

ODM Medicaid Managed Health Care

ODM Encounter Data Submission Guidelines and Quality Measure Methodology

For the Provider Agreement effective through June 30, 2017

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I. Data Submission Guidelines

General Information

Each managed care plan (MCP) is required to report encounter data to the Ohio Department of Medicaid (ODM) and ODM is required to collect this data pursuant to federal requirements. ODM uses encounter data: to measure clinical and access-related performance; to conduct access and utilization reviews; to reimburse MCPs for delivery outcomes; in the premium payment setting process; and for policy development. Thus, encounter data must be timely, accurate, and complete. Data quality and performance measures and standards are included in the MCP provider agreement.

An encounter represents all of the services, including medical supplies and medications, provided to a member of the MCP by a particular provider, regardless of the payment arrangement between the MCP and the provider. For example, if a member had an emergency department visit and was examined by a physician, this would constitute two encounters: one related to the hospital provider; and one related to the physician provider. If a member visits their primary care provider (PCP) and the PCP examines the member and has laboratory procedures done within the office, then this is one encounter between the member and their PCP. If the PCP sends the member to a lab to have procedures performed, then this is two encounters; one with the PCP and another with the lab.

Encounters include services paid for retrospectively through fee-for-service payment arrangements, and prospectively through capitation arrangements. ODM requires MCPs to submit all encounters for which the MCP paid (either in full or partial payment). In cases where a plan has a subcapitated arrangement for certain services or for particular recipients, (e.g., Partners for Kids), the plan should submit encounters as subcapitated only if the services and provider(s) on the claim are covered under the subcapitated arrangement. If a plan pays a provider directly for a claim for a recipient for whom they are paying a subcapitation payment, and the provider does not expect to be reimbursed for the claim, the encounter should be submitted as a FFS encounter.

ODM requires MCPs to submit claims which fall into the following categories:

- coordination of benefits issues;
- lack of timely filing;
- failure to receive prior authorization;
- claims from non-participating providers;
- clinical coding edits;
- benefit limits; and
- any other applicable administrative denials.

ODM defines “zero paid claims” as any claim where the recipient was enrolled as a member of the MCP as of the date of service on the encounter, where an MCP did not make any payment to a provider, but where the recipient did receive the service(s) on the claim. These encounters are used by ODM in the calculation of quality measures including HEDIS-like measures and the CMS 416 report. Incomplete submission of zero paid claims may result in an MCP having a lower rate of compliance with ODM-calculated quality measures, which may impact future MCP enrollments, P4P, and other quality-based metrics.

Denied claims should not be submitted as encounters in cases where the managed care plan denied the claim due to having previously paid the provider for the same service. When an MCP submits a denied claim, the MCP should use appropriate Claim Adjustment Reason Codes (CARCs) and, where appropriate, Remittance Advice Remark Codes (RARCs), as specified in the current version of the CORE Code Combinations for CAQH CORE 320 rule found at: <http://www.caqh.org/core/ongoing-maintenance-core-code-combinations-caqh-core-360-rule>

ODM Encounter Data File Submission Specifications include: encounter data companion guides for Institutional, professional, and dental 837 EDI transactions; NCPDP D.0 files; 824 EDI response transactions; U277 EDI response transactions; *ODM Encounter Data Submission Guidelines*; and *CFC Delivery Payment Reporting Procedures and Specifications for ODM Managed Care Plans MITS (ICD-10)*.. The encounter data companion guides must be used in conjunction with the X12 Implementation Guide for EDI transactions; instructions for submitting information that is not found within the companion guides must follow X12 Implementation Guide submission specifications.

Voiding and Adjusting Encounters

Sometimes, information on an encounter must be changed or updated, or the entire encounter must be deleted from MITS due to submission in error, or duplicate submission. In cases where the entire encounter should be deleted from MITS, or for any changes to pharmacy encounters, the entire encounter should be voided from MITS, and if appropriate (i.e., the service was delivered and will not produce a duplicate encounter in ODM’s MITS), a replacement encounter should be submitted as a new original encounter.

In cases where changes need to be made to some fields on an encounter, an adjustment should be submitted. The adjustment reflects the final status of the claim including final procedures, providers, and payment amounts. A new original encounter should not be submitted to change or update information in fields on an encounter. Doing so will result in the encounter appearing to ODM to be a duplicate encounter.

In cases where a claim has multiple detail lines, and only some of the detail lines are paid on the original encounter submission, then subsequently, additional detail lines are paid on a later claim, the original encounter must be adjusted. The updated payment information for the additional detail lines should be

included on the adjustment. MCPs should not submit a second original encounter that includes \$0 amounts on the lines that were submitted on the first encounter. Doing so will result in what appears to ODM to be a duplicate encounter, and will result in erroneous quantitation of MCP paid amounts or utilization for those services.

Acceptance Testing

Acceptance testing of encounter data is required:

- 1) Before an MCP may submit 837 EDI encounter transactions to the MITS production database
- 2) Whenever an MCP has a system's change which impacts claims data or if the MCP changes the intermediary which submits the EDI 837 transactions
- 3) If ODM determines that a MCP's encounter data has quality issues that may be discovered through: data quality performance measures; audits; or high rejection rates.

Encounter Data Submission Procedure

An electronic version of *Ohio Medicaid's Encounter Data Certification Form* must accompany the submission of an 837 EDI encounter transaction via email to the MCP's contract administrator. The certification letter must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to the MCP's CEO or CFO.

ODM's encounter data submission policy is that the MCP may not submit more than 700,000 encounters via EDI 837 transactions on a given day, with a total of no more than 999,999 encounters via EDI 837 transactions and NCPDP D.0 pharmaceutical files. In accordance with HIPAA, It is ODM's encounter data submission policy that the MCP send no more than 5,000 claims/encounters per ST/SE. The MCP can send multiple ST/SE groups within a file, but no more than 5,000 claims/encounters in a group. . If there is any X12 format error, the ST/SE will be denied at the Translator level and a TRC is generated. The MCP may only submit encounter data on the MCP's designated days on *ODM Encounter Data Submission Schedule*, unless given permission by ODM to submit on a different day.

