Webinar 7:
Attribution Patient Roster Layout

New Jersey Department of Health (NJDOH)

Delivery System Reform
Incentive Payment (DSRIP) Program

Training Session Objectives

- ✓ To review key performance measurement requirements
- ✓ To review the final attribution model
- ✓ To review the attribution patient roster layout
- ✓ To discuss next steps and timelines

Key DY3 Deliverable Timelines

Demonstration Year	Performance Period Begin	Performance Period End	Attribution Period Begin	Attribution Period End	Claims Lag Period Begin	Claims Lag Period End	Report Due Date
Waiver Period	**July 1, 2014**	**June 30, 2015**					
Performance Period	**April 1, 2014**	**March 31, 2015**					
PROGRESS REPORTS							
DY3Q1 - CYQ2	April 1, 2014	June 30, 2014	NA	NA	NA	NA	July 31, 2014
DY3Q2 - CYQ3	July 1, 2014	September 20, 2014	NA	NA	NA	NA	October 31, 2014
DY3Q3 - CYQ4	October 1, 2014	December 31, 2014	NA	NA	NA	NA	**January 31, 2015**
DY3Q4 - CYQ1	January 1, 2015	March 31, 2015	NA	NA	NA	NA	**April 30, 2015**
STAGE 3 & 4 MEASURES							
MMIS Baselines & ITGs	January 1, 2013	December 31, 2013	January 1, 2012	December 31, 2013	January 1, 2014	March 31, 2014	
Data Reporting Plan							October 31, 2014
DY3SA (19 measures)	July 1, 2014	December 31, 2014	January 1, 2013	December 31, 2014	January 1, 2015	March 31, 2015	**April 30, 2015**
DY3A (63 measures)	January 1, 2014	December 31, 2014	January 1, 2013	December 31, 2014	January 1, 2015	March 31, 2015	**April 30, 2015**

Key Performance Measure Requirements

Stages Description	Payment Mechanism	DY3	DY4	DY5
Universal Performance Pool (UPP) Carve Out		10%	15%	25%
Stages 1 Project Activities – investments in technology, tools, and human resources Stage 2 Project Activities – piloting, testing, and replicating of chronic patient care models	Pay for Achievement	75%	50%	25%
Stage 3 Quality Improvements – clinical performance measures that measure the impact of Stage 1 and 2 activities; number of measures varies by project	Pay for Reporting	15%		
	Pay for Performance		35%	50%
Stage 4 Population Focused Improvements – clinical performance measures that include reporting performance on measures across domains of care;	Pay for Reporting	10%	15%	25%

Over the course of the waiver, greater amounts of incentive payments move to reporting and performance improvement.

Key Performance Measure Requirements

Universal Performance Pool (UPP): a portion of the DSRIP funds are carved out and allocated to a performance pool that all participating hospitals are eligible for.

The UPP also includes:

- Amounts allocated to hospitals opting out of the DSRIP program
- Unmet performance metric payments
- Appeal adjustments for appeals found in favor of the hospital

- ✓ Total of 12 UPP measures (4 substitution measures available)
- ✓ An Achievement Value of 1 will be awarded if the hospital maintains or improves baseline performance
- ✓ An Achievement Value of -0.5 will be assessed if the hospital regresses from baseline
- ✓ The hospital's Percentage Achievement Value will be weighted based on the hospital's percent of Low Income admissions to all statewide Low Income admissions from audited financial cost reports
- ✓ The result will be distributed as a percentage to total

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Key Performance Measure Requirements

- ✓ UPP Achievement = PAV*(Hospital's Low Income Admission Percentage to all Statewide Low Income Admissions) *UPP funds available

Example: $5M available for distribution	A	B = A/12	C	D = B * C	E = D/.61	F = E * 5M
	Total Achievement Value Score	**Percentage Achievement Value**	**Low Income Admission % ****	**Adjusted Total Score Adjusted by Low Income Admission %**	**Percent to Total**	**UPP Payment**
Hospital A	10.5	87.50%	9%	0.08	0.13	$649,485
Hospital B	7.5	62.50%	26%	0.16	0.27	$1,340,206
Hospital C	3	25.00%	22%	0.06	0.09	$453,608
Hospital D	10.5	87.50%	8%	0.07	0.12	$577,320
Hospital E	3	25.00%	9%	0.02	0.04	$185,567
Hospital F	10.5	87.50%	18%	0.16	0.26	$1,298,969
Hospital G	9	75.00%	8%	0.06	0.10	$494,845
Total			100%	0.61	1	$5,000,000

****Percentage of hospital's Low Income (Medicaid/CHIP/Charity Care) admissions to all statewide Low Income admissions.**

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Key Performance Measure Requirements

- ✓ DSRIP measurement is based on the New Jersey Low Income population. This includes Medicaid, CHIP (Children's Health Insurance Program), and Charity Care patients.
  - Inclusive of fee-for-service, managed care, and dually-eligible patients
  - DSRIP projects do not need to limit patients by coverage criteria, but measurement will.
  - All-payer data does not meet measure criteria.

- ✓ Performance measurement can be calculated using one, or a combination, of the following methodologies:
  - Administrative Claims Data - Medicaid Management Information System (MMIS) extracts
  - Medical Records - Electronic Health Records (EHR)
  - Medical Records - Direct Chart abstraction

Key Performance Measure Requirements

- ✓ Annually reported measures capture calendar year utilization (e.g. experience). Semi-annual measures capture six months of utilization based on the calendar year.
- ✓ All MMIS measurement results are calculated on the behalf of the hospital and will be made available to the hospitals via a log-in feature on the DSRIP website.
- ✓ All medical record reviews are completed by the hospital either through in-house staff or contracted chart abstraction vendors.

