NEW YORK STATE OF OPPORTUNITY. Department of Health

# Transparency, Evaluation, and Health Information Technology Workgroup

## Meeting #9

## February 26, 2016

# Agenda

| # | Topic | Time | Leader |
|---|---|---|---|
| 1 | Welcome and Introductions | 10:30 – 10:40 | Patrick Roohan |
| 2 | Opening Remarks | 10:40 – 10:45 | Paul Francis |
| 3 | 2016 Workgroup Focus | 10:45 – 11:20 | Patrick Roohan |
| 4 | Transparency | 11:20 – 11:50 | Patrick Roohan |
| 5 | APD Update | 11:50 – 12:30 | Chris Nemeth |
| 6 | Working Lunch | 12:30 – 12:50 | |
| 7 | SHIN-NY Update | 12:50 – 1:20 | Jim Kirkwood |
| 8 | Update on and Review of Interim Data Collection Tool for APC | 1:20 – 1:50 | Anne Schettine<br>Paul Henfield |
| 9 | Discussion and Next Steps | 1:50 – 2:00 | Patrick Roohan |

# 2016 Workgroup Focus

Patrick Roohan
Director
Office of Quality and Patient Safety

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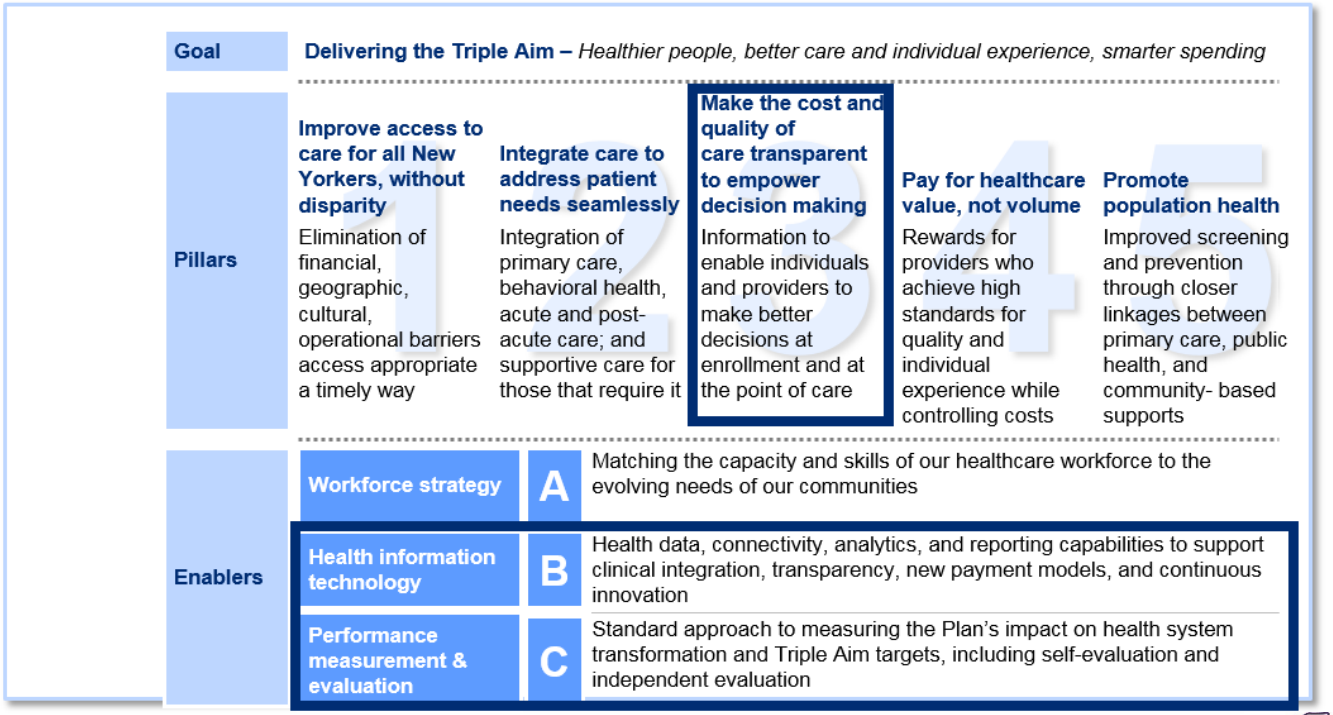
# Workgroup Focus in 2016

- Build on Success
  - HIT report is finalized
  - SHIN-NY Regulations are completed
  - APD proposed regulations will begin public process soon

- Future work will support the State Health Innovation Plan (SHIP and the grant to support it (State Innovation Model (SIM) Grant)

# HIT is a Critical Enabler and Pillar to the SHIP

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# Objectives for the Transparency, Evaluation, and HIT Workgroup

**Create a statewide HIT infrastructure that supports the goals of the Triple Aim through:**

- Implementation of a **Statewide Health Information Network of New York (SHIN-NY)** that facilitates health information exchange to improve care coordination and reduce duplication
- Implementation of an **All-Payer Database** to increase health quality and price transparency, inform policy, enable improvements in quality and performance, and inform benchmarking and comparisons
- Development of a process for **ongoing alignment of measures and technology** to evolving health needs for the State of New York, starting with an APC scorecard

# Major Areas of Focus Going Forward

- Measure Alignment
- Transparency
- HIT Infrastructure for Health Care Reform
  SHIN-NY, APD, etc.
- Align technology solutions across SIM, DSRIP and other reform efforts

# Transparency

Patrick Roohan
Director
Office of Quality and Patient Safety

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# Discussion for today:

- Overall purpose of transparency

- Current efforts related to Transparency
  - States
  - Insurance companies
  - Third parties

# Transparency is an increasingly important topic across healthcare and raises important questions for states

## Context

- Growing call for transparency throughout healthcare, driven by:
  - Shift to focus on value vs. volume, giving providers greater accountability and a need for data on cost and quality
  - Higher deductibles encouraging individuals to "shop" for healthcare
  - Consumers used to accessing information / technology / social media to support decision making (e.g., Yelp, OpenTable)
  - Sense that meaningful information not accessible and interpretable (despite deluge of data out there)
- Business interests often feel threatened by idea of transparency

## Key questions

- What do we really mean by transparency?
  - Who are the key users of data?
  - What are their 'use cases'?
- What are the most important transparency use cases to support the Triple Aim?
- Which use cases should be priority for the state specifically to address?
- What levers does the state have to shift the needle on transparency in priority cases?

# Consumers require real-time, customized cost and quality data to stand any chance of making informed decisions

| | | From . . . | To . . . |
|---|---|---|---|
| Consumers need access to relevant data . . | Price | ▪ **Consumers struggle to obtain** meaningful price data – despite a deluge of information about healthcare | ▪ Consumers can see **expected out-of-pocket contribution** based on their plan, health needs and provider |
| | Quality | ▪ Some transparency around quality . .<br>▪ . . but **confusion** around standards / metrics / how to interpret quality data | ▪ Consumers have access to clear, **standardized quality measures** for the provider / procedure they are considering:<br>– Outcomes measure<br>– Safety<br>– Other quality dimensions (e.g., timeliness) |
| . . in a timely, convenient way | Timeliness | ▪ **Data lags limit usefulness** for decisions – patients often their cost they will bear several weeks after a procedure | ▪ Relevant data available in **real-time, prior to a purchase** |
| | Channel | ▪ Data shared in **various formats**, often not electronically<br>▪ **Disparate sources** – burden on consumer to stitch together | ▪ **Electronic access** should be provided - via a website, smartphone app, with EHR interoperability and data aggregated where possible (“one stop shop”?) |

Source: Multiple sources, including GAO, Catalyst for Payment Reform

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# Enabling transparency across key users will drive affordable, efficient and high-quality healthcare

| Data user | High-level use case | Examples |
|---|---|---|
| Consumer | ▪ Access meaningful data to inform personal health-related decisions | ▪ Make an informed choice about health plans<br>▪ Select a physician or care facility for a required health procedure based on price, quality, safety etc. |
| Provider | ▪ Deliver effective care to individual patients | ▪ Select the right referral pathway for a patient, comparing specialists on price and quality etc.<br>▪ Track and analyze own performance vs. core measures |
| Network contracting lead | ▪ Access market intelligence to inform contract negotiations | ▪ A health system or payer will wish to compare the performance of different providers and/or facilities when deciding on network structure and negotiating contracts, acquisitions etc. |
| Policy maker | ▪ Inform policy design and evaluate policy impact | ▪ Evaluate implementation of the SHIP and impact:<br>– Progress towards APC<br>– VBP penetration<br>– Provider performance against core measures<br>▪ Influence public opinion/debate about healthcare costs, drivers, opportunities etc. |

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# Current Efforts Related to Transparency

- Who?
  - States
  - Insurance companies
  - Third parties

- Metrics
  - Cost/Charge
  - Quality
  - Volume
  - Patient Perspective
  - Combinations

# Sample state tools for consumer transparency

ILLUSTRATIVE

| | Goals | Approach | Results / Impact | Lessons for NY |
|---|---|---|---|---|
| Massachusetts | Empower patients to comparison-shop for care as part of legislation passed in August 2012 | ▪ Providers must disclose amount charged for admission or a service within 2 working days<br>▪ Providers must give patients or insurers information needed to calculate out-of-pocket costs for the patient | ▪ According to a Pioneer Institute study, the "transparency law is still not a reality"<br>– 9 of 23 sampled practices knew about the law<br>– 13 of 25 sampled practices provided the cost of all fees within 2 days<br>▪ Some health systems have tools to give providers access to charges and patient costs | ▪ Legislation alone cannot ensure compliance from providers and payers<br>▪ Consumers have difficulty understanding health care data without access to easy-to-use tools |
| Washington | Ensure that consumers can access cost / quality data through payer websites and mobile applications | ▪ Payers required to provide the following data on website and a mobile application:<br>– Cost data for common treatments and individual out-of-pocket costs<br>– Quality metrics by provider (where available)<br>– Options for patients to provide ratings or feedback | ▪ Too early for data on consumer utilization and impact on medical trend (requirement begins January 1, 2016) | ▪ Innovation should build off existing capabilities<br>▪ Alignment across major health care stakeholders can help enable reform |

Source: Pioneer Institute: Mass. Healthcare Price Transparency Law Still Not a Reality; Massachusetts Medical Society: Massachusetts Medical Price Transparency Law Rolls out; Washington State website; Catalyst for Payment Reform

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# Example: New Hampshire Health Cost

## Detailed estimates for Insured Procedure

**Procedure:** X-Ray - Shoulder (outpatient)
**Procedure Description:** X-ray exam of the shoulder with a minimum of two views.
**Procedure Code:** 73030
**Insurance Plan:** Harvard Pilgrim HC - Health Maintenance Organization (HMO)
**Within:** 50 Miles of Concord, NH (03301)

| Lead Provider | Estimate of What you Will Pay | Estimate of What Insurance Will Pay | Estimate of Combined Payments | Precision of the Cost Estimate | Typical Patient Complexity |
|---|---|---|---|---|---|
| LAKES REGION RADIOLOGY PA 603.524.2534 | $24 | $0 | $24 | VERY LOW | MEDIUM |
| NH NEUROSPINE INSTITUTE | $62 | $0 | $62 | VERY LOW | HIGH |
| DARTMOUTH-HITCHCOCK (MANCHESTER) 603.695.2500 | $75 | $0 | $75 | LOW | MEDIUM |
| DERRY IMAGING CENTER 603.537.1363 | $98 | $0 | $98 | VERY LOW | MEDIUM |
| SOUTHERN NEW HAMPSHIRE RADIOLOGY CONSULTANTS PC 603.627.1661 | $100 | $12 | $112 | VERY LOW | MEDIUM |
| ST. JOSEPH HOSPITAL 603.882.3000 | $100 | $30 | $130 | MEDIUM | MEDIUM |
| DARTMOUTH-HITCHCOCK (NASHUA) 603.577.4000 | $100 | $35 | $135 | LOW | MEDIUM |
| PARKLAND MEDICAL CENTER 603.432.1500 | $100 | $49 | $149 | LOW | MEDIUM |

