

Minnesota Department of Human Services

2015 Managed Care Withhold Technical Specifications

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2015 Families and Children Contract Section 4.5

2015 Hennepin Health Contract Section 4.5

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Antidepressant Medication Management: Effective Continuation Phase Treatment Measure

Managed Care Withhold Technical Specifications - Contract Year 2015

Purpose.

Hold MCOs accountable to annually increase the rate of enrollees that were newly diagnosed with major depression and treated, remaining on an antidepressant medication for at least 180 days.

Withhold Performance Target Computation.

The MCO's annual performance target will be calculated by adding ten percent (10%) of the difference between the eighty percent (80%) target goal and the Calendar Year 2013 rate. The Calendar Year 2013 rate will be the baseline year for the Contract Year 2015 calculation.

The specifications for this measure are based on NCQA's HEDIS 2013 technical specifications; to preserve the validity of the comparisons between years, changes to these specifications will not be considered by DHS unless future developments significantly influence the dependability of this measure.

Rate Calculation.

The rate will be calculated by dividing the numerator by the denominator [Rate = (N / D)]. The result will be calculated to the second decimal (e.g. 45.63).

Definitions.

- The **Intake Period** is the twelve month window starting May 1 of the year prior to the measurement year.
- The **Index Episode Start Date (IESD)** is the earliest encounter during the Intake Period with any diagnosis of major depression that has a 90 day Negative Medication History. The IESD is the anchor date for the measure.
- The **Index Prescription Start Date (IPSD)** is the earliest prescription dispensing date for an antidepressant medication during the period of 30 days prior to the IESD (inclusive) through 14 days after the IESD (inclusive).
- **Negative Medication History** is defined as a period of 90 days prior to the IPSD when the member has had no pharmacy claims for either new or refill prescriptions for antidepressant medications.

Denominator Details.

The Denominator (D) is the number of MCO enrollees that were diagnosed with major depression, and newly treated with antidepressant medication. To be included in the denominator, enrollees must meet the specific criteria listed in this section.

- **Age Criteria:** Enrollees aged 18 through 64 years old as of April 30th of the measurement year.
- **Continuous Enrollment Criteria:** Enrollees must have been continuously enrolled in the MCO from 90 days prior to the Index Episode Start Date (IESD) through 245 days after the IESD, with no more than one month gap in coverage.
- Enrollees are assigned to the MCO of enrollment as of the anchor date (IESD).
- All enrollees included in the denominator will have an IESD during the Intake Period, and a corresponding IPSD. Enrollees who do not meet the Negative Medication History and Continuous Enrollment criteria will be excluded.
- See NCQA HEDIS 2013 Technical Specifications for additional details and codes.

Numerator Details.

The Numerator (N) is the number of enrollees with at least 180 days of continuous treatment with antidepressant medication during the 231-day period following the IPSD (inclusive). See NCQA HEDIS 2013 Technical Specifications for additional details and codes.

NDC codes.

DHS will use HEDIS 2013 and succeeding years' NDC codes to calculate this measure. NDC code lists for the current and prior years' versions of HEDIS are available on the NCQA website. This alteration to the HEDIS 2013 specifications was made to address MCO concerns that, because the specific medications used in the HEDIS AMM measure change over time, without using the most current list of NDC codes the calculated rates will be inaccurate because of:

- Under-identification of eligible population,
- Misidentification of the index prescription date and treatment period,
- Under-identification of exclusions for prior antidepressant use, and
- Under-identification of medication treatment days and inaccurate numerators.

Exclusions.

- Denied encounter claims that result from the implementation of the True Denial Project will not be used in the calculation.
- Voided and replaced encounter claims are excluded.

Data Source.

- DHS Data Warehouse claims and enrollment data.
- Data used to determine the withhold measure are from records received by the STATE no later than May 31st of the year following the Contract Year.

Points Calculation.

If the MCO's measurement rate is equal to or greater than the 80% target goal, all assigned points will be awarded.

A portion of the withhold target points will be awarded commensurate with the increase achieved if the Contract Year rate is greater than the baseline year rate and less than the annual performance target.

Example of partial points calculation:

- MCO baseline year withhold rate is 40%;
- Annual Performance Target for the Contract Year is 44% (10% of the gap between 40% and the 80% target goal);
- During the measurement year the MCO achieved a rate of 42%,
- If the measure has been assigned ten points, then five of the ten points would be awarded for achieving 50% of the gap between the MCO’s baseline year rate and the annual performance target.
- If the MCO’s eligible number of enrollees (denominator) in the measurement year is 75 or less, all assigned points will be awarded.

If the MCO’s measurement rate decreases below the baseline year rate, zero points will be awarded.

Once the MCO achieves the goal of 80% or greater, in subsequent Contract Years, the MCO will only need to achieve a 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%, the MCO will not receive the points assigned to this measure, and in subsequent years a new baseline year rate will be established and the MCO must again reach either the 80% goal, or show an increase of 10% of the difference between the 80% goal and the baseline year rate, in order to receive the assigned points.

