New York State's Primary Care Core Measure Set

Presentation to the Multi-payer Primary Care Network, Milbank Memorial Fund

February 27, 2020

Agenda and Speakers

#	Topic	Speakers	Time
1.	NYS SIM Grant: Primary Care Transformation and Payment Models	• Marcus Friedrich, MD, MHCM, MBA, FACP, Chief Medical Officer, Office of Quality and Patient Safety, NYS Department of Health	5 min.
2.	Primary Care Core Measure Set: Development and Stewardship	• Pooja Kothari, Senior Program Manager, United Hospital Fund • Scott Hines, Chief Quality Officer, Crystal Run Health	10 min.
3.	Primary Care Measure Set Scorecard Overview	• Lindsay Cogan, PhD, MS, Director, Division Quality Measurement, Office of Quality and Patient Safety, NYS Department of Health	10 min.
4.	New York City Health Plan Regional Collaboration	• Amy Tippett-Stangler, Senior Vice President, Northeast Business Group on Health • Robert LaPenna, Network Director for Payment Innovation Programs, Empire	10 min.
5.	Closing Remarks	• Marcus Friedrich, MD, NYS Department of Health	5 min.
6.	Q&A	• Lisa Dulsky Watkins, MD, Director, Multipayer Primary Care (MPC) Network, Milbank Memorial Fund	20 min.

NY State SIM Introduction

Marcus Friedrich, MD, MHCM, MBA, FACP
Chief Medical Officer, Office of Quality and Patient Safety

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New York State Health Innovation Plan

Goal	**Delivering the Triple Aim -** *Healthier people, better care and individual experience, smarter spending*

Pillars	**Improve access to care for all New Yorkers, without disparity** Elimination of financial, geographic, cultural, and operational barriers to access appropriate care in 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 health care 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

Enablers	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 on health system transformation and Triple Aim targets, including self-evaluation and independent evaluation

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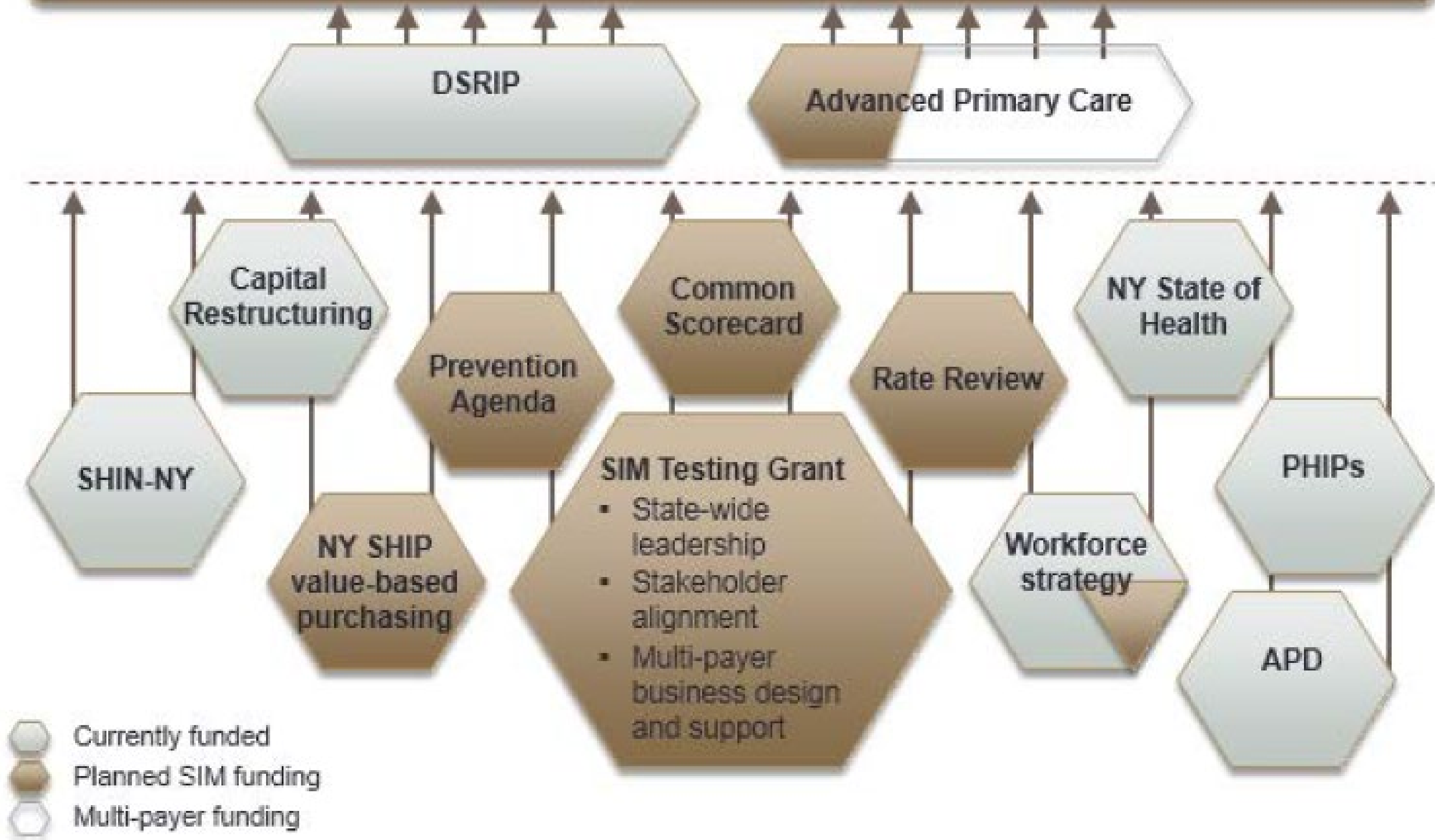
Strong, expert, coordinated state leadership can create value over the next four years
DSRIP
Advanced Primary Care
Capital Restructuring
Common Scorecard
NY State of Health
Prevention Agenda
Rate Review
SHIN-NY
SIM Testing Grant
▪ State-wide leadership
▪ Stakeholder alignment
▪ Multi-payer business design and support
PHIPs
NY SHIP value-based purchasing
Workforce strategy
APD
Currently funded
Planned SIM funding
Multi-payer funding

