NYS All Payer Database Stakeholder Meeting
Today’s Agenda

Introductions / Purpose of Today’s Meeting

National Perspectives from the APCD Council

Update on the NYS All Payer Database

Lunch Break

Overview of the Warehousing and Analytical Solution by Optum

Update on the Provider Network Data System

Facilitated Discussions

Wrap Up / Next Steps
Purpose of Today’s Meeting

• Bring together internal and external stakeholders of the NYS APD project for an update on:
  – Where we have been
  – Where we are now
  – Where we are going

• Elicit feedback and engagement from participants
Who’s here today?

- Government
- Vendors
- Organizations
- Consumers
- Academics
- Researchers

Please refer to the handout “Registered Participant Organizations” for a detailed list of who is here today either in person or via Webex.
Meeting Materials

- Informational Sheet (Directions, Parking Information, Train Schedules, Cab Services, Lunch Options)
- Map of the ESP Concourse
- Agenda
- Speaker Bios
- Summary of Registered Participant Organizations
- Facilitated Discussion Instructions
- Slide Deck
## Inputs, Stakeholders, Outputs

### APD Data Sources (Inputs)

- Commercial Payers (Claims, Benefits, Enrollment)
- Public Payers (Claims, Benefits, Enrollment data)
- Non-Claims Health Data

### APD Data Users (Stakeholders)

- Government
- Researchers
- Consumers
- Employers
- Providers
- Payers

### APD Data Uses (Outputs)

- Informing Policy
- System Performance (Quality Assurance, Cost of Care)
- Population Health
- Health Reform Evaluation
- Consumer Engagement
Logistics

• All meeting materials are available at the following direct link: http://www.health.ny.gov/technology/all_payer_database/meetings/2017-04-26/
• Wi-Fi is available in the meeting room
• We will take a 45 minute lunch break – refer to the Information Sheet handout for lunch options
• Restrooms are located outside the meeting room, additional restrooms are located on the Concourse
• Please silence cell phones and electronic devices
• Please limit side conversations during presentations
Feedback

• We welcome feedback and comments on today’s session - index cards are available on the tables
• Once completed, please drop them in the designated box at the registration desk
• Webex attendees can submit feedback via the chat function
• Phone lines will be muted throughout today’s meeting
Facilitated Discussion Topics

1. Employer Use Cases
2. APD Data Submission
3. Data Quality
4. Data Governance and Release
5. Consumer Tools / Transparency
6. General / Other
Facilitated Discussions

- See Facilitated Discussion Handout
- Colored paper and markers at each table
- One comment per sheet of paper
- @ 2:15 we will begin the exercise but please write comments throughout the day
All Payer Database Vision

“The vision of the APD is to provide policymakers, researchers and consumers with the most comprehensive health database in New York State to achieve the triple aim of improving patient experience; improving population health; and reducing the costs of health care.”
NYS Priorities and the APD

• Aligned with NY State Department of Health’s Mission Statement:
  “The Department of Health protects the health, productivity and well-being of all New Yorkers by promoting public health and patient safety, by reducing health disparities and by assuring access to affordable, high quality health services.”

• Aligned with the Triple Aim:
  Improve population health, improve quality and reduce costs
New York State All Payer Database (APD)

• Advancing health care transformation in an effective and accelerated manner requires population based data to support decision making into the challenges of access, quality, and affordability.

• An APD that includes not only health care claims data, but other health-related data, will allow a broad range of stakeholders to monitor efforts to improve quality of care, conduct population health research and reduce health care costs.

• The APD will serve as a comprehensive data and analytical resource for supporting policy and decision making and research.
Supporting Health Care System Transformation

Systematic Integration of Data & Technology
- All Payer Database Encounters and Claims
- SHIN-NY Electronic Medical Records (EMR)
- Health Assessment Data
- Public Health Data

Robust Analytics
- Quality Measurement
- Cost of Care
- Care Coordination
- Clinical Decision Support

Health Care Reform System Transformation
- DSRIP
- SIM APC Model
- TCPI, CPC, PCMH
- MACRA / MIPS
- Value Based Care
- Outcomes Based Models

Transformation Goal of The Triple Aim
Better Health, Better Care, Lower Costs
Better Health, Better Care, Lower Costs
Size and Scope of the NYS APD

- New York State Estimated Population = 19.7 million
- Anticipate 1.0 -1.2B claims processed per year

<table>
<thead>
<tr>
<th>Program</th>
<th>Estimated Beneficiaries</th>
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<tbody>
<tr>
<td>Qualified Health Plans</td>
<td>234,000</td>
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<tr>
<td>Medicaid (Dual Eligible)</td>
<td>850,000</td>
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<tr>
<td>Medicaid (excluding Dual Eligible)</td>
<td>5,150,000</td>
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<tr>
<td>Child Health Plus</td>
<td>306,000</td>
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<tr>
<td>Essential Plan</td>
<td>661,000</td>
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<tr>
<td>Commercial</td>
<td>4,500,000</td>
</tr>
<tr>
<td>Commercial (Self-Insured)</td>
<td>4,500,000</td>
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<tr>
<td>Medicare (2015)</td>
<td>3,340,000</td>
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<tr>
<td><strong>Estimated Total</strong></td>
<td><strong>19,541,000</strong></td>
</tr>
</tbody>
</table>
Enhanced Benefits of an APD

- Enhanced Security
- Ease of Visualizations
- Broadened Covered Lives
- Full Suite of Quality Measures
- Master Provider Index
- Master Patient Index
- Disease and Risk Profiles with Cost
- National Benchmarking
- Advanced Analytics
Enhanced System and Data Integration

Integrating disparate data sources toward member centered data management and analytics

» Source of truth for members and providers
  - Master Patient Index
  - Master Provider Index

» Algorithms for attribution, grouper technologies
Enhanced Security

More secure while expanding opportunities for a variety of users

» Make data more secure and in one place
» NY.Gov authenticated sign-on
» Row/column level data security
» Audit functions and monitoring access
Robust Analytics

Enhanced security and data integration lead to one-source of truth data capabilities for business intelligence and analytics

» Quick, easy, accessible counts and amounts (descriptive analytics)
» Optimization analyses, asking what-if, tools to support deciding on courses of action
» Predictive analytics, forecasting and modeling
» Data mining, network analyses, spatial analyses
Three Main APD Components

Data Intake and Acquisition
- Encounters
- Member
- Provider
- FFS Claims
- Reference
- Non Claim Based Data

Warehousing
- Optum Oracle Database (Permanent)
- OHIP Data Mart – Vertica (Interim)
- OHIP Data Mart – Oracle (Interim)

Analytics
- Data Enrichments
- Limited Identifiable
- Public Use Files
It’s Complicated.
All-Payer Claims Databases: National Landscape

NY APD Stakeholder Meeting, April 2017

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About the APCD Council

The APCD Council is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based all payer claims databases (APCDs). The APCD Council is convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

Our Work

- Early Stage Technical Assistance to States
- Shared Learning
- Catalyzing States to Achieve Mutual Goals
Welcome to the APCD Showcase where examples from state all-payer claims databases (APCDs) have been organized in order to provide stakeholders with tangible examples of APCD reports and solutions. The examples have been organized by intended audience, and are also searchable by additional criteria. We invite you to explore the site and learn more about the value that APCDs provide to states and their stakeholders.

Choose from the categories below or
See all Case Studies »

- **Consumers**
  - Consumer websites primarily focused on cost and quality

- **Employers**
  - Employer and purchasing coalition efforts

- **Providers**
  - Accountable Care Organizations and quality

- **Researchers**
  - Academic and “think tank” research

- **Population Health**
  - Incidence, prevalence, quality and utilization

- **Insurance Department**
  - Regulatory and market use cases

- **Medicaid**
  - Comparisons between Medicaid and Commercial populations

- **Health Reform**
  - Medicaid/ACE accountable care organizations & Triple Aim

http://www.apcdshowcase.org/
Use Case Examples: Colorado Annual Report

Benefit to Colorado

Total cost of care per member per year (PMPY) is calculated by adding the total amount of payments made by payers to health care providers to the total amount paid by the member (deductibles, copays, and coinsurance). The DOI analysis indicates that the during both 2014 and 2015 there was significant variation in the cost to treat patients in Boulder and how much it costs to treat patients annually in the Western portion of the state.\(^{\text{VI}}\)

These types of analyses help the DOI safeguard Coloradans’ health insurance by providing necessary information for the rate-review process. Without these benchmarks, it would be difficult to determine whether proposed rates by health insurance payers were equitable for each particular region.

Commercial Insurance Total Health Cost Comparisons (CO APCD)

Use Case Examples: MA Cost Trends Report

Exhibit 2.8: Annual out-of-pocket spending for Massachusetts residents in the lowest and highest income areas in the state, 2014

Notes: Spending includes only out-of-pocket spending within insurance benefits (e.g., copays and deductibles) and is conditional on having non-zero spending. Lowest income areas represent the quartile of zip codes in the state with the lowest median household income. Data include only privately insured individuals covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan. Data do not include spending outside of health insurance such as dental care, over-the-counter medications, or privately-paid mental health visits.

Source: HPC analysis of Massachusetts All-Payer Claims Database, 2014

Massachusetts Out-of-Pocket Spending

Exhibit 2.8: Annual out-of-pocket spending for Massachusetts residents in the lowest and highest income areas in the state, 2014

- Average $560 for the lowest income areas, 13% of residents spend 1% of their income.
- Average $620 for the highest income areas, 15% of residents spend 2% of their income.

