Statewide Steering Committee

December 09, 2019

Agenda

#	Topic	Time	Leader
1	Welcome and Introductions	10:30 - 10:45	Marcus Friedrich Susan Stuard
2	SIM Progress to Date • Primary Care Transformation • Integrated Care and Behavioral Health • Consumer Engagement • HIT, Evaluation and Transparency • Population Health • Workforce	10:45 – 12:00	Scott Rader Jim Kirkwood Amy Jones Jen Post Joan Cleary-Miron Megan Prokorym Susan Mitnick Anne Schettine
3	Quality Measure Review Subcommittee	12:00 – 12:15	Lindsay Cogan Scott Hines
4	Lunch and Networking	12:15 – 1:00	
5	Primary Care Trends and Changes	1:00 – 1:15	Meng Wu NYAM
6	Future Focus Post-SIM • ROMC • Primary Care • Future Statewide Steering Committee	1:15 - 2:15	Anne Schettine Marcus Friedrich Jim Kirkwood
7	Closing Remarks and Next Meeting	2:15 - 2:30	Susan Stuard Marcus Friedrich

SIM Progress to Date

New York State Health Innovation Plan

Goal — **Delivering the Triple Aim** - *Healthier people, better care and individual experience, smarter spending*

Pillars	**Improve access to care for all New Yorkers, without disparity** Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	**Integrate care to address patient needs seamlessly** Integration of primary care, behavioral health, acute and post-acute care, and supportive care for those that require it	**Make the cost and quality of care transparent to empower decision making** Information to enable individuals and providers to make better decisions at enrollment and at the point of care	**Pay for health care value, not volume** Rewards for providers who achieve high standards for quality and individual experience while controlling costs	**Promote population health** Improved screening and prevention through closer linkages between primary care, public health, and community-based supports

Enablers	Workforce strategy	A	Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities
	Health Information technology	B	Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation
	Performance measurement & evaluation	C	Standard approach to measuring the Plan's impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation

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High Level Accomplishments

- Creation and continuation of NYS PCMH program with NCQA which 2,800+ practices have engaged with since April 2018
- 13 health plans involved in four regional ROMCs (many in multiple regions)
- 15 TA vendors assisted 70% of NYS PCMH practices (over 1,900 practices)
- Development of Primary Care Core Measure Set with three annual versions of PC Scorecard delivered
- Project LIFT provided community resources and training to 18 counties to encourage the prevention of chronic disease
- Project ECHO certified 171 spoke sites for tele-mentoring
- When fully operational, the accredited Rural Residency sites will result in 76 additional residents being trained annually across NYS

PRIMARY CARE TRANSFORMATION

Scott Rader

Highlights of NYS PCMH Model

- In mid-2017 the Advanced Primary Care practice transformation model was launched and later transitioned to NYS Patient Centered Medical Home
- NYS PCMH model was launched in April 2018 with 12 additional standards now core to achieving the PCMH recognition in New York. Additional Standards focused on:
  - Health Information Technology
  - Care Coordination/Management
  - Population Health
  - Behavioral Health Integration
  - Value Based Payment Contracting
- Exceeded initial enrollment goals in June 2019, 7 months before the end of the SIM grant

Practice Transformation Agents

Name of Awardee	DFS Region(s) Served
Adirondack Health Institute	Capital District (1) and Adirondacks (7)
CDPHP	Capital District (1), Mid-Hudson Valley (3) and North Country (7)
Chautauqua County Health	Western (Buffalo) (2)
Chinese American IPA, Inc. d.b.a. Coalition of Asian-American IPA (CAIPA)	NYC (4)
Common Ground Health	Finger Lakes (Rochester) (5) and Central NY (Syracuse) (6)
EmblemHealth Services Company, LLC	NYC (4) and Long Island (8)
Fund for Public Health of NYC (FPHNYC) d.b.a. NYC REACH	NYC (4)
HANYS	Capital District (1) and Long Island (8)
Institute for Family Health	NYC (4)
IPRO	NYC (4), Central NY (Syracuse) (6) and Long Island (8)
Maimonides Medical Center	NYC (4)
New York eHealth Collaborative	Western NY (2), NYC (4) and Long Island (8)
Niagara Falls Memorial Medical Center	Western NY (2)
Primary Care Development Corporation	NYC (4)
Solutions 4 Community Health	Mid-Hudson Valley (3) and Long Island (8)

NYS PCMH Enrollment Stats as of 11/27/2019

2,835 Practices Engaged with NYS PCMH

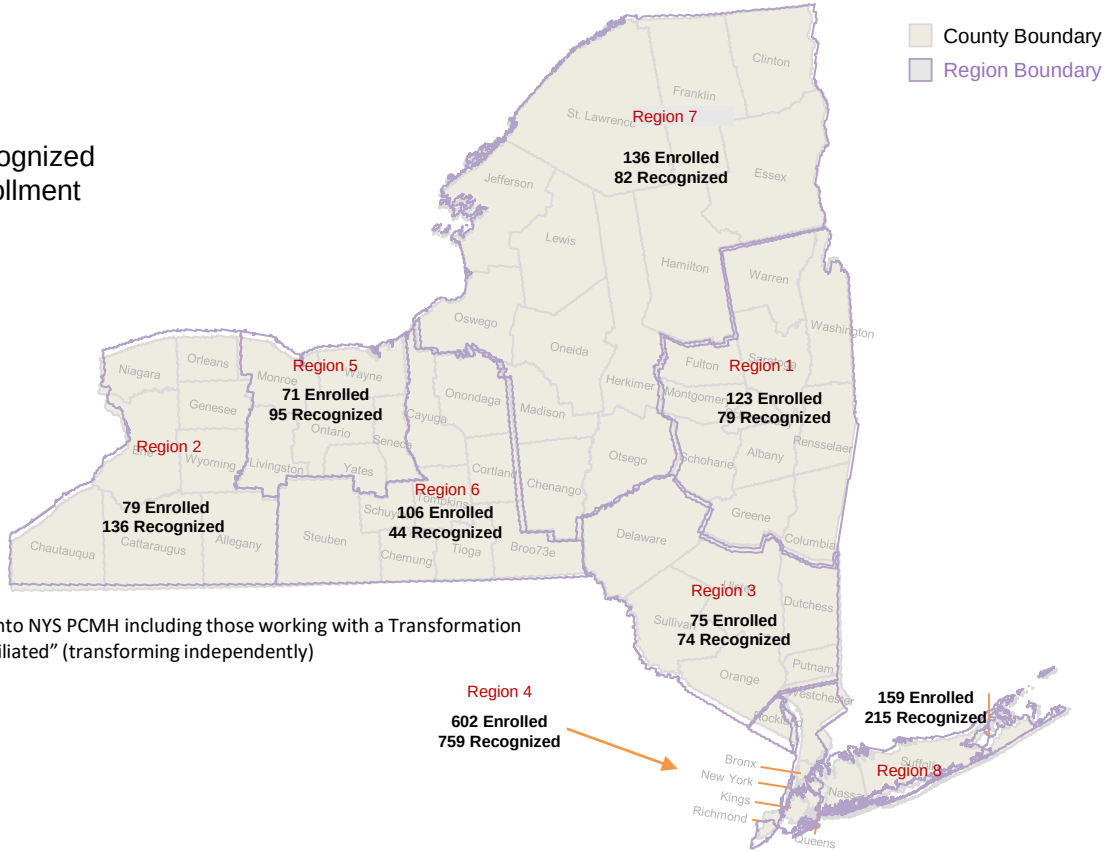
- 1,484 practices have achieved NYS PCMH recognition

- Nearly 800 practices new to PCMH transformation

  - Over 300 of these new practices have achieved NYS PCMH recognition

NYS PCMH Recruitment Status – 11/27/2019

2,439 Proposed
1,351 Enrolled
1,484 NYS PCMH Recognized
116.24% Toward Enrollment
Target



Numbers include all sites enrolled into NYS PCMH including those working with a Transformation Agent and those considered "Unaffiliated" (transforming independently)

