NEW YORK STATE | Department of Health

NY DSRIP PAM® Assessment 2015

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Introduction

The Patient Activation Measure (PAM) is an assessment tool that measures patients' behavior, knowledge, and engagement in their own healthcare decisions. All performing provider systems (PPSs) participating in the New York State Department of Health (NYSDOH) Delivery System Reform Incentive Payment (DSRIP) Program Project 2.d.i. must implement PAM for non-utilizing and low-utilizing Medicaid members within their attributed patient population and the uninsured population within their service area.

The following is intended to provide PPSs with guidance on the performance metrics associated with the PAM and how incentive payments will be calculated based on metric performance. Please refer to the *DSRIP Measure Specification and Reporting Manual* for further performance and achievement reporting requirements.

Performance and Payment Methodology

Table 1 includes all data required for establishing both the "pay for reporting" (P4R) and the "pay for performance" (P4P) metrics associated with PAM. All measures collected in DSRIP Year (DY) 2 will be based on a P4R methodology while DY3-5 will be based on a P4P methodology. The "Forestland Example" (Table 4) at the end of this document goes into greater detail on this methodology.

There are three primary reporting requirements under PAM:

- Total number of PAM assessments conducted
- Achievement of activation targets by designated DY
- All additional Domain 1 reporting requirements applicable to Project 2.d.i.

Table 1: PAM Level Measure Specification and Reporting[1]

DSRIP Year	Numerator	Denominator	Performance Goal	Payment Method
2	Total number of members administered PAM at Level 3 or 4 at the conclusion of the measurement year	Total number of members administered PAM assessment during DY2 measurement year		P4R
3 - 5	Interval measure of % of members of total with Level 3 or 4 on PAM	Baseline measure of % of members of total with Level 3 or 4 on PAM	Ratio greater than 1	P4P

PPSs will be evaluated based on the total number of PAM assessments conducted and the total number of individuals with a PAM score of 3 or 4 at the end of the DY across three population groups (uninsured (UI), Medicaid non-utilizers (NU), and Medicaid low-utilizers (LU)).

[1] Delivery System Reform Incentive Payment (DSRIP): Measure Specification and Reporting Manual. New York State Department of Health. 2 April, 2015.

In DY2, PPSs will satisfy the achievement requirements under P4R by submitting all relevant numerator and denominator information at the conclusion of the DY2 into the Medicaid Analytics Performance Portal (MAPP). For DY3-5, PPSs will be scored based on their ability to increase the ratio of actively engaged patients over the previous year. During DY3-5, numerators are based on the percentage of actively engaged patients during the most recent DY who have reached PAM level 3 or 4, while denominators are based on the percentage from the previous DY.

Actively Engaged: Payment Performance Implications

A PPS receives DSRIP funds based on scale and speed figures as included in their original DSRIP Application (Table 2). For Project 2.d.i, “actively engaged” is defined as the number of individuals who completed PAM or other patient engagement techniques.

Table 2: PPS 2.d.i Speed and Scale Targets

PPS Name	Actively Engaged (as reported in PPS DSRIP Application)	Speed to 100% Active Engagement (DY)
Adirondack Health Institute	82,783	5
Albany Medical Center Hospital	34,872	4
CNY Performing Provider System	22,300	4
Alliance for Better Health	14,715	4
Finger Lakes PPS	59,214	5
Millennium Collaborative Care PPS (ECMC)	81,000	5
Mohawk Valley PPS (Bassett)	6,518	5
Nassau University Medical Center	74,569	4
New York City Health and Hospitals-led PPS	55,000	3
Staten Island PPS	80,000	5
Samaritan Medical Center/NCI	4,000	4
Stony Brook University Hospital	45,426	5
STRIPPS/United Health Services Hospitals, Inc	89,558	5
Westchester Medical Center	81,500	5

Timeline

All Domain 1 results will be submitted in accordance with PPS regular quarterly reporting. All Domain 2 results will correspond with the following DY schedule.

Table 3: Reporting and Payment Schedule

DY	DY Dates	Payments Periods	Measurement Period
DY1	4/1/2015 to 3/31/2016	Payment 1: Q2 (9/30/2015)	N/A
		Payment 2: Q4 (3/31/2016)	7/1/2014 to 6/30/2015
DY2	4/1/2017 to 3/31/2018	Payment 1: Q2 (9/30/2016)	7/1/2014 to 6/30/2015
		Payment 2: Q4 (3/31/2017)	7/1/2015 to 6/30/2016
DY3	4/1/2017 to 3/31/2018	Payment 1: Q2 (9/30/2017)	7/1/2015 to 6/30/2016
		Payment 2: Q4 (3/31/2018)	7/1/2016 to 6/30/2017
DY4	4/1/2018 to 3/31/2019	Payment 1: Q2 (9/30/2018)	7/1/2016 to 6/30/2017
		Payment 2: Q4 (3/31/2019)	7/1/2017 to 6/30/2018
DY5	4/1/2019 to 3/31/2020	Payment 1: Q2 (9/30/2019)	7/1/2017 to 6/30/2018
		Payment 2: Q4 (3/31/2020)	7/1/2018 to 6/30/2019

PAM Administration

Defining PAM Population

The state will not provide PPSs with a list of NU and LU, and UI populations attributed to each PPS. NYSDOH previously relied on an algorithm which determines NU/LU status based upon historical claims within attributed populations; however, it is not expected that PPSs perform a similar classification exercise. Therefore, the following definitions are recommended for identification of appropriate members:

- **Utilizing member** – Medicaid member who has more than 3 claims for qualifying services* as identified by DOH through the attribution and member roster process (or >2 PCP claims)
- **Low Utilizing Member** – Medicaid member who has two or fewer primary care visits in the last 12 months (particularly despite a need for visits, such as follow-up from hospital or ER use, or chronic disease management).
- **Non-Utilizing Member** – Medicaid member who has no claims for qualifying services as identified by NYSDOH through the member roster and claims sharing process
- **Uninsured** – Individuals who are not enrolled in Medicaid, do not have commercial insurance, or do not have any other qualifying insurance at the time of survey administration.