Notes: Spending includes only out-of-pocket spending within insurance benefits (e.g., copays and deductibles) and is conditional on having non-zero spending. Lowest income areas represent the quartile of zip codes in the state with the lowest median household income. Data include only privately insured individuals covered by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan. Data do not include spending outside of health insurance such as dental care, over-the-counter medications, or privately-paid mental health visits.

Source: HPC analysis of Massachusetts All-Payer Claims Database, 2014

Use Case Examples: Disease Overview Reports

https://www.analyzehealthct.com/
A Snapshot of Hepatitis C in Colorado

Hepatitis C is a liver infection caused by the Hepatitis C virus (HCV) and is transmitted through the blood. For some people, HCV is a short-term illness, but for 70% - 85% of people who become infected, it becomes a serious, long-term, chronic infection. The majority of infected persons might not be aware of their infection because they are not clinically ill. HCV is now the leading infectious disease killer in the US, claiming approximately 20,000 American lives in 2014.\(^\text{i}\)</p>

Below is a snapshot of HCV prevalence in Colorado for 2013-2014 using claims data from the Colorado All Payer Claims Database (CO APCD). Data reflects Coloradans with claims filed through commercial payers (excluding self-insured lines of business), Medicaid, and Medicare Advantage. The largest age demographic diagnosed is the baby-boomer generation (51-71 years old) with the majority of individuals living in urban parts of the state. In spite of new, easy to administer treatment options that essentially eliminate symptoms, many Coloradans are still not receiving any treatment for HCV.

http://www.civhc.org/getmedia/4cb1331f-9717-4ac5-a8c0-2375835dc1dd/Hep-C-Infographic-May-2016.pdf.aspx/
Use Case Examples: Price Transparency Tools

http://vhi.org/healthcarepricing/procedure.asp?id=AXR11
http://nhhealthcost.nh.gov/
http://www.comparemaine.org/
Virginia Price Transparency Tool

Healthcare Pricing Transparency for Ankle X-Ray in 2015

Average Allowed Amount ($) vs Regions in Virginia

Central: Physician Office - 136
Central: Hospital Outpatient - 292
Eastern: Physician Office - 136
Eastern: Hospital Outpatient - 292
Northern: Physician Office - 136
Northern: Hospital Outpatient - 292
Northwestern: Physician Office - 136
Northwestern: Hospital Outpatient - 292
Southwestern: Physician Office - 136
Southwestern: Hospital Outpatient - 292

http://vhi.org/healthcarepricing/procedure.asp?id=AXR11
Use Case Examples: Risk Adjustment and Grouping

https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-017-2010-0

KEY REGULATORY ISSUES

• *Gobeille v. Liberty Mutual* Ruling
• 42 CFR Part 2 Rules
Summary

• In *Gobeille v. Liberty Mutual*, a self-funded plan sponsor (employer) challenged the state of Vermont’s right to compel the employer’s TPA to submit claims data to the state’s APCD regulated by the Green Mountain Care Board.

• In its March 1, 2016 decision, SCOTUS confirmed that Vermont’s statute, as applied to the self-funded employer’s Employee Retirement Income Security Act of 1974 (ERISA) plan, was preempted by ERISA in that self-funded employer submission scenario.
Key Regulatory Issues Facing APCD States Post Gobeille v. Liberty Mutual

The All Payor Claims Database (APCD) Council has collected and compiled responses to key questions posed to regulators in APCD states since the March 4 decision by the Supreme Court of the United States (SCOTUS) in Gobeille v. Liberty Mutual, related to key regulatory enforcement issues to be considered by states.

These responses are not meant to provide legal advice and should not be relied upon as such. Instead, this is a compilation of opinions and regulatory interpretations that may help guide states as they assess the impact of the SCOTUS decision on APCD efforts.

REGULATORY ENFORCEMENT ISSUES FOR APCD STATES

Issue 1: Are state APCD statutes still enforceable?

Yes. APCD statutes are and remain, for the most part, enforceable. Health insurance companies, providers, government health plans, and other APCD-regulated entities are still authorized to comply with APCD reporting statutes. Unless specifically directed by self-funded plan sponsors otherwise, Third-Party Administrators (TPAs) should also continue to comply with state APCD reporting requirements.

In Gobeille v. Liberty Mutual, a self-funded plan sponsor (employer) challenged the state of Vermont’s right to compel the employer’s TPA to submit claims data to the state’s APCD regulated by the Green Mountain Care Board. In its March 4, 2016 decision, SCOTUS confirmed that Vermont’s statute, as applied to the self-funded employer’s Employee Retirement Income Security Act of 1974 (ERISA) plan, was preempted by ERISA.

Health insurance companies and TPAs have questioned the breadth of the Gobeille decision. In light of the facts giving rise to the decision, legal scholars agree that states can continue to require the submission of claims data from regulated health insurance issuers, including fully insured plans; non-ERISA plans; and TPAs, as long as self-funded employer plans governed by ERISA have the opportunity to decide whether or not to submit their data.

Given the ruling, employers who offer self-funded ERISA plans may inform their TPA or the APCD that they decline to submit their data, and the state must comply with such a refusal.

Issue 2: Are governmental plans or other plans exempt from ERISA?

Generally, governmental plans are exempt from ERISA’s provisions and are not impacted by the Gobeille decision with regard to claims submission. ERISA defines a governmental plan as a plan established or maintained by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or
• Cross-state Response
  – Department of Labor Notice of Proposed Rule Making
  – APCD Council, NAHDO, NASHP comment to develop state response to meet DOL needs via reporting from state APCD
    • Rule not finalized
  – Development of a Common Data Layout
  – See: https://www.apcdcouncil.org/standards
State-level Responses
- Engagement with Employers
  - Focus on Employer Use Cases
  - Reach out to Businesses and Business Coalitions
- Formal Opt-in Processes Adopted in NH and UT:
Summary

42 CFR Part 2

- First Promulgated 1975, Substantive Update 1987, February 2016 NPRM, January 2017 Final Rule
- “Protects the confidentiality of the records containing the identity, diagnosis, prognosis, or treatment of any patient that are maintained in connection with the performance of any federally assisted program or activity relating to substance abuse (now referred to as substance use disorder) education, prevention, training, treatment, rehabilitation, or research.”
Summary

The SAMHSA comment says: “Regarding the specific scenario raised by commenters, SAMHSA wishes to clarify that MPCDs and other data intermediaries are permitted to obtain part 2 data under the research exception provided in § 2.52, provided that the conditions of the research exception are met. Furthermore, an MPCD or data intermediary that obtains part 2 data in this fashion would be considered a “lawful holder” under these final regulations and would therefore be permitted to re-disclose part 2 data for research purposes, subject to the other conditions imposed under § 2.52. The final rule edits the language under paragraph 2.52(a) to clarify that the regulations do not prohibit such a disclosure.”
State and National Level Work in Progress

• Short-Term Approach for Claims Submission
  – Develop a common filter to redact data that will address concerns about submitting data that could be restricted by 42 CFR Part 2
  – Leverage CMS claims redaction process
    • Diagnosis and service type

• Long-Term Solutions to Ensure Part 2 Data are Included
  - Clarification for isolating Part 2 provider for redaction
  - Clarification for how research exemption allows states to receive data
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All Payer Database Update
Building Blocks for an APD Program

- Program Resources
- Data Acquisition and Intake
- Data Access and Security
- Data Integration
- Governance
- Consumer Transparency
Building Block 1

Program Resources
Key Project Stakeholders

- **NYS DOH OQPS**  
  (Project Sponsor and Owner)

- **NYS OITS**  
  (PMO, Security and Connectivity)

- **NYS DOH OHIP**  
  Division of Systems

- **New York State of Health Marketplace**  
  (NYSoH)

- **CSRA**  
  (EIS, eMedNY, NYMMIS)

- **Optum**  
  (Warehouse and Analytics)

- **NYSTEC**  
  (Quality Assurance and Technical Assistance)

- **CMA**  
  (MDW, OHIP Data Mart)

- **APCD Council**  
  (Policy Support)

- **Rueckert Advertising**  
  (Infographics)
Regulation Update

• On August 4, 2016 the APD regulations were presented to the State’s Public Health and Health Planning Council (PHHPC)
• The APD regulations were posted for public comment on August 31, 2016
• A 45 day public comment period ran through October 17, 2016
• There were 9 public comments received representing multiple stakeholder groups
• The Assessment of Public Comment is being finalized
APD Guidance Manual Update

- An APD Guidance Manual was prepared as a companion to the APD Regulations
- Final draft going through DOH approval process
- The manual contains three sections:
  1. Program Operations
  2. Data Governance
  3. Submission Specifications
Next Steps

- Regulations adopted, hopefully early summer
- Publish APD Guidance Manual on APD website
- Continue to secure necessary resources
- Continue internal and external stakeholder outreach
Key Building Block 2

Data Acquisition and Intake
Data Sources of the APD

- Public & Private Benefit Package Data
- Public & Private Member Enrollment Data
- Public & Private Encounter/Claims Data
- Provider Data
- Public Health Registries
- Other Non-Claims Data

All Payer Data Warehousing Solution

All Payer Data Business Intelligence & Analytics Solution

Data Release/Delivery
Data Ranges within the APD

• Hospital Discharge (SPARCS) – 10 years historical
• Claims and Encounters – 5 years historical
  – Medicaid (MMC encounters & FFS claims)
  – Child Health Plus
  – Qualified Health Plan
  – Essential Plan
  – Medicare FFS – 2014 to most current available
• Vital Statistics Mortality – 10 years historical
Encounter Intake System (EIS) Component

- The APD Data Intake System was built within the New York State of Health (NYSoH) as the intake point for all reported encounters, plan benefits, member enrollment and reference data.

