Regional Accountable Entity

The Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology
SFY 2018-2019

COLORADO
Department of Health Care Policy & Financing

This document includes the details for calculations of the Regional Accountable Entity Key Performance Indicators for the seven Regional Accountable Entities*

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*The specifications for the Potentially Avoidable Cost (PAC) measure is not included in the document. PAC specifications can be found here.

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Document Information

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Document Date	**Version**	**Change Description**
7/5/2018	V4	Code 90792 was removed from the Behavioral Health Engagement measure.
10/10/2018	V5	Health Neighborhood measure was modified to exclude the Care-Compact component for Q1
10/24/2018	V6	Health Neighborhood Care Compact Targets were modified.
10/24/2018	V7	Health Neighborhood Care-Compact Payment Amounts were modified to reflect Part 1 and Part 2 of measures and remove Tiers.
10/26/2018	V8	Baseline (for all measures) was changed from SFY 2016-2017 to SFY2017-18 (7/1/2017 – 6/30/2018)

Revision History		
01/18/2019	V9	The KPI methodology document was updated (formatted) to meet the Department and RAE needs (i.e. removal of Truven Analytics branding from document as they are not the only ones calculating KPIs). The Behavioral Health Engagement and Part 1 of the Health Neighborhood KPI will be calculated internally.
4/11/2019	V10	Updated Code Value Sets, Removed Codes from Methodology Document, added to Value Set Document, updated description in Health Neighborhood claims portion,
5/14/2019	V10	Updated Section 4.5.1 Risk-Adjusted ED Visit Risk Score to be consistent with the ED Metric Detail in Appendix B. Updated Section 3.1.5 to reference the correct section of 2.3. Updated BHE Metric methodology.

SECTION 1: **INTRODUCTION**

1.1 Overview

The Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology document describes the approach the Department and IBM Watson Health (Truven Analytics) uses for calcuating the KPIs and historical KPIs of the ACC program.

Incentive Payments are a central component of the ACC Pay-for-Performance. Since the initiation of the ACC Program, the Department has made incentive payments for performance on identified Key Performance Indicators (KPIs) to signal program-level goals and objectives; encourage improved performance at the PCMP and regional level; and reward Regional Accountable Entities and managed care entities for meeting certain levels of performance. In Phase II of the ACC, incentive payments for KPIs are one of four components of Pay-for-Performance. They complement the Behavioral Health Incentive program and public reporting efforts.

The Phase II KPIs are designed to assess the functioning of the overall system and the individual RAEs and are not as focused on practice-level performance. For this reason, some of the measures are not traditional HEDIS or clinical measures. The Department has attempted to choose measures that indicate the RAEs' progress building a coordinated, community-based approach to serve the needs of Members, reduce costs, and promote health and wellbeing in their region.

1.2 Purpose

The purpose of this document is to describe the methodologies used to calculate KPI performance incentive payments for Regional Accountable Entities (RAEs) participating in the Accountable Care Collaborative (ACC) in State Fiscal Year (SFY) 18-19.

1.3 Scope

This document addresses only the methodology utilized to calculate the ACC KPIs and historical ACC KPI program measures. Though the Potentially Avoidable Costs measures is a KPI, it is not included in this document. Specification details can be found here.

1.4 Document Maintenance

This document will be reviewed annually at the start of the new State Fiscal Year and updated as necessary. This document contains a Revision History log on the Document Information page (see page ii). When changes occur, the version number will be updated to the next increment as well as the revision date and change description. Unless otherwise noted, the author of the revision will be the document's author, as identified in the Document Identification table, which is also on the Document Information page.

SECTION 2: **DATA REQUIREMENTS**

The KPIs are calculated for Regional Accountable Entities (RAEs) and Primary Care Medical Providers (PCMPs) participating in the Accountable Care Collaborative (ACC) program based on the members' utilization of services.

2.1 Background

ACC population: Four dollars of the per-member per-month (PMPM) payment to each RAE is withheld by the Department of Health Care Policy and Financing (the Department). RAEs are eligible to receive the four dollar withhold by achieving performance thresholds for the KPIs including:

- Behavioral Health Engagement
- Dental Visits
- Well Visits
- Prenatal Engagement
- Emergency Department (ED) Visits
- Potentially Avoidable Costs[1]
- Health Neighborhood

Each KPI calculation is based on the utilization of services by the population enrolled in the ACC. The following sections describe the differences in the methodologies used to calculate and evaluate these measures.

2.2 Evaluation and Baseline Period

Monthly, KPI performance is calculated. Each evaluation period is twelve rolling months of data based on service/eligibility dates allowing for three months of claims runout. The baseline period is calculated for: Dental Visits, Well Visits, Prenatal Engagement, ED Visits, the claims portion of the Health Neighborhood metric, Postpartum Visits, and Well Child Checks (Ages 3-9). However, the Behavioral Health Engagement baseline will be calculated by the Department on a quarterly basis. The baseline for State Fiscal Year 2019 is July 1, 2017 through June 30, 2018, or SFY2017-18. September 2018 RAE Enrollment will be applied to the baseline time period. RAEs will be given access to PROMETHEUS PAC results that are based on fee-for-service (FFS) claims and managed care encounters. RAEs will use these results to determine the areas of opportunity and to develop a) an action plan and b) a milestone weight table. PAC Specification details can be found here.

The baseline time period will not be updated each year and will remain the same over the course of this contract period.

[1] This measure will be calculated by the Department, therefore the methodology is not included in this document.

2.3 Baseline Population

Starting in evaluation period SFY18-19, all members with full Medicaid will be mandatorily enrolled into the ACC program. All baseline and evaluation period populations will include all members with full Medicaid residing in each of the seven regions.

> Note: Full Medicaid is defined as having a primary benefit plan of Medicaid State Plan Title Nineteen (PRMY_BPLAN_CD='TXIX') in the ACC Snapshot.

Medicaid Enrollment:

- Dental Visits, Prenatal Engagement, Well Visits, and Health Neighborhood include all members who have full Medicaid at the end of the evaluation period according to the ACC Snapshot.
- ED Visits includes members who have full Medicaid any time during the evaluation period. Enrollment at the end of the evaluation period is not required. This is because ED Visits is a PKPY metric and is based off an event or events that can occur at any time during the evaluation period.
- Behavioral Health Engagement will be based on the regional penetration rate and use of the six short-term behavioral health therapy codes for SFY17-18.

