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

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

▪ Future work will support the State Health Innovation Plan (SHIP and the grant to support it (State Innovation Model (SIM) Grant)
HIT is a Critical Enabler and Pillar to the SHIP

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

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Workforce strategy</th>
<th>Matching the capacity and skills of our healthcare workforce to the evolving needs of our communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce strategy</td>
<td>Health information technology</td>
<td>Health data, connectivity, analytics, and reporting capabilities to support clinical integration, transparency, new payment models, and continuous innovation</td>
</tr>
<tr>
<td></td>
<td>Performance measurement &amp; evaluation</td>
<td>Standard approach to measuring the Plan’s impact on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation</td>
</tr>
</tbody>
</table>
Objectives for the Transparency, Evaluation, and HIT Workgroup

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

- Implementation of a **Statewide Health Information Network of New York (SHIN-NY)** that facilitates health information exchange to improve care coordination and reduce duplication

- Implementation of an **All-Payer Database** to increase health quality and price transparency, inform policy, enable improvements in quality and performance, and inform benchmarking and comparisons

- Development of a process for **ongoing alignment of measures and technology** to evolving health needs for the State of New York, starting with an APC scorecard
Major Areas of Focus Going Forward

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

Patrick Roohan
Director
Office of Quality and Patient Safety
Discussion for today:

- Overall purpose of transparency

- Current efforts related to Transparency
  - States
  - Insurance companies
  - Third parties
## Transparency is an increasingly important topic across healthcare and raises important questions for states

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

### Key questions
- What do we really mean by transparency?
  - Who are the key users of data?
  - What are their ‘use cases’?
- What are the most important transparency use cases to support the Triple Aim?
- Which use cases should be priority for the state specifically to address?
- What levers does the state have to shift the needle on transparency in priority cases?
Consumers require real-time, customized cost and quality data to stand any chance of making informed decisions

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

Source: Multiple sources, including GAO, Catalyst for Payment Reform
Enabling transparency across key users will drive affordable, efficient and high-quality healthcare

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

- **Who?**
  - States
  - Insurance companies
  - Third parties

- **Metrics**
  - Cost/Charge
  - Quality
  - Volume
  - Patient Perspective
  - Combinations
# Sample state tools for consumer transparency

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

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

#### Detailed estimates for Insured Procedure

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LAKES REGION RADIOLOGY PA</td>
<td>$24</td>
<td>$0</td>
<td>$24</td>
<td>VERY LOW</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>NH NEUROSPINE INSTITUTE</td>
<td>$62</td>
<td>$0</td>
<td>$62</td>
<td>VERY LOW</td>
<td>HIGH</td>
</tr>
<tr>
<td>DARTMOUTH-HITCHCOCK (MANCHESTER)</td>
<td>$75</td>
<td>$0</td>
<td>$75</td>
<td>LOW</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>DERRY IMAGING CENTER</td>
<td>$98</td>
<td>$0</td>
<td>$98</td>
<td>VERY LOW</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>SOUTHERN NEW HAMPSHIRE RADIOLGY CONSULTANTS PC</td>
<td>$100</td>
<td>$12</td>
<td>$112</td>
<td>VERY LOW</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>ST. JOSEPH HOSPITAL</td>
<td>$100</td>
<td>$30</td>
<td>$130</td>
<td>MEDIUM</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>DARTMOUTH-HITCHCOCK (NASHUA)</td>
<td>$100</td>
<td>$35</td>
<td>$135</td>
<td>LOW</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>PARKLAND MEDICAL CENTER</td>
<td>$100</td>
<td>$49</td>
<td>$149</td>
<td>LOW</td>
<td>MEDIUM</td>
</tr>
</tbody>
</table>

Source: www.nhhealthcost.com
## Services listed on New Hampshire’s HealthCost

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

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

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

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

---

Example: Colorado Medical Price website

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

Source: https://www.comedprice.org/
California Healthcare Compare | Hospitals & Doctor Groups

1. Make a Selection
   - Uses CMS Measures for Hospital Quality

2. Search
   - Search by Hospital, Doctor Group, City or Zip
   - Search nearby

Uses Health Plan Quality Information

CompareMaine | Health Costs & Quality

By Procedure

Price

Quality Measures: Patient Safety, Complications, Infections

Source: CompareMaine @ http://www.comparemaine.org/?page=home&from=logo
FloridaHealthFinder.gov | Doctor Volume by Procedure

