

IHP Report Reference Documentation

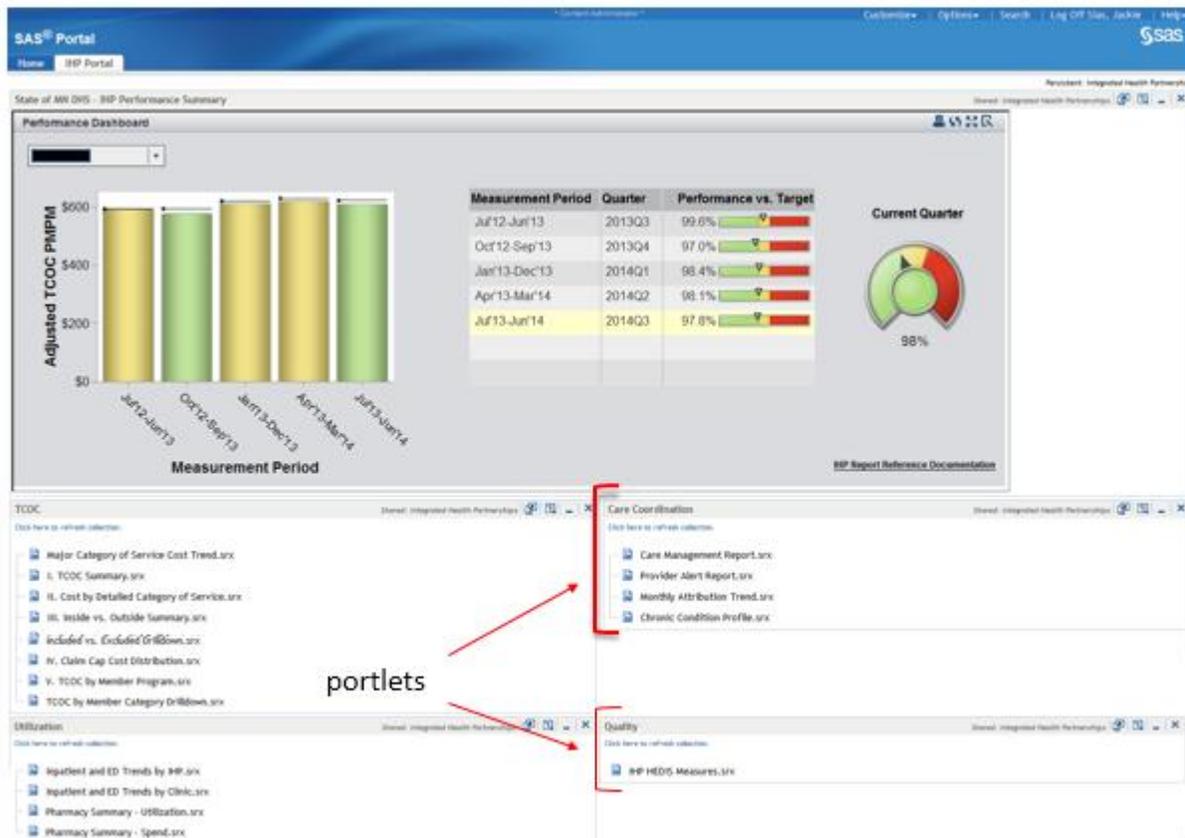
Table of Contents

Portal Layout	2
Common Data Elements.....	2
Run Month.....	2
Measurement Period.....	2
Benchmark Population	2
Dashboards.....	3
Performance Dashboard.....	3
TCOC Reports.....	3
Major Category of Service Cost Trend.....	3
I. TCOC Summary	3
II. Cost by Detailed Category of Service.....	4
III. Inside vs. Outside Summary.....	4
IV. Claim Cap Cost Distribution	5
V. TCOC by Member Program.....	5
TCOC by Member Category Drilldown.....	6
Care Coordination Reports	6
Care Management Report	6
Provider Alert Report.....	12
Monthly Attribution Trend	14
Chronic Condition Profile.....	14
Utilization Reports	15
Inpatient and ED Trends by IHP.....	15
Inpatient and ED Trends by Clinic.....	16
Pharmacy Summary - Utilization	16
Pharmacy Summary - Spend.....	17
Quality Reports	17
IHP HEDIS Measures	17

Portal Layout

Reports/dashboards are organized according to content area and displayed within portlets:

- TCOC (Total Cost of Care)
- Care Coordination
- Utilization
- Quality
- Performance Dashboard



Common Data Elements

The following data elements are common to multiple reports:

Run Month

The run month is the month and year the report was generated, and corresponds with the attribution date. The data contained in each report has a 3 month lag for claims run out ending in the previous month. For example, a run month of January 2015 coincides with dates of service October 1, 2013 - September 30, 2014.

Measurement Period

The measurement period is a twelve month period ending four months prior to run month. For example, the measurement period for Oct'13 - Sep'14 coincides with a January 2015 run month.

Benchmark Population

The benchmark population represents all MHCP attribution eligible individuals, including IHP attributed members. Members included in the benchmark must have:

[Table of Contents](#)

- had an Evaluation and Management (E&M) or Health Care Home claim at some point during the performance period;
- six months of continuous enrollment or nine months of non-continuous enrollment;
- no disqualifying enrollment characteristics such as Medicare eligibility or enrollment in partial benefit programs such as the Family Planning Program or Emergency Medical Assistance.

Dashboards

Performance Dashboard

The Performance Dashboard is updated every quarter and offers a high level summary of an IHP's performance trend over the course of the demonstration. Data in the dashboard is consistent with the results contained in the Performance Exhibit distributed every quarter; no data will display for IHPs who have yet to receive a Performance Exhibit (IHPs receive their first Performance Exhibit the quarter following target development). The graph displays the adjusted TCOC PMPM (bar height) as compared to the IHP's adjusted target PMPM (black tick marks). The bars change color to indicate whether an IHP is in a gain share/loss position for each measurement period.