Completeness and Accuracy of Encounter Data

On an ongoing basis, ODM monitors the completeness and accuracy of encounter data through performance measures, rejection reports, and studies conducted by the External Quality Review

Organization. For a listing of these measures, the standards, and the penalties for noncompliance with the standards, see appendices L and N of the most current Medicaid Managed Care provider agreement.

Timeliness of Encounter Data Submission

Measure: The percentage of encounters that are submitted to ODM and accepted within 35 calendar days of the month in which they were paid. (e.g., claims paid by the MCP in January 2016 would be reported after March 7th 2016)

Numerator: The number of claims submitted and accepted into MITS within 35 calendar days of the month in which they were paid by the MCP in the reporting month.

Denominator: The number of claims paid by the MCP in the reporting month.

NOTE: The term “submitted and accepted into MITS” means prior to adjudication in MITS and, therefore, does not account for the final adjudication status of the encounter.

Compliance with this requirement will be measured and compared to the standard set in Appendix L of the most current Medicaid Managed Care provider agreement. For MCPs that do not meet the standard, compliance will be taken as described in Appendix N of the agreement.

Encounter Submissions per Encounter Schedule

Measure: The percent of encounters listed on the Encounter Data Submission Schedule as the minimum amount for that month that were submitted to ODM and accepted.

Numerator: The number of encounters submitted and accepted into MITS per claim type

Denominator: The minimum number of encounters per claim type required to be submitted during the month per the Encounter Data Submission Schedule.

NOTE: The term “submitted and accepted into MITS” means prior to adjudication in MITS and, therefore, does not account for the final adjudication status of the encounter.

Compliance with this requirement will be measured and compared to the standard set in Appendix L of the most current Medicaid Managed Care provider agreement. For MCPs that do not meet the standard, compliance will be taken as described in Appendix N of the agreement.

The Ohio Department of Medicaid Managed Care's Encounter Data Submission Schedule for July 2016 thru June 2017

- Mondays – CareSource; Molina
- Tuesdays – United; Buckeye
- Wednesdays – Paramount; CareSource
- Thursdays – As Needed

ODM's Required Minimum Number of Encounters by MCP to be Submitted and Accepted into MITS within each Calendar Month

Managed Care Provider	Institutional/Professional	NCPDP (RX)	Dental
CareSource	750,000	1,000,000	32,000
United Health Care	275,000	320,000	15,000
Molina	222,000	312,000	14,000
Buckeye	160,000	240,000	10,000
Paramount	176,000	172,000	9,600

II. Encounter Data Quality Measures

Purpose

The purpose of the encounter data volume measures is to monitor each MCP's encounter data submissions to ensure that the data is complete and that the number of encounters, which are submitted monthly, meet minimum volume standards.

Volume measures are calculated quarterly, by service category.

Service category groupings are based on codes (i.e. CPT, HCPCS, ICD-9), which are specified under each specific service category.

When a claim line item is identified for a particular service category, the entire claim (i.e. all line items submitted on the claim) is included in that service category. Service counts are determined by

unduplicating, by Managed Care Plan, Medicaid recipient ID and date of service. Pharmacy encounters are additionally unduplicated by National Drug Code (NDC) and Prescription Number.

All volume measures are calculated based on Date of Service at a claim header level.

Encounter Data Submission Procedure

The MCP must submit encounter data files to ODM per the specified schedule and within the allotted amount established in the ODM Encounter Data Submission Specifications.

The MCP must submit a letter of certification, using the form required by ODM, with each encounter data file in the ODM-specified medium format.

The letter of certification must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEA or CFO.

Member Months

Member months are determined using files of members agreed upon by ODM and the Managed Care Plans as having been enrolled with the plan for the month in question. Those files will be generated as follows:

- 1) ODM will generate a recipient master file, showing the recipient's managed care plan enrollment for that member month as stored in MITS.
- 2) On a quarterly basis, ODM will send each Managed Care Plan a list of these recipients to validate against the plans' enrollment records.
- 3) Each plan will return to ODM the list of recipients according to the file specifications dictated in *ODM's Medicaid Managed Care/MyCare Plan Quarterly Enrollment File for Quality Measures*.
- 4) ODM will use the agreed-upon list of plan members to calculate member months, sending any discrepancies to the Bureau of Managed Care for resolution, including potential system corrections to member enrollment.
- 5) If a plan chooses not to send ODM an agreed-upon member list as described in the document above, ODM will use its recipient master file to generate managed care enrollment for that member month for that plan to calculate measures.

Encounter Data Quality Volume Approaches

Provider Agreement – Encounter Data Volume Data Quality Standards Calculation for the Adult Extension, CFC, ABD 20 and Under, and ABD 21 and Over Populations (*Appendix L*)

The measures for the Ohio Medicaid’s Adult Extension Population have thus far not been bound to Data Quality Standards (Table 2, Appendix L of the Provider Agreement) due to the nature of this population’s recent establishment in January 2014. A calculation of standard thresholds for the Extension population was conducted in order to hold Managed Care Plans accountable for following compliance in ensuring Medicaid consumers’ access to and quality of services, as well as timely submission of encounters. For every category of service, MCPs must meet the minimum data quality standard outlined in Table 2, Appendix L of the Provider Agreement. While these standards for the Adult Extension Population will be effective beginning MM/DD/YYYY, ODM will *not* be taking compliance retroactively for this population, should one of the MCPs fall below the calculated standard prior to this date.