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

Identifies doctors by license number & total volume by procedures

http://www.floridahealthfinder.gov/index.html
## Best Practices: Washington State

**Best practice tool features**
- **Payers required to offer an electronic transparency tool** to plan members that offers estimates of:
  - Out-of-pocket costs (conditional on plan specifics, personal deductible etc.)
  - Quality metrics by provider (where available)
  - Patient experience — ability to leave reviews and access the reviews of other patients

**Scope of services**
- Common treatments within:
  - In-patient
  - Outpatient
  - Diagnostic tests
  - Office visits

**Timing**
- Legislation passed 2014
- Applies to payers offering/renewing plans from Jan 2016

Source: Washington State website, Catalyst for Payment Reform
Best Practice: New Hampshire

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

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

Source: NH HealthCost, Catalyst for Payment Reform
~85% of commercially-insured New Yorkers covered by a top ten payer have access to a cost calculator, but features and usefulness varies

<table>
<thead>
<tr>
<th>Top 10 Payers in NY commercially-insured segment</th>
<th># CI Lives ('000s)</th>
<th>% CI Lives</th>
<th>Out-of-pocket cost and quality (side-by-side)</th>
<th>Out-of-pocket cost calculator</th>
<th>Other cost estimator (features tbc)</th>
<th>Services covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>EmblemHealth</td>
<td>1,623</td>
<td>17%</td>
<td></td>
<td>Rx only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empire BCBS</td>
<td>1,046</td>
<td>11%</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UnitedHealth Group</td>
<td>778</td>
<td>8%</td>
<td>✓</td>
<td></td>
<td>636 common services</td>
<td>365 care paths</td>
</tr>
<tr>
<td>Excellus BCBS</td>
<td>652</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna</td>
<td>433</td>
<td>4%</td>
<td>✓</td>
<td></td>
<td>~180 specialties (e.g., pediatrics)</td>
<td></td>
</tr>
<tr>
<td>CDPHP</td>
<td>238</td>
<td>2%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>188</td>
<td>2%</td>
<td>✓</td>
<td></td>
<td>~380 common services</td>
<td>8 chronic conditions</td>
</tr>
<tr>
<td>Cigna</td>
<td>140</td>
<td>2%</td>
<td>✓</td>
<td></td>
<td>200+ common procedures</td>
<td></td>
</tr>
<tr>
<td>Independent Health</td>
<td>140</td>
<td>2%</td>
<td>✓</td>
<td>✓</td>
<td>Various</td>
<td></td>
</tr>
</tbody>
</table>

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

1 It is assumed that unless stated otherwise payer tools are accessible by 100% of payer members
Aetna estimates deflated to account for stated access covering somewhat less than full 100% of members
Source: Interstudy data on payer lives (January 2015), payer websites for details of cost/quality tools
## Sample payer tools for consumer transparency

### Tool features

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

Source: Company websites, Company interviews

**ILLUSTRATIVE**
CIGNA’s cost-of-care estimator

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

Personalized estimates that reflect an individual’s health plan benefits

Source: CIGNA website
UnitedHealthcare’s myHealthcare Cost Estimator

Personalized estimates that reflect an individual’s health plan benefits

Costs provided in “care paths” (episodes of care)

Compare costs and quality for different health care providers

Source: UnitedHealthcare website
Independent Health offers a third-party cost-of-care calculator

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

Some basic level of cost comparison between providers

### Estimated Out-of-Pocket Costs: UCR-Based

<table>
<thead>
<tr>
<th>Code</th>
<th>Consumer Description</th>
<th>Est. Charge</th>
<th>Est. Reimbursement</th>
<th>Out-of-Pocket Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>46250</td>
<td>Removal of multiple external hemorrhoids</td>
<td>$1,504.55</td>
<td>$1,053.19</td>
<td>$451.37</td>
</tr>
</tbody>
</table>

**Estimated Out-of-Pocket Cost**

$451.37

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

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

**Adjusting Estimated Reimbursements**

Adjust Percentage

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

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

Click here to use our Advanced Charge Estimator

Source: Independent Health website; FAIR Health website
MVP Health Care | Compare Hospitals