- It is the source for intake of Qualified Health Plan and Essential Plan encounter data (anticipated June 2017), and has replaced the current eMedNY Claims System for the processing of Medicaid encounter data from Managed Care Organizations (MCO’s).

- Future data sources will include Commercial data.
EIS System Volume and Reporters

- The EIS system processes a large volume of encounter data for the APD on daily basis
- Since March 1, there have been approximately 35 million Medicaid, Child Health Plus and QHP encounters processed by the EIS system
- This represents 8,250 files by 52 Medicaid/CHP issuers and 23 QHP issuers
- This volume is for the most part stable and predictable over time, but will increase as the APD onboards commercial data
Encounter Issuer Communications

- The APD team has frequent and ongoing communication with over 70 data submitters
- **Email** inquiries happen on a daily basis
- **Encounters Issuer Status Webinars** happen on a weekly basis
- **1:1 Issuer Calls** occur on a weekly, bi-weekly and as needed basis
Encounter Intake Assessment - Internal Reports

- During July and August 2016, NYSTEC prepared a series of two internal reports for the OHIP Division of Operations and Systems
  - Encounter Intake and Data Consumption Assessment: Current State Assessment Report (July 22, 2016)
  - Encounter Intake and Data Consumption Assessment: Charter for Improvement Initiative (August 23, 2016)
- NYSTEC findings including the following 4 guiding principles
  1. Align Accountability with Organizational Goals
  2. Create Confidence in Shared Decision Making
  3. Improve Transparency and Communications
  4. Improve Confidence in Data Quality
- NYSTEC made several recommendations for improvement and suggested processes for implementation.
Encounters Steering Committee
Encounters Steering Committee Rules

• The EIS currently has a backlog of Change Requests (CRs) that require final prioritization and approval before work can be scheduled with the EIS vendor (CSRA)
• The Encounters Steering Committee will determine the prioritization of the existing backlog based upon decision criteria
• It is expected that the Encounters Steering Committee members communicate information to additional stakeholders within each Division
• The EIS Change Management process will align with the APD Systems Development Life Cycle (SDLC) process
# Encounters Steering Committee Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Office</th>
<th>Division / Bureau</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary Beth Conroy, Chair</td>
<td>OQPS</td>
<td>Division of Information and Statistics</td>
</tr>
<tr>
<td>Lindsay Cogan</td>
<td>OQPS</td>
<td>Division of Quality Measurement / Bureau of Quality Measurement and Improvement</td>
</tr>
<tr>
<td>Victoria Wagner</td>
<td>OQPS</td>
<td>Division of Performance Improvement and Patient Safety / Bureau of Research and Analysis</td>
</tr>
<tr>
<td>Mike Dembrosky</td>
<td>OHIP</td>
<td>Division of Finance and Rate Setting / Bureau of Acute &amp; Managed Care Reimbursement</td>
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<tr>
<td>Bob Biggane, Anesa Brkanovic</td>
<td>OHIP</td>
<td>Division of Health Plan Contracting and Oversight</td>
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<tr>
<td>Tiffany Lee</td>
<td>OHIP</td>
<td>Division of Long Term Care</td>
</tr>
<tr>
<td>Bill Peacock</td>
<td>OHIP</td>
<td>Division of Operations and Systems / MDW</td>
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<tr>
<td>Janet Elkind</td>
<td>OHIP</td>
<td>Division of Program Development and Management</td>
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<tr>
<td>Sonia Sehkar</td>
<td>NYSoH</td>
<td>New York State of Health</td>
</tr>
<tr>
<td>Kathleen Whitsett</td>
<td>OMIG</td>
<td>Office of Medicaid Inspector General</td>
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Next Steps

• Continue to work with DOH data owners to develop data refresh schedule

• Convene Encounters Steering Committee meeting in early summer to begin CR backlog grooming

• Implement plan for Commercial data intake
Key Building Block 3

Data Access and Security
APD Account Provisioning

• In process of defining
  – User types
  – Procedures for getting and removing access
  – Access to types of data
  – Data source forms and other training required to gain access
Data Access Processes Across DOH

- Medicaid Data Access
- Hospital Discharge (SPARCS) Data Access
- New York State of Health (NYSOH) QHP & EP Data Access
- Vital Statistics Data Access
- Medicare Data Access

Coordination of Data Access Policies Across the Department of Health
Data Access and De-identification

User Type
- State Agency Staff
- County & Local Policy Managers
- Health Care Researcher
- Insurance Carrier DM Staff
- Health Care Consumer
- Health Care Provider
- APD Mgmt Staff

NYS Provisioning Authority Creates NY Gov ID

Authenticate
- Government NY Gov ID or Equivalent
- Personal NY Gov ID or Equivalent
- Business NY Gov ID or Equivalent

NYS Provisioning Authority Assigns Security Role

Data Source Security
- Data Source Access (All)
- No Data Source Access

Column Level Security
- PHI + PII Access
- PII Access Only
- No PHI/PII Access

Governance Managed Row/Column Control Table

- Executive/Reports
- Business Intelligence
- File Extract
Authentication

- Successfully tested and implemented NY.gov ID access to APD portal
APD Portal Page

- Still in design and development
- Will be role based, meaning security controls will follow user
Next Steps

• Continue to work with Optum, NYS OITS, and DOH data stewards to create account provisioning process and technical environment

• Continue to test APD portal page based on roles and security provisions

• Further develop look and feel for APD portal page
Key Building Block 4

Data Integration
Master Member Index

- In process
- Determining ‘golden record’
- Complex task across DOH source systems
- Engaging with Subject Matter Experts (SMEs)
- Determining business rules required by program areas
Master Provider Index

- In process
- Determining categories of providers
- Engaging with Subject Matter Experts (SMEs)
- Determining business rules
- Understanding legal nature of provider definitions
Next Steps

• Continue to work with Optum to develop and test Master Patient and Master Provider Indices
• Work with other DOH stakeholders already working on Master Patient and Master Provider Indices
• SWAT team approach to data integration and modeling
Key Building Block 5

Governance
Proposed APD Advisory Group

• An APD Advisory Group will be formed through invitation and an open application process
• Consumer, multi-agency and other core stakeholder engagement and input will comprise this group’s functions
• Comprised of representatives that have both short- and long-term vested interests in the success of the APD
• Activities include: strategic planning functions, fiscal sustainability planning, data sharing and privacy protections, consumer utility framework and cross-agency resource coordination and communication
Proposed APD Advisory Group Composition

- NYS DOH Office of Quality and Patient Safety (OQPS) (Chair);
- NYS DOH Office of Health Insurance Programs (OHIP) - Medicaid Program;
- New York State of Health (NYSoH) marketplace;
- New York City Department of Health and Mental Hygiene (NYCDOHMH);
- NYS Department of Financial Services (DFS);
- NYS Department of Civil Service (DCS);
- NYS Office of Information Technology Services (OITS);
- Health insurers;
- Health care facilities;
- Health care practitioners;
- Purchasers of health insurance or health benefits;
- Health care consumers and advocates; and
- Health care researchers and professionals
Proposed Data Release and Review Committee

Data Release Review Committee Functions
- Review project requests
- Ensure adherence to DOH guidelines and Federal and State laws
- Implement DUAs when required
- Implement BAAs when required
- Communicates requests and request status

Membership (13 members)
- DFS: 1 member
- DOH - OQPS: 1 member
- DOH - OHIP - Medicaid: 1 member
- Insurers: 2 members
- Health Care Facilities: 2 members
- Health Care Practitioners: 2 members
- Purchaser: 1 member
- Consumer: 1 member
- Researcher: 2 members
## Data File Types and Data Access

<table>
<thead>
<tr>
<th>Data File Type</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>Public Use Data</strong></td>
<td>De-identified at the record-level detail or aggregated above 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.</td>
</tr>
<tr>
<td><strong>Limited Identifiable Data</strong></td>
<td>Contains indirect or partial identifiers that are deemed potentially identifiable according to HIPAA standards. Data usage requires formal approval, signed DUAs and IRB approval.</td>
</tr>
<tr>
<td><strong>Identifiable Data</strong></td>
<td>Identifiable data contains unmasked record-level data, constituting PHI and PII. Stringent controls on release. Data usage requires formal approval, signed DUAs and IRB approval.</td>
</tr>
</tbody>
</table>
Next Steps

• After regulation adoption, establish APD Advisory Group
• Continually assess data quality
• Further develop rules and processes for data file types and data access
• After regulation adoption, establish Data Release and Review Committee
Key Building Block 6

Consumer Transparency
The NYS APD and Consumer Transparency

- NYS Health Foundation sponsored a study in September 2015: **New York's All-Payer Database: A New Lens for Consumer Transparency**
- Conducted through the national APCD Council, completed in September 2015.
- The report provides insight and analysis of challenges and barriers specific to the NYS APD environment, and recommendations for ensuring a quality system that achieves goals and meets stakeholder needs and expectations.
- Available on the APD page on the DOH website under “Reports” or at the direct link: http://nyshealthfoundation.org/resources-and-reports/resource/new-yorks-all-payer-database-a-new-lens-for-consumer-transparency
Phase 1 Consumer Focus Groups