Gain share: **Adjusted TCOC PMPM** > 2% below the **Target** - **GREEN**

No savings or losses: **Adjusted TCOC PMPM** within $\pm 2\%$ of the **Target** - **YELLOW**

Loss share: **Adjusted TCOC PMPM** > 2% above the **Target** - **RED**

The dashboard also includes a chart that shows the IHP's performance reflected as a percentage (Adjusted TCOC PMPM / Target). The most recent performance is illustrated in the key performance indicator (displayed as a dial).

TCOC Reports

Major Category of Service Cost Trend

The Major Category of Service Cost Trend report is updated every quarter using DHS Medicaid enrollment and claims/encounter data. It shows the unadjusted PMPM for services **included** in the IHP's TCOC by major category of service: Inpatient, Outpatient, Pharmacy, Professional, MH/CD, and Other. The report also includes a graph showing the proportional breakdown of the total TCOC by major service category. Data is displayed for measurement periods as early as the IHP has been in existence.

I. TCOC Summary

The TCOC Summary report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. The data used comes directly from the DHS data warehouse and represents finalized, paid claims and encounters for the designated measurement period. This report displays the total claims and PMPM by major service category for the included and excluded services. In general, the inclusion or exclusion criteria are based on the DHS detailed service category definitions, and all services falling into the detailed service categories (e.g. anesthesia) are either included or excluded from the TCOC calculation. Certain services are excluded from the TCOC for purposes of developing the targets and determining the financial results for the measurement period. Included and excluded services may differ across IHPs; included services are specified within individual IHP contracts. The report allows users to display results- aggregated for the entire IHP attributed population, "All Members," and the population excluding members with third party liability (TPL),- "TPL Members Excluded".

Category of Service

The seven major service category classifications (inpatient, outpatient facility, etc.) are based on the definitions in DHS's data. The Inpatient, Outpatient facility, Professional, and Pharmacy claims are based on the DHS data warehouse major service category definitions, while the Long Term Care (LTC) and Mental Health / Chemical Dependency (MH/CD) and Other categories are carved out of the higher level categories based on DHS' detailed service category definitions. For example, the LTC claims may include services that are administered on an inpatient, outpatient facility or professional basis, but are defined as LTC due to the specific nature of the service. Because of their cost magnitude and the fact that these services are not included in the TCOC, LTC services are shown separately from the remainder of the claim cost components in the table.

Relative Risk

The relative risk scores are developed using the category-specific ACG risk weights (MCO vs. SNBC and FFS) based on 2012 claim costs.

II. Cost by Detailed Category of Service

The Cost by Detailed Category of Service report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. The data used comes directly from the DHS data warehouse and represents finalized, paid claims and encounters for the designated measurement period. This report shows the detailed service category breakdown, the amount of claims and PMPM for each detailed category of service, and whether the claims are included or excluded from the TCOC. The report has 3 separate views: claims paid to providers "inside" the IHP, claims paid to providers "outside" the IHP, and "all" claims paid. Only detailed service categories containing paid amounts display in the table. The report allows users to display results aggregated for the entire IHP attributed population "All Members" and the population excluding members with third party liability (TPL), "TPL Members Excluded".

With the exception of mental health, chemical dependency, and "uncategorized" service categories, all claims within the category are either included or excluded from the TCOC. For mental health and chemical dependency services (categories 046 and 062), the total included and excluded services are shown as two separate lines on the exhibit. As part of the target development process, DHS reviewed the uncategorized services (category 999) in the claim files to determine which claims should be included or excluded from the TCOC. Based on this review many of these services were ultimately determined to be equivalent to other services included in the TCOC (inpatient, professional chemical dependency, etc.). Although these services are shown as "uncategorized" in the exhibit, the inpatient and MHCD claims could reasonably be categorized as "001 – Inpatient General Hospital" and "062 – CD Consolidated Treatment Fund" respectively.

III. Inside vs. Outside Summary

The Inside vs. Outside Summary report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. The data used comes directly from the DHS data warehouse and represents finalized, paid claims and encounters for the designated measurement period. The report shows the total claims that were paid to providers "inside and outside" of the IHP. For some IHPs, their submitted provider rosters do not contain all providers "inside" their system. For example, an NPI for an owned pharmacy or hospitals may not be included under the expectation that no eligible E&M visits will be paid to that hospital's NPI.

The list of pay-to-provider identifiers (TIN and NPIs) as previously submitted by the IHPs were used. Because these breakdowns are based on the pay-to-provider TIN and/or NPIs submitted to DHS by the IHPs, the totals on this report rely on their accuracy and completeness. As always, participating IHPs are encouraged to continue to review the information submitted and provide updates to DHS if they wish to expand or refine the group of

associated entities that are included in the "Paid to IHP" totals. The report allows users to display results aggregated for the entire IHP attributed population "All Members" and the population excluding members with third party liability (TPL), "TPL Members Excluded".

Paid to IHP

Information based on provider lists developed from IHP-submitted Tax Identification Numbers (TINs).

Included vs. Excluded Drilldown

The Included vs. Excluded Drilldown report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. The data used comes directly from the DHS data warehouse and represents finalized, paid claims and encounters for the same measurement period as all other TCOC reports. It shows a detailed breakdown of claim paid amounts and number of claims incurred by the Inclusion Status (Included in TCOC vs. Excluded from TCOC) **and** Location ("Inside" vs. "Outside" or Paid to IHP vs. Paid Outside IHP). The report includes "drill-down" capabilities (user can expand each major category of service to see claim information for detailed categories of service).

IV. Claim Cap Cost Distribution

The Claim Cap Cost Distribution report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. The data used comes directly from the DHS data warehouse and represents finalized, paid claims and encounters for the designated measurement period. The report summarizes the member counts and total incurred claims for specific claim cost bands and demonstrates the impact of the claim cap thresholds and the PMPM difference between the total claim costs and the costs below the contracted claim cap. The "Cap Level" shown in the report represents the lower point of the cost band, and the "Claims Above the Cap Level" represent the cap level impact for the members that fall within that cost band. "Total \$\$ Above the Cap Level" shows the additional impact of the members with claims above the high end of the cost band and demonstrates the cumulative impact of the cap levels. The report allows users to display results aggregated for the entire IHP attributed population "All Members" and the population excluding members with third party liability (TPL), "TPL Members Excluded".