Key Performance Measure Requirements

- ✓ All Stage 3 and Inpatient Stage 4 Chart/ EHR measures are due to be reported as of **April 30, 2015** as described in the Databook.

- ✓ CMS has approved a one year deferral for all Outpatient Stage 4 Chart/ EHR measures. If however, the measure (Controlling High Blood Pressure) is reportable for your Stage 3 project, it is still due to be reported April 2015.

- ✓ All Stage 3 and Stage 4 Chart/ EHR measurement results are reportable by the Hospital via the Standard Reporting Workbook included in the Databook.

- ✓ The denominator for all Stage 3 and Stage 4 measures will be based on the **final retrospective attributed population** for the hospital.

Deferred Stage 4 Outpatient Measures

The following Stage 4 measures have been deferred. However, because DSRIP # 31 - Controlling High Blood Pressure is a required Stage 3 measure, it remains due April 2015 for those hospitals conducting these projects:

Project 6 – Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions
Project 7 – Extensive Patient CHF-Focused Multi-Therapeutic Model
Project 8 – The Congestive Heart Failure Transition Program (CHF-TP)
Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension
Project 12 – Diabetes Group Visits for Patients and Community Education

Data Source	DSRIP #	NQF #	Metric Name	Responsible Party	Steward	Setting of Care	Reporting Period	Experience Period	Baseline Period	Stage 3	Stage 4
Chart/EHR	30	Based on 0064	Comprehensive Diabetes Care: LDL-C Control <100mg/dL	Hospital/ DSRIP Network	NCQA	Outpatient	Annual; April	Calendar Year	CY 2015	NA	17
Chart/EHR	31	0018	Controlling High Blood Pressure (CBP)	Hospital/ DSRIP Network	NCQA	Outpatient	Annual; April	Calendar Year	Stage 3= CY 2014 Stage 4= CY 2015	6.2, 7.3, 8.3, **11.8, 12.6**	16
Chart/EHR	55	Based on 0075	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100mg/dL	Hospital/ DSRIP Network	NCQA	Outpatient	Annual; April	Calendar Year	CY 2015	6, 7, 8	18
Chart/EHR	56	0068	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	Hospital/ DSRIP Network	NCQA	Outpatient	Annual; April	Calendar Year	CY 2015	6, 7, 8	14
Chart/EHR	75	Not Found	Preventive Care and Screening: High Blood Pressure	Hospital/ DSRIP Network	CMS	Outpatient	Annual; April	Calendar Year	CY 2015	6, 7, 8	15
Chart/EHR	76	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Hospital/ DSRIP Network	AMA-PCPI	Outpatient	Annual; April	Calendar Year	CY 2015	6, 7, 8	19

Gap Reduction Formula

		Original 10% Gap Reduction Model	Incentive 8% Gap Reduction Model
Line 1	Improvement Target Goal ***(90th percentile)***	**69.60**	**69.60**
Line 2	Baseline	**42.10**	**42.10**
Line 3	Gap = Improvement Target Goal – Baseline *[Line 1 – Line 2]*	**27.50** (69.60 – 42.10)	**27.50** (69.60 – 42.10)
Line 4	Required reduction in the gap (10%) Incentive reduction (8%)	**0.10**	**0.08**
Line 5	Required reduction = Gap * Reduction % [*Line 3 * Line 4*]	**2.75** (27.50 * 0.10)	**2.20** (27.50 * 0.08)
Line 6	Expected Improvement Target *[Line 2 + Line 5]*	**44.85** (42.10 + 2.75)	**44.3** (42.10 + 2.20)
Line 7	Actual Performance Result	**50.21** ✓ Payment awarded	**44.5** ✓ Payment awarded

If an Improvement Target Goal (ITG) cannot be set, the hospital will have to achieve a simple ten percent rate of improvement over the hospital's baseline.

Performance Measure Requirements – Baseline Threshold

- **Baseline Performance Threshold –** It is the expectation that a hospital will select a project for which substantial need for improvement in the Focus Area is reflected;

  - For each Stage 3 P4P metric, a performance threshold will be established using baseline data to determine if substantial improvement is achievable.

  - the lower of 20 percentile points below the metric's high performance level (improvement target goal), based on New Jersey hospital's data, *or*

  - 20 percentile points below the 95th percentile of national performance data, if national data is available for the low income population

