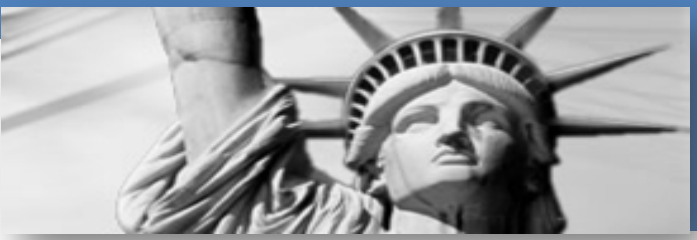


NEW YORK state department of HEALTH

Redesigning THE MEDICAID PROGRAM

New York Medicaid Redesign

Payment Reform & Quality Measurement Work Group

September 20th, 2011
Saratoga Conference Room
Frear Building
One Fulton Street
Troy, New York 12180

Dan Sisto, Co-Chair
Dr. William Streck, Co-Chair

MRT Payment Reform & Quality Measurement Work Group Members

Co-Chair: Dan Sisto, President, Healthcare Association of NYS	Co-Chair: William Streck, MD, Chair, NY State Public Health and Health Planning Council
Rick Abrams, Executive VP, Medical Society of the State of NY	**Phyllis Lantos**, Executive VP & CFO, NY Presbyterian Hospital
Elizabeth Benjamin, VP of Health Initiatives, Community Service Society	**Art Levin**, Director, Center for Medical Consumers
Scott Cooper, MD, President & CEO, St. Barnabas in the Bronx	**Joseph McDonald**, President & CEO, Catholic Health Services of Western NY
Michael Cropp, MD, President & CEO, Independent Health	**Joe Quagliata**, President & CEO, South Nassau Communities Hospital
Joanne Cunningham, HCA, President, Home Care Association of NYS	**Steven M. Safyer, MD**, President & CEO, Montefiore Medical Center
Emma DeVito, President & CEO, Village Care of NY	**Susan Stuard**, Executive Director, Taconic Health Information Network and Community
Paloma Izquierdo-Hernandez, MS, MPH, President & CEO, Urban Health Plan	**James R. Tallon, Jr.**, President, United Hospital Fund
Sneha Jacob, MD, MS, Assistant Professor of Clinical Medicine, Columbia University & Assistant Medical Director, NY Presbyterian System Select Health	**Pat Wang**, President & CEO, Healthfirst
James Knickman, President & CEO, NYS Health Foundation	**Marlene Zurack**, Senior VP, Finance, NYC Health and Hospitals Corporation
Ronda Kotelchuck, Executive Director, Primary Care Development Corporation	

Agenda

- Introductions
- MRT Progress Report
- Payment Reform & Quality Measurement Work Group: Charge, Goals & Principles
- Federal Budget Challenges
- Federal & State Innovative Payment Options
- Quality Indicators: Background
- Health Homes & ACOs
- Indigent Care/DSH
- Safety Net Providers
- Next Steps

MRT Progress Report

"It is of compelling public importance that the State conduct a fundamental restructuring of its Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control and a more efficient administrative structure." – Governor Andrew M. Cuomo, January 5, 2011

- On January 5, 2011, Governor Cuomo issued an Executive Order creating the Medicaid Redesign Team (MRT).

- The MRT was charged with uncovering ways to save money and improve quality within the Medicaid program.

- The MRT was asked to complete its charge in two phases.
  - Phase 1 – Address the current year budget situation
  - Phase 2 – Pursue comprehensive reform

Phase 1: Completed

- Developed a package of 79 reform proposals that achieved the Governor's Medicaid budget target.
  - Total Year 1 Budget Savings = $2.2 Billion (state share)
  - Total Year 2 Budget Savings = $3.3 Billion (state share)

- Introduced reform proposals that facilitate significant structural reforms that will bend the Medicaid cost curve.

- Achieved the savings without any cuts to eligibility. The plan does not eliminate any "options benefits".

Phase 2: Pursue Comprehensive Reform

- Develop a multi-year quality improvement/care management plan.
- Subdivide the MRT into 10 work groups.
- Assign work groups complex issues that were not addressed in Phase 1.
- Present recommendations to Governor Cuomo by December 2011.

Phase 2: Work Groups

- Managed Long Term Care Implementation and Waiver Redesign – In Progress
- Behavioral Health Reform – In Progress
- Program Streamlining and State/Local Responsibilities – In Progress

- **Health Systems Redesign – Brooklyn – Newly Launched**
- **Payment Reform & Quality Measurement – Newly Launched**
- **Basic Benefit Review – Newly Launched**
- **Health Disparities – Newly Launched**
  - Affordable Housing
  - Medical Malpractice Reform
  - Workforce Flexibility & Change of Scope of Practice

Phase 2: Work Group Timeline

September / October

- October 5th: Full MRT meeting (Albany); lay out revised timeline, staff provide updates on Global Cap implementation, process, new membership, etc. Work group co-chairs to provide brief work group updates.
- October 15th: First wave of final work group recommendations due (Behavioral Health Reform, Program Streamlining & State/Local Responsibilities, MTLC Implementation & Waiver Redesign).

November

- On or around November 1st: MRT meeting (NYC); MRT will vote on wave 1 work group recommendations.
- November 1st: Second wave of final work group recommendations due (Health Disparities, Payment Reform & Quality Measurement, Basic Benefit Review, Health Systems Redesign - Brooklyn).
- November 15th: Third wave of final work group recommendations due (Medical Malpractice Reform, Affordable Housing, Workforce Flexibility/Change of Scope of Practice).

December / January

- On or around December 1st: MRT meeting (Albany); MRT will vote on wave 2 & 3 work group recommendations.
- December 31st: Report submitted to Governor with MRT recommendations.
- Mid-January 2012: Governor Cuomo's Executive Budget proposal released.

Payment Reform & Quality Measurement Work Group: Charge, Goals & Principles

"It is not the strongest who survive, or the fastest. It is the ones who can change the quickest."

Charles Darwin
"On The Origin of Species"

MRT Payment Reform & Quality Measurement Work Group: Charge

- Develop a series of payment reform and quality measurement recommendations to facilitate the transformation of our health care system.

MRT Payment Reform & Quality Measurement Work Group: Goals

- Focused Activities:
  - Recommend how New York State can encourage the development of innovative payment and delivery models.
  - Explore and identify evidence-based quality indicators to benchmark New York's Medicaid program and the provider delivery system.
  - Explore issues in the New York State Disproportionate Share Program (DSH) and related indigent care funding mechanisms.
  - Consider criteria that can be used to identify "safety net" providers, and the implications of such a designation on local planning, financing, care delivery and oversight.

- Time permitting, the Work Group may also assess the implications of the product of other MRT Work Groups on:
  - Payment for workforce education, including graduate medical education
  - Workforce shortages
  - IT investment
  - Opportunities for access to capital financing

General Guiding Principles (A Work in Progress…)

Innovative payment models & quality initiatives should:

- Be transparent, fair & stimulate broad participation by providers & payers.
- Promote high value quality driven health care services in the proper setting.
- Create opportunities for both payers & providers to share savings generated if established benchmarks are achieved.
- Create opportunities for stronger collaboration & goal sharing with Medicare & other payers.
- Be scalable & flexible to allow all providers & communities (regardless of size) to participate.
- Advance other MRT objectives including placing all Medicaid patients into a care management setting within 3 years.
- Reinforce health system planning and preserve Medicaid safety net providers/care.
- Re-align legal, regulatory and financial barriers to be consistent with reform objectives.
- Allow for flexible multi-year phase in of reform initiatives due to additional systems requirements (i.e., IT).
- Enable the alignment of quality measures with policy goals.

General Guiding Principles (A Work in Progress…)

Quality measures should:

- Be based on a standard of care or evidence-based science. Pay-for-performance incentives or penalties must rely on measures that are supported by an evidence-base.
- Promote payment approaches that provide due consideration for positive incentives and align with state and federal policies.
- Accurately identify those aspects of care that are under the health care organization's control and be appropriately risk-adjusted to reflect factors influencing outcomes that are beyond the control of providers.
- Be risk-adjusted where appropriate when used for provider comparisons. Providers should be incentivized for improvement over time versus comparison with other organizations.
- Align and incentivize provider responsibilities across the continuum.
- Promote patient participation and responsibility in health care decision-making.
- Be based on data that is linked across time, place, and setting and be available for provider use in evaluating and managing patient care and services.

