Transparency, Evaluation, and Health Information Technology Workgroup

Meeting #4
February 13, 2015

Agenda

#	Topic	Time	Leader
1	**Welcome and Introductions**	10:05 – 10:10	Patrick Roohan
2	**Opening Remarks**	10:10 – 10:15	Courtney Burke

3	**Interim Workgroup Report Update**
	• Interim Report Issued
	• Outstanding Items
	    • Minor Consent
	    • Provider Liability
		10:15 – 11:00	Patrick Roohan
			James Kirkwood

4	**APD Update** • Operations Update • Regulations Discussion • Timeframe	11:00 – 11:30	Chris Nemeth
5	**SHIN-NY Update** • Status Update • Regulations Update • Payer Access to Data	11:30 – 12:00	James Kirkwood
6	**DSRIP PPS Consent**	12:00 – 12:15	Peggy Chan
7	**SIM/SHIP Update**	12:15 – 12:30	Stefanie Pawluk
8	**Discussion and Next Steps**	12:30 – 1:00	Patrick Roohan

Interim Workgroup Report Update

Patrick Roohan
Director
Office of Quality and Patient Safety

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Outstanding Items

- SHIN-NY Regulations
- APD Regulations
- Master Patient Index
- EHR Funding
- Collection of Non-Clinical Data
- Interoperability
- Provider Liability

Outstanding Items – SHIN-NY Regulations

- SHIN-NY Governance models
- Confidentiality of data collected and shared.
- Sharing of and access to patient information
- Transparency and accountability
- Financing of the SHIN-NY
- SHIN-NY technical standards
- Minor consent
- Performance benchmarks to ensure trust in the SHIN-NY and predictability for QE participants.

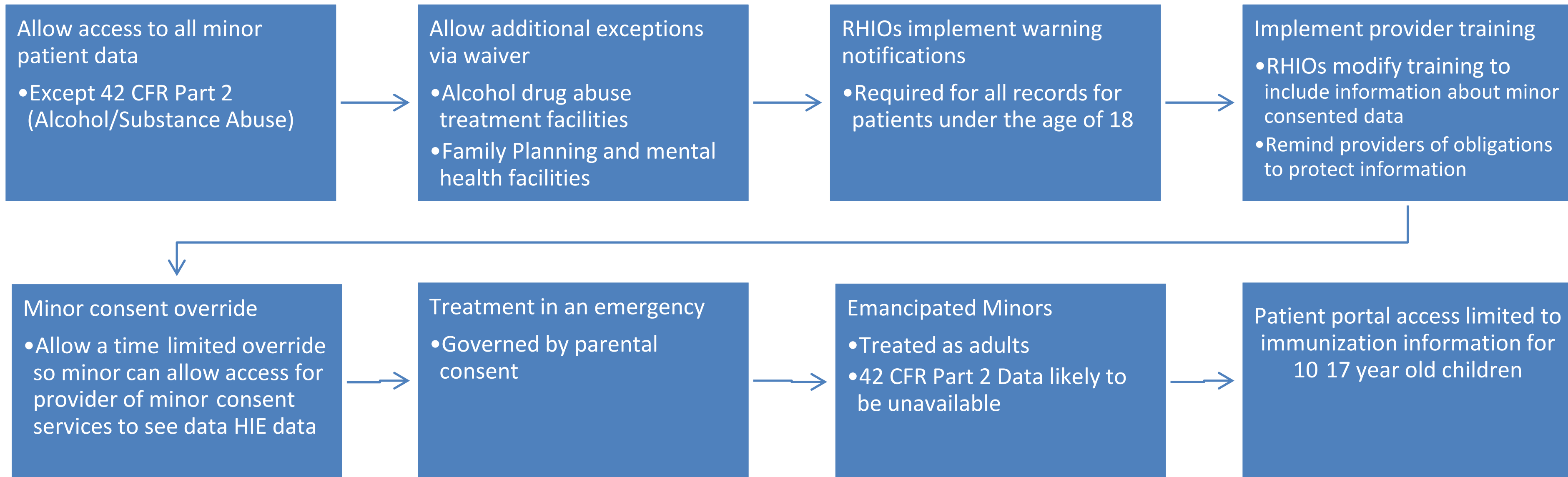
Minor Consent

- Any solution would be interim
  - Data segmentation standard not widely implemented
- Four models evaluated
  - “Let the Data Flow”
  - “Rochester Model”
  - “Hybrid LDF/Rochester Model”
  - “Parent Consent/Minor Consent”
- Let the Data Flow chosen for further evaluation of feasibility

Minor Consented Services

- Alcohol and Drug Abuse Services
- Abortions and Sexually Transmitted Infections
- Family Planning
- Mental Health Information
- HIV Testing
- Emergency Care