Exclusions:

- Members who are enrolled in any physical health Medicaid managed care plan for more than three months any time during the baseline period. This exclusion applies to all KPIs except the PAC measure, and Health Neighborhood Part 1.

  Note: these members are identified by the managed care enrollment spans on the ACC Snapshot (MTH_ACC_CLNT_SNPSHT_V). Please note that retroactive enrollment changes are not captured in the ACC snapshot. There are instances where enrollment spans change, which cause misalignment between the current record of enrollment (CLNT_ENRL_FACT_V) and the ACC Snapshot. The ACC Snapshot is used for this exclusion.

2.4 Evaluation Population

The KPI population varies slightly by KPI:

ACC Enrollment:

- Behavioral Health Engagement, Dental Visits, Prenatal Engagement, and Well Visits include all members who are enrolled in the ACC program at the end of the evaluation period according to the ACC Snapshot.
- ED Visits includes members who were enrolled in the ACC at any time during the evaluation period. Enrollment at the end of the evaluation period is not required. This is because ED Visits is a PKPY and is based off an event or events that can occur at any time during the evaluation period.

Exclusions:

- Members who are enrolled in any physical health Medicaid managed care plan for more than three month any time during the evaluation period. Note: these members are identified by the managed care enrollment spans on the ACC Snapshot (MTH_ACC_CLNT_SNPSHT_V). Please note that retroactive enrollment changes are not captured in the ACC snapshot. There are instances where enrollment spans change, which cause misalignment between the current record of enrollment (CLNT_ENRL_FACT_V) and the ACC Snapshot. The ACC Snapshot is used for this exclusion.

2.5 Claims Selection Criteria

The following criteria are used to select the claims to calculate the KPIs:

- Include:
  - Both facility and professional claims
  - Paid claims and Encounters (with three months runout)
  - Only current records
  - Last claim (after all adjustments have been taken)
  - Encounters:
    - Dental Visits will include dental encounters
    - Behavioral Health Engagement includes behavioral health and physical health encounters
- Exclude
  - Deleted records

2.6 Payment Schedule

Incentive payment files will be submitted to DXC on the third Thursday of the third month of each quarter and will cover the 3-month measurement period from six months prior. For example, incentive payment files submitted at the end of March 2019 would correspond to performance from the July 1, 2018 – September 30, 2018 measurement period. Use the following table to monitor the monthly payment schedule.

July '18	Aug '18	Sept '18	Oct '18	Nov '18	Dec '18	Jan '19	Feb '19	March '19	April '19	May '19	June '19
								Submit incentive payment file for measurement period Jul 2018 - Sep 2018 (Q1)			Submit incentive payment file for measurement period Oct 2018 – Dec 2018 (Q2)

SECTION 3: **KEY PERFORMANCE INDICATORS AND OTHER PROGRAM MEASURES**

The section below outlines the steps for creating the KPIs and other measures. For detailed specifications, please refer to Appendix B: KPI Measure Specifications.

3.1 Overview

The data displayed within the Data Analytics Portal will allow the state, RAEs and PCMPs to view how their members are performing on seven KPIs and three additional measures that are not paid out on. There are two tiers (targets) set for each KPI, which determine how much of the withheld four dollars each PCMP and RAE can earn by meeting each tier. The seven KPIs are as follows:

- Behavioral Health Engagement
- Dental Visits
- Well Visits
- Prenatal Engagement
- Emergency Department (ED) Visits
- Potentially Avoidable Costs[2]
- Health Neighborhood

Note: KPIs will be based on Paid Claims and Encounters.

The other ACC program measures, which are not utilized for incentive payments, but are used as an indicator of performance within the data analytics portal are:

- Postpartum Follow-up Care
- Well-Child Checks (WCC) Ages 3-9
- 30-Day Follow-Up Care Following Inpatient Discharge

Note: Legacy Non-KPI Measures will be based on Paid Claims Only.

3.1.1 KPI: Behavioral Health Engagement

The denominator for Behavioral Health Engagement is all members who are enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period. To be counted in the numerator, members must receive at least one behavioral health service delivered either in primary care settings or under the capitated behavioral health benefit within the 12-month evaluation period.

> **Behavioral Health Engagement (%) = # Unique Members Who Received At least One Behavioral Health Service / # Unique Members Enrolled in the ACC**

[2] This measure will be calculated by the Department, therefore the methodology is not included in this document.

3.1.2 KPI: Dental Visits

The denominator for Dental Visits includes all members who are enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period. To be counted in the numerator, members must receive at least one dental service (medical or dental claim) within the 12-month evaluation period.

Dental Visits (%) = # Unique Members Who Received At least One Dental Service / # Unique Members Enrolled in the ACC

3.1.3 KPI: Well Visits

The denominator for Well Visits includes all members who are enrolled in the ACC as of the last day of the last month of the rolling 12-month evaluation period. To be counted in the numerator, members must have at least one well visit within the 12-month evaluation period.

Well Visit (%) = # Unique Members Who Received At least One Well Visit / # Unique Members Enrolled in the ACC

3.1.4 KPI: Prenatal Engagement

The denominator for Prenatal Engagement includes all deliveries for members enrolled in the ACC as of the end of the rolling 12-month evaluation period. Members may have multiple deliveries within the evaluation period. To be counted in the numerator, members must have at least one prenatal visit within 40 weeks prior to the delivery and be Medicaid enrolled at least 30 days prior to the delivery.

Prenatal Engagement (%) = # of Deliveries with at Least One Prenatal Visit / # Deliveries

3.1.5 KPI: Emergency Department Visits PKPY (Risk Adjusted)

Member months for all members within the population as specified in Section 2.3 are included in the denominator for this measure. An ED visit will be counted in the numerator if it does not result in an inpatient admission. To normalize this measure, it is expressed as a per thousand member months per year (PKPY), meaning the rate is multiplied by 12,000 for the evaluation period. The PKPY is then risk adjusted using a RAE risk weight. The risk adjusted ED Visits PKPY will be used for payment.

