



Office of Alcoholism and Substance Abuse Services

DSRIP Knowledge Series

“Attribution for Valuation and Attribution for Performance – in depth”

What is DSRIP?

The Delivery System Reform Incentive Payment Program (DSRIP) is a statewide initiative to transform and improve healthcare throughout the state. It is an incentive payment model that rewards providers for performance on delivery system transformation projects that improve care for Medicaid and non-insured individuals. DSRIP shifts hospital supplemental payments from paying for coverage to paying for improvement efforts.

What is a PPS?

The central pillar of DSRIP is an incentive payment model that will fund hundreds of different “projects” across the State, to be developed and implemented by large provider networks, known as Performing Provider Systems (PPS). These PPSs are led by a single lead entity like a hospital or medical center, FQHC, health home, or IPA. PPS’ projects will be selected across three domains of system transformation, clinical improvements and population health. DSRIP’s overarching strategy is to integrate hospitals and community-based providers into robust networks of person-centered care that reduce avoidable inpatient stays while shifting the emphasis to ambulatory and community-based care, wellness and recovery. There can be multiple PPSs in a county or geographical region.

What is Attribution?

- Attribution is the process used in DSRIP to assign a member to a Performing Provider System (PPS). Attribution uses a combination of geography, claims records, and health plan PCP assignment to “attribute” a member to a given PPS.
- Attribution makes sure that each Medicaid member is assigned to one and only one PPS
- Although using a different process, attribution also assigns all or a portion of the uninsured individuals in each region to a PPS
- There are two kinds of attribution: Attribution for Valuation (“A4V”) and Attribution for Performance (“A4P”)

What is Attribution for Valuation (A4V)?

Attribution for valuation assigns or “attributes” a Medicaid member or uninsured individual to a specific PPS. These attributions are then tallied for use in the calculation of the (maximum)

501 7th Avenue | New York, New York 10018-5903 | oasas.ny.gov | 646-728-4720

1450 Western Avenue | Albany, New York 12203-3526 | oasas.ny.gov | 518-473-3460

potential amount of DSRIP performance dollars which a PPS may receive over the five-year demonstration period. The goal of attribution for valuation is to attempt to align the value of potential performance awards with the depth and breadth of a given PPS network: the more lives covered by a PPS in an area, the higher the potential valuation.

Individual recipients are attributed to PPS for valuation purposes depending on the type of recipient they are and depending on the type of PPS they are attributed to.

Attributing (for valuation) utilizing Medicaid (UM) members in different PPS types

In counties or regions that have only one PPS, called “Single PPS,” all the Medicaid recipients residing in the coverage area and who utilize services are attributed to that PPS. However, a utilizing Medicaid (UM) member residing in a county or region where there is more than one PPS goes through a different attribution process. In those cases, if greater than 50% of the UM member’s claims can be linked (through providers in the network) to one or more PPSs serving that person’s area of residence, then the UM member’s claims record is applied to an attribution algorithm that establishes that patient’s “loyalty” to one of those PPSs (this algorithm takes into account factors including: primary diagnosis and utilization patterns, types of providers seeing the patient, and, in cases of “tie-breaks,” total claims counts falling under each PPS and, in cases of “level 2 tie-breaks,” predominant attribution of UM residents living in the same area as the UM member in question). However, if no more than 50% of the UM member’s claims can be tied to one or more PPSs serving their area of residence, then that person is not attributed to any PPS.

Attributing (for valuation) Medicaid low- (LU) and non-utilizers (NU) in different PPS types

Of the menu of DSRIP projects from which PPSs may select, there is an “11th project,” called “Patient Activation Activities Toward Community-Based Care” (Project 2.d.i.), which focuses on increasing patient engagement of low- (LU) and non-utilizing (NU) Medicaid members (as defined for DSRIP purposes), particularly in primary and preventive services. Generally speaking, LUs and NUs are attributed for valuation only if the PPS in question is approved to pursue Project 2.d.i. The only exception is for the single PPS (again, defined as a PPS that is the only PPS serving a given county or region): a single PPS automatically gets all Medicaid LUs and NUs residing in their area, even if the PPS is not pursuing Project 2.d.i.