Baseline Rate Calculation.

The MCO CY 2013 Baseline Rates were calculated as of June 24, 2015.

Table 1: CY 2013 MCO Antidepressant Medication Management: Effective Continuation Phase Treatment Measure Baseline Rates Families and Children Contract (MA and MinnesotaCare)

MCO	Numerator	Denominator	Rate
Blue Plus	503	1,149	43.78%
HealthPartners	285	711	40.08%
Itasca Medical Care	19	52	36.54%
Medica	382	999	38.24%
PrimeWest	65	161	40.37%
South Country Health Alliance	58	152	38.16%
UCare	594	1,497	39.68%

Well-Child Visits in the First 15 Months of Life: 6+ Visits Measure

Managed Care Withhold Technical Specifications - Contract Year 2015

Purpose.

Hold MCOs accountable to annually increase the rate of children who turned 15 months old during the measurement year, and who had 6 or more well-child visits with a primary care practitioner during their first 15 months of life.

Withhold Performance Target Computation.

The MCO's annual performance target will be calculated by adding ten percent (10%) of the difference between the eighty percent (80%) target goal and the Calendar Year 2013 rate. The Calendar Year 2013 rate will be the baseline year for the Contract Year 2015 calculation.

The specifications for this measure are based on NCQA's HEDIS 2013 technical specifications; to preserve the validity of the comparisons between years, changes to these specifications will not be considered by DHS unless future developments significantly influence the dependability of this measure.

Rate Calculation.

The rate will be calculated by dividing the numerator by the denominator [Rate = (N / D)]. The result will be calculated to the second decimal (e.g. 45.63).

Denominator Details.

The Denominator (D) is the number of MCO enrollees who turned 15 months old during the measurement year. To be included in the denominator, enrollees must meet the specific criteria listed in this section.

- **Age Criteria:** Children who turned 15 months old during the measurement year.
- **Continuous Enrollment Criteria:** Children must be continuously enrolled in the same MCO from when the child turned 31 days old through the 15-month birthday.
- Enrollees are assigned to the MCO of enrollment as of the day the child turns 15 months old.
- See NCQA HEDIS 2013 Technical Specifications for additional details and codes.

Numerator Details.

The Numerator (N) is the number of enrollees who received at least 6 well-child visits with a primary care provider during their first 15 months of life. Consolidated providers are included in the definition of a primary care provider. See NCQA HEDIS 2013 Technical Specifications for additional details and codes.

Exclusions.

- Denied encounter claims that result from the implementation of the True Denial Project will not be used in the calculation.
- Voided and replaced encounter claims are excluded.

Data Source.

- DHS Data Warehouse claims and enrollment data.
- Data used to determine the withhold measure are from records received by the STATE no later than May 31st of the year following the Contract Year.

Points Calculation.

If the MCO's measurement rate is equal to or greater than the 80% target goal, all assigned points will be awarded.

A portion of the withhold target points will be awarded commensurate with the increase achieved if the Contract Year rate is greater than the baseline year rate and less than the annual performance target.

Example of partial points calculation:

- MCO baseline year withhold rate is 40%;
- Annual Performance Target for the Contract Year is 44% (10% of the gap between 40% and the 80% target goal);
- During the measurement year the MCO achieved a rate of 42%,
- If the measure has been assigned ten points, then five of the ten points would be awarded for achieving 50% of the gap between the MCO's baseline rate and the annual performance target.

If the MCO's eligible number of enrollees (denominator) in the measurement year is 75 or less, all assigned points will be awarded.

If the MCO's measurement rate decreases below the baseline year rate, zero points will be awarded.

Once the MCO achieves the goal of 80% or greater, in subsequent Contract Years, the MCO will only need to achieve a 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%, the MCO will not receive the points assigned to this measure, and in subsequent years a new baseline year rate will be established and the MCO must again reach either the 80% goal, or show an increase of 10% of the difference between the 80% goal and the baseline year rate, in order to receive the assigned points.

Baseline Rate Calculation.

The MCO CY 2013 Baseline Rates were calculated as of June 24, 2015.

**Table 2: CY 2013 MCO Well-Child Visits in the First 15 Months of Life:
6+ Visit Measure Baseline Rates
Families and Children Contract (MA and MinnesotaCare)**

MCO	Numerator	Denominator	Rate
Blue Plus	1,679	2,634	63.74%
HealthPartners	1,115	1,695	65.78%
Itasca Medical Care	72	126	57.14%
Medica	1,603	2,600	61.65%
PrimeWest	306	507	60.36%
South Country Health Alliance	273	419	65.16%
UCare	2,958	4,764	62.09%

Emergency Department (ED) Utilization Rate

Managed Care Withhold Technical Specifications - Contract Year 2015

Purpose.

