - OFFICE/OUTPATIENT VISIT, EST  
99215 - OFFICE/OUTPATIENT VISIT, EST  
99381 - INIT PREV MED EVAL/MANAG, NEW PT,< 1 YR  
99382 - PREVENTIVE VISIT,NEW,AGE 1-4  
99383 - PREVENTIVE VISIT,NEW,AGE5-11  
99384 - PREVENTIVE VISIT,NEW,12-17  
99385 - PREVENTIVE VISIT,NEW,18-39  
99386 - PREVENTIVE VISIT,NEW,40-64  
99387 - PREVENTIVE VISIT,NEW,65&OVER  
99391 - PREVENTIVE VISIT,EST,INFANT  
99392 - PREVENTIVE VISIT,EST,AGE 1-4  
99393 - PREVENTIVE VISIT,EST,AGE5-11  
99394 - PREVENTIVE VISIT,EST,12-17  
99395 - PREVENTIVE VISIT,EST,18-39  
99396 - PREVENTIVE VISIT,EST,40-64  
99397 - PREVENTIVE VISIT,EST,65&OVER  
99401 - PREVENTIVE COUNSELING, INDIV, APP 15 MIN  
99402 - PREVENTIVE COUNSELING, INDIV  
99403 - PREVENTIVE COUNSELING, INDIV  
99404 - PREVENTIVE COUNSELING, INDIV

# Valid Pay-To Provider Measure Managed Care Withhold Technical Specifications

## Contract Year 2012

**Purpose.** Hold MCOs accountable for submission of valid NPI and UMPI (as appropriate) pay-to provider information. If the MCO achieves the annual NPI (UMPI) pay-to provider performance target points will be awarded. The performance is based on the annual percent of encounters with valid NPI (UMPI) pay-to provider numbers for service dates within the Contract year for all encounters except pharmacy, transportation and interpreter services.

**Withhold Performance Target Computation.** The MCO is determined to have achieved the NPI billing provider target if the percent of encounters submitted with valid billing provider numbers is equal to or greater than 95%.

Annual Performance Target is achieved **IF:**  $R_{cy}$  is equal to or greater than **95%**  
 $R_{cy}$  : The Contract year rate.

### Rates ( $R_{cy}$ ).

- Formula: Rate = (N / D) computed to the second decimal.
- The Denominator (D) is the number of encounter headers submitted by the MCO with service dates during the Contract year. To be “eligible” for the denominator, the encounter headers must meet the criteria listed in the Denominator Detail section below.
- The Numerator (N) is the number of encounters with valid provider numbers. Appropriate individual NPIs or DHS UMPIs are those found in DHS Provider File which is updated monthly. To be “eligible” for the numerator, the encounter headers must meet the criteria listed in the Numerator Detail section below.
- The rates are calculated by dividing the numerator by the denominator. The result will be calculated to the second decimal (e.g. 45.63).

### Denominator Detail:

- Denominator is a count of encounter headers.
- Encounters with dates of service within the Contract year, received prior to May 31<sup>st</sup> of the year following the contract year.
- All types of encounter data are included except pharmacy, transportation and interpreter services (see attached listing of excluded procedure codes). In addition, encounters for MSHO/MS<sup>+</sup> Home and Community Based Services (HCBS) and encounter for MSHO/MS<sup>+</sup> and SNBC Nursing Facility (NF) will be excluded.
- Encounters are included only for those individuals enrolled in F&C MA or MinnesotaCare. DHS Fee for Service claims are not included.
- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation. Denied claims that are not a result of the implementation of the True Denial Project may be counted unless the line is denied as a duplicate or is a failed replacement.
- Voided and replaced encounters are excluded.

**Numerator Detail:** Valid and Invalid treating provider numbers are determined as follows:

- Valid = NPI (UMPI) billing provider numbers registered in DHS’ provider file.
- Invalid = Provider numbers not registered in DHS’ NPI or UMPI file
- Invalid = Encounters where MMIS has placed the MCO UMPI in the Pay-To field. This occurs when the MCO leaves the Pay-To field blank.
- Invalid = pseudo numbers
- Encounters included in the numerator must meet all criteria defined above for the denominator.

