



**Department
of Health**

Transparency, Evaluation, and Health Information Technology Workgroup

Meeting #10

May 20, 2016



**Department
of Health**

**Innovation
Center**

Agenda

| # | Topic | Time | Leader |
|---|--------------------------------|---------------|---------------------------------|
| 1 | Welcome and Introductions | 10:00 – 10:10 | Patrick Roohan |
| 2 | Opening Remarks | 10:10 – 10:25 | Paul Francis |
| 3 | Practice Transformation Update | 10:25 – 10:50 | Ed McNamara |
| 4 | Transparency Update | 10:50 – 11:20 | Natalie Helbig Anthony Shih |
| 5 | APD Update | 11:20 – 11:40 | Chris Nemeth |
| 6 | SHIN-NY Update | 11:40 – 12:00 | Jim Kirkwood |
| 7 | APC V1 Scorecard Update | 12:00 – 12:15 | Anne Schettine Paul Henfield |
| 8 | Discussion and Next Steps | 12:15 – 12:30 | Patrick Roohan |



Practice Transformation in NYS

Ed McNamara, Director
SIM Project Management
Office of Quality and Patient Safety

VISION: Achieve the Triple Aim and Support a “Sustainable Health System”

A Sustainable Health System is one that*:

- *improves the health of our population overall*
- *uses new models of care delivery*
- *delivers care in the place and at the point of time or illness progression with a workforce working in new ways*
- *is financially responsible,*
- *works within our communities*
- *values integration*
- *measures its results*
- *treats patients and families as partners in care*
- *drives change and improvement*
- *is transparent*

Advanced Primary Care is a key tool for achieving a sustainable health system

- A means, not an end
- Not the only tool



DSRIP, SIM, TCPI, CPC+ Highlights:

| DSRIP | SIM | TCPI | CPC + |
|---|--|---|---|
| <p>Focus: Primary care practices participating in PPS provider networks</p> | <p>Focus: Primary care practices: Implementation 2017</p> | <p>Focus: Clinician practices, both primary care and specialty</p> | <p>Focus: Primary care practices: Implementation 2017</p> |
| <p>Who provides funding/support to the provider: The PPS in relevant DSRIP projects.</p> | <p>Who provides funding/support to the provider: APC Technical assistance (TA) vendors.</p> | <p>Who provides funding/support to the provider: 3 TCPI funded grantees –</p> <ul style="list-style-type: none"> • Care Transitions Network for People with Serious Mental Illness • Greater New York City Practice Transformation Network • New York State Practice Transformation Network | <p>Who provides funding/support to the provider: Medicare, commercial and Medicaid payers provide prospective, risk adjusted PMPM payments</p> |
| <p>Resources/Payment: Practices are supported by PPSs to reach PCMH or APC designation</p> | <p>Resources/Payment: TA vendor paid on a per-practice basis. Focus on smaller practices.</p> | <p>Payment: TA vendors paid on a per-provider basis – Focus on larger practices.</p> | <p>Resources/Payment: No additional payments, national CMS learning networks provide support</p> |



IMPROVING THE
STATE OF HEALTH
NEW YORK

**TRANSFORMING PRIMARY CARE
 TO ACHIEVE THE TRIPLE AIM**
 Practices can accomplish this goal by choosing from one of the three
 following transformation assistance programs:

SIM*

TCPI*

DSRIP*

- Commonalities**
- Transform health system to improve performance and reduce costs
 - Provide technical assistance, funding and support to facilitate transformation
 - Shift payers from FFS to value-based reimbursement
 - Create single set of standards to drive quality improvements

- All primary care practices with focus on smaller practices
- Transformation assistance to begin Fall 2016
- Contact: sim@health.ny.gov

- Primary & specialty clinician practices with focus on larger practices
- Transformation assistance available
- Contact: info@nysptn.org
- For more information, visit www.nysptn.org

- Primary care providers participating in PPS provider networks working to achieve APC or PCMH
- Transformation assistance available
- Contact: dsrip@health.ny.gov
- For more information, www.health.ny.gov/health_care/medicaid/redesign/dsrip/pcmh/contact_list.htm