There are nine categories of service for the Adult Extension population. These are: Behavioral Health, Deliveries, Dental, DME, ED, Inpatient, Pharmacy, Primary and Specialist, and Vision. Because of the nature of Deliveries - it having very low utilization numbers a threshold will not be set for Deliveries. The numerical and statistical methods for calculating the Extension Population Standards for the remaining eight categories of service are outlined as follows:

Calculations of Thresholds/Standards for Adult Extension Population

Using Medicaid data, recent quarterly results for the Extension population have been used to calculate thresholds formulae for each of the eight applicable categories of service. Q4 2015 has not been included in calculations due to claims lag. Due to high amounts of retroactive enrollment among the Extension Population, thus resulting in highly variable data, Q1 2014, Q2 2014, and Q3 2014 have not been included in calculations.

First Group of Five Categories of Service – Formula and Thresholds

For five of the eight categories of service – Behavioral Health, ED, Inpatient, Pharmacy, and Primary and Specialist all four of the quarters Q4 2014, Q1 2015, Q2 2015, and Q3 2015 have been used in threshold calculations, in the manner described below. The calculations of the thresholds for these five categories are:

1. A sum of each of the five plans individually for these four quarters using the weighted average formula $((0.10 \times (\text{Q4 2014 Category of Service Utilization for Plan/ Q4 2014 MMs for Plan}) \times 1000 \text{ MM}) + (0.20 \times (\text{Q1 2015 Category of Service Utilization for Plan/ Q1 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.30 \times (\text{Q2 2015 Category of Service Utilization for Plan/ Q2 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.40 \times (\text{Q3 2015 Category of Service Utilization for Plan/ Q3 2015 MMs for Plan}) \times 1000 \text{ MM}))$.
2. Rank the five plans in order from highest to lowest based on the weighted average calculated in Step 1.
3. Determine the median plan based on the ranking in step 2. This is the plan which is the middle (or third) ranking out of the five plans. This is now the Median Plan of Weighted Average.
4. Set the threshold for the category of service at $0.8 \times$ Median Plan of Weighted Average.

- Complete steps 1 through 4 for Behavioral Health, ED, Inpatient, Pharmacy, and Primary and Specialist Categories of Service.

All thresholds: These are the correct thresholds calculated.

Category of Service	Utilization per 1000 Member Months
Adult Extension Behavioral Health	62.376
Adult Extension Emergency	90.121
Adult Extension Inpatient	8.208
Adult Extension Pharmacy	1511.840
Adult Extension Primary and Specialist Care	285.625

For DME Category of Service – Formula and Threshold

For DME category of service all four of the quarters Q4 2014, Q1 2015, Q2 2015, and Q3 2015 have been used in threshold calculations, in the manner described below. The calculations of the thresholds for this category are:

- A sum of each of the five plans individually for these four quarters using the weighted average formula $((0.10 \times (\text{Q4 2014 Category of Service Utilization for Plan} / \text{Q4 2014 MMs for Plan}) \times 1000 \text{ MM}) + (0.20 \times (\text{Q1 2015 Category of Service Utilization for Plan} / \text{Q1 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.30 \times (\text{Q2 2015 Category of Service Utilization for Plan} / \text{Q2 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.40 \times (\text{Q3 2015 Category of Service Utilization for Plan} / \text{Q3 2015 MMs for Plan}) \times 1000 \text{ MM}))$.
- Rank the five plans in order from highest to lowest based on the weighted average calculated in Step 1.
- Determine the median plan based on the ranking in step 2. This is the plan which is the middle (or third) ranking out of the five plans. This is now the Median Plan of Weighted Average.
- Set the threshold for the category of service at $0.7 \times \text{Median Plan of Weighted Average}$.

DME threshold: This is the correct threshold calculated.

Adult Extension DME	27.517
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Final Group of Remaining Two Categories of Service – Formula and Threshold

For the remaining two of the applicable eight categories of service –Dental and Vision, due to the nature of the data – only the last two quarters Q2 2015 and Q3 2015 have been used in the calculations. If quarters prior to Q2 2015 are used in the formula, the threshold would be higher than appropriate due to the impact of previous quarters, which are not as current and highly variable. Also, for this category of service, an average is used instead of a weighted average – because of the inclusion of only two previous quarters in the formula. The calculations of the thresholds for this category of service are:

1. A sum and average of each of the five plans individually for these two quarters using a simple average formula ($((Q2\ 2015\ Category\ of\ Service\ Utilization\ for\ Plan / Q2\ 2015\ MMs\ for\ Plan) \times 1000\ MM) + ((Q3\ 2015\ Category\ of\ Service\ Utilization\ for\ Plan / Q3\ 2015\ MMs\ for\ Plan) \times 1000\ MM)$).
2. Rank the five plans in order from highest to lowest based on the average calculated in Step 1.
3. Determine the median plan based on the ranking in step 2. This is the plan which is the middle (or third) ranking out of the five plans. This is now the Median Plan of Average.
4. Set the threshold for the category of service at $0.7 \times$ Median Plan of Average.

The factor used for these two categories of service is 0.7 instead of 0.8 because of the different volume and dispersion of Dental and Vision encounters compared to the other categories of service. Dental has some volatility in the data and a cluster of three plans at a much higher level than the other two over the time period in question, causing a higher median than typical and thus necessitating the lower threshold.

All Thresholds:

Category of Service	Utilization per 1000 Member Months
Adult Extension Dental	42.338
Adult Extension Vision	17.276

Encounter Data Volume Data Quality Standards

Calculations for CFC, ABD 21 and over, ABD 20 and under

In addition to Adult Extension, CFC, ABD 21 and over, and ABD 20 and under categories are also included in this methodology. This is done to provide clear, known standards for all population groups and to have consistent, reliable methodology on which to base the standards.

CFC

CFC standards are calculated the same using the same methodology as the standards for the Adult Extension population.