- Presented results at the December 2015 APD stakeholder meeting
- Phase 2 work is building off of findings from Phase 1
- Report is available on the APD page on the DOH website under “Reports or at the direct link:

Phase 2 Consumer Focus Groups

- “Shoppable” goods and services
- Internal report and presentation
- Results will continue to inform the development of consumer tools
Next Steps

• Developing strategies for consumer access
  – Working with Optum to build an APD public website
  – Explore options for Tableau views to be public
  – Explore options on open data; Health Data NY – Public Use Data

• Next round of consumer focus groups will start in early summer
Overview of the Warehousing and Analytical Solution by Optum
Optum’s DW/APCD National Footprint
Optum’s Data Analytics Engagements

Red: Project-specific contracts
Blue: IDIQ
Data Enrichment - Master Indices

• Master Indices (patient and provider) are created that link individuals and organizations across multiple data sources

• Collects data about individuals from multiple systems

• Matches and links person-level records
  – Figures out which records belong to the same person
  – Creates “master” list of distinct individuals

• This matching and linking is required in order to integrate data from multiple data sources
Data Enrichment – Master Index Example


Load Cleansed Data To Staging Tables. Enhance-Geocode

Invoke matching engine. Determine Total Weight Score. Add or Create Index Record Based On Score.

Apply Master Data Index to Data Fabric

Generate Master Demographic Record

Medicaid Member

Medicare Member

Other Data

Staging Data

Member Master Demographic

MCAID NY1234 19856
MCARE MC577 19856
MCAID NY5678 27994

Patient Id Master Index

MCAID NY1234 19856
MCARE MC577 19856
MCAID NY5678 27994
### Symmetry Toolkit

#### Episode Treatment Groups (ETGs)
- Episode Grouper
- Clinical Resource Measurement

#### Episode Risk Groups (ERGs)
- Risk Adjustment
- Predictive Modeling

#### Evidence Based Medicine (EBM Connect)
- Quality Measurement
- Endorsed by AHRQ and HEDIS
- Over 650 Quality Measures
- Managed Care Plan Validation
Pilot Release

Descriptive Analytics
Goals of Internal Pilot Release

• Test Tableau server functionality within NY.Gov environment
• Get a baseline for performance/connectivity
• Experiment with look and feel and APD standardization
• Understand user needs and desired functions
• Get a better look at the data
Round 1 Agile Design Sessions

- Utilization
- Quality
- Mortality
- Cost
- Disease Markers
- Providers
- Members
Single Sign-On Using NY.Gov

APD Portal

Welcome

What is in the NY APD?

<table>
<thead>
<tr>
<th>Subject Area</th>
<th>Data Source</th>
<th>Load Date 1</th>
<th>Load Date 2</th>
<th>Data Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider - Facilities</td>
<td>IHS</td>
<td>12/13/16</td>
<td>01/01/16 - 01/23/16</td>
<td></td>
</tr>
<tr>
<td>SPARCS</td>
<td>OHP</td>
<td>12/18/16</td>
<td>01/01/16 - 02/14/16</td>
<td></td>
</tr>
<tr>
<td>Mail Statistics - Deaths</td>
<td>NYSDOH</td>
<td>02/01/17</td>
<td>01/01/16 - 12/31/16</td>
<td></td>
</tr>
</tbody>
</table>

Announcements

03/02/2017: A new file for Business Specification Documents have been loaded to NYAPD Portal for UAT testing.
02/27/2017: A new file for both Business and Technical Specification Documents have been loaded to NYAPD Portal for UAT testing.
02/23/2017: A new file for both Business and Technical Specification Documents have been loaded to NYAPD Portal for UAT testing.
02/15/2017: The NYAPD Interim Release 2 is scheduled to go live on June 1, 2017.

Help Desk

The NYAPD Help Desk will be available starting implementation of Release 2 on June 1, 2017.
APD Portal

Welcome to APD Report(s) page. Please select from the following report(s):

INPATIENT
- Targeted Inpatient Disease Conditions Report
- AHQR PDI Report
- AHQR PDI Report
- DRG Severity of Illness Report/DRG Service Intensity Weight(s)
- Inpatient Utilization Summary Report
- DRG Summary Report
- Inpatient Utilization Rates Per Region
- Primary Inpatient Diagnoses
- Principal Inpatient Procedures
- AHQR IQI Report
- AHQR PSI Report

EMERGENCY DEPARTMENT
- Primary ED Diagnoses
- Necessity of ED Visits
- ED Utilization Rates
- ED Frequent Users
- ED Utilization Summary Report
- ED Procedures

AMBULATORY SURGERY
- Ambulatory Surgery Procedures
- Ambulatory Surgery Utilization
- Ambulatory Surgery Utilization Rates

OUTPATIENT
- Outpatient Hospital Procedures
- Outpatient Hospital Utilization
- Outpatient Hospital Utilization Rates
## Inpatient Summary Report: Top 20 Discharges by APR-DRGs

Most Frequent APR DRGs by Total Discharges
Click on a DRG, use Selection Filters on the Right
Select a Variable below to stratify and see more details (Bottom Graph)

<table>
<thead>
<tr>
<th>DRG</th>
<th>Condition Description</th>
<th>Total Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>640</td>
<td>Neonate, Bwt &gt; 2499 g, Normal Newborn Or Neonate Death</td>
<td>197,933</td>
</tr>
<tr>
<td>550</td>
<td>Vaginal Delivery</td>
<td>146,961</td>
</tr>
<tr>
<td>720</td>
<td>Septicemia &amp; Disseminated Infections</td>
<td>84,984</td>
</tr>
<tr>
<td>540</td>
<td>Cesarean Delivery</td>
<td>75,916</td>
</tr>
<tr>
<td>194</td>
<td>Heart Failure</td>
<td>56,556</td>
</tr>
<tr>
<td>139</td>
<td>Other Pneumonia</td>
<td>42,986</td>
</tr>
<tr>
<td>140</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>40,754</td>
</tr>
<tr>
<td>302</td>
<td>Knee Joint Replacement</td>
<td>38,490</td>
</tr>
<tr>
<td>750</td>
<td>Schizophrenia</td>
<td>35,559</td>
</tr>
<tr>
<td>383</td>
<td>Cellulitis &amp; Other Bacterial Skin Infections</td>
<td>34,713</td>
</tr>
<tr>
<td>201</td>
<td>Cardiac Arrhythmia &amp; Conduction Disorders</td>
<td>32,926</td>
</tr>
<tr>
<td>301</td>
<td>Hip Joint Replacement</td>
<td>32,589</td>
</tr>
<tr>
<td>450</td>
<td>Renal Failure</td>
<td>29,250</td>
</tr>
<tr>
<td>453</td>
<td>Kidney &amp; Urinary Tract Infections</td>
<td>28,473</td>
</tr>
<tr>
<td>753</td>
<td>Bipolar Disorders</td>
<td>27,611</td>
</tr>
<tr>
<td>751</td>
<td>Major Depressive Disorders &amp; Other/Unspecified P.</td>
<td>27,025</td>
</tr>
<tr>
<td>045</td>
<td>CVA &amp; Pecerebral Occlusion w/ Infarct</td>
<td>25,317</td>
</tr>
<tr>
<td>053</td>
<td>Seizure</td>
<td>25,267</td>
</tr>
<tr>
<td>950</td>
<td>Rehabilitation</td>
<td>23,805</td>
</tr>
<tr>
<td>775</td>
<td>Alcohol Abuse &amp; Dependence</td>
<td>23,438</td>
</tr>
</tbody>
</table>

Note: Preliminary Data Results Subject to Change
Inpatient Summary Report: Top 20 Commercial Discharges by APR-DRG

Most Frequent APR-DRGs by Total Discharges
Click on a DRG, use Selection Filters on the Right
Select a Variable below to stratify and see more details (Bottom Graph)

Note: Preliminary Data Results Subject to Change
Inpatient Summary Report: Normal Newborn Discharges by Primary Payor

<table>
<thead>
<tr>
<th>DRG</th>
<th>Description</th>
<th>Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>640</td>
<td>Neonate, &lt; 2500g, Normal Newborn Dr. Neonate</td>
<td>197,933</td>
</tr>
<tr>
<td>660</td>
<td>Vaginal Delivery</td>
<td>1,467,961</td>
</tr>
<tr>
<td>720</td>
<td>Septicemia &amp; Disseminated infections</td>
<td>64,964</td>
</tr>
<tr>
<td>540</td>
<td>Cesarean Delivery</td>
<td>72,996</td>
</tr>
<tr>
<td>194</td>
<td>Heart Failure</td>
<td>5,325</td>
</tr>
<tr>
<td>139</td>
<td>Other Pneumonia</td>
<td>42,985</td>
</tr>
<tr>
<td>140</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>140,754</td>
</tr>
<tr>
<td>302</td>
<td>Knee Joint Replacement</td>
<td>39,490</td>
</tr>
<tr>
<td>750</td>
<td>Schizophrenia</td>
<td>35,599</td>
</tr>
<tr>
<td>383</td>
<td>Cellulitis &amp; Other Bacterial Skin Infections</td>
<td>54,713</td>
</tr>
<tr>
<td>201</td>
<td>Cardiac Arrhythmia &amp; Conductive Disorders</td>
<td>52,926</td>
</tr>
<tr>
<td>301</td>
<td>Hip Joint Replacement</td>
<td>32,389</td>
</tr>
<tr>
<td>460</td>
<td>Sepsis</td>
<td>26,250</td>
</tr>
<tr>
<td>463</td>
<td>Kidney &amp; Urinary Tract Infections</td>
<td>10,473</td>
</tr>
<tr>
<td>753</td>
<td>Bipolar Disorders</td>
<td>27,631</td>
</tr>
<tr>
<td>751</td>
<td>Major Depressive Disorders &amp; Other/Unspecified P.</td>
<td>27,026</td>
</tr>
<tr>
<td>045</td>
<td>CVI &amp; Preeclampsia Oclusion w/ Infert</td>
<td>29,317</td>
</tr>
<tr>
<td>653</td>
<td>Seizure</td>
<td>8,287</td>
</tr>
<tr>
<td>860</td>
<td>Rehabilitation</td>
<td>23,806</td>
</tr>
<tr>
<td>775</td>
<td>Alcohol Abuse &amp; Dependence</td>
<td>23,408</td>
</tr>
</tbody>
</table>