*Qualifying services can include a wide variety of health care services, such as those received in primary, specialty, emergency room, or acute hospital inpatient settings. Individuals who receive care through the following settings should not be considered LU or NU members:

- Ongoing services for developmentally disabled
- Nursing home or other ongoing Long Term Supports and Services
- Care received through a health home, care manager, or some other ongoing support or service

It is the responsibility of the PPS to identify which of their PPS current members are LU or NU. PPSs are also responsible for identifying the uninsured population within their service area through their own methodology.[2] It is the PPS' decision whether to pre-screen potential participants to determine which patients are eligible for PAM.

Some exceptions do exist for targeted PAM populations. The PAM tool is designed for adults over the age of 18. For any pediatric patients who are assessed by a PPS, the parent or legal guardian of the patient should complete the PAM assessment on behalf of their dependent. Medicaid individuals across all PPSs may also choose to opt out of the DSRIP program entirely at any time. It is the responsibility of the PPS to be aware of their attributed populations which have opted out and avoid targeting those individuals in all interventions, including PAM.

Unique Patient Identification

All individuals who receive a PAM assessment need a unique identifier for each submission. If enrolled in Medicaid (low-utilizers and non-utilizers), this identifier will be the enrollee's Medicaid identification number. For the pediatric population, use the child's Medicaid ID and do not include birthday in the demographic section. If uninsured, PPSs are to use a unique PAM ID following the format outlined below:

DOB (YYYYMMDD) + First Name (first 2 letters) + Last Name (first letter) + Zip Code (last 3 digits)

For homeless patients, 5HH will be substituted for the zip code digits.

It is the PPSs and provider's responsibility to collect appropriate identifying information prior to populating the Insignia survey tool.

Duplicate Results

PPSs will need to ensure that duplication of initial PAM assessments does not occur by checking PAM ID or Medicaid IDs entered in the PPS' PAM tool prior to the administration of the assessment. The survey administrator should also verify with the patient whether he or she has participated in a recent PAM survey. PPSs may be asked to attest that a reasonable effort has been made to prevent misidentification of patients and avoid duplication should submitted PAM results be audited.

Due to patient migration, individuals may receive PAM assessments from multiple PPSs. All PAM results conducted will count towards achievement value scores regardless of whether the

[2] PPS uninsured populations are not included in the member roster file

individual receiving the assessment has been previously administered a PAM assessment at a separate PPS.

Over time, it is the intent of the program to demonstrate patient engagement via multiple PAM assessments on the same individual during each DY and to reflect an increasing engagement in that member's understanding of and engagement in their own health care. For the purposes of assessing achievement values during pay for performance years, any individual receiving more than one PAM assessment within a given reporting period, will be counted using their most recent PAM score.

Protected Patient Information

NYSDOH has not developed a formal consent process for PAM. It is at each PPSs discretion how much demographic information is requested, captured, and included during each assessment.

Results Submission

PPSs will be responsible for reporting their PAM results in accordance with their regularly submitted quarterly reports under Domain 1.

PAM Data Sharing Privacy Policy

Each PPS should have a HIPAA-compliant data sharing agreement between all providers in its network, as well as any other affiliated PAM administering providers. PPSs are expected to adhere to State and Federal law as they apply to PHI and data sharing.

Forestland Example

Forestland, a fictional PPS, is participating in Project 2.d.i. Table 4 illustrates the calculation of Forestland's PAM performance.

Table 4: Forestland PAM Performance Example

	DY1	DY2	DY3	DY3 P4P Score	DY4	DY4 P4P Score
Total # Members Scoring PAM Level 3 or 4 (cumulative)	8,000	20,250	36,500	36,500 - 20,250 = **16,250**	46,850	46,850 – 36,500 = **10,350**
Total # Members Administered PAM (cumulative)	20,000	45,000	76,500	76,500 – 45,000 = **31,500**	99,000	99,000 – 76,500 = **22,500**
Baseline Percentage	40%	45%	47%		47.3%	
Interval Percentage	N/A	N/A	N/A	16,250 / 31,500 = 51%		10,350 / 22,500 = 46%
Performance Ratio				0.51 / 0.45* = **1.13**		0.46/0.47* = **0.98**
				*From DY2 Baseline %		*From DY3 Baseline %

Note: DY5 will be scored identically to DY3 and DY4

- For DY1-DY2, payments will be based on successful submission of quarterly reporting.
- For DY3-DY5, payments will be based on achieving a performance ratio greater than 1.0.

In this example, Forestland PPS achieved the performance goal in DY3 (1.13) but failed in DY4 (.98). As a result, Forestland PPS will not receive Domain 2 PAM performance funding.