Each MCO must decrease their Emergency Department Utilization rate by a total of twenty-five percent (25%) from their 2009 baseline rate. [Minnesota Statutes 256B.69, subdivision 5a(e)]

Withhold Performance Target Computation.

The MCO's performance target for the Contract Year will be calculated as a ten percent (10%) reduction from the previous year's Emergency Department (ED) Utilization rate. If the MCO achieved reduction is less than 10%, a portion of the assigned points will be awarded commensurate with the achieved rate.

Subsequent annual performance targets will be based on the previous year's ED Utilization rate until a total reduction of twenty-five percent (25%) from the baseline rate is achieved.

The specifications for the ED Utilization Withhold Measure calculation are based on NCQA's HEDIS 2010 Ambulatory Care measure's technical specifications; to preserve the validity of the comparisons between years, changes to these specifications will not be considered by DHS unless future developments significantly influence the dependability of this measure.

Rate Calculation.

The rate will be calculated by dividing the number of ED visits by the number of enrollee-months, then multiplying by 1000 [Rate = (N / D) * 1000]. The result will be calculated to the second decimal (e.g. 45.63).

Denominator Details.

The Denominator (D) is the total number of enrollee-months during the year. To be included in the denominator, enrollees must meet the specific criteria listed in this section.

- **Age Criteria:** 0 through 64 years of age, calculated as of December 31st of the Contract Year. Enrollees over 64 years of age are excluded.
- **Enrollment Criteria:** Enrolled in an MCO for at least one month during the calendar year in Families and Children MA or MinnesotaCare Programs.
- One enrollee-month is attributed to the MCO's denominator for each month an enrollee was enrolled in that MCO. Some enrollees may be attributed to multiple MCOs.

Numerator Details.

The Numerator (N) is the unduplicated number of ED Visits during the year, for enrollees who meet the denominator criteria.

- HEDIS 2010 Technical Specifications are used to identify ED encounters and required exclusions are applied. The ED Visit must be provided during the Contract Year.

- ED Visits are attributed to the MCO's denominator if they occur during a month that the enrollee was enrolled in that MCO.
- An ED Visit is defined as CPT code = '99281-99285'; UB Revenue = 045x, 0981 or CPT = 10040-69979 with POS = 23.

Exclusions.

- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation.
- 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 Source.

- DHS Data Warehouse claims and enrollment data.
- Data (visits and enrollment) used to determine the withhold measure are from records received by the STATE no later than May 31st of the year following the Contract Year.

Points Calculation.

If the MCO's measurement rate is equal to or less than the performance target, all assigned points will be awarded.

A portion of the withhold target points will be awarded commensurate with the achieved reduction if the Contract Year rate is less than the previous year's rate and greater than the annual performance target.

Example of partial points calculation:

- MCO previous year rate is 60 per 1,000 enrollee-months;
- Annual performance target for the Contract Year is 54 per 1,000 enrollee-months (10% reduction from previous year's rate);
- During the measurement year the MCO achieved a rate of 56 per 1,000 enrollee-months;
- The proportion of the annual reduction achieved is $(60 - 56) / (60 - 54) = 4/6 = 0.6$ or 60%;
- If the measure has been assigned ten points, then six of the ten points would be awarded for achieving 60% of the annual reduction target.

If the MCO's measurement rate is greater than the previous year's rate, zero points will be awarded.

If the MCO meets or surpasses its final performance target (25% reduction from the 2009 baseline year ED Utilization rate) during the Contract Year, the MCO will be considered to have fully met the Contract Year performance target for purposes of collecting the withheld funds. When measuring performance, the STATE must consider the difference in health risk in the

MCO's membership in the baseline year compared with the Contract Year, and work with the MCO to account for differences that they agree are significant.

Baseline Rate Calculation.

The MCO CY 2009 Baseline Rates were calculated as of June 25, 2012. The Hennepin Health CY 2012 Baseline Rate was calculated as of June 5, 2013.

The tables below provide the baseline year rate and final performance target rate for each MCO:

Table 3: CY 2009 MCO ED Utilization Baseline Rates Families and Children Contract (MA and MinnesotaCare)

MCO	Baseline Numerator (ED Visits)	Baseline Denominator (Enrollee Months)	Baseline ED Utilization Rate (ED Visits per 1000 enrollee months)	Final Performance Target (25% reduction from baseline)
Blue Plus	61,932	1,253,534	49.41	37.05
HealthPartners	34,631	627,297	55.21	41.41
Itasca Medical Care	4,492	62,704	71.64	53.73
Medica	102,008	1,524,139	66.93	50.20
PrimeWest	12,653	196,353	64.44	48.33
South Country Health Alliance	21,359	319,542	66.84	50.13
UCare	63,263	1,103,256	57.34	43.01

Table 4: Hennepin Health CY 2012 ED Utilization Baseline Rate

MCO	Baseline Numerator (ED Visits)	Baseline Denominator (Enrollee Months)	Baseline ED Utilization Rate (ED Visits per 1000 enrollee months)	Final Performance Target (25% reduction from baseline)
Hennepin Health	8,341	62,216	134.07	100.55

Hospital Admission Rate

Managed Care Withhold Technical Specifications - Contract Year 2015

Purpose.