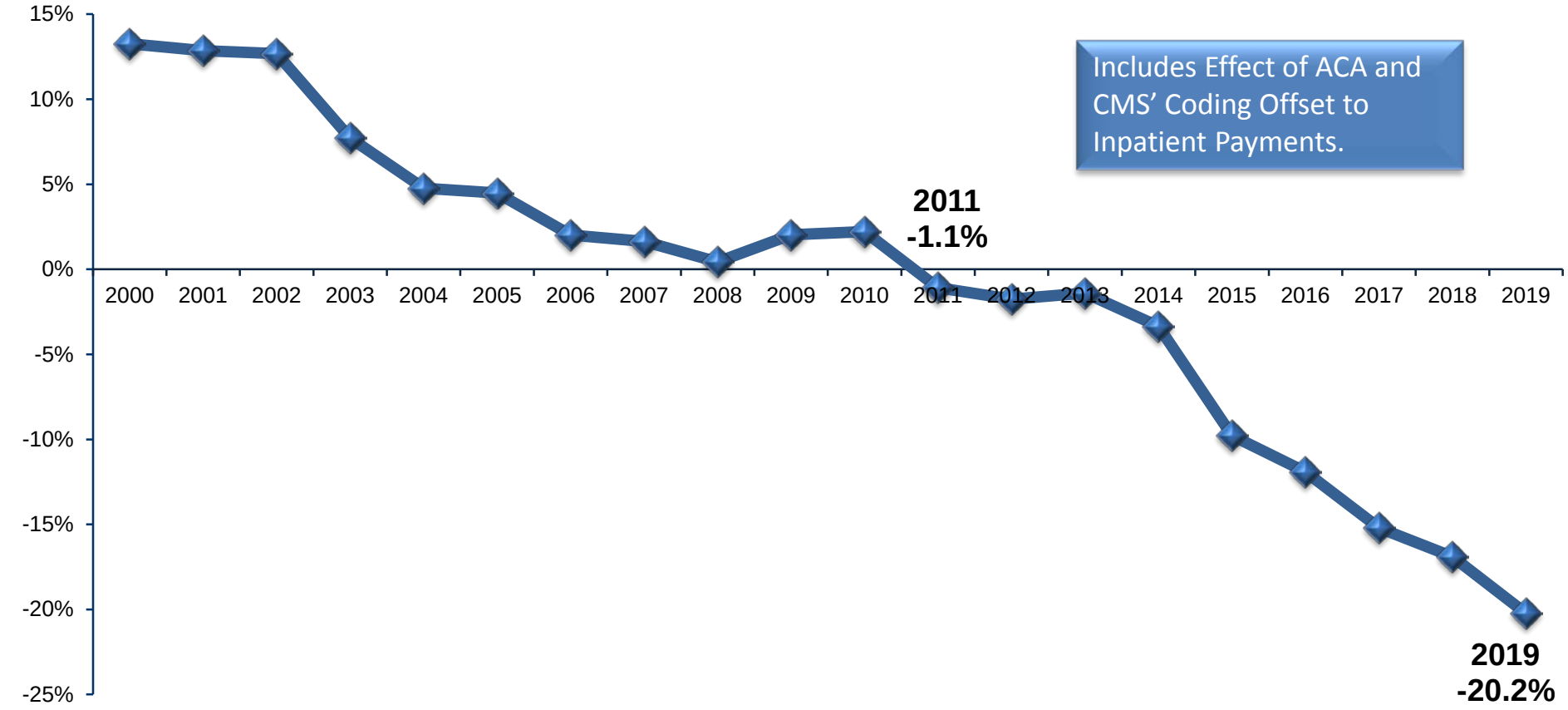
Federal Budget Challenges

The Federal Squeeze

Federal Payment Reductions

- Affordable Care Act (ACA) mandates
  - Medicare rate update reductions for hospitals, skilled nursing facilities and home care agencies
  - Medicare and Medicaid disproportionate share hospital reductions
  - Medicare home care cuts
  - Medicare readmission penalties
- Additional administrative reductions
  - Medicare coding reductions for hospitals, skilled nursing facilities and home care agencies
- As a result, providers will experience decreases in Medicare payments that will compound over the next 10 years
  - $15 billion in reductions to New York providers over 10 years

The ACA's Effect on New York Hospitals' Medicare Management



Note: *This chart reflects the estimated changes in Medicare revenues and costs over time. Hospitals' overall financial performance will also be impacted by changes to revenues and costs for non-Medicare payers, including the positive revenue impact (beginning in FFY 2014) due to expanded health insurance coverage under the ACA. Please note that these margins exclude impacts on Medicaid DSH payments.*

Sources: *CMS' 2000-2009 HCRIS data, the CMS FFY 2011 IPPS Impact File, the 2008 MedPAR database, and national ACA estimates as provided by the CBO. Does not include benefit from people being insured.*

Federal Debt Ceiling/Deficit Reduction Update

- Phase 1: Providers were spared in this phase of the deficit reduction deal.

- Phase 2:
  - A congressional select commission was established to recommend up to $1.5 trillion in cuts over 10 years.
    - All programs including Medicare and Medicaid subject to cuts
  - If Congress fails to act on the recommendations, 10 years of mandatory across-the-board cuts are triggered.
    - Medicare provider cuts are capped at 2% of program spending ($3 billion for NY over 10 years)
    - Medicaid exempt from cuts

Select Committee Reduction Options

(based on prior deficit reduction plans)

- **Medicare Provider Cuts:**
  - GME cuts (up to $13 billion for NY over 10 years)
  - Bad debt cuts ($400 million for NY over 10 years)

- **Medicaid Reductions:**
  - FMAP reconfiguration and cut (over $100 billion nationwide over 10 years; NY impact unknown)
  - Provider tax cut ($18-$44 billion nationwide; up to $3.6 billion for NY annually)

Medicare Recovery Audit Contractor

Status Update: Audits Continue

- Frequent medical necessity reviews
- Record requests increased from 300 to 500
  - This affects providers with over $100 million in Medicare revenue.
  - Congress authorized this increase because RACs are not returning enough money.
  - From October of 2009 through June of 2011 (7 quarters), RACs collected $575 million in overpayments nationwide for the Medicare Trust Fund and returned $109 million in underpayments to providers.
- Periodic Interim Payment Hospitals not excluded from review
- 11% interest penalty if appeals are unsuccessful

Federal & State
Innovative Payment Options

Centers for Medicare & Medicaid Innovation (CMMI)

- Congress created the CMMI under section 3021 of the Affordable Care Act.
- Goal: Test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care for those who get Medicare, Medicaid or CHIP benefits.
- CMMI will allocate $10 billion over 10 years nationwide to fund testing of innovative care delivery models.
- Current initiatives:
  - Medicare Pioneer ACOs
  - Medicare Bundled Payments for Care Initiative