For PPSs in multiple-PPS counties or regions, Medicaid LUs and NUs are attributed to a PPS only if the PPS in question pursues Project 2.d.i. If the PPS pursuing Project 2.d.i is led by a public (as defined by DSRIP), hospital or medical center, they are attributed all the Medicaid LUs and NUs residing in the county or region (if there are more than one public-led PPS in the county or region, each is apportioned a percentage of the LUs and NUs residing in the area UMs based on its percentage share of UMs attributed in that county or region). If none of the PPSs in the county or region in question are led by a public institution, and only one of those PPSs pursues Project 2.d.i,

then that PPS is attributed all of the LUs and UMs. If more than one non-public PPSs in the county or region pursues Project 2.d.i, each is apportioned a percentage of the LUs and NUs residing in the based on its percentage share of UMs attributed in that county or region. If none of the multiple PPSs for a county or region pursue Project 2.d.i, then none of the LUs or UMs for that area will be attributed for valuation.

Attributing (for valuation) the uninsured (UI) in different PPS types

Uninsured (UI) individuals are attributed for valuation only if the PPS in question is approved to pursue Project 2.d.i. The uninsured population are identified from census data. If a public PPS pursues Project 2.d.i, then all the UIs residing in their service area are attributed to them. If the public PPS is in a county or region with other non-public PPSs pursuing project 2.d.i, the public PPS still gets all the UIs in that county or region attributed to them. If there is more than one public-led PPS in the county or region pursuing Project 2.d.i, each is apportioned a percentage of the UIs residing in the area based on its percentage share of UMs attributed in that county or region. If a county or region has only one non-public PPS (and they are pursuing Project 2.d.i), then that PPS gets all the UIs attributed to them. If the county or region has multiple non-public PPSs (and no public PPSs) and only one of those non-public PPSs is pursuing Project 2.d.i, then that PPS gets all the UIs attributed to them. If more than one of the non-public PPSs in the county or region pursues Project 2.d.i, each is apportioned a percentage of the UIs based on its percentage share of UMs attributed in that county or region. If there are no PPSs (public or non-public) in a county or region pursuing Project 2.d.i, then none of the UIs for that area will be attributed for valuation.

NOTE: Depending on the type of recipient and PPS, providers who joined PPS networks with a signed Attestation Form prior to December 1, 2014, contributed to A4V counts in the PPS(s), essentially helping to drive the total amount of money the PPS(s) can potentially receive over the five-year demonstration period.

See DOH DSRIP Attribution for Valuation Webinar and Slides (and scroll down to “Attribution and Valuation Webinar” section):

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/webinars_presentations.htm

What is Attribution for Performance (A4P)?

Attribution for performance (A4P) refers to assigning Medicaid and uninsured lives to a specific PPS for purposes of measuring engagement, interventions, and other healthcare-related activities and, ultimately, improvements (or lack of improvements) in health outcomes. A4P applies only to PPS projects in domains 2 and 3. Activities and outcomes for the A4P lives will count toward the performance, or achievement values (AV), used to calculate DSRIP incentive payments (see below). Depending on the type of recipient and PPS, any service provider joining PPS networks on or before March 9, 2015 may contribute A4P counts to the PPS(s) they joined.

As with A4V, each Medicaid or uninsured person that is attributed will be assigned to only one PPS for measurement purposes. The patient population attributed for performance will be used to determine the baseline data against which future changes will be measured. In order to allow for project planning and application completion, there is an initial, prospective attribution at the start of the measurement year to determine the populations to be included. Consistent with the CMS Medicare Shared Savings Program (MSSP), there will also be a final attribution at the end of the year for evaluation and measurement.