Each MCO must reduce their Hospital Admission rate by a total of twenty-five percent (25%) from their 2011 baseline rate. [Minnesota Statutes 256B.69, subdivision 5a(f)]

Withhold Performance Target Computation.

The MCO's performance target for the Contract Year will be calculated as a five percent (5%) reduction in its Hospital Admission rate compared with the previous year. If the MCO achieved reduction is less than 5%, a portion of the assigned points will be awarded commensurate with the achieved rate.

Subsequent annual performance targets will be based on the previous year's Hospital Admission rate until a total reduction of twenty-five percent (25%) from the baseline rate is achieved.

Rate Calculation.

The rate will be calculated by dividing the number of index admissions by the number of enrollee-months, then multiplying by 1000 [Rate = (N / D) * 1000]. The result is calculated to the second decimal (e.g. 45.63).

Denominator Details.

The Denominator (D) is the total number of enrollee-months during the year. To be included in the denominator, enrollees must meet the specific criteria listed in this section.

- Age Criteria: One through 64 years of age, calculated as of December 31st of the Contract Year. Enrollees under 1 year of age and over 64 years of age are excluded.
- Enrollment Criteria: Enrolled in an MCO for at least one month during the calendar year in F&C MA or MinnesotaCare programs.
- One enrollee-month is attributed to the MCO's denominator for each month an enrollee was enrolled in that MCO. Some enrollees may be attributed to multiple MCOs.
- Enrollment data is used to identify programs (Families and Children MA, and MinnesotaCare) and payment system (fee-for-service vs. managed care).

Numerator Details.

The Numerator (N) is the unduplicated number of Index Admissions during the year. Index Admissions exclude readmissions as defined for the 30 Day Readmission Percentage Managed Care Withhold Technical Specifications, described elsewhere in this document.

MCOs must monitor and analyze bimonthly DHS remittance advice and enrollment reports to accurately identify Admissions and enrollee months.

A Hospital Admission is defined as an inpatient stay indicated by:

- DHS claim types C (inpatient hospital) and U (Medicare crossover inpatient hospital) with provider type 01 (inpatient hospital), or
- provider types 24 (MCO) and 33 (consolidated provider) with general inpatient bill types 110-117 and exclude mental health and chemical dependency inpatient DRGs¹, and
- beginning date of service during the measurement year; and
- the encounter includes room and board revenue codes.

The admission date is defined as the beginning service date on the managed care encounter claim. Admissions less than two days apart for the same enrollee will be “collapsed” into one admission to avoid over counting of admissions due to transfers and multiple claims for an inpatient stay. Inpatient claims that are collapsed may be for the same or for different hospitals.

Admission date is used to correctly assign the responsible MCO for enrollees that may change MCOs during the admission span.

Exclusions.

- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation.
- Voided and replaced encounters are excluded.
- Admissions are excluded from the numerator if:
 - the admission results in the death of enrollee during the stay (patient status 20 or 41), or
 - the admission has a diagnosis of pregnancy (ICD-9 CM diagnosis codes 630-679, V22, V23, V28) in any position on the encounter.
 - 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.
- Readmissions are excluded from the numerator if within 30 days of a previous discharge (admission ending service date) for the same enrollee. Readmissions may be to the same or a different hospital from the index admission. Refer to the 30 Day Readmission Percentage Managed Care Withhold Technical Specifications, elsewhere in this document.

Data Source.

- DHS Data Warehouse claims and enrollment data.
- Data used to determine the withhold measure are from records received by the STATE no later than May 31st of the year following the Contract Year.

¹ Currently CMS DRG Grouper Software version 23.0, issued 10/05. DRGs 425-432, & 521-523. Definition will be updated when APR-DRG is implemented.

Points Calculation.

If the MCO's measurement rate is equal to or less than the performance target, all assigned points will be awarded.

A portion of the withhold target points will be awarded commensurate with the achieved reduction if the Contract Year rate is less than the previous year's rate and greater than the annual performance target.

Example of partial points calculation:

- MCO previous year rate is 4.0 per 1,000 enrollee-months;
- Annual performance target for the Contract Year is 3.6 per 1,000 enrollee-months (10% reduction from previous year's rate);
- During the measurement year the MCO achieved a rate of 3.8 per 1,000 enrollee-months;
- The proportion of the annual reduction achieved is $(4.0 - 3.8) / (4.0 - 3.6) = 0.2/0.4 = 0.5$ or 50%;
- If the measure has been assigned ten points, then five of the ten points would be awarded for achieving 50% of the annual reduction target.

If the MCO's measurement rate is greater than the previous year's rate, zero points will be awarded.