Highlights of NYS PCMH Model

- In mid-2017 the Advanced Primary Care practice transformation model was launched and later transitioned to NYS Patient Centered Medical Home
- NYS PCMH model was launched in April 2018 with 12 additional standards now core to achieving the PCMH recognition in New York. Additional Standards focused on:
  - Health Information Technology
  - Care Coordination/Management
  - Population Health
  - Behavioral Health Integration
  - Value Based Payment Contracting
- Exceeded initial enrollment goals in June 2019, 7 months before the end of the SIM grant

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NY State SIM Project- High Level Accomplishments

- Creation and continuation of NYS PCMH program with NCQA which 2,800+ practices have engaged with
- 13 health plans involved in four regional ROMCs (many in multiple regions) offering aligned VBP contracts
- 15 TA vendors assisted 70% of NYS PCMH practices (over 1,900 practices)
- Development of Primary Care Core Measure Set with three annual versions of PC Scorecard delivered

New York State Primary Care Core Measure Set: Development and Stewardship

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Pooja Kothari, Senior Program Manager, United Hospital Fund
Scott Hines, Chief Quality Officer, Crystal Run Health

February 27, 2020

United Hospital Fund

New York State Primary Care Core Measure Set

- What is the Core Measure Set?
  - A **set of 27 standardized quality measures***
  - **Aligned** with several national and state quality measure programs
  - **Six domains** salient to primary care: prevention, chronic disease, behavioral health/substance use, patient-reported, appropriate use, and cost
- What is the purpose of the Core Measure Set?
  - A valid practice-level performance profile integral to quality monitoring and improvement, primary care practice transformation, and with relevance for payment models

*As of January 2020

NYS Primary Care Core Measure Set Recommended for 2020

DOMAIN	MEASURE	POPULATIONS	DATA SOURCE
Prevention	**Cervical Cancer Screening** (#32/HEDIS)	Adults: 21 – 64 years	Claims-only possible
	Breast Cancer Screening (#2372/HEDIS)	Adults: 50 – 74 years	Claims-only possible
	Colorectal Cancer Screening (#34/HEDIS)	Adults: 50 - 75 years	Claims/EHR
	Chlamydia Screening (#33/HEDIS)	Adolescents/Adults: 16 - 24 years	Claims-only possible
	Influenza Immunization - all ages (#41/AMA)	All: 6 months+	Claims/EHR/Survey
	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life (NQF #1516)	Children: 3-6 years	Claims/EHR
	Immunizations for Adolescents (NQF #1407)	Adolescents: 13 years	Claims/EHR
	Childhood Immunization Status (#38/HEDIS)	Children: 2 years old	Claims-only possible
Chronic Disease	**Tobacco Use Screening and Intervention** (#28/AMA)	Adults: 18 years+	Claims/EHR
	Controlling High Blood Pressure (#18/HEDIS)	Adults: 18 - 85 years	Claims/EHR
	Diabetes: A1C Poor Control (#59/HEDIS)	Adults: 18 - 75 years	Claims/EHR
	Diabetes: Eye Exam (#55/HEDIS)	Adults: 18 - 75 years	Claims
	Diabetes: Medical Attention for Nephropathy (#62/HEDIS)	Adults: 18 - 75 years	Claims
	Persistent Beta Blocker Treatment after Heart Attack (#71/HEDIS)	Adults: 18 years+	Claims/EHR
	Medication Management for People with Asthma (#1799/HEDIS)	All: 5 - 65 years	Claims-only possible
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (#24/HEDIS)	Child/Adolescents: 3 - 17 years	Claims/EHR
	BMI Screening and Follow-Up (#421/CMS)	Adults: 18 years+	Claims/EHR
Behavioral Health/ Substance Use	**Screening for Clinical Depression and Follow-up Plan** (#418/CMS)	Adolescents/Adults: 12 years+	Claims/EHR
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (#4/HEDIS)	Adolescents/Adults: 13 years+	Claims/EHR
	Antidepressant Medication Management (#105/HEDIS)	Adults: 18 years+	Claims
Patient-Reported	**Advance Care Plan** (#326/HEDIS)	Adults: 65 years+	Claims-only possible
	CAHPS Access to Care, Getting Care Quickly (#5/AHRQ)	All	Claims/EHR
Appropriate Use	**Use of Imaging Studies for Low Back Pain** (#52/HEDIS)	Adults: 18 – 50 years	Survey
	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (#58/HEDIS)	Adults: 18 – 64 years	Claims
	Inpatient Hospital Utilization (HEDIS)	All	Claims
	Plan All-Cause Readmissions (#1768/HEDIS)	Adults: 18 years+	Claims
	Emergency Department Utilization (HEDIS)	All	Claims
Cost	(Pending measure review)		

Populations: Children, ages 0 - 9; Adolescents, ages 10 - 17; Adults, ages 18+. The WHO defines adolescence as the age range 10 – 19 years. The AAP/Bright Futures defines it as the age range 11 – 21 years.
Data Sources: Claims-only possible refers to the fact that the measure requires use of both claims and other sources (EHR, survey) but using only claims is a feasible alternative.