Select Variable to Stratify By (Applies to bottom Bar Graph only)
- Primary Payor
- Select Metrics
- Total Discharges
- Select Time Period
- Year
- Select Specific Date
- 2015
- Select HSA
- All
- Select Facility County
- All
- Select Facility
- All
- Select Patient County
- All
- Select Teaching Facility
- All
- Select DRG Category (Med/Surg)
- All
- Select Primary Payor Code
- All
- Select Dual Eligibility
- All
- Select Emergency Admit Status
- All

Note: Preliminary Data Results Subject to Change
Inpatient Summary Report: Hip Joint Replacement Discharges by Primary Payor

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>Condition Description</th>
<th>Total Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>640</td>
<td>Neonate, Bwt &gt; 2499g, Normal Newborn or Neonate</td>
<td>697,933</td>
</tr>
<tr>
<td>560</td>
<td>Vaginal Delivery</td>
<td>4,461,962</td>
</tr>
<tr>
<td>720</td>
<td>Septicemia &amp; Disseminated Infections</td>
<td>84,954</td>
</tr>
<tr>
<td>540</td>
<td>Cesarean Delivery</td>
<td>78,949</td>
</tr>
<tr>
<td>194</td>
<td>Heart Failure</td>
<td>16,306</td>
</tr>
<tr>
<td>139</td>
<td>Other Pneumonia</td>
<td>42,967</td>
</tr>
<tr>
<td>140</td>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>40,754</td>
</tr>
<tr>
<td>302</td>
<td>Knee Joint Replacement</td>
<td>38,436</td>
</tr>
<tr>
<td>750</td>
<td>Schizophrenia</td>
<td>34,569</td>
</tr>
<tr>
<td>383</td>
<td>Cellulitis &amp; Other Bacterial Skin Infections</td>
<td>34,713</td>
</tr>
<tr>
<td>201</td>
<td>Cardiac Arrhythmia &amp; Conduction Disorders</td>
<td>32,934</td>
</tr>
<tr>
<td>301</td>
<td>Hip Joint Replacement</td>
<td><strong>32,989</strong></td>
</tr>
<tr>
<td>460</td>
<td>Renal Failure</td>
<td>23,290</td>
</tr>
<tr>
<td>463</td>
<td>Kidney &amp; Urinary Tract Infections</td>
<td>23,473</td>
</tr>
<tr>
<td>753</td>
<td>Bipolar Disorders</td>
<td>27,511</td>
</tr>
<tr>
<td>751</td>
<td>Major Depressive Disorders &amp; Other/Unspecified P.</td>
<td>27,028</td>
</tr>
<tr>
<td>045</td>
<td>CVA &amp; Precerebral Occlusion w/ Infarc</td>
<td>26,317</td>
</tr>
<tr>
<td>653</td>
<td>Seizure</td>
<td>25,487</td>
</tr>
<tr>
<td>860</td>
<td>Rehabilitation</td>
<td>23,458</td>
</tr>
<tr>
<td>775</td>
<td>Alcohol Abuse &amp; Dependence</td>
<td>23,408</td>
</tr>
</tbody>
</table>

Select Metric: Total Discharges
Select Time Period: Year 2015
Select Specific Date:
Select HSA:
Select Facility County:
Select Facility:
Select Patient County:
Select Teaching Facility:
Select DRG Category (Med/Surg):
Select Primary Payor Code:
Select Primary Payor:
Select Dual Eligibility:
Select Emergency Admit Status:

Total Discharges - for DRG 301 / Stratified by Primary Payor

<table>
<thead>
<tr>
<th>Payor</th>
<th>Total Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>19,112</td>
</tr>
<tr>
<td>Commercial</td>
<td>10,031</td>
</tr>
<tr>
<td>Medicaid</td>
<td>2,667</td>
</tr>
<tr>
<td>Other</td>
<td>920</td>
</tr>
<tr>
<td>Self-Pay</td>
<td>259</td>
</tr>
</tbody>
</table>

Note: Preliminary Data Results Subject to Change
### Inpatient Summary Report: Use of Multiple Filters

Most Frequent APR-DRGs by Total Discharges

Click on a DRG, use Selection Filters on the Right
Select a Variable below to stratify and see more details (Bottom Graph)

<table>
<thead>
<tr>
<th>DRG Code</th>
<th>DRG Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>720</td>
<td>Septicemia &amp; Disseminated Infections</td>
<td>1,748</td>
</tr>
<tr>
<td>383</td>
<td>Cellulitis &amp; Other Bacterial Skin Infections</td>
<td>1,195</td>
</tr>
<tr>
<td>201</td>
<td>Cardiac Arrhythmia &amp; Conduction Disorders</td>
<td>1,041</td>
</tr>
<tr>
<td>225</td>
<td>Appendectomy</td>
<td>872</td>
</tr>
<tr>
<td>775</td>
<td>Alcohol Abuse &amp; Dependence</td>
<td>845</td>
</tr>
<tr>
<td>174</td>
<td>Percutaneous Cardiovascular Procedures w/ AMI</td>
<td>823</td>
</tr>
<tr>
<td>175</td>
<td>Percutaneous Cardiovascular Procedures w/o AMI</td>
<td>798</td>
</tr>
<tr>
<td>045</td>
<td>CVA &amp; Precerebral Occlusion w/ Infarct</td>
<td>751</td>
</tr>
<tr>
<td>194</td>
<td>Heart Failure</td>
<td>713</td>
</tr>
<tr>
<td>203</td>
<td>Chest Pain</td>
<td>709</td>
</tr>
<tr>
<td>282</td>
<td>Disorders of Pancreas Except Malignancy</td>
<td>687</td>
</tr>
<tr>
<td>244</td>
<td>Diverticulitis &amp; Diverticulosis</td>
<td>685</td>
</tr>
<tr>
<td>139</td>
<td>Other Pneumonia</td>
<td>508</td>
</tr>
<tr>
<td>460</td>
<td>Renal Failure</td>
<td>571</td>
</tr>
<tr>
<td>253</td>
<td>Laparoscopic Cholecystectomy</td>
<td>552</td>
</tr>
<tr>
<td>420</td>
<td>Diabetes</td>
<td>518</td>
</tr>
<tr>
<td>753</td>
<td>Bipolar Disorders</td>
<td>506</td>
</tr>
<tr>
<td>192</td>
<td>Cardiac Catheterization for Ischemic Heart Disease</td>
<td>494</td>
</tr>
<tr>
<td>254</td>
<td>Other Digestive System Diagnoses</td>
<td>463</td>
</tr>
<tr>
<td>247</td>
<td>Intestinal Obstruction</td>
<td>461</td>
</tr>
</tbody>
</table>

Note: Preliminary Data Results Subject to Change
Inpatient Summary Report: Patient Attraction Patterns

Note: Preliminary Data Results Subject to Change
## Inpatient Prevention Indicators: Top AHRQ PQI Ranking (Rate Per 100,000 Population) by Age Group