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Source: www.nhhealthcost.com

# Services listed on New Hampshire's HealthCost

### Office visits

1. Basic office visit
2. Office visit, established Pt
3. Office visit of moderate complexity
4. Comp preventative medicine 18 – 39 years old
5. Comp preventative medicine 40 – 64 years old
6. New patient, Comp preventative medicine 18 – 39 years old
7. New patient, Comp preventative medicine 40 – 64 years old

### Emergency visits

8. Emergency room visit – very minor (outpatient)
9. Emergency room visit – medium (outpatient)

### Radiology

10. Bone density scan (outpatient)
11. CT – abdomen (outpatient)
12. CT – chest (outpatient)
13. CT – pelvis (outpatient)
14. Mammogram
15. MRI – back
16. MRI – brain
17. MRI – knee
18. MRI – pelvis
19. Myocardial imaging
20. Ultrasound – breast
21. Ultrasound – pelvic
22. Ultrasound – pregnancy
23. X-ray – ankle
24. X-ray – chest
25. X-ray – foot
26. X-ray – knee
27. X-ray – shoulder
28. X-ray – spine
29. X-ray – wrist

### Procedures

30. Arthrocentesis
31. Arthroscopic knee surgery
32. Breast biopsy
33. Colonoscopy
34. Destruction of lesion
35. Gall bladder surgery
36. Hernia repair
37. Kidney stone removal
38. Tonsillectomy with adenoidectomy

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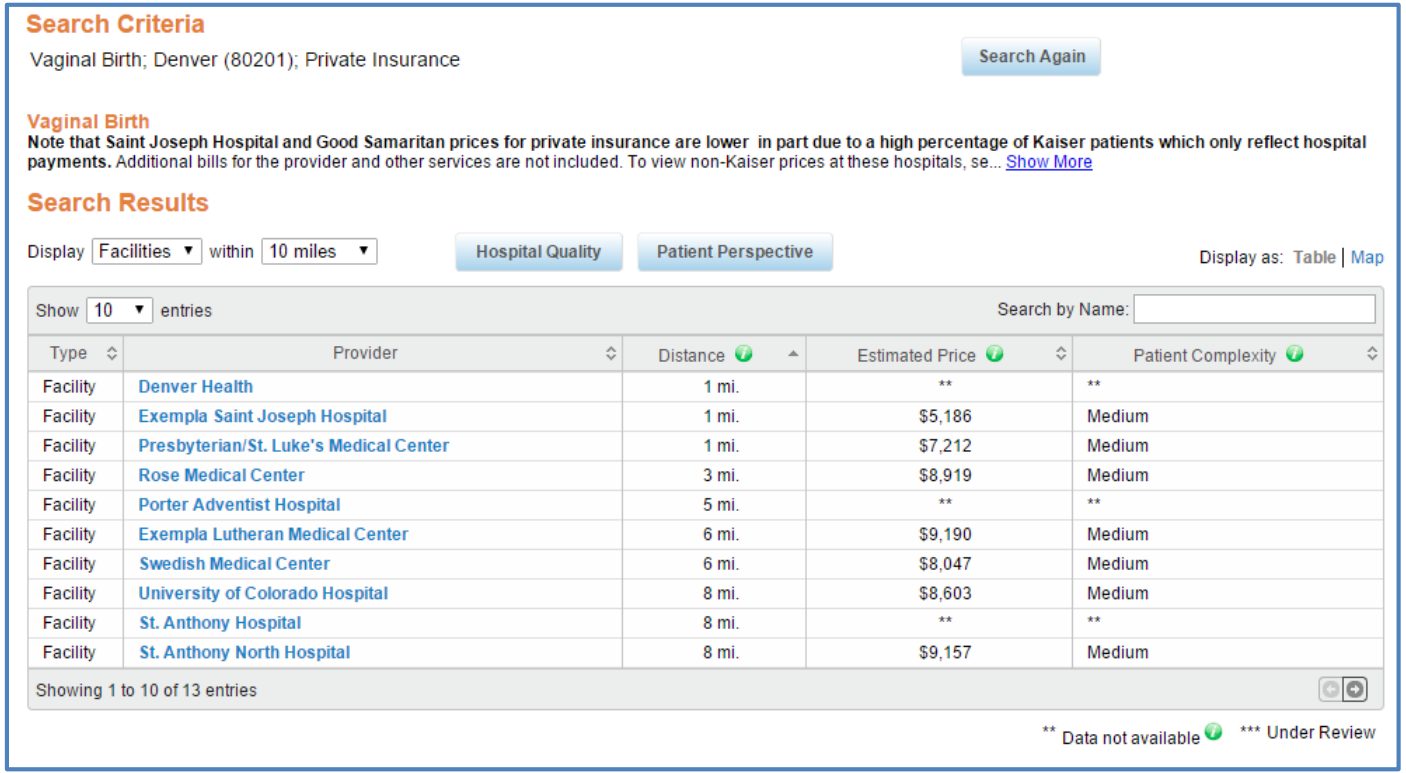
Source: New Hampshire's HealthCost website, http://nhhealthcost.nh.gov/insured

# Example: Colorado Medical Price website



## Search Criteria

Vaginal Birth; Denver (80201); Private Insurance

Search Again

### Vaginal Birth

**Note that Saint Joseph Hospital and Good Samaritan prices for private insurance are lower in part due to a high percentage of Kaiser patients which only reflect hospital payments.** Additional bills for the provider and other services are not included. To view non-Kaiser prices at these hospitals, se... Show More

## Search Results

Display Facilities within 10 miles | Hospital Quality | Patient Perspective | Display as: Table | Map

Show 10 entries | Search by Name:

| Type | Provider | Distance | Estimated Price | Patient Complexity |
|---|---|---|---|---|
| Facility | Denver Health | 1 mi. | ** | ** |
| Facility | Exempla Saint Joseph Hospital | 1 mi. | $5,186 | Medium |
| Facility | Presbyterian/St. Luke's Medical Center | 1 mi. | $7,212 | Medium |
| Facility | Rose Medical Center | 3 mi. | $8,919 | Medium |
| Facility | Porter Adventist Hospital | 5 mi. | ** | ** |
| Facility | Exempla Lutheran Medical Center | 6 mi. | $9,190 | Medium |
| Facility | Swedish Medical Center | 6 mi. | $8,047 | Medium |
| Facility | University of Colorado Hospital | 8 mi. | $8,603 | Medium |
| Facility | St. Anthony Hospital | 8 mi. | ** | ** |
| Facility | St. Anthony North Hospital | 8 mi. | $9,157 | Medium |

Showing 1 to 10 of 13 entries

** Data not available *** Under Review

**CO provides this information for 4 encounter types: Maternity care (vaginal birth, Cesarean) and for Surgical (Hip joint replacement, knee joint replacement)**

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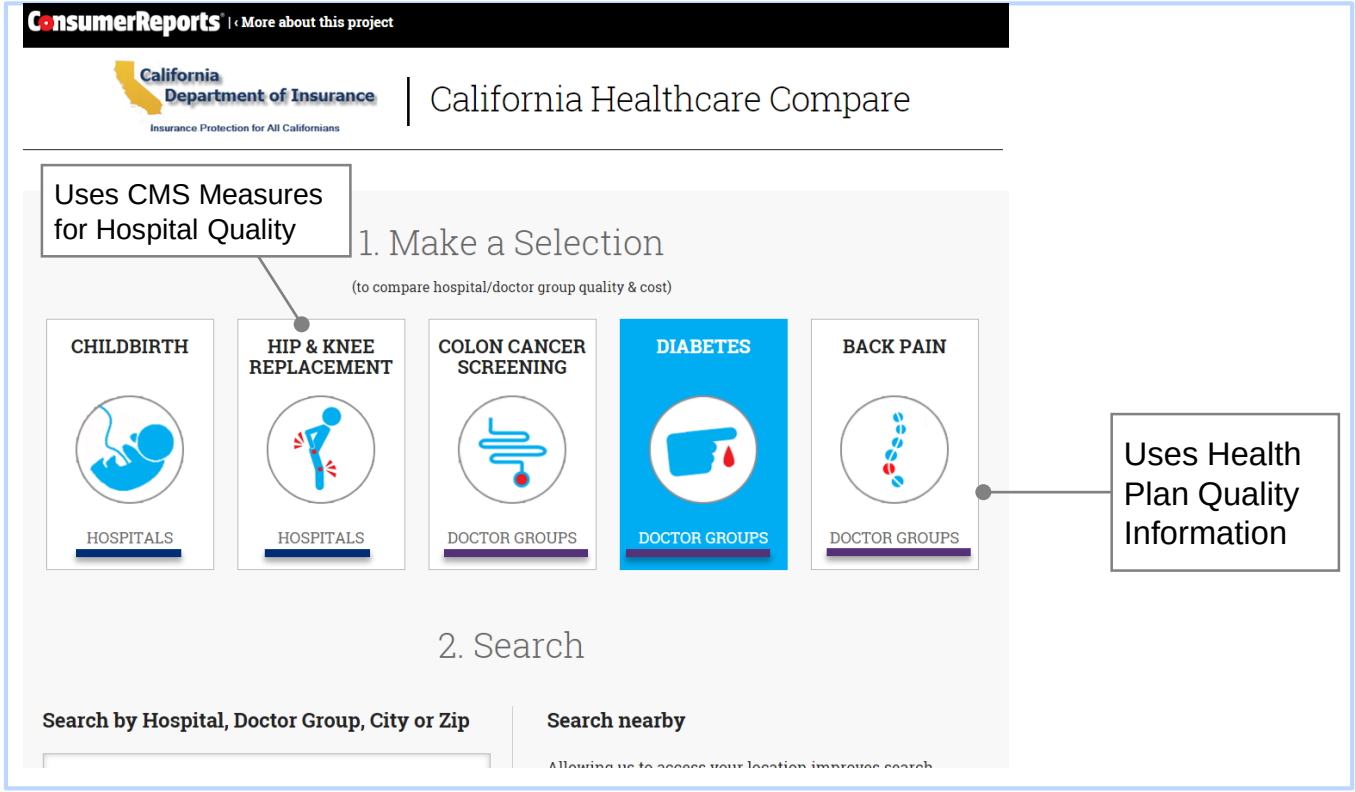
Source: https://www.comedprice.org/

# California Healthcare Compare| Hospitals & Doctor Groups




http://www.consumerreports.org/cro/health/california-health-cost-and-quality---consumer-reports/index.htm