Claims Above Cap Level

The combined claims above the Cap Level for all members whose claims fall within the cost band.

Total Above Cap Level

The claims above the Cap Level for all members whose claims fall within and above the cost band.

V. TCOC by Member Program

The TCOC by Member Program report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. The data used comes directly from the DHS data warehouse and represents finalized, paid claims and encounters for the designated measurement period. This report shows the relative claim cost and risk for the primary population segment breakdowns of the attributed population (FFS, SNBC and MCO-enrolled members). FFS members are defined as those who were enrolled in FFS throughout their entire enrollment period and the SNBC members are defined as those enrolled in SNBC at some point during the year. In 2012, all SNBC members were enrolled in managed care, but their claim utilization and relative risk indicate they should be analyzed separately from the remainder of the MCO-enrolled population and grouped with the FFS members for purposes of developing the risk weights. The report allows users to display results aggregated for the entire IHP attributed population "All Members" and the population excluding members with third party liability (TPL), "TPL Members Excluded".

SNBC Members

Members enrolled in SNBC at some point in their enrollment period.

MCO Members

Non-SNBC members enrolled in an MCO at some point during their entire enrollment period. Members enrolled in both FFS and an MCO are included in the MCO totals, so long as they did not have SNBC enrollment during the year.

FFS Members

Members enrolled in FFS throughout their entire enrollment period

TCOC by Member Category Drilldown

The TCOC by Member Category Drilldown report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. The data used comes directly from the DHS data warehouse and represents finalized, paid claims and encounters for the same measurement period as all other TCOC reports. It shows a detailed breakdown of claim paid amounts and number of claims incurred by member program: SNBC, MCO, and FFS. The report includes “drill-down” capabilities (user can expand Major Category of Service to see claim information for Detailed Category of Service).

Care Coordination Reports

Care Management Report

The Care Management Report mirrors the Comprehensive Patient Clinical Profile Report available from John Hopkins ACG System. The report is generated monthly using DHS Medicaid enrollment and claims/encounter data. It allows users to filter results by IHP Clinic.

The areas addressed and the questions this report is able to inform include:

- Is this recipient potentially in need of better care coordination? What were the number and types of providers seen during the observation period?
- What are the recipient’s costs for the prior observation period?
- Summary utilization statistics for the recipient including outpatient visit counts, Emergency Room visits, and Inpatient Admissions.
- Predictive information for resource utilization including cost and likelihood of hospitalization based on the recipient’s prior history and risk indicators.
- An indication of whether the recipient’s diagnosis and pharmacy history indicates the presence of chronic conditions.

Column Name	Definition
MCO	The managed care organization in which the recipient was enrolled during the last month of the observation period. If the recipient was not enrolled in an MCO, the field will display “FFS” for “fee-for-service”.
Current MCO	The managed care organization in which the recipient is enrolled during the Report month (date report was generated). If the

Column Name	Definition
	recipient was not enrolled in an MCO, the field will display “FFS” for “fee-for-service”. If the recipient was eligible during the observation period, but in their current enrollment month is no longer in an attribution eligible group, this field will be empty.
IHP Clinic NPI	This is the “Billing/Pay-To” NPI (National Provider Identifier – type 2) on the encounter where the recipient had their most recent E&M visit. This clinic identifier reflects where WITHIN the IHP, the attributed recipient was last seen. This is not always the clinic within the IHP where the recipient is seen most.
Clinic Name	Name of the clinic where the recipient had their most recent E&M visit.
IHP Treating Provider NPI	The NPI of the IHP treating provider with whom the recipient had the most recent E&M visit.
IHP Treating Provider Name	The Name of the IHP treating provider with whom the recipient had the most recent E&M visit.
Date of Last IHP Visit	The date of the most recent E&M visit occurring within the IHP.
Recipient ID	8-digit (char) DHS patient identification number. Only those recipients attributed to the IHP based on the prior 12 months of claim history are included in the report. The recipients included in this report may change between reporting periods as additional claim run-out is received.
NameLast	Last name of recipient.
NameFirst	First name of the recipient.
NameMiddleInitial	Middle initial of the recipient.
Birthdate	Birthdate of recipient.
Gender	The recipient’s gender (F=Female, M=Male)
County	The county in which the recipient was a resident according to the eligibility/enrollment information for the last month in the report observation period. If a MN county of residence is not available, the county of financial responsibility is displayed.
HCH Claims	A ‘Yes’ or ‘No’ indicator of whether care coordination claims (S0280/S0281) were paid for this recipient during the report observation period.

Column Name	Definition
Resource Utilization Band	<p>The Resource Utilization Band (RUB) assigned to the patient. The RUB band is an estimate of concurrent resource use associated with the recipient's current ACG score.</p> <p>0 = No Use/Only Invalid Diagnoses</p> <p>1 = Healthy User</p> <p>2 = Low User</p> <p>3 = Moderate User</p> <p>4 = High User</p> <p>5 = Very High User</p>
Rescaled Reference Weight	<p>The concurrent reference weight for this recipient rescaled so that the mean across the DHS population is 1.0. Note that this risk weight is not rescaled to the IHP's attribution eligible population as is done for the TCOC target and settlement calculations.</p>
ACG Code	<p>The adjusted Clinical Group code actuarial cell assigned to the recipient.</p>
Recipient Member Months	<p>The number of months the recipient was enrolled in a Minnesota Medicaid Health Care Program during the observation period (for IHP attributed members, this will be a minimum of 6 and a maximum of 12).</p>
Prior Total Cost	<p>The recipient's total claim and reported encounter costs during the observation period. Note that cost information is a current snapshot of all dollars associated with services as reported on claims and encounter records for the observation period. As described in the IHP contracts, costs for some services will be excluded from the total cost of care for which the IHP is at risk.</p>
Prior RX Cost	<p>The recipient's pharmacy costs during the observation period. Pharmacy costs are included in the prior total cost.</p>
IHP Included Services - Total Cost	<p>The claim and encounter costs during the observation period for services that are included in the core set of services for which an IHP' total cost of care is measured. This total cost excludes services such as dental, transportation, long term care, residential mental health, etc.</p>
	Predictive Values