Innovative Payment Models

Bundling

Gainsharing

Shared Savings

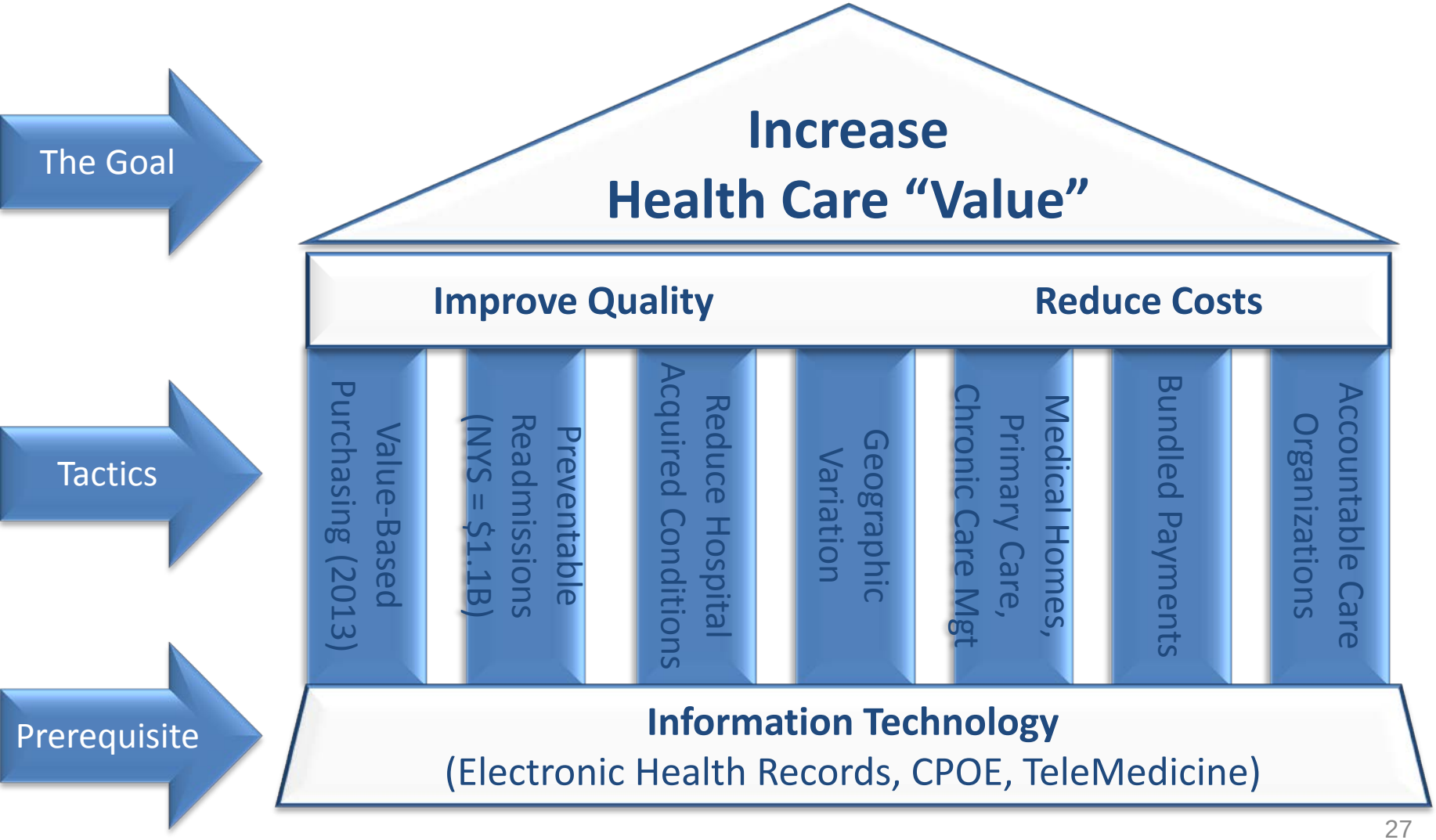
Patient Centered Medical Home

Health Homes

Accountable Care Organizations

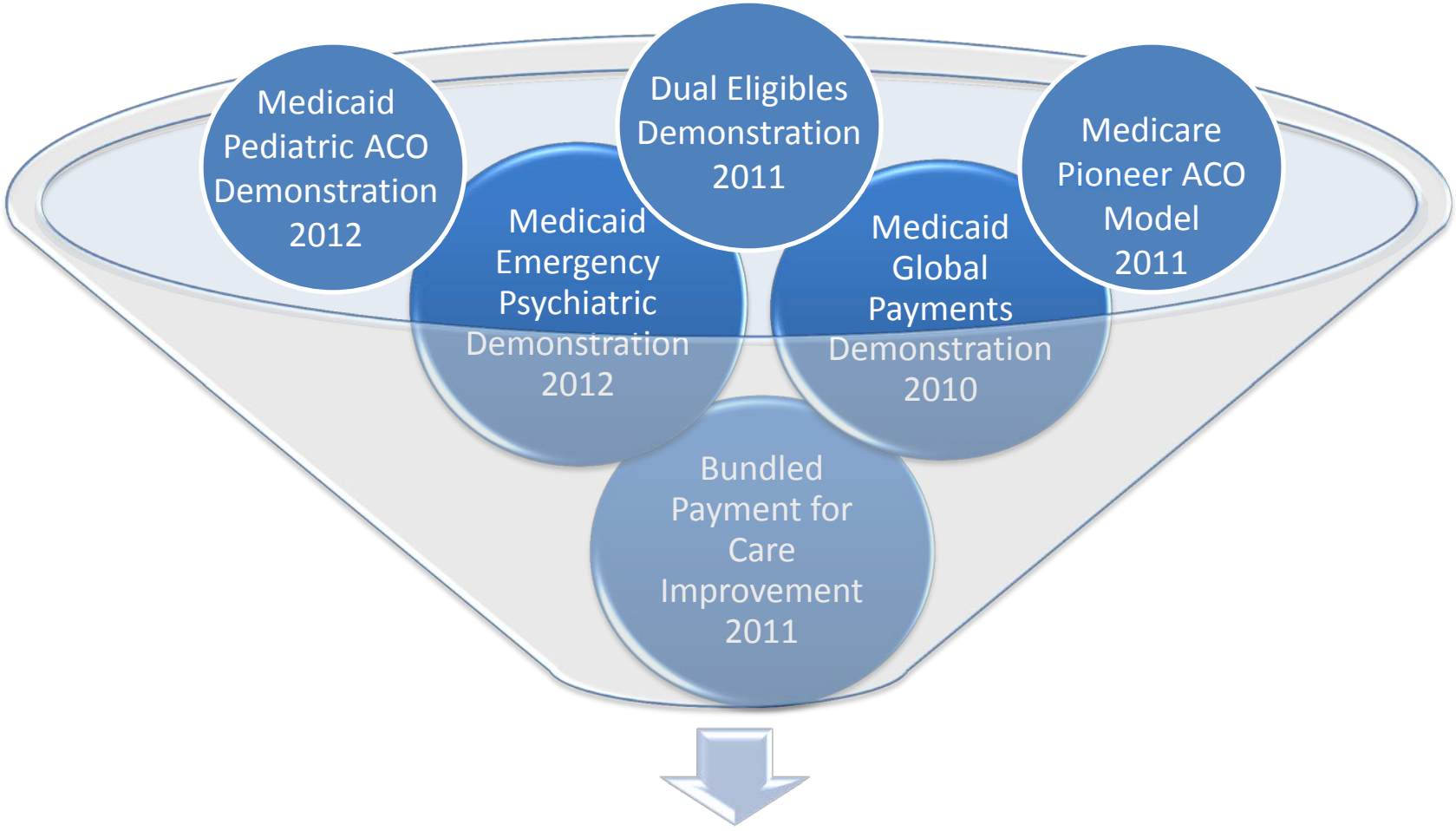
Clinical Integration

Builds Health Care Delivery System Reform



Source: HFMA-Modified

Federal Demonstrations



Better Health Care Delivery & Reduced Costs

CMS Models to Share Savings with States

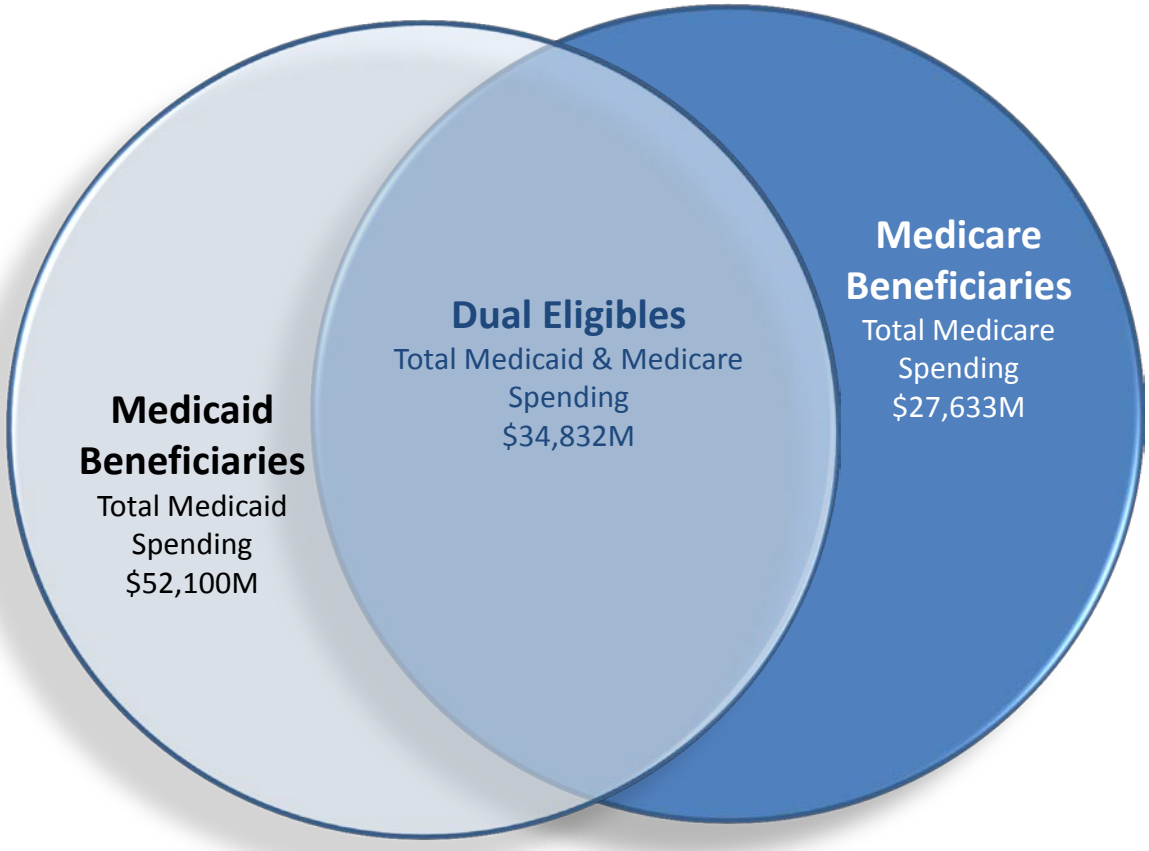
Managed Care:

- States can add a contract and receive a blended capitated rate for the full continuum of benefits provided to Medicare – Medicaid enrollees across both programs.
- The capitated model will target aggregate savings through actuarially developed blended rates that will provide savings for both states and the federal government.
- Plans are required to meet quality thresholds.