**Data Sources.**

- DHS Claims Database

**Example.**

R<sub>cy</sub>:

	Denominator	Numerator	(N \ D)
<b>MCO</b>	<b>Count of encounter claims in CY that meet denominator criteria above.</b>	<b>Number of encounters with valid billing provider NPIs or UMPIs in CY that meet denominator criteria above.</b>	<b>Rate: percent of encounter claims with valid billing provider NPIs or UMPIs in CY</b>
GoodCare	35,665	33,882	95.00%

- **95.00 % target met - withhold returned**

**Listing of Excluded Procedure Codes**

ProcedureCode	ProcedureName
A0080	NON-EMERG TRANS / MILE NON-INT VOLUNTEER
A0090	NON-EMERG TRANS /IND. VESTEDPER MILE
A0100	NON-EMERG TRANS: TAXI-INTRA-CITY
A0110	NON-EMERG TRANS BUS INTRA/INTER STATE
A0120	NON-EMERG TRANS: MINI-BUS, NON-PROFIT
A0130	NON-EMER TRANSP: WHEELCHAIR VAN
A0140	NON-EMERG TRANS: AIR INTRA/INTER STATE
A0170	NON-EMERG TRANS: ANCILLARY FEES, TOLLS
A0180	NON-EMERG TRANS: ANCILLARY LODGING RECIP
A0190	NON-EMERG TRANS: ANCILLARY MEALS RECIP
S0209	WC VAN MILEAGE PER MILE
S0215	NONEMERG TRANSP MILEAGE PER MILE
T1013	SIGN LANGUAGE OR ORAL INTERPRETER SVS
T1023	PROGRAM INTAKE ASSESSMENT
T2001	NON-EMERG TRANSPORT; ATTENDANT/ESCORT
T2003	NON-EMERG TRANSPORT; ENCOUNTER/TRIP
T2005	NON-EMERG TRANSPORT; STRETCHER VAN
T2049	N-ET; STRETCHER VAN, MILEAGE

# Valid PCA Treating Provider NPI/UMPI Measure Managed Care Withhold Technical Specifications

## Contract Year 2012

**Purpose.** Hold MCOs accountable for submission of valid Personal Care Attendant (PCA) treating provider information. If the MCO achieves the annual PCA treating provider performance target points will be awarded. The performance target is based on the annual percent of valid National Provider ID (NPI) or a Unique Minnesota Provider Identifier (UMPI) numbers for treating providers on encounter claim lines for PCA services with service dates within the Contract year.

**Withhold Performance Target Computation.** The MCO is determined to have achieved the PCA treating provider target if the percent of PCA encounter lines submitted on CMS-1500 with valid NPI/UMPI individual treating provider numbers is equal to or greater than 95.00%.

Annual Performance Target is achieved **IF:**  $R_{Cy}$  is equal to or greater than 95.00%  
 $R_{Cy}$  : The Contract year rate.

### **Rates ( $R_{Cy}$ ).**

- Formula: Rate = (N / D) computed to the second decimal.
- The Denominator (D) is the number of encounter lines submitted by the MCO with service dates during the Contract year with HCPCS code T1019 without an UA modifier. To be “eligible” for the denominator, the lines must meet the criteria listed in the Denominator Detail section below.
- The Numerator (N) is the number of CMS-1500 lines with valid individual NPI/UMPI treating provider numbers. Appropriate individual NPI/UMPIs are those found in DHS Provider File which is updated monthly. To be “eligible” for the numerator, the encounters must meet the criteria listed in the Numerator Detail section below.
- The rates are calculated by dividing the numerator by the denominator. The result will be calculated to the second decimal (e.g. 45.63).

### **Denominator Detail:**

- Denominator is a count of lines.
- Encounters with dates of service within the Contract year, received prior to May 31<sup>st</sup> of the year following the contract year.
- Encounter lines having HCPCS code T1019 without an UA modifier are included in the denominator.
- Encounters are included only for those individuals enrolled in Managed Care Minnesota Health Care Programs. DHS Fee for Service claims are not included.
- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation. Denied claims that are not a result of the implementation of the True Denial Project may be counted unless the line is denied as a duplicate or is a failed replacement.
- Voided and replaced encounters are excluded.

- SNBC encounters are excluded because the Contract does not include a PCA withhold.
- MSHO/MSH+ Home and Community Based Services (HCBS) and Nursing Facility (NF) encounters will be excluded.

**Numerator Detail:** Valid encounter type is CMS-1500. Encounters submitted on other claim types are not valid. Valid and Invalid treating provider numbers are determined as follows:

- Valid = Individual NPI/UMPI treating provider numbers registered in DHS’ provider file with a PCA provider type. The Individual NPI/UMPI treating provider number must differ from the pay-to provider number.
- Invalid = Group provider numbers.
- Invalid = Consolidated NPIs.
- Invalid = Same individual provider is both the pay-to and treating provider.
- Invalid = Same group provider is both the pay-to and treating provider.
- Invalid = Provider numbers that do not identify a PCA provider type.
- Invalid = Provider numbers not registered in DHS’ NPI/UMPI file.
- Invalid = Pseudo numbers.
- Invalid = Encounters where MMIS has placed the MCO NPI/UMPI or pay-to provider NPI/UMPI in the treating provider field. MMIS placements occur if the MCO has left either or both the pay-to and the treating provider fields blank.
- Invalid = No treating provider present. No MMIS placement as described above will occur if the MCO leaves the treating provider blank and the pay-to provider number is a consolidated NPI.

