Regional Accountable Entity

The Accountable Care Collaborative (ACC) Key Performance Indicators (KPI) Methodology
SFY 2021-2022

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.

Table of Contents

Document Information

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SECTION 3: **INTRODUCTION**

3.2 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 Performance Pool, 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.

3.3 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) 21-22.

3.4 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.

3.5 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 iv). 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 4: **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.

4.2 Background

ACC population: Four dollars and thirteen cents of the per-member per-month (PMPM) payment to each RAE is withheld by the Department of Health Care Policy and Financing (the Department). Seventy-five percent of this amount is available for RAEs to earn on the following KPIs:

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

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.

4.3 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, Child and Adolescent Well Visits, Prenatal Engagement, ED Visits, and retired KPIs (see 3.1.7, 3.1.8, and 3.1.9). However, the Behavioral Health Engagement baseline will be calculated by the Department on a quarterly basis. The baseline for State Fiscal Year 2022 is July 1, 2019 through June 30, 2020, or SFY2019-20. There is one exception to this baseline: the Child and Adolescent Well Visits measure uses calendar year 2020 as the baseline. 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 be updated each year to align with the most recent full year of performance data. Due to claims runout and processing, the baseline year will generally be two years behind the performance year.

4.4 Baseline Population

All members with full Medicaid are 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.

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

Medicaid Enrollment:

- Dental Visits, Prenatal Engagement, and Child and Adolescent Well Visits 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 SFY20-21.

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 the Child and Adolescent Well Visits measure, which has criteria for continuous enrollment.

  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.

4.5 Evaluation Population

The KPI population varies slightly by KPI:

ACC Enrollment:

- Behavioral Health Engagement, Dental Visits, Prenatal Engagement, and Child and Adolescent 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.

4.6 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

4.7 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 2022 would correspond to performance from the July 1, 2021 – September 30, 2021 measurement period. Use the following table to monitor the monthly payment schedule.

July '21	Aug '21	Sept '21	Oct '21	Nov '21	Dec '21	Jan '22	Feb '22	March '22	April '22	May '22	June '22
								Submit incentive payment file for measurement period Jul 2021 - Sep 2021 (Q1)			Submit incentive payment file for measurement period Oct 2021 – Dec 2021 (Q2)

July '22	Aug '22	Sept '22	Oct '22	Nov '22	Dec '22
		Submit incentive payment file for measurement period Jan 2022 - Mar 2022 (Q3)			Submit incentive payment file for measurement period April 2022 - June 2022 (Q4)

SECTION 5: **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.

5.2 Overview

The data displayed within the Data Analytics Portal will allow the state, RAEs and PCMPs to view how their members are performing on six KPIs and three additional measures that are not paid out on. There are two tiers (targets) set for each KPI (with the exception of child and adolescent well visits), which determine how much of the withheld $4.13 each RAE can earn by meeting each tier. The seven KPIs are as follows:

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

Note: KPIs will be based on Paid Claims and Encounters. Telemedicine visits and services are included in KPI calculations as long as Department policy allows for reimbursement. See the most recent Code Value Set posted on the Department website for more details.

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
- Well Visits for Adults and Children

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

5.2.6 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.

5.2.7 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

5.2.8 KPI: Child and Adolescent Well Visits

The denominator for Child and Adolescent Well Visits includes 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 the appropriate minimum number of well visits based on their age and according to HEDIS standards. This is a composite measure comprised of two HEDIS measures.

Child and Adolescent Well Visit Part 1 (HEDIS W30) (%) = # Children Who Had Six or More Well Visits with a Primary Care Provider On or Before Their 15th Month Birthday or Had Two or More Visits Between the Child's 15-month Birthday and 30-month Birthday / # Children Who Turn 15 Months Old and 30 Months Old During the Performance Period

Child and Adolescent Well Visit Part 2 (HEDIS WCV) (%) = # of Children and Adolescents With One or More Well Visits During the Performance Period / # of Members Ages 3-21 as of the End of the Performance Period

5.2.9 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

5.2.10 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. This risk adjustment methodology was updated for the baseline and target for SFY21-22.