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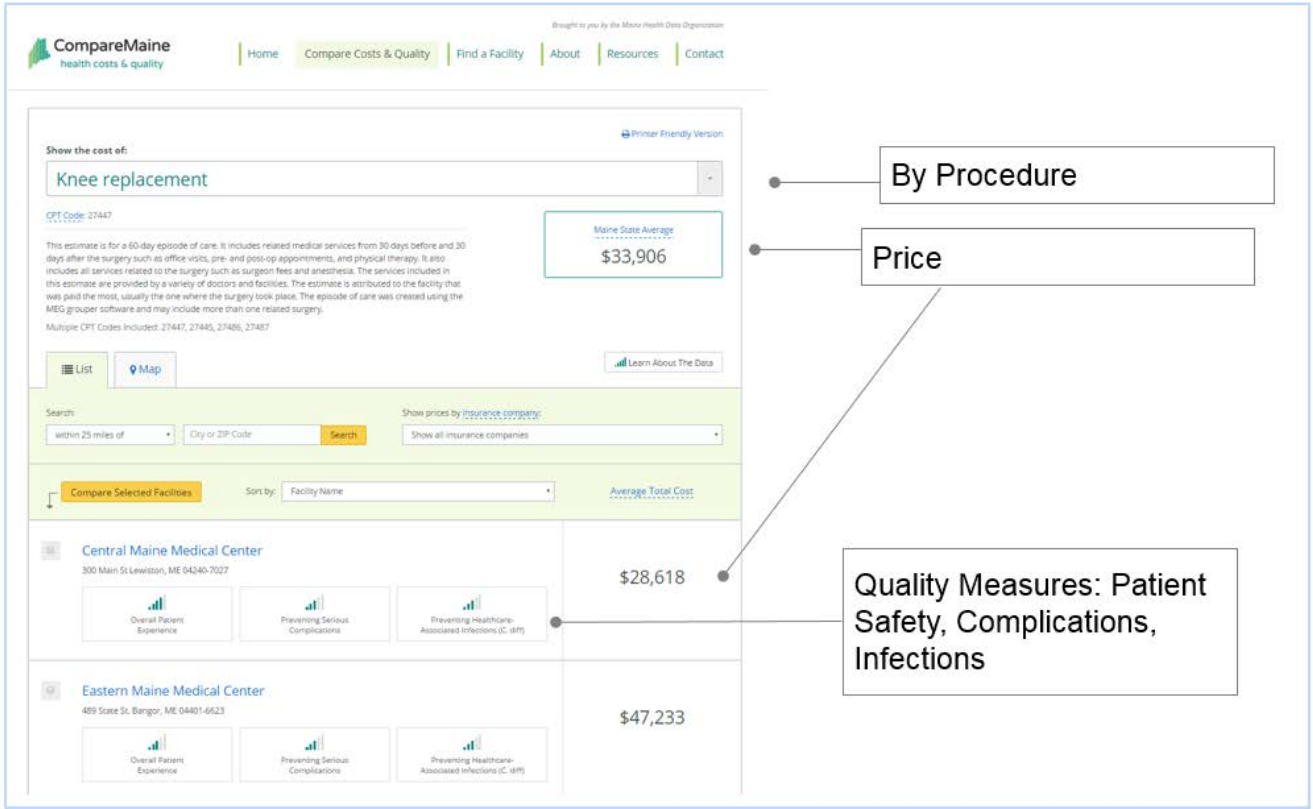
# CompareMaine| Health Costs & Quality




Source: CompareMaine @ http://www.comparemaine.org/?page=home&from=logo

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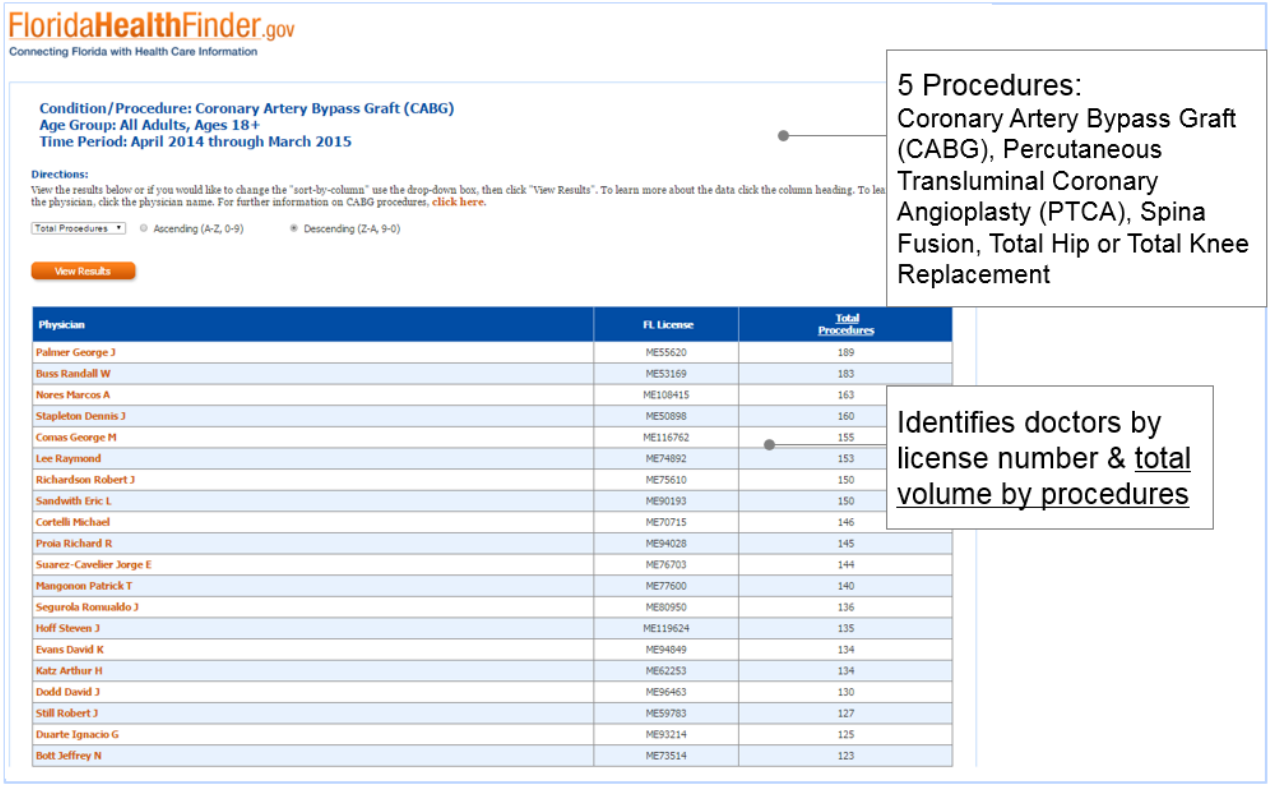
# FloridaHealthFinder.gov| Doctor Volume by Procedure



FloridaHealthFinder.gov
Connecting Florida with Health Care Information

**Condition/Procedure: Coronary Artery Bypass Graft (CABG)**
**Age Group: All Adults, Ages 18+**
**Time Period: April 2014 through March 2015**

**Directions:**
View the results below or if you would like to change the "sort-by-column" use the drop-down box, then click "View Results". To learn more about the data click the column heading. To lea
the physician, click the physician name. For further information on CABG procedures, click here.

Total Procedures ▾ Ascending (A-Z, 0-9) Descending (Z-A, 9-0)

View Results

| Physician | FL License | Total Procedures |
|---|---|---|
| Palmer George J | ME55620 | 189 |
| Buss Randall W | ME53169 | 183 |
| Nores Marcos A | ME108415 | 163 |
| Stapleton Dennis J | ME50898 | 160 |
| Comas George M | ME116762 | 155 |
| Lee Raymond | ME74892 | 153 |
| Richardson Robert J | ME75610 | 150 |
| Sandwith Eric L | ME90193 | 150 |
| Cortelli Michael | ME70715 | 146 |
| Proia Richard R | ME94028 | 145 |
| Suarez-Cavelier Jorge E | ME76703 | 144 |
| Mangonon Patrick T | ME77600 | 140 |
| Segurola Romualdo J | ME80950 | 136 |
| Hoff Steven J | ME119624 | 135 |
| Evans David K | ME94849 | 134 |
| Katz Arthur H | ME62253 | 134 |
| Dodd David J | ME96463 | 130 |
| Still Robert J | ME59783 | 127 |
| Duarte Ignacio G | ME93214 | 125 |
| Bott Jeffrey N | ME73514 | 123 |

5 Procedures:
Coronary Artery Bypass Graft (CABG), Percutaneous Transluminal Coronary Angioplasty (PTCA), Spina Fusion, Total Hip or Total Knee Replacement

Identifies doctors by license number & total volume by procedures

http://www.floridahealthfinder.gov/index.html

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# Best Practices: Washington State

| Best practice tool features | Scope of services | Timing |
|---|---|---|
| ▪ **Payers required to offer an electronic transparency tool** to plan members that offers estimates of:<br>– Out-of-pocket costs (conditional on plan specifics, personal deductible etc.)<br>– Quality metrics by provider (where available)<br>– Patient experience – ability to leave reviews and access the reviews of other patients | ▪ Common treatments within:<br>– In-patient<br>– Outpatient<br>– Diagnostic tests<br>– Office visits | ▪ Legislation passed 2014<br>▪ Applies to payers offering/renewing plans from Jan 2016 |

Source: Washington State website, Catalyst for Payment Reform

# Best Practice: New Hampshire

| Best practice tool features | Scope of services | Timing |
|---|---|---|
| ▪ NH aggregates payer claims data state-wide and leverages this to provide:<br>– Out-of-pocket cost estimates for different providers<br>– Side-by-side estimate of case-mix complexity for provider/facility[1]<br>▪ Versions of the tool available for insured individuals (taking into account deductible and coinsurance) and uninsured<br>▪ Tool updated quarterly<br>▪ Uses data from their APCD | ▪ More than two dozen procedures (primarily outpatient) including:<br>– MRIs<br>– CT scans<br>– Ultrasounds<br>– X-rays | ▪ Statute passed 2004<br>▪ Commercial carriers began submitting data October 2005<br>▪ First reports released June 2006 |

NH HealthCost

1 State also requires payers to submit HEDIS quality measures, but unclear from website whether these are used to show quality and cost estimates side by side within the transparency portal

Source: NH HealthCost, Catalyst for Payment Reform

# ~85% of commercially-insured New Yorkers covered by a top ten payer have access to a cost calculator, but features and usefulness varies

| Top 10 Payers in NY commercially-insured segment | # CI Lives ('000s) | % CI Lives | Out-of-pocket cost and quality (side-by-side)[1] | Out-of-pocket cost calculator[1] | Other cost estimator (features tbc)[1] | Services covered |
|---|---|---|---|---|---|---|
| EmblemHealth | 1,623 | 17% | | Rx only | | .. |
| Empire BCBS | 1,048 | 11% | | ✓ | | .. |
| UnitedHealth Group | 779 | 8% | ✓ | | | 636 common services<br>365 care paths |
| Excellus BCBS | 652 | 7% | | | | .. |
| Aetna | 433 | 4% | ✓ | | | ~190 specialties (e.g,. pediatrics) |
| CDPHP | 238 | 2% | | | | ... |
| MVP Health Care | 198 | 2% | | ✓ | | ~330 common services<br>8 chronic conditions |
| Cigna | 149 | 2% | | ✓ | | 200+ common procedures |
| Independent Health | 148 | 2% | | | ✓ | Various |

- **~85%** of New Yorkers covered by a top ten commercial insurer have access to a **cost calculator (of some kind)** via their plan
- **~45%** appear to have access to a tool that offers **out-of-pocket cost estimates**
- Only **~20%** can access a tool giving **quality/safety information alongside out-of-pocket cost** (quality metrics often not clear)
- **Scope of services covered varies** by payer and is unclear in several cases

1 It is assumed that unless stated otherwise payer tools are accessible by 100% of payer members
Aetna estimates deflated to account for stated access covering somewhat less than full 100% of members

Source: Interstudy data on payer lives (January 2015), payer websites for details of cost/quality tools

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# Sample payer tools for consumer transparency

ILLUSTRATIVE

| | Tool features | Scope of services |
|---|---|---|
| Cigna | ▪ **Personalized information** on physician and health facility quality and pricing<br>▪ Access to **real-time** status of health plan deductibles and co-insurance, as well as available health spending account funds | ▪ Estimates cover more than 200 common procedures that represent 80 percent of Cigna's medical claims. |
| UnitedHealth Group | ▪ Review **market average prices** for various medical services<br>▪ Locate nearby health care providers, and convenience care, urgent care and emergency care facilities | ▪ 520 medical services across 290 episodes of care |
| Independent Health | ▪ Directs patients towards FairHealth, **a third party online tool** that offers **non-personalized estimate of costs** for health services | ▪ Thousands of medical and dental services<br>▪ Medical supplies<br>▪ Anesthesia services<br>▪ Ambulance rides |

