

SOONER EXCEL

Methodology Effective January 1, 2009

Quarterly incentive payments are based on claims with dates of service during each quarter that are paid within 90 days following the end of the quarter. For all incentives except the EPSDT screening incentive, the first payment will be made in April of 2009 based on claims with dates of service between October 1, 2008 and December 31, 2008 with paid dates through March 31, 2009. For EPSDT screenings, the first payment will be made in July 2009 based on dates of service between January 1, 2009 and March 31, 2009 with paid dates through June 30, 2009.

For SoonerExcel purposes, each service location is considered a unique PCP.

Inpatient Admitting and Visits

Summary

The inpatient admitting and visits incentive consists of two levels with a total pool of approximately \$850,000. The amount available per quarter is \$212,500. The incentive's purpose is to compensate PCPs who admit and visit their panel members while in an inpatient setting.

Criteria

Level I: All PCP's that admit and visit members in an inpatient setting (procedure codes 99221 – 99239) will receive up to an additional 25% of the rate for the procedure code according to the current fee schedule (unenanced). This percent increase is contingent on available funds and may be less.

Level II: An inpatient visiting and admitting average percent for all PCP's will be computed by dividing the total number of inpatient admits and visits provided to panel members by their PCPs by the total number of all inpatient admits and visit provided to panel members of all PCPs . To qualify for an incentive payment , an individual PCP's inpatient visiting and admitting percent must be above the average for all PCP's or above 20%; whichever is lower. All providers that qualify receive an additional \$20 per inpatient admit/visit. This additional amount is contingent on available funds and may be less.

Example Calculation

Level I Example1

Inpt Admit/Visit Proc Code	# of Inpt Svcs Performed	Medicaid Allowable	25% Incentive Amount	Total Amount
99222	8	111.00	27.75	222.00
99231	2	33.57	8.39	16.79
99238	5	60.89	15.22	76.11
Total Level I Incentive Payment				\$314.90

Example Calculation (cont'd)***Level II Example 1***

Inpatient Visit/Admit Percentage for all PCP's	Total number of Inpatient Admits/Visits to PCP Panel Member's	Number that were Performed by PCP	Provider's Inpatient Visit/Admit Percent	Does PCP Qualify for Incentive	Level II Incentive Amount
16%	30	10	33%	YES	\$200.00

Total Inpatient Admitting Incentive Payment: \$514.90

Level I Example 2

Inpt Admit/Visit Proc Code	# of Inpt Srvcs Performed	Medicaid Allowable	25% Incentive Amount	Total Amount
99222	14	111.00	27.75	388.50
99231	2	33.57	8.39	16.79
99238	1	60.89	15.22	15.22

Total Level I Incentive Payment

\$420.51

Level II Example 2

Average PCP Percent Visit/Admit for all PCP's	Total number of Inpatient Admits/Visits to PCP Panel Member's	Number that were Performed by PCP	Providers Percent	Does PCP Qualify for Incentive	Level II Incentive Amount
16%	17	2	12%	NO	-

Total Inpatient Admitting Incentive Payment: \$420.51

Breast and Cervical Cancer Screening Incentives**Summary**

The Breast and Cervical Cancer screening incentives' purpose is to incentivize PCPs to perform and recommend appropriate breast and cervical cancer screening services. Additional payment is made to PCPs who meet or exceed expectations for screens.

Criteria

Payment is based on screens performed on members of the PCP’s panel, regardless of whether or not the PCP performs the screen. Each PCP currently receives an OHCA Provider Profile which rates his or her performance as “More Tests Than Expected”, “No Significant Difference” and “Fewer Tests Than Expected” based on the number of screens received by members of the PCP’s panel, member characteristics and recommended screening frequency.

A “relative number of screens” is calculated by multiplying the actual number of screens by a factor determined in the following manner:

- Providers with “More Tests Than Expected” on his or her most recent Provider Profile receive a relative screen count of double their actual screens.
- Providers with “No Significant Difference” receive a relative screen count of one and one half times their actual screens.
- Providers with “Fewer Tests Than Expected” receive a relative screen count equal to their actual screens performed.

A percentage of relative tests performed is calculated for each PCP by dividing the number of relative screens performed on the PCP’s members by the total number of relative screens performed on all Choice members. This percentage is multiplied by the total dollar amount available for the quarter for each particular measure, breast or cervical cancer screening.

Panel Eligibility

Members must be enrolled with the provider during the quarter for which the incentive is calculated. Screens are only counted for members while they are enrolled in the provider’s panel.

Claims – Breast Cancer Screenings

To identify breast cancer screenings the most recent HEDIS specifications are used:

Procedure Codes	76090, 76091, 76092, 76083, 77055-77057
Revenue Codes	401
ICD9 Procedure Codes	87.36, 87.37
Diagnosis Codes	V76.11, V76.12

Screens are counted only for members who are 40 years of age or older.