THE TRIPLE AIM
 Better Health, Better Care, Lower Costs



Department of Health

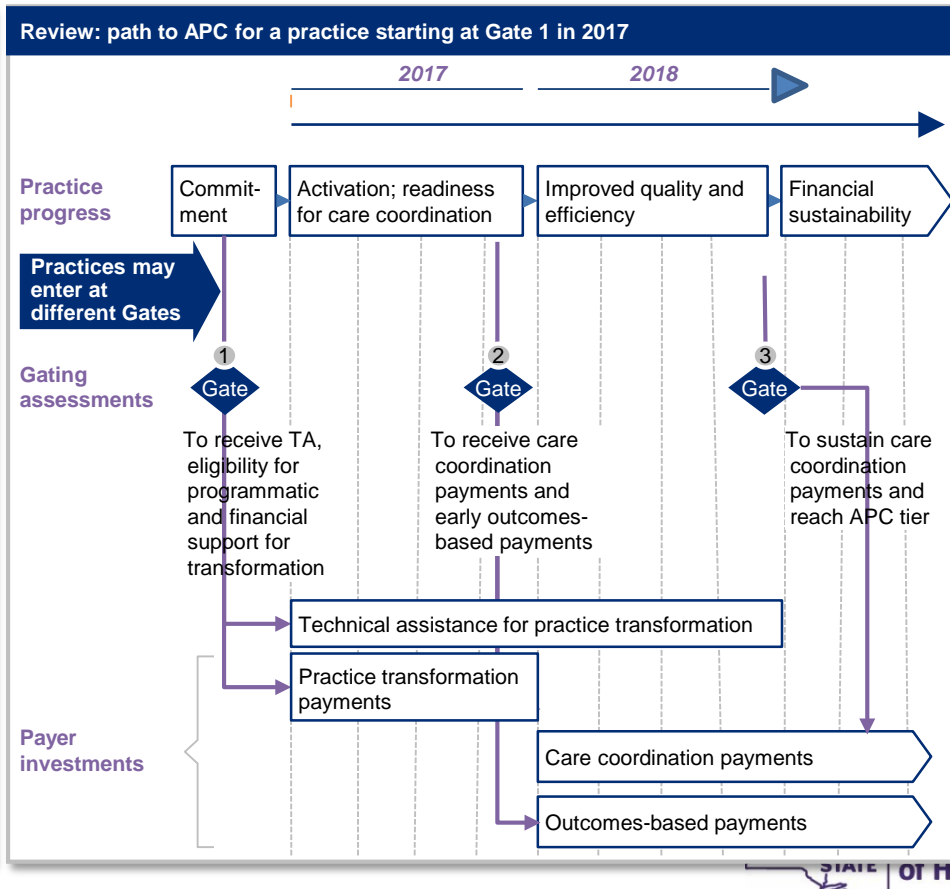
Innovation Center

*Practices may only receive assistance from one federally funded practice transformation program at a time.




The APC model

The **common APC framework**, in which individual payers develop and implement APC-qualified contracts, include:

- **Defined Practice Capabilities**
- **Milestones** that define a practice's capabilities over time
 - **Structural milestones** – describing practice-wide process changes
 - **Performance milestones** – describing performance on Core Measures
- **Core Measures** that ensure consistent reporting and incentives
- **Progression to Outcome-based payments** to promote and pay for quality and outcomes
- A common on-site assessment to certifies practices' progress through **Gates** which mark progress through performance Milestones that trigger practice transformation, care management and outcome-based payments



APC Structural Milestones Overview

| | Commitment  Gate 1 | Readiness for care coordination  Gate 2 | Demonstrated APC Capabilities  Gate 3 |
|------------------------------------|--|--|--|
| | What a practice achieves on its own, before any TA or multi-payer financial support | What a practice achieves after 1 year of TA and multi-payer financial support, but no care coordination support yet Prior milestones, plus ... | What a practice achieves after 2 years of TA, 1 year of multi-payer financial support, and 1 year of multi-payer-funded care coordination Prior milestones, plus ... |
| Milestone 1 Participation | i. APC participation agreement ii. Early change plan based APC questionnaire iii. Designated change agent / practice leaders iv. Participation in TA Entity APC orientation v. Commitment to achieve gate 2 milestones in 1 year | i. Participation in TA Entity activities and learning (if electing support) | |
| Milestone 2 Patient centered care | i. Process for Advanced Directive discussions with all patients | i. Advanced Directive discussions with all patients >65 ii. Plan for patient engagement and integration into workflows within one year | i. Advanced Directives shared across medical neighborhood, where feasible ii. Implementation of patient engagement integrated into workflows including QI plan (grounded in evidence base honed in Gate 2, where applicable) |
| Milestone 3 Population Health | | | i. Participate in local and county health collaborative Prevention Agenda activities ii. Annual identification and reach-out to patients due for preventative or chronic care management iii. Process to refer to structured health education programs |
| Milestone 4 Care Management/ Coord | i. Commitment to developing care plans in concert with patient preferences and goals ii. Behavioral health: self-assessment for BH integration and concrete plan for achieving Gate 2 BH milestones within 1 year | i. Identify and empanel highest-risk patients for CM/CC ii. Process in place for Care Plan development iii. Plan to deliver CM / CC to highest-risk patients within one year iv. Behavioral health: Evidence-based process for screening, treatment where appropriate ¹ , and referral | i. Integrate high-risk patient data from other sources (including payers) ii. Care plans developed in concert with patient preferences and goals iii. CM delivered to highest-risk patients iv. Referral tracking system in place v. Care compacts or collaborative agreements for timely consultations with medical specialists and institutions vi. Post-discharge follow-up process vii. Behavioral health: Coordinated care management for behavioral health |
| Milestone 5 Access to Care | i. 24/7 access to a provider | i. Same-day appointments ii. Culturally and linguistically appropriate services | i. At least 1 session weekly during non-traditional hours |
| Milestone 6 HIT | i. Plan for achieving Gate 2 milestones within one year | i. Tools for quality measurement encompassing all core measures ii. Certified technology for information exchange available in practice for iii. Attestation to connect to HIE in 1 year | i. 24/7 remote access to Health IT ii. Secure electronic provider-patient messaging iii. Enhanced Quality Improvement including CDS iv. Certified Health IT for quality improvement, information exchange v. Connection to local HIE QE vi. Clinical Decision Support |
| Milestone 7 Payment Model | i. Commitment to value-based contracts with APC-participating payers representing 60% of panel within 1 year | i. Minimum FFS with P4P ² contracts with APC-participating payers representing 60% of panel | i. Minimum FFS + gainsharing ³ contracts with APC-participating payers representing 60% of panel |

