Webinar 9:
Performance Measurement

April 07, 2015
New Jersey Department of Health (NJDOH)

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Training Session Objectives

✓ To review performance measurement requirements

✓ To review sampling procedures

✓ To review FAQs

Databook

➢ Databook is posted on the dsrip.nj.gov website.

- Includes a revision log to indicate changes that were made between the draft and the first edition. This will be maintained as updates occur throughout the waiver.

➢ **Please note:** It was identified that the Standard Reporting Workbook is not calculating the CLABSI rate as expected. This will be corrected upon submission. The workbook will be updated through the next revision.

Final Patient Attribution Match Rates:

Medicaid/CHIP & Charity Care

➢ 96% (48 hospitals) submitted final attribution match rates

➢ Of those hospitals that submitted a response:

- 83% (40 Hospitals) had 90%, or better, match rates

- 8% (4 hospitals) had less than 50% match rates

- Reach out to the DSRIP Team if you are still significantly below the expected 90% match rate

➢ This is improved results compared to the February 2015 survey:

- 72% (36 hospitals) attempted to match their preliminary attribution patient list with 22% (11 Hospitals) having 90%, or better, match rate

Question:

I am looking at the "Patient Account Number" in the attribution sheet we received. We cannot seem to correlate the number provided to anything related to the patient. Can you provide information as to what this number is? This is true of Medicaid and Charity Care patients.

Answer:

For Medicaid and CHIP patients, as defined on the layout description, the information available 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."

For Charity Care patients, the information 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."

Baseline Performance Threshold and Substitution Measures

➢ Baseline Performance Threshold –

- CMS requires that there be a threshold for improvement for P4P measures.
- Criteria requires that the threshold be set at 20 percentile points below the measure's Improvement Target Goal (ITG).

➢ The Quality & Measures Committee has approved final ITG recommendations for the MMIS-calculated P4P measures.

- Upon final approval from CMS, hospitals will be notified whether and for which measure(s) they are required to select a substitution measure.

➢ Selection of substitution measures will be based on the following:

- *Exceeds a Single Measure* – The hospital will have the option of:
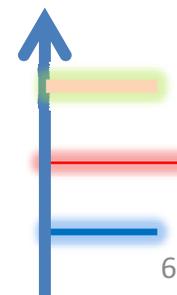 1) receiving payment using one less measure, or
  2) substituting the measure

Metric Improvement Target Goal

Baseline Performance Threshold

Hospital Metric Baseline

Baseline Performance Threshold and Substitution Measures

- *Exceeds Multiple Measures* - More than one, but not all project-specific P4P measures - **on a one for one basis:**

  Non-cardiac project –For projects other than cardiac care projects, where the hospital's baseline performance is lower than the metric baseline performance threshold the substitution measure may be either:
  - 1) The hospital's lowest performing Stage 4 metric, *or*

  - 2) Approved substitution measures by the Department and CMS

  Cardiac project –
  - 1) Approved Million Hearts substitution measures by the Department and CMS

➢ **Procedures for making hospital selection for substitution criteria will be communicated upon CMS approval of Improvement Target Goals.**

Baseline Performance Threshold and Substitution Measures

➢ Stage 3 substitution measures are included in Addendum 1 - Stage 3 Measures Catalogue and marked as substitution measures, as well as included in the databook.

➢ 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.

Enhanced Reporting Entities

➢ Hospitals will be expected to submit information regarding selecting enhanced reporting entities by July 1st, 2015.

Criteria	Community-based Reporting Partner	Enhanced Reporting Partner
Is NOT a hospital-based clinic that bills under the hospital's provider identifier with specified revenue codes 510 – 519	☑	☑
Is a Medicaid-enrolled clinic, facility or physician practice group that can/ will comply with reporting outpatient data	☑	☑
Has/ will have a Data Use Agreement, or other formal data sharing arrangement in place by	October 2014	July 2015
Employment relationship or ownership with the hospital/ hospital system	May have an existing relationship	May Not have an existing relationship
Eligible for an incentive adjustment from 10% to 8% Gap Reduction	If patient volume ≥ 1000 NJ DSRIP Low Income	☑

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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.

Measure Specification

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

✓ 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

Measure Specifications

➢ Databook specifications were compiled from the measure steward. If there is information that is not applicable to how your hospital captures information, your hospital must determine whether to pull data from your billing system or electronic medical record system.

➢ 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.

➢ The Department continues to await feedback from CMS regarding retired measures.

