NEW YORK STATE | Department of Health | Medicaid Redesign Team

DSRIP Performance Measurements: Project 11

Date: September 15th, 2015

Purpose of document

This Q&A document has been created to provide PPS's with additional information on Project 2.d.i ("Project 11") survey-based outcome measures concerning the Patient Activation Measure and CG-CAHPS surveys in relation to survey outreach and scoring for DSRIP Domain 1 and 2.

1. Patient Activation Measure (PAM) Survey

There are two measures in the DSRIP program associated with Project 11 PAM surveys:

- Domain 1: The number of individuals that completed a PAM (this must equal quarterly targets that were set by the PPS using State provided patient volume data during the application plan process)

- Domain 2: Interval measure of % of members of total with Level 3 or 4 on PAM (these must improve over the course of DSRIP according to the statewide performance annual improvement target)

The Target Population

The NYSDOH developed a complex algorithm for defining each of the target populations for Project 11. However, the PPS will not be able to easily utilize this algorithm in order to define low utilizing (LU), non-utilizing (NU) and uninsured (UI) populations. For convenience, the NYSDOH recommends using the following definitions to identify the appropriate members by using internal data systems, current PPS membership rosters and implementation plans for outreach:

- **Utilizing Member** – Medicaid eligible 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 eligible 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 eligible member who has no claims for qualifying services as identified by NYSDOH through the member roster and claims sharing processes.

- **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.

*A qualifying service is defined as:

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.

Q 1: I have not received a list of non-utilizing (NU) and low-utilizing (LU) patients eligible for PAM administration, nor for those uninsured (UI) persons. How will I determine which persons eligible are UI/LU/NU and are attributed to my PPS that should be surveyed? In addition, how should I be counting these patients in the Domain 1 and 2 measures?

The State will not be providing a list of low or non-utilizing recipients attributed to the PPS or the uninsured persons living within the PPS's service area. PPSs should identify which members from the current member roster and claims files are LU or NU and to determine appropriate workflow to identify outreach efforts to these patients. PPSs should also use their internal datasets and network resources to identify intended populations and conduct outreach. The PPS must be able to demonstrate that efforts were undertaken to establish the patient as meeting the LU/NU patient definition.

For example: PPSs will have a field screening tool. The data collected from the tool will allow PPSs to build a database of LU/NU patients that would be PAM survey eligible and demonstrate an effort to identify LU/NU patients in a manner that is consistent with program requirements.

It is assumed that a PPS will conduct financial screening (at a provider or hospital location at the time of registration) to identify if a patient is uninsured or insured. This will enable a PPS to count any person that identifies as uninsured at a participating network partner, so long as reasonable measures are in place to prevent multiple surveying of the same patient at the same level of engagement early on within the PPS.

PPSs pursuing Project 11 may count all PAM surveys undertaken with uninsured/low utilizer/non-utilizing persons towards both Domain 1 active engagement counts and Domain 2 measure outputs. Additionally, PPSs should focus on administering PAM to all targeted individuals regardless of their previous PAM status, as over time, those individuals' understanding and engagement in their own health care progressively increases. Overall achievement values for PAM will not be determined based on performance inside of these groups, but rather based on the aggregate PAM population including NU, LU, and UI

Q 2: My list of eligible PAM patients could change over time. For example, patients could move in and out of the NU and LU designation. How will this affect the ability to include past surveys in Domain 1 and Domain 2 measure counts?

For Domain 1 and 2, all PAM survey results will count towards Domain 1 patient activation commitments, if they were performed on a NU/LU/UI individual. The PPS can therefore continue outreach efforts and obtain credit towards engagement of the intended patient population. However, for Domain 2, once a PPS has performed a PAM on a qualifying individual, that individual remains in the database for the Project 11 metrics, regardless of whether his/her status changes over time.

Q 3: The existing Insignia PAM contract includes an estimated eligible 2.d.i population for calculating the annual license fee. The contract includes a clause for expansion of the target population size and/or expansion of PAM administration to other populations at $0.86 per participant per year. As patients move in and out of eligibility my list could grow and I may begin to over-survey eligible patients. Does the State pick up these costs?

Any additional cost to survey a larger audience of members will be incurred by the PPS. The State will not be responsible.

Q 4: Given the current restrictions on sharing PHI from the PPS lead to partners, my network providers will not be able to determine up front whether the PAM survey is conducted on an eligible member who can count towards Domain 1 and 2 measures and/or whether a PAM has already been administered to a patient by a different provider. What is the expected role of the PPS lead in this situation?