### Quality Measures:
- Patient Safety,
- Clinical,
- Estimated Costs

### Top Ten Procedures Performed

Sample third party tools for consumer transparency

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

Source: FAIR Health website, NH Health Cost website, Company interviews
8 Elective Procedures:
- Knee Replacement
- Hip Replacement
- Gallbladder Removal
- Lumbar Spinal Fusion (posterior or anterior)
- Prostate (removal or resection)

Identifies surgeons at hospitals with "high adjusted complication rates".
Common Procedures: COPD, Heart Bypass, Heart Failure, Hip Replacement, Knee Replacement

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

Next Steps:

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

Chris Nemeth, Director
All Payer Database Development Bureau
Office of Quality and Patient Safety
2015 APD Year End Milestones

• December APD Stakeholder Forum

• APD Data Warehousing & Analytics Award

• APD Regulations Adoption Process Begun; Work also started on Governance Policies and Procedures document (addressing key issues such as data release)
APD Stakeholder Forum

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

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

Attendee Categories

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

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

Topics Discussed by Stakeholders
• Claims collection schedules and formats
• Implementation Timelines
• Data Confidentiality
• Data Release
• Data Quality
• Data Access

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

• On December 21, 2015 Optum Government Solutions, Inc. (Optum) was named the winning bidder to provide data warehousing and data analytics services for the NYS APD (over a $70 million contract span of 5 years).

• Optum is a large scale firm that serves as a leader in the health care services industry, with over 20 years of experience helping state governments solve their biggest and most complex challenges – leveraging data and analytics for better decision making.

• The selection was made upon receipt of 8 proposals in response to a competitive procurement.
APD Data Warehousing & Analytics Award

• Optum will work with the APD data intake system to aggregate, link, de-identify and store the data that is received from all of the different sources.

• Optum will develop both a business intelligence/analytics solution that will facilitate data analysis and reporting, and a data delivery solution that will produce extracts and de-identified data sets for researchers and other stakeholders approved through a data governance process.
NYS APD Implementation Update

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

• Governance
  • Regulations
  • Operations Guide (submission specifications, validation methods, etc.)
  • Data Governance Manual (advisory committees, data release, user agreements, etc.)
Data Warehouse & Analytics Schedule

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

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

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

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

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

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

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

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

Types of Release:

• Public Use Data – Consumer Facing Website, Customizable Population Health Views (DW&A Vendor Developed) – Jan. 2017

• Identifiable Data (Includes Limited Identifiable) – 2018
  • Requires Final Data Release Policies & Procedures
  • Will require Data Use Agreement
  • Will require Application, and Review for appropriateness of use and adequate protection of PHI and PII
Proposed Data Release Framework - handling of price data (from early draft Data Governance Policies & Procedures)

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

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

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

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

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

3) **Limited Identifiable**
   Data Element List: includes all of De-identified above, plus
   Plan’s National or NAIC ID (not name)
   Group and Policy Number
   Provider Detail (Name, NPI, zip plus 4)
Limited and controlled release of APD data is allowable under draft NYS regulations, provided Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules are strictly enforced and the purpose of the data request meets established APD public health goals. Release of APD data will require that a multi-stakeholder DRRC review data requests and advise the APD Administrator whether, (a) such requests meet pre-determined criteria for allowable uses, and (b) applicant appears capable to protect data and successfully achieve purported aims and analyses.

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

James Kirkwood
Director
Health Information Exchange Bureau
Office of Quality and Patient Safety
SHIN-NY Regulations

• Approved by PHHPC on February 11th, will be released in State Register March 9th

• Changes as a result of comment period:
  • Section 300.2: “Establishing the SHIN-NY. The New York State Department of Health [may] shall:
    (a) Oversee the implementation and ongoing operation of the SHIN-NY.”
  • Section 300.3: “Statewide collaboration process and SHIN-NY policy guidance.
    (a) SHIN-NY policy guidance. The New York State Department of Health [may] shall establish SHIN-NY policy guidance as set forth below:’”
To date, roughly 7.7 MM New Yorkers have provided patient consent, an increase of 13% overall in 2015.

Drop in consents for November and December is mostly due to a decrease in consents as reported by Healthix due to a consolidation of their HIE platforms.