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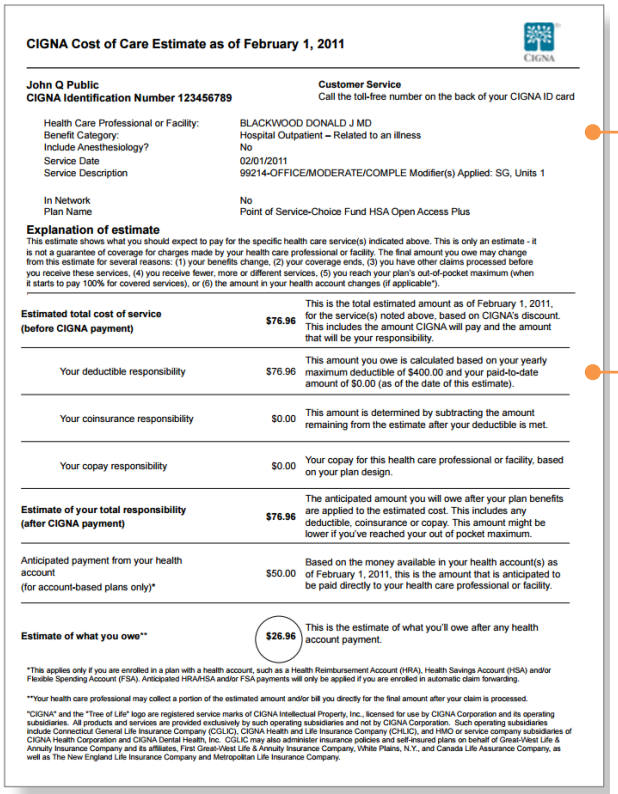
Source: Company websites, Company interviews

# CIGNA's cost-of-care estimator



**CIGNA Cost of Care Estimate as of February 1, 2011**

CIGNA

**John Q Public**
**CIGNA Identification Number 123456789**

**Customer Service**
Call the toll-free number on the back of your CIGNA ID card

| | |
|---|---|
| Health Care Professional or Facility: | BLACKWOOD DONALD J MD |
| Benefit Category: | Hospital Outpatient – Related to an illness |
| Include Anesthesiology? | No |
| Service Date | 02/01/2011 |
| Service Description | 99214-OFFICE/MODERATE/COMPLE Modifier(s) Applied: SG, Units 1 |
| In Network | No |
| Plan Name | Point of Service-Choice Fund HSA Open Access Plus |

**Explanation of estimate**

This estimate shows what you should expect to pay for the specific health care service(s) indicated above. This is only an estimate - it is not a guarantee of coverage for charges made by your health care professional or facility. The final amount you owe may change from this estimate for several reasons: (1) your benefits change, (2) your coverage ends, (3) you have other claims processed before you receive these services, (4) you receive fewer, more or different services, (5) you reach your plan's out-of-pocket maximum (when it starts to pay 100% for covered services), or (6) the amount in your health account changes (if applicable*).

| | | |
|---|---|---|
| **Estimated total cost of service (before CIGNA payment)** | **$76.96** | This is the total estimated amount as of February 1, 2011, for the service(s) noted above, based on CIGNA's discount. This includes the amount CIGNA will pay and the amount that will be your responsibility. |
| Your deductible responsibility | $76.96 | This amount you owe is calculated based on your yearly maximum deductible of $400.00 and your paid-to-date amount of $0.00 (as of the date of this estimate). |
| Your coinsurance responsibility | $0.00 | This amount is determined by subtracting the amount remaining from the estimate after your deductible is met. |
| Your copay responsibility | $0.00 | Your copay for this health care professional or facility, based on your plan design. |
| **Estimate of your total responsibility (after CIGNA payment)** | **$76.96** | The anticipated amount you will owe after your plan benefits are applied to the estimated cost. This includes any deductible, coinsurance or copay. This amount might be lower if you've reached your out of pocket maximum. |
| Anticipated payment from your health account (for account-based plans only)* | $50.00 | Based on the money available in your health account(s) as of February 1, 2011, this is the amount that is anticipated to be paid directly to your health care professional or facility. |
| **Estimate of what you owe**** | **$26.96** | This is the estimate of what you'll owe after any health account payment. |

*This applies only if you are enrolled in a plan with a health account, such as a Health Reimbursement Account (HRA), Health Savings Account (HSA) and/or Flexible Spending Account (FSA). Anticipated HRA/HSA and/or FSA payments will only be applied if you are enrolled in automatic claim forwarding.

**Your health care professional may collect a portion of the estimated amount and/or bill you directly for the final amount after your claim is processed.

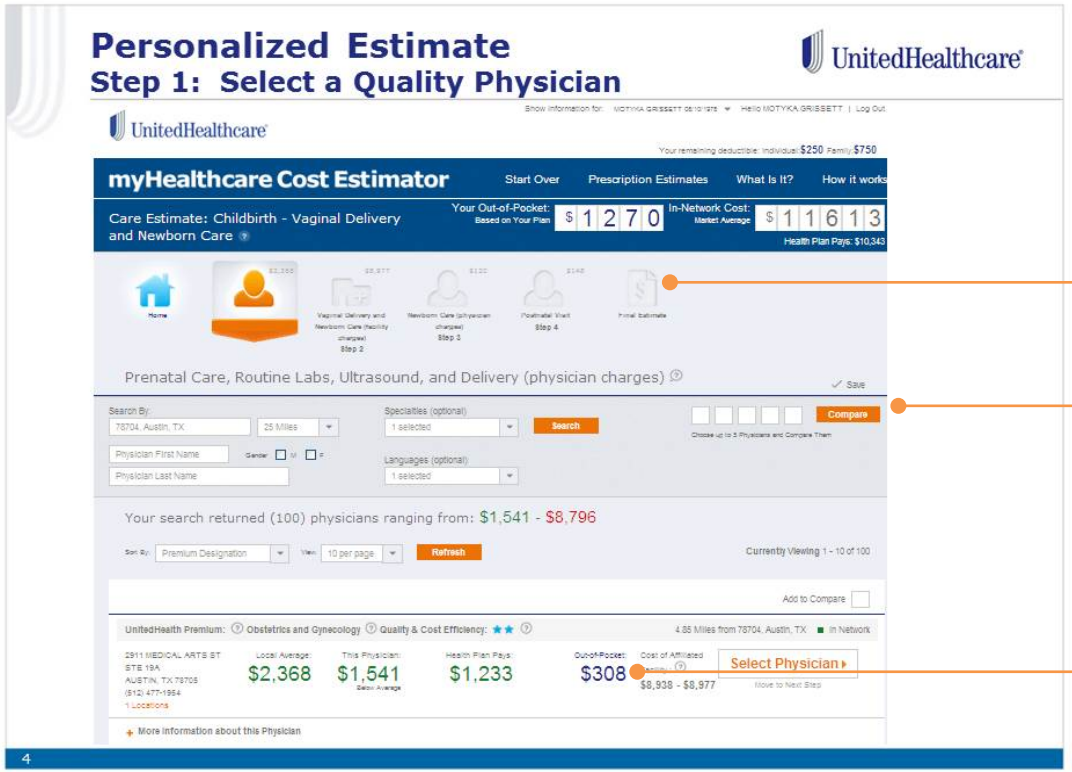


Printable "Explanation of Estimate" to educate users on how their CIGNA medical benefits influence what they owe

Personalized estimates that reflect an individual's health plan benefits

Source: CIGNA website

# UnitedHealthcare's myHealthcare Cost Estimator




Costs provided in "care paths" (episodes of care)

Compare costs and quality for different health care providers

Personalized estimates that reflect an individual's health plan benefits

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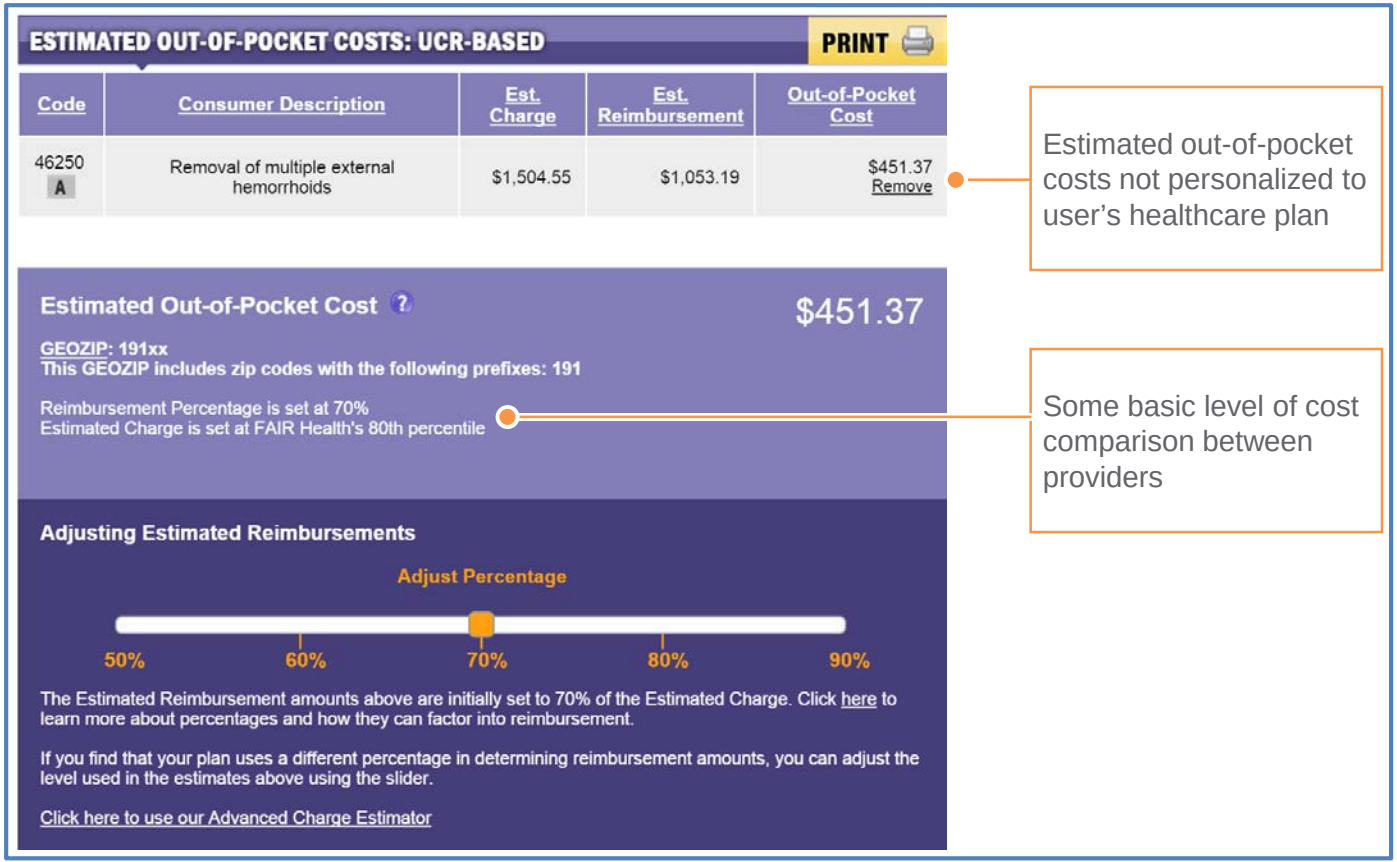
Source: UnitedHealthcare website

# Independent Health offers a third-party cost-of-care calculator



**ESTIMATED OUT-OF-POCKET COSTS: UCR-BASED** PRINT

| Code | Consumer Description | Est. Charge | Est. Reimbursement | Out-of-Pocket Cost |
|---|---|---|---|---|
| 46250 A | Removal of multiple external hemorrhoids | $1,504.55 | $1,053.19 | $451.37 Remove |

**Estimated Out-of-Pocket Cost** $451.37

GEOZIP: 191xx
This GEOZIP includes zip codes with the following prefixes: 191

Reimbursement Percentage is set at 70%
Estimated Charge is set at FAIR Health's 80th percentile

**Adjusting Estimated Reimbursements**

Adjust Percentage

50% 60% 70% 80% 90%

The Estimated Reimbursement amounts above are initially set to 70% of the Estimated Charge. Click here to learn more about percentages and how they can factor into reimbursement.