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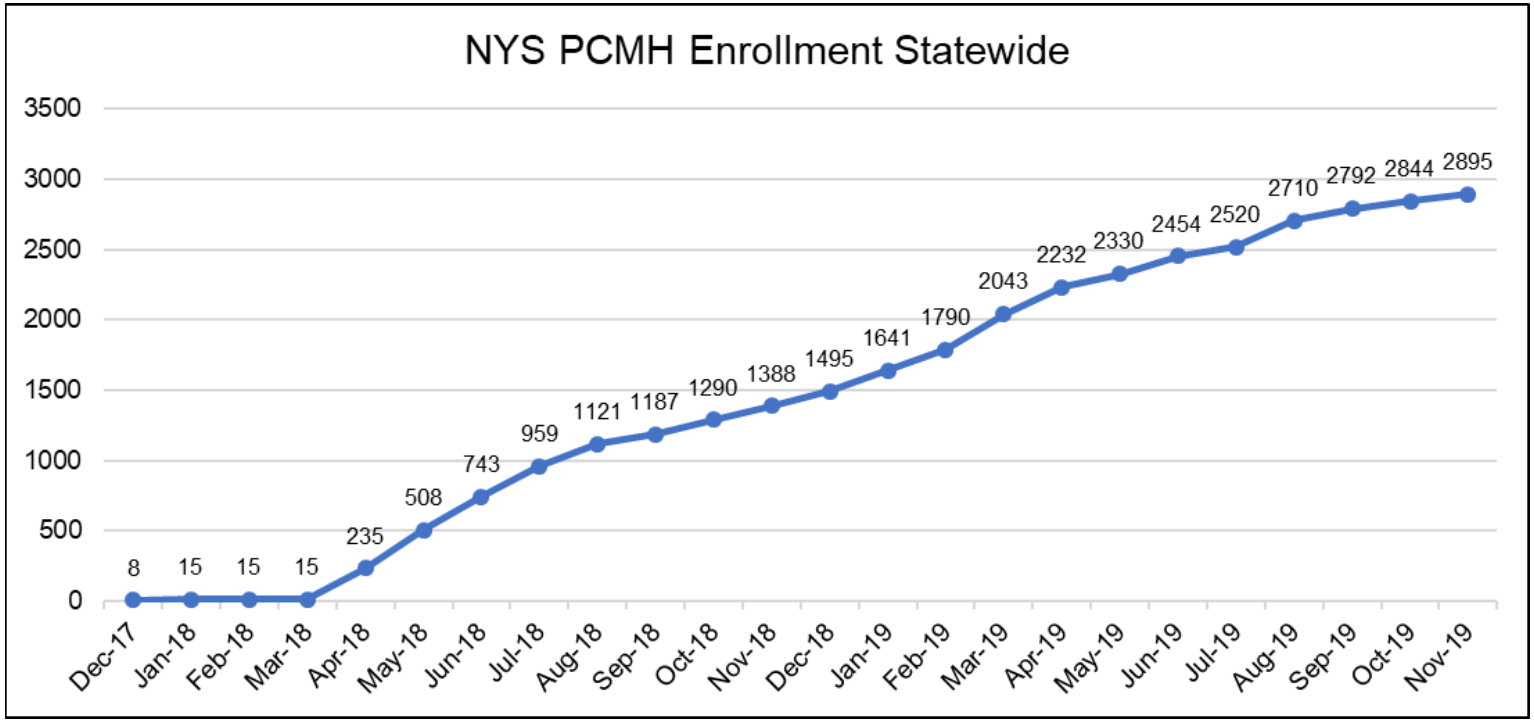
NYS PCMH Practice Enrollment Over Time



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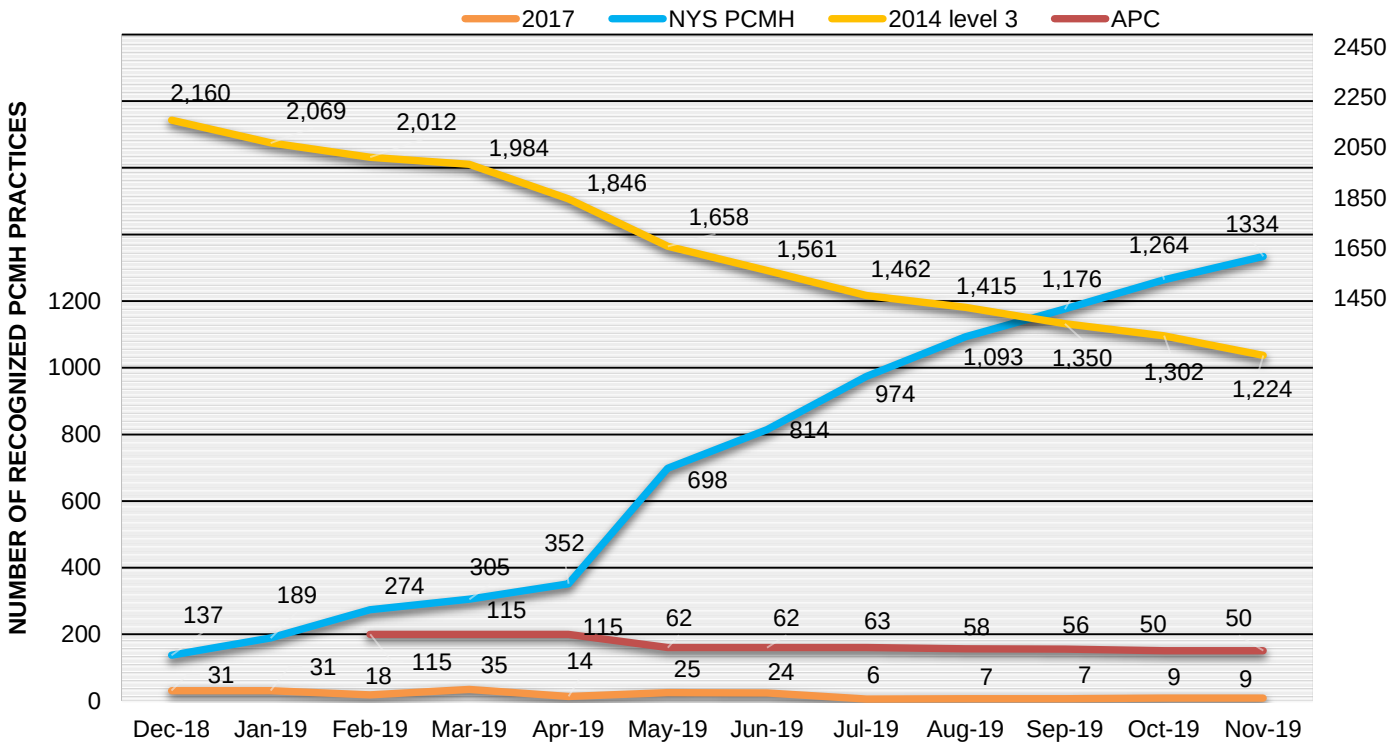
Counts of Recognized PCMH Practices in NYS



