Webinar 6:
Project Partners and Attribution

New Jersey Department of Health (NJDOH)

Training Session Objectives

- ✓ To review key performance measurement requirements
- ✓ To review and understand the definitions of project partners and their impact on DSRIP
- ✓ To review the final attribution model that will include specific types of project partners
- ✓ To review Stage 3 Pay for Performance Gap Reduction methodology
- ✓ To discuss next steps and timelines

Review of Key Performance Measure Requirements

Stages Description	Payment Mechanism	DY3	DY4	DY5
Stages 1 Project Activities – investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services 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 involves the measurement of care processes and outcomes 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; 45 universal measures unless the service is not offered	Pay for Reporting	10%	15%	25%

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

Review of 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. This table indicates the carve out percentage per demonstration year:

DY3	DY4	DY5
10%	15%	25%

The UPP 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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Review of 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.

- ✓ 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.

- ✓ 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.

Review of 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.
- ✓ 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 October 31, 2014 progress report should include a plan describing the steps required by the Hospital to report the metric by its deadline. Each Stage 3 and Stage 4 Chart/ EHR measure must separately be described, otherwise funding for the metric will be forfeited.
    - Be specific in your plan
    - Describe systems and queries that will be utilized
    - Identify vendors, partners and departments that will be play a role in development or maintenance of measures

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Review of Key Performance Measure Requirements

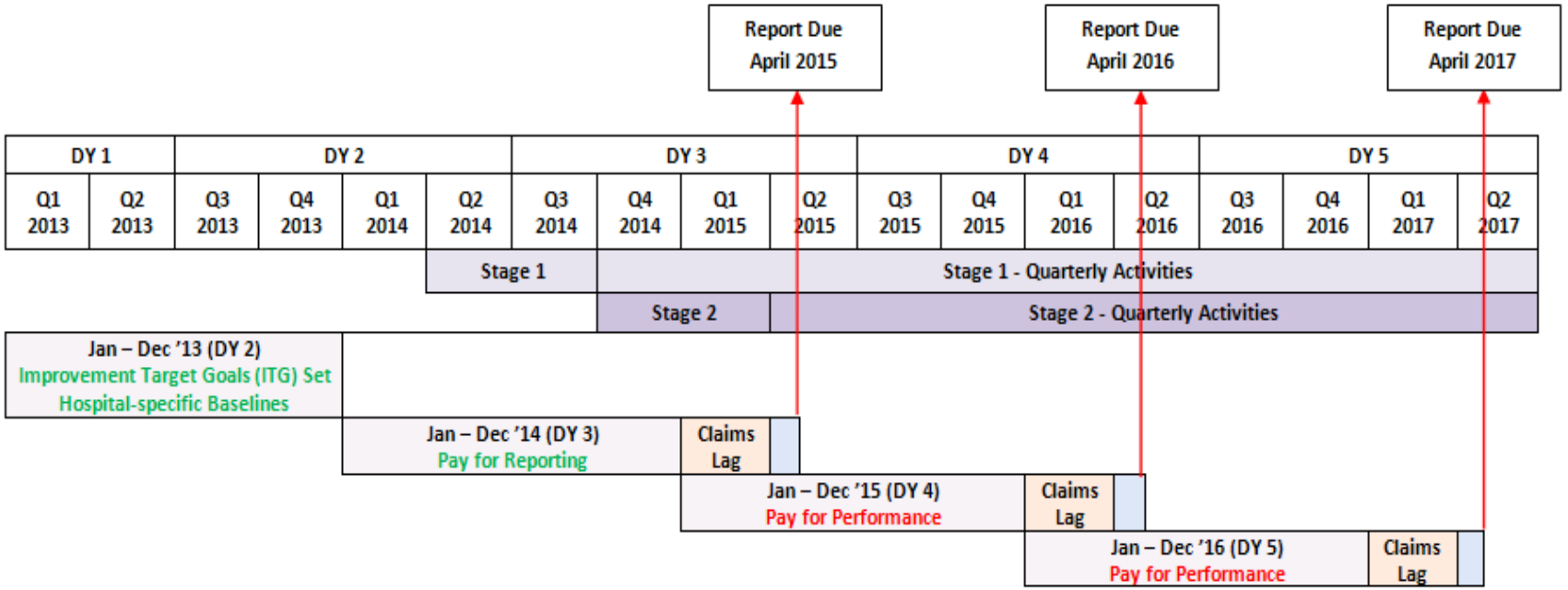
- ✓ The denominator for all Stage 3 and Stage 4 measures will be based on the **final retrospective attributed population** for the hospital.

- ✓ The Databook includes specifications for all available measures for the DSRIP program. It will be updated with the materials described during today's presentation.