1 Uncomplicated, non-psychotic depression

2 Equivalent to Category 2 in the October 2015 HCP LAN Alternative Payment Model (APM) Framework

3 Equivalent to Category 3 in the APM framework



Medicaid alignment with APC

DSRIP: PPSs receive funds to support Primary Care Practices to meet PCMH (NCQA 2014) or APC (SHIP) standards.

- Achieving these standards is vital to amount of DSRIP payments the PPSs receive.

Transforming Clinical Practice Initiative (TCPI)

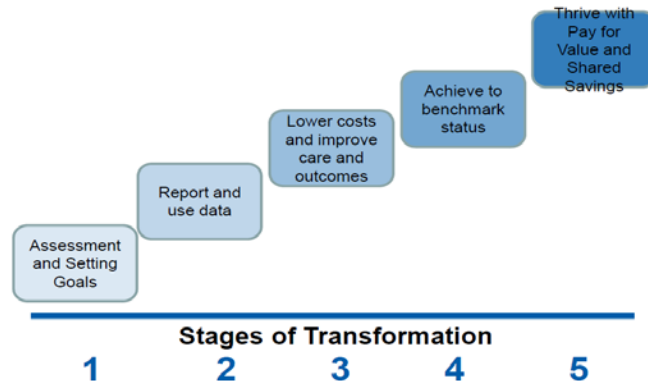
The Program: CMMI is funding **Practice Transformation Networks (PTNs)**, to support transformation of practices to a new care model, improving care and reducing costs

Goal: To enable primary care and specialty practices to thrive in under “Value-Based Payment”

- Improve performance, broadly, and quality/outcomes
- Reduce preventable ED visits and admissions

Content: Five phases, representing different levels of mastery

- Core competencies of a PCMH (Population Health Management)
- Continuous quality improvement (Document, report and improve performance on quality metrics)



Comprehensive Primary Care Plus (CPC+)

- Advanced primary care medical home model, led by CMMI/CMS, to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation
 - 20 regions/5000 practices/20,000 doctors/25 million patients
 - 5 year demonstration begins January 2017
 - Significantly aligned with APC
- 2 tracks
 - Advanced primary care (monthly care management fee + FFS)
 - Advanced primary care plus care management for complex patients (monthly care management fee + hybrid of comprehensive payments and reduced FFS)
- Multi-payer payment redesign is required
- DOH/DFS encouraging plans to apply

INSTITUTE FOR URBAN
HEALTH

Consumer Perspectives on Health Care Decision-Making: Quality, Cost and Access to Information

Natalie Helbig, Linda Weiss, PhD, Maya Scherer, MPH, Anthony Shih,
MD, MPH



Department
of Health

Innovation
Center

Presentation Outline

1. Project Goal
2. Methods
3. Findings
 - a. Perspectives on Health Care Quality
 - b. Perspectives on Health Care Costs
 - c. Participant Recommendations
4. Key Takeaways

Project Goal

To provide the New York State Department of Health and Department of Financial Services with consumer perspectives from focus groups to inform data elements and dissemination modalities regarding quality and cost information that meet the needs of New Yorkers.

Methods

Participant Eligibility Criteria

- 18 years or older
- Privately insured
- Seen a doctor 2 or more times in the past year
- Used publicly available data to make health care decisions in the past year
- Prioritized individuals with a high deductible (defined as \geq \$1,000)



Methods

Focus Group Locations and Sample Sizes

Focus Group Recruitment

- Posted Ads on Craigslist in Albany, Buffalo and NYC
- Disseminated focus group information to:
 - Local community based organizations
 - The Northeast Business Group on Health
- Eight focus groups in New York State (N=80 participants)
 - Four groups in New York City (n=45)
 - Two groups in Albany (n=19)
 - Two groups in Buffalo (n=16)



Methods

Discussion Topics

1. Quality and cost related considerations consumers use for health care decision-making
2. Current sources of quality and cost information
3. Preferences regarding:
 - Indicators
 - Sources
 - Format
 - Dissemination



Methods

Data Analysis

- Focus groups audio recorded and professionally transcribed
- Coding scheme reflects study goals and focus group questions as well as emerging themes
- Data coded, maintained and analyzed using NVivo
- Unless otherwise noted, only themes common and consistent across focus groups are reported