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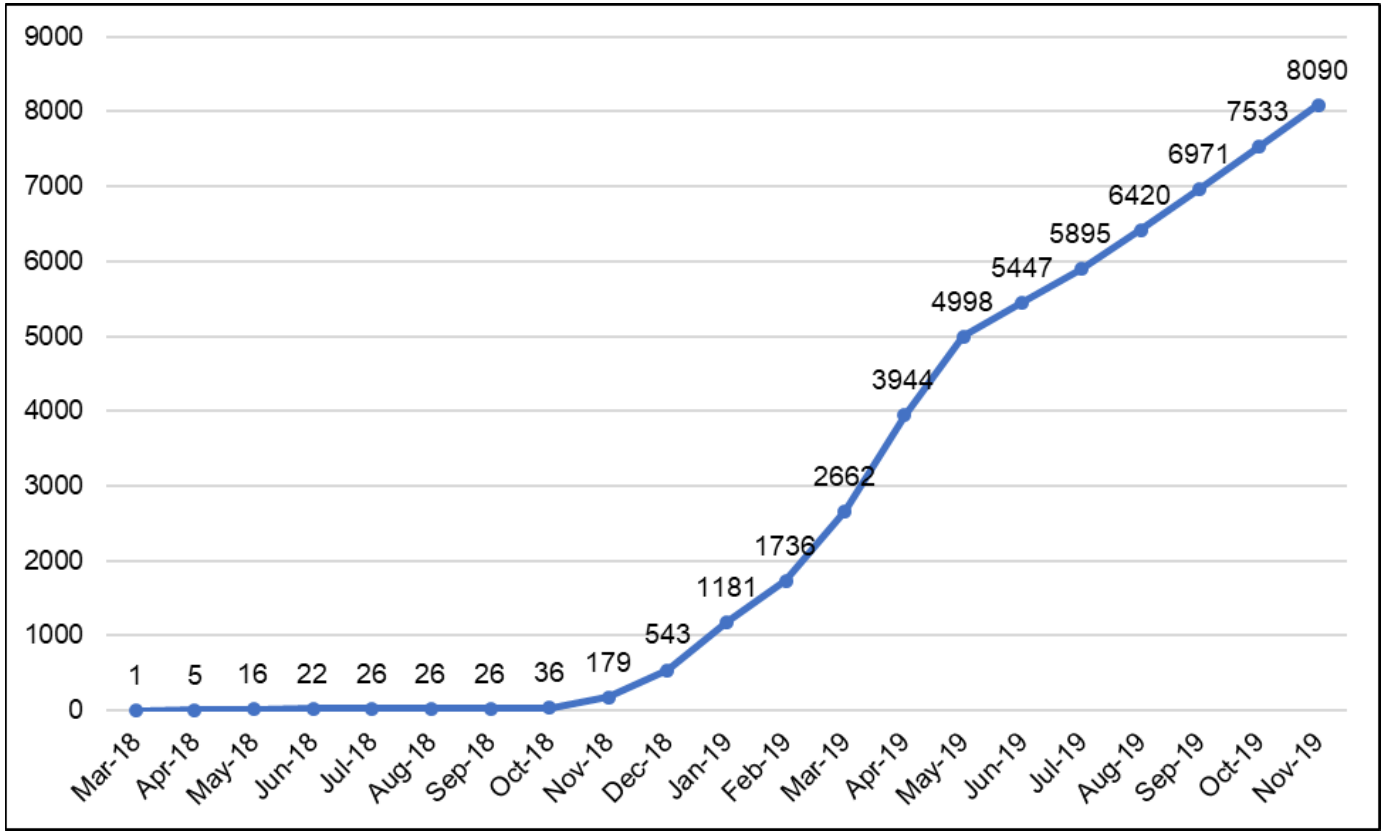
NYS PCMH Recognized Providers Over Time



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QE PILOTS & QUALITY MEASUREMENT

Jim Kirkwood

HIT Enabled Quality Measurement

An infrastructure of ***technology and policies*** that allow ***multiple stakeholders*** to access ***high-quality data*** that represents a ***complete picture of the care*** delivered to a patient and enables ***measurement*** of the ***health outcomes of a population.***

HIT Enabled Quality Measurement

Objectives

Improve electronic clinical data quality to facilitate accurate quality measure calculation

Establish QEs as verified sources of ECDS & standard supplemental data

Facilitate provider and health plan use of timely, actionable data to inform clinical decision making

Guide health plans through their adoption of electronic reporting methodology

Enable NYSDOH reporting activities for specific populations and programs

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QE Quality Measurement Pilot

This project seeks to:

- Demonstrate the QEs' potential as a source of high-quality clinical data to support NYSDOH's HIT-Enabled Quality Measurement Vision and ROMC participant's quality measure needs

This will be accomplished by:

- QEs generating quality measures for NYS PCMH practices
- QEs delivering high quality clinical data to health plans in support of the Primary Care Scorecard

All solutions should adhere to these guiding principles:

Timely performance feedback for practices	Files approved as standard supplemental data	ROMC participant needs drive the activities	Solutions are scalable

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QE Pilot Progress

QM Selection

- All QEs have selected measures
- 3 of 4 QEs have completed their measure analysis
- All QEs are working on Controlling High Blood Pressure, A1c Poor Control & Colorectal Cancer Screening

QM Generation

- All pilots have identified one or more practice(s) for engagement
- 2 of 4 QEs are live with measures

Data Delivery

- 2 of 4 QEs have live data feeds with health plans

QE Quality Measurement Projects

Digital Measure Pilot

Activities
- QEs evaluate measure specifications
- QEs generate digital measures

Outcomes

Short Term
- Increased understanding of:
  I. Measure alignment
  II. Data availability

Long Term
- Recommendations for measure alignment across organizations
- Understanding of availability of data necessary for HEDIS reporting of digital measures

Data Aggregator Project

Activities
- QEs will produce data feeds to be audited by NCQA

Outcomes

Short Term
- QEs certified for production of standard outputs
- Increased supplemental data feeds
- QEs approved as standard supplemental data feeds

Long Term
- National standards for supplemental data feed requirements for traditional measures
- QEs are source of ECDS data
- Reduced Medical Record Review reliance

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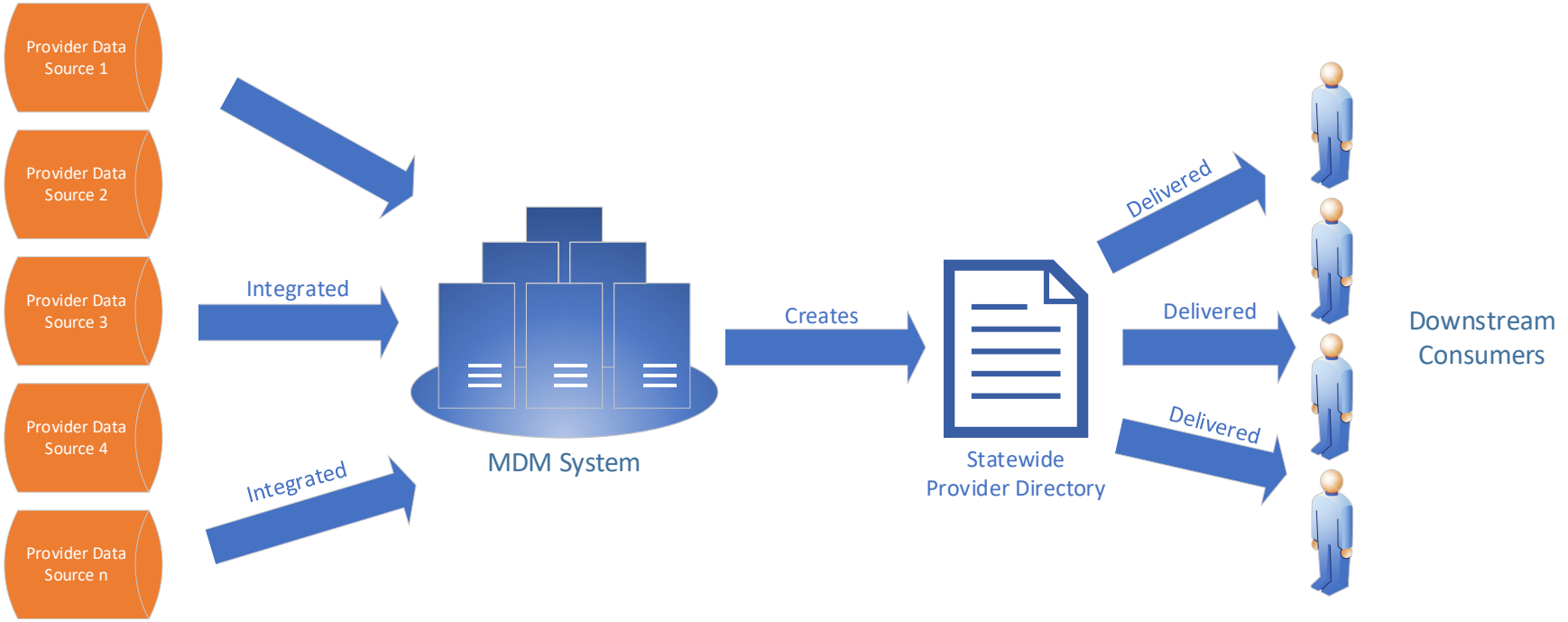
Statewide Provider Directory Project Overview

- A critical component in healthcare transformation is access to high quality, consistent, and accurate data on all types of healthcare providers.