Column Name	Definition
Probability High Total Cost	The probability that this patient will be in the top 5 percent of total cost in the subsequent year.
Predicted Total Cost Range	The predicted total cost for this patient for the subsequent year.
Probability High RX Cost	The probability that this patient will be in the top 5 percent of pharmacy cost in the subsequent year.
Predicted Rx Cost Range	The predicted pharmacy cost for this patient for the subsequent year.
High Risk Unexpected Rx	A flag (Y = Yes, N = No) indicating the patient has a probability > 0.4 of being high morbidity and having unexpectedly high pharmacy use.
	Coordination of Care
Chronic Condition Count	The chronic condition count assigned to this patient.
Unique Providers Seen	An indication of the number of physicians providing outpatient evaluation and management services to this patient.
Specialty Types Seen	An indication of the number of specialists providing outpatient evaluation and management services to this patient.
Generalist Seen	“Y” indicates that a generalist was involved in face-to-face visits for the patient.
Provider Seen Most 1	The name of the provider who had the most face-to-face visits with the recipient during the observation period per ACG. This provider is not necessarily on the IHP roster (IHP providers are aggregated for purposes of attribution). If there are providers with the same percentage of visits, up to 2 are displayed.
Provider Seen Most 1 Specialty Description	The specialty category for the Provider Seen Most.
Provider 1 Percentage of Visits	The percentage of the outpatient visits provided by the provider(s) that saw the patient most over the observation period.
Provider Seen Most 2	If a Provider Seen Most 2 is listed, then this provider had an equal percentage of face-to-face visits with the recipient during the observation period per ACG as the Provider Seen Most 1. Additional providers may have had equal percentage of visits but only 2 are included.

Column Name	Definition
Provider Seen Most 2 Specialty Description	The specialty category for the additional Provider Seen Most.
Provider 2 Percentage of Visits	The percentage of the outpatient visits provided by the provider(s) that saw the patient most over the observation period.
Frailty Flag	A flag indicating the presence of a diagnosis associated with marked functional limitations (Malnutrition, Incontinence, Dementia, Decubitus Ulcer, Fall, Difficulty Walking, etc.).
Coordination Risk Indicator	A marker that can be used to stratify the likelihood of coordination issues. Values include: <ul style="list-style-type: none"> ·UCI – recipient is unlikely to experience coordination issues ·PCI – recipient may possibly experience coordination issues ·LCI – recipient is likely to experience coordination issues
	Utilization
Outpatient Count	Count of ambulatory and hospital outpatient visits (unique count of recipient, provider, and date of service where place of service is 11 or 22).
ED Count	Count of emergency room visits that did not lead to a subsequent acute care inpatient hospitalization.
Inpatient Count	Count of acute care inpatient stays for causes that are not related to child-birth and injury.
Major Procedure Performed	A flag (Y or N) indicating whether the patient had a major inpatient procedure performed.
Dialysis Service	A flag (Y or N) indicating the patient had a dialysis service performed.
Nursing Service	A flag (Y or N) indicating the presence of nursing home services as defined by the CPT code range (94004 – 94005, 99304-99337) for the recipient.
Active Drug Count	Count of individual ingredient/route of administration combinations in the recipient’s prescription regimen based on pharmacy claims.
	Likelihood of Hospitalization

Column Name	Definition
Hospital Dominant Count	The count of ACG condition groups present for the recipient which contain trigger diagnoses for high (typically greater than 50%) probability of future admission.
Probability Hospital Admission in 6 months	The probability that this patient will experience a hospitalization in the subsequent 6 months.
Probability IP Hospitalization	The probability that this patient will experience a hospitalization in the subsequent 12 months.
Probability ICU or CCU Admission	The probability that this patient will experience a ICU/CCU hospitalization in the subsequent 12 months.
Probability Injury Related Admission	The probability that this patient will experience an injury-related hospitalization in the subsequent 12 months.
Probability Long-Term Admission	The probability that this patient will experience an extended hospitalization (12+ days) in the subsequent 12 months.
	Condition Indicators
Age-Related Macular Degeneration	A flag indicating if this patient has this medical condition and how it was indicated (NP = Not Present, ICD = ICD Indication, Rx = Rx Indication, BTH = ICD and Rx Indication, TRT = Meets Diagnosis/Treatment criteria).
Bi-Polar Disorder	
Ischemic Heart Disease	
Schizophrenia	
Congestive Heart Failure	
Depression	
Diabetes	
Glaucoma	
Human Immunodeficiency Virus	
Disorders of Lipid Metabolism	
Hypertension	
Hyperthyroidism	

Column Name	Definition
Immunosuppression/Transplant	
Osteoporosis	
Parkinson's Disease	
Persistent Asthma	
Rheumatoid Arthritis	
Seizure Disorders	
COPD	
Chronic Renal Failure	
Low Back Pain	
	Other
TPL Indicator	A flag (Y or N) indicating whether the recipient had a health insurance policy for medical services at some point during the observation period in addition to Medical Assistance.
Newly Attributed	A flag (Y or N) indicating whether this recipient is new to your IHP in this assessment period.