Fee-for-Service:

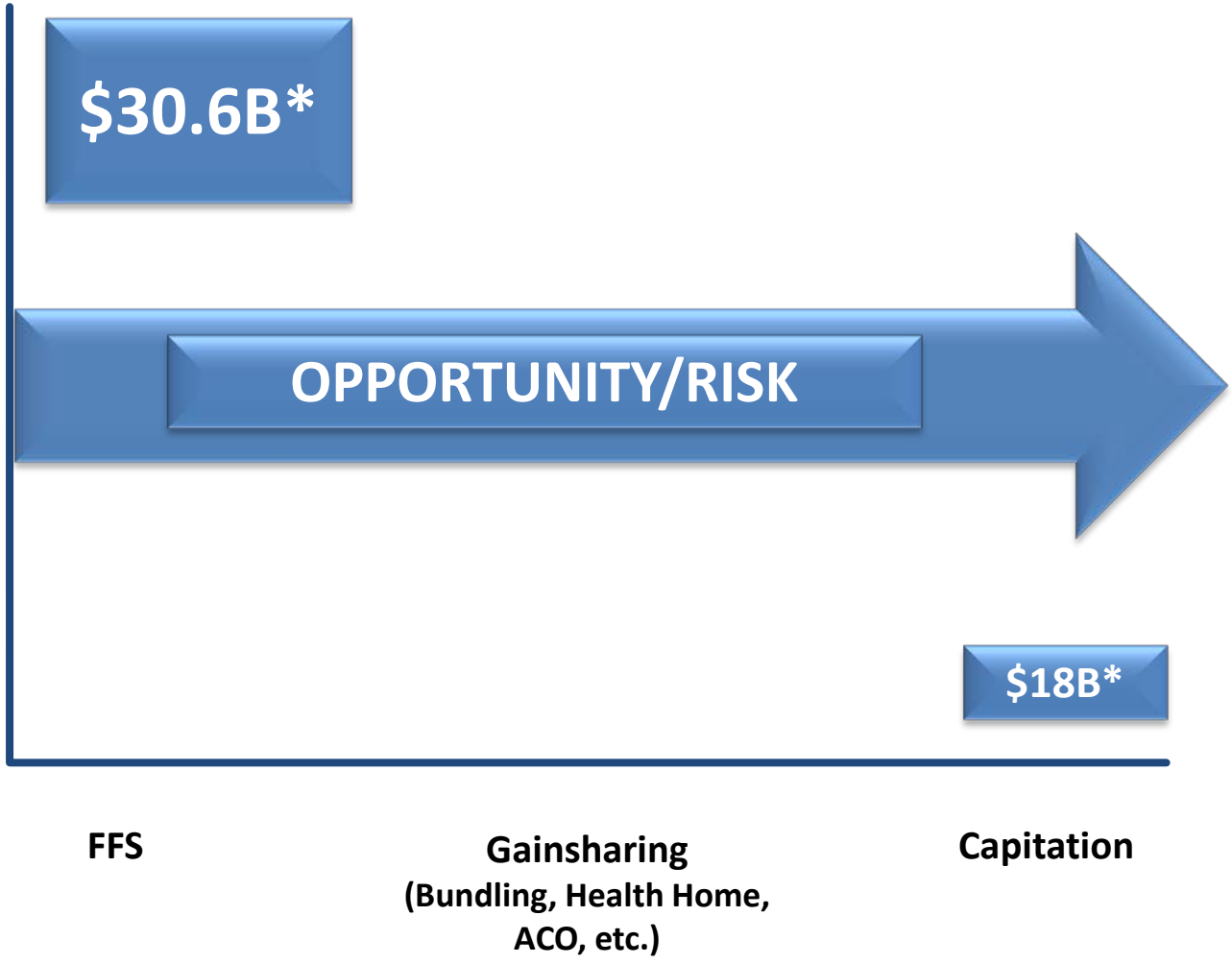
- Retrospective performance payment to states based on Medicare savings achieved for Medicare-Medicaid enrollees.

Dual Eligible Recipients (700,000 approx.)
Comprises 45.00% of Medicaid Spending ($52.1B)
Comprises 41.21% of Medicare Spending ($27.6B)



Sources: Medicare – National health expenditure data (2004) trended by Medicare market basket to 2010; Medicaid – United Hospital Fund (2010) data net administration costs; Duals – Kaiser (2005) data trended by market basket to 2010 & Kaiser (2007) dual eligibles share percentage (45%) applied to 2010 Medicaid spending estimate. Note: DOH is in the process o working with CMS to update data.

MRT Will Provide Opportunities for Shared Savings & to Shift Risks to Plans/Providers Over the Next 3 Years



*Source: Medicaid claims data from the Salient Tool (SFY 2010-11): Managed Care: $18 billion & FFS: $30.6 billion. MMC (including Family Health Plus) includes drug spending that currently occurs in the FFS system. Excludes off-line payments such as DSH.

New York MRT Reform Options

- Authorizes the Commissioner to engage in supervision and administrative actions necessary to promote state action immunity under state and federal anti-trust laws.
- DOH may issue regulations providing standards for determining which collaborations, integrations, mergers or acquisitions shall be covered.

State Action Immunity & Supervision

- DOH is authorized to approve up to seven ACO demonstrations prior to December 31, 2015.
- DOH will issue regulations to establish criteria for certificates of authority, quality standards and reporting requirements.

Medicaid ACO Demonstration

- Provider has met quality & reporting requirements.
- Annual aggregate expenses + Medicaid care coordination fee (MCCF) is below 85% of CG expenditures + annual aggregate MCCF.
- $6 million pool each for contract years 2 & 3.
- Shared savings reimbursed up to 50% of the funds available in the pool.
- Total cost savings exceed the pool – reimbursement weighted by % of total CIDP savings for each CIDP.

Chronic Illness Demonstration Project Model

New York MRT Reform Options

Patient Centered Medical Home (PCMH)

- Incentive for Article 28 clinics and physicians to establish PCMHs that meet NCQA standards.
- Provides enhanced Medicaid rate for primary care services to Medicaid fee-for-service and managed care beneficiaries.
- There are 3,800 recognized providers as of 6/30.
  - *Significantly higher than any other state*
  - *60%are level 3 recognized*
- Almost 900,000 Medicaid members received primary care in a medical home.
  - *1/3 of all enrollees*

Multi-Payer PCMH

- Commissioner may establish voluntary multi-payer PCMH programs.
- May develop methodologies to pay additional amounts to providers that meet process or outcomes standards.
- May test alternatives including global payments and pay-for-performance.
- Adirondack Medical Home Demonstration Project is included.