Context for Developing the Core Measure Set

- Measure **proliferation** is a nationally recognized **problem**.
- **Priority given to more efficient measure sets** that **minimize reporting burdens** and are:
  - Lean, relevant to stakeholders, and aligned across payers and federal and state programs
- Quality measurement is **shifting toward value** and emphasizing measures that are:
  - Patient-centered and meaningful to patients
  - Actionable, relevant, and important to providers and payers
  - Focused on outcomes where possible, and away from process measures

The Evolution of the Core Measure Set

Development (2015-2016)

- NYSDOH appointed a stakeholder workgroup to advise on the building blocks of primary care transformation and provide input on the development of the Core Measure Set.

Stewardship (2017->)

- NYSDOH formed a subcommittee* to help establish a stewardship process for the Core Measure Set.

*A subcommittee of a Statewide Steering Committee charged with providing strategic direction for the SIM award

Stewardship of the Core Measure Set

- **Annual review and maintenance** of quality measures to ensure that the Core Measure Set:
  - Is informed by advances in measurement science
  - Reflects changes in national and NYS healthcare environment – VBP and other policies
  - Relies on available data and feasible and valid methods for assessing the value of primary care
  - Reflects NYSDOH measurement goals, priorities, and parameters
  - Minimizes collection and reporting burdens
  - Reflects gap areas that are identified and incorporates potential measures for those areas

Process for Annual Review of the Core Measure Set

Formed scoring cohorts with volunteers assigned to 4 stakeholder groups (consumer, payer, provider, NYSDOH)

Scored measures using scoring tool to assess individual measures

Presented cohort scoring results to the full Subcommittee for discussion and voting on measure disposition

Finalized recommendations to NYSDOH for updating the Core Measure Set

Scoring Tool for Assessing Measures

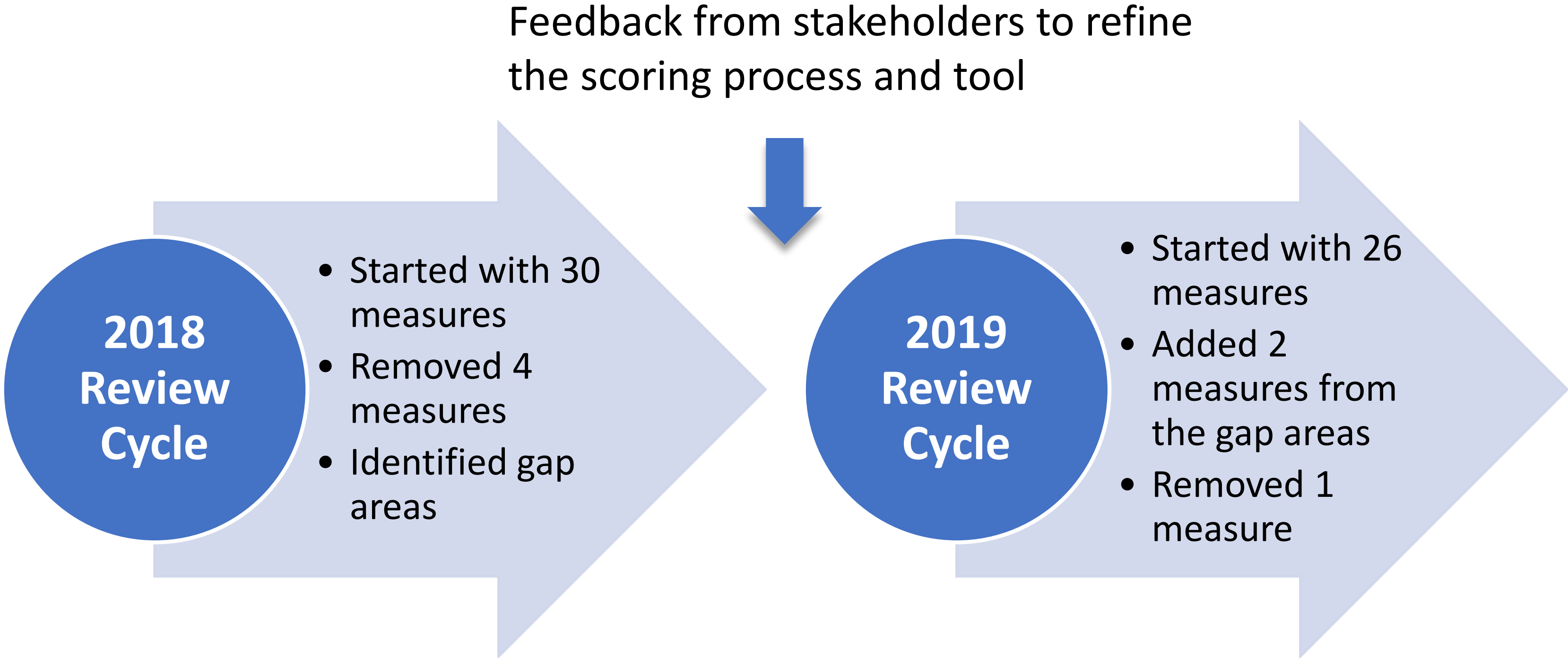
MEASURE PRINCIPLES, CRITERIA, CONSIDERATIONS	
Relevant to special populations	
PRINCIPLES	**Relevant to NYS primary care goals**
	Addresses the Quadruple Aim
	Standardized
ESSENTIAL CRITERIA	**Ease of reporting/Can be verified by practices**
	Addresses high prevalence/impact area
	Aligned with payer measure sets
	Type of measure
KEY CONSIDERATIONS	**Measure can be evaluated at the level of analysis for intended use**
	Notable performance gap or opportunity for improvement in NYS