There are nine categories of service for the CFC population. These are: Behavioral Health, Deliveries, Dental, DME, ED, Inpatient, Pharmacy, Primary and Specialist, and Vision. Because of the nature of Deliveries - it having very low utilization numbers a threshold will not be set for Deliveries. The numerical and statistical methods for calculating the CFC Population Standards for the remaining eight categories of service are outlined as follows:

Calculations of Thresholds/Standards for CFC Population

Using Medicaid data, recent quarterly results for the CFC population have been used to calculate thresholds formulae for each of the eight applicable categories of service. Q4 2015 has not been included in calculations due to claims lag.

First Group of Five Categories of Service – Formula and Thresholds

For five of the eight categories of service – Behavioral Health, ED, Inpatient, Pharmacy, and Primary and Specialist all four of the quarters Q4 2014, Q1 2015, Q2 2015, and Q3 2015 have been used in threshold calculations, in the manner described below. The calculations of the thresholds for these five categories are:

1. A sum of each of the five plans individually for these four quarters using the weighted average formula $((0.10 \times (\text{Q4 2014 Category of Service Utilization for Plan} / \text{Q4 2014 MMs for Plan}) \times 1000 \text{ MM}) + (0.20 \times (\text{Q1 2015 Category of Service Utilization for Plan} / \text{Q1 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.30 \times (\text{Q2 2015 Category of Service Utilization for Plan} / \text{Q2 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.40 \times (\text{Q3 2015 Category of Service Utilization for Plan} / \text{Q3 2015 MMs for Plan}) \times 1000 \text{ MM}))$.
2. Rank the five plans in order from highest to lowest based on the weighted average calculated in Step 1.
3. Determine the median plan based on the ranking in step 2. This is the plan which is the middle (or third) ranking out of the five plans. This is now the Median Plan of Weighted Average.
4. Set the threshold for the category of service at $0.8 \times \text{Median Plan of Weighted Average}$.

All thresholds: These are the correct thresholds calculated.

Category of Service	Utilization per 1000 Member Months
CFC Behavioral Health	35.900
CFC Emergency	65.462
CFC Inpatient	4.237
CFC Pharmacy	600.258
CFC Primary and Specialist Care	224.436

For DME Category of Service – Formula and Threshold

For DME category of service all four of the quarters Q4 2014, Q1 2015, Q2 2015, and Q3 2015 have been used in threshold calculations, in the manner described below. The calculations of the threshold for this category are:

1. A sum of each of the five plans individually for these four quarters using the weighted average formula $((0.10 \times (\text{Q4 2014 Category of Service Utilization for Plan} / \text{Q4 2014 MMs for Plan}) \times 1000 \text{ MM}) + (0.20 \times (\text{Q1 2015 Category of Service Utilization for Plan} / \text{Q1 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.30 \times (\text{Q2 2015 Category of Service Utilization for Plan} / \text{Q2 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.40 \times (\text{Q3 2015 Category of Service Utilization for Plan} / \text{Q3 2015 MMs for Plan}) \times 1000 \text{ MM}))$.
2. Rank the five plans in order from highest to lowest based on the weighted average calculated in Step 1.

3. Determine the median plan based on the ranking in step 2. This is the plan which is the middle (or third) ranking out of the five plans. This is now the Median Plan of Weighted Average.
4. Set the threshold for the category of service at 0.7 x Median Plan of Weighted Average.

DME threshold: This is the correct threshold calculated.

CFC DME	10.087
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Final Group of Remaining Two Categories of Service – Formula and Thresholds

For the remaining two of the applicable eight categories of service –Dental and Vision, due to the nature of the data – only the last two quarters Q2 2015 and Q3 2015 have been used in the calculations. If quarters prior to Q2 2015 are used in the formula, the threshold would be higher than appropriate due to the impact of previous quarters, which are not as current and highly variable. Also, for this category of service, an average is used instead of a weighted average – because of the inclusion of only two previous quarters in the formula. The calculations of the thresholds for this category of service are:

1. A sum and average of each of the five plans individually for these two quarters using a simple average formula (((Q2 2015 Category of Service Utilization for Plan/ Q2 2015 MMs for Plan) x 1000 MM) + ((Q3 2015 Category of Service Utilization for Plan/ Q3 2015 MMs for Plan) x 1000 MM)).
2. Rank the five plans in order from highest to lowest based on the average calculated in Step 1.
3. Determine the median plan based on the ranking in step 2. This is the plan which is the middle (or third) ranking out of the five plans. This is now the Median Plan of Average.
4. Set the threshold for the category of service at 0.7 x Median Plan of Average.

The factor used for these two categories of service is 0.7 instead of 0.8 because of the different volume and dispersion of Dental and Vision encounters compared to the other categories of service. Dental has some volatility in the data and a cluster of three plans at a much higher level than the other two over the time period in question, causing a higher median than typical and thus necessitating the lower threshold.

All Thresholds:

Category of Service	Utilization per 1000 Member Months
CFC Dental	45.236
CFC Vision	14.948

ABD 21 and over, and ABD 20 and under

There are differences for ABD Under 21 and ABD 21 and over compared to CFC and Adult Extension populations. Therefore, the thresholds and formulae are changed slightly to reflect the high variability. See below. ABD 21 and over and ABD 20 and under populations will use the same formulae as each other.

There are nine categories of service for the ABD 21 and over and ABD 20 and under populations. These are: Behavioral Health, Deliveries, Dental, DME, ED, Inpatient, Pharmacy, Primary and Specialist, and Vision. Because of the nature of Deliveries - it having very low utilization numbers a threshold will not be set for Deliveries. The numerical and statistical methods for calculating the ABD 21 and over and ABD 20 and under populations Population Standards for the remaining eight categories of service are outlined as follows:

Calculations of Thresholds/Standards for ABD 21 and Over and ABD 20 and Under Populations

Using Medicaid data, recent quarterly results for the ABD 21 and over and ABD 20 and under populations have been used to calculate thresholds formulae for each of the eight applicable categories of service. Q4 2015 has not been included in calculations due to claims lag.