To share PHI data received from NYS Department of Health within the PPS and downstream, there are several steps that must be completed first: the member opt out process must be finalized, data sharing agreements must be in place between each network partner and vendors conducting the PAM, and the PPS Systems Security Plan must be completed and attestation submitted to DOH.

However, within the PPS, there is potential for sharing of data originating within that PPS. Since the PPS knows what the definitions of NU and LU are, it can develop strategies to identify relevant persons from its and its partners' own databases and work flows. To share this data, the PPS needs to develop its own data sharing procedure in accordance with HIPAA regulations and in concert with the PPS System Security Plan. Each PPS should review its options with its own legal consultant. The NYS DOH cannot provide legal advice on this matter. PPS and its partners are required to follow all State and federal law as they apply to PHI and data sharing and must adhere to the policies of Insignia related to data collection and sharing through the PAM instrument.

It is the PPS' and provider's responsibility to collect the appropriate identifying information prior to inputting patient information into the Insignia tool. The PPS will also need to ensure that duplication of member initial assessments does not occur early on in the PAM survey planning and execution process. The survey administrator should verify with the patient whether he or she has participated in a recent PAM survey and not resurvey that member again without that patient having increased their understanding and health care engagement levels over time.

If the PPS can show that reasonable steps have been undertaken to appropriately outreach to the LU/NU/UI over time, prevent duplicate initial PAM assessments and PAM re-assessments of the same patients and that data has been entered appropriately, the criteria for the Independent Assessor will have been met. In addition, Insignia has set up a standard patient coding method for the uninsured so they can be consistently identified, thus minimizing patients being surveyed more than once without the ability to reconcile the results. See Q5 below.

Q 5: When I perform the PAM Survey on a patient and enter results into the Insignia Tool, what if a patient Medicaid ID and/or alternative unique ID is not available? What if another patient without a Medicaid ID receives the same alternative ID elsewhere?

All individuals who receive a PAM survey will either receive a uniquely created PAM ID (if uninsured and if they do not have a Medicaid ID) as proscribed by Insignia, or will have their Medicaid Identification Number (if Medicaid enrolled) attached to their survey results. If a member does not have a Medicaid number, then the alternative uniquely created ID has been developed in the format of DOB (year, month, day), first 2 letters of the first name, the initial letter of the last name, and last 3 numbers of the member's zip code of residence: i.e. yyyymmddPEC123. For those homeless individuals the following

identifier has been developed: yyyymmddPEC5HH (with a last name example PE and first name C the number 5HH indicates homeless).

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2. CG-CAHPS Survey

There is one measure in the DSRIP program associated with Project 11 CG-CAHPS surveys:
Domain 2: Using the C&G Visit Survey, Annual measure of four composite measures:

1) Getting timely appointments, care, and information (5 items)
2) How well providers (or doctors) communicate with patients (6 items)
3) Helpful, courteous, and respectful office staff (2 items)
4) Patients' rating of the provider (or doctor) (1 item)

Q 1: I do not have a list of uninsured patients since this group does not have a traceable ID, which would be used to ensure CG-CAHPS eligibility. How will I know if another PPS has already conducted a CG-CAHPS Survey on these patients?
Each PPS can count every CG-CAHPS survey for any PPS-identified uninsured person completed in its network. *Note: Refer to the answer on Q1 on the PAM above in relation to the uninsured population for more information.*

Q 2: Is there a statewide mandated vendor?
No. The PPSs can choose any *CG-CAPHS certified* vendor they would like, so long as they agree to administer the CG-CAHPS survey to all referred patients.

Q 3: What if I receive a low response rate leading my PPS to a low reward activity?
The State will set a minimum number of observations required in order to score an achievement value on the Domain 2 measure associated with the C&G CAHPS for Project 11. The minimum response rate has been set to 300 surveys. If the PPS can demonstrate it has hit this target, the PPS will receive its achievement value.

Q 4: A de-identified response set will be used by the DOH to calculate measure results. Once the survey is conducted and results obtained by the PPS, does the PPS provide a de-identified response set to the Independent Assessor?
The lead PPS will provide raw data from the vendor to the State. The State will then create the de-identified response set and work with the Independent Assessor to determine composite measure scores and associated Achievement Values.

Updates on this information will continually be made available. Further questions should be addressed to: dsrip@health.ny.gov with subject line "Project 11".