The Ohio Department of Medicaid’s Methodology for MyCare Ohio Encounter Data Quality Measures

Provider Agreement Effective July 1, 2019 through June 30, 2020

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Purpose

The purpose of the encounter data volume measures is to monitor each MCOP’s encounter data submissions, 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 cost report service classification logic from ODM’s Actuary (per Q2 2019 data dictionary logic). All volume measures are calculated at either the detail or header level, according to the methodology.

Measure Specification

Numerator: Count of unique patient visits/admissions/scripts by MyCare Plan, Medicaid recipient ID, and by Date of Service for each Category of Services (e.g. outpatient, inpatient, dental) and Program Types (i.e. Medicaid & Medicare). Only non-duplicative and last encounter claims are counted.

Denominator: Unique member count for each month of eligibility by MyCare Plan, Medicaid recipient ID, and by Date of Service for each Program Types.

Data Source: Medicaid Informational Technology System (MITS)

Encounter Data Quality Volume Approaches

The MyCare of Ohio measure is an Ohio specific data quality measure and therefore, does not have applicable national benchmarks to assist standard setting. The performance target is set based on Ohio program experience and expectations. Each MCOP will have its own minimum performance standard that is distinct from each of the other plans for each category of service. The minimum performance standard for each MCOP for each category of service is based on a weighted formula derived from that MCOP’s rates for a duration of six quarters, using a multiplicative factor of the weighted formula to set a MCOP specific standard for that category of service. This approach takes into consideration the MCOP performance baseline and potential seasonal effects, as well as allowing for differences between MCOP’s in enrollment size and business strategy.

Inpatient Hospital

This measure calculates the utilization rate for general/acute inpatient services: the number of admissions per 1,000 member months.
<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medicaid</td>
<td></td>
</tr>
<tr>
<td>COS15</td>
<td>Inpatient — Hospital</td>
<td>All CLAIM_TYPE = I OR (CLAIM_TYPE = L AND NOT BILL_PRVDR_TYPE = 86)</td>
<td>Admits per 1,000 MM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare – Informational Only</td>
<td></td>
</tr>
<tr>
<td>COS01</td>
<td>Inpatient — Hospital</td>
<td>All CLAIM_TYPE = I OR (CLAIM_TYPE = L AND NOT BILL_PRVDR_TYPE = 86)</td>
<td>Admits per 1,000 MM</td>
</tr>
</tbody>
</table>

**Numerator:** Admissions X 1,000

Admissions = 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.

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.

<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>COS22</td>
<td>Behavioral Health</td>
<td>CLAIM_TYPE = M AND (BILL_PRVDR_TYPE = 84,95 OR Proc = 90785, 90791-90792, 90801-90899, 96101-96120, G0396-G0397, G0409-G0411, H0001–H0044, H0046-H2037, T1016, Z0802–Z0819)</td>
<td>Visits per 1,000 MM</td>
</tr>
<tr>
<td>COS08</td>
<td>Behavioral Health</td>
<td>CLAIM_TYPE = M AND (BILL_PRVDR_TYPE = 84,95 OR Proc = 90785, 90791-90792, 90801-90899, 96101-96120, G0396-G0397, G0409-G0411, H0001–H0044, H0046-H2037, T1016, Z0802–Z0819)</td>
<td>Visits per 1,000 MM</td>
</tr>
</tbody>
</table>

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.*

<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>COS26</td>
<td>Dental</td>
<td>(CLAIM_TYPE = D) OR (CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = DXXX)</td>
<td>Visits per 1,000 MM</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAID</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COS21</strong></td>
<td>Vision</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 92002–92499, V0000–V2629, V2786-V2799, W2004–W2014, W2048, S0500-S0596</td>
<td>Visits per 1,000 MM</td>
</tr>
<tr>
<td><strong>MEDICARE – INFORMATIONAL ONLY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COS07</strong></td>
<td>Vision</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 92002–92499, V0000–V2629, V2786-V2799, W2004–W2014, W2048, S0500-S0596</td>
<td>Visits per 1,000 MM</td>
</tr>
</tbody>
</table>

**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.*

<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>COS29</td>
<td>Pharmacy</td>
<td>CLAIM_TYPE = P</td>
<td>Scripts per 1,000 MM</td>
</tr>
</tbody>
</table>

**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
MyCare Ohio Waiver Services
This measure calculates the MyCare Ohio Waiver Services utilization rate per 1,000 member months.