Actual ED Visits PKPY = # ED Visits / # Member Months *12000

Risk Adjusted ED Visits PKPY = Actual ED Visits PKPY / Average ED RAE Risk Weight

3.1.6 KPI: Health Neighborhood

Health Neighborhood is a composite measure made up of two parts. Part 1 calculates the percentage of RAE's PCMP's with Colorado Medical Society's Primary Care-Specialty Care Compacts in effect with specialty care providers. Part 2 calculates the percentage of members who had an outpatient visit with a specialist who saw a PCMP within 60 days prior to the specialist visit and included a referring PCMP on the claim. The denominator for Part 2 of the Health Neighborhood measure includes all specialty visits for members enrolled in the ACC as of the end of the rolling 12-month evaluation period. Members may have multiple visits within the evaluation period. To be counted in the numerator, members must have at least one PCMP visit within 60 days prior to the specialty visit and a PCMP must be listed as the referring provider on the specialty claim (denominator claim).

Health Neighborhood (Part 2) = # of Specialty Visits with at Least One PCMP Visit AND PCMP Referral on the Claim / # Specialty Visits

3.1.7 Other Program Measure: Postpartum Follow-Up Care

The denominator for Postpartum Follow-Up Care includes the number of live deliveries for members enrolled in the ACC as of the end of the evaluation period. Members may have multiple deliveries within the evaluation period. The evaluation period for this KPI is offset by 56 days from the current rolling 12-month period to allow up to 56 days following the delivery for a follow-up visit to occur. For example, if the evaluation period ends 12/31/2016, the delivery date range utilized would be 11/05/2015 to 11/06/2016. Due to some inconsistencies in coding that were discovered, delivery visits are consolidated in the following manner: service dates that occurred within 60 days of each other were assumed to have occurred within the same delivery; service dates that were more than 60 days apart were considered separate deliveries. In these cases, the first service date in the chain of claims is considered the delivery date.

A numerator follow-up visit is considered compliant if it was between 21 and 56 days following the delivery.

Postpartum Follow-Up Care Rate (%) = # Deliveries with at Least One Postpartum Visit / # Deliveries

3.1.8 Other Program Measure: Well-Child Checks (Ages 3-9)

The denominator for Well-Child Checks includes children ages 3-9 years old as of the end of the evaluation period, who are enrolled in the ACC on the snapshot date to meet the numerator, the child must have a well-child check during the measurement year.

Well-Child Check Rate (%) = # Unique Members Who Received At least One Well-Child Check / # Unique Members Eligible for a Well-Child Check Ages 3-9

3.1.9 Other Program Measure: 30-Day Follow-Up Care Following Inpatient Discharge

The denominator for this measure is the count of inpatient discharges for those members enrolled in the ACC at the end of the evaluation period. A single member may have multiple inpatient discharges counted towards the denominator. However, inpatient discharges that result in a readmission within 30 days or death will not be counted in the denominator. Following discharge, an evaluation and management (E&M) claim within 30 days will fulfill the numerator requirement (only one is needed, multiple follow-up E&M visits will not count multiple times in the numerator).

30-Day Inpatient Follow-Up Rate (%) = # Inpatient Discharges with 30-Day Follow-Up Visit / # Inpatient Discharge

SECTION 4: **RISK ADJUSTMENT**

The ED Visit KPI is the only measure that is risk adjusted. The risk adjustment methodology used for this measure is outlined below.

4.1 Overview

Healthcare cost and utilization for a given population are dependent on the health status of that population. When comparing the per capita experience of various member populations at a summary level, population-based risk adjustment makes the comparison more analytically valid by considering underlying member risk, by looking at member acuity, or level of severity of illness. Once the level of riskiness of a RAEs population is considered by weighting their results, we can make comparisons across RAEs in a meaningful way.

Diagnostic Cost Groupers (DCGs), a healthcare risk assessment method created and licensed through Verscend®, Inc., are used to risk adjust population-based performance and baselines. The DCG models are patient classification systems that evaluates and forecasts healthcare utilization and costs. The models use data from a specific timeframe to predict the healthcare cost of individuals. The predictions are based on the conditions and diseases for which an individual receives treatment over the past year, and the age and gender of the individual.

4.2 DCG Extract

4.2.1 Eligibility Records

DCGs are calculated for all Medicaid members for a given month. The following fields are utilized for eligibility:

- Member ID
- Age (in years) as of reporting period end date
- Gender
- Eligible months – number of months eligible (partial months are counted as full months)

4.2.2 Medical Claims

For members in the population, the following fields are required for medical claims:

- Member ID
- Diagnosis codes – all diagnosis codes – and which version, ICD-9/ICD-10
- Claim service start/end dates
- Service location – ER, inpatient, other
- Source – inpatient facility, outpatient, long-term care, diagnostics, DME, or other services
- Medical expenditure – total paid amount

4.3 Software Parameters

Verscend's DCG software allows for multiple configuration parameters to be set. The following are the parameters utilized for ED visits:

- Partial eligibility is allowed (i.e. partial month of eligibility);
- The risk adjustment model that is run is: Medicaid FFS All-Medical Predicting Concurrent Total Risk (#73)

4.4 Model Output

The outputs of the DCG software are raw cost risk score (ranging from 0.000 to 999.000) and an aggregated diagnostic cost grouper (ADCG) per member. The ADCG categorizes the raw cost risk scores into the five risk levels listed below.

DCG Range	ADCG Value
0.000 to 0.499	0.00 (very low risk)
0.500 to 0.999	0.50 (low risk)
1.000 to 2.499	1.00 (moderate risk)
2.500 to 7.499	2.5 (high risk)
7.500 and higher	7.50 (very high risk)

4.5 Rescaling

After running the DCG software, several calculations must be done to convert the raw cost risk scores into an ED visit risk weight by RAE region, as explained below.