Provider Alert Report

The Provider Alert report is generated monthly and lists recipients for whom a claim was submitted for an emergency room visit or hospital admission in the previous month. DHS Medicaid enrollment and claims/encounter data are used to create this report. The areas addressed and the questions this report is able to inform include:

- Which recipients attributed to the IHP during this observation period recently had a hospitalization service?
- Which recipients attributed to the IHP during this observation period recently visited an emergency room?
- Counts of hospitalization, re-admissions, and emergency room visits for the recipient in the past year.
- Probability of hospitalization in the next 12 months based on ACGv10 risk models.

Column Name	Definition
Report Month	The month the report is generated. Report is based on enrollment and claims data through the first DHS warrant cycle of this month.
Recipient ID	8-digit (char) DHS patient identification number. Recipients in this report:

Column Name	Definition
	<ul style="list-style-type: none"> · are currently enrolled in Minnesota Health Care Programs (MHCP); · had a claim/encounter for an ER or hospital service submitted in the last month or through most recent DHS warrant cycle in the Report month, and · the date of service for the claim/encounter is within the past 6 months.
First Name	First name of the recipient.
MI	Middle initial of the recipient.
Last Name	Last name of recipient.
Birthdate	Birthdate of recipient.
Interpreter Needed	An indicator of the patient's need for an interpreter; based on the current month's enrollment data. A supplemental tier modifier (U3) can be used on HCH care coordination claims (S0280/S0281) for recipients with language/communication barriers.
Number of ED Visits - Month	Count of emergency department visits for which a claim was submitted to DHS in the previous month or by the first warrant cycle in the reporting month and which had a date of service within 6 months of the reporting month.
Number of ED Visits – 12 Months	Count of emergency department visits for which a claim was submitted to DHS during the prior 12 month period.
Number of Admissions - Month	Count of hospital admissions for which a claim was submitted to DHS in the previous month or by the first warrant cycle in the reporting month and which had a date of service within 6 months of the reporting month. Claims submitted by the following mid-month warrant cycle are included in this report.
Number of Readmission - Month	Count of hospital 30-day re-admissions (all cause) for which a claim was submitted to DHS in the previous month or by the first warrant cycle in the reporting month. Re-admit counts are a subset of the Hospital Admission counts (not mutually exclusive).
Number of Admissions – 12 Months	Count of hospital admissions for which a claim was submitted to DHS during the prior 12 month period.
Inpatient Hospital Probability	The probability of an acute care inpatient hospital admission in the year following the observation period. Calculated by ACGv100 risk-adjustment software using a prediction model calibrated with utilization markers to identify patients with risk of future hospitalization. Observation period: Previous 12 months plus a 3 month run out (ex. Dec 2012 would contain observation period of 09/01/11 – 8/31/12).

Column Name	Definition
HCH Claims	A 'Yes' or 'No' indicator of whether care coordination claims (S0280/S0281) were paid for this recipient during the report observation period.
County	This is the county in which the recipient was a resident according to the eligibility/enrollment information for the last month in the report observation period. If a MN county of residence is not available, the county of financial responsibility is displayed.
Clinic NPI	This is the Clinic NPI (National Provider Identifier – type 2) where the recipient had their most recent E&M visit. This clinic identifier reflects where WITHIN the IHP, the attributed recipient was last seen. This is not always the clinic within the IHP where the recipient is seen most.
IHP Provider NPI	The NPI of the IHP treating provider with whom the recipient had the most recent E&M visit.
IHP Provider Name	The Name of the IHP treating provider with whom the recipient had the most recent E&M visit.
Date of Last IHP Visit	The date of the most recent E&M visit occurring within the IHP.

Monthly Attribution Trend

The Monthly Attribution Trend is updated monthly using DHS Medicaid enrollment and claims/encounter data. It shows the total number of attributed IHP members and monthly population percent change for the previous 12 months. The Percent Change values in the chart will change color to highlight drastic population fluctuations.

Percent Change > 4% - GREEN

Percent Change < -4% - RED

Chronic Condition Profile

The Chronic Condition Profile report is generated monthly using DHS Medicaid enrollment and claims/encounter data. It shows the prevalence of chronic conditions in an IHP population as it compares to the Benchmark population. The graph displays the 10 most prevalent chronic conditions, whose rates are expressed as a percentage of the IHP attributed population identified as having the condition. Results are aggregated based on the following Age Groups: All Ages, 18 & Over, 17 & Under.

Chronic Conditions

The ACG System identifies specific conditions that are high prevalence chronic conditions, commonly selected for disease management or warranting ongoing medication therapy. The conditions are identified through diagnoses, pharmacy information, and/or specific treatment criteria.

The following conditions are included:

Age Related Macular Degeneration, Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Chronic Renal Failure, Congestive Heart Failure, Depression, Diabetes, Disorders of Lipid Metabolism, Glaucoma, Human

[Table of Contents](#)

Immunodeficiency Virus, Hypertension, Hypothyroidism, Immunosuppression Transplant, Ischemic Heart Disease, Low Back Pain, Osteoporosis, Parkinson's Disease, Persistent Asthma, Rheumatoid Arthritis, Schizophrenia, and Seizure Disorders.

The report includes a table with linking capabilities. Clicking on any underlined text will display a list of **ALL** IHP attributed members with a particular chronic condition. For example, clicking on the underlined text: [depression](#) will display a list of all IHP members identified as having depression (clicking other data elements within the same row as [depression](#) will result in the same list). The following data elements (displayed in the linked table) are also found in the Care Management Report.

[Recipient ID](#)

[First Name](#)

[Last Name](#)

[Birthdate](#)

[Clinic NPI](#)

[Clinic Name](#)

[Condition Criteria](#)

Utilization Reports

Inpatient and ED Trends by IHP

The Inpatient and ED Trends by IHP report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. It displays a risk adjusted hospitalization rate and risk adjusted emergency department rate trend as it compares to the Benchmark population. Data for measurement periods up to Apr'13 - Mar'14 were gathered 6 months following the end of the period, while data for all measurement periods after March 2014 are gathered 3 months following the end of the measurement period. The difference in claim lag may result in artificially lower rates for the most recent measurement periods as opposed to the earlier measurement periods.