If the MCO meets or surpasses its final performance target (25% reduction from the 2011 baseline year Hospital Admission rate) during the Contract Year, the MCO will be considered to have fully met the Contract Year performance target for purposes of collecting the withheld funds. When measuring performance, the STATE must consider the difference in health risk in the MCO's membership in the baseline year compared with the Contract Year, and work with the MCO to account for differences that they agree are significant.

Baseline Rate Calculation.

The MCO 2011 Baseline Rates were calculated as of July 3, 2012. The Hennepin Health CY 2012 Baseline Rate was calculated as of June 4, 2013.

The tables below provide the baseline year rate and final performance target rate for each MCO:

**Table 5: CY 2011 MCO Hospital Admission Baseline Rates
Families and Children Contract (MA and MinnesotaCare)**

MCO	Baseline Numerator (Index Admissions)	Baseline Denominator (Enrollee Months)	Baseline Hospital Admissions Rate (Index Admissions per 1000 enrollee months)	Final Performance Target (25% reduction from baseline)
Blue Plus	5,006	1,559,793	3.21	2.41
HealthPartners	2,503	752,271	3.33	2.50
Itasca Medical Care	198	66,379	2.98	2.24
Medica	5,759	1,748,945	3.29	2.47
PrimeWest	738	222,096	3.32	2.49
South Country Health Alliance	822	256,001	3.21	2.41
UCare	4,470	1,379,468	3.24	2.43

Table 6: Hennepin Health CY 2012 Hospital Admission Baseline Rate

MCO	Baseline Numerator (Index Admissions)	Baseline Denominator (Enrollee Months)	Baseline Hospital Admissions Rate (Index Admissions per 1000 enrollee months)	Final Performance Target (25% reduction from baseline)
Hennepin Health	587	61,856	9.49	7.12

30 Day Readmission Percentage

Managed Care Withhold Technical Specifications - Contract Year 2015

Purpose.

Each MCO must reduce their 30 Day Readmission Percentage by a total of twenty-five percent (25%) from their 2011 baseline rate. [Minnesota Statutes 256B.69, subdivision 5a(g)]

Withhold Performance Target Computation.

The MCO's performance target for the Contract Year will be calculated as a five percent (5%) reduction in its 30 Day Readmission Percentage compared with the previous year. If the MCO achieved reduction is less than 5%, a portion of the assigned points will be awarded commensurate with the achieved rate.

Subsequent annual performance targets will be based on the previous year's 30 Day Readmission Percentage until a total reduction of twenty-five percent (25%) from the baseline rate is achieved.

Percentage Calculation.

The percentage will be calculated by dividing the number of 30 Day Readmissions by the total number of admissions (index admissions plus readmissions) during the measurement year, multiplied by 100 [Percentage = (N / D)*100]. The result will be calculated to the second decimal (e.g. 45.63).

Denominator Details.

The Denominator (D) is the total number of index admissions during the measurement year as defined in the Hospital Admission Rate Withhold measure, plus the number of readmissions as defined in the Numerator Details below, during the measurement year. Index admissions included in the denominator must meet the criteria described in the Numerator Details section of the Hospital Admission Rate Managed Care Withhold Technical Specifications, elsewhere in this document.

Numerator Details.

The Numerator (N) is the unduplicated number of 30 Day Readmissions during the measurement year.

Readmissions are included in the numerator if within 30 days of a previous discharge (admission ending service date) for the same enrollee. Readmissions may be to the same or a different hospital from the index admission.

Admission date is defined as the beginning service date on the managed care encounter claim.

Admissions less than two days apart for the same enrollee will be "collapsed" into one admission to avoid over counting of admissions due to transfers and multiple claims for an

inpatient stay. Inpatient claims that are collapsed may be for the same or for different hospitals.

Admission date for the readmission is used to correctly assign the responsible MCO for enrollees that may change MCOs during the readmission span.

MCOs must monitor and analyze bimonthly DHS remittance advice and enrollment reports to accurately identify admissions and enrollee months.

Exclusions.

- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation.
- Voided and replaced encounters are excluded.

Data Source.

- DHS Data Warehouse claims and enrollment data.
- Data used to determine the withhold measure are from records received by the STATE no later than May 31st of the year following the Contract Year.

Points Calculation.

If the MCO's measurement rate is equal to or less than the performance target, all assigned points will be awarded.

A portion of the withhold target points will be awarded commensurate with the achieved reduction if the Contract Year rate is less than the previous year's rate and greater than the annual performance target.

Example of partial points calculation:

- MCO previous year percentage is 10%;
- Annual performance target for the Contract Year is 9.5% (5% reduction from previous year's rate);
- During the measurement year the MCO achieved a percentage of 9.8%;
- The proportion of the annual reduction achieved is $(10 - 9.8) / (10 - 9.5) = 0.2/0.5 = 0.4$ or 40%;
- If the measure has been assigned ten points, then four of the ten points would be awarded for achieving 40% of the annual reduction target.