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Group: 18-39</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diabetes Short-Term Complications</td>
<td>72.14</td>
</tr>
<tr>
<td>2</td>
<td>Asthma in Younger Adults</td>
<td>66.08</td>
</tr>
<tr>
<td>3</td>
<td>Urinary Tract Infection</td>
<td>42.43</td>
</tr>
<tr>
<td>4</td>
<td>Bacterial Pneumonia</td>
<td>34.99</td>
</tr>
<tr>
<td>5</td>
<td>Diabetes Long-Term Complications</td>
<td>29.56</td>
</tr>
<tr>
<td>6</td>
<td>Dehydration</td>
<td>25.12</td>
</tr>
<tr>
<td>7</td>
<td>Heart Failure</td>
<td>15.51</td>
</tr>
<tr>
<td>8</td>
<td>Hypertension</td>
<td>11.69</td>
</tr>
<tr>
<td>9</td>
<td>Uncontrolled Diabetes</td>
<td>6.26</td>
</tr>
<tr>
<td>10</td>
<td>Lower-Extremity Amputation among Patients with Diabetes</td>
<td>1.31</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Group: 40-64</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COPD or Asthma in Older Adults</td>
<td>331.08</td>
</tr>
<tr>
<td>2</td>
<td>Heart Failure</td>
<td>199.50</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes Long-Term Complications</td>
<td>145.51</td>
</tr>
<tr>
<td>4</td>
<td>Bacterial Pneumonia</td>
<td>136.14</td>
</tr>
<tr>
<td>5</td>
<td>Dehydration</td>
<td>75.31</td>
</tr>
<tr>
<td>6</td>
<td>Urinary Tract Infection</td>
<td>69.14</td>
</tr>
<tr>
<td>7</td>
<td>Diabetes Short-Term Complications</td>
<td>65.46</td>
</tr>
<tr>
<td>8</td>
<td>Hypertension</td>
<td>64.26</td>
</tr>
<tr>
<td>9</td>
<td>Uncontrolled Diabetes</td>
<td>20.55</td>
</tr>
<tr>
<td>10</td>
<td>Lower-Extremity Amputation among Patients with Diabetes</td>
<td>17.61</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Group: 65-74</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>COPD or Asthma in Older Adults</td>
<td>749.98</td>
</tr>
<tr>
<td>2</td>
<td>Heart Failure</td>
<td>697.91</td>
</tr>
<tr>
<td>3</td>
<td>Diabetes Long-Term Complications</td>
<td>361.40</td>
</tr>
<tr>
<td>4</td>
<td>Bacterial Pneumonia</td>
<td>257.09</td>
</tr>
<tr>
<td>5</td>
<td>Diabetes Long-Term Complications</td>
<td>227.57</td>
</tr>
<tr>
<td>6</td>
<td>Urinary Tract Infection</td>
<td>222.97</td>
</tr>
<tr>
<td>7</td>
<td>Hypertension</td>
<td>107.54</td>
</tr>
<tr>
<td>8</td>
<td>Diabetes Short-Term Complications</td>
<td>54.84</td>
</tr>
<tr>
<td>9</td>
<td>Lower-Extremity Amputation among Patients with Diabetes</td>
<td>41.98</td>
</tr>
<tr>
<td>10</td>
<td>Uncontrolled Diabetes</td>
<td>33.47</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Group: 75+</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Heart Failure</td>
<td>2,237.71</td>
</tr>
<tr>
<td>2</td>
<td>COPD or Asthma in Older Adults</td>
<td>1,141.77</td>
</tr>
<tr>
<td>3</td>
<td>Bacterial Pneumonia</td>
<td>1,090.92</td>
</tr>
<tr>
<td>4</td>
<td>Urinary Tract Infection</td>
<td>977.04</td>
</tr>
<tr>
<td>5</td>
<td>Dehydration</td>
<td>854.32</td>
</tr>
<tr>
<td>6</td>
<td>Diabetes Long-Term Complications</td>
<td>328.09</td>
</tr>
<tr>
<td>7</td>
<td>Hypertension</td>
<td>203.96</td>
</tr>
<tr>
<td>8</td>
<td>Diabetes Short-Term Complications</td>
<td>50.39</td>
</tr>
<tr>
<td>9</td>
<td>Lower-Extremity Amputation among Patients with Diabetes</td>
<td>46.53</td>
</tr>
<tr>
<td>10</td>
<td>Uncontrolled Diabetes</td>
<td>43.51</td>
</tr>
</tbody>
</table>

Notes: Preliminary Data Results Subject to Change
Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (AHRQ PQI)
### Inpatient Prevention Indicators: Diabetes Short-Term Complication Rate Details

<table>
<thead>
<tr>
<th>Condition</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Short-Term Complications</td>
<td>65.68</td>
<td>66.41</td>
<td></td>
</tr>
<tr>
<td>Diabetes Long-Term Complications</td>
<td>127.74</td>
<td>112.71</td>
<td>17.95</td>
</tr>
<tr>
<td>COPD or Asthma in Older Adults</td>
<td>511.86</td>
<td>496.87</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>60.17</td>
<td>55.00</td>
<td>13.07</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>330.29</td>
<td>362.29</td>
<td>92.71</td>
</tr>
<tr>
<td>Dehydration</td>
<td>320.20</td>
<td>122.52</td>
<td>33.54</td>
</tr>
<tr>
<td>Bacterial Pneumonia</td>
<td>201.20</td>
<td>198.06</td>
<td>55.44</td>
</tr>
<tr>
<td>Urinary Tract Infection</td>
<td>150.90</td>
<td>144.25</td>
<td>31.99</td>
</tr>
</tbody>
</table>

#### By Gender - Diabetes Short-Term Complications
- **Female**: 66.41
- **Male**: 73.78

#### By Age Group - Diabetes Short-Term Complications
- 18-39: 69.55
- 40-64: 65.90
- 65-74: 60.64
- 75+: 82.38

#### By Race - Diabetes Short-Term Complications
- White: 42.77
- Black - Afro American: 168.47
- American Indian: 66.79
- Asian: 10.37
- Multi Race: 15.40
- All Other: 190.79
- Native Hawaiian: 214.86

#### By Ethnicity [Hispanic] - Diabetes Short-Term Complications
- No: 67.59
- Yes: 60.75

Notes: Preliminary Data Results Subject to Change
Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (AHRQ PQI)
Emergency Department Utilization: Visits Per 100,000 Rate by Patient County

Select any Time Period to see the Utilization Rates distribution by Age Group, Gender, Race, Ethnicity and Patient County.

### Overall Rates
**Visits per 100,000 Population**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>33,765</td>
</tr>
</tbody>
</table>

### By County

<table>
<thead>
<tr>
<th>County</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery</td>
<td>88,558</td>
</tr>
<tr>
<td>Fulton</td>
<td>64,664</td>
</tr>
<tr>
<td>Bronx</td>
<td>57,020</td>
</tr>
<tr>
<td>Chenango</td>
<td>53,470</td>
</tr>
<tr>
<td>Saint Lawrence</td>
<td>51,551</td>
</tr>
<tr>
<td>Chemung</td>
<td>49,274</td>
</tr>
<tr>
<td>Jefferson</td>
<td>48,742</td>
</tr>
<tr>
<td>Delaware</td>
<td>45,277</td>
</tr>
<tr>
<td>Schuyler</td>
<td>45,756</td>
</tr>
<tr>
<td>Cortland</td>
<td>43,123</td>
</tr>
<tr>
<td>Clinton</td>
<td>42,927</td>
</tr>
<tr>
<td>Essex</td>
<td>42,914</td>
</tr>
<tr>
<td>Lewis</td>
<td>41,946</td>
</tr>
<tr>
<td>Sullivan</td>
<td>41,537</td>
</tr>
<tr>
<td>Allegheny</td>
<td>40,926</td>
</tr>
<tr>
<td>Chautauqua</td>
<td>40,838</td>
</tr>
<tr>
<td>Steuben</td>
<td>39,799</td>
</tr>
<tr>
<td>Schenectady</td>
<td>38,881</td>
</tr>
<tr>
<td>Orleans</td>
<td>38,608</td>
</tr>
<tr>
<td>Ulster</td>
<td>37,208</td>
</tr>
<tr>
<td>Schenectady</td>
<td>36,642</td>
</tr>
<tr>
<td>Yates</td>
<td>36,308</td>
</tr>
<tr>
<td>Oneida</td>
<td>36,156</td>
</tr>
<tr>
<td>Kings</td>
<td>35,915</td>
</tr>
</tbody>
</table>

### By Age

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>65,938</td>
</tr>
<tr>
<td>1-2</td>
<td>54,203</td>
</tr>
<tr>
<td>65-74</td>
<td>26,951</td>
</tr>
<tr>
<td>6-14</td>
<td>22,913</td>
</tr>
<tr>
<td>19-44</td>
<td>39,599</td>
</tr>
<tr>
<td>45-64</td>
<td>30,673</td>
</tr>
<tr>
<td>75-84</td>
<td>21,127</td>
</tr>
<tr>
<td>3-5</td>
<td>16,408</td>
</tr>
<tr>
<td>65-74</td>
<td>15,612</td>
</tr>
</tbody>
</table>

Note: Preliminary Data Results Subject to Change
Emergency Department Utilization: ED Frequent User Map View

Distribution of Visits by Patient County

This view displays how often patients would visit the emergency department within a selected time period.

Select a county or selection filters on right hand side to display total number of patients for each visit distribution category.

Note: Preliminary Data Results Subject to Change
Emergency Department Utilization: **Avoidable ED Visits by Diagnosis by Facility**

Select a diagnosis in the below chart to show top diagnoses by facility.

<table>
<thead>
<tr>
<th>Diagnosis Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other upper respiratory infections</td>
<td>970</td>
</tr>
<tr>
<td>Otitis media and related conditions</td>
<td>938</td>
</tr>
<tr>
<td>Spondylosis; Intervertebral disc disorders, etc.</td>
<td>538</td>
</tr>
<tr>
<td>Other non-traumatic joint disorders</td>
<td>488</td>
</tr>
<tr>
<td>Headache, including migraine</td>
<td>381</td>
</tr>
<tr>
<td>Acute bronchitis</td>
<td>312</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>427</td>
</tr>
<tr>
<td>Other connective tissue disease</td>
<td>419</td>
</tr>
<tr>
<td>Allergic reactions</td>
<td>416</td>
</tr>
<tr>
<td>Viral infection</td>
<td>405</td>
</tr>
<tr>
<td>Disorders of teeth and jaw</td>
<td>403</td>
</tr>
<tr>
<td>Noninfectious gastroenteritis</td>
<td>402</td>
</tr>
<tr>
<td>Inflammation; infection of eye (except that caused by bacterial or parasitic organisms)</td>
<td>368</td>
</tr>
<tr>
<td>Other complications of pregnancy</td>
<td>207</td>
</tr>
<tr>
<td>Conditions associated with dizziness or vertigo</td>
<td>125</td>
</tr>
</tbody>
</table>

Note: ED Category of “Other” contains Not Classified and Unassigned Visits.