If you find that your plan uses a different percentage in determining reimbursement amounts, you can adjust the level used in the estimates above using the slider.

Click here to use our Advanced Charge Estimator

Estimated out-of-pocket costs not personalized to user's healthcare plan

Some basic level of cost comparison between providers

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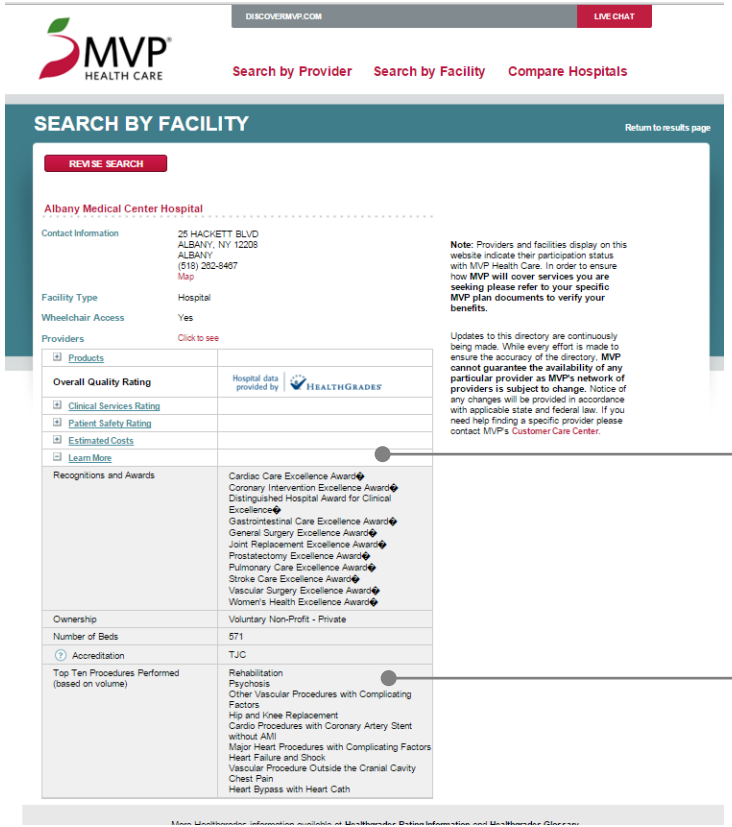
Source: Independent Health website; FAIR Health website

# MVP Health Care| Compare Hospitals




Quality Measures: Patient Safety, Clinical, Estimated Costs

Top Ten Procedures Performed

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Source: http://mvp.prismisp.com/index.php?tab=condition

# Sample third party tools for consumer transparency

ILLUSTRATIVE

| | Tool features | Scope of services |
|---|---|---|
| FAIR HEALTH Know Your Source | ▪ **Free online tool** that gives both insured and uninsured users access to cost data<br>▪ For the insured, **non-personalized estimation of cost** for out of network vs in network provider | ▪ Thousands of medical and dental services<br>▪ Medical supplies<br>▪ Anesthesia services<br>▪ Ambulance rides |
| guroo | ▪ Offers a **free transparency tool** with national, state and local **non-personalized** cost and quality information for common health conditions and services<br>▪ Uses claims from Aetna, Assurant Health, Humana, and UnitedHealthcare | ▪ Search by condition or care bundle for over 70 services<br>▪ Review step-by-step breakdown of the steps and costs of a care bundle (not out of pocket) |
| castlight HEALTH | ▪ Employers **purchase Castlight subscription**, and employees gain access to provider listings, **out-of-pocket costs, and quality metrics** | ▪ Thousands of medical services |

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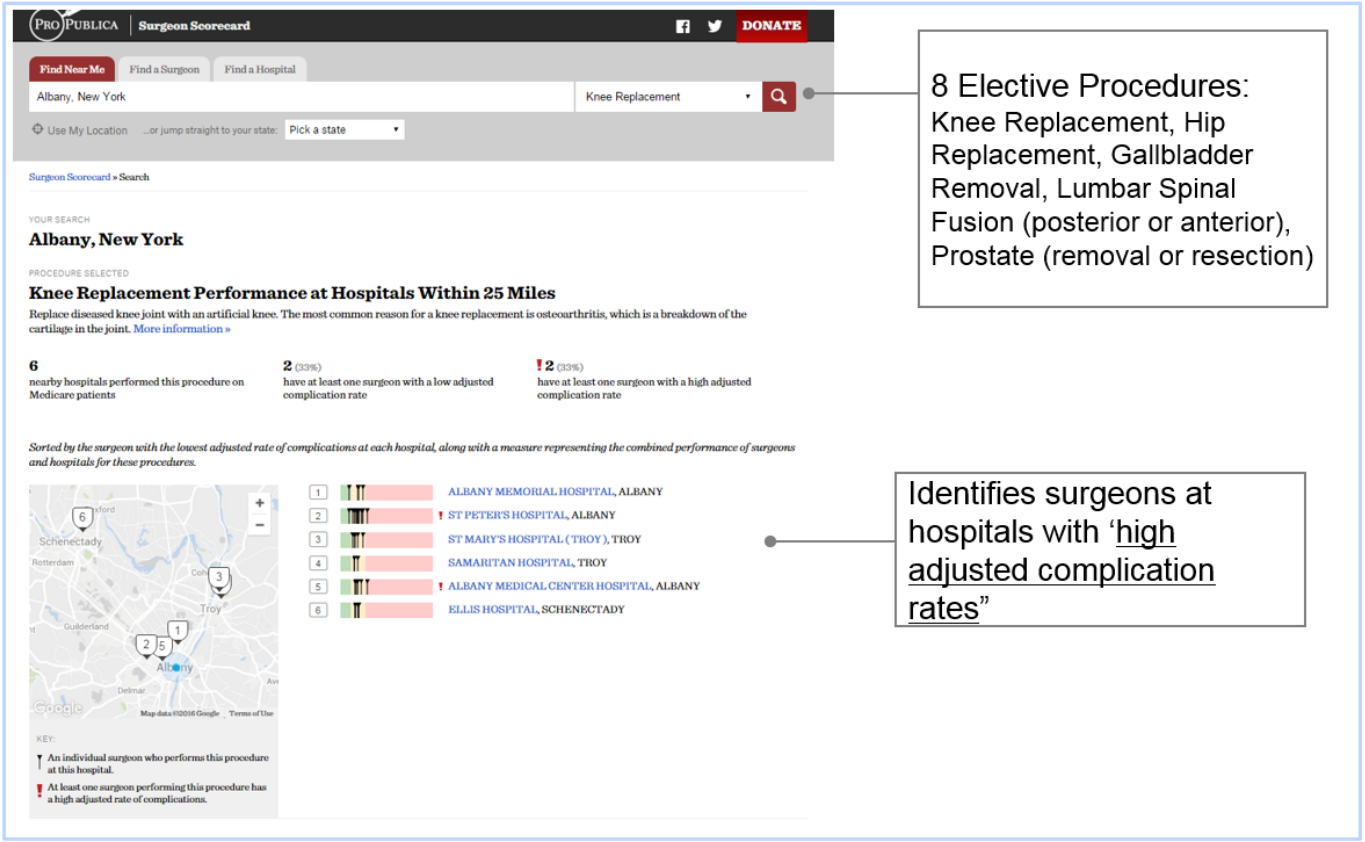
Source: FAIR Health website, NH Health Cost website, Company interviews

# ProPublica | Surgeon Scorecard




8 Elective Procedures: Knee Replacement, Hip Replacement, Gallbladder Removal, Lumbar Spinal Fusion (posterior or anterior), Prostate (removal or resection)

Identifies surgeons at hospitals with 'high adjusted complication rates"

Source: ProPublica | Surgeon Scorecard @ https://projects.propublica.org/surgeons/

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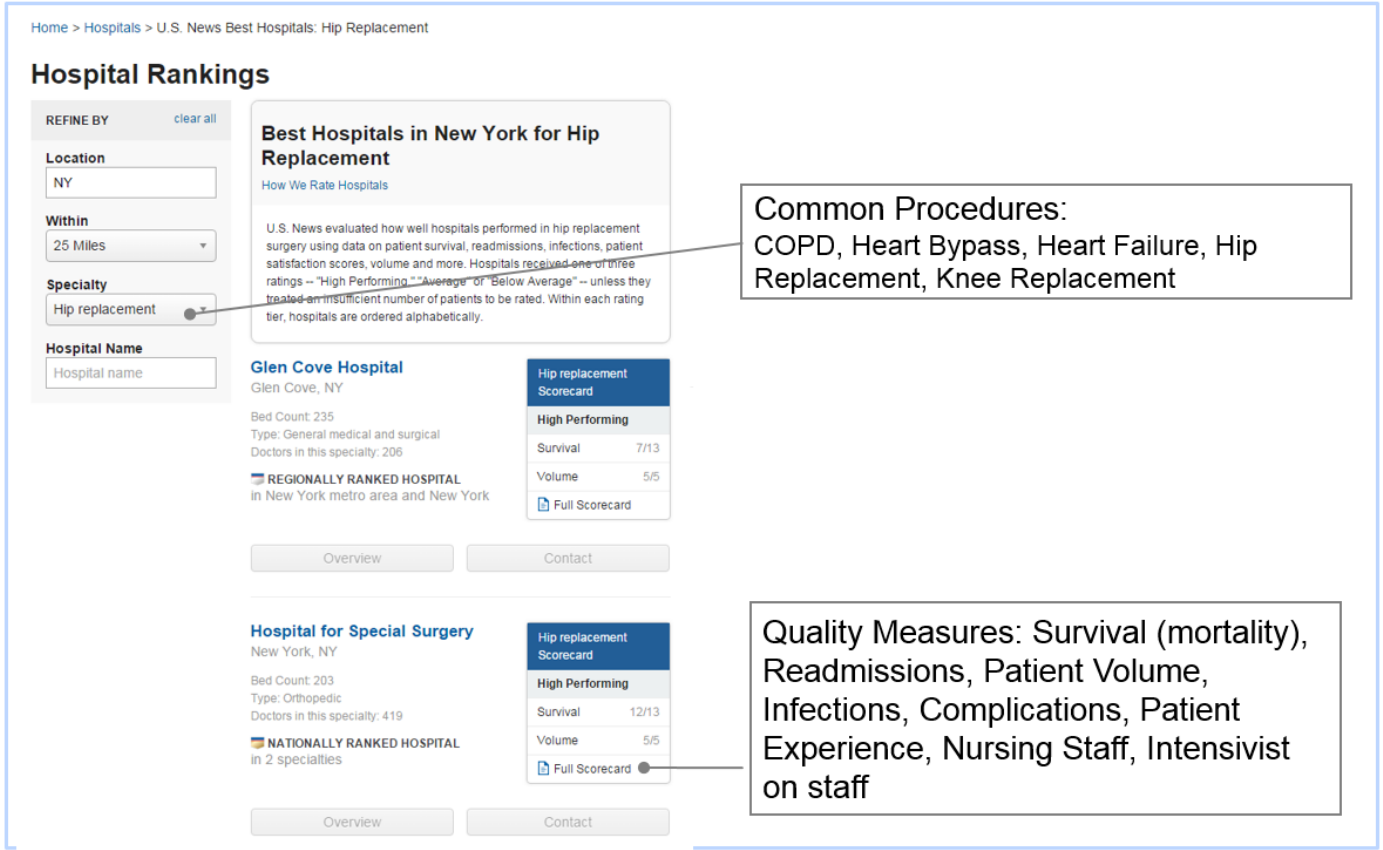
# US News & World Report | Common Care Scorecard




Common Procedures:
COPD, Heart Bypass, Heart Failure, Hip Replacement, Knee Replacement

Quality Measures: Survival (mortality), Readmissions, Patient Volume, Infections, Complications, Patient Experience, Nursing Staff, Intensivist on staff

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Source: US News & World Report @ http://health.usnews.com/best-hospitals

# Next Steps:

- Continue review of what is available today across the country
- Propose a framework for New York to promote price and quality transparency
- Develop tools for consumers, providers and payers that meet the needs of the future

# APD Update

Chris Nemeth, Director
All Payer Database Development Bureau
Office of Quality and Patient Safety

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# 2015 APD Year End Milestones

- December APD Stakeholder Forum
- APD Data Warehousing & Analytics Award
- APD Regulations Adoption Process Begun; Work also started on *Governance Policies and Procedures* document (addressing key issues such as data release)

# APD Stakeholder Forum

On December 9, 2015 the NYS APD Team, NYS Health Foundation, and APCD National Council hosted a forum to provide stakeholders with information about how the APD fits within NYS healthcare priorities, and new APD implementation timelines.