Hospitalization Rate

The hospitalization rate is based upon the ACG® count of inpatient events occurring within the observation period which excludes admissions with a primary diagnosis for pregnancy, delivery, newborns, and injuries. Transfers made within and between providers count as a single hospitalization event. The hospitalization rate is reflected per 1,000 of the IHP's attributed population.

ED Rate

The ED Rate is the number of emergency room visits that did not lead to a subsequent acute care inpatient hospitalization during the observation period, reflected per 1,000 members of the IHP's attributed population. The ED count is calculated as part of the ACG® definition which considers place of service, procedure code, and revenue code to identify emergency room visits.

Risk Adjustment Methodology

In order to compare utilization rates among IHPs and the benchmark population, DHS used ACG® risk weights, customized by program categories (FFS+SNBC and MCO), in order to adjust for differences in aggregate risk among these populations. Although the aggregate relative risk between populations may not be fully applicable

[Table of Contents](#)

to the relative risk differential for an individual utilization rate (i.e. a population with a 10% higher overall TCOC risk, could have a different relative risk for inpatient admissions), these utilization adjustment factors should provide a reasonable, high-level way for the IHPs to understand how their population risk may be impacting their observed utilization relative to the benchmark.

The risk adjustment factor is produced by first calculating the average risk scores for the individual IHPs and the overall benchmark population, based on the Category Specific ACG weights (FFS+SNBC vs. MCO) used for the IHP performance measurement and quarterly reporting. Using the risk score for the benchmark population as a reference point, the IHP utilization adjustment factors are calculated based upon the ratio between the IHP risk score and the benchmark risk score. The utilization factor represents the difference in IHP risk relative to the benchmark. For example, an IHP risk score of 1.26 and a benchmark risk score of 1.17 results in an adjustment factor of 1.08 ($1.26 / 1.17 = 1.08$). This factor is used to adjust the IHP utilization by dividing the unadjusted rate by the adjustment factor. Using the example above, an IHP unadjusted inpatient hospitalization rate of 85.0 per 1,000 members, results in an adjusted rate of 78.7 per 1,000 ($85 / 1.08 = 78.7$).

Inpatient and ED Trends by Clinic

The Inpatient and ED Trends by Clinic report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. It displays a risk adjusted hospitalization rate and risk adjusted emergency department rate trend for an IHP clinic as it compares to the Benchmark population and IHP population. Clinics are ranked within an IHP based on their risk adjusted rates in a given measurement period.

Members are attributed to the clinic within an IHP where the most recent E&M visit occurred. Clinics whose population was less than 100 members for all measurement periods are excluded from the analysis. ******Results for some clinics are unreliable due to drastic population fluctuations and small population sizes (clinics whose population > 100 for one measurement period are still included in the analysis even if their population drops dramatically in subsequent periods); in some cases clinics have no attributed members for a given measurement period.

Data for measurement periods up to Apr'13 - Mar'14 were gathered 6 months following the end of the period, while data for all measurement periods after March 2014 are gathered 3 months following the end of the measurement period. The difference in claim lag may result in artificially lower rates for the most recent measurement periods as opposed to the earlier measurement periods. The same methodology is used to produce risk scores for an individual IHP clinic as it is for IHPs. The IHP ED Rate and IHP Hospitalization Rate are both risk adjusted and should match the risk adjusted rates in the Inpatient and ED Trends by IHP report.

Pharmacy Summary - Utilization

The Pharmacy Summary - Utilization report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. The report displays the total number of prescriptions aggregated by drug class and individual drug (grouped by generic drug name). Analysis excludes over the counter prescriptions and compound drugs, but the "paid amount", "% of included TCOC", and "Rx PMPM" in the summary chart at the top of the report are calculated using all pharmacy claims and should match the pharmacy paid amount and PMPM on the TCOC Summary report.

Generic vs. Brand Name

Drugs are classified as "generic" or not based on an indicator - drug NDC (National Drug Classification) codes with a missing indicator value are classified as "generic".

Drug Class

Drug groupings based on the AHFS (American Hospital Formulary Service) - Therapeutic Classification

Pharmacy Summary - Spend

The Pharmacy Summary - Spend report is generated every quarter using DHS Medicaid enrollment and claims/encounter data. The report displays prescription costs aggregated by drug class, individual drug, and specialty drug. Analysis excludes over the counter prescriptions and compound drugs, but the “paid amount”, “% of Included TCOC”, and “Rx PMPM” in the summary chart at the top of the report are calculated using all pharmacy claims and should match the pharmacy paid amount on the TCOC Summary report.

Specialty Drug

Drugs classified as high cost

Specialty Description

Specialty drug groupings (not the same as “drug class”)

Specialty Rx Scripts

Total number of prescriptions for specialty drugs

% Specialty

Percentage of specialty drug prescriptions (denominator excludes over the counter and compound drugs)

Specialty \$\$

The total paid amount for specialty drugs

Quality Reports

IHP HEDIS Measures

The IHP HEDIS Measures report is run annually. All HEDIS measures are limited to enrollees who were attributed to an IHP in April following the measurement year, using claims for services provided during the calendar year. For example, measurement year 2013 would include members attributed in April 2014 for claims incurred during calendar year 2013. The report includes HEDIS measures for an individual IHP as well as an aggregated measure based on the entire IHP population - “All IHPs”. IHPs joining the demonstration after 2013 will still see data aggregated measures even if their individual scores for that year are not included.

For more specific information on any measure, refer to the NCQA publication “Technical Specifications for Health Plans, HEDIS 2014 Volume 2”.

Adults’ Access to Preventive/Ambulatory Health Services

- 1) This measure shows the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.
- 2) This report follows HEDIS 2014, Volume 2 specifications with the exception that inpatient professional and emergency room claims were excluded.
- 3) Highlights of the HEDIS specifications are as follows:
 - Limited to ages 20 and older as of December 31 of the measurement year.
 - The denominator is the number of members meeting eligibility criteria.
 - The numerator is the number members having received an ambulatory or preventive care visit during the measurement year.
- 4) There were HEDIS 2014 changes to this measure:

- Coding changes for Ambulatory Visits.
- Coding tables removed from the technical specifications and replaced coding table references with value set references.