4.5.1 Risk-Adjusted ED Visit Risk Score

The relationship of the risk score that is predicted by the DCG cost model to the member's cost is linear, meaning that the higher the cost for a member, the higher their risk score is. Due to the nature of ED Visits, when translating this cost risk score to ED Visits, the relationship is no longer linear. To account for this skewed relationship, the cost risk scores get categorized into "buckets" called diagnostic cost groups (DCGs), to better predict this utilization measure. Annually, Truven Health updates their ED Visit risk scale "buckets" based on Medicaid MarketScan data. ED visits risk score buckets are defined using the following criteria:

- (Claim Type O, C, M, B
- AND (Revenue Code in (0450, 0451, 0452, 0456, 0459, 0981)
- OR CPT Procedure Code in (99281, 99282, 99283, 99284, 99285)
- OR (Place of Service = 23
- AND CPT Procedure Codes >= 10030 and <= 69979)))

From the DCG, Truven Health generates an ED risk score for each member. The bucketed risk score is used to calculate ED Risk Adjustment. The bucketing is also used to do a transformation of the cost score into predicting ED likelihood. Below is the table of buckets.

DCG Risk Score Minimum	DCG Risk Score Maximum	ED Visit Risk Score
0.000	0.099	0.068
0.100	0.199	0.154
0.200	0.299	0.298
0.300	0.399	0.467
0.400	0.499	0.642
0.500	0.699	0.863
0.700	0.999	1.235
1.000	1.499	1.714
1.500	1.999	2.265
2.000	2.499	2.808
2.500	2.999	3.231
3.000	3.999	3.731
4.000	4.999	4.385
5.000	5.999	5.029
6.000	7.499	5.796
7.500	9.999	6.866
10.000	14.999	7.987
15.000	19.999	9.069
20.000	24.999	9.467
25.000	29.999	10.900
30.000	39.999	11.277
40.000	49.999	11.399
50.000	59.999	12.232
60.000	69.999	14.701
70.000	and higher	12.974

4.5.2 Rescaled Cost Risk Score

The ED risk score output is scaled based on the population from which Verscend derived its model (Medicaid MarketScan); therefore, to adjust these scores to the Colorado ACC population, the raw ED risk scores are divided by the overall ACC mean to calculate the rescaled ED risk score. Due to the high churn of the Medicaid population, a weighted average is used for the ACC mean. To calculate the weighted average, a member's raw ED risk score is multiplied by the number of months they are enrolled. Then, these values are summed for the entire population and divided by the total number of months of enrollment for the entire state.

Average ED risk score ∑(raw ED risk score x member months) / ∑(member months)

Rescaled ED risk score = raw ED risk score / average ED risk score

For example, if the ACC population consisted of the members in the example below, each member's raw ED risk score would be multiplied by their number of member months. This is then summed and divided by the total number of member months for everyone enrolled in Medicaid with full benefits (288.984/42 = 6.881), so the average ED risk score is 6.881. Then each member's raw ED risk score gets divided by this average to create the rescaled risk score, with those with higher risk being greater than 1.0 and those lower risk being less than 1.0.

Member	RAE Region	DCG Cost Score	Raw ED Risk Score	ED visits	Member Months	Raw ED Risk Score Member Months	Average ED Risk Score	Rescaled ED Risk Score
A	1	7.025	5.796	4	12	69.552	6.881	0.842
B	1	9.014	6.866	3	9	61.794	6.881	0.998
B	2	9.014	6.866	2	3	20.598	6.881	0.998
C	2	13.012	7.987	2	10	79.870	6.881	1.161
C	0	13.012	7.987	1	2	15.974	6.881	1.161
D	0	8.203	6.866	2	6	41.196	6.881	0.998
Total					42	288.984		

The raw DCG cost score will appear on the My Members dashboard as an indicator of overall cost risk for the member compared to other Colorado Medicaid members with full Medicaid benefits.

4.5.3 Risk-Adjusted ED Visits PKPY (ACC Statewide & by RAE Region)

The ED Visit risk score is used to calculate the risk-adjusted ED Visit PKPY using the following formulas:

Average ED risk weight (RAE, ACC or Medicaid) = ∑(rescaled ED risk score x member months) / ∑(member months)

Risk-Adjusted ED Visits PKPY = ED Visits PKPY / Average ED Risk Weight

Using the same example above, the Average ED Risk Weight for all members statewide enrolled in the ACC would be 0.991. Since members may switch RAEs during the year, their risk scores and ED visits will be scaled to reflect their membership months in each RAE. The Average ED Risk Weight for RAE 1 would be 0.909. The Average ED Risk Weight for all of Medicaid would be 1.000.

Aggregation	ED Visits PKPY*	Average ED Risk Weight (RAE)	Risk-Adjusted ED Visits PKPY
RAE 1	4000	0.909	4400
RAE 2	3692	1.123	3287
ACC	3882	0.991	3918
Medicaid	4000	1.000	4000

SECTION 5: **PAYMENT TIERS**

Targets for Tier 1 and Tier 2 incentive payments are established by the Department. Targets are based on an improvement percentage as compared to regional RAE performance during a baseline period. Two different targets are set for each KPI: Tier 1 Target and Tier 2 Target, which equate to different incentive payment amounts if a tier is met during the evaluation period.

5.1 Incentive Payment Amounts PMPM

The $4 PMPM withhold will be evenly distributed among each of the KPI measures identified for the year

For the first year of the program, payment for the KPI's will be established as follows:

KPI	Tier 1 Payment	Tier 2 Payment
Behavioral Health Engagement[3]	$0.428 PMPM	$0.571 PMPM
Dental Visits	$0.428 PMPM	$0.571 PMPM
Well Visits	$0.428 PMPM	$0.571 PMPM
Prenatal Engagement	$0.428 PMPM	$0.571 PMPM
Emergency Department (ED) Visits	$0.428 PMPM	$0.571 PMPM
Potentially Avoidable Costs[4]	$0.428 PMPM	$0.571 PMPM
Health Neighborhood P1 (25%)[5]	$0.143 PMPM	
Health Neighborhood P2 (75%)	$0.321 PMPM	$0.428 PMPM

[3] IBM does not currently pay out on this metric. The Department will calculate and pay this metric.
[4] This measure will be calculated by the Department, therefore the methodology is not included in this document.
[5] IBM does not currently pay out on this metric. The Department will calculate and pay this metric.