**Number of ED Visits by Facility**

<table>
<thead>
<tr>
<th>Facility Name (Provider Facility)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ST. MARY’S HEALTHCARE - AMSTERDAM ME.</td>
</tr>
<tr>
<td>ST. MARY’S HEALTHCARE</td>
</tr>
<tr>
<td>LITTLE FALLS HOSPITAL</td>
</tr>
<tr>
<td>NATHAN LITTauer HOSPITAL</td>
</tr>
<tr>
<td>ALBANY MEDICAL CENTER HOSPITAL</td>
</tr>
<tr>
<td>ELIS HOSPITAL</td>
</tr>
<tr>
<td>MARY IMogene BASSETT HOSP*</td>
</tr>
</tbody>
</table>

Note: Preliminary Data Results Subject to Change
Vital Statistics: Map View of Heart Disease Death Counts

Cause of Death from Heart Disease Stratified by Gender
Click on specific county to see details by the Stratified Variable Below

Residence County: Dutchess
Number of Deaths: 636
Selected Rank Percentiles along Residence County: 80th

Note: Preliminary Data Results Subject to Change
Vital Statistics: Heart Disease Death Counts by Age Group for Suffolk County, CY 2015

Select Variable to Stratify By
Age Group

Cause of Death Stratified by Age Group

- 85+: 1,696
- 75-84: 792
- 65-74: 456
- 55-64: 279
- 45-54: 113
- 35-44: 33
- 20-24: 5
- 25-34: 5
- 0-9: 2
- 10-19: 1

Note: Preliminary Data Results Subject to Change
Map View of Opioid Inpatient Discharges

Total Discharges / Month: All / Opioid Type: All

Click on a Opioid Type and Time Period to see metrics by County
Use selection filters on the right
Total Discharges

<table>
<thead>
<tr>
<th>Year</th>
<th>Heroin Opioid</th>
<th>Non-Heroin Opioid</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-1</td>
<td>73</td>
<td>201</td>
<td>274</td>
</tr>
<tr>
<td>2015-2</td>
<td>71</td>
<td>179</td>
<td>250</td>
</tr>
<tr>
<td>2015-3</td>
<td>79</td>
<td>175</td>
<td>254</td>
</tr>
<tr>
<td>2015-4</td>
<td>96</td>
<td>234</td>
<td>330</td>
</tr>
<tr>
<td>2015-5</td>
<td>94</td>
<td>203</td>
<td>292</td>
</tr>
<tr>
<td>2015-6</td>
<td>76</td>
<td>229</td>
<td>305</td>
</tr>
<tr>
<td>2015-7</td>
<td>78</td>
<td>231</td>
<td>309</td>
</tr>
<tr>
<td>2015-8</td>
<td>102</td>
<td>213</td>
<td>315</td>
</tr>
<tr>
<td>2015-9</td>
<td>89</td>
<td>191</td>
<td>280</td>
</tr>
<tr>
<td>2015-10</td>
<td>68</td>
<td>127</td>
<td>195</td>
</tr>
<tr>
<td>2015-11</td>
<td>95</td>
<td>160</td>
<td>255</td>
</tr>
<tr>
<td>2015-12</td>
<td>81</td>
<td>100</td>
<td>241</td>
</tr>
<tr>
<td>Grand Total</td>
<td>992</td>
<td>2,308</td>
<td>3,300</td>
</tr>
</tbody>
</table>

Note: Preliminary Data Results Subject to Change
Vital Statistics: Opioid Overdose Related Death Rates

Select options from the Selection Filter to see results in the map and table formats. Click counties in map to see specific results in the table, if needed.

Note: Rate is calculated as per 100,000 population.

<table>
<thead>
<tr>
<th>County</th>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erie</td>
<td>11.70</td>
<td>25.47</td>
</tr>
<tr>
<td>Essex</td>
<td>5.17</td>
<td>25.99</td>
</tr>
<tr>
<td>Franklin</td>
<td>3.90</td>
<td>7.90</td>
</tr>
<tr>
<td>Fulton</td>
<td>1.85</td>
<td>7.41</td>
</tr>
<tr>
<td>Genesee</td>
<td>1.69</td>
<td>16.97</td>
</tr>
<tr>
<td>Greene</td>
<td>10.42</td>
<td>16.80</td>
</tr>
<tr>
<td>Hamilton</td>
<td>21.21</td>
<td>21.21</td>
</tr>
<tr>
<td>Herkimer</td>
<td>3.14</td>
<td>9.51</td>
</tr>
<tr>
<td>Jefferson</td>
<td>10.09</td>
<td>7.65</td>
</tr>
<tr>
<td>Kings</td>
<td>6.18</td>
<td>5.04</td>
</tr>
<tr>
<td>Lewis</td>
<td>3.67</td>
<td>14.84</td>
</tr>
<tr>
<td>Livingston</td>
<td>1.55</td>
<td>6.18</td>
</tr>
<tr>
<td>Madison</td>
<td>9.67</td>
<td>9.74</td>
</tr>
<tr>
<td>Monroe</td>
<td>8.40</td>
<td>10.81</td>
</tr>
<tr>
<td>Montgomery</td>
<td>4.02</td>
<td>10.07</td>
</tr>
<tr>
<td>Nassau</td>
<td>9.06</td>
<td>12.19</td>
</tr>
<tr>
<td>New York</td>
<td>6.42</td>
<td>4.33</td>
</tr>
<tr>
<td>Niagara</td>
<td>9.03</td>
<td>20.22</td>
</tr>
<tr>
<td>Not Coded</td>
<td>15.46</td>
<td>15.48</td>
</tr>
<tr>
<td>Oneida</td>
<td>10.9</td>
<td>14.94</td>
</tr>
<tr>
<td>Onondaga</td>
<td>15.46</td>
<td>15.47</td>
</tr>
</tbody>
</table>

Note: Preliminary Data Results Subject to Change
Provider Availability: Female Family Medicine Doctors by County (Map & Table Views)

Note: Preliminary Data Results Subject to Change
April 26, 2017

Provider Availability: Provider Address Locations

Note: Preliminary Data Results Subject to Change
Member Enrollment: Child Health Plus Member Counts by County Map View

Note: Preliminary Data Results Subject to Change
Quality: Symmetry Evidence Based Medicine (EBM) Measures

Adherence to Quality Measures

Select a Measure Type, Quality Measures, and Measure Description from the drop downs on the left. Click on a measure bar to drill down into adherence by the factor selected from the “Drill into Difference by” drop down menu. Reset Measure Description to “All” before changing Quality Measures. Reset Quality Measure to “All” to view the entire list of Measure Types.

Select Measure Type:

Select Quality Measures(s):

Inter search text

Asthma Patients with One or More Asthma-Related Emergency Room Visit (National Standard), Chlamydia Screening (National Standard), Low Back Pain, Use of Imaging Studies (National Standard)

Cancel Apply

Note: Sample Data
Quality: Adherence Rates by MCOs (Chlamydia screening is illustrated)

Chlamydia Screening (National Standard)

Click on a Measure Description to view breakdown by demographic category.

Case Name: Patient(s) 16 - 24 years of age that had a chlamydia screening test in last 12 reported months. 25%

Case Name: Patient(s) 16 - 20 years of age that had a chlamydia screening test in last 12 reported months. 25%

Case Name: Patient(s) 21 - 24 years of age that had a chlamydia screening test in last 12 reported months. 25%

MCO 8: 23%
MCO 1: 27%
MCO 6: 26%
MCO 7: 26%
MCO 10: 26%
MCO 9: 25%
MCO 2: 25%
MCO 5: 25%
MCO 3: 24%
MCO 4: 23%

Note: Sample Data
Symmetry’s Episode Risk Group (ERG) Cost by Disease Condition Group

Disease Prevalence (%) and Cost by Condition

Select a condition to view ETO details. Deselect to hide ETO details.
To sort the conditions, select the Disease Prevalence or Total Paid Amount ($) x-axis, then choose a sort order using the sort tools that appear.