First Group of Five Categories of Service – Formula and Thresholds

For five of the eight categories of service –DME, ED, Inpatient, Pharmacy, and Primary and Specialist all four of the quarters Q4 2014, Q1 2015, Q2 2015, and Q3 2015 have been used in threshold calculations, in the manner described below. The calculations of the thresholds for these five categories are:

1. A sum of each of the five plans individually for these four quarters using the weighted average formula $((0.10 \times (\text{Q4 2014 Category of Service Utilization for Plan/ Q4 2014 MMs for Plan}) \times 1000 \text{ MM}) + (0.20 \times (\text{Q1 2015 Category of Service Utilization for Plan/ Q1 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.30 \times (\text{Q2 2015 Category of Service Utilization for Plan/ Q2 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.40 \times (\text{Q3 2015 Category of Service Utilization for Plan/ Q3 2015 MMs for Plan}) \times 1000 \text{ MM}))$.
2. Rank the five plans in order from highest to lowest based on the weighted average calculated in Step 1.
3. Determine the median plan based on the ranking in step 2. This is the plan which is the middle (or third) ranking out of the five plans. This is now the Median Plan of Weighted Average.
4. Set the threshold for the category of service at $0.7 \times \text{Median Plan of Weighted Average}$.

All thresholds: These are the correct thresholds calculated.

Category of Service	Utilization per 1000 Member Months
ABD 20 and under DME	54.794
ABD 20 and under Emergency	60.834
ABD 20 and under Inpatient	5.115
ABD 20 and under Pharmacy	834.894
ABD 20 and under Primary and Specialist Care	196.625

Category of Service	Utilization per 1000 Member Months
ABD 21 and over DME	116.390
ABD 21 and over Emergency	125.953
ABD 21 and over Inpatient	18.919

ABD 21 and over Pharmacy	3717.270
ABD 21 and over Primary and Specialist Care	451.635

Behavioral Health ABD 20 and Under and ABD 21 and Over – Formula and Thresholds

For Behavioral Health, all four of the quarters Q4 2014, Q1 2015, Q2 2015, and Q3 2015 have been used in threshold calculations, in the manner described below. The calculations of the thresholds for this category is:

1. A sum of each of the five plans individually for these four quarters using the weighted average formula $((0.10 \times (\text{Q4 2014 Category of Service Utilization for Plan/ Q4 2014 MMs for Plan}) \times 1000 \text{ MM}) + (0.20 \times (\text{Q1 2015 Category of Service Utilization for Plan/ Q1 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.30 \times (\text{Q2 2015 Category of Service Utilization for Plan/ Q2 2015 MMs for Plan}) \times 1000 \text{ MM}) + (0.40 \times (\text{Q3 2015 Category of Service Utilization for Plan/ Q3 2015 MMs for Plan}) \times 1000 \text{ MM}))$.
2. Rank the five plans in order from highest to lowest based on the weighted average calculated in Step 1.
3. Determine the median plan based on the ranking in step 2. This is the plan which is the middle (or third) ranking out of the five plans. This is now the Median Plan of Weighted Average.
4. Set the threshold for the category of service at $0.4 \times \text{Median Plan of Weighted Average}$.

BH will use $0.4 \times \text{median of Weighted Average}$, due to the high level of variability in ABD 21 and over and 20 and under.

ABD 20 and under Behavioral Health	120.237
ABD 21 and over Behavioral Health	74.896

Final Group of Remaining Two Categories of Service – Formula and Thresholds

For the remaining two of the applicable eight categories of service –Dental and Vision, due to the nature of the data – only the last two quarters Q2 2015 and Q3 2015 have been used in the calculations. If quarters prior to Q2 2015 are used in the formula, the threshold would be higher than appropriate due to the impact of previous quarters, which are not as current and highly variable. Also, for this category of service, an average is used instead of a weighted average – because of the inclusion of only two previous quarters in the formula. The calculations of the thresholds for this category of service are:

1. A sum and average of each of the five plans individually for these two quarters using a simple average formula $((\text{Q2 2015 Category of Service Utilization for Plan/ Q2 2015 MMs for Plan}) \times 1000 \text{ MM}) + ((\text{Q3 2015 Category of Service Utilization for Plan/ Q3 2015 MMs for Plan}) \times 1000 \text{ MM}))$.
2. Rank the five plans in order from highest to lowest based on the average calculated in Step 1.
3. Determine the median plan based on the ranking in step 2. This is the plan which is the middle (or third) ranking out of the five plans. This is now the Median Plan of Average.
4. Set the threshold for the category of service at $0.6 \times \text{Median Plan of Average}$.

The factor used for these two categories of service is 0.6 instead of 0.7 because of the different volume and dispersion of Dental and Vision encounters compared to the other categories of service. Dental has some volatility in the data and a cluster of three plans at a much higher level than the other two over the time period in question, causing a higher median than typical and thus necessitating the lower threshold.

All Thresholds:

Category of Service	Utilization per 1000 Member Months
ABD 20 and under Dental	35.546
ABD 20 and under Vision	15.297

Category of Service	Utilization per 1000 Member Months
ABD 21 and over Dental	30.903
ABD 21 and over Vision	21.323

Inpatient Hospital

This measure calculates the utilization rate for general/acute inpatient services: the number of discharges per 1,000 member months. Newborn and mental health inpatient stays are excluded.

Acute inpatient hospital services are identified by the following Type of Bill codes: 11X, 12X, 41X, and 84X.