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

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

5.2.11 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 12/31/2020, the delivery date range utilized would be 11/05/2019 to 11/06/2020. 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

5.2.12 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

5.2.13 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

5.2.14 Other Program Measure: 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

SECTION 6: **RISK ADJUSTMENT**

The ED Visit KPI is the only measure that is risk adjusted. In SFY 2021-2022, the methodology will be updated and those changes will be reflected in a subsequent version of this document.

The methodology used for this measure is outlined below.

6.2 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.

6.3 DCG Extract

6.3.6 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)

6.3.7 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

6.4 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)

6.5 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)

6.6 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.

6.6.6 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

6.6.7 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.

6.6.8 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 7: **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. The only exception to the two-tier payment structure is the Child and Adolescent Well Visit measure which will only have one tier.

7.2 Incentive Payment Amounts PMPM

Of the total $4.13 PMPM withhold, roughly two-thirds will be distributed among KPIs and one-third among Performance Pool measures. Any unearned KPI dollars will also carryover and add to the Performance Pool incentive amount. The dollars from the Health Neighborhood KPI, which has been removed as of SFY2021-2022, have transferred to the Performance Pool.

The one exception to this payment structure is the Child and Adolescent Well Visits measure. The goal is based on gap closure, not improvement over baseline, and consequently, the goal is either met or not met with one payment opportunity for Part 1 and one payment opportunity for Part 2.

Payment for the KPIs will be established as follows:

KPI	Tier 1 Payment	Tier 2 Payment
Behavioral Health Engagement[3]	$0.3319 PMPM	$0.4425 PMPM
Dental Visits	$0.3319 PMPM	$0.4425 PMPM
Child and Adolescent Well Visits P1[4]	N/A	$0.2213 PMPM
Child and Adolescent Well Visits P2[5]	N/A	$0.2213 PMPM
Prenatal Engagement	$0.3319 PMPM	$0.4425 PMPM
Emergency Department (ED) Visits	$0.3319 PMPM	$0.4425 PMPM
Potentially Avoidable Costs[6]	$0.3319 PMPM	$0.4425 PMPM

Note: Payment amounts have been rounded, but the total amount to earn remains $2.655 PMPM or 64.3% of the PMPM.

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

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
HEDIS	Healthcare Effectiveness Data and Information Set
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: 8/10/2020
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. Telemedicine claims are included in this measure and indicated by a Place of Service code. RAEs have discretion within specific policy parameters for the specific behavioral health services that can be reimbursed through telehealth. These codes have not been listed in the Code Value Set because they are part of the capitated behavioral health benefit.
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,		During evaluation period

		[placeholder for new code)] and CLM_STS_CD= 'P')		

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 18-19 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 paid FFS Claims and the behavioral health services submitted via flat file until data is fully accessible in interChange.**

Dental Visits

Last Updated: 8/10/2020

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. Several telemedicine codes are allowed: D9995, D0140, and D9996. The first two codes correspond to synchronous teledentistry for emergencies. The third code is for asynchronous teledentistry for providers participating in the SMILES Dental Home project, which was reimbursable before the COVID-19 pandemic.

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 18-19 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 and encounters submitted through the MMIS (interChange) will be used for this measure

Child and Adolescent Well Visits

Last Updated: 7/1/2021

Note: This KPI measure is structured differently in terms of baseline, target, specifications, and payment due to the Department's shift toward incorporating more standard measures.

Measure Name: Child and Adolescent Well Visits – This is a composite measure with Part 1 (HEDIS W30) for children 30 months and younger, and Part 2 (HEDIS WCV) for children and adolescents ages 3-21

Owners: Colorado Department of Health Care Policy and Financing and IBM Watson Health

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

Measure Description: Percent of children and adolescents who receive the appropriate minimum number of well visits for their age during the performance period as indicated in the HEDIS measure.