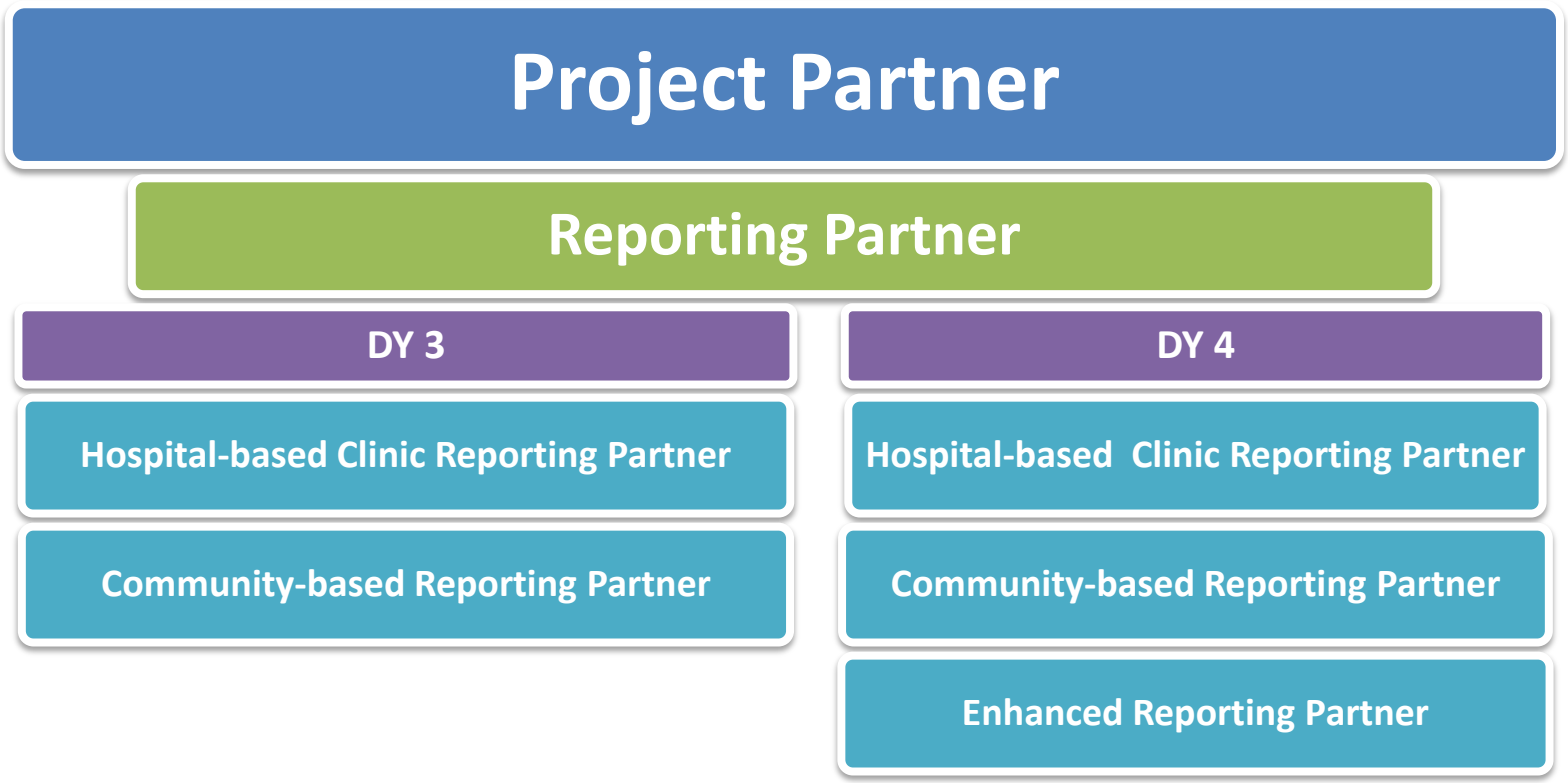
Example:
Improvement target goal = 90th percentile

Baseline performance threshold =
90th percentile – 20 percentile points = 70th percentile

Substitution Measures

- If a hospital's Stage 3 P4P baseline year performance exceeds the baseline performance threshold, the measure will be replaced by a substitution measure.
- Stage 3 Substitution measures are included in Addendum 1 - Stage 3 Measures Catalogue and marked as substitution measures.
- Refer to Planning Protocol pages 39-41 for further information regarding Stage 3 substitution requirements. Substitution measures are not required to be reported unless determined as such by the Department.
- UPP substitution measures for maternity and pediatric services have been determined based on your hospital's completion of your Data Reporting Plan. Stage 4 pay for reporting does not require substitution.