- Using a Master Data Management (MDM) system, this project will leverage and optimize existing provider data assets available to the state, as well as include over 600 nationally available sets, for expanded ease of use, analytics, continuity in evaluation, and public distribution.

Provider Directory Project Future State



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INTEGRATED CARE & BEHAVIORAL HEALTH

Amy Jones

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Achievements in Behavioral Health

- Convened workgroup on workforce challenges for BH Integration
  - Reviewed roles and tasks performed in integrated setting, and identified workforce barriers to integration
  - Made recommendations to SIM/DSRIP Workforce Workgroup

- Conducted a webinar series for PTTAs to provide guidance on working with sites to integrate BH in PCMH
  - Topics included: Assessment, Screening, Depression treatment in Primary Care, Medication Adherence, Workflows, Sustainability/VBP
    - Recordings available as resource

- Provided best practices and resources to primary care based on experience with the Collaborative Care Medicaid Program

Future Directions for Behavioral Health

- Continue to promote the integration of physical and behavioral health
  - Encourage the adoption of evidence-based best practices
- Provide resources and support to providers looking to integrate
- Share knowledge on adoption of BH in primary care and using measurement to drive accountability and fidelity
- Encourage measurement-based care for BH
- Evaluate potential cost-savings and factors that impact successful implementation

PROJECT LIFT

Jen Post, Project Manager, Health Systems and Public Health Integration

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Linking Interventions for Total Population Health

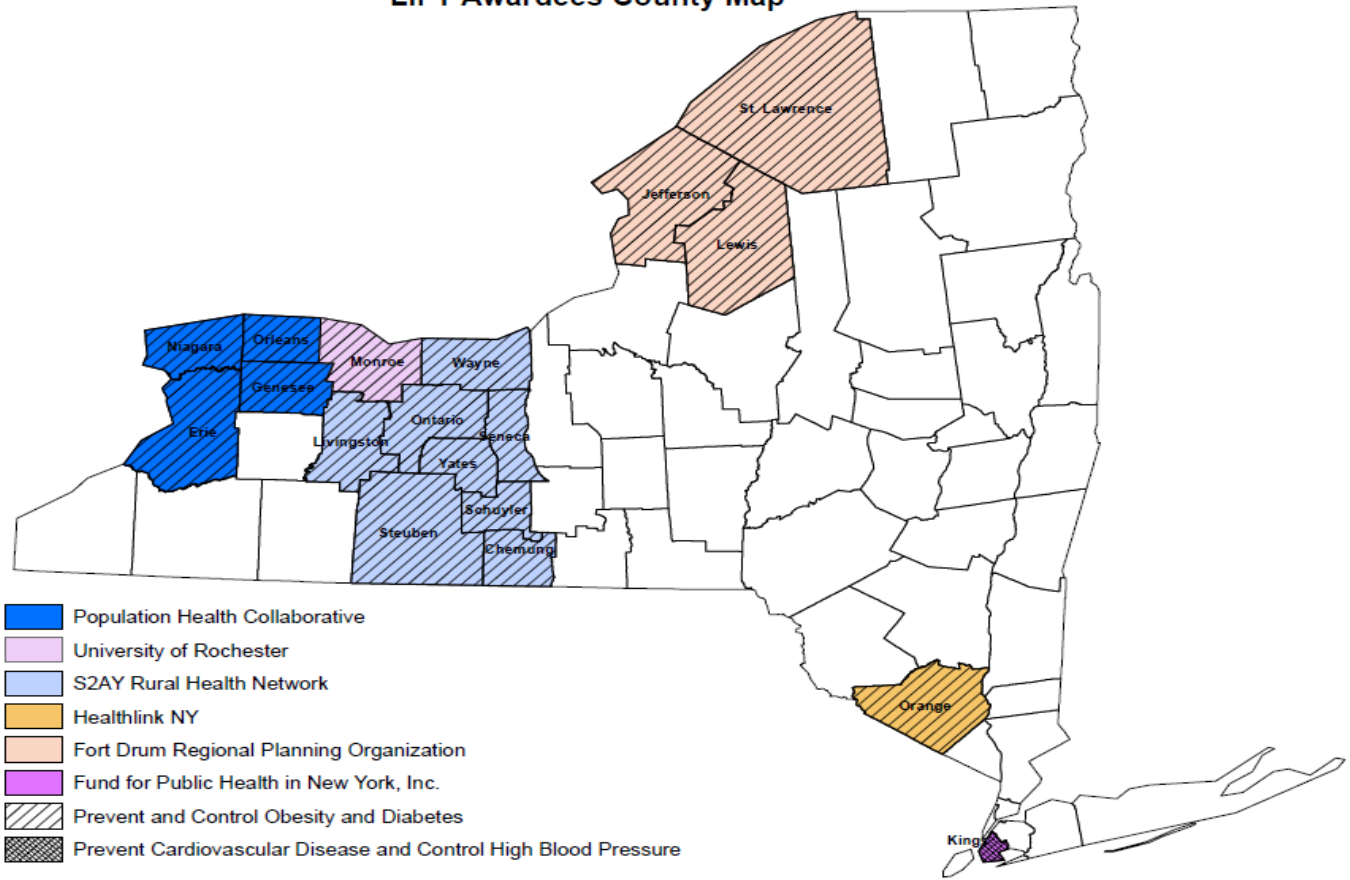
- Total of six awards covering 18 counties

- Interventions and activities developed by awardee to align with other existing initiatives in their community (DSRIP, Prevention Agenda, PHIP and other state and CDC-funded initiatives)

LIFT AWARDEES

Organization	Focus Area	Counties Covered
Fort Drum Regional Health Planning Organization	Prevent and Control Obesity and Diabetes	Jefferson, Lewis and St. Lawrence
Fund for Public Health in NYC	Prevent Cardiovascular Disease and Control High Blood Pressure	Kings
Healtheconnections	Prevent and Control Obesity and Diabetes	Orange
Population Health Collaborative of Western NY	Prevent and Control Obesity and Diabetes	Erie, Niagara, Orleans & Genesee
S2AY Rural Health Network, Inc.	Prevent and Control Obesity and Diabetes	Chemung, Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne & Yates
University of Rochester	Prevent and Control Obesity and Diabetes	Monroe

LIFT Awardees County Map



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Focus of LIFT

Communities focused on one of five issues related to the Prevent Chronic Disease priority area of the New York State Prevention Agenda

- Five projects chose Prevent and Control Obesity and Diabetes
- One project chose Prevent Cardiovascular Disease and Control High Blood Pressure

Awardees developed a portfolio of interventions across three categories or “buckets”

1. Traditional Clinical Prevention (10% of effort)
2. Innovative Clinical Prevention (30% of effort)
3. Total Population or Community-Wide Prevention (60% of effort)

Three Buckets of Prevention

Auerbach J., The 3 Buckets of Prevention. Journal of Public Health Management and Practice 2016.
http://journals.lww.com/jphmp/Citation/publishahead/The_3_Buckets_of_Prevention_.99695.aspx