Part 1 (HEDIS W30):

- Numerator: Number of members who had the following number of well child visits with a primary care provider in the last 15 months: 6 or more well child visits on different dates of service on or before the 15-month birthday; and two or more visits on different dates between the child's 15-month birthday and 30-month birthday.
- Denominator: Children who turn 15 months old during the performance period and children who turn 30 months old during the performance period.

Part 2 (HEDIS WCV):

- Numerator: Number of members with one or more well visits during the performance period.
- Denominator: Members 3-21 years of age as of the end of the performance period.

The well visit codes that are counted for this measure are available in the proprietary HEDIS specifications. The questions and answers below provide additional detail about the measures for those who are unable to access the HEDIS specifications.

Question: What types of visits generally are included or not included in the definition of a well visit?

Answer: Any well visit procedure code or diagnosis code as recognized by HEDIS. In-person and telemedicine visits are permitted. Well visits include visits by a PCMP or OBGYN and does not have to be with the provider that a member is attributed to. Visits for immunizations only are not included in the calculation. For more information about well visit standards, view the Bright Futures guidelines.

Question: Which telemedicine well visits are permitted with these measures?

Answer: Any well visit code that HEDIS recognizes that has also been approved by Colorado Medicaid policy will be counted in this measure. Telemedicine options for children's well visits were not permitted until mid-November 2020, and this measure may be impacted by the timing of the public health emergency period and any subsequent telemedicine policy changes.

Question: Do multiple visits on the same date count toward the measure?

Answer: No, visits must be distinct with different service dates.

Continuous Enrollment Criteria:

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Continuous enrollment	Members must be continuously enrolled with no more than a one-time gap of 45 days during the performance period	N/A	SFY 2021-2022

Population Exclusions

Condition Description	Detailed Criteria	Criteria Connector	Timeframe
Populations excluded from the measure	Members are enrolled in hospice are excluded from the measure	OR	As of the last day of the performance period
Populations excluded from the measure	Members enrolled in a managed care organization (MCO) plan		Any length of time with the exception of a 45-day gap

Baseline and Targets

Condition Description	Detailed Criteria
Performance Period	The Performance Period will be SFY21-22 with an overlap between the baseline and performance period of one quarter. This overlap will only occur for the SFY21-22 period.
Baseline	Calendar Year 2020 (The baseline for Performance Period SFY22-23 will be SFY20-21 to align with other KPIs)
Target	The target for both Part 1 and Part 2 of this measure will vary by RAE based on gap closure between the baseline and the national goal of 80%. There is only one tier for performance and payment. The target is 2.5% per quarter, for a cumulative gap closure of 10%. For Part 1 of the measure, the RAE must achieve the target for both age groups to receive payment.

Notes:

- 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. Only claims submitted through the MMIS (interChange) will be used for this measure

Prenatal Engagement

Last Updated: 10/29/2020

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. Prenatal visits that are allowable for telemedicine are included in this measure as indicated by the OB global bill. Additional telehealth covered codes for OB-related appointments are listed in the telemedicine billing manual, such as codes for ultrasounds.

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 18-19 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: 10/29/2020

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

The risk-adjustment methodology will be updated for the baseline and performance period when the adjusted DCG methodology is ready for implementation. Q1 baselines and targets currently follow the existing DCG methodology. Please refer to Section 4 for more details on this change and the methodology.

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 18-19 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

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

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, Z02.2, Z02.3, Z02.4, Z02.5, Z02.6, Z02.81, Z02.82, Z02.83, Z02.89)	or	

		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

Well Visits

Last Updated: 8/10/2020

Note: This KPI was retired at the end of SFY20-21 due to an interest in moving toward a more evidence-based, standard measure.

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. Several telemedicine services are included in this measure and indicated in the Code Value Set. For SFY 20-21, telemedicine options for children's well visits were not available until mid-November 2020.