If the MCO's measurement rate is greater than the previous year's rate, zero points will be awarded.

If the MCO meets or exceeds its final performance target (25% reduction from the 2011 baseline year 30 Day Readmission Percentage) during the Contract Year, the MCO will be considered to have fully met the Contract Year performance target for purposes of collecting the withheld funds. When measuring performance, the STATE must consider the difference in health risk in the MCO's membership in the baseline year compared with the Contract Year, and work with the MCO to account for differences that they agree are significant.

Small Population.

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, the STATE will determine the performance target measure is not dependable. The measure will be eliminated and the MCO shall be scored based on the remaining performance measures.

Baseline Percentage Calculation.

The MCO 2011 Baseline Percentages were calculated as of July 3, 2012. The Hennepin Health CY 2012 Baseline Rate was calculated as of June 4, 2013.

The tables below provide the baseline year rate and final performance target rate for each MCO:

Table 7: CY 2011 MCO 30 Day Readmission Baseline Percentages Families and Children Contract (MA and MinnesotaCare)

MCO	Baseline Index Admissions	Baseline Readmissions	Baseline Total Admissions (sum of Index Admissions and Readmissions)	Baseline 30 Day Readmission Percentage (Readmissions divided by Total Admissions)	Final Performance Target (25% reduction from baseline)
Blue Plus	5,006	582	5,588	10.42	7.81
HealthPartners	2,503	261	2,764	9.44	7.08
Itasca Medical Care	198	9	207	4.35	3.26
Medica	5,759	546	6,305	8.66	6.49
PrimeWest	738	56	794	7.05	5.29
South Country Health Alliance	822	74	896	8.26	6.19
UCare	4,470	468	4,938	9.48	7.11

Table 8: Hennepin Health CY 2012 30 Day Readmission Baseline Percentage

MCO	Baseline Index Admissions	Baseline Readmissions	Baseline Total Admissions (sum of Index Admissions and Readmissions)	Baseline 30 Day Readmission Percentage (Readmissions divided by Total Admissions)	Final Performance Target (25% reduction from baseline)
Hennepin Health	587	97	684	14.18	10.64

Hennepin Health – Initiation of Alcohol & Other Drug Dependence Treatment Rate

Managed Care Withhold Technical Specifications - Contract Year 2015

Purpose.

This withhold measure only applies to the DHS contract with Hennepin Health. Hennepin Health is accountable to achieve an annual increase in the percentage of enrollees who initiate treatment through an inpatient alcohol or other drug admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Withhold Performance Target Computation.

Hennepin Health's annual performance target for the Contract Year will be calculated by adding ten percent (10%) of the difference between the eighty percent (80%) target goal and the previous year's rate. The Calendar Year 2014 rate will be the baseline rate for the Contract Year 2015 calculation.

The specifications for this measure are based on NCQA's HEDIS 2012 Technical Specifications; to preserve the validity of the comparisons between years, changes to these specifications will not be considered by DHS unless future developments significantly influence the dependability of this measure.

Rate Calculation.

The rate will be calculated by dividing the numerator by the denominator [Rate = (N / D)]. The result will be calculated to the second decimal (e.g. 45.63).

Definitions.

- The **Intake Period** is January 1 through November 15 of the Contract Year.
- The **Index Episode Start Date (IESD)** is the earliest date of service for an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department encounter during the Intake Period with a diagnosis of alcohol or other drug dependence.
- **Negative Diagnosis History** is defined as a period of 60 days before the IESD when the enrollee had no claims or encounters with a diagnosis of alcohol or other drug dependence.

Denominator Details.

The Denominator (D) is the number of enrollees with a new episode of alcohol or other drug dependence during the measurement period. To be included in the denominator, enrollees must meet the specific criteria listed in this section.

- **Age Criteria:** Enrollees aged 18 through 64 years old as of December 31st of the measurement year.

- **Continuous Enrollment Criteria:** An enrollee is attributed to the denominator if the enrollee was enrolled in Hennepin Health for 60 days prior to the IESD through 44 days after the IESD.
- All enrollees included in the denominator will have an IESD during the Intake Period.
- Enrollees are excluded from the denominator whose initiation encounter is an inpatient stay with a discharge date after December 1 of the measurement year.
- See NCQA HEDIS 2012 Technical Specifications for additional details and codes.

Numerator Details.

The Numerator (N) is the number of enrollees in the Denominator that initiated alcohol or other drug dependency treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

See HEDIS 2012 Tables IET-A, IET-B, IET-C, IET-D and IET-E for codes to identify: alcohol or other drug dependence; outpatient/intensive outpatient and partial hospitalization visits; detoxification visits; ED visits; and alcohol or other drug dependence procedures.

See NCQA HEDIS 2012 Technical Specifications for additional details and codes.

Exclusions.

- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation.
- Voided and replaced encounters are excluded.

Data Source.