Attributing (for performance) utilizing Medicaid (UM) members in different PPS types

Except for Project 2.d.i, A4P measurement uses a modified definition of utilization for network attribution. Any member meeting one of the following criteria will be considered a utilizing member (this includes low-utilizing Medicaid members):

- More than 50% of “qualifying” services within any PPS network(s), OR
- More than 50% of “non-qualifying” services within any PPS network(s)

Qualifying services fall under four general categories, or populations: developmental disabilities, long-term care, behavioral health, and “all other” (excluding those covered under special waiver authorities). Non-qualifying services are those services covered under special waiver authorities, including 1915(c).

If an individual meets either of the two criteria listed above, they are considered a utilizing Medicaid (UM) member for A4P purposes. Regardless of whether a PPS is the only PPS in a county or region or whether they are one of multiple PPSs in a county or region, UMs residing in that area are only attributed to a PPS if they received services at a provider(s) that is in that PPS network. UMs residing in a county or region where there is more than one PPS are attributed using the same loyalty logic described above in A4V (and as explained in the DSRIP Attribution and Valuation Webinar).

However, low-utilizers—as defined in A4V—do get attributed differently from other UMs if they have a network connection to a PPS in their county of residence that is pursuing Project 2.d.i. In that case, the individual will be tracked for the purposes of measuring that PPSs performance in Project 2.d.i. In addition, if one or more of the PPSs in a given area pursues Project 2.d.i, each PPS receives a portion of the low-utilizing UMs, for the purpose of measuring Project 2.d.i. performance, based on its percentage share of non-LU UMs attributed in that county or region.

Note that in A4P, a low-utilizing UM may therefore in some cases get attributed to two PPSs: one in which the individual is tracked for assessing 2.d.i. performance and the other in which the individual

is tracked as part of measuring performance in all the other Domain 2 and 3 projects which the second PPS is pursuing.

Finally, if no more than 50% of the UM member's claims for qualifying or non-qualifying services can be tied to one or more PPSs serving their area of residence, then that person is not attributed for performance to any PPS.

Attributing (for performance) Medicaid non-utilizers (NU) in different PPS types

In A4P, NU members are defined as those that are enrolled in the NYS Medicaid program but did not use services in the past 12 months and/or did not utilize PCP-type/ambulatory outpatient care services in the past 24 months. A4P of NUs takes into account whether the person has been assigned to a PCP and, if so, which PPS networks that PCP is in. Regardless of whether a PPS is the only PPS in a county or region or whether they are one of multiple PPSs in a county or region, NUs residing in that area are only attributed to a PPS if they were assigned to a PCP that is in that PPS. Note that a PPS does not have to be approved to pursue Project 2.d.i in order to be attributed a non-utilizing (NU) Medicaid member.

However, NU's may get tracked differently when there is one or more PPSs in their county of residence pursuing Project 2.d.i. For counties with a single PPS pursuing project 2.d.i, all NU members in the county that have a PCP connection to that PPS are attributed to the PPS for measuring its Project 2.d.i performance. For counties with multiple PPSs pursuing project 2.d.i, each of those PPSs receives a portion of the NUs, for the purpose of measuring Project 2.d.i performance, based on its percentage share of UMs attributed in that county or region.

Note that in A4P, a NU may therefore in some cases get attributed to two PPSs: one in which the individual is tracked for assessing 2.d.i performance and the other in which the individual is tracked as part of measuring performance in all the other Domain 2 and 3 projects which the second PPS is pursuing.

Finally, if the NU does not have a plan-assigned PCP and none of the PPSs in his or her county or region pursue Project 2.d.i, then that NU will not be attributed for performance.