Project Partners versus Reporting Partners



Attribution Model - hierarchical, with 10% threshold

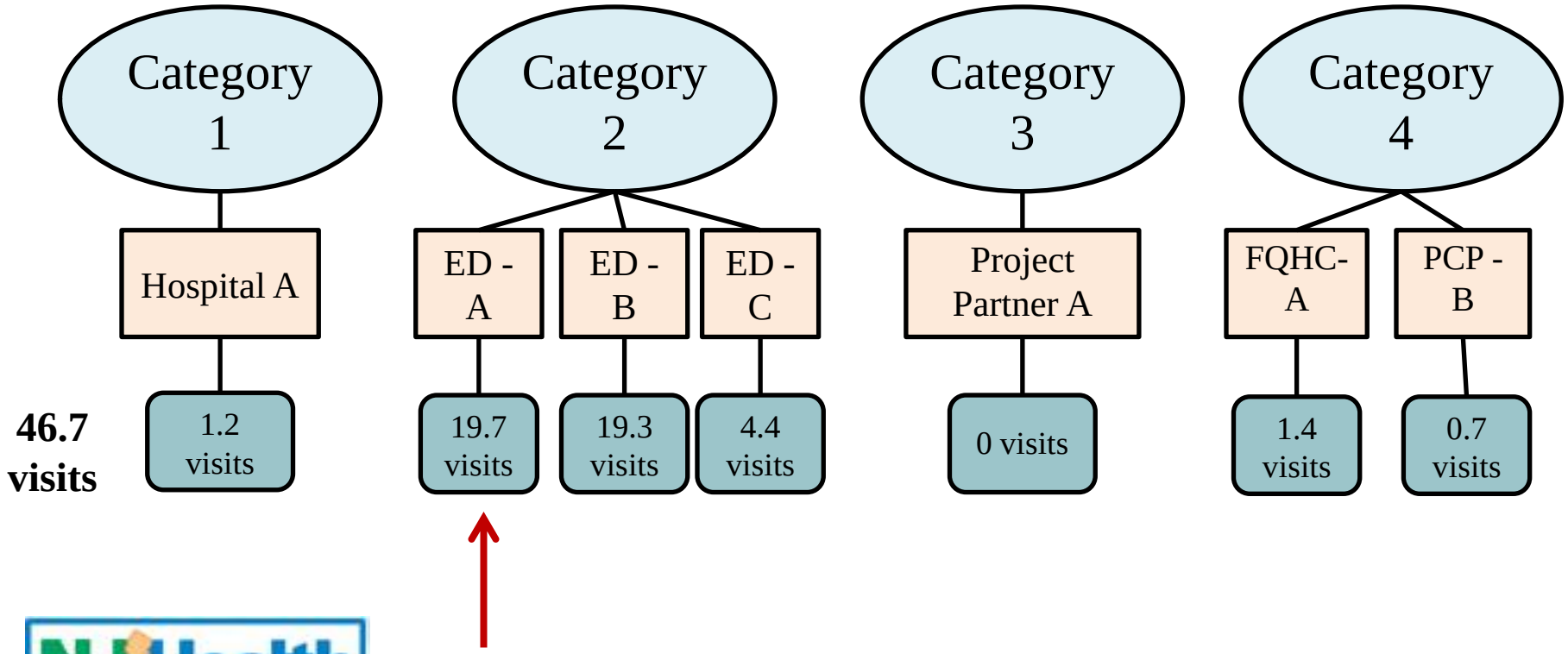
- ✓ Links patients to hospitals based on two years of a patient's utilization pattern identified through claims
- ✓ Based on Evaluation and Management Visits – code list is located in the Appendix B - Programming Assumptions document
- ✓ 30/70 Weighting – most current year's utilization has higher weighting value as it reflects more current patient behavior
- ✓ To act as evidence of an established relationship with a provider, a minimum threshold of ten percent (10%) of ***utilization per category*** is included in the attribution approach

NJ DSRIP Attribution Patient Example

Patient Smith - Attribution Example:

Provider	Visits (unweighted)	Weighted Visits	Attribution Category
Category 1: Hospital-based Clinics			
Hospital- based Clinic A	4	1.2	Hospital-based Clinic
Category Total	4	1.2	
Category %	5.19%	2.57%	Hospital-based Clinic
Category 2: Emergency Departments			
Hospital ED A	31	19.7	ED
Hospital ED B	31	19.3	ED
Hospital ED C	8	4.4	ED
Category Total	70	43.4	
Category %	90.91%	92.93%	ED
Category 3: Community-based Project Partners			
Community-based Partner	0	0	Project Partner
Category Total	0	0	
Category %	0.00%	0.00%	Project Partner
Category 4: All other providers; No attribution			
FQHC	2	1.4	Non-Hospital
Physician	1	0.7	Non-Hospital
Category Total	3	2.1	
Category %	3.90%	4.50%	Non-Hospital
Overall Total	**77**	**46.7**	

Patient Smith Example:



Retrospective versus Prospective Attribution

- Prospective attribution is computed at the ***start*** of a performance period to offer insight into who may be included in the measurement calculation. This takes into account loss of eligibility information.

- Retrospective attribution is computed at the ***end*** of a performance period and utilizes the most up to date experience and claims history.

- Preliminary roster of patients that have had visits to your hospital are now being uploaded to your hospital contacts' FTP sites.

- Utilize this roster to begin to match patients and develop requirements for reporting measure performance.

Final Retrospective Attribution Patient Roster

- Your hospital will receive the final patient roster for the CY 2013/2014 period.
- The final retrospective patient roster will be computed and released after the administrative claims data is received from the Medicaid data warehouse vendor after the end of the quarter.
- **Utilize the FINAL retrospective patient roster to compute your chart/EHR measures.**

Performance Measure Calculation

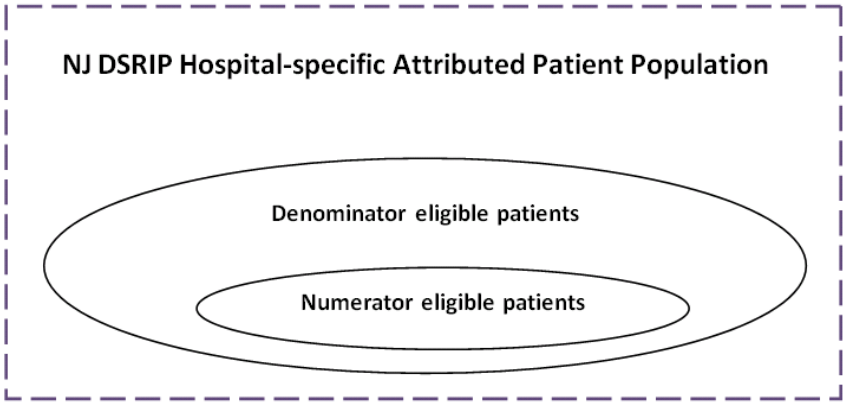
- The denominator population is identified as:
  1. The NJ DSRIP Low income population attributed to each hospital within the specified performance period.
  2. The measure steward denominator specifications.
     - population inclusions: diagnosis, age
     - population exclusions: patients with limited coverage duration

- The numerator is identified as:
  1. The denominator patients that meet the numerator criteria.
     - patients who have received defined treatment protocols or services

$$\text{Result} = \frac{\text{Numerator}}{\text{Denominator}}$$

Performance Measure Calculation

Hospital Entity Only



Represents data "walls" which excludes a much larger universe of patients that are not included in the DSRIP dataset (non-attributed Medicaid, commercial, Medicare-only)

A patient does not have to be enrolled in your project to be attributed to your hospital.