Performance Measure Calculation

➢ The <u>denominator</u> 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 <u>numerator</u> is identified as:

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

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

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Performance Measure Calculation - Sampling

➢ **As a result of the following previous guidance, hospitals requested that DSRIP allow exclusions to reduce the denominator sample total following Joint Commission rules.**

Question: I need clarification on sampling. If we were to run a query to determine the denominator for multiple chart abstracted measures there are certain fields that cannot be generated by a query. So for example DSRIP #23. I ran a query of all Medicaid patients with V27.0, LOS<=120 days, 8 <Age<65. For this I got 846 patients. However, what I could not put together in that query was whether they were nulliparious, enrolled in clinical trials, and gestational age.

Is the expectation that we then review those 846 charts to see if any of the above exclusion criteria is met and then come up with the "True" Denominator? From there we can sample? Or can the Sampling be based off the 25% of the 846 generated from the initial criteria. This would then give us 212 charts to review but in some of them the exclusion criteria would kick in so the submitted denominator would then be less than 212.

Answer: The hospital would be required to oversample until the 212 charts are met.

Performance Measure Calculation - Sampling

➢ The NJ DSRIP sampling process and corresponding tables have been standardized for usage across all chart/EHR measures available for sampling, except for the CAC and VTE measures which have specific sub-populations and follows strictly the Joint Commission rules.

➢ Because hospitals do not have standard capabilities to collect information, particularly clinical data (i.e. gestational age), to further standardize across DSRIP hospitals and measures, DSRIP will allow the following:

- Hospitals are expected to use all administrative data that hospitals can query on regarding your attributed population (i.e. Age, LOS, ICD-9s) to pull back your denominator patients.
- Hospitals are expected to identify at least a **minimum threshold of criteria**, including at least the 1) age and 2) diagnosis denominator criteria.

Performance Measure Calculation - Sampling

➢ *Take note:* Hospitals are expected to keep clear documentation on all aspects of the chart/ EHR collection process, including what data elements are used to determine the Initial Patient Total.

➢ Once the Initial Patient Total is identified, the denominator sample will be established based on DSRIP sampling rules.

  ▪ Refer to Slide 20 or Section III Sampling Methodology in the databook for the annual and semi-annual sampling tables.

➢ For criteria that cannot be identified through a query, the remaining denominator criteria is identified through chart review. If exclusionary criteria is identified while reviewing the chart, the sampled case can be removed from the denominator, *and no back filling, or over-sampling, will be required in order to maintain the initial denominator sample.*

Performance Measure Calculation – Sampling Example:

Elective Delivery, DSRIP #37:

Step 1 - Determine Initial Patient Population. Query all DSRIP attributed patients that meet the following criteria to determine initial denominator:

Perform Query

1. Age between 8 and 64
2. LOS <=120 Days
3. Diagnosis Codes = Joint Commission tables that identify delivery
4. Diagnosis Codes <> "Conditions possibly justifying elective delivery prior to 39 weeks gestation, Appendix A-10)

➢ *Initial Patient Total population based upon above criteria = 800*

Performance Measure Calculation – Sampling Example:

Step 2 - Determine sample needed using databook sampling rules = 800 * 25% = *200*

➤ *Denominator Sample = 200*

Step 3 - Chart abstract those 200 patients and look for the following exclusionary criteria:

Perform Chart Review

1. Patients enrolled in clinical trials = 1 case
2. Patients with prior uterine surgery = 9 cases
3. Gestational Age < 37 or >=39 weeks = 40 cases

➤ *Therefore with the 50 exclusions the final submitted denominator would be <u>150</u> in this example.*

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Performance Measure Calculation – Sampling Example:

Step 4 - Determine Numerator. Query the 150 patients in the denominator:

Perform Query

1. Procedure Codes = "Codes to Identify Medical Induction of Labor, Table 37.1" OR "Codes to Identify Cesarean Section, Table 37.2"

➢ *Based on numerator query there are 4 patients who meet the criteria from Table 37.1. Those 4 are in the numerator.*

➢ *There are 5 other patients who do not meet criteria from Table 37.1 but do from Table 37.2.*

Step 5 - Chart abstract those 5 patients and look for the following exclusionary criteria:

1. Patient in Labor = 3 cases
2. Spontaneous Rupture of membrane = 1 case

Performance Measure Calculation – Sampling Example:

➢ *Out of those 5 patients, 4 met numerator exclusion criteria, so 1 more rolls up in to the numerator.*

➢ *Based on numerator query and the chart abstracted exclusionary criteria there are 5 total patients who meet the numerator criteria.*

➢ Step 6 - Submit numbers to DSRIP on Standard Reporting Workbook. On the Workbook, capture the final denominator post exclusion criteria that was used to identify the numerator.

Performance Measure Calculation – Sampling Example:

Initial Patient Total [Enter the total number of patients that meet the denominator criteria.]	800
Denominator [Enter the total number of records that are required to be sampled based off the measure's specification sampling table.]	150
Numerator [Enter the total number of patients that meet the numerator criteria.]	5

Initial sample of 200 is replaced by the 150.