Attributing (for performance) the uninsured (UI) in different PPS types

As with A4V, uninsured (UI) individuals are attributed for performance only if the PPS in question is approved to pursue Project 2.d.i. The uninsured population are identified from census data. For single PPSs pursuing Project 2.d.i (or in counties or regions with multiple PPSs where only one of the PPSs is pursuing Project 2.d.i), all the UIs residing in their service area are attributed to them. If more than one of the PPSs in the county or region pursues Project 2.d.i, each is apportioned a percentage of the UIs based on their percentage share of UMs attributed in that county or region.

For each PPS, performance on UIs will be measured by changes in patient activation measure (PAM) scores of statistical samples of the UI population for that PPS.

Finally, if none of the multiple PPSs for a county or region pursues Project 2.d.i, then none of the UIs for that area will be attributed for performance.

Illustrating the difference between A4V and A4P (or, “How do Payments work?”)

Essentially, DSRIP payments to PPSs, which will be made on a semi-annual basis, can basically be thought of in terms of two multipliers: 1) PPS Valuation/6-month period; and 2) PPS “Performance” as a function of % of milestones achieved for that 6-month (two quarters) period.¹

The general “equation” for determining DSRIP payment to a PPS network as a whole is:

DSRIP payment/6-month period to a PPS = (PPS Valuation for that 6-month period) x (PPS Performance for that 6-month period)

(Note that DSRIP payment to a PPS for any given 6-month period is contingent on the State meeting its milestones for that period.)

So, for example, assume a hypothetical PPS called “Forestland” received an overall A4V of \$200 million over the 5 year demonstration period. Let’s say Forestland PPS’s total (potential) valuation for DSRIP Year 2, quarters 3 and 4 is \$18 million.² If Forestland accumulates achievement values that roll up to an 83% “performance score” for Year 2, quarters 3 and 4, the DSRIP payment to Forestland for that 6-month period will be \$14.94 million:

$$\begin{array}{rcl} \$18 \text{ million} & \times & 83\% \\ (\text{Yr 2, Qs 3 and 4 valuation}) & (\text{“Performance”}) & \\ & & = \$14.94 \text{ million.} \\ & & (\text{Actual payment for Yr 2, Qs 3 and 4}) \end{array}$$

The point here to remember is that attribution of lives for valuation goes into the first multiplier, while attribution of lives for performance goes into the second multiplier.

¹ Each quarterly reporting period, PPSs may actually earn up to a certain maximum number of “achievement values,” depending on a number of factors, including number of projects selected, reporting period, and implementation speed and scale commitments made. These values, scored as either “1” (met the requirements) or “0” (did not meet the requirements) cover distinct reporting and performance areas, and are then aggregated to measure a PPS overall performance for that quarter. Payments are made every other quarter. For additional information on how achievement values for Doman 1 process milestones are derived please visit http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/webinars_presentations.htm and scroll to “Domain 1 Project Requirements Reporting Guidance.”

² A PPSs total valuation is not evenly divided over the five years. Percentage distribution of the PPSs valuation peaks in DSRIP Year 3. In our example, instead of the 6-month valuation being an even \$20 million (\$200 million divided by 10, 6-month periods), the formula works out to \$18 million.

Attribution Resources

If you have any questions or comments, please contact your KPMG DSRIP Support Team member or email the DOH team at: dsrip@health.ny.gov.

To see how performance will be measured within the implementation plan structure, go to the following URL and under the Implementation Plan section, select Implementation Plan Template (for general template) and Implementation Plan Prototype (to see an example using a hypothetical PPS called “Forestland”):

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/providers_professionals.htm

If you have questions about DSRIP more generally, click on the “Questions? Check-out the DSRIP FAQ” link in the Contact section of:

http://www.health.ny.gov/health_care/medicaid/redesign/listserv.htm.

If you have questions about OASAS’ role in DSRIP, you can reach any of the following OASAS DSRIP team leads: Stephan Brown (stephan.brown@oasas.ny.gov), Colette Poulin (colette.poulin@oasas.ny.gov), or Trishia Allen (trishia.allen@oasas.ny.gov).