Performance Measure Calculation – Chart measures

There may be multiple reporting entities if the following applies:

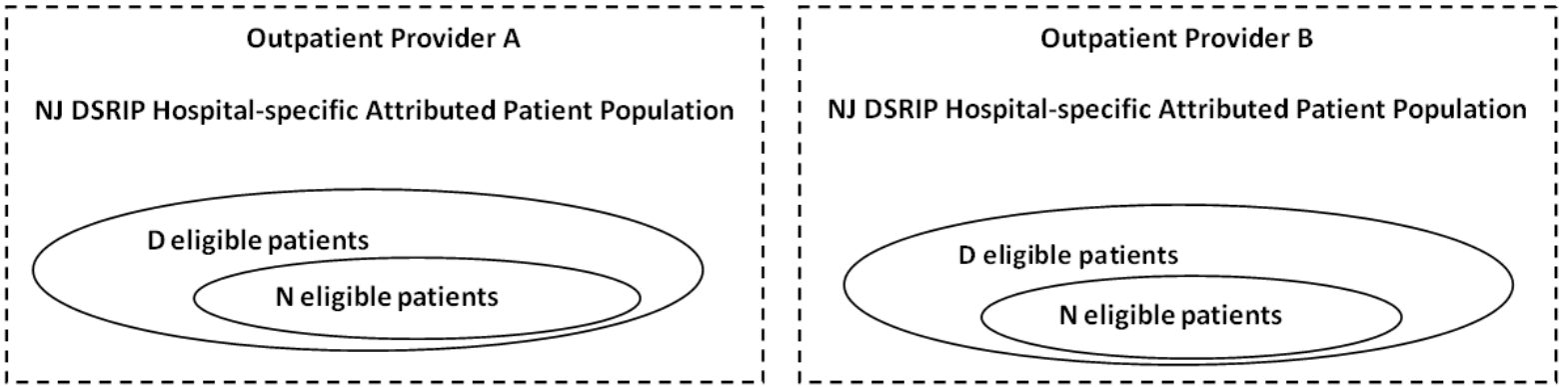
- Inpatient measures –
  - A hospital system has multiple hospital reporting sites

- Outpatient measures –
  - A DSRIP network has a hospital-based clinic and a community-based partner reporting the same outpatient measure
  - A DSRIP network has multiple hospital-based clinic sites
  - A DSRIP network has multiple community-based partners reporting the same outpatient measure

Performance Measure Calculation

Multiple Reporting Entities

Data collection is limited to the provider's data only. Provider A will collect information available to Provider A. Provider B will collect information available to Provider B.



Represents SEPARATE data "walls"

Performance Measure Calculation – Chart/ EHR measures

Sampling Tables - Because chart abstraction is very resource intensive (labor and cost), hospitals can choose to calculate results based on a representative sample.

Annual Sample Size

Sample size is calculated based on the minimum sample required to estimate the proportion with 95% confidence and a 5 point margin of error.

Annual Denominator Patient Population "*N*"	Minimum Required Sample Size "n"
>1001	250
401 - 1000	25% of the Denominator Patient Population
151 - 400	100
76 - 150	75
46 - 75	45
1-45	No sampling; 100% of the Denominator Patient Population is required

Semi-Annual Sample Size

Sample size is calculated based on the minimum sample required to estimate the proportion with 95% confidence and a 5 point margin of error.

Semi-Annual Denominator Patient Population "*N*"	Minimum Required Sample Size "n"
>501	150
301 - 500	25% of the Denominator Patient Population
76 - 300	75
46 - 75	45
1-45	No sampling; 100% of the Denominator Patient Population is required

Multiple Reporting Entity Measure Calculation

- If there are multiple reporting entities, weighting calculations apply and impact the overall hospital adjusted total rate.

BH Clinic A	**BH Clinic B**	**Total Calculated Rate =**
Query identifies = 500 patients	Query identifies = 1500 patients	2000 NJ Low Income patients
Sample required = 25% = 125	Sample required = 250	375 samples
N = 38	N = 63	N +N = 38 + 63 = 101
D = 125	D = 250	D +D = 125 + 250 = 375
% = 30% (38/125 =.304)	% = 25% (63/250 = .252)	
Clinic Adjusted Rate = (Calculated Result)(Weighted Factor)		**Hospital Adjusted Total Rate**
Weighted Factor for Clinic A - 500/2000 = 25%	(.304)(.25) = .076	.076 + .189 = .265 = **26.50%**
Weighted Factor for Clinic B - 1500/2000 = 75%	(.252)(.75) = .189	

Measurement Calculation Process – PER REPORTING ENTITY

PROCESS	PATIENT EXAMPLE 1	PATIENT EXAMPLE 2	PATIENT EXAMPLE 3	PATIENT EXAMPLE 4
Entity downloads attributed patient roster from FTP site.	Patient Harris – Commercial patient who visited ED in 2014 NOT included in file.	Patient Jones – Dually-eligible patient who visited ED in 2013 included in file.	Patient Smith – Medicaid patient who visited ED in 2014 included in file.	Patient Sanchez – Medicaid patient who visited ED in 2014 included in file.
Entity matches attributed patient list to internal data systems.	Patient Harris does not qualify for DSRIP measurement.	Patient Jones identified through matching logic.	Patient Smith identified through matching logic.	Patient Sanchez identified through matching logic.
Entity runs query to identify patient total who meet denominator measure specifications.		Patient Jones does NOT match denominator criteria for any measure.	Patient Smith matches denominator criteria for measure.	Patient Sanchez matches denominator criteria for measure.
Entity identifies chart sample from that initial patient total.		Patient Jones does not qualify for inclusion during 2014 performance period.	Patient Smith is NOT randomly selected in the sample.	Patient Sanchez is randomly selected in the sample.
Entity determines if chart sample meets numerator criteria.			Patient Smith medical record does NOT qualify for review.	Upon chart review, patient has NOT had required treatment protocol.
				Patient does not qualify for numerator.