Sample Characteristics

Table 1 : Focus Group Participant Characteristics (N=80)

| | N | % |
|---------------------------------|----|-------|
| Age* | | |
| 18-35 | 26 | 32.5% |
| 36-45 | 22 | 27.5% |
| 46-55 | 13 | 16.3% |
| 56-64 | 16 | 20.0% |
| 65 and older | 2 | 2.5% |
| Education | | |
| Less than HS Graduate | 1 | 1.3% |
| HS Graduate or GED | 8 | 10.0% |
| Some College but no Degree | 15 | 18.8% |
| College Degree or Higher | 56 | 70.0% |
| Gender | | |
| Male | 28 | 35.0% |
| Female | 52 | 65.0% |
| Race/Ethnicity** | | |
| White | 44 | 55.0% |
| Black or African American | 18 | 22.5% |
| Hispanic/Latino | 12 | 15.0% |
| Asian/Asian American | 7 | 8.8% |
| American Indian/Native American | 4 | 5.0% |
| Other | 3 | 3.8% |

* Percentages do not add to 100 due to missing data

** Multiple responses permitted



Sample Characteristics

Table 1 Continued : Focus Group Participant Characteristics (N=80)

| | N | % |
|-------------------------------------|----|-------|
| Work Status | | |
| Employed Full Time | 55 | 68.8% |
| Employed Part Time | 13 | 16.3% |
| Not Working | 12 | 15.0% |
| Annual Household Income* | | |
| Less than \$10,000 | 6 | 7.5% |
| \$10,000 to \$49,000 | 21 | 26.3% |
| \$50,000 to \$89,000 | 29 | 36.3% |
| \$90,000 to \$119,000 | 8 | 10.0% |
| \$120,000 or more | 12 | 15.0% |
| Health Insurance Deductible* | | |
| Less than \$1,000 | 25 | 31.3% |
| \$1,000 - \$2,000 | 29 | 36.3% |
| \$2,001 - \$5,000 | 17 | 21.3% |
| Greater than \$5,000 | 7 | 8.8% |

* Percentages do not add to 100 due to missing data



Findings

Perspectives on Health Care Quality: Defining Quality

Participants described a broad range of attributes that they use to define quality. Chief among them were:

- Interpersonal skills: provider has evident interest in patient well-being, pleasant personality, willingness to listen to patients and takes the time needed for optimal care.
- Competency: provider has knowledge and skills for diagnosis and treatment.



Findings

Perspectives on Health Care Quality: Defining Quality

I felt she was competent and thorough, but what made the difference to me or what stood out, because I'm sure there are a lot of competent physicians in the area, is just that she had a very good bedside manner. She was very compassionate, very caring and it felt like a personal touch -- combined with the expertise.
(Albany participant)

Somebody that understands or is aware of, say, new diseases or new genetic issues, or something that – they're not necessarily old school. They're not diagnosing you with something brand new and the disease of the week, but they're also not telling you to stick a leech on it.
(Buffalo participant)



Findings

Perspectives on Health Care Quality: Defining Quality

Characteristics related to accessibility and the office environment were often closely associated with quality and described as essential by many.

I honestly think you can tell more about a doctor – like if you just go in the waiting room and sit there for like 20 minutes, you can pretty much tell how the visits gonna be ...If they got young girls sitting at the desk playing on their phones, joking around with each other. You can sort of tell the kind of place that you're in. (Buffalo participant)

*With the quality...sometimes it's clear that [if you have to wait too long], it's a money mill, that they're... overbooking and you're not getting the care that you need.
(Albany participant)*



Findings

Perspectives on Health Care Quality: Measuring Quality

Participant knowledge of clinical quality indicators was limited.

- Most participants did not readily describe indicators or predictors of quality used by the medical field (e.g., high volume with respect to a particular procedure) and in many cases these indicators were unfamiliar.
- Most often cited were personal quality indicators such as education, hospital affiliation, years practicing, certification, and malpractice information.



Findings

Perspectives on Health Care Quality: Defining Quality

Before I even go see my doctor, I would try to find out background information, how long he had his residency, what's his specialty. Because I need to know if something happens to me, this doctor is able to handle my case. And what surrounding doctors or hospitals that he's affiliated with that he could refer you to for services.
(New York City participant)



Findings

Perspectives on Health Care Quality: Defining Quality

Volume and outcomes were identified by some participants as quality indicators for specialist care.

I recently had a knee surgery and I wanted to choose somebody that actually performed the procedure more often than somebody that was maybe more focused in another area ... Because I had a torn patellar tendon... So I wanted to find a doctor who was very fluent in that type of procedure. (Albany participant)



Findings

Perspectives on Health Care Quality: Information Sources

Participants most often depend on personal (e.g., family and friends) and professional recommendations to make choices about where to go for care.

- Described as easiest and most trustworthy sources of information.
- Participants were often unsure of where else to look for information about provider quality.