APPENDIX A: GLOSSARY

Acronym	Definition
ACC	Accountable Care Collaborative
BIDM	Business Intelligence and Data Management System and Services
CMS	Centers for Medicare and Medicaid Services
Colorado BIDM SharePoint site	The SharePoint site that is hosted by Truven Health for the BIDM project.
DCG	Diagnostic Cost Group
E&M	Evaluation and Management
ED	Emergency Department
HCPF	Health Care Policy and Financing
KPI	Key Performance Indicator
MMP	Medicare-Medicaid Program
PCMP	Primary Care Medical Provider
PKPY	Per Thousand Per Year
PPA	Physician Performance Assessment
RAE	Regional Accountable Entity

APPENDIX B: KPI MEASURES SPECIFICATIONS

Behavioral Health Engagement

Last Updated: 5/7/19

Measure Name: Behavioral Health Engagement

Owner: Colorado Department of Health Care Policy and Financing

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Percent of distinct members who received at least one behavioral health service delivered in a primary care setting within the 12-month evaluation period or under the Capitated Behavioral Health Benefit within the 12-month evaluation period. The Department will calculate the Capitated Behavioral Health portion outside of this measure.
The Department will also calculate the Baseline and final rate for this measure.

Denominator:
Members will be counted in the denominator if they are enrolled in the ACC on the last day of the last month of the 12-month evaluation period

Denominator Units: Distinct count of members meeting the above criteria

Denominator Eligibility/Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
Enrolled in the ACC	1	• RAE Enrolled Indicator='Y' • Snapshot Date = last month of the evaluation period • RAE Enrollment End Date>=last day of the month of the evaluation period	Last month of the 12-month rolling evaluation period

Numerator: Members in the denominator who have had at least one behavioral health visit billed in a primary care setting or a behavioral health encounter within the rolling 12-month rolling evaluation period.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members included in the denominator	1		and	
Behavioral health visit in primary care for clients enrolled in FFS	1	CPT Code in **BH in PC Value Set**	and	During evaluation period
		(ENC_IND='N'	or	During evaluation period
Any behavioral health encounter within the evaluation period submitted by a physical health managed care excluding a BHO or RAE	1	ENC_IND = 'Y' and MC_PROV_TYP_CD not in ('31','85'))	or	During evaluation period

Any behavioral health encounter within the evaluation period	1	Any BH encounter (ENC_IND='Y' and HLTH_PGM_CDE in (BHO, [placeholder for new code)] and CLM_STS_CD= 'P')		During evaluation period

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from this measure	Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period (Per Decision Log #304)		>3 months

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 17-18 regional penetration rate
Target	**Tier 1**: 1<5% improvement receives 75% of payment **Tier 2:** 5%+ receives 100% of payment.

Notes:

- Multiple numerator events in an evaluation period for a unique member will only be counted once
- All diagnosis codes on the claim will be considered, not just the primary diagnosis
- This measure will be manually calculated by the Department. Only the fee-for-service component of the measure will be displayed on the Data Analytics Portal.
- **The Department will manually calculate this measure to include FFS Claims and the behavioral health services submitted via flat file until data is fully accessible in interChange.**

Dental Visits

Last Updated: 5/7/19

Measure Name: Dental Visits

Owner: IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Percent of distinct count of members who received professional dental services. This includes dental services from both medical and dental claims.

Denominator:
Members will be counted in the denominator if they are enrolled in the ACC on the last day of the last month of the 12-month evaluation period

Denominator Units: Distinct count of members meeting the above criteria

Denominator Eligibility/Enrollment Inclusion Criteria:

Condition Description	Condition Description	Condition Description	Condition Description
Enrolled in the ACC	1	• RAE Enrolled Indicator='Y' • Snapshot Date = last month of the evaluation period • RAE Enrollment End Date>=last day of the month of the evaluation period	Last month of the 12-month rolling evaluation period

Numerator: Distinct count of members who received dental services

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members included in the denominator	1		and	During evaluation period
Dental Visits	1	CDT Code in **Dental Visits Value Set**		

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period		>3 months

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 17-18 performance for members with full Medicaid residing in each RAE region
Target	**Tier 1:** 1<5% improvement receives 75% of payment **Tier 2:** 5%+ receives 100% of payment.

Notes:

Well Visits

Last Updated: 5/7/19

Measure Name: Well Visits

Owner: IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Percent of distinct members who received a well visit within the 12-month evaluation period

Denominator: Members will be counted in the denominator if they are enrolled in the ACC on the last day of the last month of the 12-month evaluation period

Denominator Units: Distinct count of members meeting the above criteria

Denominator Eligibility/Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
Enrolled in the ACC	1	• RAE Enrolled Indicator='Y' • Snapshot Date = last month of the evaluation period • RAE Enrollment End Date>=last day of the month of the evaluation period	Last month of the 12-month rolling evaluation period

Numerator: Well Visits

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Members included in the denominator	1		and	
Preventive Visits	1	CPT Code in **Well Visits Value Set**	or	During evaluation period
Annual Wellness or Preventive Visit	1	HCPCs in **Well Visits Value Set**	or	
Office Visits	1	(CPT Code in **Office Visits Value Set**	and	
Encounter with preventive care diagnosis	1	ICD 10 Code in **Well Visits Value Set**)		

- Multiple numerator events in an evaluation period for a unique member will only be counted once
- All diagnosis codes on the claim will be considered, not just the primary diagnosis
- Paid claims and Encounters will be considered as part of the numerator/denominator/exclusion criteria
- Only claims and encounters submitted through the MMIS (interChange) will be used for this measure

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period		> 3 months

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 17-18 performance for members with full Medicaid residing in each RAE region
Target	**Tier 1:** 1<5% improvement receives 75% of payment, **Tier 2:** 5%+ receives 100% of payment.

Notes:

- Multiple numerator events in an evaluation period for a unique member will only be counted once
- All diagnosis codes on the claim will be considered, not just the primary diagnosis
- Paid claims and Encounters will be considered as part of the numerator/denominator/exclusion criteria
- Only claims submitted through the MMIS (interChange) will be used for this measure

Prenatal Engagement

Last Updated: 5/7/19

Measure Name: Prenatal Engagement

Owner: IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Percent of members who received a prenatal visit during pregnancy

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Denominator:

Members will be counted in the denominator if they meet the following criteria:

- Are enrolled in the ACC as of the last month of the evaluation period
- Have gender code= F
- Have had a delivery (as described below)

Denominator Units: Unduplicated count of deliveries meeting the above criteria. Members can have multiple deliveries within an evaluation period, but only one delivery within a 60-day period. Delivery logic will incorporate the earlier delivery date if two claims fall within 60 days of each other.