Measure Specifications

1. Databook specifications were compiled from the measure steward. If there is information, such as coding information, that is not applicable to how your hospital captures data, your hospital may determine to pull data from your billing system instead of your electronic medical record system.

2. If your hospital does not have the referenced measure steward CPT codes, your hospital can utilize the corresponding codes utilized by your hospital. If you crosswalk codes, ensure that your facility maintains documentation of the crosswalk.

3. The Department continues to await feedback from CMS regarding the databook and retired measures. The current draft can be downloaded at:
   - http://dsrip.nj.gov/Home/Resources
     - DRAFT Databook and Standard Reporting Workbook

NJ DSRIP Baseline Attribution Results

- 761,152 patients were attributed.
- 71% of the patents were attributed based on visits to the ED.
- 22% of the patients were attributed based on visits to the clinic.
- 6% of the patients were attributed based on visits to the reporting partner.

- Statistics for the patient volume by hospitals:
  Average -15,223 attributed number of patients to a hospital
  Minimum - 2,914
  Maximum - 65,522

Attribution Category	Recipients
Hospital-Based Clinic	168,023
ED Hospital	543,944
Reporting Partner	49,185
Total	**761,152**

Attributed Recipients by NJ Hospital:

Charity Care	224,702
Medicaid/CHIP	536,450
Total	**761,152**

➢ PATIENT ROSTER LAYOUT

- PLEASE NOTE THIS ROSTER DOES NOT INCLUDE PATIENTS WHO ONLY RECEIVED SERVICES AT THE REPORTING PARTNER LOCATION

- Reporting partner patient rosters will be refined and separated so that they only receive patients that they have seen.
- This will limit the amount of resources required by them for their patient matching processes because they will not have patients who have only visited the hospital. This is expected to be a more efficient process.

Patient Roster Layout

Introduction Tab:

Background:

Per the Planning Protocol, page 38, performance measurement for both Stage 3 and 4 metrics will measure improvement for specified population groups, including the Charity Care, Medicaid and CHIP populations, collectively referred to as the Low Income population. An attribution model to link the Low Income (Charity Care, Medicaid and CHIP) population for Stage 3 and 4 performance measurement has been developed as required by the Planning Protocol.

The purpose of this workbook is to provide a roster of your hospital's attributed population based on that attribution model.

For information regarding the attribution model, refer to the NJ DSRIP Databook and Standard Reporting Workbook which can be downloaded from the New Jersey DRIP website at http://dsrip.nj.gov/Home/Resources.

Patient Roster Layout

Objectives:

This patient information can be used preliminarily for the objectives of chart/ EHR measure development and/or patient outreach. A final retrospective patient attribution roster will be sent to your hospital that is required to be used for the calculation of your hospital's, and your reporting partner(s) (as applicable), chart/EHR measure results.

Inclusive Patients:

Patients that are included in this workbook have been attributed based on services received at your hospital-based clinic, emergency department (ED), or reporting partner. A patient may have received services at one or more of these locations. Therefore, patients included on this roster may not have been seen at your hospital because they have only received services at your reporting partner's service location.

PLEASE NOTE: This preliminary roster has been adjusted to remove patients ONLY seen by a reporting partner.

Patient Roster Layout

Data Sources:

The information that is included in this workbook is based on the following data sources:

(1) administrative claims data that is captured in the New Jersey Medicaid Management Information System (MMIS).

(2) eligibility enrollment files for recipients enrolled, or have been enrolled, in the Medicaid/CHIP programs.

Patient Roster Layout

This workbook is divided into three tabs. Each tab includes your hospital's data and a layout description of the information for each tab to refer to.

Tab 1 - Summary: This tab includes summary level data regarding your hospital's overall attributed population.

Tab 1 - Summary Desc: This describes what information is included in each field for this tab.

Tab 2 - Medicaid: This tab includes patient-level information for all Medicaid and CHIP-only patients attributed to your hospital.

Tab 2 - Medicaid Desc: This describes what information is potentially included in each field for this tab.

Patient Roster Layout

Tab 3 - Charity Care: This tab includes patient-level information for all Charity Care patients, and current Charity Care patients who are, or were previously, Medicaid/ CHIP enrolled, attributed to your hospital. [There are some patients that can be identified as recipients of both Medicaid and Charity Care. In some instances on Tab 3, eligibility file information can be populated.]

Tab 3 - Charity Care Desc: This describes what information is potentially included in each field for this tab.

For some fields, the data may be populated differently based on the program type (Medicaid/CHIP versus Charity Care). If this is the case, there will be two available field descriptions shown as: (1) -OR- (2), with a full explanation describing when each description applies.

Patient Roster Layout

If information is not available, or not applicable, the field will be left blank unless otherwise specified.

For some fields, the data may be blank because the information is not yet available. The administrative claims data source is being updated to submit additional fields for the purposes of DSRIP. Information will be available on the next attribution cycle and is noted as such in the field description.