The full afternoon event was attended by approximately 140 diverse stakeholders.

Attendee Categories

- NYS Government Agencies (DOH, DFS, Executive Chamber, OITS, NYS Assembly, OMIG, OMH)
- Consumer Advocacy Groups
- NYS Health Providers
- NYS Health Insurers
- Researchers
- IT Vendors

# APD Stakeholder Forum

Much of the open discussion was talk of how health insurers could effectively submit quality data:

Topics Discussed by Stakeholders

- Claims collection schedules and formats
- Implementation Timelines
- Data Confidentiality
- Data Release
- Data Quality
- Data Access

Feedback from the forum has proved positive and served to re-engage stakeholders in implementation planning at the time an APD vendor has been selected.

# APD Data Warehousing & Analytics Award

- On December 21, 2015 Optum Government Solutions, Inc. (Optum) was named the winning bidder to provide data warehousing and data analytics services for the NYS APD (over a $70 million contract span of 5 years).
- Optum is a large scale firm that serves as a leader in the health care services industry, with over 20 years of experience helping state governments solve their biggest and most complex challenges – leveraging data and analytics for better decision making.
- The selection was made upon receipt of 8 proposals in response to a competitive procurement.

# APD Data Warehousing & Analytics Award

- Optum will work with the APD data intake system to aggregate, link, de-identify and store the data that is received from all of the different sources.
- Optum will develop both a business intelligence/analytics solution that will facilitate data analysis and reporting, *and* a data delivery solution that will produce extracts and de-identified data sets for researchers and other stakeholders approved through a data governance process.

# NYS APD Implementation Update

- Major Components / Infrastructure
  - Data Intake
  - Data Warehousing & Analytics

- Governance
  - Regulations
  - Operations Guide (submission specifications, validation methods, etc.)
  - Data Governance Manual (advisory committees, data release, user agreements, etc.)

# Data Warehouse & Analytics Schedule

- Vendor Award
  - Projected Contract Start – April 2016
  - Interim vs. Permanent Solutions

- Interim Data Analytics (Jan 2017)
  - 200 State Agency Users
  - Consumer Facing Website

- Permanent Data Warehouse (Oct 2017)
  - Data Aggregation, Linking, and De-identification
  - Data Validation: Across All Payers - Expected to be complete by 2018

- Permanent Data Analytics (Oct 2017)
  - User Stories Reflecting 7 Stakeholder Groupings
    - APD Management Staff, Consumer Healthcare Services, Data Management Staff from Insurance Carriers, Healthcare Researchers, Information and Policy Managers from County & Other NYS Agencies, NYSDOH Information and Policy Managers, Providers of Healthcare Services

# Overall Governance Development Schedule

- Regulation – 2016 Publication
  - Regulatory Package Initiated Dec. 2015
  - Requires Public Comment & Public Health and Health Planning Council Review (estimated by Aug. 2016)

- Submission Specifications – Public Posting w/ Commercial Data Intake Implementation
  - Developed & Maintained by Data Intake Vendor
  - Currently covers QHP and MMC/CHIP Encounter Submissions

- Operations Manual – 2016 Release
  - General Governance – APD: What it is, how it operates, how and why it came to be, who it can benefit & how

- Final Data Release Process Manual – 2018 Completion date (influenced by SPARCS Model and most highly developed APCDs of other states)
  - Coincides with Completion of Data Validation Activities
  - Will Provide Detail on Release Policy, Procedure and Criteria

# Data Release Development Schedule

Types of Release:

- Public Use Data – Consumer Facing Website, Customizable Population Health Views (DW&A Vendor Developed) – Jan. 2017
- Identifiable Data (Includes Limited Identifiable) – 2018
  - Requires Final Data Release Policies & Procedures
  - Will require Data Use Agreement
  - Will require Application, and Review for appropriateness of use and adequate protection of PHI and PII

# Proposed Data Release Framework - handling of price data (from early draft *Data Governance Policies & Procedures)*

Approach Mainly Combines Elements from Colorado and New Hampshire APCDs –
3 Data Types for Release:

1) **Public Use/Reporting Tools:**

   Prices displayed represent the **median total amount paid** (by the insurance plan and the patient) for specific procedures performed at a particular facility. Website price information display is **based on actual amounts paid for health care services and include facility, professional and any other payments made**. These **reflect both payer** (private insurance or Medicaid) **and patient paid** (copay, coinsurance, deductible) amounts and total charged amounts for uninsured.
   Features median prices paid across all commercial health insurers (including patient copays/deductibles) and Medicaid payments to a hospital, health care
   professional and any ancillary (transportation, lab, etc.) payments made for that service.

# Proposed Data Release framework for handling of price data (cont.)

2) **De-identified Data:** accessed only through application process

Custom Reports and De-Identified Data contain no Protected Health Information (PHI) and requests must be granted under the terms of a Data Use Agreement executed to establish the terms and conditions of use and to protect APD interests.

**Data Element List**: APD Member Composite ID and APD Member ID within Plan (APD Plan ID, not receive the Plan's National or NAIC ID on any De-Identified Member File to determine exact plan)

- Plan Paid Amount, Pre Paid Amount
- Copay/Co-insurance/Member Liability
- Ingredient Cost & Dispensing fee
- Line of Business ( Commercial, Medicaid, Medicare, etc.)
- Insurance Product Type Codes
- APD created Provider ID for grouping and linking across payers (this is not linkable back to provider file to determine exact provider information, i.e, true Provider ID **not** available in **both** sets for De-Identified Files)

# Proposed Data Release framework for handling of price data (cont.)

3) **Limited Identifiable**

Data Element List: includes all of De-identified above, plus

Plan's National or NAIC ID (not name)

Group and Policy Number

Provider Detail (Name, NPI, zip plus 4)

# Data Release Review Committee (DRRC) Basics:

- Limited and controlled release of APD data is allowable under draft NYS regulations, provided Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules are strictly enforced and the purpose of the data request meets established APD public health goals. Release of APD data will require that a multi-stakeholder DRRC review data requests and advise the APD Administrator whether, (a) such requests meet pre-determined criteria for allowable uses, and (b) applicant appears capable to protect data and successfully achieve purported aims and analyses.

- All data release applications must be submitted in writing and describe in detail:
  - The purpose of the project and intended use of the data
  - Methodologies to be employed
  - Type of data and specific data elements requested along with justification for inclusion
  - Qualifications of the entity requesting the data
  - The specific Privacy and Security measures that will protect the data
  - Description of how the results will be used, disseminated or published

# Working Lunch

# SHIN-NY Update

James Kirkwood
Director
Health Information Exchange Bureau
Office of Quality and Patient Safety

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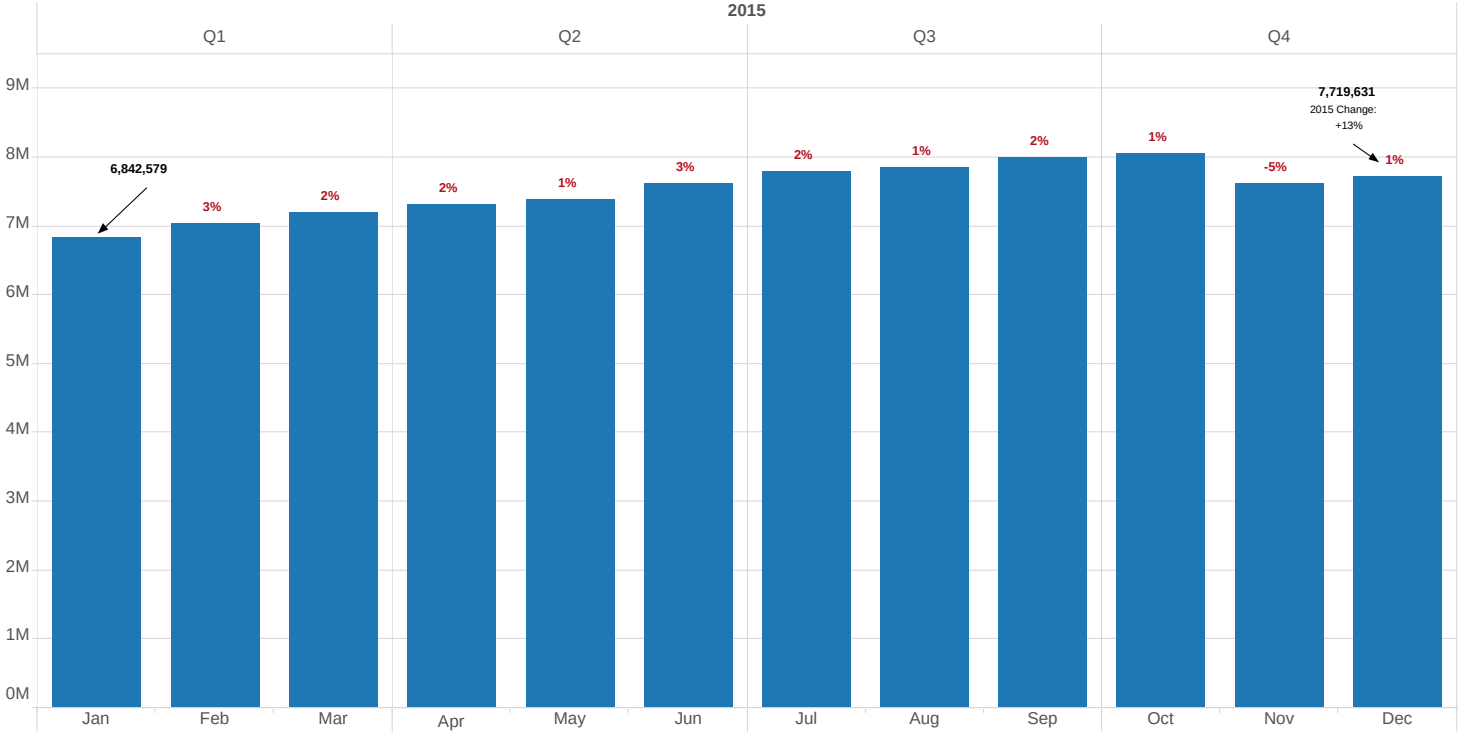
# SHIN-NY Regulations

- Approved by PHHPC on February 11th, will be released in State Register March 9th
- Changes as a result of comment period:
  - Section 300.2: “Establishing the SHIN-NY. The New York State Department of Health [may] shall:

    (a) Oversee the implementation and ongoing operation of the SHIN-NY.”
  - Section 300.3: “Statewide collaboration process and SHIN-NY policy guidance.