Claims – Cervical Cancer Screenings

To identify cervical cancer screenings the most recent HEDIS specifications are used:

Procedure Codes	88141, 88142, 88143, 88147, 88148, 88150, 88152, 88153, 88154, 88155, 88164, 88165, 88166, 88167, 88174, 88175
Revenue Code	923
ICD9 Procedure Code	91.46
Diagnosis Codes	V76.2, V72.32

Screens are counted only for members that are 18 years of age or older.

Breast & Cervical Cancer Screening Quarterly Payment Example

The allotment for these measures is \$350,000 annually or \$87,500 quarterly. For this example, the quarterly funds are divided up with Breast Cancer Screenings receiving \$13,125 and Cervical Cancer Screenings receiving \$74,375.

The example shows providers with comparable screen volumes, but different provider profile ratings. An amount per screen performed is shown for information purposes.

Breast Cancer Screens Performed	Provider Profile Rating	Profile Factor	Relative Screens Performed	PCP's % of Relative Screens Performed	Amount Paid	Amount Per Screen
5	No Significant Difference	1.5	7.5	0.54%	\$70.88	\$14.18
5	More tests than expected	2	10	0.72%	\$94.50	\$18.90
5	Fewer tests than expected	1	5	0.36%	\$47.25	\$9.45
42	More tests than expected	2	84	6.02%	\$790.13	\$18.81
35	No Significant Difference	1.5	52.5	3.76%	\$493.50	\$14.10

Cervical Cancer Screens Performed	Provider Profile Rating	Profile Factor	Relative Tests Performed	PCP's % of Relative Tests Performed	Amount Paid	Amount Per Exam
97	No Significant Difference	1.5	145.5	1.75%	\$1,301.56	\$13.42
92	More tests than expected	2	184	2.21%	\$1,643.69	\$17.87
12	Fewer tests than expected	1	12	0.14%	\$104.13	\$8.68
12	No Significant Difference	1.5	18	0.22%	\$163.63	\$13.64
12	More tests than expected	2	24	0.29%	\$215.69	\$17.97

Emergency Department Utilization

Summary

The Emergency Department (ED) utilization incentive's purpose is to incentivize PCP's to educate panel members about proper ED usage. Additional payment is made to PCPs that meet or exceed the ED utilization compliance rate.

Criteria

PCPs are paid a per member per month rate for the relative member months in his or her panel. The relative member months are calculated by multiplying the actual panel member months by a factor determined as follows:

- Providers with observed-to-expected (O/E) ratios of member ED visits and office visits below the lower end of the historical 95% confidence interval will have their actual panel member months count twice. (Highest level of compliance)

- Providers with O/E ratios above the upper end of the historical 95% confidence interval will have their actual panel member months count once. (Lowest level of compliance)
- All other providers will have their actual panel member months count one and a half times. (Moderate level of compliance)

Payment to each PCP is calculated by multiplying the percentage of relative member months in a provider's panel out of all relative member months by the funds available for the quarter.

Panel Eligibility

For ED utilization, the base payment is determined by the consistent SoonerCare Choice memberships from the provider's panel. These are the members that are most likely to be affected with proper education about emergency room practices. Members must be enrolled with the PCP in the quarter for which the incentive is being calculated and the previous quarter a combined total of at least 4 months.

Claims

ED claims are SoonerCare Choice physician fee-for-service claims with procedure codes between 99281 and 99285. Office visit (OV) claims are SoonerCare Choice encounters on PCP claims only. The claim status must be different than "denied". Only claims with a first date of service in the quarter for which the incentive is being calculated are included in the calculations.

Risk Adjustment

Provider panels are risk adjusted using the John Hopkins University Adjusted Clinical Group (ACG) Case-Mix System. SoonerCare Choice members are designated a categorical ACG score by the John Hopkins University ACG Case-Mix System based on the claim history and characteristics of the members. Although there are over 100 categories available, members will only fall into one category. Hence, qualifying members on the PCP panel are categorized by the ACG score. ACG values are updated semi-annually. The ACG Specific ED rate is calculated for each ACG value by dividing the number of ED visits by all members in that ACG category by the number of all visits (ED and OV) by members in that category.

<i>ACG Rates for Selected ACG Scores</i>			
<i>ACG Score</i>	<i>Office Visit Count</i>	<i>ED Visit Count</i>	<i>ACG Specific ED Rate</i>
0100	3962	637	0.1385
0200	8766	2638	0.2313
0300	9737	3606	0.2702
...

A PCP's expected ED rate is the sum of the expected ACG specific ED rates of each member in his or her panel that had either an ED visit or an OV visit in the quarter for which the incentive is being calculated divided by the same count of members. In the example below, the provider will have an expected ED rate of $.1853 = (0.9268/5)$.