Encounter lines included in the numerator must meet all criteria defined above for the denominator.

**Data Sources.**

- DHS Claims Database

Data used to determine treating provider withhold are from records received by the STATE no later than May 31<sup>st</sup> of the year following the Contract year.

**Example. R<sub>CY</sub>:**

	Denominator	Numerator	(N \ D)
<b>MCO</b>	<b>Count of encounter lines in CY that meet denominator criteria above.</b>	<b>Number of valid individual PCA provider NPI/UMPIs in CY submitted on a CMS-1500 that meet denominator criteria above.</b>	<b>Rate: Percent of encounter lines with valid treating provider NPIs or UMPIs in CY</b>
GoodCare	2,000	1,900	95.00%

- **95.00 % target met - withhold returned**

# Lead Screening Managed Care Withhold Technical Specifications

## Contract Year 2012

**Purpose.** Hold MCOs accountable to achieve an annual blood lead screening performance target. If the MCO achieves the annual lead screening performance target points will be awarded. The MCO's performance target is based on the annual increase in the rate of blood lead tests for children who were between 9 and 30 months of age within the contract year and had one or more lead tests.

**Withhold Performance Target Computation.** The MCO is determined to have achieved the lead screening target if the percent of children screened in the contract year minus the percent of children screened in baseline year exceeds 10% of the difference between the 80% goal and the baseline year rate. There is no penalty if the MCO achieves a rate greater than 80%.

Annual Performance Target is achieved **IF:**  $(R_{Cy} - R_{By})$  is equal to or greater than  $(80\% - R_{By}) * 10\%$   
 $R_{Cy}$ : The contract year rate.  
 $R_{By}$ : The baseline year rate.

Once the MCO achieves the annual lead screening rate goal of eighty percent (80%) or greater, in subsequent Contract Years, the MCO will only need to achieve a lead screening rate of seventy-five percent (75%) or greater in order to receive all points available for this performance target. If the MCO's annual rate falls below 75.0 percent (75%) the MCO will not receive the points assigned, and must again reach either the 80% goal, or the new annual rate must show an increase of 10% of the difference from the previous Contract Year in order to receive the assigned points.

### **Rates ( $R_{cy}$ & $R_{by}$ ).**

- Formula: Rate =  $(N / D)$  computed to the second decimal.
- The Denominator (D) is the number of unduplicated children enrolled in the MCO during the Contract year. To be "eligible" the enrollee must meet the criteria listed in the Denominator Detail section below.
- The Numerator (N) is the unduplicated number of children that received lead screenings during the year between their 9<sup>th</sup> month birth date and the 30<sup>th</sup> month birthdate. To be "eligible" the enrollee must meet the criteria listed in the Numerator Detail section below.
- The rates are calculated by dividing the numerator by the denominator. The result will be calculated to the second decimal (e.g. 45.63).

### **Denominator Detail:**

- Age: 9 months through 30 months calculated as of the last day of each month.
- Enrolled in an MCO for at least one month during the Contract year in F&C MA or MinnesotaCare.
- Each child is attributed to the MCO's denominator if they were enrolled in that MCO for at least one month of the Contract year. Some children are attributed to multiple MCOs.

**Numerator Detail:**

- The lead screening must be provided during the Contract year or prior to the Contract year, but only between the 9th month birth date and the 30th month birth date.
- Lead screening is defined as CPT code = ‘83655’.
- Encounters are included for all MCOs in which the child was enrolled.
- MDH data and Fee for Service claims are included.
- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation. Denied claims that are not a result of the implementation of the True Denial Project may be counted unless the line is denied as a duplicate or is a failed replacement.
- Voided and replaced encounters are excluded.
- All denied Fee for Service claims are excluded.
- Lead screenings associated with diagnosis of elevated blood levels are not excluded.

**Data Sources.**

- DHS Minnesota Health Care Programs Eligibility Database
- DHS Claims Database
- Minnesota Department of Health (MDH) lead data base

Data used to determine lead withhold are from records received by the STATE no later than May 31<sup>st</sup> of the year following the contract year.