Findings

Perspectives on Health Care Quality: Information Sources

It's like I don't know where to look, because I feel like it's not a wide database of information. [The] only [resources are] some of your friends, like she was saying, and recommendations from other doctors that you might trust. (Buffalo participant)

Trying to find a good doctor is really hard. I look at reviews, and it's not enough. I feel like, sometimes, through friends and family is the best way. (New York City participant)



Findings

Perspectives on Health Care Quality: Information Sources

General search engines and rating sites (e.g., Google, Yelp) were widely used to gather information about providers.

Google gives you a lot of different websites. ... And then, I don't know, I just look at cost, how far from my house, and reviews, and I just compare a few and then pick one. So yeah, some people have stars. Some people just have testimonials. I definitely read it. I go on the website. So for me, I usually like to do a little more research. So it's a lot of different aspects. (Albany participant)



Findings

Perspectives on Health Care Quality: Information Sources

Internet sources utilized were found to be lacking.

I think it's very telling that we've been talking about so many review sites and so many reviews – like a number of us have mentioned doing hours of research on these things and it's like if these were good sources of clear information we wouldn't have this. So we'd be like, "Oh yeah, we go here and we spend ten minutes." Definitely my experience has been that I go and look and I look and I look and I feel like I haven't gotten anywhere and I'm just kind of having to like, "Okay, well this sort of looks good I guess," and then I – interacting with the doctor I can make an actual judgment. (New York City participant)



Findings

Perspectives on Health Care Quality: Information Sources

Most participants could not recall, or were uncertain of, the specific sources they had used to retrieve quality information.

*Like, when I was looking for a pediatrician for my ...
I think it was just a Google search of the doctor's name.
(Albany participant)*

*There is also a website. I forget what it was. But it's a disciplinary board where you can
check your doctor's name against it to see if they have a past history.
(New York City participant)*



Findings

Perspectives on Health Care Quality: Information Sources

Participants' first hand impressions were described as most important.

You almost have to interact with them, be in their office, and just kind of the feeling you get from them. You've gotta feel comfortable. (New York City participant)

I can look online all day long, but that doesn't mean when I get to the doctor's it's [not] a different thing. He might act completely different than what the paperwork on the computer's saying, or something like that. (Buffalo participant)



Findings

Perspectives on Health Care Cost

Because of insurance, many did not take the cost of care into account.

I don't think most people pay attention to cost quite frankly. If you have insurance, I don't think most people in this room are gonna get excited if the insurance company has to pay this much or that much. I was not insured until I was in my mid-30s, and I used to pay cash out of pocket for medical. Then I wanted to know what everything cost, everything. (New York City participant)



Findings

Perspectives on Health Care Cost

Many viewed the health care payment system as confusing and difficult to navigate, which made searching for cost information frustrating.

I guess you'd call the office and see what they charge, but I think sometimes don't they charge one price for your insurance, out of pocket they might charge you something else. So I'm not sure you'd ever get a clear answer on that, to be honest. (Buffalo participant)

You go to a mechanic and get an estimate. But you can't go to somebody who's going to be feeling your body to get an estimate? (New York City participant)



Findings

Perspectives on Health Care Cost

Cost-related decisions largely centered on in-network versus out-of-network care and whether a service is covered by insurance.

For me, it's whether it's in network or out of network. My insurance pretty much covers that doctor within that certain area or whatever, if there are any out of pocket expenses that I'm going to have to pay. So that's always a determining factor. (New York City participant)



Findings

Perspectives on Health Care Cost

Other commonly reported reasons participants did not seek specific cost information were:

- Cost-based decisions were perceived as somewhat incompatible with quality-based decisions.
- Uncomfortable or inappropriate to think/ask about cost when health care needs are serious.
- Costs cannot be considered in an emergency or other urgent health condition.



Findings

Perspectives on Health Care Cost

I think it's a mental thing. If you find a doctor that's cheap, you're like, "What is – what are they doing wrong?" But it really might just be that they're cutting all the crap out that other doctors aren't, and they're just giving you the base, like, "This is what you pay." But, it's a mental game with yourself, of you just see lower price then think of lower quality. (Buffalo participant)

In a case of emergency you don't think, "Where is my insurance going to be taken, where can I get service for free?" You kind of just go with the flow and try to get service. (Albany participant)



Findings

Perspectives on Health Care Cost

The impact of having a high deductible plan was unclear.

We've now gone to a high deductible plan and the idea behind was to make us savvy consumers, but I get like frustrated I guess. Thinking, "Why should I have to be a consumer for my healthcare?" So, I've never done that, I've never researched that. I still just continue to go to the doctors that we've gone to and who knows, maybe I could be getting a better deal somewhere else, but, I've not done that. (Buffalo participant)

Now that I have a terrible, high deductible plan where I have to pay out of pocket, up until \$3000 before anything kicks in, I'm always asking about cost. (Buffalo participant)



Findings

Perspectives on Health Care Cost: Information Sources

Participants who wanted cost information most often sought it from their insurers. A smaller number sought information from providers.