Because there are not fields for both the initial and the final denominator – only provide the final denominator amount after denominator exclusions have been removed.

Performance Measure Calculation - Sampling

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

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

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

Question:

If patient abc is in the attribution list with Medicaid policy 123, and a metric requires to search for that patient history; if we happen to find qualifying history under a commercial payer, would that still count for inclusion or do we need to search history when the patient was low income population?

Answer:

The qualifying denominator is for the attributed low income, therefore, treatment history during the performance period should consider care while the patient was low income.

Question:

Data reporting partners will receive their own patient attribution list and submit their own data?

Answer:

Reporting partners will not submit their own data. Reporting partners must follow the steps described in the databook (refer to pages 14-18). This includes sending the results to the hospital, the hospital entering the information into the Standard Reporting Workbook, and submitting all reportable data by the required deadlines.

Question: How are the results of reporting partners supposed to be documented on the Standard Reporting Workbook? If the reporting entity has the same provider number, can they be reported collectively on the same column?

Answer: Yes, if there are multiple outpatient sites with the same provider number and the data was queried and calculated based on that single provider number, then the results should be captured as a single reporting entity on the Workbook.

Standard Reporting Workbook – Content

> If a hospital has three hospital sites reporting data, 3 columns should be filled out for inpatient measures.

	B	C	D	E	F
7	Measure - Format				
8					
9	**Measure Name**	**Provider's Name**	**Provider's Name**	**Provider's Name**	**Provider's Name**
10	[Name of Measure is Pre-populated]	[Enter the operating name of the reporting entity.]	[Enter the operating name of the reporting entity.] *Once all reporting entities have been entered, leave the remaining columns blank.*	[Enter the operating name of the reporting entity.] *Once all reporting entities have been entered, leave the remaining columns blank.*	[Enter the operating name of the reporting entity.] *Once all reporting entities have been entered, leave the remaining columns blank.*
11	**DSRIP #**	**Provider's NJ Medicaid Identification Number**	**Provider's NJ Medicaid Identification Number**	**Provider's NJ Medicaid Identification Number**	**Provider's NJ Medicaid Identification Number**
12	[DSRIP Number is Pre-populated]	[Enter the NJ Medicaid ID that is related to the reporting entity.]	[Enter the NJ Medicaid ID that is related to the reporting entity.] *Once all reporting entities have been entered, leave the remaining columns blank.*	[Enter the NJ Medicaid ID that is related to the reporting entity.] *Once all reporting entities have been entered, leave the remaining columns blank.*	[Enter the NJ Medicaid ID that is related to the reporting entity.] *Once all reporting entities have been entered, leave the remaining columns blank.*
13	**Initial Patient Total** [Enter the total number of patients that meet the denominator criteria.]	0	0	0	0
	Denominator [Enter the total number of records that are required to be	0	0	0	0

Question: How should the Standard Reporting Workbook be submitted?

Answer: Submit the completed Standard Reporting Workbook through the Myers and Stauffer secure FTP site. *Refer to the Databook, page 20 that discusses the submission process.*

Question:

In order for us to abstract the Medication Reconciliation measure we need to identify patients that were discharged and seen by external reporting partners within 30 days. Will the attribution list that we receive identify those patients discharged from the hospital and also seen by the partners within 30 days? Otherwise how would we be able to identify these patients? The file for the partners are not being given to us. How would we find/match to those patients?

Answer:

As described in the specification, the denominator for the Medication Reconciliation is:
"Of the New Jersey Low Income attributed population, all patients aged 18 years and older discharged from any inpatient facility (i.e. hospital) between January 1 and December 1 of the measurement year and seen within 30 days of discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care." This is an outpatient measure monitoring outpatient provider patterns. It is expected that outpatient providers are receiving discharge information, and for those patients who are being seen post discharge, medication reconciliations are being conducted.

Update:

One hospital has suggested completing a 100% reconciliation by receiving the visit information for all attributed patients from the reporting partner with the CPT code to identify medication reconciliation and will compare outpatient visit dates to inpatient discharges and determine if it has been within 30 days.

Question: For the list of ICD-9 and CPT service codes. Are we looking for those codes as a primary diagnosis or for any diagnosis?

Answer: It would be for that diagnosis attached to that patient, not just the primary diagnosis unless there is a measure where identification of restriction to a primary diagnosis is outlined in the numerator.

Question: What are the expectations for validating MMIS-calculated measures?

Answer: MMIS-calculated measures take into account all services received by a patient across settings by all providers who have submitted a claim for payment during the measurement period. Hospitals only have data accessible for treatment provided within their system. It is expected that hospitals will view and export the MMIS-calculated data for tracking and comparison to other related performance.

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Q & A