Provider ABC's Expected ED Rate				
Provider	Client ID	ACG Score	ACG Specific ED Rate	Provider ED Rate
ABC	Member 1	4910	0.2039	---
ABC	Member 2	2900	0.2321	---
ABC	Member 3	0100	0.1385	---
ABC	Member 4	1900	0.1773	---
ABC	Member 5	4220	0.1750	---
TOTALS	5		0.9268	.1853

Actual Visits by Provider ABC's Clients			
Client ID	Office Visit Count	ED Visit Count	All Visits
Member 1	4	2	6
Member 2	5	0	5
Member 3	0	1	1
Member 4	9	1	10
Member 5	1	0	1
TOTALS	19	4	23

A provider's observed ED rate is the sum of the actual observed ED visits by members in his or her panel that had any type of visit in the period divided by the total visits (ED and OV). In this example, the observed ED rate is $.1739 = (4/23)$.

The O/E ratio is the observed ED rate divided by the expected ED rate.

Provider ABC's O/E Ratio		
Expected ED rate	Observed ED rate	O/E Ratio
<i>.1853</i>	<i>.1739</i>	<i>.9385</i>

ED Utilization Quarterly Payment Example

The allotment for this measure is \$500,000 annually or \$125,000 quarterly.

The example shows providers with comparable member months, but different performance measures. In this example, O/E ratios less than 1.05 receive a factor of 2 and O/E ratios greater than 1.17 receive a factor of 1. O/E ratios between 1.05 and 1.17 receive a factor of 1.5. The payment per member month is shown for illustrative purposes.

Observed ED Visit Rate	Expected ED Visit Rate	O/E Ratio	Actual Member Months	Factor	Relative Member Month Count	PCP's % of Relative Member Months	Quarterly Payment	Payment per Member Month
0.20747906	0.2261484	0.9174465	23,150	2	46,300.00	0.0369656	\$4,620.67	\$0.20
0.33538251	0.2724188	1.2311284	18,178	1	18,178.00	0.0145132	\$1,814.14	\$0.10
0.29776446	0.2687024	1.108157	13,653	1.5	20,479.50	0.0163507	\$2,043.82	\$0.15
0.24612403	0.269446	0.9134448	1,419	2	2,838.00	0.0022658	\$283.23	\$0.20
0.38378378	0.2367489	1.6210586	1,401	1	1,401.00	0.0011185	\$139.82	\$0.10
0.34080717	0.3084303	1.1049732	1,371	1.5	2,056.50	0.0016419	\$205.24	\$0.15

EPSDT Screenings

Summary

The EPSDT incentive's purpose is to incentivize PCP's to perform more initial and periodic screening services. PCPs receive payment for meeting or exceeding the compliance rate for screenings. The EPSDT incentive will consist of a total pool of \$1,000,000 annually or \$250,000 quarterly for all PCPs.

Criteria

All PCPs that meet or exceed the specified EPSDT compliance rate of 65% for medical home members for each age group receive an incentive payment of up to 25% of the rate for the age appropriate procedure code (listed in the table below) according to the current fee schedule (unenhanced). This percent increase is contingent on available funds and may be less. The PCP's compliance rate is calculated dividing the actual number of screens performed by the expected number of screens for the PCP's panel members. The expected number of screens is determined by the state periodicity schedule and is adjusted for the ages of panel members and months of eligibility.

EPSDT Procedure Codes

<i>Procedure Codes</i>	99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99431, 99432
<i>Or</i>	
<i>Procedure Codes and required accompanying Diagnosis Codes</i>	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215
	V20,V200,V201,V202,V700,V703,V704,V705,V706,V7

	07, V708,V709
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Example Calculation**Table 1: EPSDT Bonus Payment per Screen**

Proc Code Description	Age Group	Medicaid Allowable	Bonus % Rate	Bonus Amount
EPSDT Blended Rate	< 1	\$ 67.14	@ 25%	\$ 16.78
EPSDT Blended Rate	1-5	\$ 76.96	@ 25%	\$ 19.24
EPSDT Blended Rate	6-14	\$ 78.36	@ 25%	\$ 19.59
EPSDT Blended Rate	15-20	\$ 86.35	@ 25%	\$ 21.59

Compliance Rate Determination Example

The total unduplicated number of all individuals under the age of 21 determined to be eligible for EPSDT services is listed, distributed by age and by basis of Medicaid eligibility. The number of required screens per age group is specified according to the state's periodicity schedule and the number of years in the age group is determined by the age group.

Compliance Rate Calculations (based on CMS-416 -methodology)	< 1	1	2-5	6-14	15-20
Total Individuals Eligible for EPSDT	212	181	486	796	87
Number of Required Screens	6	2	4	5	3
Number of Years in Age Group	1	1	4	9	6

Divide the number of required screens by the number of years in age group to calculate the number of expected screens in one year.