Scoring Key	
Principles *(prepopulated)*	
P	Pass
F	Fail
Essential Criteria (0-3)	
0	No
1	Low
2	Medium
3	High
Essential Criteria (0-1) - Aligned with Payer Measure Sets *(prepopulated)*	
0	No
1	Yes
Essential Criteria (0-3) - Type of Measure *(prepopulated)*	
0	Utilization/Structure
1	Process
2	Interim Outcome
3	Outcome
3	Patient Reported Outcome
Key Considerations	
0	No
1	Low
2	Medium
3	High

Achievements

- Developed a Core Measure Set and an annual review process and engaged Subcommittee participants in stewardship activities.
- Specified principles and criteria and created a scoring and voting system for assessing and prioritizing measures.
- Evaluated stakeholder experience and refined the scoring process and tool based on feedback.
- Developed an approach for gap areas and identified new measures for consideration.
- Completed 2 review cycles and provided recommendations to NYSDOH.

Updates to the Core Measure Set



The Subcommittee recommended 27 measures for the 2020 Core Measure Set. Recommendations were approved by NYSDOH and presented to the SSC.

Primary Care Measure Set Scorecard Overview

Lindsay Cogan, PhD, MS

Director, Division Quality Measurement, Office of Quality and Patient Safety

Primary Care Scorecard Purpose

What the Scorecard is:

- Aggregated, multi-payer information to view practice performance across a consistent set of measures for their entire patient panel (rather than on a per payer basis)
  - For use by payers in VBP arrangements
  - For use by practices to identify areas with improvement opportunities
- Monitoring improvement in results are necessary for practices in NYS practice transformation.

What the Scorecard isn't:

- A replacement for scorecards and measures required for ACOs, MA Stars, etc.
- A gap in care report from payers to provide services to specific patients
- A collection of brand new measures

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Need for Interim Solution

The **eventual Primary Care Scorecard** should leverage both administrative claims data from the APD* and clinical data from EHRs.

The **timelines for launch and APD roll out did not align**. The program launched in 2016, while the APD completion is not anticipated until 2020.

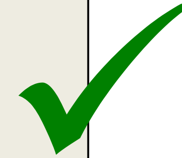
We needed **an interim non-APD solution** that:

- Used easily accessible data
- Minimized burden on providers and payers
- Is high quality and consistent across all types of patients and payers
- Leveraged already existing processes
- Employed processes that can be used in future versions of the scorecard

*APD: All Payer Database system. We anticipate commercial data intake to begin in 2020.