    (a) SHIN-NY policy guidance. The New York State Department of Health [may] shall establish SHIN-NY policy guidance as set forth below:”

# 2015 SHIN-NY Consent - Total NY State




- To date, roughly 7.7 MM New Yorkers have provided patient consent, an increase of **13%** overall in 2015
- Drop in consents for November and December is mostly due to a decrease in consents as reported by Healthix due to a consolidation of their HIE platforms.

*the aggregate consents of RHIO reported metrics. Not adjusted for cross-community patient consent values and may be an overestimate of the population of patients in New York that have consented in aggregate.

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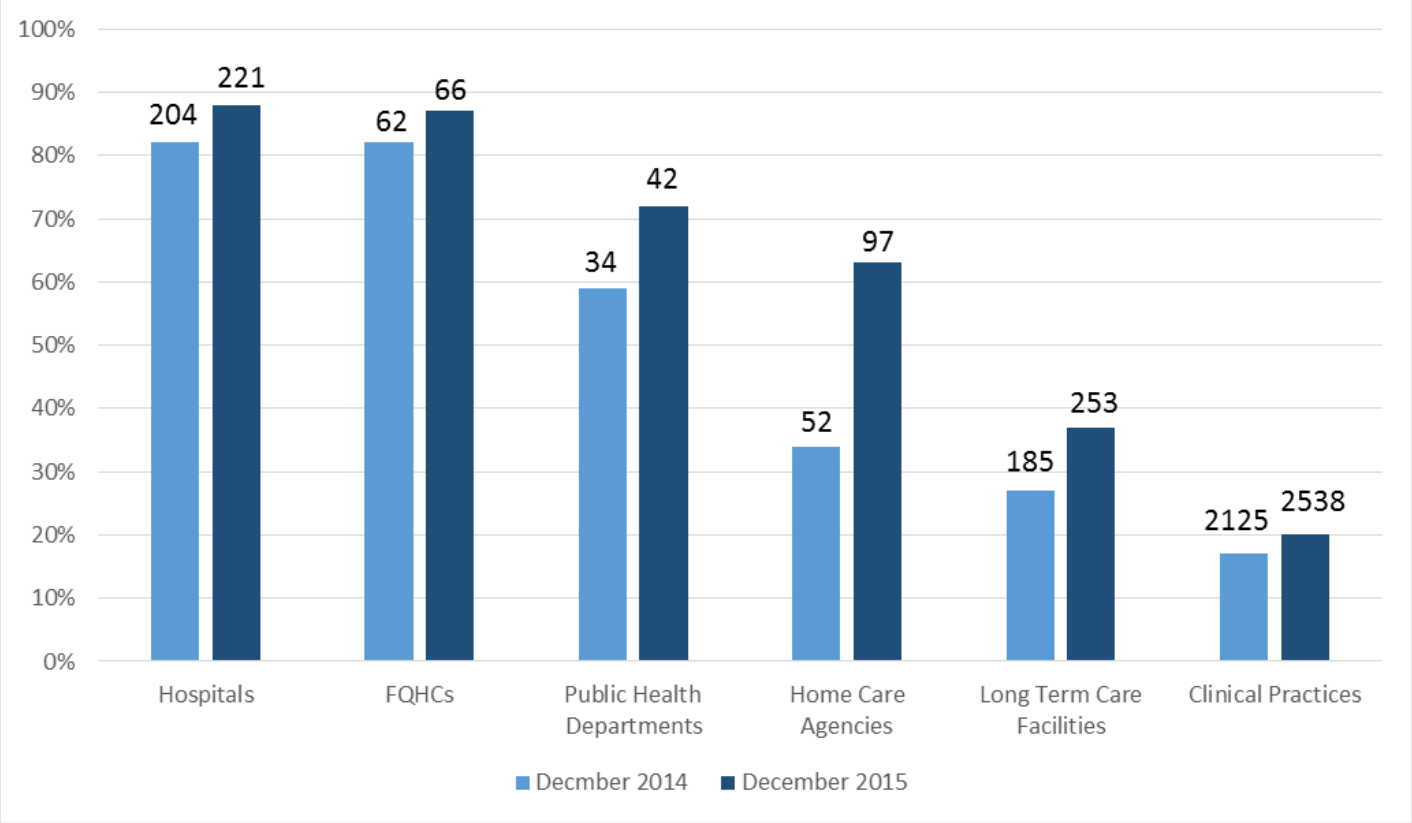
# Percent of Facilities Participating in SHIN-NY: 2014 vs. 2015

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# SHIN-NY Objectives

- Making Medicaid claims available through the SHIN-NY
  - Outlining a process for security evaluation to align with SHIN-NY certification process
- Increasing outpatient provider participation
- Increasing engagement with PPSs
- Increasing data quality and completeness
- Increasing HIE usage
- Increase payer participation
- Implementing cross-QE alerts
- Increasing affirmative consent

# SHIN-NY Policy Committee Activities

- Re-evaluation of consent model
  - Does it fit the direction of healthcare?
  - Value based purchasing models
- Focus on security
- SHIN-NY data usage

# Focus on data quality and completeness

- Quality/Completeness of data dependent on:
  - Variability of EHR implementation
  - Variability of use of EHR in workflow
  - Variability between EHR vendors
  - Data made available for exchange

- Increasing network participation makes the network more valuable as participants make minimum set of data available

# Minimum Data Set: Aligning with Certified Health IT

| | |
|---|---|
| Demographics | Encounters |
| Medications | Lab Results |
| Allergies | Procedures |
| Diagnoses | Problems |
| Care Plan | Transition of Care Document |

# Update on and Review of Interim Data Collection Tool for APC

Anne Schettine
Health Program Director
Office of Quality and Patient Safety

Paul Henfield
Senior Director
IPRO

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# The scorecard is a cornerstone of the APC program

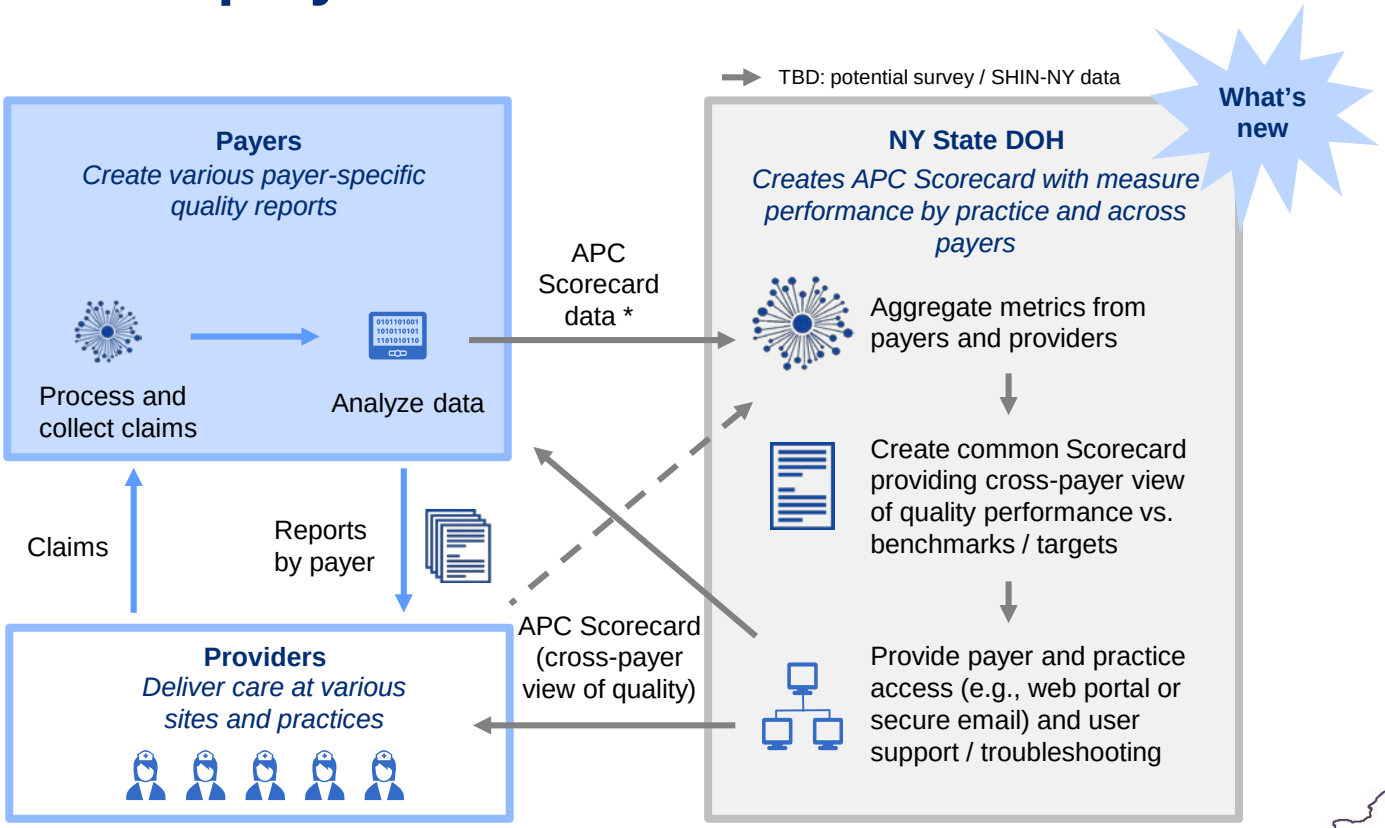
**What the Scorecard is:**

- A statewide report aggregating all primary care data relevant to APC Core Measures
- The first tool to enable practices to view their performance across a consistent set of measures for their entire patient panel (rather than on a per payer basis)
- The basis for practices to pass APC gates and access outcome-based payments

**What the Scorecard isn't:**

- A replacement for scorecards and measures required for ACOs, MA Stars, etc.
- A collection of brand new measures

# Payers will play a critical role in the launch of the scorecard

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# Given the APD timeline, we need an interim version 1.0 scorecard

The **eventual APC Scorecard** leverages both administrative claims data from the APD and clinical data from EHRs.

The **timelines for APC launch and APD roll out do not align**. The APC program launches in 2016, while the APD launch is not anticipated until mid-2017.