Let the Data Flow Model



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Outstanding Items – APD Regulations

- Mechanisms for capturing data on the uninsured
- How best to capture non-health such as data from community-based providers
- How to overcome instances, such as bundled payments, that will ‘mask’ some details that may be useful to evaluate quality, costs and outcomes
- Long-term sustainability of the system
- Structuring data collection and reporting mechanisms to minimize burden

Outstanding Items – Master Patient Index

- Data integrity
- Match Strength
- Prioritization of datasets for linking
- Data Governance

Outstanding Items – EHR Funding and Adoption

- Exploration of funding mechanisms for:
  - home care
  - case management
  - Housing
  - Senior centers.
  - Client based in-home technologies

Outstanding Items – Collection of Non-Clinical Health Data

It was recommended that the State explore options for collecting and integrating heath and “non-health” data (i.e., housing) to create a more holistic picture of the individual, to address social determinants of health and to promote overall population health.

Outstanding Items – Interoperability

- The State should explore ways to incentivize the adoption and use of interoperable electronic health records for multiple provider types, including home care and social service providers to assure that electronic health information can be broadly shared across and between providers to promote health and wellbeing.

Outstanding Items – Provider Liability

- Issues pertaining to provider liability should be further explored as they pertain to the potential use of erroneous data included in an electronic record, misuse of accurate information, and potential downstream breaches of data.
- This issue is being evaluated in the legal sub-workgroup.

APD Update

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

IT Status and Timelines

Encounters Intake Data Solution – Finishing First Stage Development

- Built new Data Intake System in conjunction with the NYSoH Qualified Health Plans (began processing Production Data on 1/8); will expand sequentially to receive data from: Medicaid Managed Care, Large Group Commercial Payers, Medicare

- Targeted completion for all data types is early 2016; Interim milestones:
  - Initial Model of NYSoH data built for OHIP Datamart (March ‘15)
  - Begin system requirements identification for the inclusion of private payer commercial data (June ’15)
  - Develop & test first phase of APD with quality metrics and dashboards for NYSoH and Medicaid Managed Care (Spring 2016)

Process Status and Timelines

- Completed first phase APD staff build: 8 FTEs, 2 contract programmers (Dec 2014)
- Obtain CMS approval of APD implementation Advanced Planning Document (iAPD) – Secures contribution of federal Medicaid funding (Feb ‘15)
- Contracted Solution for Data Warehousing & Analytics Platform – Targeted release for competitive Request For Proposals (RFP) is 3/15
- Identify sustainability models for APD funding post 16/17 budget cycle (ongoing strategic planning)
- Draft and Review proposed *APD regulations to finalize by fall 2015

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Regulations Challenges

- Last quarter efforts were geared toward completion of Encounter Intake System (QHP data), RFP approval, and staff build of APD Development Bureau
- Development of draft regulations and data governance framework did not keep pace with projected timelines; a new work plan has been devised to assign additional staffing and closely monitor progress
- External reaction/input to early regs draft has been limited; to increase engagement, a broad based Advisory Group of (20 plus) stakeholders was reconvened in a recent conference call; newly added members increase consumer representation

Revised Timeline for Regulations Adoption

External Preview:

- Release new draft to HIT members and Advisory workgroup: March 31
- Receive comments through April 15

Begin SAPA Process:

- Early Summer 2015: Publish in State Register
- 45-day comment period
- DOH reviews comments; if substantial comments must re-release for 30-day comment period
- Final publication in state register (Target: October 2015)

Primary Regulatory Concerns Continue to be:

- **Data Release, Use & Governance** to maximize APD stakeholder utility **-** New York has identified a multitude of stakeholders (consumers, payers, providers, researchers, policy makers, etc.) who will benefit from easy and understandable access to these data; yet broad access and utility is not possible without stringent treatment of privacy and security concerns

- **Data Sharing Fee Structures -** it is standard practice for states to charge for access to data and New York must determine a fee structure covering all user types and requestors

- **Price and Quality Transparency**

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SHIN-NY Update

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

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SHIN-NY

- Technical infrastructure, policies and agreements that support the secure exchange of protected health information to enable higher quality care and reduce costs.