A Claims-Based Version 1.0

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



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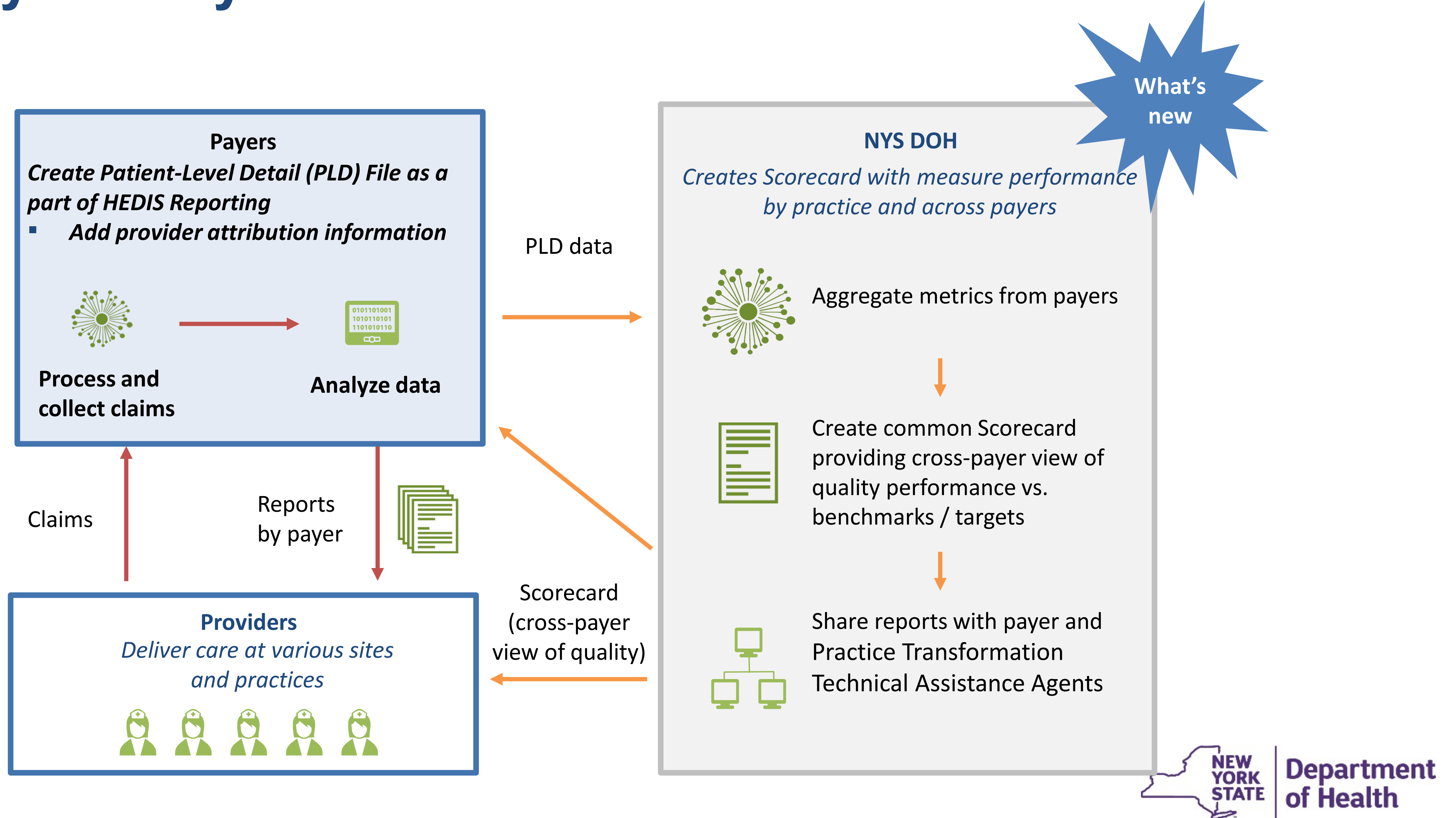
Payers Played a Critical Role in the Interim Solution

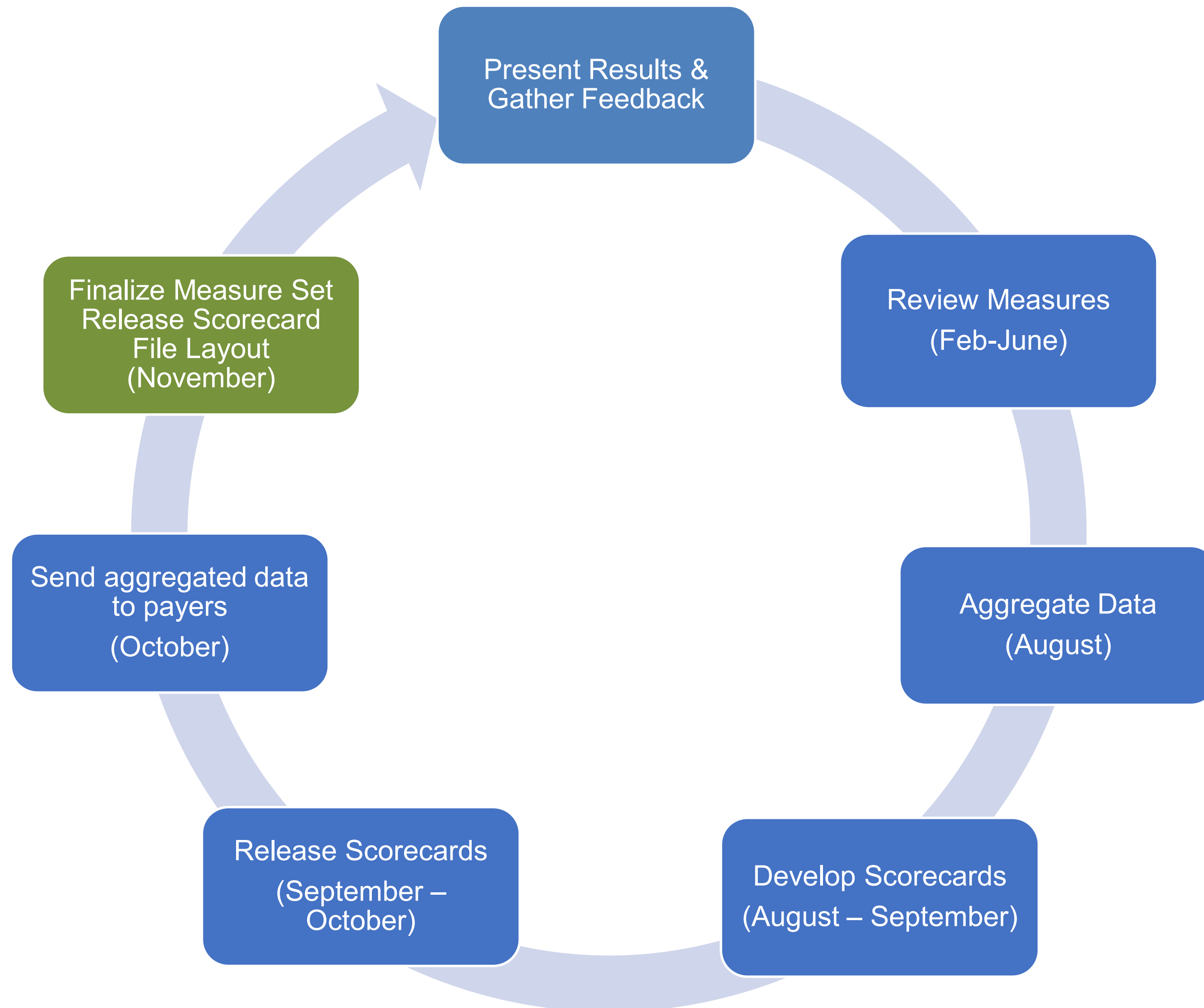


Path Towards Interim Solution

- Three Project Phases:

  - Pre Pilot testing (Summer 2016)
  - Pilot testing (Winter 2016)
  - Reporting (2017, 2018, 2019, *2020- ETA August*)

Annual Cycle



Annual Reporting:
Yearly and aligns with health plan reporting requirements to the state

Future Plans:
More frequent reporting may be possible when we are able to use data from the All Payer Database

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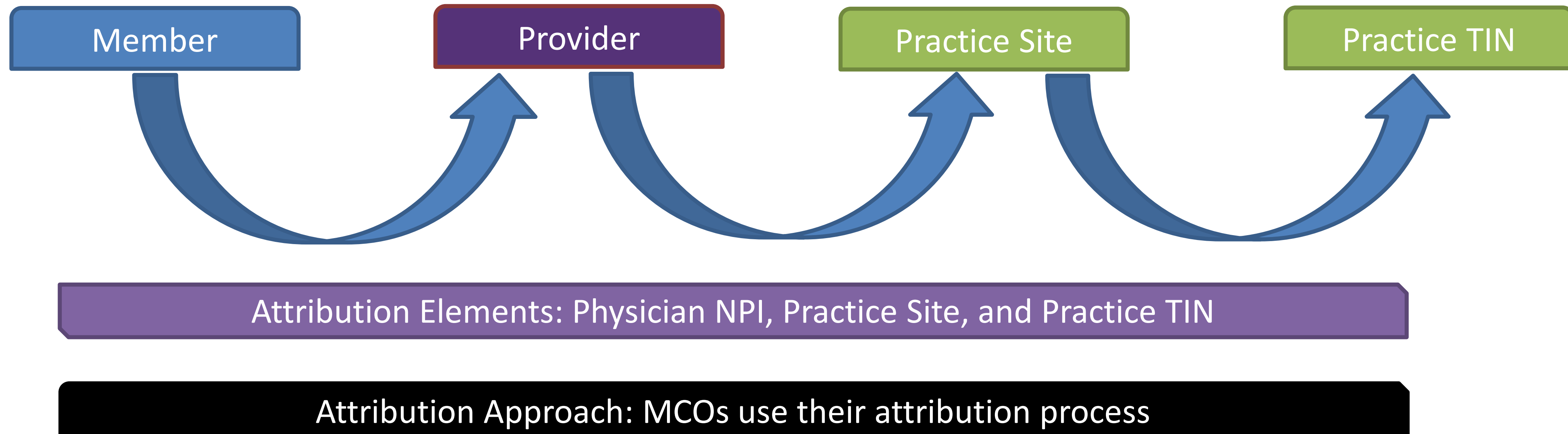
Patient Attribution Approach

- Practice TIN used to aggregate practices across health plans
  - Used to generate practice reports