**Example.**

R<sub>Cy</sub>:

	Denominator	Numerator	(N \ D)
<b>MCO</b>	<b>Count of children between 9 and 30 months old in CY</b>	<b>Number of children who received lead screenings identified in Denominator in CY</b>	<b>Rate: Percent of children who received lead screenings in CY</b>
GoodCare	1,500	875	58.33%

R<sub>By</sub>:

	Denominator	Numerator	Round(N \ D)
<b>MCO</b>	<b>Count of children between 9 and 30 months old in BY</b>	<b>Number of children who received lead screenings identified in Denominator in BY</b>	<b>Rate: Percent of children who received lead screenings in BY</b>
GoodCare	1,475	805	54.58%

- $(R_{Cy} - R_{By}) \geq (80\% - R_{By}) * 10\%$
- $(58.33\% - 54.58\%) \geq (80\% - 54.58\%) * 10\%$
- $3.75\% \geq 25.42\% * 10\%$
- $3.75\% \geq 2.54\%$  **target met withhold returned**

## **ED Utilization Rate Managed Care Withhold Technical Specifications**

### **Contract Year 2012**

**Purpose.** Annual reduction targets will be based on the MCO's previous calendar year's ED Utilization rate until a total of a twenty-five percent reduction has been achieved from the 2009 baseline rate [Minnesota Statute (256B.69, subdivision 5 (g))].<sup>1</sup> In Contract Year 2012, the MCO will be required to achieve a ten percent reduction. If the MCO achieved reduction is less than then ten percent, awarded points will be commensurate with the achieved rate.

Subsequent annual contract year performance targets will be based on the previous year's annual ED Utilization rate until a total reduction of twenty-five percent is achieved.

The ED Utilization Withhold Measure calculation is based on NCQA's HEDIS 2010 Ambulatory Care measure's technical specifications. Unless there are significant future changes to the HEDIS 2010 Technical Specification for this measure, and in-order to preserve the long term withhold goal, only changes consistent with NCQA's HEDIS Ambulatory Care measure specifications will be considered.

**Withhold Performance Target Computation.** The MCO is determined to have achieved the annual ED Utilization performance target if the 2012 Contract Year's rate is ten percent less than the 2011 ED Utilization rate.

$$\text{ED Utilization Rate} = \text{ED Visits} / 1,000 \text{ member months}$$

#### **Rates.**

- Formula: Rate = [(N / D)\* 1000] computed to the second decimal.
- The Denominator (D) is the total number of enrollee-months during the year. To be “eligible” the enrollee must be enrolled in MA F&C or MinnesotaCare Programs one month during the measurement period.
- Enrollment data used to identify programs (MA F&C, and MinnesotaCare) and pay system (FFS vs. managed care). Pay system is assigned according to the last month of the recipient's eligibility during the reporting time period.
- Each eligible is attributed to a single major program.
- The Numerator (N) is the unduplicated number of ED Visits during the year. To be “eligible” the enrollee must meet the criteria listed in the Numerator Detail section below.
- HEDIS specifications are used to identify ED encounters and HEDIS Technical Specifications exclusions are applied.
- MA F&C, and MinnesotaCare enrollees over 64 years of age are excluded.
- The rate will be calculated to the second decimal (e.g. 45.49).

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<sup>1</sup> DHS' request was granted by the 2012 Minnesota Legislature to amend the 2011 First Special Session legislation requirement to use of CY 2011 as the baseline and replace with a baseline of CY 2009.

**Denominator Detail.**

- Enrolled in an MCO for at least one month during the calendar year in MA F&C or MinnesotaCare Programs.
- Each enrollee-month is attributed to the MCO’s denominator if the enrollee was enrolled in that MCO for at least one month of the year. Some enrollees may be attributed to multiple MCOs.

**Numerator Detail.**

- The ED Visit must be provided during the contract year.
- An ED Visit is defined as CPT code = ‘99281-99285’; UB Revenue = 045x, 0981 or CPT = 10040-69979 with POS = 23.
- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation. Denied claims that are not a result of the implementation of the True Denial Project may be counted unless the line is identified as a duplicate or is a failed replacement.
- Voided and replaced encounters are excluded.
- ED Visits are counted once if the visit does not result in an inpatient stay, regardless of the intensity or duration of the visit. ED visits that result in an inpatient stay within one calendar day of the ED visit are not counted. Multiple ED visits on the same date are only counted as one visit.

**Data Sources.**

- DHS Minnesota Health Care Programs Eligibility Database
- DHS Claims Database

Data (visits and enrollment) used to determine ED Utilization Rate are from records received by the STATE no later than May 31<sup>st</sup> of the year following the Contract year. The MCO 2009 Baseline Rates were calculated as of June 25, 2012.