*the aggregate consents of RHIO reported metrics. Not adjusted for cross-community patient consent values and may be an overestimate of the population of patients in New York that have consented in aggregate.
Percent of Facilities Participating in SHIN-NY: 2014 vs. 2015

- **Hospitals**: 204/221 (88% in December 2014, 93% in December 2015)
- **FQHCs**: 62/66 (95% in December 2014, 98% in December 2015)
- **Public Health Departments**: 34/42 (81% in December 2014, 97% in December 2015)
- **Home Care Agencies**: 52/97 (104% in December 2014, 102% in December 2015)
- **Long Term Care Facilities**: 185/253 (100% in December 2014, 100% in December 2015)
- **Clinical Practices**: 2125/2538 (100% in December 2014, 100% in December 2015)
SHIN-NY Objectives

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

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

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

• Increasing network participation makes the network more valuable as participants make minimum set of data available
# Minimum Data Set: Aligning with Certified Health IT

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Encounters</th>
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<tr>
<td>Medications</td>
<td>Lab Results</td>
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<td>Allergies</td>
<td>Procedures</td>
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<td>Diagnoses</td>
<td>Problems</td>
</tr>
<tr>
<td>Care Plan</td>
<td>Transition of Care Document</td>
</tr>
</tbody>
</table>
Update on and Review of Interim Data Collection Tool for APC
Anne Schettine
Health Program Director
Office of Quality and Patient Safety
Paul Henfield
Senior Director
IPRO
The scorecard is a cornerstone of the APC program

What the Scorecard is:

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

What the Scorecard isn’t:

- A replacement for scorecards and measures required for ACOs, MA Stars, etc.
- A collection of brand new measures
Payers will play a critical role in the launch of the scorecard

**Payers**
Create various payer-specific quality reports

Process and collect claims

**Providers**
Deliver care at various sites and practices

Reports by payer

**NY State DOH**
Creates APC Scorecard with measure performance by practice and across payers

Aggregate metrics from payers and providers

Create common Scorecard providing cross-payer view of quality performance vs. benchmarks / targets

Provide payer and practice access (e.g., web portal or secure email) and user support / troubleshooting

* Note: No identifiable PHI will be collected by the State

TBD: potential survey / SHIN-NY data

What’s new
Given the APD timeline, we need an interim version 1.0 scorecard

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

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

We need an interim non-APD solution that:

- Uses easily accessible data
- Minimizes burden on providers and payers
- Is high quality and consistent across all types of patients and payers
- Leverages already existing processes
- Employs processes that can be used in future versions of the scorecard
### A claims-based version 1.0 is the best available option

<table>
<thead>
<tr>
<th>Options</th>
<th>Considerations</th>
</tr>
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<tbody>
<tr>
<td>Payers submit numerators and denominators of measures to the State</td>
<td>- Minimal burden on payers; uses easily accessible, already existing data&lt;br&gt;- High quality standardized data&lt;br&gt;- Builds towards eventual APD version</td>
</tr>
<tr>
<td>Providers self-report (EMR and other data)</td>
<td>- Burden on providers (not all have EMRs)&lt;br&gt;- Difficult to assure quality</td>
</tr>
<tr>
<td>Payers submit raw claims to the State</td>
<td>- Duplicative of upcoming APD&lt;br&gt;- Operationally challenging</td>
</tr>
<tr>
<td>Individual payers send providers reports with a common measure set</td>
<td>- Burden on payers and providers&lt;br&gt;- No synergies with eventual APD version</td>
</tr>
<tr>
<td>Status quo: Individual payers send providers reports with no common measure set or cross-payer view</td>
<td>- Burden on providers to receive and interpret varying reports&lt;br&gt;- No standardized measure set&lt;br&gt;- No synergies with eventual APD version</td>
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The APC scorecard aspires to include 20 common measures