The insurance tells me in advance how much it's going to cost. (New York City participant)

I go to my HR Department [to get cost information] first... Obviously they refer you to the insurance company that you have and then I reach out to them. I don't trust the doctors, they're not going to know... they just want to do the procedure, to charge you or the insurance company. So, I double check with the insurance company before I do anything. (New York City participant)



Findings

Participant Recommendations for Health Care Information

Participants recognized that priorities differed by person and by circumstances. Information sources must be responsive to these differences.

She's looking for someone with a good bedside manner, who is a good, warm, caring person... Give me a cold robot that's going to answer all my questions and I'm fine. We're going to rate doctors differently. Why can't there just be some sort of a database full of questions and answers and honestly [a] scale of one to ten? How close is this doctor a match for what you're looking for? For what you're being treated for?
(New York City participant)



Findings

Participant Recommendations for Health Care Information

Having quality and cost information available in one location via the Internet or an App. Information must be easy to comprehend and incorporate a range of quality indicators.

- **Some prioritized breadth of information while others prioritized simplicity.**

There must be one website that people can type in zip code and have available doctors or specialties with detailed reviews, because I feel that people need to know ahead of time about price and quality of service.

(Albany participant)



Findings

Participant Recommendations for Health Care Information

Many participants reported that they would use standardized quality indicators if accessible.

If [the data were] somewhere and I knew to go there and put in a doctor's name and have statistics pop up as opposed to me having to figure out what those statistics are, I'd probably look at them and consider them.

(Albany participant)



Findings

Participant Recommendations for Health Care Information

Participants listed a number of indicators that might help them with health care choices, including:

| <i>Preferred Quality Indicators</i> |
|--|
| <i>Provider background</i> |
| <ul style="list-style-type: none">• Education• Certification• Years in practice• Malpractice information |
| <i>Practice information</i> |
| <ul style="list-style-type: none">• Hospital affiliation• Average wait time• Procedure volume• Patient volume• # of repeat patients• Outcomes data (both positive and negative) |
| <i>Hospital-specific information</i> |
| <ul style="list-style-type: none">• Nurse to patient ratio• Infection rate |

Findings

Participant Recommendations for Health Care Information

Participants recommended ratings that aggregate different measures.

I would like a five star rating system of how good the doctor is and number of patients, how many patients recover, things like that. (New York City participant)



Findings

Participant Recommendations for Health Care Information

Recommended Models:

- Yelp
- Consumers Reports
- Kayak
- Match.com
- Better Business Bureau
- Angie's List

I mean simply something like the Better Business Bureau. That's still a very powerful organization. If you have a bad review from them, you're not gonna make the sales that you normally would. So if we had something, again, similar to that.

(New York City participant)



Findings

Participant Recommendations for Health Care Information: Dissemination

Participants felt that the resource on cost and quality yet to be created should have good name recognition and branding.

- **Advertising suggestions included through Facebook, billboards, radio, TV, insurance companies and provider waiting rooms.**

Ease of access and a catchy name – something that people will remember and they'll go, "Oh, I need to know about healthcare and I live in New York State. I'm gonna go to New York whatever."

(Buffalo participant)



Findings

Participant Recommendations for Health Care Information: Dissemination

A neutral, trustworthy source of information was considered very important, one without financial or other vested interest.

- **Some felt it was the government was most neutral, while others felt that the private or non-profit sectors would be better.**

I'd want somebody that was like third party, not government, not New York State, not insurance just somebody that really, truly had the best interest of just the people. (Buffalo participant)

There must be some kind of like, ratings for doctors, but as I said, [a] neutral organization has to say this doctor's rating is five, this doctor's is four. [If] it's five stars but the prices are higher...it's up to you if you can afford, and you want the best doctor, you can decide to go to the doctor. But yes, you need to have a trusted source. (Albany participant)



Key Takeaways

- Participants are not using objective data for decisions regarding health care provider choices.
 - Don't know where to find such information.
 - Have little exposure to or understanding of objective data.
- Consumers appear more interested in information on quality than on costs.
 - Finding accurate cost information is difficult.
 - Participants perceive they have little control over cost.
 - Cost decisions focus more on in or out of network and general service use, rather than fees charged by a particular provider.
- Participants would like to have and use better data sources.
 - Recommend ratings that aggregate different measures and are from a neutral and trustworthy source.



Questions? Comments?

Many thanks to Natalie Helbig and Chitra Iyer for their invaluable support throughout this project.

To read the detailed report, please visit [The Academy's website](#)

Report Citation: Weiss L, Scherer M, Shih A. *Consumer Perspectives on Health Care Decision-Making Quality, Cost and Access to Information*. New York City; 2016. http://www.nyam.org/media/filer_public/2f/a8/2fa832b1-77ed-43be-bb94-3232eab8c2b4/cearconsumerperspectivesonhealthcaredecmakingfinal4-29.pdf.