Per patient, some fields may be blank if the data is not available for that patient.

Patient Roster Layout

Recommended Steps to Identify and Match Attributed Patient-level Data to Hospital Patient-level Data
Tab 1 Summary Review - 1. Review the total attribution counts. If the patient received services at your hospital, the patient counts by visit will assist your hospital in determining at an aggregate level where services are being received.
Step 1 - Pursue matching: 1. Match data through column “Recipient Medicaid ID (Current)” to your hospital's internal “Policy Number” field in your hospital’s information management systems/databases.
Step 2 - Pursue matching: 2. Those that did not match on Step 1, match data using column “Recipient Medicaid ID (Original)” column to your hospital's internal “Policy Number” field in your hospital’s information management systems/databases.
Step 3 - Pursue matching: 3. Those that did not match on either Step 1 or Step 2, match data using column “Patient Account Number” to your hospital's internal patient account number in your hospital's information management systems/databases.

Patient Roster Layout

Step 4 - Pursue matching:

4. Those remaining patients that did not match on either Step 1, 2, or 3, match data using demographic information including name, social security number, gender, date of birth to your hospital's information management systems/databases

Recommended Steps to Identify and Match Attributed Patient-level Data to Reporting Partner Patient-level Data

Submit the patient attribution roster to your reporting partner(s). Reporting partners may determine that following the same matching procedures will be feasible, however they may determine that a hierarchy of matching based off of demographic information first may be more suitable. Step 3 would not apply to reporting partners.

Patient Roster Layout

Tab 1 – Summary Tab

Run date:

Attribution Period:

				Visits				
Attribution_ID	**Hospital_Name**	**Attribution Category**	**Recipients**	**Hospital-Based Clinic**	**ED Hospital**	**Reporting Partner**	**Other Provider**	**Totals**
		Hospital-Based Clinic	0	0	0	0	0	0
		ED Hospital	0	0	0	0	0	0
		Reporting Partner	0	0	0	0	0	0

				Visits				
Attribution_ID	**Hospital_Name**	**Claim Source Category**	**Recipients**	**Hospital-Based Clinic**	**ED Hospital**	**Reporting Partner**	**Other Provider**	**Totals**
		Charity Care	0	0	0	0	0	0
		Medicaid/CHIP	0	0	0	0	0	0

Patient Roster Layout

Tab 2 – Medicaid Layout Description

Attribution Category	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN (from Eligibility)	Recipient Last Name (from Eligibility)	Recipient First Name (from Eligibility)	Recipient Middle Initial (from Eligibility)	Date of Birth (from Eligibility)	Gender (from Eligibility)	SSN (from Claims)	Recipient Full Name (from Claims)	Preliminary Prospective Indicator

Column Label	Column Description
Attribution Category	Indicates what category the patient was attributed to based on either: Hospital-based Clinic (Category 1), the emergency department (ED) (Category 2), or reporting partner (Category 3).
Recipient Medicaid ID (Original)	(1) The original unique Medicaid ID that is assigned to a Medicaid member. This applies to claims with Claim Source = "Encounter - HMO" or "Fee for Service." Medicaid and CHIP patients are included on Tab 2 - Medicaid. *-OR-* (2) Because Charity Care patients do not enroll and receive a Medicaid ID, providers are instructed to submit the patient's social security number in this field. This applies to claims with Claim Source = "Charity Care." Charity Care patients are included in Tab 3 - Charity Care. The patient's social security number included in this field, the patient's date of birth and the patient's gender are matched to distinguish a unique individual for the Charity Care program.

Tab 2 – Medicaid Layout Description

Attribution Category	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN (from Eligibility)	Recipient Last Name (from Eligibility)	Recipient First Name (from Eligibility)	Recipient Middle Initial (from Eligibility)	Date of Birth (from Eligibility)	Gender (from Eligibility)	SSN (from Claims)	Recipient Full Name (from Claims)	Preliminary Prospective Indicator

Recipient Medicaid ID (Current)	(1) The current Medicaid ID is a second Medicaid number that provides information on the member's current eligibility enrollment. This number changes as a member moves between programs, categories, counties and age groups. The maximum date of service (most recent date) in the attribution period with a claim will be used. This applies to claims with Claim Source = "Encounter - HMO" or "Fee for Service." Medicaid and CHIP patients are included on Tab 2 - Medicaid. -*OR*- (2) Because Charity Care patients do not enroll and receive a Medicaid ID, this field is used to indicate the percentage of Charity Care coverage that the patient has. (e.g. 800000000000 = 80%) This applies to claims with Claim Source = "Charity Care." Charity Care patients are included on Tab 3 - Charity Care.

Tab 2 – Medicaid Layout Description

Attribution Category	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN (from Eligibility)	Recipient Last Name (from Eligibility)	Recipient First Name (from Eligibility)	Recipient Middle Initial (from Eligibility)	Date of Birth (from Eligibility)	Gender (from Eligibility)	SSN (from Claims)	Recipient Full Name (from Claims)	Preliminary Prospective Indicator

Patient Account Number	(1) This is the internal claim number of the managed care organization (MCO) responsible for payment of the claim. During the transmission of data from the MCO to the Medicaid fiscal agent, the data in this field is changed. The hospital provider's patient account number as indicated on the claim form is replaced by the MCO internal claim number. The MCO claim number may be data returned to the hospital provider when the claim is processed for payment. The maximum date of service (most recent date) in the attribution period with a claim will be used for that patient for that hospital. Patient account numbers of project partners are not utilized. This applies to claims with Claim Source = "Encounter - HMO." *-OR-* (2) This may be the hospital provider's patient account number as indicated on the claim form when the claim is submitted for payment to the Medicaid program. This number is not expected to be altered from what was originally submitted on the claim. Patient account numbers of project partners are not utilized. This applies to claims with Claim Source = "Fee for Service" or "Charity Care."