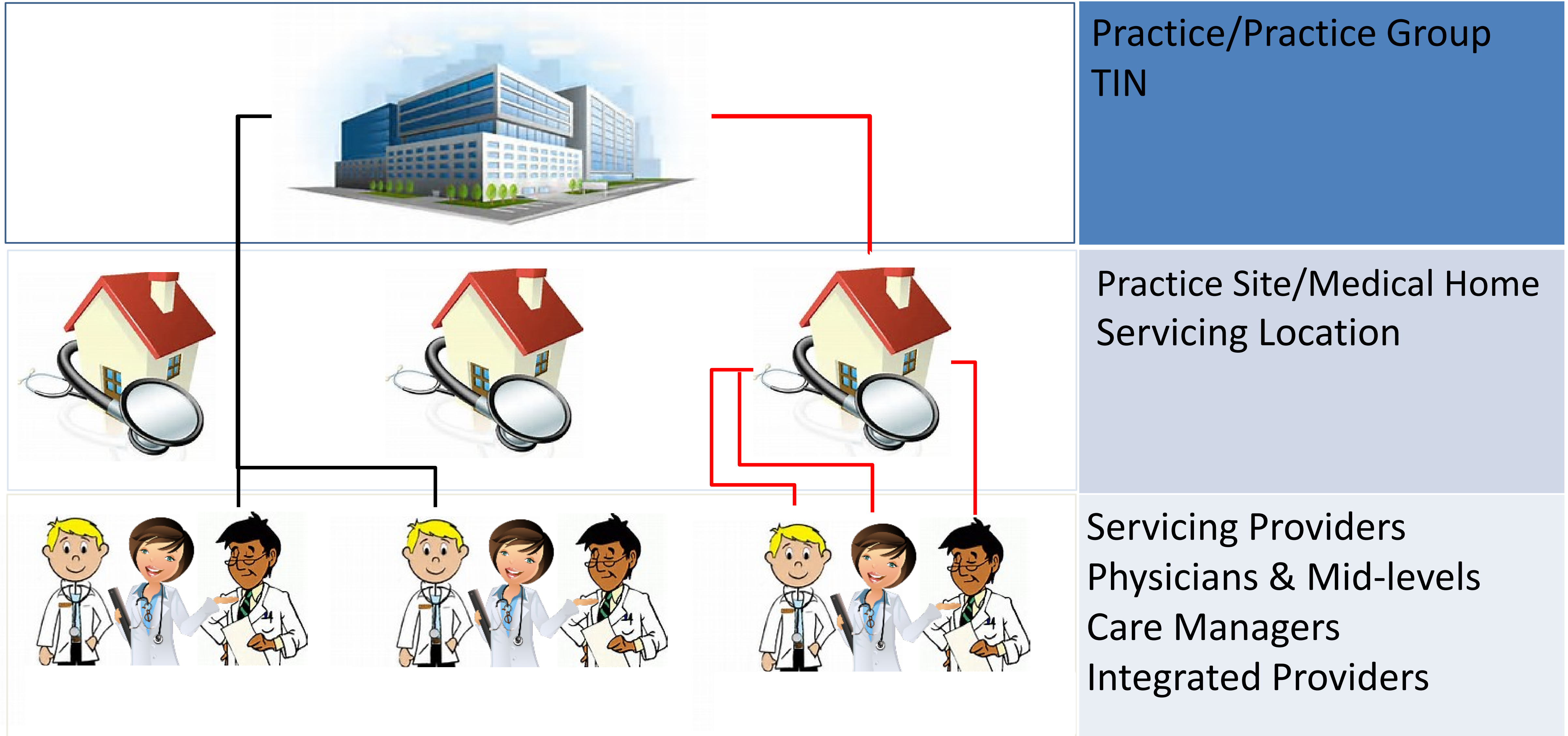
Defining Practice Site

Practice/Practice Group
TIN

Practice Site/Medical Home
Servicing Location

Servicing Providers
Physicians & Mid-levels
Care Managers
Integrated Providers

Practices and Providers easier to define than Practice Site



Practice Report Example

- Only practices having 2 measures with denominator ≥ 20 received results
  - Practices that not did fulfill criteria received benchmarks for informational purposes
- Table displays measure results grouped by domain with product line benchmarks corresponding to measure

Domain	Measure	Your Practice			Statewide Benchmarks		
		Numerator	Denominator	Result(%)	Commercial(%)	Medicaid(%)	Medicare(%)
Appropriate Use	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	26	79	33	32	35	25
	Use of Imaging Studies for Lower Back Pain	196	267	73	74	77	76

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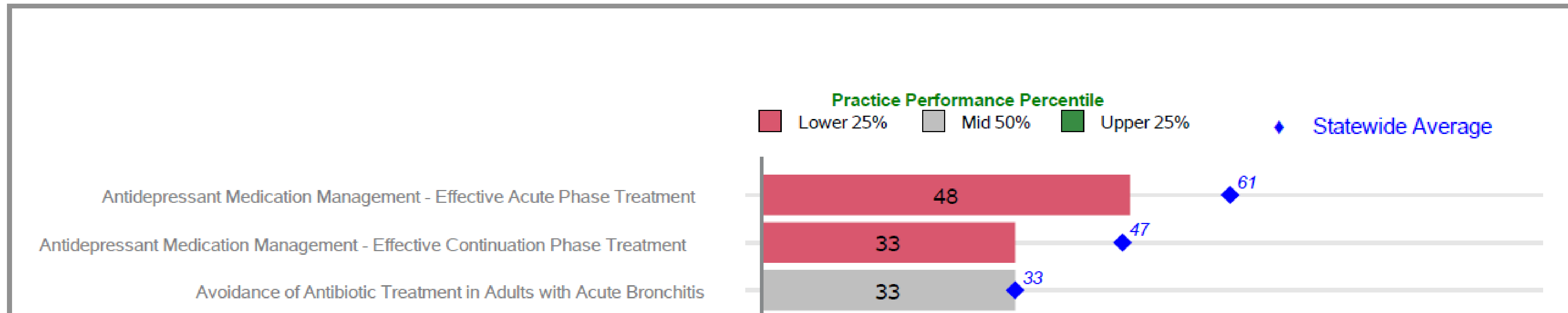
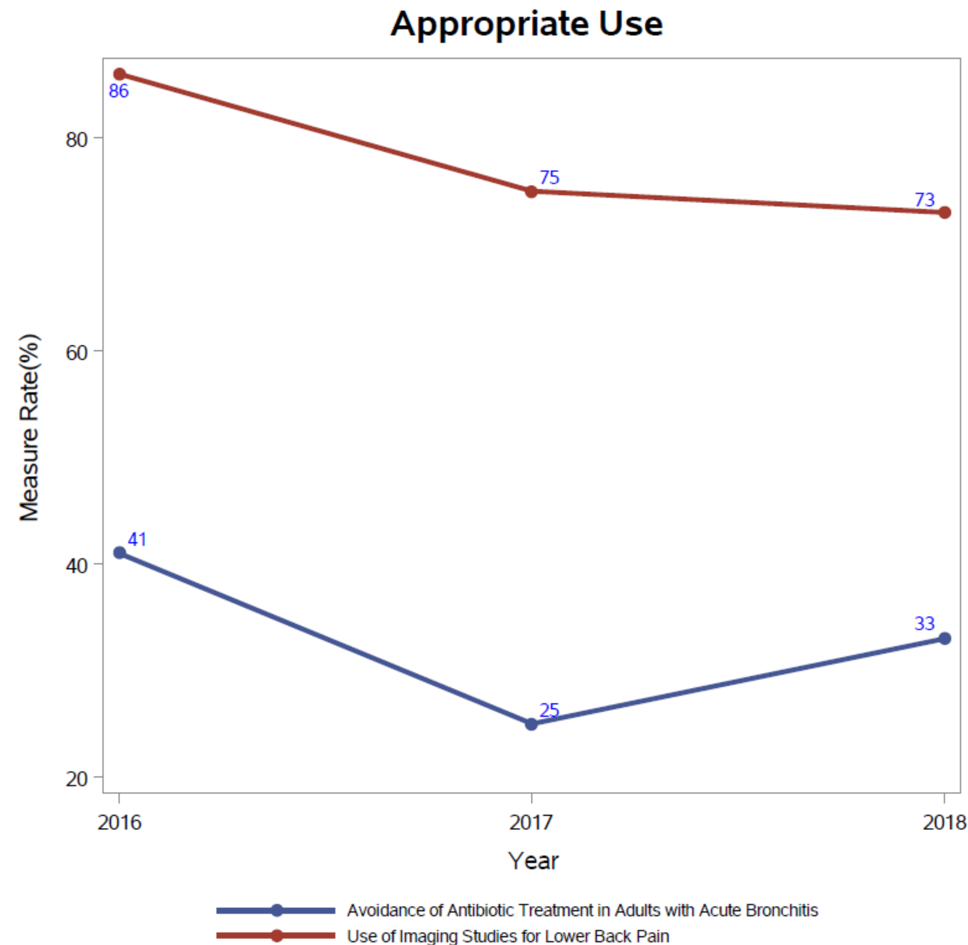
Practice Report Benchmarks