APD Update

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

NYS APD Implementation Update

- Major Components / Infrastructure
 - Data Warehousing & Analytics

- Governance
 - Regulations
 - Operations Guide (submission specifications, validation methods, etc.)
 - Data Governance Manual (advisory committees, data release, user agreements, etc.)
 - Supreme Court Decision: no reporting mandate for Self-Insured Plans



Data Warehouse & Analytics Schedule

- Vendor Award – Optum Government Solutions
 - Contract Start – mid May

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

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

- Permanent Data Analytics (Jan 2018)
 - 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 Oct. 2016, if assuming 2 rounds of public comment)
- 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 and 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 Final Version of Release Policy, Procedure and Criteria



Governance Policy (DRAFT) Document Highlights

- Data Access & Release
 - Data Types
 - Process for user requests
 - Structure of Data Release Review Committee (DRRC)

Data Types and Access

Public Use Data Sets:

- Data has been de-identified at the basic record-level detail, or aggregated above basic record-level detail. Does not contain PHI or PII, and cannot be used to identify specific individuals, either alone or in combination with other data.
- Public Use Data posted to DOH public web – Includes customizable population health views.
- Customized public use data extracts also available – Must have approved APD Data Use Agreement (DUA).

Limited Identifiable Data Sets:

- Data contains indirect or partial identifiers that are deemed potentially identifiable according to HIPAA standards.
- Available under certain circumstances:
 1. Existing statutory/regulatory authority to collect/access; and APD Data Use Agreement (DUA) Approval.

OR

 2. APD Data Release Review Committee (DRRC Approval); and APD Data Use Agreement (DUA) Approval.

Data Types and Access (cont.)

Identifiable Data Sets:

- **Available ONLY to DOH programs** and under certain circumstances:
 1. DOH IRB approval; and APD Data Release Review Committee (DRRC Approval); and APD Data Use Agreement (DUA) Approval.
OR
 2. Existing statutory/regulatory authority to collect/access; and APD Data Use Agreement (DUA) Approval.

- Available to other State Agencies under certain circumstances:
 - Existing statutory/regulatory authority to collect/access; and APD Data Release Review Committee (DRRC Approval); and APD Data Use Agreement (DUA) Approval.

Data Release Development Schedule

Types of Release:

- Public Use Data – Consumer Facing Website, Customizable Population Health Views (DW&A Vendor Developed) – March 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

Data Access Limitations

Line of Business Specific Policies and/or Limitations:

- Medicare Fee-for-Service data release contingent upon requirements of DOH DUA with CMS:
 - Can be released in aggregated public use files.
 - Can release limited identifiable or identifiable within DOH if added as a documented user on CMS DUA, and complies with all DUA requirements.

Program Specific Limitations:

- Potential de-identification of sensitive medical data:
 - Behavioral Health
 - Reproductive and Sexual Health
 - Communicable diseases



Data Access Limitations (cont.)

Plan / Provider Specific Limitations:

- Release of Price/Cost data limited in certain situations:
 - Public Use Data Sets include median prices only.
 - Custom De-identified Data Sets provide limited specific information on Member, Plan, Line of Business, Insurance Product Type, Provider, and Amounts Paid.
 - Limited Identifiable Data Sets provide additional information on Plan, Policy and Provider.
 - Release of specific price information cannot be accompanied by release of any identifiable member information.

Other Limitations:

- Electronic format only – No hardcopies of data.
- In addition to direct identifiers, categories of data elements reviewed for potential anonymization include indirect identifiers, certain identifying provider information, sensitive health care service areas, and other non-claim based data elements collected for DOH program administration.

Data Release Review Committee (DRRC)

- Chaired by the Commissioner of Health's designee, and members appointed by the Commissioner
- Provide non-binding advice and opinion to the Commissioner, as requested, on the merits of applications for access to limited use data sets. If the Commissioner requests review of an application, the DRRC provides the Commissioner with any comment on the merits of the application and the research protocol described therein within thirty (30) days.
- DRRC is comprised of the Committee Chair and ten (10) members, including:
 - One member representing the NYS Department of Financial Services;
 - One member representing the NYS Medicaid Program;
 - Two members representing health insurers;
 - Two members representing health care facilities;
 - One member representing health care practitioners;
 - One member representing purchasers of health insurance or health benefits;
 - One member representing health care consumers; and,
 - One member representing health care researchers.

DRRC Authority

The DRRC has non-binding authority to make recommendations to the Commissioner on the disposition of data release requests; release requests be recommended for full approval, conditionally approval, or denial. DRRC recommendations are received by the APD Director, who makes the preliminary decision to approve or deny, which is then presented to the Commissioner of Health or his/her designee for final decision.



March Supreme Court Decision, Gobeille vs. Liberty Mutual – disallowed APD reporting mandate on Self-Insured Plans (ERISA pre-emption ruling)

- In essence, the ruling presents structural blind spot to statewide health system analysis

New York Covered Lives Distribution *Estimate, N= 18.1 million

QHP (NYS Health Exchange) = 1,000,000

Medicaid and CHIP = 6,500,000

Medicare = 3,100,000

Large Group Commercial = 4,500,000

Self-Insured Commercial estimated at over 3,000,000 and growing / in number to over 40% of Commercial market, 16% overall

*Figures are NOT point estimates, broadly stated values only due overlapping groups



March Supreme Court Decision (cont.)