CDC

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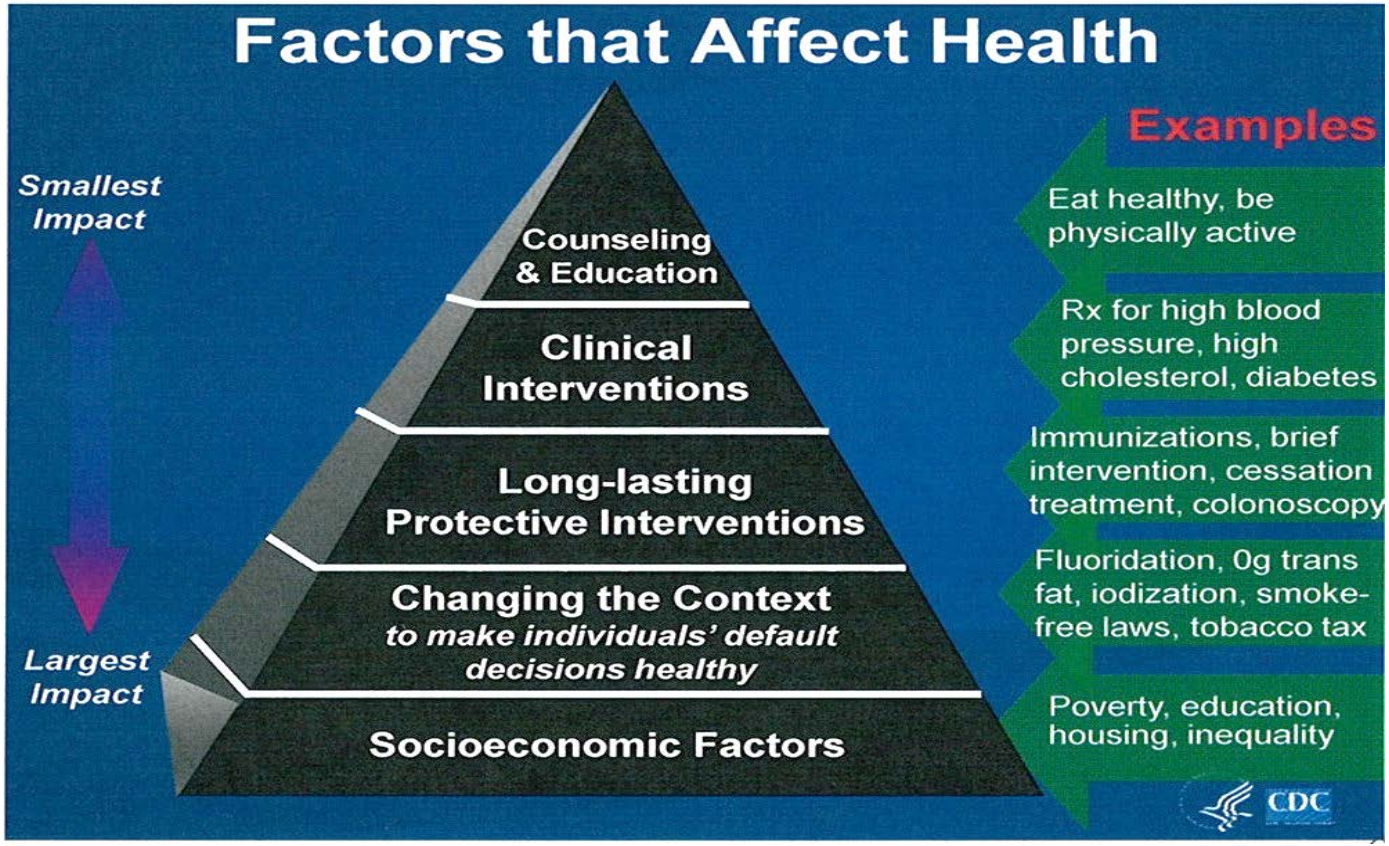

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Achievements to Date: Buckets 1 & 2

Prevent and Control Obesity and Diabetes projects

- 23 primary care delivery sites sent referrals to 58 evidence based program delivery sites
- 64 sessions of National Diabetes Prevention Program (NDPP) were held (826 adults attended, 542 completed)

Prevent Cardiovascular Disease and Control High Blood Pressure project

- Public health detailing conducted at 132 primary care sites
- Visits made and materials distributed to 104 pharmacy sites

Achievements to Date: Bucket 3 Community-wide Efforts

246 projects in progress or completed

Examples include:

- Implementation of school and worksite wellness policies
- Conducting a multi-faceted prediabetes risk factor public awareness campaign
- Inventory and promotion of summer feeding programs and farmer's markets
- Promotion of breastfeeding as a social norm and working with businesses, community-based organizations and public spaces to adopt breastfeeding friendly policies

Sustainability of LIFT Interventions

- Community-clinical linkages built
- Policies implemented at schools, worksites and at the community level
- Environmental changes
- Payment for NDPP

PROJECT EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES (ECHO)

Joan Cleary-Miron & Megan Prokorym

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Project ECHO: Access to Care

Goal: Increase workforce capacity in rural and underserved areas.

Objective: Providers will practice at the highest level of their license.

Activity: Establish tele-mentoring, specialist Hubs.

Agencies/Contractors Involved:

- **Champlain Valley Physicians Hospital**
  - Hepatitis C and Tick Borne Diseases
- **Montefiore Medical Center**
  - Alzheimer's Disease & Dementia, Opioid Use Disorder Treatment for Prescribers, and Opioid Use Disorder Treatment for Non-Prescribers
- **SUNY Upstate Medical Center**
  - Endocrinology and Diabetes Prevention & Management
- **Westchester Medical Center**
  - Behavioral Health and Perinatal Health

Project ECHO: Access to Care

Achievements to Date:

1. Certified **171** primary care, spoke sites
2. Held **137** virtual sessions
3. First Perinatal and Tick-Borne Illness ECHO Hubs

Sustainability:

All funded contractors plan to continue ECHO activities.

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Project ECHO: Change Achieved

Westchester Medical Center – Behavioral Health ECHO

"I feel that there is always something new I can take away and use to look at a situation, symptom or approach differently than the way I always tend to do things"

Westchester Medical Center – Perinatal ECHO

"Management of chronic hypertension with super-imposed pre-eclampsia"

Champlain Valley Physicians Hospital – Hepatitis C ECHO

"Treat HCV myself instead of immediately referring patients"

Project ECHO: Change Achieved

Champlain Valley Physicians Hospital – Hepatitis C ECHO

- *Five PCPs in N. Country now testing for and treating HCV in their practices*

Cross-ECHO Hub Survey Results (n=81)

- 94% Agreed/strongly agreed participation increased their confidence in providing care to patients with the condition
- 93% Agreed/strongly agreed participation improved the quality of care they provide to patients with the condition
- 91% Agreed/strongly agreed participation increased knowledge of best practices for treating patients with the condition

RURAL RESIDENCY PROGRAM

Susan Mitnick & Barb Gillen

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Rural Residency

Goal(s):

- Address primary care shortages in rural areas through rural residency training and physician retention strategies
- Support development of accredited rural-based GME programs to help alleviate primary care workforce shortages and prepare physicians to deliver quality services in a networked, team-based, value-driven primary care model

Agencies/Contractors Involved:

- Arnot Ogden Medical Center (AOMC)
- Champlain Valley Physicians Hospital (CVPH)
- Cayuga Medical Center (CMC)
- Mary Imogene Bassett Hospital
- Samaritan Medical Center (SMC)

Achievements to Date

Arnot Ogden Medical Center

- ✓ Expansion program accredited, began training July 2018
- ✓ 4 residents currently in training
- ✓ 6 residents in training when fully operational

Champlain Valley Physicians Hospital

- ✓ expanded existing ACGME Family Medicine Residency to a rural health clinic and began training residents in July 2018.
- ✓ Currently training 16 residents in 3 training years
- ✓ When fully implemented an additional 6 residents will train each year

Samaritan Medical Center

- ✓ working on ACGME approval to expand its existing Family Medicine Residency program through a rural pathway initiative
- ✓ Up to 6 additional residents will be trained

Achievements (Continued)

Cayuga Medical Center

- ✓ ACGME accreditation for a new two-track Internal Medicine residency in partnership with New York Presbyterian-Cornell
- ✓ Currently 1 resident in 1st year of training at New York Presbyterian-Cornell for 1st year and 2 at CMC
- ✓ In 2020, CMC plans to train 10 residents (2-4 at NY Presbyterian-Cornell).
- ✓ Up to 30 residents will train annually.

Mary Imogene Bassett Hospital

- ✓ Working on new ACGME Family Medicine Residency program,
- ✓ Awarded a Statewide Health Care Facility Transformation grant to construct a new building to house the program.
- ✓ Train 12 residents annually.

Related Innovations

- Mary Imogene Basset plans to merge their 1-year Family Medicine Nurse Practitioner training program training with the Family Medicine residency.

- UPMC Chautauqua is developing a Family Medicine Residency Program. First class anticipated for July 2021.

CONSUMER ENGAGEMENT

Anne Schettine

Consumer Engagement

Goal: To convene a wide range of stakeholders in developing recommendations for NYS DOH for designing more user-friendly and meaningful provider profiles to help inform health care decisions that New Yorkers commonly face.