- Bar graph displaying practice results compared to the statewide benchmark
- Visual snapshot of performance



Practice Report Trending

- Line graph displaying practice results over time



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Future State HIT Enabled Quality Measurement

Objectives

Improve electronic clinical data quality to facilitate accurate quality measure calculation

Establish QEs as verified sources of ECDS & standard supplemental data

Facilitate provider and health plan use of timely, actionable data to inform clinical decision making

Guide health plans through their adoption of electronic reporting methodology

Enable NYSDOH reporting activities for specific populations and programs

QE: Qualified Entity, or regional health information organization, is a regional network where electronic health information is stored and shared.

Quality Measurement Pilot

This project seeks to:

- Demonstrate the QEs' potential as a source of high-quality clinical data to support NYSDOH's HIT-Enabled Quality Measurement Vision and ROMC participant's quality measure needs

This will be accomplished by:

- QEs generating quality measures for NYS PCMH practices
- QEs delivering high quality clinical data to health plans in support of the Primary Care Scorecard

All solutions should adhere to these guiding principles:

Timely performance feedback for practices	Files approved as standard supplemental data	ROMC participant needs drive the activities	Solutions are scalable

ROMC: Regional Oversight Management Committees which harness the expertise of healthcare delivery system members towards healthcare system transformation.

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Questions

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New York City Metro Payer Collaboration

Amy Tippett-Stangler, Senior Vice President, Northeast Business Group on Health

Robert LaPenna, Network Director for Payment Innovation Programs, Empire

NORTHEAST BUSINESS GROUP ON HEALTH

NYC Metro Area: Primary Care Core Measure Set

- Goal: align around a focused set of measures across payers and primary care practices
- Six health plans provided information about the measures they use most commonly for primary care payment models
- UHF Quality Institute prepared a crosswalk of core measures to these health plan measures
- Health plans agree on a subset of core measures to use as part of their payment models
- Health plans may have additional measures but would seek to prioritize shared measures in performance based payments

Domain	APC Core Measure[i]	NQF# / Developer	# of Payers Collecting	*Statewide Rate (APC)*	*Include in Measure Menu?*		
					Yes	*No*	*Not Sure*
Prevention	**Cervical Cancer Screening**	32/HEDIS	**5**	*74%*			
	Breast Cancer Screening	2372/HEDIS	**6**	*73%*			
	Colorectal Cancer Screening	34/HEDIS	**6**				
	Chlamydia Screening	33/HEDIS	**4**	*69%*			
	Childhood Immunization Status: Combo 3	38/HEDIS	**5**	*66%*			
Chronic Disease	**Controlling High Blood Pressure**	18/HEDIS	**3**				
	Diabetes: A1C Poor Control	59/HEDIS	**6**				
	Diabetes: Eye Exam	55/HEDIS	**6**	*56%*			
	Diabetes: Foot Exam	56/HEDIS	**1**				
	Diabetes: Medical Attention for Nephropathy	62/HEDIS	**6**	*91%*			
	Medication Management for People With Asthma	1799/HEDIS	**4**	*65%* *41%*			
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents AND BMI Screening and Follow-Up Plan (for Adults)	24/HEDIS 421/CMS	**1**				
Behavioral Health/ Substance Use	**Screening for Clinical Depression and Follow-up Plan**	418/CMS	**1**				
Appropriate use	**Plan All-Cause Readmissions**	1768/HEDIS	**3**				

Closing Remarks

Marcus Friedrich, MD, MHCM, MBA, FACP
Chief Medical Officer, Office of Quality and Patient Safety

Questions & Answers