- The New York State Health Insurance Program (NYSHIP) includes both state and local government enrollees with coverage for 1.2 million
- APD discussions are ongoing with Civil Service as voluntary reporting by this payer would instantly pull in a third of NY's currently self-insured pool (though continued growth in the self-insured segment is expected to erode NYSHIP's portion of the pie)
- More limited dialogue on voluntary reporting has also taken place with smaller self-insured plans in western and northern NY
- Lastly, the Court suggests that states' APD interests might be served pursuing newly created reporting rules from the US Depts. of Labor or Health and Human Services (removing federal statute pre-emption from the equation); the APCD National Council is coordinating a unified states' dialogue with USDOL

SHIN-NY Update

Jim Kirkwood, Director

Health Information Exchange Bureau
Office of Quality and Patient Safety

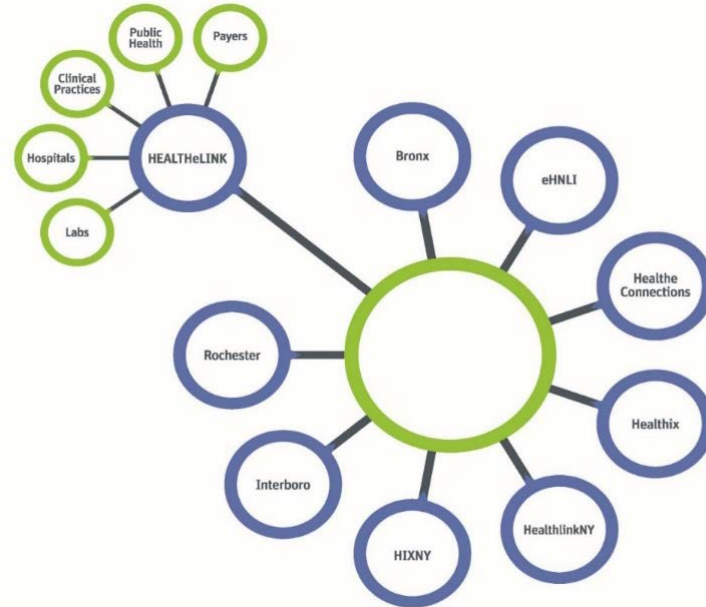
SHIN-NY: Issues and Challenges

1. Duplication
 - “Wire Once” policy
2. Consent
 - Opted In; Opted Out; CFR 42 restrictions; adolescent consent
3. Increase Adoption, improve completeness and data quality
4. Sustainability
 - New CMS 90-10 opportunity
 - State HCRA and Medicaid funds



SHIN-NY: Structure Today

- RHIOs are connected to each other via a central bus (the green ring in the middle)
- Data from a participant of any RHIO is available to any other RHIO's participant statewide
- This system is called Statewide Patient Record Lookup (sPRL)



SHIN-NY Timeline

Statewide patient lookup (connecting RHIOs to each other)

- All 8 RHIOs are connected and sharing data
- NYeC provides a Master Patient Index to support exchange across RHIOs

Concentrated efforts on adoption

- Individual providers
- Provider systems

DSRIP

- SHIN-NY is the primary vehicle for HIE for DSRIP

Regulation development

- Regulations went into effect on March 9, 2016
- SHIN-NY Policies and Procedures established*

*Policies: <https://www.health.ny.gov/technology/regulations/shin-ny/>



SHIN-NY Evaluation

Audacious Inquiry (AI)

- NYS engaged AI to develop an objective, fact-based assessment of the current status of both state-level and regional health information exchange efforts and make recommendations for moving forward.

- Report will assist DOH on the future SHIN-NY focusing on:
 - Governance
 - Technology
 - Sustainability

APC Scorecard V1.0

Payer Readiness

Anne Schettine, Director

Division of Quality Measurement

Office of Quality and Patient Safety

Paul Henfield, IPRO



Department
of Health

Innovation
Center

Pre-Reporting Evaluation of Systems Survey (PRESS)

PRESS was sent to 6 payer organizations in April 2016

A. Data Collection Processes

- System capabilities and limitations
- Data completeness with 3 month claim lag
- Capability to capture EHR, data sources for quarterly reporting
- Capacity for production of HEDIS and non-HEDIS measures for rolling 12 month period

B. Attribution Methodology

- Capability to report results at provider or practice level
- Attribution algorithm high level description
- Ability to attribute all membership and product lines

C. Reporting of APC Measures

- Create member file across all product lines
- Ability to report measures and current uses of measure with practices



APC Scorecard Preparation – Next Steps

Interviews – individual interviews with the payer organizations

- Follow up questions regarding responses
- Understanding of resources needed for APC Scorecard data production

Confirm payer participation in pilot test of reporting – summer 2016

- Test of member-level file production
- Validation of member and provider attribution to practices

Share findings, lessons learned and best practices from the pilot with all payers in preparation for Jan 2017 first quarterly report submissions



Discussion and Next Steps

Patrick Roohan
Director
Office of Quality and Patient Safety

Next meeting September 23, 2016