New York MRT Reform Options

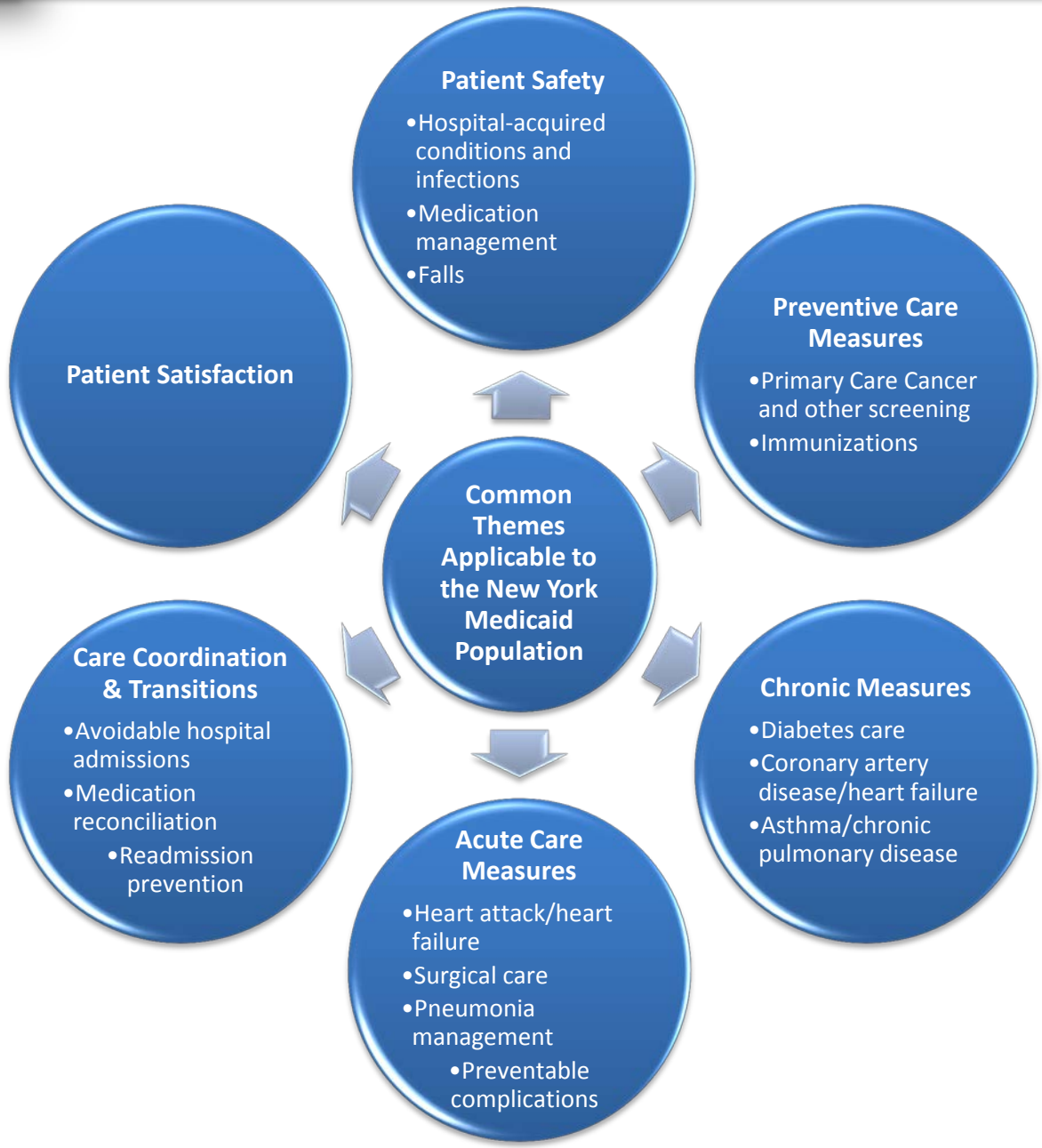
- Funds for states (90% FMAP) to enroll Medicaid beneficiaries with two or more chronic conditions, including serious mental illness or substance use disorders, in health homes.
- Targets high cost Medicaid enrollees with complex medical, behavioral and long-term care needs.
- Provides financial incentives to meet quality measures.
- Expect launch of Medicaid Health Home program in the Fall of 2011.

Medicaid Health Home

- Clinical integration programs will increase the ability of hospitals and physicians to work together and be responsible for an entire episode of care or population of patients.
- Enables hospitals and physicians to better evaluate their performance, thereby leading to measurable improvements in outcomes and sustainable cost control in physician practices and hospital care.
- Work with providers to develop clinical integration demonstrations.

Clinical Integration

Quality Indicators


Patient Safety
•Hospital-acquired conditions and infections
•Medication management
•Falls
Preventive Care Measures
•Primary Care Cancer and other screening
•Immunizations
Chronic Measures
•Diabetes care
•Coronary artery disease/heart failure
•Asthma/chronic pulmonary disease
Acute Care Measures
•Heart attack/heart failure
•Surgical care
•Pneumonia management
•Preventable complications
Care Coordination & Transitions
•Avoidable hospital admissions
•Medication reconciliation
•Readmission prevention
Patient Satisfaction
Common Themes Applicable to the New York Medicaid Population

Current Quality Measures

Agency	Provider	Measure Number	Measure Type
Centers for Medicare & Medicaid Services	Hospital Inpatient	•55 measures •Most are all-payer •Chart & claims extracted – moving to electronic measures •Validated	AMI, CHF, surgical care, mortality, readmissions, AHRQ patient safety, complications, VTE, stroke, emergency department, patient experience, immunization, cost efficiency
Centers for Medicare & Medicaid Services	Hospital Outpatient	•33 measures •Most are all-payer •Chart & claims extracted- moving to electronic •Validated	AMI, surgical care, emergency department, imaging, diabetes
New York State Department of Health	Hospitals	•Variety of types and sources	NYPORTS, stroke, cardiac surgery, PCI, perinatal, nursing- sensitive, infections, complications, readmissions, potentially avoidable admissions, serious adverse events, and registries for communicable diseases, cancer, trauma, lung

Current Quality Measures

Agency	Provider	Measure Number	Measure Type
Centers for Medicare & Medicaid Services Physician Quality Reporting Initiative (PQRI)	Physician Offices/ Clinics	•Eligible providers must report on at least 3 of 240 measures for incentives • Will be incorporated into physician VBP in 2015.	Disease management, heart failure, coronary artery disease, surgical safety, preventative screening, medications, pulmonary disease, asthma, cancer, communicable diseases, depression
Healthcare Effectiveness Data and Information Set (HEDIS)	Health Plans	•75 measures across 8 domains	Health screening, pulmonary disease, asthma, disease mgmt, immunizations, access, substance abuse, patient experience, falls, drug interactions, behavioral health

Quality Measurement in Medicaid

- New York has a well-established system to monitor quality of care called the Quality Assurance Reporting Requirements (QARR). Over time, measures have evolved from preventive care to measures of chronic care and outcomes.
  - Based on the national measurement set (HEDIS)
  - Measures have been collected over 15 years
  - Multi-payer – includes Medicaid, Child Health Plus, commercial HMO and commercial PPO

- Since 2001, a managed care pay for performance program has been a driver of improved care and has focused on quality and patient satisfaction measures.

Measurement Domains in QARR

Child and Adolescent Health (15)	Women's Health (9)
Chronic Care Managing Acute Illness (6) Managing Preventive Care (4) Managing Cardiovascular Conditions (3) Managing Respiratory Conditions (6) Managing Diabetes Care (9) Managing Medications (7) Managing HIV / AIDS (3)	Behavioral Health (4)
	Patient Satisfaction (10)
	Provider Network (7)
	Access to Care (7)
	Utilization (4)
	Preventive Quality Indicators (2)

Measurements in Development

Efficiency Measurements

- **Preventable Hospitalizations**
- **Potentially Preventable Readmissions**
- **Potentially Preventable Conditions**

Quality Measurements

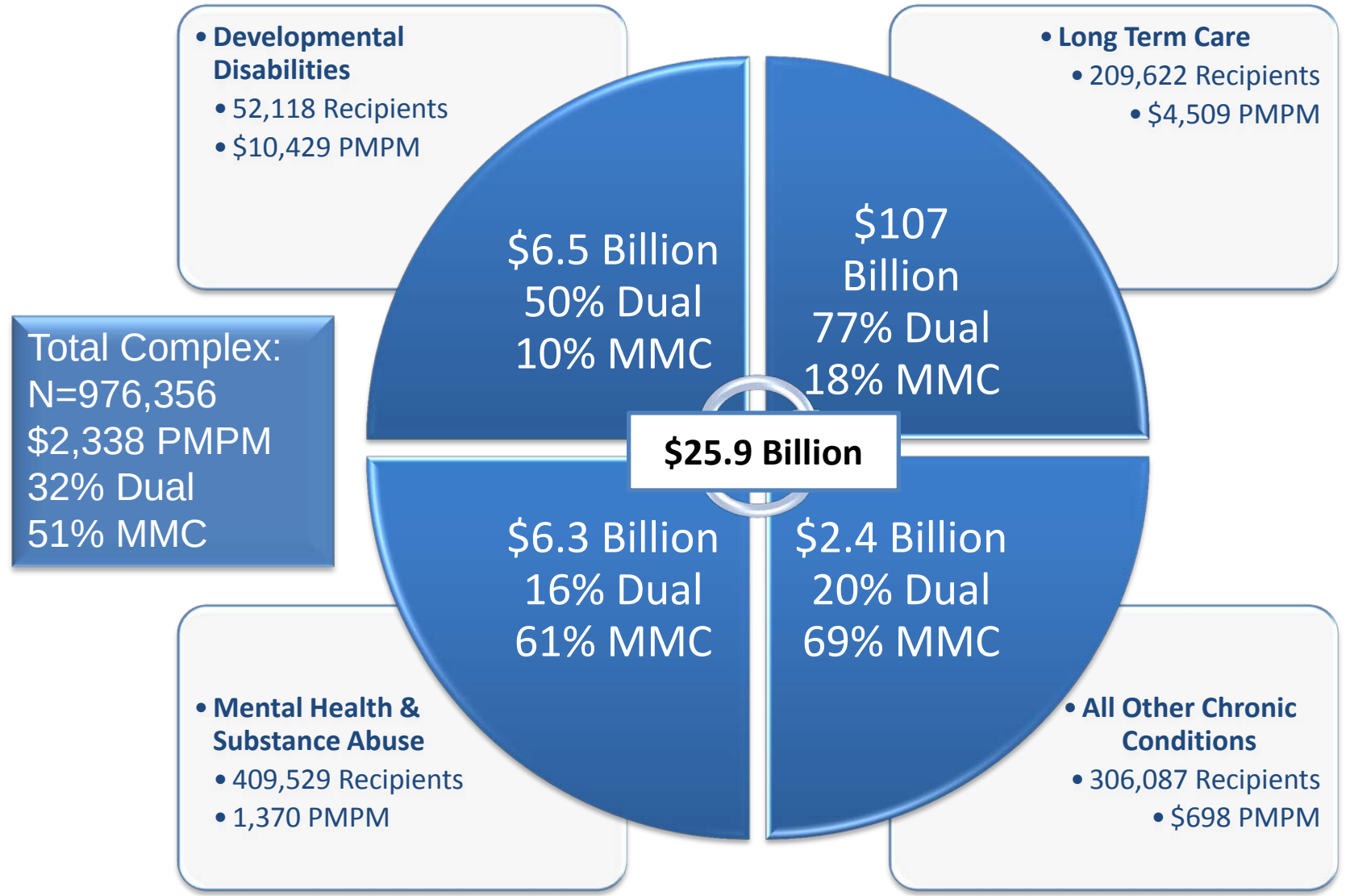
- **Mental Health/Substance Abuse**
  - Early stages of measurement development with OMH
- **Long Term Care**
  - In 2012, public release of a Managed LTC Quality Report
  - Intend to align measures across LTC settings
  - UAS will be the future basis for most LTC measures