Denominator Eligibility/ACC Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
Enrolled in the ACC	1	• RAE Enrolled Indicator='Y' • Snapshot Date = last month of the evaluation period • RAE Enrollment End Date>=last day of the month of the evaluation period	Last month of the 12-month rolling evaluation period
Enrolled in Medicaid at least 30 days prior to delivery		• Medicaid Enrollment Effective Date<=30 days prior to the delivery	30 days
Gender		Gender Code = F	Female

Denominator: Number of deliveries

Detailed Criteria	# Event	Detailed Criteria	Criteria Connector	Timeframe
Women with a delivery procedure code	1	CPT Code in **Deliveries Value Set**	or	During evaluation period
	2	ICD-10 Procedure Code in **Deliveries Value Set**		

Denominator Exclusion Criteria:

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe

Exclude pregnancies not ending with a live birth		ICD-10-CM Codes in **Non-Live Births Value Set**		From the Delivery Date through 60 days after the delivery date

Numerator: Number of deliveries where the member had at least one prenatal visit prior to delivery
*Note: in the event that a delivery claim contains bundled services, the pre-natal visits will be counted in the numerator as long as pre-natal falls within the 40 weeks prior to the delivery date, including the delivery date.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Deliveries included in the denominator	1		and	
Prenatal Visit	1	CPT Code in **Prenatal Visits Value Set**	or	<= 40 weeks preceding delivery Note: these criteria include service dates 40 weeks prior to the start of the evaluation period
	1	(CPT Code in **Office Visits Value Set**	and	
	1	Modifier=TH)		

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Medicaid Enrolled	Medicaid enrolled at least 30 days prior to the delivery.		30 days prior to delivery

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period		> 3 months

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 17-18 performance for members with full Medicaid residing in each RAE region
Target	**Tier 1**: 1-5% improvement receives 75% of payment **Tier 2:** greater than 5% receives 100% of payment

Notes:
- All diagnosis codes on the claim will be considered, not just the primary diagnosis
- Paid claims and Encounters will be considered as part of the numerator/denominator/exclusion criteria
- Only claims submitted through the MMIS (interChange) will be used for this measure

Emergency Department (ED) Visits

Last Updated: 5/7/19

Measure Name: Emergency Department (ED) Visits

Owner: IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Number of emergency department visits per-thousand members per-year (PKPY) risk adjusted

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Denominator: Members will be counted in the denominator if they are enrolled in the ACC any month in the rolling 12-month evaluation period.

Denominator Units: Count of ACC member months

Denominator Eligibility Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
Enrolled in the ACC	1	• RAE Enrolled Indicator='Y' • Snapshot Date = at least one month in the evaluation period • RAE Enrollment End Date>=last day of each month	Last month of the 12-month rolling evaluation period

Numerator: Number of emergency department visits

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Emergency Department Visit	1	(Claim type in ('O','C','M','B') - Outpatient, Outpatient Crossover, Professional, Professional Crossover	and	During evaluation period
	1	(Revenue Code in **ED Visits Value Set**	or	During evaluation period
	1	CPT Code in **ED Visits Value Set**	or	During evaluation period
	1	(Claim with Place of Service = 23	and	During evaluation period
	1	CPT Code in **ED Visits 2 Value Set**)))		

Continuous Enrollment Criteria

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
ED visit ending in an inpatient admission	Claim type in (I, A) – Inpatient and Inpatient Crossover	and	On the same day as the ED visit or 1 day following
	Rendering provider type not in (20, 36) – Nursing facility, Home and Community Health Services		On the same day as the ED visit or 1 day following
Populations excluded from the measure	Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period		> 3 months

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 17-18 performance for members with full Medicaid residing in each RAE region
Target	**Tier 1**: 1-5% improvement receives 75% of payment **Tier 2:** greater than 5% receives 100% of payment

Notes:

- Multiple ED claims in a single date of service will only be counted once
- This measure will be reflected as a PKPY (Per Thousand per Year). PKPY Calculation = (Annual ED Visits/Member Months) x 12,000.
- This measure is risk adjusted
- All diagnosis codes on the claim will be considered, not just the primary diagnosis
- Paid claims and Encounters will be considered as part of the numerator/denominator/exclusion criteria
- Only claims submitted through the MMIS (interChange) will be used for this measure
- Any historical ED Visits prior to 7/1/2018 will be attributed to the new RAE regions effective 7/1/2018.
- New visits as of 8/1/2018 will attributed to RAE regions effective 8/1/2018, going forward.

Health Neighborhood

Last Updated: 5/7/19

Measure Name: Health Neighborhood

Owner: Colorado Department of Health Care Policy and Financing & IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: A composite measure focused on the relationship between PCMP's and specialty care providers.

Measure Components	% Breakdown
1. Percentage of RAE's PCMP's with Colorado Medical Society's Primary Care-Specialty Care Compacts in effect with specialty care providers (calculated and paid out annually)	25%
2. Percentage of outpatient specialist visits with a PCMP visit within 60 days prior to the specialist visit and including a referring PCMP on the claim (calculated monthly, paid out quarterly).	75%

1. Percentage of Primary Care-Specialty Care Compacts

Denominator:
PCMPs will be counted in the denominator if they are contracted with a RAE during the last month of the 12-month evaluation period.

Denominator Units: Unduplicated count of PCMP's meeting the above criteria

Denominator Eligibility/Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
PCMP contracted with the RAE	1	N/A	Last month of the 12-month rolling evaluation period

Numerator: PCMPs in the denominator who have at least one primary care-specialty care compacts in place within the 12-month rolling evaluation period.