- The SHIN-NY consists of:
  - 8 Regional Health Information Organizations
  - Statewide services for data exchange across regions
  - Proposed regulations incorporate policy standards on:
    - Minimum set of technical services
    - Privacy and security
    - Oversight and enforcement
    - QE participation agreement
    - Standardized consent form (opt-in)

SHIN-NY Stakeholder Adoption – NY State

Stakeholder	Adoption
% Hospitals	84%
% FQHC	78%
% Public Health Depts	60%
% Home Care Agencies	42%
% Long Term Post Acute Care	29%
% Ambulatory Physicians	17%
% Clinical Practice Sites	14%

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Data as of January 2015

Consent Landscape in NY

- Opt-in: Patient must proactively agree to allow provider to view records available on SHIN-NY
  - Consent must be signed for each provider visited

- Community Opt-in (HealtheLink, WNY)
  - Opt-in once and allows for exceptions:
    - Consent to all exchange
    - Consent to exchange with exception of certain providers
    - Only in case of medical emergency

- Minor Consent
  - NYSDOH evaluating policy and technical framework to allow minor patient data to flow but appropriately limit minor consented information

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SHIN-NY Regulations

- Proposed in late summer 2014
- Significant revisions include
  - Simplifying language
  - Only include requirements of SHIN-NY participants
  - Give NYSDOH flexibility to implement SHIN-NY activities and policies
  - Remove language that would normally be done by implementing contracts

Proposed Regulation Changes

Old Section	Changes
Preamble	Shorten
300.1- Definitions	Remains similar
300.2- Contract with State Designated Entity	Requirements of the Department
300.3- Statewide Collaboration Process	Reduced in structure. Department performs activities.
300.4- Qualified entities	Combined with 300.7

Proposed Regulation Changes, cont.

Old Section	Changes
300.5 Sharing patient information	Remains the same
300.6 Patient rights	Remains the same
300.7 Contracts with state designated entity	Combined with 300.4
300.8 Participation of health care facilities	Remains the same
300.9 Financing of SHIN-NY	Remove

Payer Access to SHIN-NY Data

- Payers currently treated under SHIN-NY policies as a participant in SHIN-NY similar to providers, hospitals
  - Must gain consent from each member
- Does not support payer use of SHIN-NY for quality measurement
- Department exploring how allow access but assuring appropriate consent

Department of Health | Office of Health Insurance Programs

The Planned Consent Process for Delivery System Reform Incentive Payment Program: Rules for Sharing of Medicaid Data with PPSs

Peggy Chan, MPH
DSRIP Program Director

January 2015

OHIP has chosen an OPT-OUT consent process for DSRIP

- The process addresses the sharing of Medicaid PHI data available from the state with the PPS administrative lead and from the PPS administrative lead with down stream partners. Usual clinical data sharing between providers does not change.
- Consistent with the process utilized by CMS for the Medicare ACOs.
- There are many similarities between DSRIP PPSs and ACOs, particularly the responsibility for the health of a specific attributed population.
- The Medicaid recipient has already been provided a notice of privacy practices applicable to Medicaid and agreed to specific data sharing upon joining Medicaid.
- This will result in a more manageable process for data management.
- The Medicaid recipient still owns control of the access to his/her own data.

Key Concepts for Opt Out Process

- The process will be managed by OHIP and utilize resources already in place
  - Recipient communication through the Medicaid call center, including providing required language access
  - Data management through CMA and eMEDNY CSC.
- Because DSRIP is a state-wide program, all Medicaid recipients have the opportunity to benefit from its initiatives.
- Members who opt out will be opting out of the full DSRIP program.
- When the state is unable to reach Medicaid recipients, the attributed PPSs will be utilized to find these recipients.
- Recipients will be provided a specific opt-out period, but can opt-out at any time. The state will re-educate recipients on a periodic basis.
- Newly enrolled recipients will be provided information about DSRIP and opt-out option.

Privacy Structure:

- Each PPS will complete a DEAA, a data sharing agreement with the state that will define the data sharing responsibilities of the PPS in compliance with state and federal laws:
  - Until the completion of the opt out process, PPSs will only receive demographic information to assist in finding otherwise unreachable recipients.
  - The lead PPS Administration only will be allowed to use a limited data set to begin to structure programs.
- The PPS Administration which holds the DEAA with the state will need to execute down stream provider DEAAs including BAAs with all Medicaid providers and execute contracts including BAAs with other community based providers. Each of these documents will need to be specific to the type of administrative data that can be shared and how it will be shared and reference specific applicable state and federal laws.
- Clinical data sharing between PPS partners will continue to be done as previously established under state and federal guidelines.

Organized Health Care Arrangement

- HIPAA allows health care organizations functioning in an integrated way as defined in 45CFR 160.103 to define themselves as an "organized health care arrangement"
- Such entities can use a properly developed Notice of Privacy Practices to advise patients of data sharing within such an arrangement. This does not replace the need for properly executed lead and subcontractor DEAAs for state provided data.
- Organizations will need to seek their own legal counsel regarding the applicability of this to their PPS.

Questions?