Health Homes

Health Homes: What is a health home?

"The goal in building 'health homes' will be to expand the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses." - *CMS Medicaid Director Letter*

Health Home Populations



Proposed Quality Measures for Health Homes

** Many of these measures are targeted at reducing cost.*

Health Homes: Payment

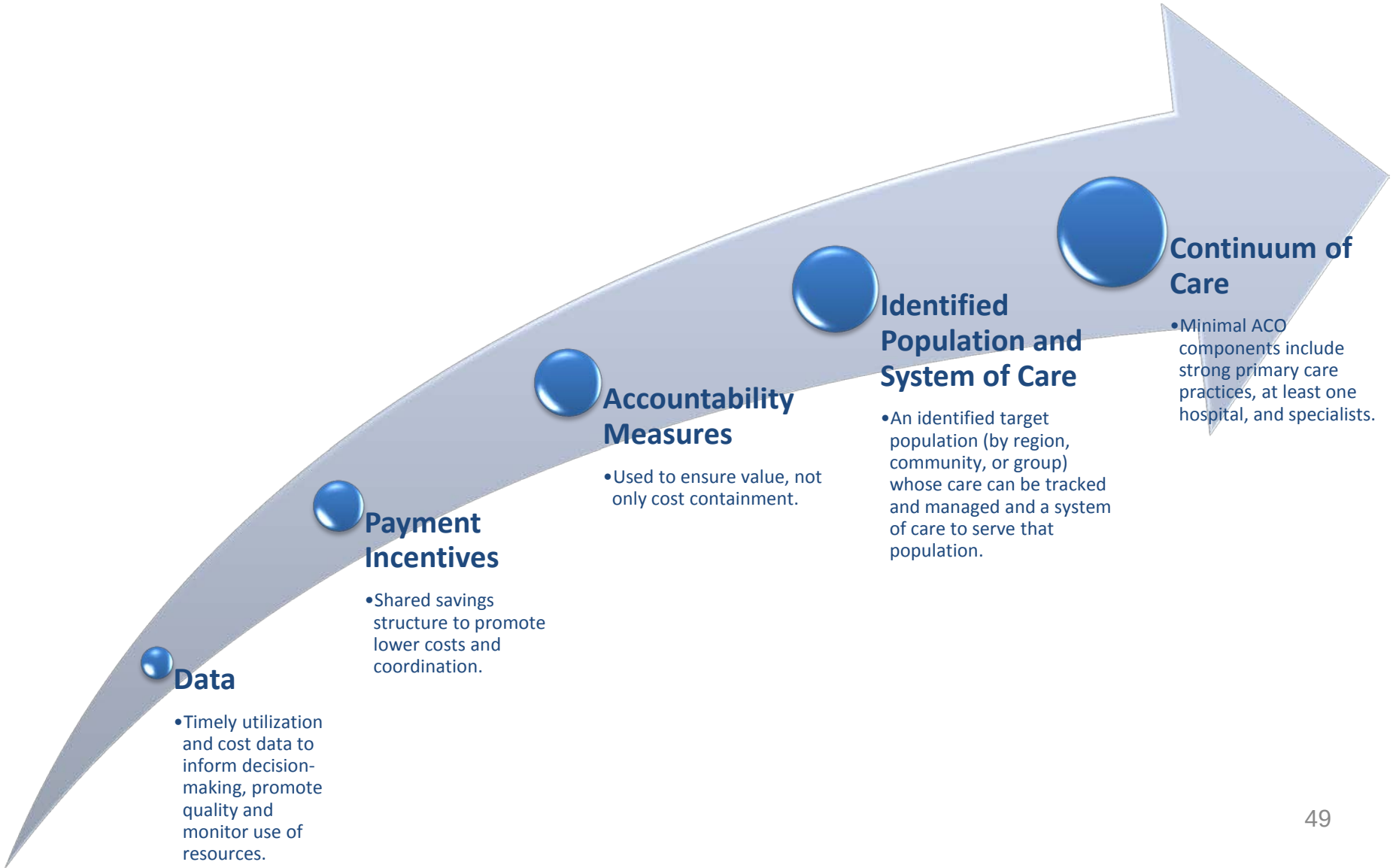
- PMPM care management fee that is adjusted based on:
  - Region
  - Case Mix (from Clinical Risk Group (CRG) method)
  - Fee will eventually be adjusted (after the data is available) on patient functional status
- A lower fee (80% of full fee) may be paid during outreach and engagement.
- A portion of the fee may be retained (10%) against achievement of core quality measures.
- Gainsharing on federal share of both Medicaid and Medicare is under discussion with CMS.

Health Homes: A Step Toward Integrated Care and Consolidated Accountability

Health homes provide a platform from which to study cost effective care management and network management design (including promising HIE models) – perhaps a precursor to ACO-type relationships with advanced provider networks to share risk and reward.

ACOs

State Role in the Development of ACOs



Other Innovative ACO Approaches

Name	Payment Measures	Quality Measures
Brookings-Dartmouth	•3 potential incentive pools for distribution •Shared savings to offset lost revenue due to change in practice patterns •Shared savings for cost savings •Incentive pool for return of capital to the principle ACO investors	•Phase in of performance measurement to align with access to multiple data sources so that ACOs with a "basic" health IT infrastructure are phased in a different rate than ACOs with an "advanced" health IT infrastructure •**4 categories of quality measures**: care effectiveness/population health, safety, patient engagement, overuse/efficiency •Measures based on widely accepted and endorsed measures •Performance benchmarks to be met in order to earn points and become eligible for shared savings
Maryland	•**Payers**: 5 commercial plans, self-insured, Medicaid; starting April 1, 2011 •**Fixed PPPM Payment**: •Shared savings 30-50% relative to a practice's historical baseline •Quality requirements separated into two groups: quality measures and utilization •Implemented as part of state's PCMH pilot in April 2011	•**Requirements**: 21 quality measures and 4 utilization reduction measures •Phase in over 3 years from reporting only to meeting measures •Requirements different for pediatric and adult practices

Other Innovative ACO Approaches

Name	Payment Measures	Quality Measures
Massachusetts	•**Global Payment**: Blue Cross Blue Shield to cover all of the services and costs: hospital inpatient, outpatient, pharmacy & behavioral health •Based on risk adjusted average medical expense in geographic region •Performance incentive based on aggregate performance across the set of ambulatory and hospital performance measures	•**Requirements**: 32 ambulatory measures and 32 hospital inpatient measures •**3 categories of quality measures**: processes, outcomes, patient experience •Each measure has designated performance thresholds ranging from low to high •Scores for all measures are weighted and summed to a total score
Vermont	•Multi-payer collaborative shared savings ACO pilot January 2012 •Primary care/physician based •Negotiated per capita benchmark based on its current provider contracts •Participation and shared savings models •May require medical home as the ACO center	•National Committee for Quality Assurance guidelines

Disproportionate Share Program (DSH)
(New Yorker's Indigent Care)

DSH: Current Federal Medicaid Allotment

FFY 2010-11 DSH Allotment:

- Total Federal = $11.0 billion
- NYS $ Share = $1.6 billion
  - $3.2 billion gross spending
- NYS % share = 14.2%

Note: All amounts shown are expressed in federal share dollars (50% of total), except as noted. The FFY 2011-2012 DSH Allotment is the same as the FFY 2010-2011 DSH Allotment.