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**		

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

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

APPENDIX D: RAE BASELINES AND TARGETS

Measure	Baseline SFY 2019-2020	Tier 1 Target Value		Tier 2 Target Value	
Emergency Department PKPY*	**Risk Adjusted PKPY**				
RAE1	**556.1**	550.5		528.3	
RAE2	**559.9**	554.3		531.9	
RAE3	**602.7**	596.7		572.6	
RAE4	**496.1**	491.1		471.3	
RAE5	**587.9**	582.0		558.5	
RAE6	**534.6**	529.3		507.9	
RAE7	**660.1**	653.5		627.1	
Behavioral Health Engagement	**Rate**				
RAE1	**15.28%**	15.43%		16.04%	
RAE2	**16.16%**	16.32%		16.97%	
RAE3	**16.37%**	16.53%		17.19%	
RAE4	**18.97%**	19.16%		19.92%	
RAE5	**20.32%**	20.52%		21.34%	
RAE6	**19.73%**	19.93%		20.72%	
RAE7	**18.40%**	18.58%		19.32%	
Well Visits Part 1 (First 15 months)	**Rate (Baseline is Calendar Year 2020)**	**Q1**	**Q2**	**Q3**	**Q4**
RAE1	**45.71%**	46.57%	47.42%	48.28%	49.14%
RAE2	**44.77%**	45.65%	46.53%	47.41%	48.29%
RAE3	**36.36%**	37.45%	38.54%	39.63%	40.72%
RAE4	**42.23%**	43.17%	44.12%	45.06%	46.01%
RAE5	**42.85%**	43.78%	44.71%	45.64%	46.57%
RAE6	**36.95%**	38.03%	39.10%	40.18%	41.26%
RAE7	**53.33%**	54.00%	54.66%	55.33%	56.00%
Well Visits Part 1 (15-30 months)	**Rate (Baseline Calendar Year 2020)**	**Q1**	**Q2**	**Q3**	**Q4**
RAE1	**54.23%**	54.87%	55.52%	56.16%	56.81%
RAE2	**51.92%**	52.62%	53.32%	54.03%	54.73%
RAE3	**45.70%**	46.56%	47.42%	48.27%	49.13%
RAE4	**50.61%**	51.34%	52.08%	52.81%	53.55%
RAE5	**56.72%**	57.30%	57.88%	58.47%	59.05%
RAE6	**48.23%**	49.02%	49.82%	50.61%	51.41%
RAE7	**55.68%**	56.29%	56.90%	57.50%	58.11%

Well Visits Part 2	Rate (Baseline Calendar Year 2020)	Q1	Q2	Q3	Q4
RAE1	**31.20%**	32.42%	33.64%	34.86%	36.08%
RAE2	**29.87%**	31.12%	32.38%	33.63%	34.88%
RAE3	**31.87%**	33.07%	34.28%	35.48%	36.68%
RAE4	**25.61%**	26.97%	28.33%	29.69%	31.05%
RAE5	**43.12%**	44.04%	44.96%	45.89%	46.81%
RAE6	**31.22%**	32.44%	33.66%	34.88%	36.10%
RAE7	**31.75%**	32.96%	34.16%	35.37%	36.58%
Dental Visits	**Rate**				
RAE1	**39.35%**		39.74%		41.32%
RAE2	**37.66%**		38.04%		39.54%
RAE3	**40.98%**		41.39%		43.03%
RAE4	**35.19%**		35.54%		36.95%
RAE5	**42.08%**		42.50%		44.18%
RAE6	**37.85%**		38.23%		39.74%
RAE7	**37.48%**		37.85%		39.35%
Prenatal Visits	**Rate**				
RAE1	**55.42%**		55.97%		58.19%
RAE2	**63.67%**		64.31%		66.85%
RAE3	**61.06%**		61.67%		64.11%
RAE4	**70.22%**		70.92%		73.73%
RAE5	**72.67%**		73.40%		76.30%
RAE6	**59.38%**		59.97%		62.35%
RAE7	**65.00%**		65.65%		68.25%

*Baselines and targets will be updated once the adjusted DCG methodology has been incorporated.