Number of Expected Screen in One	6	2	1	0.5	0.5
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Year					
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Total eligible months is the number of months of eligibility for the total individuals eligible for EPSDT.

Total Eligible Months	892	670	2693	4938	472
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Divide the total eligible months by the total individuals eligible for EPSDT and then divide by 12 to calculate the average period of eligibility.

Average Period of Eligibility	0.35	0.31	0.46	0.52	0.45
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Multiply the number of expected screens in one year by the average period of eligibility to calculate expected number of screens per eligible.

Expected Number of Screens Per Eligible	2.10	0.52	0.46	0.26	0.23
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Multiply total individuals eligible for EPSDT by expected number of screens per eligible to calculate expected number of screens per group.

Expected Number of Screens Per Group	446	112	224	206	20
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Total screens received is the total number of initial or periodic screens furnished to eligible individuals.

Total Screens Received	291	109	200	175	2
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Divide the total screens received by the expected number of screens per group to calculate the screening ratio. The screening ratio is then compared to the OHCA required compliance rate.

<i>Screening Ratio</i>	.65	.97	.89	.85	.10
OHCA Required Compliance Rate	.65	.65	.65	.65	.65

The complete table is shown below.

Compliance Rate Calculations (based on CMS-416 -methodology)	< 1	1	2-5	6-14	15-20
Total Individuals Eligible for EPSDT	212	181	486	796	87
Number of Required Screens	6	2	4	5	3
Number of Years in Age Group	1	1	4	9	6
Number of Expected Screen in One Year	6	2	1	0.5	0.5
Total Eligible Months	892	670	2693	4938	472
Average Period of Eligibility	0.35	0.31	0.46	0.52	0.45
Expected Number of Screens Per Eligible	2.10	0.52	0.46	0.26	0.23
Expected Number of Screens Per Group	446	112	224	206	20

Total Screens Received	291	109	200	175	2
Screening Ratio	.65	.97	.89	.85	.10
OHCA Required Compliance Rate	.65	.65	.65	.65	.65

Bonus Payment Determination Example

The difference between the screening ratio and the OHCA required compliance rate is listed to determine % above compliance per age group.

Bonus Payment Calculations	< 1	1	2-5	6-14	15-20
% Above Compliance	0	.32	.24	.20	(.55)

The number of EPSDT screens is the total number of initial or periodic screens furnished to eligible individuals and is **ONLY** listed if screening ratio is at or above OHCA required compliance rate. If provider is below the required compliance rate enter 0.

Number of EPSDT Screens from Line 6	291	109	200	175	-
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The bonus payment per screen is a fixed number to be determined by the OHCA and is based on a percent of the actual cost of an EPSDT screen per age group (see Table 1 above for example).

Bonus Payment Per Screen	\$16.78	\$19.24	\$19.24	\$19.59	\$21.59
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Multiply number of EPSDT screens by bonus payment per screen to calculate bonus payment per age group.

Bonus Payment Amount Per Age Group	\$4,883	\$2,097	\$3,848	\$3,428	\$0
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Sum the bonus payments per age group to calculate total EPSDT bonus payment.

Total EPSDT Bonus Payment	\$14,256				
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The complete table is shown below.

Bonus Payment Calculations	< 1	1	2-5	6-14	15-20
% Above Compliance	0	.32	.24	.20	(.55)
Number of EPSDT Screens from Line 6	291	109	200	175	-
Bonus Payment Per Screen	\$16.78	\$19.24	\$19.24	\$19.59	\$21.59
Bonus Payment Amount Per Age Group	\$4,883	\$2,097	\$3,848	\$3,428	\$0
Total Potential Bonus Payment	\$14,256				

4th DTaP Screenings

Summary

The 4th DTaP incentive's purpose is to improve the health of our children by promoting immunization prior to the second birthday. The 4th DTaP incentive will consist of a total pool of \$50,000 for all PCP's annually, or \$12,500 per quarter.

Criteria

All PCP's that immunize a child with the 4th DTaP prior to age 2, file a claim for the service and the claim is in a paid status will be eligible to receive \$3.00 per child. The payment amount is based on available funds and may be less.

4th DTaP Procedure Codes

Procedure Codes	90700, 90471, 90742
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Oklahoma State Department Health (OSDH) will send quarterly Oklahoma State Immunization Information System (OSIIS) data related to the SoonerCare children who received the fourth DTaP immunizations before turning two years old. OHCA will pull claims data for the same quarter. The following criteria will be used to match data to evaluate the number of children with paid claims for the fourth DTaP.

SoonerCare ID Match

or

SSN Match

or

First 3 characters of the last name match

and

First 2 characters of the first name match

and

Date of Birth match

And

Gender match

OHCA will determine if the child was immunized before the age of two and if the PCP/medical home rendered the service.