DSRIP e-mail:
dsrip@health.state.ny.us

SIM/SHIP Update

Stefanie Pawluk
Project Manager
Office of Quality and Patient Safety

New York State Health Innovation Plan

Goal Delivering the Triple Aim – Better health, better care, lower costs

Pillars

1	2	3	4	5
Improve access to care for all New Yorkers, without disparity	**Integrate care to address patient needs seamlessly**	**Make the cost and quality of care transparent to empower decision making**	**Pay for healthcare value, not volume**	**Promote population health**
Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in a timely way	Integration of primary care, behavioral health, acute and postacute care; and supportive care for those that require it	Information to enable consumers and providers to make better decisions at enrollment and at the point of care	Rewards for providers who achieve high standards for quality and consumer experience while controlling costs	Improved screening and prevention through closer linkages between primary care, public health, and community-based supports

Enablers

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

SHIP Objectives and Goals

Three Core Objectives within 5 Years:

1. 80% of the state's population will receive primary care within an APC setting, with a systematic focus on population health and integrated behavioral healthcare;
2. 80% of the care will be paid for under a value-based financial arrangement; and,
3. Consumers will be more engaged in, and able to make more informed choices about their own care, supported by increased cost and quality transparency.

We aspire to:

1. Achieve or maintain top-quartile performance among states for adoption of best practices and outcomes in disease prevention and health improvement within five years;
2. Achieve high standards for quality and consumer experience;
3. Generate savings by reducing unnecessary care, shifting care to more appropriate settings, reducing avoidable hospital admissions and readmissions and assuring a clear link between cost and quality.

For more information, visit the below webpage to view the SHIP: https://www.health.ny.gov/technology/innovation_plan_initiative/docs/ny_state_health_innovation_plan.pdf)

Centers for Medicare and Medicaid Innovation (CMMI)

SIM Model Testing Awards – Round Two

Model Test Awards
Model Design Awards

RI
CT
DE
DC
AS
MP
PR

Source: Centers for Medicare & Medicaid Services

New York State of Opportunity. Department of Health

SIM Grant Application

Over the next 48 months, NYS will receive ~$100 million to implement and test the SHIP.

New York will promote a tiered ***Advanced Primary Care*** (APC) conceptual model. This model includes behavioral and population health integration, coupled with an appropriately trained workforce and engaged consumers, with supportive payment and common metrics. The state will:

1) institute a state-wide program of regionally-based primary care practice transformation activities to help practices across New York deliver 'advanced primary care';
2) expand the use of value-based payments so that 80% of New Yorkers are receiving value-based care by 2020;
3) support performance improvement and capacity expansion in primary care by expanding New York's primary care workforce through innovations in professional education and training;
4) integrate APC with population health through Public Health Consultants funded to work with regional Population Health Improvement Program (PHIP) contractors;
5) develop a common scorecard, shared quality metrics and enhanced analytics to assure that delivery system and payment models support three-part aim objectives; and
6) provide state-funded health information technology, including enhanced capacities to exchange clinical data and an all-payer database.

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SIM Grant Application

Breakout of NY SIM Testing Application Funds

- Practice Transformation Support: 67%
- APC Design and Multipayer Commitment: 12%
- Innovation Center/Implementation: 8%
- Population Health: 4%
- Workforce Initiatives: 3%
- Evaluation: 3%
- Value Based Insurance Design: 2%
- Standard Scorecard: 1%

Further detail available, including Project Narrative and budget summary, at the following link:
http://www.health.ny.gov/technology/innovation_plan_initiative/

SHIP Advanced Primary Care Model (APC)

Pre-APC
- Transitional, **time-limited** status with obligation to reach APC status
- Demonstrate capacity/willingness to 'transform'

APC
- **Potential final destination** for some practices without infrastructure to reach Premium APC
- Key infrastructure in place for management of complex populations
- Demonstrated higher level PCMH with results

Premium APC
- Practices manage population health, integrating behavioral health
- Medical neighborhood and community-facing care coordination
- 'ACO-ish'
- Performance driven payments

No Quality Measurement → *More Quality Measurement*

FFS → P4P → Care Coordination → Episodes of Care → Shared Savings → Shared Risk → Global Payments

No Financial Risk → *More Financial Risk*

DRAFT

A critical goal of design and implementation is for multi-payer alignment on this multi-tiered model coupled with payment support for transformation, care management AND value based payment.

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SHIP & SIM Resources

SHIP and SIM Materials including SIM application, updates, and more:
https://www.health.ny.gov/technology/innovation_plan_initiative/

CMMI's State Innovation Models Program:
http://innovation.cms.gov/initiatives/state-innovations/

Contact us:

- The SHIP Team – sim@health.ny.gov
    - Register for our newsletter by sending an email
- Stefanie Pawluk – stefanie.pawluk@health.ny.gov

Discussion and Next Steps

Patrick Roohan
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