- DHS Data Warehouse claims and enrollment data.
- Data used to determine the withhold measure are from records received by the STATE no later than May 31st of the year following the Contract Year.

Points Calculation.

If the MCO's measurement rate is equal to or greater than the 80% target goal, all assigned points will be awarded.

A portion of the withhold target points will be awarded commensurate with the increase achieved if the Contract Year rate is greater than the baseline year rate and less than the annual performance target.

Example of partial points calculation:

- MCO baseline year withhold rate is 40%;
- Annual Performance Target for the Contract Year is 44% (10% of the gap between 40% and the 80% target goal);
- During the measurement year the MCO achieved a rate of 42%,
- If the measure has been assigned ten points, then five of the ten points would be awarded for achieving 50% of the gap between the MCO's baseline year rate and the annual performance target.

If the MCO's measurement rate decreases below the baseline year rate, zero points will be awarded.

Once the MCO achieves the goal of 80% or greater, in subsequent Contract Years, the MCO will only need to achieve a 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%, the MCO will not receive the points assigned to this measure, and in subsequent years a new baseline year rate will be established and the MCO must again reach either the 80% goal, or show an increase of 10% of the difference between the 80% goal and the baseline year rate, in order to receive the assigned points.

Baseline Rate Calculation.

The Hennepin Health CY 2014 baseline rate was calculated as of June 25, 2015.

Table 9: Calendar Year 2014

Hennepin Health Initiation of Alcohol & Other Drug Dependence Treatment Rate

MCO	Numerator	Denominator	Rate
Hennepin Health	272	884	30.77%

Hennepin Health – 30 Day Follow-Up After Hospitalization for Mental Illness Rate

Managed Care Withhold Technical Specifications - Contract Year 2015

Purpose.

This withhold measure only applies to the DHS contract with Hennepin Health. Hennepin Health is accountable to achieve an annual increase in the percentage of hospital discharges for treatment of selected mental health disorders for which the enrollee received a follow-up visit with a mental health practitioner within 30 days of discharge.

Withhold Performance Target Computation.

Hennepin Health's annual performance target for the Contract Year will be calculated by adding ten percent (10%) of the difference between the eighty percent (80%) target goal and the previous year's rate. The Calendar Year 2014 rate will be the baseline rate for the Contract Year 2015 calculation.

The specifications for this measure are based on NCQA's HEDIS 2012 Technical Specifications; to preserve the validity of the comparisons between years, changes to these specifications will not be considered by DHS unless future developments significantly influence the dependability of this measure.

Rate Calculation.

The rate will be calculated by dividing the numerator by the denominator [Rate = (N / D)]. The result will be calculated to the second decimal (e.g. 45.63).

Denominator Details.

The Denominator (D) is the number of discharges from acute inpatient settings (discharged alive) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year. If enrollees have more than one discharge during the year all discharges will be included. To be included in the denominator, enrollees must meet the specific criteria listed in this section.

- **Age Criteria:** 18 through 64 as calculated as of December 31st of the measurement year.
- **Continuous Enrollment Criteria:** Enrollees must have been enrolled in Hennepin Health for at least 30 days following the discharge during the Contract Year.
- **ICD-9-CM Diagnosis to identify mental health diagnosis:** 295-299, 300.3, 300.4, 301, 308, 311-314 (Table FUH-A, HEDIS 2012 Technical Specifications).
- **Mental health readmission or direct transfer:** only the readmission discharge or the discharge from the facility to which the enrollee was transferred will be counted. Discharges followed by readmission or direct transfer to a nonacute facility for mental health principal diagnosis will be excluded. See HEDIS 2012 Tables MPT-A, MPT-B for a listing of mental health principal diagnoses and Table FUH-B for codes to identify nonacute care.

- Non-mental health readmission or direct transfer: discharges of patients transferred directly or readmitted to an acute or nonacute facility for a non-mental health principal diagnosis will be excluded.
- See NCQA HEDIS 2012 Technical Specifications for additional details and codes.

Numerator Details.

The Numerator (N) is an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner, or a mental health follow-up visit with a primary care provider, within 30 days after discharge.

A mental health practitioner is defined in HEDIS 2012 Technical Specifications Appendix 3 as a MD or DO certified as a psychiatrist; licensed psychologist; certified clinical social worker; a registered psychiatric nurse or mental health clinical nurse specialist; individual practicing as a marital and family therapist and licensed or certified counselor; or individual practicing as a professional counselor and licensed or certified.

A mental health follow-up visit with a primary care provider is defined as follows:

- Current Procedural Terminology (CPT) code in the range 99201 – 99215
- Primary care provider is defined using DHS provider specialty data, and includes the following specialty types: general practice, internal medicine, pediatrics, preventative medicine, obstetrics and/or gynecology, primary care
- ICD-9-CM diagnosis code to identify mental health diagnosis in the first 4 positions on the claim: 295-299, 300.3, 300.4, 301, 308, 311-314

See NCQA HEDIS 2012 Technical Specifications for additional details and codes.