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
PCMPs included in the denominator	1		and	
Number of new compacts	1	RAEs will submit a detailed list that includes the number of new compacts, PCMP and specialist names, and the signed date of the compact.	and	During evaluation period
Number of renewed compacts	1	RAEs will submit a detailed list that includes the number of renewed compacts, PCMP and specialist names, and the signed date of the compact		During evaluation period

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Baseline and Targets

Condition Description	Detailed Criteria			
Baseline	SFY 17-18			
Target	**Quarter 1:** 25%+ of PCMP network has 1 or more executed care compacts in place	**Quarter 2:** 50%+ of PCMP network has 1 or more executed care compacts in place	**Quarter 3:** 75%+ of PCMP network has 1 or more executed care compacts in place	**Quarter 4:** 50%+ of PCMP network has 2 or more executed care compacts in place (at least one needs to be behavioral health)

Notes:
- This component will be manually calculated by the Department and will not be displayed in the Data Analytics Portal.

2. Percentage of outpatient visits with a specialist

Denominator: Claims will be counted in the denominator if they meet the following criteria:
- Member on the claim was enrolled in the ACC during the last month of the 12-month the evaluation period.
- Claim is a professional or outpatient claim type.
- Billing provider on the claim is a specialty provider.

Denominator Units: Unduplicated count of claims meeting the above criteria

Denominator Eligibility/ACC Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
Enrolled in the ACC	1	• RAE Enrolled Indicator='Y' • Snapshot Date = last month of the evaluation period • RAE Enrollment End Date>=last day of the month of the evaluation period	Last month of the 12-month rolling evaluation period

Denominator: Number of specialty claims

Detailed Criteria	# Event	Detailed Criteria	Criteria Connector	Timeframe
Claim is a professional or outpatient claim type	1	Claim type in ('O','C','M','B','D') - Outpatient, Outpatient Crossover, Professional, Professional Crossover, Dental	and	During the evaluation period

Billing, Rendering, and Attending provider is a specialty provider [Specialty Provider Value Set]	1	Provider information matches specialty criteria.		During the evaluation period

Numerator: Claims in the denominator with a referring PCMP and visit

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Claims included in the denominator	1		and	During the evaluation period
Claims with a referring provider listed	1	Referring provider ID is not listed as 'N/A' or '(BLANK)'	and	During the evaluation period
Referring provider is a PCMP	1	Referring Provider is a PCMP in the PROV_LOC_PMP_PRFL_DIM	and	Last month of the 12-month rolling evaluation period
Member also had a claim with a PCMP provider within 60 days prior to the denominator claim	1	Claim with a PCMP		<=60 days prior to denominator claim Note: these criteria include service dates 60 days prior to the start of the evaluation period

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	Members who were enrolled in any physical health managed care plan for more than 3 months anytime during the evaluation period		> 3 months

Baseline and Targets

Condition Description	Detailed Criteria
Baseline	SFY 17-18 performance for members with full Medicaid residing in each RAE region
Target	**Tier 1:** 1-5% improvement receives 75% of payment **Tier 2:** greater than 5% receives 100% of payment

Notes:

- Multiple specialist visits on a single date of service will only be counted once
- Paid claims and encounters will be considered as part of the numerator/denominator/exclusion criteria
- Only claims submitted through the MMIS (interChange) will be used for this measure

APPENDIX C: NON-KPI ("OTHER") MEASURES SPECIFICATIONS

The other ACC program measures, which are not utilized for incentive payments, are used as an indicator of performance within the data analytics portal:

Postpartum Follow-up Care

Measure Name: Postpartum Follow-up Care

Owner: IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Rate of eligible deliveries who have received Postpartum Follow-up Care

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Denominator:
Members will be counted in the denominator if they meet the following criteria:

- Are enrolled in the ACC as of the last month of the evaluation period
- Have gender code= F

Denominator Eligibility/Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Enrolled in the ACC on the last day of the 12-month rolling evaluation period	1	Eligibility effective date <= enrollment date Eligibility end date >= enrollment date	and	The end of the 12-month rolling evaluation period (enrollment date)

Denominator Eligibility/Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Women with delivery Procedure codes	1	CPT Procedure Code in: 59400, 59409, 59410, 59510, 59514, 59515, 59610, 59612, 59614, 59618, 59620, 59622	or	Delivered a live birth on or between 56 days prior to the first day of the reporting period and 56 days prior to the last day of the reporting period (i.e. for the reporting period ending 12/31/2016, the denominator date range would be 11/05/15 to 11/06/16.) Note: If there are service dates within 60 days of each other, set the Delivery Date as the first date. Deliveries more than 60 days apart are considered separate deliveries.
		ICD-10 Procedure Code in (10D00Z0, 10D00Z1, 10D00Z2, 10D07Z3, 10D07Z4, 10D07Z5, 10D07Z6, 10D07Z7, 10D07Z8, 10D17ZZ, 10D18ZZ, 10D27ZZ, 10D28ZZ, 10E0XZZ)	or	

Denominator Exclusion:

Condition Description	# Event	Detailed Criteria	Timeframe
Exclude pregnancies not ending with a live birth	1	ICD-10-CM Codes (O00.0, O00.1, O00.2, O00.8, O00.9, O01.0, O01.1, O01.9, O02.0, O02.1, O02.81, O02.89, O02.9, O03.0, O03.1, O03.2, O03.30, O03.31, O03.32, O03.33, O03.34, O03.35, O03.36, O03.37, O03.38, O03.39, O03.4, O03.5, O03.6, O03.7, O03.80, O03.81, O03.82, O03.83, O03.84, O03.85, O03.86, O03.87, O03.88, O03.89, O03.9, O04.5, O04.6, O04.7, O04.80, O04.81, O04.82, O04.83, O04.84, O04.85, O04.86, O04.87, O04.88, O04.89, O07.0, O07.1, O07.2, O07.30, O07.31, O07.32, O07.33, O07.34, O07.35, O07.36, O07.37, O07.38, O07.39, O07.4, O08.0, O08.1, O08.2, O08.3, O08.4, O08.5, O08.6, O08.7, O08.81, O08.82, O08.83, O08.89, O08.9, Z37.1, Z37.4, Z37.7)	From the Delivery Date through 60 days after the delivery date