- ✓ Key changes to the Databook will include:
  - Section I. D. General Overview, Data Reporting and Calculation Methods – updated to reflect reporting partner definitions
  - Section II. Attribution Methodology - updated
  - Updated American Medical Association (AMA) measures as applicable per AMA request
  - Corrected DSRIP # 58 reporting period, experience period and baseline periods to reflect an annual measurement
  - Reporting deadlines for DSRIP # 56, 75, 31, 55, 76 will be updated

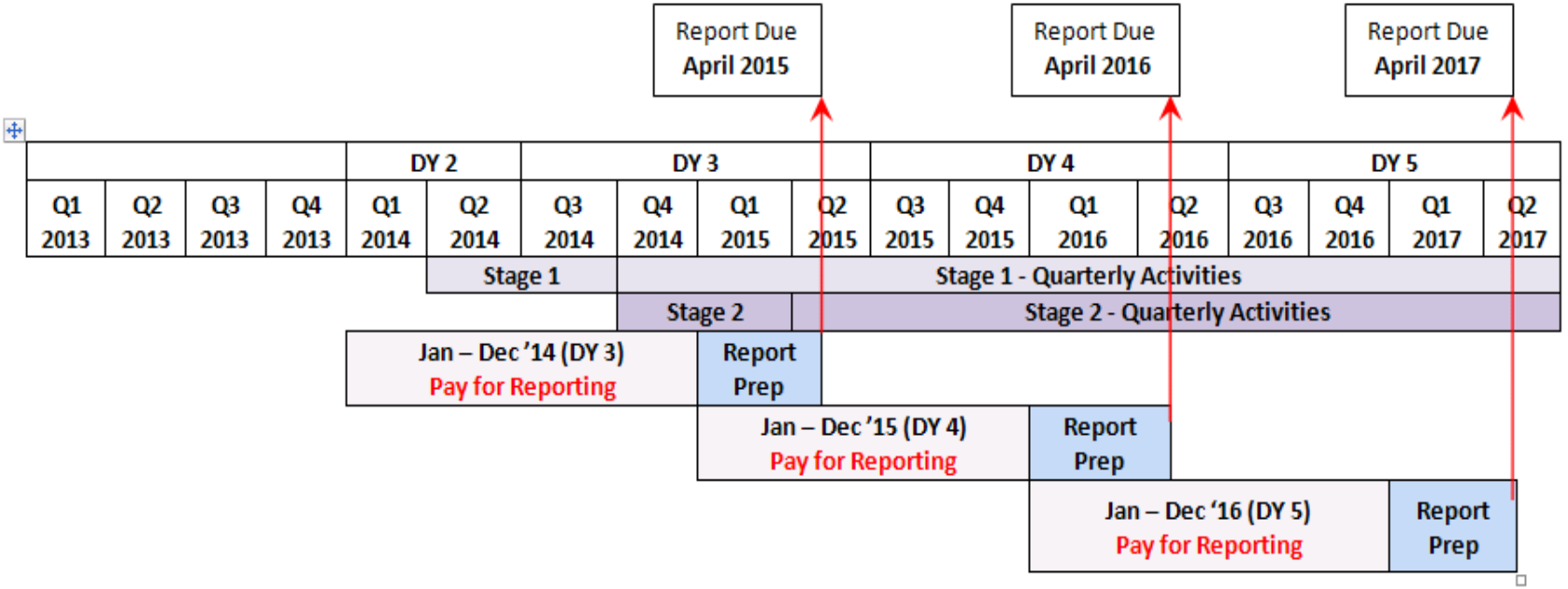
Review of Key Performance Measure Requirements

Stage 3 Annual MMIS Measurement and Reporting Time Periods



Review of Key Performance Measure Requirements

Stage 4 Annual Chart/ EHR Measurement and Reporting Time Periods



Definitions and Roles of Project Partners

According to the Planning Protocol Toolkit, Application and Progress Report information:

- Stage 1, Activity 4 – Procure Project Partners.
  - S1A4 – Action/Milestone 1 - Identify partners who would be beneficial to the project development and maintenance.
  - Minimum Submission Requirements – Partnerships are in place for initiation of the project
    - Contracts/ memorandums of understanding/ letters of engagement with partners.

Definitions and Roles of Project Partners

The broadest term:

- ✓ Your Project Partners are those partners that help your hospital and your patients achieve the aims of the DSRIP program

Program **objectives** include**:**

- Improved quality and access of care
- Improved delivery and consistency of care
- Expansion of primary care

Program **goals** include:

- Improve population health
- Reduce unnecessary admissions/ readmissions
- Reduce unnecessary emergency department visits
- Manage the trajectory of the cost of health care

Definitions and Roles of Project Partners

What is the Key Difference between Project Partners and Reporting Partners?

1. Reporting Partners will be included in the attribution model
2. Reporting Partners are required to collect and report outpatient data

Why does there need to be a distinction between types of reporting partners?