We need **an interim non-APD solution** that:

- Uses easily accessible data
- Minimizes burden on providers and payers
- Is high quality and consistent across all types of patients and payers
- Leverages already existing processes
- Employs processes that can be used in future versions of the scorecard

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# A claims-based version 1.0 is the best available option

| | Options | Considerations |
|---|---|---|
| A | **Payers submit numerators and denominators of measures to the State** | ▪ Minimal burden on payers; uses easily accessible, already existing data<br>▪ High quality standardized data<br>▪ Builds towards eventual APD version |
| B | **Providers self-report (EMR and other data)** | ▪ Burden on providers (not all have EMRs)<br>▪ Difficult to assure quality |
| C | **Payers submit raw claims to the State** | ▪ Duplicative of upcoming APD<br>▪ Operationally challenging |
| D | **Individual payers send providers reports with a common measure set** | ▪ Burden on payers and providers<br>▪ No synergies with eventual APD version |
| E | **Status quo: Individual payers send providers reports with no common measure set or cross-payer view** | ▪ Burden on providers to receive and interpret varying reports<br>▪ No standardized measure set<br>▪ No synergies with eventual APD version |

# The APC scorecard aspires to include 20 common measures

| Categories | | Measures | Measure steward | Claims | EHR | Survey |
|---|---|---|---|---|---|---|
| Prevention | 1 | Colorectal Cancer Screening | HEDIS | ✓ | ✓ | |
| | 2 | Chlamydia Screening | HEDIS | ✓ | ✓ | |
| | 3 | Influenza Immunization - all ages | AMA (all ages) or HEDIS (18+) | ✓ | ✓ | ✓ |
| | 4 | Childhood Immunization (status) | HEDIS | ✓ | ✓ | |
| | 5 | Fluoride Varnish Application | CMS (steward), NQF, MU | ✓ | | |
| Chronic disease identification and treatment | 6 | Tobacco Use Screening and Intervention | CMS (steward), NQF, MU | ✓ | ✓ | |
| | 7 | Controlling High Blood Pressure | HEDIS | ✓ | ✓ | |
| | 8 | Diabetes A1C Poor Control | HEDIS | ✓ | ✓ | |
| | 9 | Medication Management for People with Asthma | HEDIS | ✓ | ✓ | |
| | 10 | Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults | *Children*: HEDIS<br>*Adults:* CMS | ✓ | ✓ | |
| BH/Substance abuse | 11 | Depression screening and management | CMS | ✓ | ✓ | |
| | 12 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | HEDIS | ✓ | | |
| Patient reported | 13 | Record Advance Directives for 65 and older | HEDIS | ✓ | ✓ | ✓ |
| | 14 | CAHPS Access to Care, Getting Care Quickly | HEDIS | | | ✓ |
| Overuse and Use of Services | 15 | Use of Imaging Studies for Low Back Pain | HEDIS | ✓ | | |
| | 16 | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | HEDIS | ✓ | | |
| | 17 | Hospitalization | HEDIS | ✓ | | |
| | 18 | Readmission | HEDIS | ✓ | | |
| | 19 | Emergency Dept. Utilization | HEDIS | ✓ | | |
| Cost | 20 | Total Cost Per Member Per Month | | ✓ | | |

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# CMS and AHIP release of Core Set for PCMH and Primary Care – areas of overlap with APC Core set highlighted

| Categories | | Measures | Measure steward | Claims | EHR | Survey |
|---|---|---|---|---|---|---|
| Prevention | 1 | Colorectal Cancer Screening | HEDIS | ✓ | ✓ | |
| | 2 | Chlamydia Screening | HEDIS | ✓ | ✓ | |
| | 3 | Influenza Immunization - all ages | AMA (all ages) or HEDIS (18+) | ✓ | ✓ | ✓ |
| | 4 | Childhood Immunization (status) | HEDIS | ✓ | ✓ | |
| | 5 | Fluoride Varnish Application | CMS (steward), NQF, MU | ✓ | | |
| Chronic disease identification and treatment | 6 | Tobacco Use Screening and Intervention | CMS (steward), NQF, MU | ✓ | ✓ | |
| | 7 | Controlling High Blood Pressure | HEDIS | ✓ | ✓ | |
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| | 9 | Medication Management for People with Asthma | HEDIS | ✓ | ✓ | |
| | 10 | Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults | *Children*: HEDIS<br>*Adults:* CMS | ✓ | ✓ | |
| BH/Substance abuse | 11 | Depression screening and management | CMS | ✓ | ✓ | |
| | 12 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | HEDIS | ✓ | | |
| Patient reported | 13 | Record Advance Directives for 65 and older | HEDIS | ✓ | ✓ | ✓ |
| | 14 | CAHPS Access to Care, Getting Care Quickly | HEDIS | | | ✓ |
| Overuse and Use of Services | 15 | Use of Imaging Studies for Low Back Pain | HEDIS | ✓ | | |
| | 16 | Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | HEDIS | ✓ | | |
| | 17 | Hospitalization | HEDIS | ✓ | | |
| | 18 | Readmission | HEDIS | ✓ | | |
| | 19 | Emergency Dept. Utilization | HEDIS | ✓ | | |
| Cost | 20 | Total Cost Per Member Per Month | | ✓ | | |

# Version 1.0 will focus on 11 claims-only measures and 2 interim process measures

✓ Proposed for version 1.0

| Categories | Ultimate measures | Proposed interim measures | |
|---|---|---|---|
| Prevention | 1 Colorectal Cancer Screening | | |
| | 2 Chlamydia Screening | | ✓ |
| | 3 Influenza Immunization - all ages | | |
| | 4 Childhood Immunization (status) | | ✓ |
| | 5 Fluoride Varnish Application | | ✓ |
| Chronic disease | 6 Tobacco Use Screening and Intervention | | |
| | 7 Controlling High Blood Pressure | | |
| | 8 Diabetes A1C Poor Control | **Member-level composite (HbA1c test + Eye Exam + Nephropathy) (HEDIS)** | ✓ |
| | 9 Medication Management for People with Asthma | | ✓ |
| | 10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults | | |
| BH/Substance abuse | 11 Depression screening and management | **Antidepressant medication management (HEDIS)** | ✓ |
| | 12 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | | ✓ |
| Patient reported | 13 Record Advance Directives for 65 and older | | |
| | 14 CAHPS Access to Care, Getting Care Quickly | | |
| Appropriate use | 15 Use of Imaging Studies for Low Back Pain | | ✓ |
| | 16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis | | ✓ |
| | 17 Hospitalization | | ✓ |
| | 18 Readmission | | ✓ |
| | 19 Emergency Dept. Utilization | | ✓ |
| Cost | 20 Total Cost Per Member Per Month | | ✓ |

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# IPRO's Role in APC Scorecard V1.0

1. Data Aggregation

2. Technical Assistance

# Pre-Pilot Phase

1. **Engage pilot payers (6-8)**

   - Representing varying plan types – membership size, expertise and experience in reporting, geography, product types

2. **Preparation for reporting**

   - Feasibility of Data Collection
   - Identification of Anticipated Challenges
   - Technical Assistance and Support
     Calculating metrics with emphasis on two non-HEDIS measures
     Process for reporting, data elements, aggregation algorithm…
   - Payer Survey

# Version 1.0 scorecard: Payer Survey: Key design questions

| | | Issues to address |
|---|---|---|
| Feasible reporting | Reporting window | ▪ **What are your reporting period capabilities?**<br>– Typical run-out period?<br>– Calendar year to date?<br>– Rolling view (e.g., rolling 12 month)? |
| | Unit of reporting | ▪ **Would it be possible to report at individual provider per site level?**<br>▪ What unique identifiers are used to distinguish between providers? Practices? Sites? How do you define a "practice"? |
| | Attribution | ▪ **What attribution methodology do you use? Are you able to do attribution across the entire membership or just a subset?**<br>– What happens when a physician moves practices? How do you know when a physician moves?<br>– How are patients attributed when a physician works in multiple locations? Or as a solo practitioner as well?<br>▪ How often are attribution lists updated and how are they shared with practices?<br>▪ How frequently could attribution lists be updated, theoretically? |
| | Quality control and adjustments | ▪ **How are current reports quality and accuracy tested (e.g., taking sample of claims/members and cross-checking quality)?**<br>▪ Are ethnic stratification or health literacy indices currently used to address requirements to "reduce disparity"? |
| | Other | ▪ **Would it be feasible to submit numerators, denominators and provider information for each measure ?**<br>▪ When could this information be submitted, and what barriers may limit your ability to do so? (e.g., measurement cycles, budget cycles, staff time, data sharing agreements, ramp-up to incorporate new measure methodologies)?<br>▪ How much historical data could be provided (to generate a baseline? 6 month, 1yr? 2yr? 3yr? |
| Existing reporting | Benchmarks and goals | ▪ **What benchmarks / goals are currently used? What is the rationale?**<br>– Absolute goal?<br>– Gap to goal?<br>– Performance against own practice (requires access to historical data)? |
| | Payer to provider reports | ▪ **Which measures and other ancillary information are included?**<br>▪ How frequently are the scorecards produced?<br>▪ How are the reports delivered? |
| | Provider measure submission to state | ▪ **Do you currently require providers to submit any e-measures or other measures of quality? What is the penetration of e-measure submissions among the providers? Do providers submit service information via EHRs?**<br>▪ Does your organization currently leverage RHIOs to get an early read on test results / outcome measures / utilization or keep abreast of how these are developing on a more regular basis? Is member-level information accessible? |
| | Other | ▪ **Can you report on metrics for your entire membership (vs. just on selected products)? Do you report on your entire book of business or just for certain products? Do you outsource reporting software or develop internally?** |

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# Pilot Phase

**Survey will help inform data reporting process**

- data elements to collect
- timeframe for reporting
- aggregation methodology
- benchmarking

**Reporting tool, data elements and data dictionary will be developed by IPRO**

**Payers will report 13 interim measures**

**Pilot test results will be used to evaluate**

- data elements that posed challenges
- issues in data analysis and aggregation
- functionality of the reporting tool
- stratification alternatives
- reportability of the metrics
- benchmarking options

# Post-pilot Validation

## Was the Attribution successful?

### Verification of patient to provider/practice attribution

A sample of practices to verify that the scorecard accurately reflected patients and providers associated with their practice

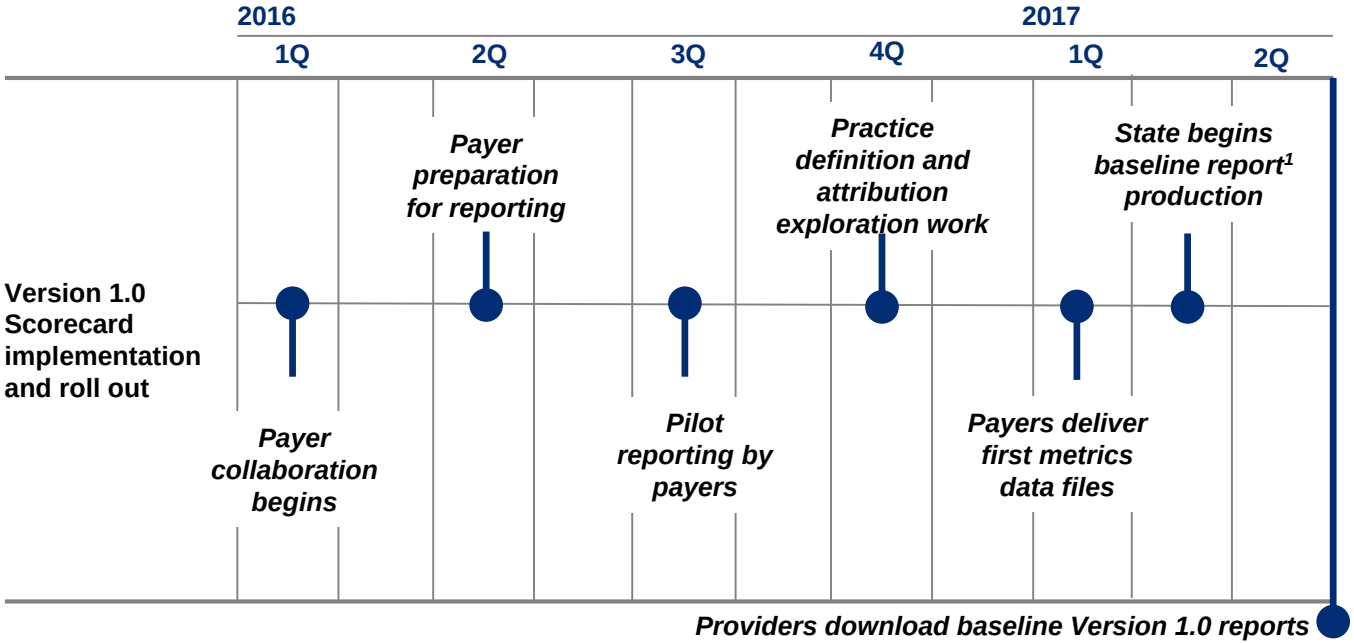
### Potential Sources of Error:

provider→ practice → payer → DOH/IPRO

# Preparation for Quarterly Reporting

- Payers engaged and supported
- Data elements and reporting tool finalized
- Attribution methodology determined
- Timeframe for reporting identified
- Format/Content of the Scorecard:
  - Additional stratifications
  - Benchmarks selected

# Version 1.0 launch is planned for January 2017




[1] *Baseline reports are based on recent 12-month performance*

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# Discussion and Next Steps

Patrick Roohan
Director
Office of Quality and Patient Safety

*Next meeting May 20, 2016*

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