**CY 2009 MCO ED Utilization Baseline Rates Families and Children’s Contract**

MCO	ED Visits	Enrollee Months	ED Rate/ 1000 months
Blue Plus	61,932	1,253,534	49.41
HealthPartners	34,631	627,297	55.21
IMCare	4,492	62,704	71.34
Medica	102,008	1,524,139	66.93
PrimeWest	12,653	196,353	64.44
SCHA	21,359	319,542	67.84
UCare	63,263	1,103,256	57.34

**Portion of Target Points.** As required by Minnesota Statutes, § 256B.69, subd.5a (g), a portion of the withhold target points will be awarded commensurate with the achieved reduction less than the targeted amount. The percentage of reduction will be calculated to the second decimal place.

The number of points will be awarded based on the percentage of reduction achieved. For example; if the MCO achieved a 4.20% reduction of an annual targeted reduction of 5%, the MCO achieved 84% ( $4.2/5$ ) of the annual reduction. If the measure has been assigned 10 points, 8.40 points (eighty-four percent of ten) would be awarded.

## ED Withhold Based on HEDIS 2010 Technical Specifications Below

286 Ambulatory Care

### Ambulatory Care (AMB)

#### SUMMARY OF CHANGES TO HEDIS 2010

- Added CPT code 99461 to Table AMB-A.

#### Description

This measure summarizes utilization of ambulatory care in the following categories.

- Outpatient Visits
- ED Visits
- Ambulatory Surgery/Procedures
- Observation Room Stays

#### Calculations

<b>Product lines</b>	Report the following tables for each applicable product line. <ul style="list-style-type: none"><li>• Table AMB-1a Total Medicaid</li><li>• Table AMB-1b Medicaid/Medicare Dual-Eligibles</li><li>• Table AMB-1c Medicaid—Disabled</li><li>• Table AMB-1d Medicaid—Other Low Income</li><li>• Table AMB-2 Commercial—by Product or Combined HMO/POS</li><li>• Table AMB-3 Medicare</li></ul>
<b>Member months</b>	For each product line and table, report all member months for the measurement year. IDSS automatically produces member years data for the commercial and Medicare product lines. Refer to <i>Specific Instructions for Use of Services Tables</i> for more information.
<b>Counting multiple services</b>	<p><i>For ambulatory surgery/procedures</i> that occur on the same date of service as an ED visit, report as a single ED visit.</p> <p><i>For Observation Room visits</i> that occur on the same date of service as an ambulatory surgery/procedure, report as a single ambulatory surgery/procedure.</p> <p><i>For Observation Room visits</i> that occur on the same date of service as an ED visit, report as a single ED visit.</p> <p><i>For all other combinations of multiple ambulatory services</i> falling in different categories on the same day, report each service that meets the criteria in the appropriate category.</p>

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HEDIS 2010, Volume 2

**Outpatient visits** Use Table AMB-A to identify outpatient visits. Count each occurrence of the CPT codes listed in Table AMB-A if rendered by different practitioners (a CPT code may count more than once on the same date of service if rendered by different practitioners).

Report services without regard to practitioner type, training or licensing. Include office-based surgical procedures (use the Ambulatory Surgery/Procedures codes in Table AMB-C and include surgeries conducted at the practitioner's office).

**Table AMB-A: Codes to Identify Outpatient Visits**

Description	CPT	UB Revenue
Office or other outpatient visits	99201-99205, 99211-99215, 99241-99245	051x, 052x, 0982, 0983
Home visits	99341-99345, 99347-99350	
Nursing facility care	99304-99310, 99315, 99316, 99318	
Domiciliary or rest home care	99324-99328, 99334-99337	
Preventive medicine	99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429	
Newborn care	99432, 99461	
Ophthalmology and optometry	92002, 92004, 92012, 92014	

**ED visits** Use Table AMB-B to identify ED visits. Count once each visit to an ED that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.

**Table AMB-B: Codes to Identify ED Visits**

CPT	UB Revenue
99281-99285	045x, 0981
OR	
CPT	POS
10040-69979	23

**Ambulatory surgery/procedures** Use Table AMB-C to identify ambulatory surgeries/procedures. Identify encounters using Option A or Option B. Option A is the preferred method for this measure, though when necessary, the organization should use Option A and Option B.

Report only ambulatory surgeries/procedures performed at a hospital outpatient facility or at a free-standing surgery center. Do not report office-based surgeries/procedures in this category; report them under *Outpatient Visits*. Count multiple ambulatory surgeries/procedures on the same date of service as one ambulatory surgery/procedure.