Tab 2 – Medicaid Layout Description

Attribution Category	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN (from Eligibility)	Recipient Last Name (from Eligibility)	Recipient First Name (from Eligibility)	Recipient Middle Initial (from Eligibility)	Date of Birth (from Eligibility)	Gender (from Eligibility)	SSN (from Claims)	Recipient Full Name (from Claims)	Preliminary Prospective Indicator

SSN (from Eligibility)	The patient's social security number as indicated on the eligibility enrollment file received for the patient. This number has been reduced to show only the last four digits. Because Charity Care patients do not enroll and receive a Medicaid ID, this information is unavailable.
Recipient Last Name (from Eligibility)	The patient's last name as indicated on the eligibility enrollment file received for the patient. Because Charity Care patients do not enroll and receive a Medicaid ID, this information is unavailable.
Recipient First Name (from Eligibility)	The patient's first name as indicated on the eligibility enrollment file received for the patient. Because Charity Care patients do not enroll and receive a Medicaid ID, this information is unavailable.

Tab 2 – Medicaid Layout Description

Attribution Category	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN (from Eligibility)	Recipient Last Name (from Eligibility)	Recipient First Name (from Eligibility)	Recipient Middle Initial (from Eligibility)	Date of Birth (from Eligibility)	Gender (from Eligibility)	SSN (from Claims)	Recipient Full Name (from Claims)	Preliminary Prospective Indicator

Recipient Middle Initial (from Eligibility)	The patient's middle initial as indicated on the eligibility enrollment file received for the patient. Because Charity Care patients do not enroll and receive a Medicaid ID, this information is unavailable.
Date of Birth (from Eligibility)	The patient's date of birth (DOB) as indicated on the eligibility enrollment file received for the patient. Because Charity Care patients do not enroll and receive a Medicaid ID, this information is unavailable.
Gender (from Eligibility)	The patients gender as indicated on the eligibility enrollment file received for the patient. Because Charity Care patients do not enroll and receive a Medicaid ID, this information is unavailable.

Tab 2 – Medicaid Layout Description

Attribution Category	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN (from Eligibility)	Recipient Last Name (from Eligibility)	Recipient First Name (from Eligibility)	Recipient Middle Initial (from Eligibility)	Date of Birth (from Eligibility)	Gender (from Eligibility)	SSN (from Claims)	Recipient Full Name (from Claims)	Preliminary Prospective Indicator

SSN (from Claims)	The patient's social security number as indicated on the claim. This number has been reduced to show only the last four digits. The claim with the maximum date of service (most recent date) in the attribution period will be used. This data will be available beginning next attribution cycle. If this information is available for a Charity Care program recipient, it is expected that the value in this field will match to the value in field "Recipient Medicaid ID (Original)".
Recipient Full Name (from Claims)	The patient's full name as indicated on the claim. The claim with the maximum date of service (most recent date) in the attribution period will be used. This data will be available beginning next attribution cycle.
Preliminary Prospective Indicator	This will indicate Yes or No if the patient is still eligible for the Medicaid/CHIP program as of the first day of the new calendar year.

Tab 3 – Charity Care Layout Description

Attribution Category	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN (from Claims)	Date of Birth (from Claims)	Gender (from Claims)	Recipient Full Name (from Claims)	Recipient Last Name (from Eligibility)	Recipient First Name (from Eligibility)	Recipient Middle Initial (from Eligibility)

Date of Birth (from Claims)	The patient's date of birth as indicated on claims submitted for payment. The social security number, date of birth and gender are matched to distinguish a unique individual for the Charity Care program.
Gender (from Claims)	The patient's gender as indicated on claims submitted for payment. The social security number, date of birth and gender are matched to distinguish a unique individual for the Charity Care program.

Hospital Next Steps:

1. Obtain secure File Transfer Protocol (FTP) log-in for each reporting entity.
   - Detailed instructions will be forthcoming.

2. Ensure each reporting partner has been trained on NJ DSRIP Databook and Standard Reporting Workbook requirements.

3. Complete overall matching process [see slide #36 and #37]. Identify matching percentage. This will be an iterative process. It is expected that progressively you will see higher match results.

Hospital Next Steps:

4. Run a test query to identify initial patient total for one or two measures.

5. Select a statistically valid random sampling process.

6. Review your timelines with vendors and reporting entities.

Recommendations:

1. Stay in frequent contact with your reporting partners and/or vendors.

2. Ensure data download within 14 days of file load. Data is **auto-deleted** from the FTP site after 14 days.

3. Based on measure requirements, consider the number or type of reporting partners you have in place. Are adjustments necessary? Should your hospital reduce the number of reporting partners?

4. Remember that your Learning Collaborative peers are important resources. Go to them for support and assistance in problem-resolution.

Recommendations:

5. Hospitals should proactively manage population health outcomes based on real-time data systems. Patients enrolled in your project who are not on your preliminary roster, may be identified in your final retrospective roster because of a change to their utilization pattern. They may be visiting your DSRIP network more frequently due to enhanced network relationships, a change in address, or a change in treatment needs.

6. Submit questions to the njdsrip@mslc.com email address. The Department will schedule follow-up meetings with the industry, as needed.

Q & A