Two groups were convened – one for decisions about primary care providers and one for decisions about hospitals

Agencies/Contractors Involved: United Hospital Fund

Consumer Engagement

Achievements to Date:

- Convened a series of meetings with stakeholders to gather recommendations and input on design aspects including 1) scope and content; 2) methodology; 3) navigation; and 4) dissemination

- Draft recommendations have been developed and provided to the workgroups to finalize. Memos will be provided to NYSDOH in January 2020

Future Similar Work/Sustainability Plans:

Recommendations will be used by NYSDOH to modify/develop quality ratings/profiling information for the website that consumers can use when making health care decisions.

Consumer Engagement

Considerable discussion occurred in both groups about the *purpose* of the quality ratings/profiling information, with both groups agreeing that the focus was on *meeting consumers where they are* in their needs for health care decisions.

SSC Measures Subcommittee Achievements

December 9, 2019

United Hospital Fund

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Who's Who of the Subcommittee

- **Chairs**
  - Lindsay Cogan (NYSDOH)
  - Scott Hines (Crystal Run Healthcare)
- **Project Directors**
  - Marcus Friedrich, James Kirkwood, Anne Schettine (NYSDOH)
- **Advisors**
  - Anne-Marie Audet, Lynn Rogut, Pooja Kothari, Kristina Ramos-Callan (United Hospital Fund)
- **Stakeholders**

Goals of the Subcommittee

- Collaborate with NYSDOH on **stewardship** of the NYS Primary Care Core Measure Set to ensure that it:
  - Is informed by advances in measurement science
  - Reflects delivery and financing reforms nationally and statewide
  - Reflects NYS DOH measurement goals, priorities, and parameters
- Implement an **annual process to review** quality measures
- Convene and solicit input from a diverse set of stakeholders (~30) including providers, consumers, payers, technical assistance providers, researchers

Subcommittee Achievements

- Developed a Core Measure Set annual review process and engaged Subcommittee participants in stewardship activities.
- Specified measure assessment criteria and created a scoring and voting system for selecting measures.
- Conducted 1st review cycle in 2017-18, with recommendations for NYSDOH.
- Evaluated stakeholder experience and refined the process and scoring system based on feedback.
- Conducted 2nd review cycle in 2018-19, focused on gap measures, and submitted recommendations to NYSDOH.

Process for Annual Review of the Core Measure Set

Scoring Cohorts formed	• Subcommittee scoring volunteers assigned to 4 stakeholder cohorts: consumer, payer, provider, NYSDOH
Volunteers scored measures	• Cohort volunteers use measure scoring matrix developed with subcommittee input; technical assistance provided to reviewers • Each measure scored by at least 2 cohorts
Voted on measure disposition	• Cohort scoring results presented to the full Subcommittee for discussion and voting • 51% majority vote on measure disposition with 1 person from each organization voting
Reached consensus on recommendations	• Finalized recommendations to NYSDOH for updating the Core Measure Set

Criteria and Scoring System for Assessing Measures

MEASURE PRINCIPLES, CRITERIA, CONSIDERATIONS	
Relevant to special populations	
PRINCIPLES	**Relevant to NYS primary care goals**
	Addresses the Quadruple Aim
	Standardized
ESSENTIAL CRITERIA	**Ease of reporting/Can be verified by practices**
	Addresses high prevalence/impact area
	Aligned with payer measure sets
	Type of measure
KEY CONSIDERATIONS	**Measure can be evaluated at the level of analysis for intended use**
	Notable performance gap or opportunity for improvement in NYS

Scoring Key
Principles *(prepopulated)*
P Pass
F Fail
Essential Criteria (0-3)
0 No
1 Low
2 Medium
3 High
Essential Criteria (0-1) - Aligned with Payer Measure Sets *(prepopulated)*
0 No
1 Yes
Essential Criteria (0-3) - Type of Measure *(prepopulated)*
0 Utilization/Structure
1 Process
2 Interim Outcome
3 Outcome
3 Patient Reported Outcome
Key Considerations
0 No
1 Low
2 Medium
3 High

Evolution of the Core Measure Set to-Date

2018 Review Cycle

- Started with 30 measures
- Removed 4 measures:
  - Fluoride Varnish Application
  - Diabetes HbA1C Testing
  - Diabetes Foot Exam
  - Total Cost Per Member Per Month (but kept the Cost domain)

2019 Review Cycle

- Started with 26 measures
- Added 2 gap measures:
  - Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life
  - Immunizations for Adolescents
- Removed 1 measure
  - Outpatient Utilization

The Subcommittee recommended 27 measures for inclusion in the 2020 Core Measure Set*

*Final decisions remain within the purview of NYSDOH.

NYS Primary Care Core Measure Set Recommended for 2020

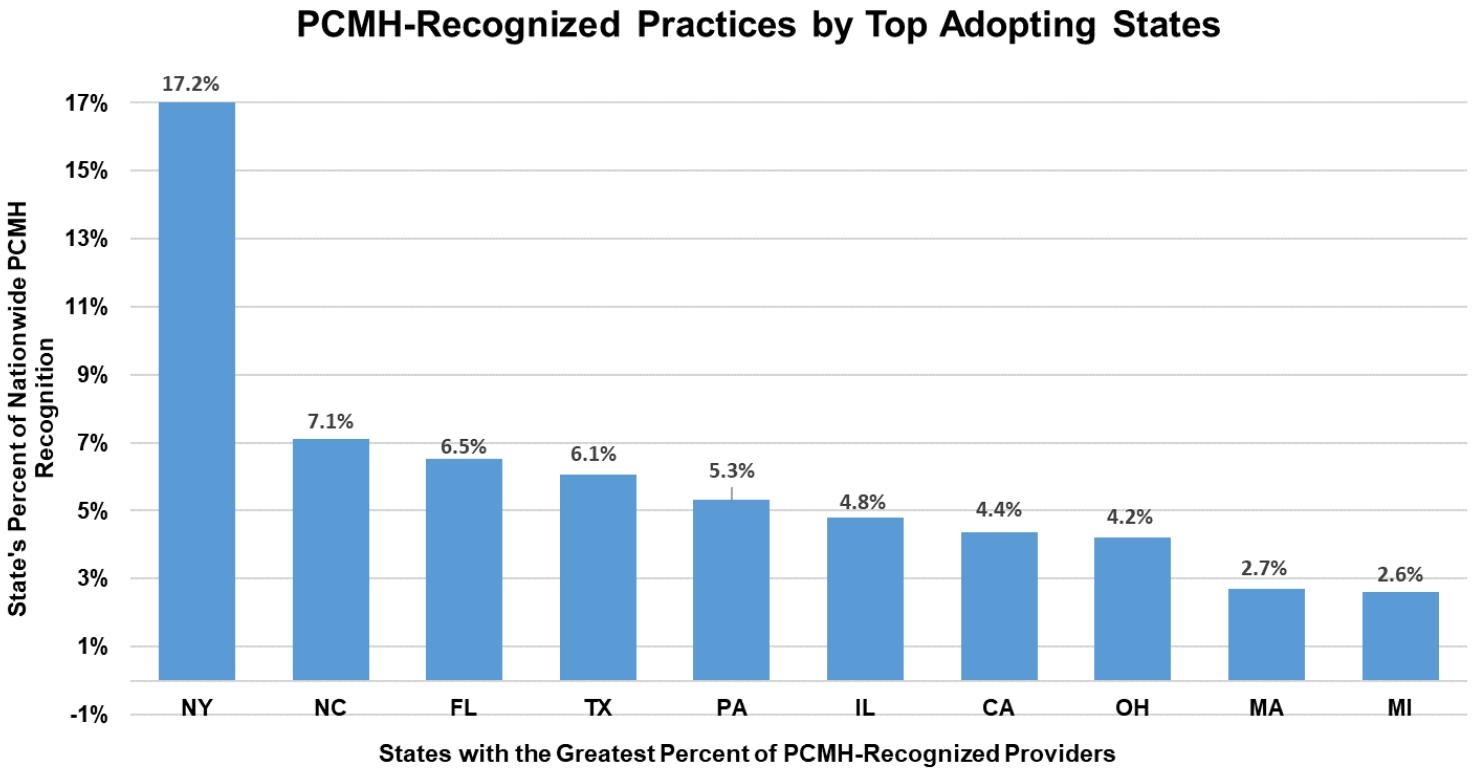
DOMAIN	MEASURE	POPULATIONS	DATA SOURCE
Prevention	**Cervical Cancer Screening** (#32/HEDIS)	Adults: 21 – 64 years	Claims-only possible
	Breast Cancer Screening (#2372/HEDIS)	Adults: 50 – 74 years	Claims-only possible
	Colorectal Cancer Screening (#34/HEDIS)	Adults: 50 - 75 years	Claims/EHR
	Chlamydia Screening (#33/HEDIS)	Adolescents/Adults: 16 - 24 years	Claims-only possible
	Influenza Immunization - all ages (#41/AMA)	All: 6 months+	Claims/EHR/Survey
	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (NQF #1516)	Children: 3-6 years	Claims/EHR
	Immunizations for Adolescents (NQF #1407)	Adolescents: 13 years	Claims/EHR
	Childhood Immunization Status (#38/HEDIS)	Children: 2 years old	Claims-only possible
Chronic Disease	**Tobacco Use Screening and Intervention** (#28/AMA)	Adults: 18 years+	Claims/EHR
	Controlling High Blood Pressure (#18/HEDIS)	Adults: 18 - 85 years	Claims/EHR
	Diabetes: A1C Poor Control (#59/HEDIS)	Adults: 18 - 75 years	Claims/EHR
	Diabetes: Eye Exam (#55/HEDIS)	Adults: 18 - 75 years	Claims
	Diabetes: Medical Attention for Nephropathy (#62/HEDIS)	Adults: 18 - 75 years	Claims
	Persistent Beta Blocker Treatment after Heart Attack (#71/HEDIS)	Adults: 18 years+	Claims/EHR
	Medication Management for People with Asthma (#1799/HEDIS)	All: 5 - 65 years	Claims-only possible
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (#24/HEDIS)	Child/Adolescents: 3 - 17 years	Claims/EHR
	BMI Screening and Follow-Up (#421/CMS)	Adults: 18 years+	Claims/EHR
Behavioral Health/ Substance Use	**Screening for Clinical Depression and Follow-up Plan** (#418/CMS)	Adolescents/Adults: 12 years+	Claims/EHR
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (#4/HEDIS)	Adolescents/Adults: 13 years+	Claims/EHR
	Antidepressant Medication Management (#105/HEDIS)	Adults: 18 years+	Claims
Patient-Reported	**Advance Care Plan** (#326/HEDIS)	Adults: 65 years+	Claims-only possible
	CAHPS Access to Care, Getting Care Quickly (#5/AHRQ)	All	Claims/EHR
Appropriate Use	**Use of Imaging Studies for Low Back Pain** (#52/HEDIS)	Adults: 18 – 50 years	Survey
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (#58/HEDIS)	Adults: 18 – 64 years	Claims
	Inpatient Hospital Utilization (HEDIS)	All	Claims
	Plan All-Cause Readmissions (#1768/HEDIS)	Adults: 18 years+	Claims
	Emergency Department Utilization (HEDIS)	All	Claims
Cost	(Pending measure review)		