CMS wishes to incent hospitals to:

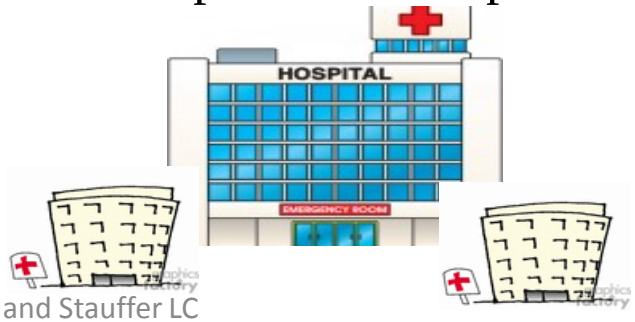
- ✓ Support stronger partnerships between existing inpatient and outpatient providers who care for Medicaid patients
- ✓ Develop NEW partnerships

Definitions and Roles of Project Partners

Definitions and Roles of Project Partners

Community-based 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
- Agrees to support the objectives of the DSRIP program
- May have an existing employment relationship or ownership with the hospital/ hospital system



Definitions and Roles of Project Partners

Community-based Reporting Partner –

- Has/ will have a Data Use Agreement, or other formal data sharing arrangement in place by **October 2014 (DY 3)**

- Will be included in the attribution model for purposes of identifying and linking patients to a hospital

✓ Eligible for an incentive provision IF – a single community-based reporting partner, or a collection of partners, hold a patient roster of not less than 1,000 unique NJ Low Income patients during the attribution period

Definitions and Roles of Project Partners

Enhanced Reporting Partner –

- Is a Medicaid-enrolled clinic, facility or physician practice group that can/ will comply with reporting outpatient data
- Agrees to support the objectives of the DSRIP program
- Does NOT have an existing employment, relationship or ownership with the hospital/ hospital system during DY 3 period

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Definitions and Roles of Project Partners

Enhanced Reporting Partner –

- Has/ will have a Data Use Agreement, or other formal data sharing arrangement in place by **July 2015 (DY 4)**
- Will be added to the attribution model for purposes of identifying and linking patients to a hospital for DY 4 measurement. (Improvement Target Goals will not be reset.)

✓ Eligible for an incentive provision

✓ Incentive Provision:

- For hospitals that meet the incentive provision, Stage 3 Pay for Performance Improvement Gap Reduction will be modified from a required 10% to 8%

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Definitions and Roles of Project Partners

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	☑

Definitions and Roles of Project Partners

Reporting Partner Limitations:

- Because we are seeking to link patients to a single hospital for monitoring performance, reporting partners generally cannot be shared.
- If, an FQHC has separate identifiable Medicaid provider identifiers for each location, then different hospitals can partner with the various FQHC reporting partner locations.

> ***PLEASE NOTE:*** **A project partner can work with multiple hospitals for coordination of treatment and provide services for patients**. This will still benefit hospitals in the measurement of performance.

- The number of reporting partners selected must take into account your hospital's ability to manage the reporting requirements.

Definitions and Roles of Project Partners

- Because the Databook draft included "community-based project partners" the general principles described remain unchanged.

- If there are multiple reporting entities, the 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	

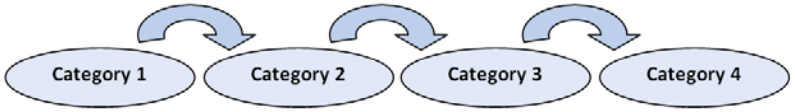
Performance Improvement - Gap Reduction Formula

		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

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

Attribution Model - hierarchical, with 10% threshold



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 Reporting 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**	

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Attribution Model - hierarchical, with 10% threshold

Retrospective versus Prospective Attribution

- Both types of attribution models utilize historical claims to link patients.
- 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.
- Participating hospitals will be given a preliminary prospective attribution patient roster and a final retrospective attribution roster.

Next Steps and Timelines

1. Complete 4 Training Webinars – *September 9th*

2. Send each hospital a project partner profile spreadsheet - *September 19th*
   - This spreadsheet will be based on the last version that was submitted
   - It will indicate whether it appears that the provider could be a reporting partner.
     - It is very difficult to determine by name alone if the provider is a single physician or a physician practice group
   - It will indicate the patient volume for the listed provider during the attribution period.

3. Hospitals meet with prospective reporting partner(s) – *September 26th*
   - This includes meeting with legal counsel to discuss reporting requirements

Next Steps and Timelines

4. Hospitals submit an updated reporting partner list – *September 29th*
   - This must indicate the data use agreement commencement date(s).

5. Preliminary prospective attributed patient roster sent to hospitals. – *October 10th*

6. Each measure is updated and re-run to determine baseline and Improvement Target Goals. – *December 12th*

7. Baseline performance is entered in to the Gap Reduction formula and the Expected Improvement Target Goal is computed. – *January 9th*

Q & A