Adolescent Well–Care visits

- 1) This measure shows the percentage of enrolled members 12–21 years of age who had at least one comprehensive well–care visit with a primary care practitioner (PCP) or an OB/GYN practitioner during the measurement year.
- 2) This report follows HEDIS 2014, Volume 2 specifications. However, DHS does not have a single code designating a provider as a PCP or OB/GYN provider. Instead a provider was classified as a PCP or OB/GYN if:
 - One or more of 8 HEDIS-specified procedure codes, or 7 HEDIS-specified diagnosis codes was used, and
 - The pay-to-provider type or the treating-provider type had any of a list of codes considered to encompass primary care practice or OB/GYN practice.
- 3) Highlights of the HEDIS specifications are as follows:
 - Adolescents were defined as members aged 12 through 21 on December 31 of the measurement year.
 - For calculating the percentage, the numerator was the number of members who had 1 or more visits and the denominator was the number of members who met eligibility criteria.
- 4) Certain changes were made to this HEDIS measure for Report Year 2014, as follows:
 - Five CPT codes (99381, 99382, 99391, 99392, and 99461) were added to the list of codes that help to define a visit as a visit to PCP.
 - Three ICD-9 codes (V20.3, V20.31, and V20.32) were added to the list of codes that help to define a visit as a visit to a PCP.
 - The means of identifying a provider as a PCP was revised to add “pay-to” provider type 33 (“consolidated provider”) to the list of providers that, if all other criteria were met, qualified the provider to be classified as a PCP. This revision causes a slight increase in the count of visits and hence the numerator, and the AWC performance rate, will increase somewhat compared to prior years.

Breast Cancer Screening for Women

- 1) The BCS measure shows the percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.
- 2) This report follows HEDIS 2014, Volume 2 specifications except DHS does not have any modifier codes larger than two digits, so modifier code 09950 listed in the Bilateral Modifier Value Set is not included.
- 3) Highlights of the HEDIS specifications are as follows:
 - Limited to women 50-74 years as of December 31 of the measurement year
- 4) Certain changes were made to this HEDIS measure for Report Year 2014, as follows:
 - The age criterion is revised to women 50-74 years of age
 - The numerator time frame is revised to one or more mammograms any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year.
 - Coding tables are removed and replaced with value set references.

Children and Adolescents’ Access to Primary Care Practitioners

- 1) This measure shows the percentage of members 12 months to 19 years of age who had a visit with a Primary Care Practitioner (PCP). Four separate percentages were reported:
 - Children 12-24 months who had a visit with a PCP during the measurement year

- Children 25 months-6 years who had a visit with a PCP during the measurement year
 - Children 7-11 who had a visit with a PCP during the measurement year or the year prior to the measurement year
 - Adolescents 12-19 who had a visit with a PCP during the measurement year or the year prior to the measurement year
- 2) This report followed HEDIS 2014 (Volume 2) specifications. Highlights of the HEDIS specifications are as follows:
- Limited to ages 12 months to 19 years as of December 31 of the measurement year
 - The numerator was the count of members included in the denominator who had an ambulatory or preventive care visit to any PCP.
- 3) Certain changes were made to this HEDIS measure for Report Year 2014, as follows:
- Four CPT codes (99386, 99387, 99396, and 99397) were added to the list of codes that help to define a visit as a visit to PCP.
 - One HCPCS code (G0402) was added to the list of codes that help to define a visit as a visit to a PCP.
 - Nineteen new Revenue Codes [0982, 0983, and 0510 through 0529, excluding 0518, 0523, 0524, and 0525]) were added to the list of codes that help to define a visit as a visit to PCP.
 - Note especially: New programming code was added to classify a provider as a Primary Care Provider. Since no such attempt had been made to do this prior to 2014, the new programming language in 2014 has the effect of restricting somewhat the number of visits classified as visits to a PCP. This causes the count of such visits to go down, and hence the numerator, and the CAP performance rate, will decrease somewhat compared to prior years.

Cervical Cancer Screening

- 1) This measure shows the percentage of women age 24 to 64 who were screened for cervical cancer using the two step criteria described in 2a below.
- 2) This report follows HEDIS 2014, Volume 2 specifications. Highlights of the HEDIS specifications are as follows:
 - First identify women 24-64 years of age as of December 31 of the measurement year who had cervical cytology during the measurement year or the two years prior to the measurement year. For those women who don't meet the first criteria, identify women age 30 to 64 years of age as of December 31 of the measurement year who had cervical cytology and a HPV test with service dates four or fewer days apart during the measurement year or the four years prior to the measurement year. Steps 1 and 2 are summed to obtain the rate for the measure.
 - The numerator contains all women who had one or more Pap tests during the measurement year or during the two years prior to that year.
 - The denominator contains all women who meet the criteria listed in the first bullet with the exception of those who had previously received a total hysterectomy.
- 3) HEDIS 2014 specification deleted the following CPT and ICD9PC codes, respectively: 88155, 91.46.

Chlamydia Screening in Women

- 1) This measure shows the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
- 2) This report followed HEDIS 2014, Volume 2 specifications. Highlights of the HEDIS specifications are as follows:
 - Limited to ages 16-24 as of December 31 of the measurement year.
 - Pharmacy data and claim/encounter data were used to identify the eligible population (denominator) during each measurement year. However, a member was eligible for the measure if they received

contraceptives or had an encounter with a sexually active CPT, HCPCS, ICD-9 Diagnosis, ICD-9 Procedure or UB Revenue code

- The numerator included women who had at least one chlamydia test with a service date within the measurement year. A woman could only be counted once in each measurement year
 - The HEDIS optional exclusion removed members who had a pregnancy test during the measurement year followed within seven days by either isotretinoin (Accutane) or an x-ray. This exclusion only applied to the members who were included in the denominator by the pregnancy test alone
 - NDC codes and medication lists to identify contraceptives and exclusions were obtained from NCQA
- 3) Changes to the CHL measure for HEDIS 2014 include the deletion of the following CPT codes for sexual activity: 11975 and 11977. The following CPT codes were deleted for diagnostic radiology: 71090, 73542, 75722, 75724, and 75940.