<table>
<thead>
<tr>
<th>Categories</th>
<th>Measures</th>
<th>Measure steward</th>
<th>Claims</th>
<th>EHR</th>
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<td>Prevention</td>
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<td>✔</td>
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<tr>
<td></td>
<td>Chlamydia Screening</td>
<td>HEDIS</td>
<td>✔</td>
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<td></td>
<td>Influenza Immunization - all ages</td>
<td>AMA (all ages) or HEDIS (18+)</td>
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<td>Childhood Immunization (status)</td>
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<tr>
<td></td>
<td>Fluoride Varnish Application</td>
<td>CMS (steward), NQF, MU</td>
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<td>Chronic disease identification and treatment</td>
<td>Tobacco Use Screening and Intervention</td>
<td>CMS (steward), NQF, MU</td>
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<td></td>
<td>Controlling High Blood Pressure</td>
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<td>Medication Management for People with Asthma</td>
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<td>Weight Assessment and Counseling for nutrition and physical activity</td>
<td>Children: HEDIS Adults: CMS</td>
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<td>BH/Substance abuse</td>
<td>Depression screening and management</td>
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<td></td>
<td>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
<td>HEDIS</td>
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<tr>
<td>Patient reported</td>
<td>Record Advance Directives for 65 and older</td>
<td>HEDIS</td>
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<td>Overuse and Use of Services</td>
<td>Use of Imaging Studies for Low Back Pain</td>
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<td>Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
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<td>Hospitalization</td>
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<td>Readmission</td>
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<td>Emergency Dept. Utilization</td>
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<td>Cost</td>
<td>Total Cost Per Member Per Month</td>
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### CMS and AHIP release of Core Set for PCMH and Primary Care – areas of overlap with APC Core set highlighted

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<tr>
<td>1. Colorectal Cancer Screening</td>
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<td>6. Tobacco Use Screening and Intervention</td>
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<td>7. Controlling High Blood Pressure</td>
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<td>8. Diabetes A1C Poor Control</td>
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<td>10. Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults</td>
<td>Adults: HEDIS, Children: HEDIS</td>
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<td>11. Depression screening and management</td>
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<td><strong>Patient reported</strong></td>
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<td>14. CAHPS Access to Care, Getting Care Quickly</td>
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<td>15. Use of Imaging Studies for Low Back Pain</td>
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<td><strong>Cost</strong></td>
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Version 1.0 will focus on 11 claims-only measures and 2 interim process measures

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<tr>
<th>Categories</th>
<th>Ultimate measures</th>
<th>Proposed interim measures</th>
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<td>3 Influenza Immunization - all ages</td>
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<td>4 Childhood Immunization (status)</td>
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<td>5 Fluoride Varnish Application</td>
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<td>Chronic disease</td>
<td>6 Tobacco Use Screening and Intervention</td>
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<td>7 Controlling High Blood Pressure</td>
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<td></td>
<td>8 Diabetes A1C Poor Control</td>
<td>Member-level composite (HbA1c test + Eye Exam + Nephropathy) (HEDIS)</td>
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<td>9 Medication Management for People with Asthma</td>
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<td></td>
<td>10 Weight Assessment and Counseling for nutrition and physical activity for children and adolescents and adults</td>
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<td>BH/Substance abuse</td>
<td>11 Depression screening and management</td>
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<td>12 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment</td>
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<td>14 CAHPS Access to Care, Getting Care Quickly</td>
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<td>Appropriate use</td>
<td>15 Use of Imaging Studies for Low Back Pain</td>
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<td>16 Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis</td>
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<td>20 Total Cost Per Member Per Month</td>
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</table>
IPRO’s Role in APC Scorecard V1.0

1. Data Aggregation

2. Technical Assistance
Pre-Pilot Phase

1. Engage pilot payers (6-8)
   - Representing varying plan types – membership size, expertise and experience in reporting, geography, product types

2. Preparation for reporting
   - Feasibility of Data Collection
   - Identification of Anticipated Challenges
   - Technical Assistance and Support
     - Calculating metrics with emphasis on two non-HEDIS measures
     - Process for reporting, data elements, aggregation algorithm...
   - Payer Survey
## Version 1.0 scorecard: Payer Survey: Key design questions