**Table AMB-C: Codes to Identify Ambulatory Surgery/Procedures**

**Option A**

CPT	WITH	POS
All codes included in the CMS 2009 ASC Approved HCPCS Codes and Payment Rates file* and 92953, 92970, 92971, 92975, 92980, 92982, 92986, 92990, 92992, 92993, 92995, 92996, 93501-93533, 93600-93652		22, 24

**Option B**

ICD-9-CM Procedure	WITH	UB Revenue	WITH	UB Type of Bill
01-86, 88.4, 88.5, 98.5		0320, 0321, 0323, 036x, 0480, 0481, 049x, 075x, 079x		13x, 83x

\*The CMS 2009 ASC Approved HCPCS Codes and Payment Rates files are available on the CMS Web site (<http://www.cms.hhs.gov/ASCPayment/>) under the *Addenda Updates* section. Use the file that was valid at the end of the measurement year.

**Observation Room stays** Use Table AMB-D to identify Observation Room stays.

Count once, each observation visit that does not result in an inpatient stay, regardless of the intensity or duration of the visit. Count multiple observation visits on the same date of service as one visit.

**Table AMB-D: Codes to Identify Observation Room Stays**

CPT	UB Revenue
99217-99220	0762

**Exclusions (required)**

- The measure does not include mental health or chemical dependency services. Exclude from all categories claims and encounters that contain any code in Table AMB-E.

**Table AMB-E: Codes to Identify Exclusions**

CPT	Principal ICD-9-CM Diagnosis	ICD-9-CM Procedure
90801-90899	290-316	94.26, 94.27, 94.6
Principal ICD-9-CM Diagnosis	WITH	Secondary ICD-9-CM Diagnosis
960-979		291-292, 303-305

**Note**

- This measure provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.

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Table AMB-1: Ambulatory Care

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
<i>Total:</i>	_____

Age	Outpatient Visits		ED Visits		Ambulatory Surgery/ Procedures		Observation Room Stays	
	Visits	Visits/1,000 Member Months	Visits	Visits/1,000 Member Months	Procedures	Procedures/ 1,000 Member Months	Stays	Stays/ 1,000 Member Months
<1	_____	_____	_____	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____	_____	_____
<i>Total:</i>	_____	_____	_____	_____	_____	_____	_____	_____

# Hospital Admission Rate Managed Care Withhold Technical Specifications

## Contract Year 2012

**Purpose.** Each MCO must reduce their Hospital Admission rate by a total of twenty-five percent. Based on the MCO's 2011 Contract Year (baseline) rate, the MCO will be required to achieve an annual five percent reduction until a total of a twenty-five percent reduction has been achieved [Minnesota Statute (256B.69, subdivision 5a (h))].

If the MCO achieves an annual five percent reduction in its Hospital Admission target rate, all assigned points will be awarded. However, if the MCO achieved reduction is less than then five percent, points will be commensurate with the achieved rate.

Subsequent annual performance targets will be based on the previous year's annual rate until a total reduction of twenty-five percent is achieved.

**Withhold Performance Target Computation.** The MCO's 2012 Contract Year performance target will be achieved if the 2012 Hospital Admission rate is five percent less than the 2011 baseline rate.

$$\text{Admission Rate} = \frac{\text{Admissions} - \text{Readmissions}}{1,000 \text{ member months}}$$

### Rates.

- The Denominator is the total number of the MCO's enrollee-months age 1 through 64 years old during the year. To be "eligible" the enrollee must be enrolled in F&C MA or MinnesotaCare Programs one month during the measurement period.<sup>2</sup>
- The Numerator is the unduplicated numbers of hospital Admissions during the year minus excluded admission types, minus readmissions as defined in the 30 Day Readmission Percentage Withhold. To be "eligible" the enrollee must meet the criteria listed in the Numerator Detail section below.
- F&C MA, and MinnesotaCare enrollees over 64 years of age are excluded.
- MCOs must monitor and analyze bimonthly DHS remittance advice and enrollment reports to accurately identify Admissions and enrollee months.
- The results are calculated to the nearest second decimal (e.g. 45.455 = 45.46; or 45.454 = 45.45).

### Denominator Detail.

- F&C MA or MinnesotaCare Program enrollee member months, 1 through 64 years old, calculated as of December 31 of the measurement year.
- Enrolled in an MCO for at least one month during the calendar year in F&C MA or MinnesotaCare Programs.

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<sup>2</sup> Includes MA Expansion enrollees.

- Each enrollee-month is attributed to the MCO’s denominator if the enrollee was enrolled in that MCO for at least one month of the year. Some enrollees may be attributed to multiple MCOs.
- Enrollment data used to identify programs (F&C MA, and MinnesotaCare).