Inpatient Hospital - Exclusions	
Newborns exclusions	Mental Health and Chemical Dependency exclusions
ICD-9 V codes	ICD-9 Primary Diagnosis
V30 – V39 Liveborn infants	290 to 316 Mental Disorders
ICD-10 Z codes	ICD-10 Primary Diagnosis
Z37.0 – Z37.9 Outcome of delivery	F0150 – F99 Mental, Behavior, and Neurodevelopmental disorders

Numerator: Discharges X 1,000

Discharges = encounters unduplicated by recipient ID and last date of the inpatient stay.

Denominator: Member Months

Data Source: Institutional Encounters

Behavioral Health

This measure calculates the behavioral health utilization rate: behavioral health visits per 1,000 member months. Emergency department visits for behavioral health diagnoses are included in this measure.

A behavioral health visit is defined as a non-institutional behavioral health visit, an institutional outpatient behavioral health visit, or an institutional inpatient behavioral health stay. The encounters used to calculate the numerator are unduplicated by recipient ID and date of service.

Codes to Identify Behavioral Health Services	
CPT	ICD-9 Diagnosis and Procedure codes
90801 to 90899 Psychiatry	290 to 316 Mental Disorders
HCPCS	960 to 979 Poisoning w/ secondary Dx of alcohol/drug psychoses, dependence or abuse (291,292, 303 – 305, 535.3, 571.1)
T1015 w/ modifier U3 FQHC/Outpatient Health Facility	94.26, 94.27, 94.61 to 94.69 ECT, Alcohol/drug rehab & detox
	ICD-10 Diagnosis and Procedure codes
	[See Inpatient Hospital Exclusions]
	HZ30ZZZ to HZ3BZZZ, HZ40ZZZ to HZ4BZZZ, HZ50ZZZ to HZ5BZZZ, HZ5CZZZ, HZ5DZZZ, HZ63ZZZ, HZ80ZZZ to HZ99ZZZ Substance Abuse Treatment GZB0ZZZ – GZB4ZZZ Electroconvulsive Therapy HZ2ZZZZ Detox HZ93ZZZ, HZ96ZZZ Pharmacotherapy for Sub. Abuse K70.0 to K70.9 Alcoholic Liver Disease K29.20, K29.21 Alcoholic Gastritis T36-T39, T40-T49, T50 Poisoning

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Emergency Department

This measure calculates an emergency department (ED) utilization rate: ED visits per 1,000 member months. It includes all encounters with the codes(s) specified below.

Codes to Identify Emergency Department Visits					
Institutional Encounters			Non-Institutional Encounters		
Type of Bill		UB Revenue Codes ¹	CPT Codes ²		Place of Service Code
13X, 43X	and	045x, 981	10040 - 69979, 99281 - 99288	and	23 (Emergency Room-hospital)

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Dental

This measure calculates the utilization rate for dental services: dental visits per 1,000 member months. Emergency department visits for dental related diagnoses are included in the Emergency Department measure and are not included in this measure.

Codes to Identify Dental Visits	
CPT	CDT
70300, 70310, 70320, 70350, 70355 Radiology	D0120– D9999
	HCPCS
	T1015 w/ modifier U2 OHF / FQHC
ICD-9 Procedure Codes	ICD-10 Procedure Codes
23.xx and 24.xx Teeth, gums, and alveoli	0C5WXZ0-0C5WXZ2, 0C5XXZ0-0C5XXZ2, 0C95-0C96, 0C9WXZ0-0C9WXZ2, 0C9XXZ0-0C9XXZ2, 0CB5-0CB6, 0CBWXZ0-0CBWXZ2, 0CBXXZ0-0CBXXZ2, 0CC50ZZ, 0CC53ZZ, 0CC60ZZ, 0CC63ZZ, 0CDW-0CDX, 0CJY0ZZ-0CJY8ZZ, 0CN4-0CN6, 0CNWXZ0-0CNWXZ2, 0CNXXZ0-0CNXXZ2, 0CQ5-0CQ6, 0CQW-0CQX, 0CR6 (exclude 0CR6XJZ), 0CRW0J0-0CRW0J2, 0CRWXJ0-0CRWXJ2, 0CRX0J0-0CRX0J2, 0CRXXJ0-0CRXXJ2, 0CSW-0CSX, 0CTW-0CTX, 0CU5-0CU6, 0N9R, 0N9S, 0N9T, 0N9V (exclude Diagnostic procedures), 0NBR, 0NBS, 0NBT, 0NBV, 0NCR, 0NCS, 0NCT, 0NCV, 0NQR, 0NQS, 0NQT, 0NQV – Teeth, gums, alveoli
87.11, 87.12 Dental x-rays	BN0JZZZ, BN0GZZZ, BN0HZZZ – Radiography
89.31, 93.55, 96.54, 97.22, 97.33 - 97.35 99.97 Other dental procedures	0CJYXZZ, 2W31X9Z, 0CCWXZ0-0CCWZ2, 0CCXXZ0-0CCXXZ2, Other dental procedures 2Y00X5Z, 2W51XYZ, 2Y50X5Z, 0CPYXJZ, F0DZ8UZ

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Vision

This measure calculates the utilization rate for vision services: vision visits per 1,000 member months. Emergency department visits for vision-related diagnoses are included in the Emergency Department measure and are not included in this measure. Codes for eyeglass frames and lenses, contact lenses, ocular prosthetics and other vision aids are not included in this measure.