<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>COS31</td>
<td>Personal Care/ Home Care Attendant</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = S5125, S5130, S5135, T1019</td>
<td>Services per 1,000 MM</td>
</tr>
<tr>
<td>COS32</td>
<td>Home Delivered Meals</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = S5170</td>
<td>Services per 1,000 MM</td>
</tr>
<tr>
<td>COS33</td>
<td>Assisted Living</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = T2031</td>
<td>Services per 1,000 MM</td>
</tr>
<tr>
<td>COS34</td>
<td>Adult Day Care</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = A0080, A0090, S5100–S5102, T2003</td>
<td>Services per 1,000 MM</td>
</tr>
<tr>
<td>COS36</td>
<td>Nursing Services (RN, LPN, &amp; LVN)</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = T1002–T1003</td>
<td>Services per 1,000 MM</td>
</tr>
<tr>
<td>COS37</td>
<td>Waiver Transportation</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = A0100, A0200, S0215</td>
<td>Services per 1,000 MM</td>
</tr>
<tr>
<td>COS38</td>
<td>Personal Emergency Response Systems</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = S5160–S5162</td>
<td>Services per 1,000 MM</td>
</tr>
<tr>
<td>COS39</td>
<td>Assistive Equipment / Home Modification</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = S5165, T2029, T1999</td>
<td>Services per 1,000 MM</td>
</tr>
<tr>
<td>COS40</td>
<td>Other Waiver Services</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = G0155, H0045, S5121, S9470, T2025, T2038</td>
<td>Services per 1,000 MM</td>
</tr>
</tbody>
</table>

**Numerator:** Services X 1,000

Services = encounters unduplicated by recipient ID and date of service

**Denominator:** Member Months

**Data Source:** Non-institutional encounters
Home Health
*This measure calculates the home health utilization rate per 1,000 member months.*

<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
</table>

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

**Denominator:** All MyCare Member Months for the Medicaid Encounter Rate

**Data Source:** Non-institutional encounters
Long Term Care (LTC)

This measure calculates the LTC utilization rate: long term care stays per 1,000 member months.

<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COS17</td>
<td>Nursing Facility Per Diem</td>
<td>(CLAIM_TYPE = L AND BILL_PRVDR_TYPE = 86) AND (Rev_Cd = 0101, 0110, 0120, 0130, 0140, 0150, 0160, 0169, 0170, 0180, 0183, 0185, 0189, 0190, 0220, 0658)</td>
<td>Visits per 1,000 MM</td>
</tr>
<tr>
<td>Medicare – Informational Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COS03</td>
<td>Nursing Facility Per Diem</td>
<td>(CLAIM_TYPE = L AND BILL_PRVDR_TYPE = 86) AND (Rev_Cd = 0101, 0110, 0120, 0130, 0140, 0150, 0160, 0169, 0170, 0180, 0183, 0185, 0189, 0190, 0220, 0658)</td>
<td>Visits per 1,000 MM</td>
</tr>
<tr>
<td>COS04</td>
<td>Nursing Facility Other</td>
<td>(CLAIM_TYPE = L AND BILL_PRVDR_TYPE = 86) AND NOT (Rev_Cd = 0101, 0110, 0120, 0130, 0140, 0150, 0160, 0169, 0170, 0180, 0183, 0185, 0189, 0190, 0220, 0658)</td>
<td>Visits per 1,000 MM</td>
</tr>
<tr>
<td>COS05</td>
<td>Hospice Room and Board</td>
<td>CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = T2046</td>
<td>Visits per 1,000 MM</td>
</tr>
</tbody>
</table>

**Numerator:** Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

**Denominator:** All MyCare Member Months for the Medicaid Encounter Rate
Opt-In Member Months for the Medicare Encounter Rate

**Data Source:** Institutional encounters
Outpatient

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

<table>
<thead>
<tr>
<th>COS ID</th>
<th>COS Description</th>
<th>Service Classification Logic</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>COS16</td>
<td>Outpatient - Hospital</td>
<td>All CLAIM_TYPE = O AND NOT Rev_Cd=976–979, 983, 985–986</td>
<td>Visits per 1,000 MM</td>
</tr>
</tbody>
</table>

Medicare – Informational Only

| COS02  | Outpatient - Hospital         | All CLAIM_TYPE = O AND NOT Rev_Cd=976–979, 983, 985–986                                                                 | Visits per 1,000 MM       |

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
Notes:

[1] Units should be reported for each program in which a claim is paid. A claim is considered ""crossover"" if one of the following occurs, otherwise the claim is considered ""non-crossover"":

1) The claim is classified as Nursing Facility or Inpatient Hospital and the Medicare paid amount associated with the claim is nonzero; or

2) There is a nonzero Medicare allowed amount associated with the claim.

[2] CLAIM_TYPE = I shall be applied to claims submitted on the 837-I file with facility type codes (CLM05-1) equal to 011X or 012X.

[3] CLAIM_TYPE = L shall be applied to claims submitted on the 837-I file with facility type codes (CLM05-1) equal to 021X-029X, 051X-059X, or 061X-069X.

[4] CLAIM_TYPE = O shall be applied to claims submitted on the 837-I file with facility type codes (CLM05-1) equal to 013X-019X, 031X-039X, 041X-049X, 071X-079X, 081X-089X, or 091X-099X.


[7] CLAIM_TYPE = P shall be applied to claims submitted on the NCPDP file.
NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers

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 MyCare of Ohio 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
Incomplete Billing Provider Data

Data Source: Encounter Data

Incomplete Billing Provider Data

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 MyCare of Ohio 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