Populations: Children, ages 0 - 9; Adolescents, ages 10 - 17; Adults, ages 18+. The WHO defines adolescence as the age range 10 – 19 years. The AAP/Bright Futures defines it as the age range 11 – 21 years.

Data Sources: Claims-only possible refers to the fact that the measure requires use of both claims and other sources (EHR, survey) but using only claims is a feasible alternative.

Lunch and Networking Break

Primary Care Trends and Changes



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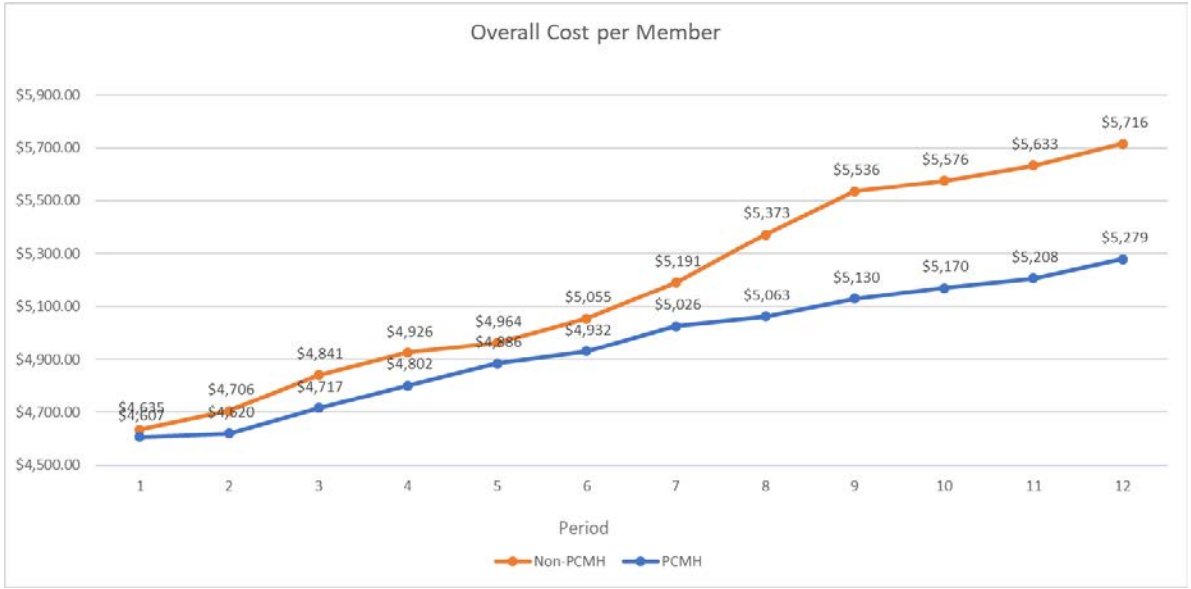
Medicaid Average Total Medical Cost for Non-dual Members by PCMH Status

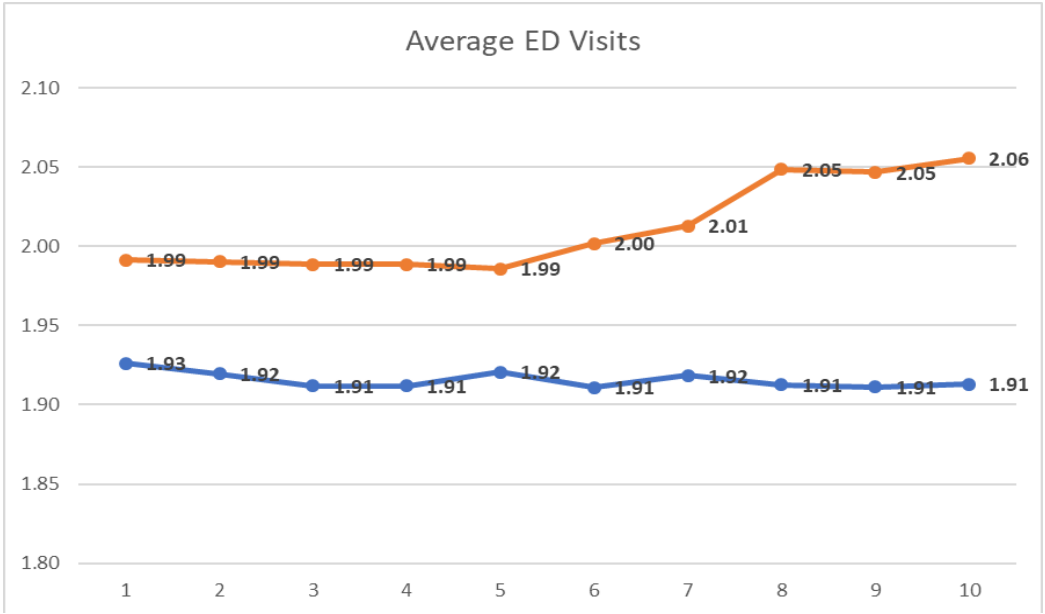


Reporting Period	Start	End
1	2015-07-01	2016-06-30
2	2015-10-01	2016-09-30
3	2016-01-01	2016-12-31
4	2016-04-01	2017-03-31
5	2016-07-01	2017-06-30
6	2016-10-01	2017-09-30
7	2017-01-01	2017-12-31
8	2017-04-01	2018-03-31
9	2017-07-01	2018-06-30
10	2017-10-01	2018-09-30
11	2018-01-01	2018-12-31
12	2018-04-01	2019-03-31

- Members attributed to PCMH providers have lower total medical cost than members attributed to Non-PCMH providers.
- The difference starts to increase in 2017.