Codes to Identify Vision Visits	
CPT	HCPCS
92002 to 92371, 92499 Ophthalmology	T1015 w/ modifier U7 OHF / FQHC
65091 to 68899 Surgery, Eye	S0620, S0621, S0625, S3000
ICD-9 Procedure Codes	ICD-9 Diagnosis Codes
08.xx to 16.xx Operations on the eye	V72.0
95.0x to 95.2x Ophthalmologic Dx and treatment	
ICD-10 Procedure Codes	ICD-10 Diagnosis Codes
08J0XZZ, 08J1XZZ, 4A07X0Z, 4A07X7Z – Inspection and measurement B30N0ZZ-B30NYZZ, B803ZZZ-B805ZZZ, B806ZZZ-B807ZZZ – Radiography B845ZZZ-B847ZZZ – Ultrasound C8191ZZ, C819YZZ, C81YYZZ - Imaging	Z01.00, Z01.00
ICD-10 Procedure Codes (continued): 080-081, 085* (exclude 0854, 0855, 085G, 085H, 085L, 085M), 0892-0897, 089C-089D, 089N-089T, 089X-089Y, 08B*, 08C0-08C1, 08C23ZZ, 08C33ZZ, 08C4-08C5, 08C8-08C9, 08CA-08CF, 08CGXZZ, 08CHXZZ, 08CJ-08CK, 08CLXZZ, 08CMXZZ, 08CN-08CT, 08CV3ZZ, 08CVXZZ, 08CW3ZZ, 08CWXZZ, 08CX-08CY, 08D*, 08H* (exclude infusion devices), 08J*, 08L*, 08N2-08N5, 08NC-08ND, 08NJ-08NT, 08P003Z, 08P070Z, 08P080Z, 08P00CZ, 08P03CZ, 08P07CZ, 08P08CZ, 08P00DZ, 08P03DZ, 08P07DZ, 08P08DZ, 08P00JZ, 08P03JZ, 08P07JZ, 08P08JZ, 08P103Z, 08P10CZ, 08P10DZ, 08P10JZ, 08P13CZ, 08P13DZ, 08P13JZ, 08P170Z, 08P17CZ, 08P17DZ, 08P17JZ, 08P180Z, 08P18CZ, 08P18DZ, 08P18JZ, 08PJ-08PK	ICD-10 Procedure Codes (continued): 08Q0-08QF, 08QJ-08QY, 08R0-08R7, 08R8-08R9 (exclude synthetic substitute), 08RC-08RD, 08RJ-08RK (exclude substitute tissue), 08RN-08RY, 08SC-08SD, 08SL-08SR, 08TO-08T5, 08TC-08TD, 08TL-08TM, 08TV-08TW, 08U00JZ, 08U03JZ, 08U10JZ, 08U13JZ, 08U807Z, 08U80KZ, 08U837Z, 08U83KZ, 08U8X7Z, 08U8XKZ, 08U907Z, 08U90KZ, 08U937Z, 08U93KZ, 08U9X7Z, 08U9XKZ, 08UC-08UD, 08UE0JZ, 08UE3JZ, 08UF0JZ, 08UF3JZ, 08UN-08UY, 08W00JZ, 08W03JZ, 08W10JZ, 08W13JZ, 08X*

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and last date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Primary & Specialist Care

This measure calculates a utilization rate for primary and specialist care services: visits per 1,000 member months. Included are all physician office, clinic and hospital outpatient evaluation and management services provided by general practice providers and specialists, and other ambulatory care such as pregnancy-related and family planning services.

Codes to Identify Primary & Specialist Care			
CPT		HCPCS	
99201 to 99215	Office/Other Outpatient Services	T1015 w/ modifier U1	OHF / FQHC
99241 to 99245	Office/Other Outpatient Consults	H1000 to H1005	At-risk pregnancy services
99301 to 99337	Nursing Facility, Domiciliary, Rest Home, Custodial Care	H1011	Family planning educational visit
		S0610 to S0612	Annual gynecological exams
99341 to 99350	Home Services	S9436, S9437,	Pregnancy related services
99381 to 99429	Preventive Medicine Services	S9444, S9447,	
99499	Other evaluation & mgt. services	S9452, S9470	
59425 to 59430	Antepartum & postpartum care	G0344	Preventive Medicine Services
ICD-9 V Codes		ICD-10 Z Codes	
V20.2	Routine infant/child health check	Z00.121, Z00.129	Routine child health check
V70.0, V70.3 V70.5, V70.6 V70.8, V70.9	Other medical exams	Z00.00 – Z00.01, Z02.0 – Z02.6, Z02.71, Z02.82, Z02.89, Z00.8	Other medical exams

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Pharmacy

This measure calculates utilization rate for drugs: prescriptions per 1,000 member months.

Numerator: Prescriptions X 1,000

Prescriptions = encounters unduplicated by managed care plan, recipient ID, date of service, and NDC code

Denominator: Member Months

Data Source: Pharmacy encounters

Durable Medical Equipment (DME) – Reporting Only

This measure calculates the Durable Medical Equipment (DME) utilization rate per 1,000 member months.

Codes to Identify Durable Medical Equipment (DME)	
CPT	
A4206 to A8004, A9040	XX001, XX002, XX004, X1422 to X1428
B4034 to B9999	Y0021 to Y0024
E0100 to E8002	Y0499, Y0500, Y2010 to Y2083
K0001 to K0898	
L0100 to L9999	Y2271, Y2845, Y4211
Q0036, Q0040, Q0046	Y9039 to Y9049
S5517, S5518, S5520, S5521	Y9101 to Y9190
T4521 to T5999	Z7038

Numerator: Services X 1,000
 Services = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Deliveries – Reporting Only

This measure calculates the rate of deliveries per 1,000 member months.