- Eye Conditions: 14.0% - $7,535,441
- Asthma: 12.8% - $28,967,680
- Orthopedics: 5.2% - $18,121,524
- Normal Pregnancy: 10.3% - $46,984,547
- Behavioral Disorders: 7.4% - $28,148,626
- Neurology including Epilepsy: 6.3% - $11,974,740
- Obstetrics and Gynecology: 3.3% - $33,755,266
- Neonatal Care: 4.0% - $10,816,647
- Other Endocrine Disorders: 4.1% - $6,568,666
- Low and Moderate Cost Cardiology: 3.8% - $1,846,030
- Mental Health: 2.5% - $21,571,284
- Diabetes and Diabetic Retinopathy: 3.0% - $7,943,865
- Arthritis: 4.6% - $11,687,310
- Hypertension: 3.4% - $24,345,063
- Severe and Persistent Mental Illness: 2.6% - $3,724,711
- Poisoning and Toxic Drug Effects: 4.1% - $8,946,173
- Substance Abuse: 1.7% - $3,086,875
- High Cost Cardiology: 1.1% - $22,152,962
- Gastroenterology: 0.5% - $10,205,734
- Hyperlipidemia: 1.7% - $541,021
- Hepatology: 1.2% - $10,624,198
- Urology: 1.1% - $7,582,714
- Malignancies: 0.5% - $17,035,485
- Pulmonology: 0.6% - $7,111,044
- Non HIV Infectious Diseases: 0.6% - $5,330,063

Note: Sample Data
Symmetry’s Episode Treatment Group (ETG) Cost by Disease Condition Group

### Disease Prevalence (%) and Cost by Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence (%)</th>
<th>Total Paid Amount ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes and Diabetic Retinopathy</td>
<td>2.6</td>
<td>10,634,917</td>
</tr>
<tr>
<td>Arthritis</td>
<td>2.7</td>
<td>5,449,206</td>
</tr>
<tr>
<td>Hypertension</td>
<td>2.7</td>
<td>7,444,342</td>
</tr>
<tr>
<td>Severe and Persistent Mental Illness</td>
<td>2.1</td>
<td>8,355,106</td>
</tr>
<tr>
<td>Poisoning and Toxic Drug Effects</td>
<td>1.6</td>
<td>2,136,313</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>2.6</td>
<td>8,955,376</td>
</tr>
<tr>
<td>Hematology</td>
<td>1.0</td>
<td>3,984,570</td>
</tr>
<tr>
<td><strong>High Cost Cardiology</strong></td>
<td><strong>1.3</strong></td>
<td><strong>1,160,863</strong></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1.3</td>
<td>7,927,952</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>1.2</td>
<td>758,299</td>
</tr>
<tr>
<td>Hepatology</td>
<td>1.0</td>
<td>6,073,109</td>
</tr>
<tr>
<td>Urology</td>
<td>0.7</td>
<td>6,622,941</td>
</tr>
<tr>
<td>Malignancies</td>
<td>0.8</td>
<td>6,183,241</td>
</tr>
<tr>
<td>Pneumology</td>
<td>0.5</td>
<td>5,499,025</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>661,996,806</strong></td>
<td><strong>32,041,117</strong></td>
</tr>
</tbody>
</table>

**Note:** Sample Data
Symmetry’s Episode Treatment Group (ETG) Potential Savings Opportunities

This graph shows statewide percentiles and cost breakdowns for the ETG above.

Click on a the title to view a list of all providers with this ETG.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,049,026.60</td>
<td>5,409</td>
<td>5,409</td>
<td>$193.94</td>
<td>$119.57</td>
<td>$0.00</td>
<td>$74.16</td>
<td>$1.07</td>
<td>$0.66</td>
<td>$1.24</td>
</tr>
</tbody>
</table>

**State Percentiles**
This graph shows the amount paid per ETG divided up into percentiles.

**Opportunity for Saving**
This graph show the opportunity for savings that could be generated if costs above the 95th, 90th, etc percentiles were eliminated.

Note: Sample Data
Next Steps

• Pilot internal dashboards
• Finalize APD visualization standards
• Start more advanced analytics using enrichment tools like Symmetry
Moving forward…

Next Six Months
All Payer Database Key Milestones

- Optum Warehouse and Analytics Contract Signed
  - May 27, 2016
- Design Sessions and Deliverable Quality Assurance and Monitoring
  - Summer 2016 – Early Spring 2017
- Internal Release of Counts and Amounts Data Visualizations
  - Spring - Summer 2017
- Warehouse and Analytics Solution Implementation
  - Winter 2017
- Begin Release Schedule for Data Warehousing
  - Summer 2017
- Continued additional data sources, enhancements and expansion of users
  - Winter/Spring 2017-2018 and forward
APD Communication Plan

“The overall objective of the communication plan is to provide a clear strategy for communicating the benefits of the NYS APD to all stakeholders.”

- Public websites:
  - Existing APD site on DOH public web: http://www.health.ny.gov/technology/all_payer_database/
  - APD website (in development as part of RFP)
- Partner websites (NAHDO, APCD Council, NYS Health Foundation)
- APD Listserv
- Conference calls/webinars
- Press releases, fact sheets, reports
- Annual stakeholder meeting
- Social Media
Introduction

The Provider Network Data System (PNDS) will be used to create a Master Provider Index in the APD.

Today’s presentation will describe:
  • What’s in the PNDS, how often it’s collected, and its different uses
  • How will this data be useful in the APD?
Network Data Collection

• NYSDOH has been collecting provider network data (PNDS) from health plans since 1996:
  • Providers and sites in their networks, including addresses and identifiers
  • Specialties and Credentials
  • Accessibility information
  • Panel status and size
• Two files collected on a quarterly basis: Provider file (individuals in network) and Ancillary file (sites in network)
• **NEW**: A new intake system was built in 2016, allowing for faster, larger uploads and enhanced data standardization
Who submits?

- Medicaid Managed Care
- Health and Recovery Plans (HARP)
- HIV-SNP
- Child Health Plus
- Medicaid Advantage
- Managed Long Term Care
- Medicaid Advantage Plus
- Program for All Inclusive Care for the Elderly (PACE)
- Fully Integrated Duals Advantage (FIDA)
- Qualified Health Plans
- Essential Plans
- Commercial MCOs
- **NEW**: Commercial Non-HMOs (medical, dental, and vision)
Frequency and Size

• **NEW:** Plans are asked to submit new data to the PNDS within 15 days of any network change. All plans must submit new data at least on a quarterly basis.

• The system now collects provider and site data from about 80 health plans
  • Q4 2016 provider submission totaled about 4 million rows
  • Q4 2016 ancillary submission totaled about 150,000 rows
Data Layout

- Each plan submits one row per provider-location-specialty in their network. Product indicators tell us which lines of business a provider participates in.
- Provider specialty and network participation can differ by office location and plan.
- **NEW:** Multiple products can be submitted on one file. Our system now handles variation in addresses by providing standardization:

<table>
<thead>
<tr>
<th>Plan ID</th>
<th>Provider Last Name</th>
<th>Provider First Name</th>
<th>Provider NPI</th>
<th>Provider Address 1</th>
<th>Provider Address1 Standardized</th>
<th>Primary Specialty</th>
<th>Medicaid Indicator</th>
<th>NYSOH Indiv St Bronze Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1111</td>
<td>Smith</td>
<td>Jay</td>
<td>1234567890</td>
<td>1 Main St.</td>
<td>1 Main Street</td>
<td>Cardiology</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1111</td>
<td>Smith</td>
<td>Jay</td>
<td>1234567890</td>
<td>4 W. 10th St.</td>
<td>4 West 10th Street</td>
<td>Cardiology</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2222</td>
<td>Smith</td>
<td>Jay</td>
<td>1234567890</td>
<td>4 West Tenth</td>
<td>4 West 10th Street</td>
<td>Internal Med</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

PNDS Validation

• Submissions are checked against several sources to confirm accuracy and remove deactivated or sanctioned providers:
  • CMS’ NPI data (NPPES)
  • Exclusion Lists from OMIG, OIG, & OPMC
  • NYS Department of Education Licensure data
  • NYS Medicaid participation data
  • Health Facilities Information System (HFIS) data for facilities

• Health plans can review excluded providers on their submissions and update their networks accordingly.
PNDS Uses

Health plans submit data

Data is validated and names/addresses standardized

- Health Data NY
- NYS Provider & Health Plan Look-Up
- NYSoH Provider Lookup Tool
- Networks Reviewed Against Standards
- Physician Profiles
- All Payer Database
PNDS Uses

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NYSSoH Provider Lookup Tool

Networks Reviewed Against Standards
Physician Profiles
All Payer Database

Health Data NY
Publicly Available PNDS Data

**NEW:** Anonymous search tool [pndslookup.health.ny.gov](pndslookup.health.ny.gov)

- **Health Data NY**
  - Full PNDS datasets available for download

- **NYSOH Provider Look-Up**
  - A searchable directory within the Marketplace
Health plans submit data

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Review by NYSDOH (OHIP, NYSoH) & NYSDFS based on analyses by Quest Analytics
PNDS in the APD: Master Provider Index

- PNDS is one source of data that will feed the APD’s Master Provider Index
  - Helps create a full picture of health providers in NYS
  - Allows for analytics on plan and product participation, ex:
    - A count of providers in Albany county with a primary specialty of cardiology by product (Medicaid, Essential Plan, Commercial HMO, etc.)
    - Mapping/visualization of network information
Questions?

Questions can be sent to:
pnds@health.ny.gov
or
kate.bliss@health.ny.gov
Facilitated Discussions
(Refer to Handout)
Concluding Remarks / Next Steps
Moving Forward

• Finalize regulations and publicly release APD Guidance Manual as an informational resource
• Data intake enhancements and evolution
• Commercial data intake development and “go live”
• Integration of additional datasets (e.g., SHIN-NY, public health registries)
• System operations and maintenance, enhancements and evolution
• Continued refinement of use cases and analytics
Initial Design with APD and SHIN-NY Unconnected
The Future: Systematic Integration of Data Sets to Evaluate and Drive Program and Policy
Next Steps

• Summary of facilitated discussions will be posted to APD Public Webpage
• All comments received via WebEx chat will be incorporated into post meeting materials
• APD Listserv announcements
• Please remember to fill out the index card with any feedback on today’s meeting
FIND OUT MORE.

nysapd@health.ny.gov

https://www.health.ny.gov/technology/all_payer_database/