Exclusions.

- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation.
- Voided and replaced encounters are excluded.

Data Source.

- DHS Data Warehouse claims and eligibility data.
- Data used to determine the withhold calculation are from records received by the STATE no later than May 31st of the year following the Contract Year.

Points Calculation.

If the MCO's measurement rate is equal to or greater than the 80% target goal, all assigned points will be awarded.

A portion of the withhold target points will be awarded commensurate with the increase achieved if the Contract Year rate is greater than the baseline year rate and less than the annual performance target.

Example of partial points calculation:

- MCO baseline year withhold rate is 40%;
- Annual Performance Target for the Contract Year is 44% (10% of the gap between 40% and the 80% target goal);
- During the measurement year the MCO achieved a rate of 42%,
- If the measure has been assigned ten points, then five of the ten points would be awarded for achieving 50% of the gap between the MCO’s baseline year rate and the annual performance target.

If the MCO’s measurement rate decreases below the baseline year rate, zero points will be awarded.

Once the MCO achieves the goal of 80% or greater, in subsequent Contract Years, the MCO will only need to achieve a 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%, the MCO will not receive the points assigned to this measure, and in subsequent years a new baseline year rate will be established and the MCO must again reach either the 80% goal, or show an increase of 10% of the difference between the 80% goal and the baseline year rate, in order to receive the assigned points.

Baseline Year Calculation.

The Hennepin Health CY 2014 baseline rate was calculated as of June 25, 2015.

**Table 10: Calendar Year 2014
Hennepin Health 30 Day Follow-Up After Hospitalization for Mental Illness Rate**

MCO	Numerator	Denominator	Rate
Hennepin Health	59	121	48.76%

Hennepin Health – Dental Visit Rate

Managed Care Withhold Technical Specifications - Contract Year 2015

Purpose.

This withhold measure only applies to the DHS contract with Hennepin Health. Hennepin Health is accountable to achieve an annual increase in the percentage of enrollees with an annual dental visit.

Withhold Performance Target Computation.

Hennepin Health's annual performance target for the Contract Year will be calculated by adding ten percent (10%) of the difference between the eighty percent (80%) target goal and the previous year's rate. The Calendar Year 2014 rate will be the baseline rate for the Contract Year 2015 calculation.

The specifications for this measure are based on NCQA's HEDIS 2012 Technical Specifications; to preserve the validity of the comparisons between years, changes to these specifications will not be considered by DHS unless future developments significantly influence the dependability of this measure.

Rate Calculation.

The rate will be calculated by dividing the numerator by the denominator [Rate = (N / D)]. The result will be calculated to the second decimal (e.g. 45.63). The

Denominator Details.

The Denominator (D) is the number of Hennepin Health enrollees that meet these criteria:

- Age Criteria: Enrollees aged 18 through 64 years calculated as of December 31st of the measurement year.
- Continuous Enrollment Criteria: Enrolled in Hennepin Health for the entire measurement year (January 1 through December 31) with no more than a 1 month gap in enrollment.

Numerator Details.

The Numerator (N) is the number of enrollees who had one or more dental visits with a dental practitioner during the measurement year.

A dental visit is defined as indicated in Table ADV-A, HEDIS 2012 Technical Specifications.

Exclusions.

- Denied claims that result from the implementation of the True Denial Project will not be used in the calculation.
- Voided and replaced encounters are excluded.

Data Source.

- DHS Data Warehouse claims and eligibility data.
- Data used to determine the withhold calculation are from records received by the STATE no later than May 31st of the year following the Contract Year.

Points Calculation.

If the MCO's measurement rate is equal to or greater than the 80% target goal, all assigned points will be awarded.

A portion of the withhold target points will be awarded commensurate with the increase achieved if the Contract Year rate is greater than the baseline year rate and less than the annual performance target.

Example of partial points calculation:

- MCO baseline year withhold rate is 40%;
- Annual Performance Target for the Contract Year is 44% (10% of the gap between 40% and the 80% target goal);
- During the measurement year the MCO achieved a rate of 42%,
- If the measure has been assigned ten points, then five of the ten points would be awarded for achieving 50% of the gap between the MCO's baseline year rate and the annual performance target.

If the MCO's measurement rate decreases below the baseline year rate, zero points will be awarded.

Once the MCO achieves the goal of 80% or greater, in subsequent Contract Years, the MCO will only need to achieve a 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%, the MCO will not receive the points assigned to this measure, and in subsequent years a new baseline year rate will be established and the MCO must again reach either the 80% goal, or show an increase of 10% of the difference between the 80% goal and the baseline year rate, in order to receive the assigned points.

Baseline Year Calculation.

The Hennepin Health CY 2014 baseline rate was calculated as of June 25, 2015.

**Table 11: Calendar Year 2014
Hennepin Health Dental Visit Rate**

MCO	Numerator	Denominator	Rate
Hennepin Health	1,064	3,290	32.34%