### **Numerator Detail.**

- A hospital Admission is defined as an inpatient stay indicated by:
  - 1) DHS claim types C and U with provider type 01 (inpatient hospital), or
  - 2) provider types 24 (MCO) and 33 (consolidated provider) with general inpatient bill types 110-117 and exclude mental health and chemical dependency inpatient DRGs<sup>3</sup>, and
  - 3) beginning date of service during the measurement year; and
  - 4) the encounter includes room and board revenue codes.
- Admissions are excluded if:
  - 1) the admission results in the death of enrollee during the stay (patient status 20 or 41), or
  - 2) the admission has a diagnosis of pregnancy (ICD-9 CM diagnosis codes 630-679, V22, V23, V28) in any position on the encounter.
  - 3) the admission has a diagnosis of conditions originating in the Perinatal period (ICD-9 CM diagnosis codes 760-779, V21, V29-V39) in any position on the encounter.
- Admissions less than two days apart will be “collapsed” into one admission to avoid over counting of transfers and multiple claims for an inpatient stay. Inpatient collapsed Admissions (readmissions) are counted based on the enrollee’s MCO enrollment and the hospital is not considered.
- Admission date is used to correctly assign the responsible MCO for enrollees that may change MCOs during the admission span.
- For encounters that do not include a pay-to-provider NPI, the MCO will appear as the pay-to-provider.
- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation. Denied claims that are not a result of the implementation of the True Denial Project may be counted unless the line is identified as a duplicate or is a failed replacement.
- Voided and replaced encounters are excluded.
- Readmissions are only counted if within 30 days of a previous discharge (admission ending service date), based on the person and does not consider the hospital.

### **Data Sources.**

- DHS Minnesota Health Care Programs Eligibility Database
- DHS Claims Database

Data used to determine Hospital Admission rates are from records received by the STATE no later than May 31<sup>st</sup> of the year following the Contract year. The MCO 2011 Baseline Rates were calculated as of July 3, 2012.

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<sup>3</sup> CMS DRG Grouper Software version 23.0, issued 10/05. DRGs 425-432, & 521-523

**CY 2011 MCO Hospital Admission Baseline Rates Families and Children’s Contract**

<b>MCO</b>	<b>Index Admissions</b>	<b>Readmissions</b>	<b>Enrollee Months</b>	<b>Admissions/1000 months<sup>4</sup></b>
<b>Blue Plus</b>	5,006	582	1,559,793	3.21
<b>HealthPartners</b>	2,503	261	752,271	3.33
<b>IMCare</b>	198	9	66,379	2.98
<b>Medica</b>	5,759	546	1,748,945	3.29
<b>PrimeWest</b>	738	56	222,096	3.32
<b>SCHA</b>	822	74	256,001	3.21
<b>UCare</b>	4,470	468	1,379,468	3.24

**Portion of Target Points.** As required by Minnesota Statutes, § 256B.69, subd.5a (h), a portion of the withhold target points will be awarded commensurate with the achieved reduction less than the targeted amount. The percentage of reduction will be calculated to the second decimal place.

The number of points will be awarded based on the percentage of reduction achieved. For example; if the MCO achieved a 4.20% reduction of an annual targeted reduction of 5%, the MCO achieved 84% (4.2/5) of the annual reduction. If the measure has been assigned 10 points, 8.40 points (eighty-four percent of ten) would be awarded.

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<sup>4</sup> Admission Rate = Index Admissions/1000 member months

## **30 Day Readmission Percentage Managed Care Withhold Technical Specifications**

### **Contract Year 2012**

**Purpose.** Each MCO must reduce their 30 Day Readmission rate by a total of twenty-five percent. Based on the MCO's 2011 Contract Year (baseline) rate, the MCO will be required to achieve an annual five percent reduction until a total of a twenty-five percent reduction has been achieved [Minnesota Statute (256B.69, subdivision 5a (h))].

If the MCO achieves an annual five percent reduction in its 30 Day Readmission target rate, all assigned points will be awarded. However, if the MCO achieved reduction is less than then five percent, points will be commensurate with the achieved rate.

Subsequent annual performance targets will be based on the previous year's annual rate until a total reduction of twenty-five percent is achieved.