Codes to Identify Deliveries	
ICD-9 Procedure codes	ICD-9 CM Diagnosis codes
72.x Forceps, vacuum, and breech delivery	V24.0 – Postpartum care and examination immediately after delivery
	V27.x – Outcome of Delivery
73.51 Manual rotation of fetal head	<i>Except for code 650, the following codes must have a 5th digit equal to 1 or 2 to be included:</i>
73.59 Other manually assisted delivery	
73.8 Operations on fetus to facilitate delivery	
73.9 Other operations assisting delivery	640-649 Complications mainly related to pregnancy
74.x Cesarean section and removal of fetus	650-659 Normal delivery and other indications for care in pregnancy, labor and delivery
CPT	
59400-59410 Vaginal Delivery, Antepartum and Postpartum Care	660-669 Complications occurring mainly during the course of labor and delivery
59510-59515 Cesarean Delivery	
59610-59622 Delivery after Previous Cesarean Delivery	670-676 Complications of the puerperium
ICD-10 Procedure Codes*	
10D07Z3-10D07Z8, 10D00Z0-10D00Z2, 10E0XZZ Products of Conception	
<i>*Only ICD-10 Procedure Codes will be used when calculating this measure, because they trigger delivery kick payments.</i>	

Numerator: Deliveries X 1,000

Deliveries = encounters unduplicated by managed care plan, recipient ID and date of service

Denominator: Member Months of Females

Data Source: Institutional and non-institutional encounters

Incomplete Rendering Provider Data

Measure: The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in MITS.*

Dates: Date of Service on the line-level procedure, in the measurement period described in Appendix L of the Medicaid Managed Care Provider Agreement.

Numerator: The number of line-level procedures in the denominator that do not have individual-level Medicaid and/or Reporting provider numbers as identified in MITS associated with an NPI as submitted on the encounter.

In order to be identified in MITS, a Provider NPI must match an NPI found in MITS' Provider Master File. Each managed care plan should ensure that rendering provider NPIs being submitted to MITS are in the Provider Master File. Managed care plans are encouraged to work with providers and with ODM's Provider Enrollment area to ensure accurate provider enrollment information in MITS.

Denominator: The number of line-level procedures reported on professional 837 EDI transactions and accepted in MITS, excluding the following categories of procedures:

-Anesthesia CPT codes within the range:

-00100-01999

-Radiology CPT codes within the range:

-70010-79999

-Pathology and Laboratory CPT codes within the range:

-80047-89398; also 36415, 36416, 36420,36425

-Laboratory HCPCPs codes that begin with S or Q; also 99001, G0103, G0123, G0431, G0434, P9604, G6030-G6058, G0477-G0438

All provider types are included in the denominator, even those for which a Rendering Provider NPI is not required to be submitted. If a Rendering Provider NPI is blank upon submission of an encounter to MITS, then as described in the process below, MITS will populate the Billing Provider NPI as the Rendering Provider NPI. If the Billing Provider NPI matches an NPI in MITS Provider Master File, then the Rendering Provider NPI will be considered in compliance for this measure.

*Rendering Provider Information: Rendering provider information may be provided on an encounter at either the claim- or the line-level; or the encounter may be submitted with only one provider in the billing provider data element. The rendering provider information retained by ODM will be as follows:

1. If the rendering provider is submitted on the encounter at the line-level, the line-level rendering provider information is retained;

2. If the rendering provider is only submitted at the claim-level or partially on the line-level, the claim-level rendering provider information is retained for any line item without a rendering provider;
3. If only the billing provider is submitted at the claim-level, without any rendering provider, the claim-level billing provider information is retained for all of the line items.

Data Source: Encounter Data

NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers

Measure: The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data fields that do not have a Medicaid or Reporting Provider Number in MITS.

For this measure, an individual encounter/claim is considered an EDI transaction.

Dates: Date of Service on the encounter/claim at the header level, in the measurement period described in Appendix L of the Medicaid Managed Care Provider Agreement.

Numerator: The number of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions submitted and accepted in MITS where the NPI submitted on the encounter is not associated with a Medicaid or Reporting Provider Number in MITS.

Denominator: The number of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions submitted and accepted in MITS with dates of service during the quarter.

In order to be identified in MITS, a Provider NPI must match an NPI found in MITS' Provider Master File. Each managed care plan should ensure that billing provider NPIs being submitted to MITS are in the Provider Master File. Managed care plans are encouraged to work with providers and with ODM's Provider Enrollment area to ensure accurate provider enrollment information in MITS.

Data Source: Encounter Data

Rejected Encounters (Measure 1 and Measure 2)

The percentage of encounters submitted to ODM that are rejected.

Measure 1 (only applies to MCPs that have had Medicaid membership for more than one year):

Numerator: The number of encounters that are rejected (meet a Threshold error). A separate numerator will be calculated for each of the following file types: EDI 837 I, EDI 837 P, EDI 837 D, and NCPDP D.O.

Denominator: The number of submitted encounters in MITS (including those with a Paid, Threshold, and Informational status). A separate denominator will be calculated for each of the following file types: EDI 837 I, EDI 837 P, EDI 837 D, and NCPDP D.O.

Data Source: Encounter Data

Compliance with this requirement will be measured and compared to the standard set in Appendix L of the most current Medicaid Managed Care provider agreement. For MCPs that do not meet the standard, compliance will be taken as described in Appendix N of the agreement.

Measure 2 (only applies to MCPs that have had Medicaid membership for one year or less):

For MCPs with less than one year of operation within the program, results are calculated and performance is monitored monthly. The report period varies depending on when the MCP began participation. The first reporting month begins with the third month of enrollment. The report period only extends throughout the MCP's first year of operation within the program. Measure 2 will not be calculated for SFY 2017.

Encounter Data Accuracy Study

Purpose of Studies:

The purpose of this study is to assess the accuracy and completeness of payment and provider data submitted on the encounter claims. The study will compare payment and provider data stored in the MCPs' claim systems with payment data submitted to and accepted by ODM.

Methods:

The studies will be conducted by the External Quality Review Organization during contract year 2016. The methods will be developed once the studies are initiated and the draft methods will be shared with the MCPs to obtain comment and input.

Measure will be calculated per MCP and include all members serviced by the MCP.