### Issues to address

<table>
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<th>Feasible reporting</th>
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<tbody>
<tr>
<td><strong>Reporting window</strong></td>
<td></td>
</tr>
<tr>
<td>• What are your reporting period capabilities?</td>
<td></td>
</tr>
<tr>
<td>— Typical run-out period?</td>
<td></td>
</tr>
<tr>
<td>— Calendar year to date?</td>
<td></td>
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<tr>
<td>— Rolling view (e.g., rolling 12 month)?</td>
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<tr>
<td><strong>Unit of reporting</strong></td>
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<tr>
<td>• Would it be possible to report at individual provider per site level?</td>
<td></td>
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<tr>
<td>• What unique identifiers are used to distinguish between providers? Practices? Sites? How do you define a “practice”?</td>
<td></td>
</tr>
<tr>
<td><strong>Attribution</strong></td>
<td></td>
</tr>
<tr>
<td>• What attribution methodology do you use? Are you able to do attribution across the entire membership or just a subset?</td>
<td></td>
</tr>
<tr>
<td>— What happens when a physician moves practices? How do you know when a physician moves?</td>
<td></td>
</tr>
<tr>
<td>— How are patients attributed when a physician works in multiple locations? Or as a solo practitioner as well?</td>
<td></td>
</tr>
<tr>
<td>• How often are attribution lists updated and how are they shared with practices?</td>
<td></td>
</tr>
<tr>
<td>• How frequently could attribution lists be updated, theoretically?</td>
<td></td>
</tr>
<tr>
<td><strong>Quality control and adjustments</strong></td>
<td></td>
</tr>
<tr>
<td>• How are current reports quality and accuracy tested (e.g., taking sample of claims/members and cross-checking quality)?</td>
<td></td>
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<tr>
<td>• Are ethnic stratification or health literacy indices currently used to address requirements to “reduce disparity”?</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>• Would it be feasible to submit numerators, denominators and provider information for each measure?</td>
<td></td>
</tr>
<tr>
<td>• When could this information be submitted, and what barriers may limit your ability to do so? (e.g., measurement cycles, budget cycles, staff time, data sharing agreements, ramp-up to incorporate new measure methodologies)?</td>
<td></td>
</tr>
<tr>
<td>• How much historical data could be provided (to generate a baseline? 6 month, 1yr? 2yr? 3yr)?</td>
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</table>

<table>
<thead>
<tr>
<th>Existing reporting</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Benchmarks and goals</strong></td>
<td></td>
</tr>
<tr>
<td>• What benchmarks / goals are currently used? What is the rationale?</td>
<td></td>
</tr>
<tr>
<td>— Absolute goal?</td>
<td></td>
</tr>
<tr>
<td>— Gap to goal?</td>
<td></td>
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<tr>
<td>— Performance against own practice (requires access to historical data)?</td>
<td></td>
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<tr>
<td><strong>Payer to provider reports</strong></td>
<td></td>
</tr>
<tr>
<td>• Which measures and other ancillary information are included?</td>
<td></td>
</tr>
<tr>
<td>• How frequently are the scorecards produced?</td>
<td></td>
</tr>
<tr>
<td>• How are the reports delivered?</td>
<td></td>
</tr>
<tr>
<td><strong>Provider measure submission to state</strong></td>
<td></td>
</tr>
<tr>
<td>• Do you currently require providers to submit any e-measures or other measures of quality? What is the penetration of e-measure submissions among the providers? Do providers submit service information via EHRs?</td>
<td></td>
</tr>
<tr>
<td>• Does your organization currently leverage RHIOs to get an early read on test results / outcome measures / utilization or keep abreast of how these are developing on a more regular basis? Is member-level information accessible?</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>• Can you report on metrics for your entire membership (vs. just on selected products)? Do you report on your entire book of business or just for certain products? Do you outsource reporting software or develop internally?</td>
<td></td>
</tr>
</tbody>
</table>
Pilot Phase

Survey will help inform data reporting process
- data elements to collect
- timeframe for reporting
- aggregation methodology
- benchmarking

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

Payers will report 13 interim measures

Pilot test results will be used to evaluate
- data elements that posed challenges
- issues in data analysis and aggregation
- functionality of the reporting tool
- stratification alternatives
- reportability of the metrics
- benchmarking options
Post-pilot Validation

Was the Attribution successful?

Verification of patient to provider/practice attribution
A sample of practices to verify that the scorecard accurately reflected patients and providers associated with their practice

Potential Sources of Error:
provider → practice → payer → DOH/IPRO
Preparation for Quarterly Reporting

— Payers engaged and supported
— Data elements and reporting tool finalized
— Attribution methodology determined
— Timeframe for reporting identified

— Format/Content of the Scorecard:
  Additional stratifications
  Benchmarks selected
Version 1.0 launch is planned for January 2017

Providers download baseline Version 1.0 reports

Version 1.0 Scorecard implementation and roll out

Payer preparation for reporting

Payer collaboration begins

Practice definition and attribution exploration work

Pilots reporting by payers

Payers deliver first metrics data files

State begins baseline report production

Providers download baseline Version 1.0 reports

1 Baseline reports are based on recent 12-month performance
Discussion and Next Steps

Patrick Roohan
Director
Office of Quality and Patient Safety

Next meeting May 20, 2016