Childhood Immunization Status

- 1) This measure shows the percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.
- 2) This report follows HEDIS 2014, Volume 2 specifications. Highlights of the HEDIS specifications are as follows:
 - Limited to children who turn 2 years of age as of December 31 of the measurement year.
 - The denominator is the same for Combination Vaccinations 2 through Combination Vaccinations 10.
- 3) Certain changes were made to this HEDIS measure for Report Year 2014, as follows:
 - Removed coding tables and replaced all coding table references with value set references.
 - Codes deleted for DTaP (99.39 ICD9PCS), Influenza (99.52 ICD9PCS), IPV (99.41 ICD9PCS), Measles (99.45 ICD9PCS), MMR (99.48 ICD9PCS), Mumps (99.46 ICD9PCS), and Rubella (99.47 ICD9PCS).
- 4) Immunization records from the DHS Data Warehouse are supplemented with the Minnesota Department of Health immunization records.

Follow-up after Hospitalization for Mental Illness

- 1) This measure shows the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:
 - The percentage of discharges for which the member received follow-up within 30 days of discharge
 - The percentage discharges for which the member received follow-up within 7 days of discharge
- 2) This report follows HEDIS 2014, Volume 2 specifications. Highlights of the HEDIS specifications are as follows:
 - The denominator was defined as an event. In order to count as an event, the recipient must have been discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December 1 of the measurement year.
 - The denominator for this measure was based on discharges, not members. If a given member had more than one discharge, all discharges were included if between January 1 and December 1 of the measurement year.
 - Discharges were excluded when there were certain kinds of mental health related re-admissions and/or certain non-mental health re-admissions within 30 days. Subsequent mental health discharges

were then eligible to be used as events as long as they were prior to December 1st of the measurement year and as long as they were not followed by excluded re-admissions within 30 days.

- 3) Changes for 2014: Add CPT codes 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840

Appropriate Treatment for Children with Upper Respiratory Infection

- 1) The URI measure shows the percentage of children 3 months–18 years of age who were given a diagnosis of upper URI and were not dispensed an antibiotic.
- 2) This report follows HEDIS 2014, Volume 2 specifications. Highlights of the HEDIS specifications are as follows:
 - Limited to children 3 months of age as of July 1 of the year prior to the measurement year to 18 years of age as June 30 of the measurement year.
 - Eligible outpatient or emergency department visits with a diagnosis of URI are limited to a 12-month window that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.
- 3) There were no HEDIS 2014 changes to this measure.

Well-Child Visits in the First 15 Months of Life

- 1) This measure shows the percentage 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 (PCP) during their first 15 months of life.
- 2) This report follows HEDIS 2014, Volume 2, technical specifications. However, the following issue may be noted:
 - MHCP does not have a single code designating a provider as a PCP provider. Instead a provider was treated as a PCP if:
 - One or more of the HEDIS-specified procedure codes or diagnosis codes was used, AND
 - The pay-to or treating provider had any of a list of codes considered to encompass primary care practice.
 - The HEDIS specs call for calculating the percentage of children who had zero, 1, 2, 3, 4, 5, and 6 or more well-child visits. For MHCP purposes only the last percentage (children with 6 or more visits) is calculated.
- 3) Highlights of the HEDIS specifications are as follows:
 - Limited to children who turned 15 months old during the measurement year.
 - For calculating the percentage, the numerator was the number of members who had 6 or more visits between their date of birth and their 15-month-old date, and the denominator was the number of members who met eligibility criteria above.
- 4) Certain changes were made to this HEDIS measure for Report Year 2014, as follows:
 - Six CPT codes (99383, 99384, 99385, 99393, 99394, and 99395) were added to the list of procedure codes that help to define a visit as a visit to PCP.
 - The means of identifying a provider as a PCP was revised to add “pay-to” provider type 33 (“consolidated provider”) to the list of providers that, if all other criteria were met, qualified the provider to be classified as a PCP. This revision causes a slight increase in the count of visits, and hence the numerator, and the W15 performance rate, will increase somewhat compared to prior years.

Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

- 1) The W34 measure shows the percentage of enrolled members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.
- 2) This report follows HEDIS 2014, Volume 2, technical specifications. However the following issues may be noted:
 - MHCP does not have a single code designating a provider as a PCP provider. Instead a provider was treated as a PCP if:
 - One or more of the HEDIS-specified procedure codes or diagnosis codes was used, AND
 - The pay-to or treating provider had any of a list of codes considered to encompass primary care practice.
- 3) Highlights of the HEDIS specifications are as follows:
 - Limited to children 3, 4, 5 or 6 years old on December 31 of the measurement year.
 - For calculating the percentage, the numerator was the number of members who had 1 or more visits and the denominator was the number of members who met the eligibility criteria above.
- 4) Certain changes were made to this HEDIS measure for Report Year 2014, as follows:
 - Seven CPT codes (99381, 99384, 99385, 99391, 99394, 99395, and 99461) were added to the list of procedure codes that help to define a visit as a visit to PCP.
 - Three ICD-9 codes (V20.3, V20.31, and V20.32) were added to the list of procedure codes that help to define a visit as a visit to PCP.
 - The means of identifying a provider as a PCP was revised to add “pay-to” provider type 33 (“consolidated provider”) to the list of providers that, if all other criteria were met, qualified the provider to be classified as a PCP. This revision causes a slight increase in the count of visits, and hence the numerator, and the W15 performance rate, will increase somewhat compared to prior years.