**Withhold Performance Target Computation.** The MCO is determined to have achieved the annual 30 Day Readmission performance target if the 2012 Contract Year's rate is five percent less than the 2011 percentage.

$$\text{30 Day Remission Percentage} = (\# \text{ of 30 Day Readmissions} / \# \text{ Admissions}) \times 100$$

#### **Percentage.**

- Formula: The number of 30 Day Readmissions divided by the total number of admissions during the measurement year, multiplied by 100 [(N / D)\* 100].
- The Denominator (D) is the total numbers of admissions during the measurement year as defined in the hospital Admission Rate Withhold measure. To be “eligible” the enrollee must be enrolled in F&C MA or MinnesotaCare Programs one month during the measurement period.
- The Numerator (N) is the unduplicated number of 30 Day Readmissions during the measurement year. To be “eligible” the enrollee must meet the criteria listed in the Numerator Detail section below.
- F&C MA, and MinnesotaCare enrollees over 64 years of age are excluded.
- MCOs must monitor and analyze bimonthly DHS remittance advice and enrollment reports to accurately identify Admissions and enrollee months.
- The results are calculated to the nearest second decimal (e.g. 45.455 = 45.46; or 45.454 = 45.45).

#### **Denominator Detail.**

- A hospital Admission is defined as an inpatient stay indicated by:
  - 1) DHS claim types C and U with provider type 01 (inpatient hospital), or

- 2) provider types 24 (MCO) and 33 (consolidated provider) with general inpatient bill types 110-117 and exclude mental health and chemical dependency inpatient DRGs, and
  - 3) beginning date of service during the measurement year; and
  - 4) the encounter includes room and board revenue codes.
- Admissions are excluded if:
    - 1) the admission results in the death of enrollee during the stay (patient status 20 or 41), or
    - 2) the admission has a diagnosis of pregnancy (ICD-9 CM diagnosis codes 630-679, V22, V23, V28) in any position on the encounter.
    - 3) the admission has a diagnosis of conditions originating in the Perinatal period (ICD-9 CM diagnosis codes 760-779, V21, V29-V39) in any position on the encounter.
  - Admissions less than two days apart will be “collapsed” into one admission to avoid over counting of transfers and multiple claims for an inpatient stay.
  - Admission date is used to correctly assign the responsible MCO for enrollees that may change MCOs during the admission span.
  - For encounters that do not include a pay-to-provider NPI, the MCO will appear as the pay-to-provider.
  - Denied claims that result from the implementation of the True Denial Project will not be used in the calculation. Denied claims that are not a result of the implementation of the True Denial Project may be counted unless the line is identified as a duplicate or is a failed replacement.
  - Voided and replaced encounters are excluded.

**Numerator Detail.**

- Readmissions are only counted if within 30 days of a previous discharge (admission ending service date), based on the person and does not consider the hospital.

**Small Population Calculations.**

- MCOs with small populations may have very few readmissions that could result in a 30 Day Readmission Percentage not sufficiently precise to result in an equitable return of withheld funds. If the 30 Day Readmission Percentage fails to achieve the annual performance target, and the measurement year’s readmissions are less than 100, DHS will calculate a 95 percent confidence interval for the measurement year. If the 95 percent confidence interval lower boundary includes the annual performance target, the assigned points will be awarded even though the actual percentage may be higher than the target.

$$LCI = p - 1.96 \sqrt{\frac{p(1-p)}{n} - \frac{1}{2n}}$$

p = current rate and n = total admissions

**Data Sources.**

- DHS Minnesota Health Care Programs Eligibility Database
- DHS Claims Database

Data used to determine hospital admissions and readmissions are from records received by the STATE no later than May 31<sup>st</sup> of the year following the Contract year. The MCO 2011 Baseline Rates were calculated as of July 3, 2012.

**CY 2011 MCO 30 Day Readmission Baseline Rates Families and Children’s Contract**

<b>MCO</b>	<b>Index Admissions</b>	<b>Readmissions</b>	<b>Readmissions % of Admissions<sup>5</sup></b>
<b>Blue Plus</b>	5,006	582	10.42
<b>HealthPartners</b>	2,503	261	9.44
<b>IMCare</b>	198	9	4.35
<b>Medica</b>	5,759	546	8.66
<b>PrimeWest</b>	738	56	7.05
<b>SCHA</b>	822	74	8.26
<b>UCare</b>	4,470	468	9.48

- Enrollment data used to identify programs (F&C MA, and MinnesotaCare).

**Portion of Target Points.** As required by Minnesota Statutes, § 256B.69, subd.5a (i), a portion of the withhold target points will be awarded commensurate with the achieved reduction less than the targeted amount. The percentage of reduction will be calculated to the second decimal place.

The number of points will be awarded based on the percentage of reduction achieved. For example; if the MCO achieved a 4.20% reduction of an annual targeted reduction of 5%, the MCO achieved 84% (4.2/5) of the annual reduction. If the measure has been assigned 10 points, 8.40 points (eighty-four percent of ten) would be awarded.

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<sup>5</sup> Readmission % = [(Readmissions/(Index Admissions + Readmissions)]\*100