NEW YORK STATE Department of Health

Medicaid Average Number of ED Visits for ED Utilizers by PCMH Status

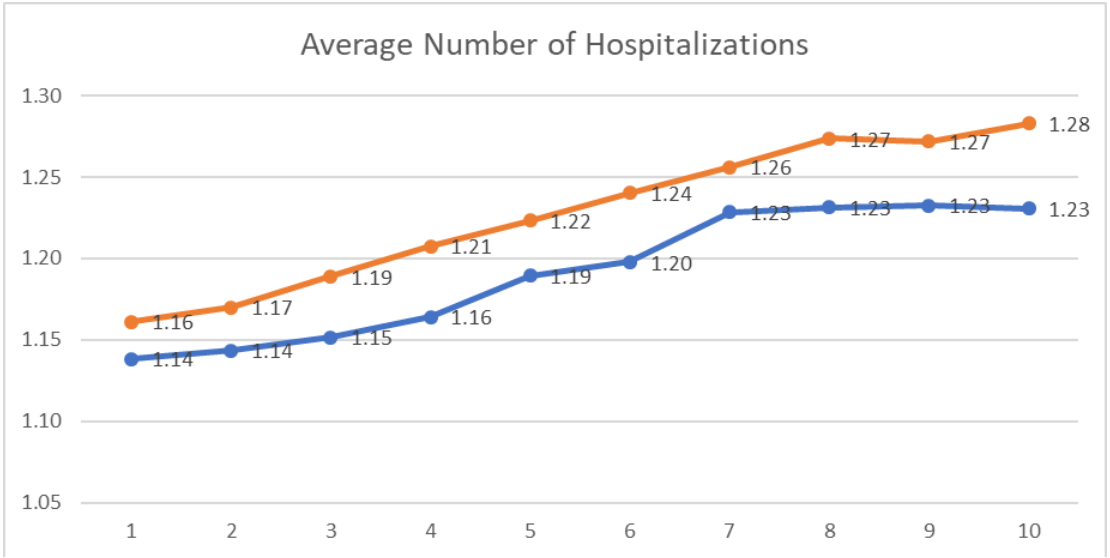


Reporting Period	Start	End
1	2015-07-01	2016-06-30
2	2015-10-01	2016-09-30
3	2016-01-01	2016-12-31
4	2016-04-01	2017-03-31
5	2016-07-01	2017-06-30
6	2016-10-01	2017-09-30
7	2017-01-01	2017-12-31
8	2017-04-01	2018-03-31
9	2017-07-01	2018-06-30
10	2017-10-01	2018-09-30

- For members who utilized ED services, PCMH group has a lower average visits than Non-PCMH group over time.
- The difference starts to increase in 2017.

NEW YORK STATE Department of Health

Medicaid Average Number of Hospitalizations for Inpatient Utilizers by PCMH Status



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10	2017-10-01	2018-09-30

- For members who had hospitalizations, PCMH group has a lower average than Non-PCMH group over time.

NEW YORK STATE Department of Health

PCMH Practice Quality of Care (2018 Score Card Data)

Domain	Measure	Average Practice Rate PCMH	Not PCMH	Difference	Significance
Prevention	Cervical Cancer	69.83%	69.19%	0.64%	
	Breast Cancer	74.45%	71.50%	2.95%	***
	Chlamydia Screening (16-20)	70.77%	69.30%	1.47%	
	Chlamydia Screening (21-24)	74.90%	72.28%	2.62%	***
	Chlamydia Screening (Total)	71.99%	70.97%	1.02%	
	Child Immunization- Combo 3	75.19%	72.05%	3.14%	
Chronic Disease	HBa1C	92.22%	90.88%	1.34%	***
	Eye Exam	64.19%	59.80%	4.39%	***
	Nephropathy	92.79%	91.60%	1.19%	***
	Medication Management for Asthma (50%)	42.99%	43.99%	-1.00%	
	Medication Management for Asthma (75%)	39.95%	41.55%	-1.60%	
Behavioral Health / Substance Abuse	Antidepressant Medication-Acute Phase	58.30%	57.82%	0.48%	
	Antidepressant Medication-Continuation Phase	42.83%	43.94%	-1.11%	
	Inititaion of Alcohol and Other Drug Treatment-Initiation	44.38%	42.78%	1.60%	
	Inititaion of Alcohol and Other Drug Treatment- Engagement	16.71%	17.81%	-1.10%	
Appropriate Use	Avoidance of Antibiotic Treatment in	33.52%	31.88%	1.64%	
	Use of Imaging Studies for Lower Back Pain	78.04%	80.18%	-2.14%	

Future Analysis

- Continue to examine outcome changes Pre- and Post-PCMH transformation
- Focusing on priority populations
  - Behavioral and chronic conditions
  - Children with special health needs
  - Dual population
- Study the impact of health IT on quality outcomes
- Evaluation of challenges in the transformation process
- Conduct analysis of provider type and network to support incentive program

Future Focus Post-SIM

Potential Focus Areas for DOH

Area 1: Importance and Future of Primary Care

Area 2: Data Infrastructure

Area 3: Payment Models

Area 4: Regional Priorities for Health Care

Focus Areas (1 of 2)

Area 1: Importance and Future of Primary Care. Topics regarding primary care impact or needs in a region and statewide such as:

a) NYS PCMH evaluation and impact to achieving high-quality, cost-effective care;
b) defining and monitoring proportion of overall expenditures on primary care;
c) practice engagement in advanced primary care; and
d) expansion of patient centered care model with other providers.

- Outputs: Figures on the performance of PCMH providers compared to non-PCMH providers. Engagement on a New York State primary care definition and reporting requirements.

Area 2: Data Infrastructure. Topics regarding use of data or information such as:

a) All-Payer Database capacity for provider-level results using multi-payer data;
b) HIE quality measurement capacity;
c) involvement of QEs, plans (or APD) and providers to increase completeness and utility of integrated information; and
d) aligning quality measures across plans using VBP arrangements ('super six' outcome measures).

- Outputs: Updates on New York technology/data infrastructure progress and demonstrations of use-cases. Forum for discussion of payer alignment of quality measures.

Discussion

Focus Areas (2 of 2)

Area 3: Payment Models. Topics around payment models such as:

a) federal, state or local emerging payment models;

b) what state support is needed for regional payment reform (safe harbor);

c) feedback on implementation, what is and isn't working with VBP in NYS, what are the barriers to or successes with VBP, what effect is VBP contracting having on payers, and

d) how will plans evaluate if NYS PCMH is successful and financially viable to continue to incentivize.

- Outputs: Direct payer feedback which can be incorporated into emerging models or escalated appropriately for existing models.

Area 4: Regional Priorities for Health Care. Topics around regional priorities such as:

a) how primary care providers could impact improving population health;

b) regional needs or initiatives to integrate behavioral health; and

c) regional needs or initiatives to address social determinants of health.

- Outputs: Coordination between payers, providers, and state-level programs addressing population health, behavioral health, or social determinants of health.

Discussion

ROMC Future Focus

Western

- Alignment with CPC+ efforts in region

Finger Lakes

- Regional priorities

Metro

- SHIN-NY integration and HIT

Capital District/Hudson Valley

- Alignment with CPC+ efforts in region

Primary Care and Statewide Steering Committee

- Future primary care initiatives in NYS
  - CPC+/Primary Care First
  - Measuring primary care spending
    - Definition Development
    - Collaboration on Analysis

- Future of Statewide Steering Committee

Closing Remarks

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The contents provided are solely the responsibility of this organization, the New York State Department of Health.