Numerator: Postpartum Visits

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Deliveries included in the denominator	1			
A Postpartum Visit	1	CPT Procedure Code in: (57170, 58300, 59430, 99501, 0503F, 88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88164, 88165, 88166, 88167, 88174, 88175)	Or	Date of Service = between >=21 and <=56 days from Delivery Date. Note: care delivered before RCCO enrollment is included.
	1	HCPCS Procedure Code in (G0101, G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091)	or	
	1	UBREV Code=0923	or	
	1	ICD-10 Diagnosis Codes in (Z01.411, Z01.419, Z01.42, Z30.430, Z39.1, Z39.2)		

Continuous Enrollment Criteria: Enrolled on the snapshot date

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	Clients who are dually eligible or enrolled in the ACC: Medicare-Medicaid Program (MMP)	or	During evaluation period
	Clients who are enrolled in any manage care plan for more than 3 months during the reporting period		

Notes:

- The Postpartum Bundled Services Value Set is not used in the numerator, because the date the post-partum was rendered is not identifiable.
- The Deliveries Infant Record Value Set is not included in the denominator.
- All diagnosis codes on the claim will be considered, not just the primary diagnosis.
- Only PAID claims will be considered as part of the numerator/denominator/exclusion criteria.

Well-Child Checks (WCC) Ages 3-9

Measure Name: Well-Child Checks for Ages 3-9

Owner: IBM Watson Health

Minimal Data (annual/monthly): Rolling 12 months; 90 days run out

Denominator:
Clients will be counted in the denominator if they meet the following criteria:

- Are between ages of 3-9 of the last day of the evaluation period
-
- Are enrolled in the ACC as of the Enrolment Date (defined above).

Denominator Units:
Unduplicated count of clients meeting the above criteria**.**

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
ages 3-9	1	Age >= 3 Age <= 9	and	If the client is enrolled in the ACC program as of the snapshot date and will look back 12 rolling months to see if there is utilization of the service pertaining to a particular measure.
90 days continuous enrollment	1			During the 12-month rolling evaluation period
Enrolled in the ACC on the last day of the 12-month rolling evaluation period	1	Eligibility effective date <= enrollment date Eligibility end date >= enrollment date	and	The end of the 12-month rolling evaluation period (enrollment date)

Numerator: Wellness Visits

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Clients included in the denominator	1			
Wellness Visit	1	CPT Procedure Code in (99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99460, 99461, 99463)	or	During evaluation period
		(CPT Procedure Code between 99202 and 99205 or CPT Procedure Code between 99213 and 99215) AND (ICD-10 Diagnosis Codes Z76.2, Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8, Z02.0, Z02.1,	or	

		Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.81, Z02.82, Z02.83, Z02.89)		
		Provider Type in 32 (FQHC) OR 45 (RHC) mapped to 200, 202, 204, 240, 400, 825, 845 AND (ICD-10 Diagnosis Codes Z76.2, Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8, Z02.0, Z02.1, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.81, Z02.82, Z02.83, Z02.89)		

Continuous Enrollment Criteria: Enrolled on the snapshot date

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	Clients who are dually eligible or enrolled in the ACC: Medicare-Medicaid Program (MMP)	or	During evaluation period
	Clients who were enrolled in any managed care plan for more than 3 months during the reporting period		

Notes:

All diagnosis codes on the claim will be consider, not just the primary diagnosis.
Only PAID claims will be considered as part of the numerator/denominator/exclusion criteria.

30-Day Follow-Up Care Following Inpatient Discharge

Last Updated: 03/23/2018

Measure Name: 30-day Follow-up Care Following Inpatient Discharge

Owner: IBM Watson Health

Evaluation Period: Rolling 12 months; 90 days claims run out

Measure Description: Rate of discharges from an inpatient hospital stay who receive follow-up care with a physician within 30 days.

Denominator: Clients will be counted in the denominator if they meet the following criteria:

- Clients who are discharged from an inpatient hospital stay, who have not had a subsequent readmission.
- Are enrolled in the ACC as of the Enrollment Date (defined above).

Denominator Units: Count of inpatient hospital stays meeting the above criteria.
A client can have multiple IP stays and can be counted multiple times in the reporting period.

Denominator Eligibility Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Enrolled in the ACC on the last day of the 12-month rolling evaluation period	1	Eligibility effective date <= enrollment date Eligibility end date >= enrollment date	and	The end of the 12-month rolling evaluation period (enrollment date)

Denominator Claim Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Clients discharged from an inpatient hospital stay (Inpatient, Skilled Nursing, Medicare Part A Crossover).	1	Claim Type: 'I' or 'A' for Inpatient) Note: since QME cannot use claim type, these will be mapped to revenue code 0100 at the header	and	Discharge 30 days on or prior to the first day of the reporting period and 30 days prior to the last day of the reporting period (i.e. for the reporting period ending 12/31/2016, the denominator date range would be 12/02/15 to 12/01/16.)
		Provider type <> 20 (Nursing Facility), 36 (HCBS)	and	
		Discharge status <> 02, 03, 04, 05, 09, 20, 21, 30, 31, 40, 41, 42, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70		

Denominator Exclusion Criteria:

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Inpatient readmission within 30 days of discharge	1	Claim Type: 'I' or 'A' for Inpatient) Note: since QME cannot use claim type, these will be mapped to revenue code 0100 at the header	and	Within 30 days from Date of Discharge of Inclusion Claim
		Provider type <> 20 (Nursing Facility), 36 (HCBS)	and	
		Discharge status <> 02, 03, 04, 05, 09, 20, 21, 30, 31, 40, 41, 42, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70		

Numerator: E&M Claim within 30 days of inpatient discharge

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Client had a subsequent Evaluation and Management Claim within 30 days of inpatient discharge	1	CPT Procedure Code in (99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245)		Within 30 days from Date of Discharge of the original inclusion Claim Note: Do not include BHO encounters.

Continuous Enrollment Criteria: Enrolled on the snapshot date

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
N/A			

Population Exclusions

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	1	Clients who are dually eligible or enrolled in the ACC: Medicare Medicaid Program (MMP)	or	During evaluation period
		Clients who were enrolled in any managed care plan for more than 3 months during the reporting period	or	

Notes:

Only PAID claims will be considered as part of the numerator/denominator/exclusion criteria