SFY 2011-12 Projected Statewide DSH Allocations (Gross Spending in Millions)

	Voluntary Hospitals	Public Hospitals	Total
*Indigent Care Pool (192 hospitals)	$656	$139	$795
Indigent Care Adjustment (Federal/Local Funding) (21 hospitals)	$0	$412	$412
Public Hospital DSH IGT (Federal/Local Funding) (24 hospitals)	$0	$1,369	$1,369
OMH Psych Hospital (25 state operated hospitals)	$0	$605	$605
OMH & OASAS Voluntary Hospital DSH (63 hospitals)	$60	$0	$60
Total	$716	$2,525	$3,241

* Indigent Care Pool allocations of $1,182.5M are reduced by the Voluntary Hospital UPL payment of $387.2M, resulting in a Net Pool Allocation of $795.3M.

Current Indigent Care Methodology and Funding

$1,182.5M in Total Funds

$395.2 Based on Uninsured Allocations*, $787.3 based on "Other" Allocations

** $310.5M of the $395.2M is targeted to specific groups of hospitals*

$765M: PHL 2807-k

Major Public Distribution: **$139.3M**

($125.4M distribution based on 1996 allocation; $13.9M based on uninsured units x MA rates)

Voluntary High Need: **$32.4M**

(Distribution based on BDCC targeted need > 4% of costs)

Voluntary Distribution: **$593.3M**

($530.7M distribution on BDCC targeted need; $62.6M on uninsured units x MA rates)

$82M: PHL 2807-w

Rural Hospitals Distributions: **$32.3M**

($126K grants + BDCC based upon bed size and need statistic)

Supplemental Voluntary High Need: **$32.4M**

(Distribution based on BDCC targeted need > 4% of costs)

Supplemental Voluntary Distribution: **$17.3M**

($9.1M distribution on BDCC targeted need; $8.2M on uninsured units x MA rates)

$335.5M: PHL 2807-k (5-b)

Voluntary Teaching Regional Distributions:

$269.5M

(Based on 2007 unmet need - uninsured units x MA rate less hospital share of $847M allocation)

Voluntary High MA Safety Net: **$25M**

(Uncompensated care based on uninsured units x MA rates)

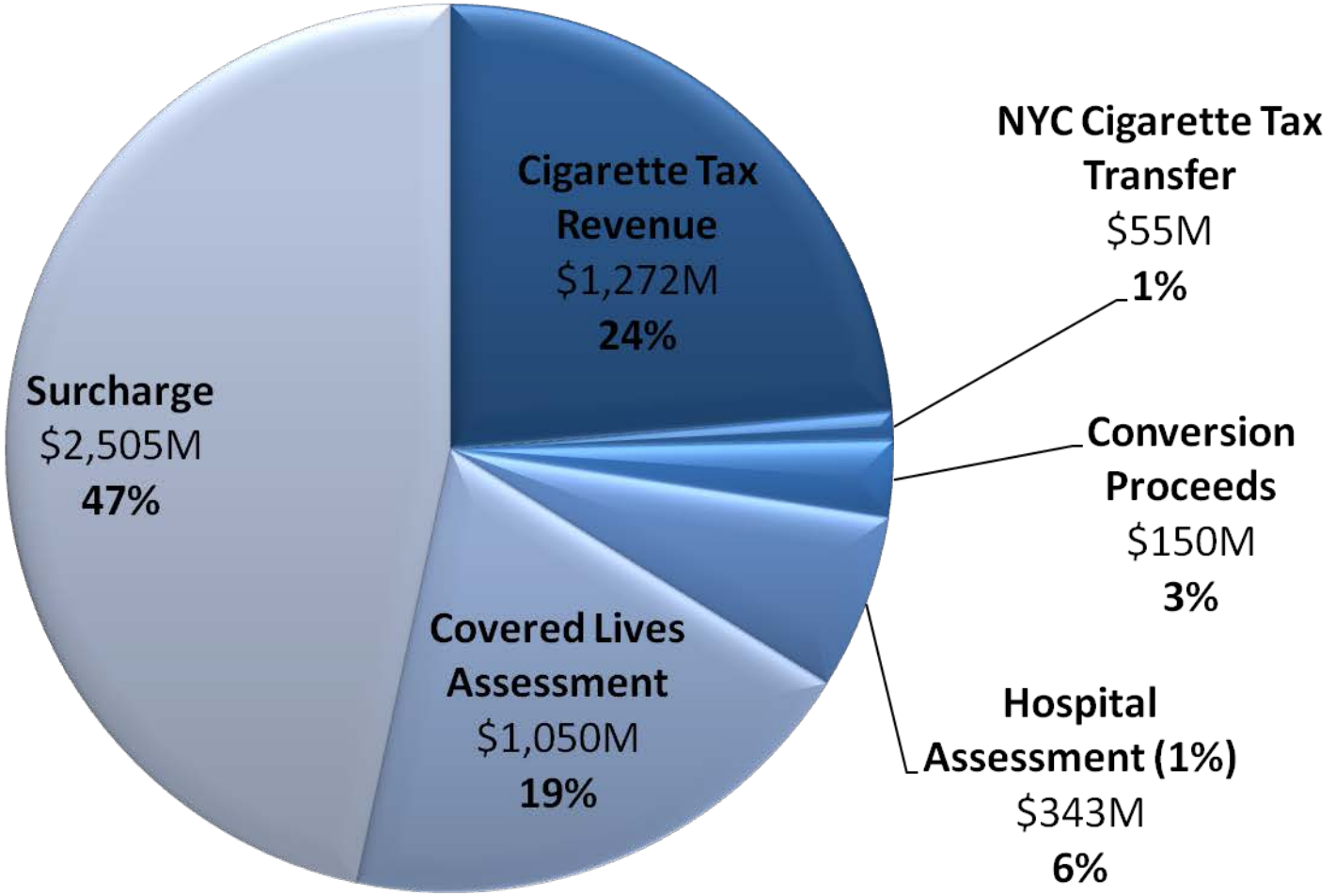
Voluntary High MA Safety Net: **$25M**

(Net MA losses from reform/DRP)

Non-Teaching Hospitals: **$16M**

(Uncompensated care based on uninsured units x MA rates)

HCRA Sources of Funds
SFY 2011-2012 (Projected) Total Funding = $5,375M



Source: State of New York, 2011-2012 Executive Budget, Five Year Financial Plan

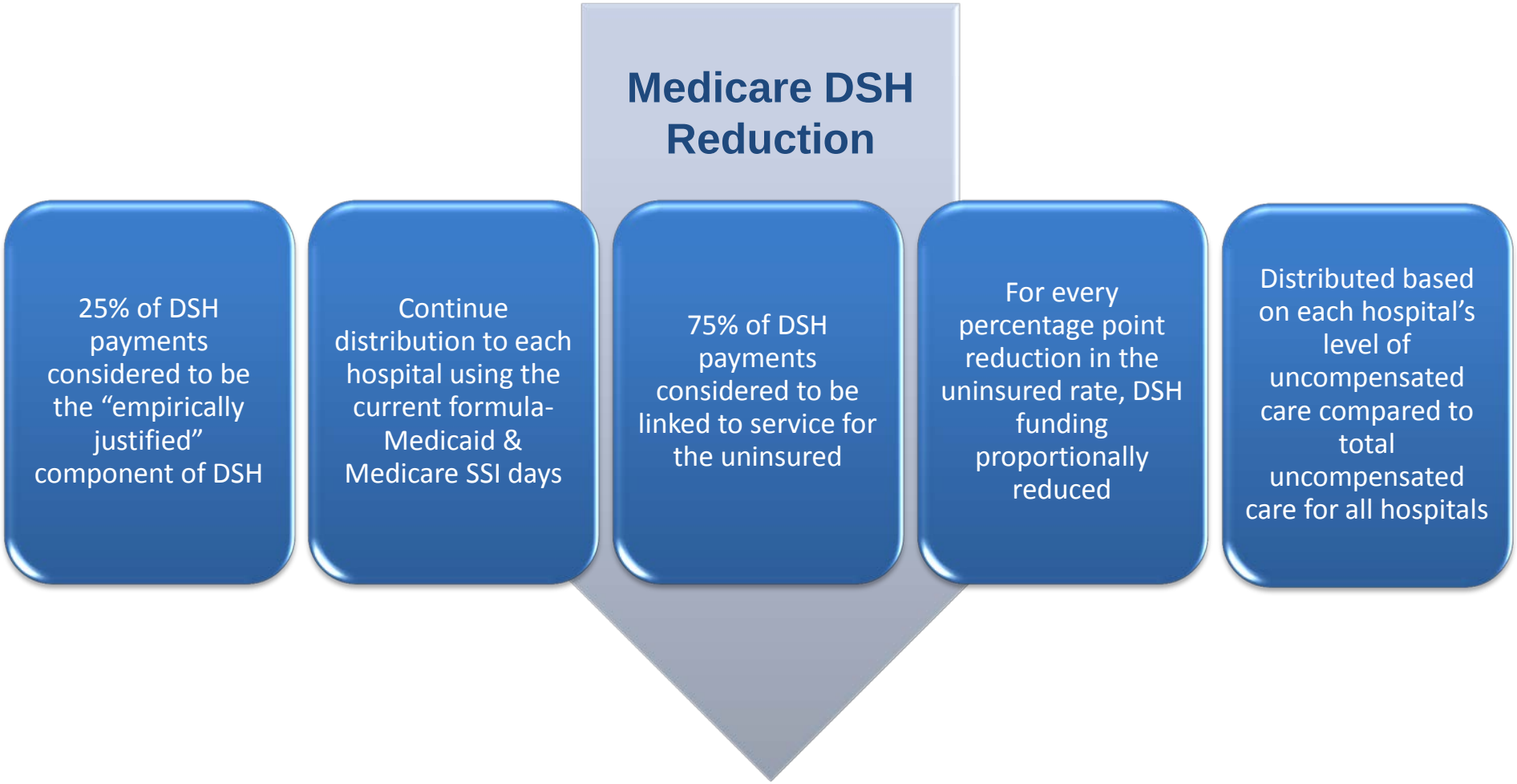
Federal DSH Reform Methodology

Reduction methodology to be applied to each state by three criteria as determined by the Secretary of Health and Human Services:

- Numbers of uninsured.
- How the state uses DSH to subsidize hospitals with high Medicaid and uncompensated care volumes (excluding bad debt).
- Portion of a state's DSH allotment used to expand eligibility through a section 1115 waiver as of July 31, 2009.

Note: Low DSH states will experience a smaller percentage reduction than high DSH states. New York is considered a high DSH state.

DSH: Federal Requirements



Medicare DSH Reduction - $22B over 10 years for the nation
Potential impact on NY hospitals - $2.5B

Aggregate Medicaid DSH Reduction (in millions)

Federal Fiscal Year	National DSH Reduction	Estimated New York State Share of Reduction
2013-14	$500	$71.0
2014-15	$600	$85.2
2015-16	$600	$85.2
2016-17	$1,800	$255.6
2017-18	$5,000	$710.0
2018-19	$5,600	$795.2
2019-20	$4,000	$568.0
Total	**$18,100**	**$2,570.2**

**Assumes a linear reduction equivalent to New York State's 14.2 percent share of total national DSH spending. The actual reduction to New York State's DSH allotment can not be determined at this time, and will be dependent on how much of New York's DSH dollars are targeted to providing services to Medicaid and uninsured patients.*

Safety Net Providers

Assistance to Safety Net Hospitals, Nursing Homes and Clinics

- A safety net provider could range from a sole community provider in a rural area of the State to an urban hospital that provides a disproportionally large number of services to the uninsured. A safety net provider could also be a nursing home or diagnostic & treatment center. Determining factors include:
  - Demonstrated historical financial distress; or
  - Been deemed, to the satisfaction of the Commissioner, to be a provider that fulfills an unmet health care need for the community.

- Assistance should provide operating and restructuring assistance to make critical decisions to either close, merge or restructure.
  - Closures can negatively impact needed health care services
  - Providers at risk for closing may be able to survive through right sizing and/or a change in its mission

Assistance to Safety Net Hospitals, Nursing Homes and Clinics

- Elements of assistance are:
  - (1) Reimbursement rate increases on a short term basis could be provided to providers, to ensure they have adequate resources to transition services and patients to their facilities or complete a merger;
  - (2) FSHRP/HEAL capital grants;
  - (3) Explore use of other capital/debt assistance;
  - (4) Use of State oversight to assist mergers;
  - (5) Direct workforce retraining funds to assist restructuring;
  - (6) Provide hospitals with financial incentives to voluntarily reduce excess staffed bed capacity and redirect Medicaid resources to expand outpatient/ambulatory surgery capacity. Hospitals opting into this program may receive an APG rate enhancement.

Process for Assistance

- The Department of Health will create a process whereby significantly troubled hospitals, nursing homes and clinics may submit applications to the Department seeking assistance to facilitate an orderly closure, merger or restructuring.

- Such applications must be accompanied with a highly specific plan enumerating the financial and programmatic challenges facing the facility, a transition plan for merger, closure or restructuring, the type and amount of resources needed to accomplish the plan, and the anticipated impact of the plan on the overall community.

Next Steps

Upcoming Meetings:

- **Tuesday, September 27, 10:30 am – 3:00 pm**

  4th Floor Conference Room A/B
  Flanigan Square
  547 River Street
  Troy, NY 12180

- **TBD: October, 10:30 am – 3:00 pm**

Please visit our website:

http://www.health.ny.gov/health_care/medicaid/redesign/payment_reform_work_group.htm

Please feel free to submit any comments or inquiries to the following email address:

paymentreform@health.state.ny.us

Appendix

Glossary of Terms

- **Accountable Care Organization (ACO)** – An organization of clinically integrated health care providers that work together to provide, manage, and coordinate health care (including primary care) for a defined population; with a mechanism for shared governance; the ability to negotiate, receive, and distribute payments; and accountability for the quality, cost and delivery of health care to the ACO's patients […]. (NYS 2011-2012 Budget Bill)

- **Pioneer ACO -** Aimed at organizations that already have experience coordinating care across care settings and are "positioned to transform both their care and financial models from fee-for-service to a three-part aim, value-based model" according to CMS. The model aims to test a "more rapid transition" from traditional fee-for-service payments to payments for "coordination and outcomes" and to "promote a diversity of successful ACOS." CMS expects up to 30 organizations, with a minimum of 15, 000 beneficiaries each (5,000 beneficiaries for rural applicants), to participate in the model. (AHA Special Bulletin – May 17, 2011)

- **Bundled Payment** – A single negotiated episode payment of a predetermined amount for all services (physician, hospital, and/or other provider services) furnished during an episode of care […]. In contrast to a fee-for-service (FFS) payment, the bundled payment may cover services furnished by multiple providers in multiple care delivery settings. (CMS)

- **Bundled Payment Participating Organization** – All providers or suppliers, other than physicians and/or practitioners, with whom the awardee plans to partner. Examples include acute care hospitals, skilled nursing facilities, and home health agencies.

Glossary of Terms

- **Bundled Payment Physicians/Practitioners –** All physicians and/or practitioners who are expected to participate in the episode of care, including suppliers who may be paid separately by Medicare for their professional services (e.g., physicians, nurse practitioners, physician assistants, and physical therapists).

- **Bundled Payment Participating Providers -** For the purposes of this initiative, all Bundled Payment participating providers fall into one of the above definitions (Bundled Payment participating organization or Bundled Payment physicians/practitioners). Collectively, these providers are termed Bundled payment participating providers.

- **Clinical Integration** – A framework that allows hospitals and physicians to work together to improve clinical care and efficiency through the development and implementation of evidence-based care protocols and best practices. It includes the collection of performance-related data, using cost and quality benchmarks to set improvement goals, and the pooling of resources to achieve those goals. Clinical integration programs create the potential for improved consistency and utilization of care and changing the practices of individual clinicians based on evaluation of individual aggregate performance.

- **Convener** – An entity that can bring together multiple participating health care providers, such as a state hospital association or a collaborative of providers. For the purposes of this initiative, a convener may be the applicant, but may be subject to special provisions. A risk-bearing convener who also may receive payments from CMS can participate in the initiative as an awardee. A convener that is not able to bear risk may not receive payments from CMS but may participate in the initiative as a facilitator for participating awardee providers.

- **Episode** – Defined period of time during which all Medicare-covered services required to manage the specific medical condition of a patient are grouped and paid as a unit. Episodes that are subject to episode payment are identified by an episode anchor. The episode may include the episode anchor and can include a period of time both before and/or after the anchor.

Glossary of Terms

- **Episode Anchor** – The event which triggers beneficiary inclusion in the episode. In Model 1, this is any admission to a participating acute care hospital; in Model 2 this is admission to a participating acute care hospital for the agreed-upon MS-DRG; in Model 3 this is initiation of post-acute services at a participating organization (LTCH, SNF, IRF, HHA) within 30 days of beneficiary discharge from an acute care hospital stay for an agreed-upon MS-DRG; in Model 4 this is admission to a participating acute care hospital for an agreed-upon MS-DRG.

- **Episode Reconciliation** – A regular comparison of the total FFS payment to providers for services included in the episode with the predetermined target price for the episode. If aggregate FFS payments exceed the predetermined target price, the awardee must repay Medicare. If aggregate FFS payments are less than the predetermined price, the awardee will be paid the difference, which may be shared among the participants.

- **Episode Target Price** – The agreed upon total Medicare payment for the episode.

- **Facilitator** – A convener who is participating in the Bundled Payments for Care Improvement initiative as a partner with providers, but who does not assume financial risk or receive payment directly under an agreement with Medicare.

- **Fee-for-Service (FFS)** – The original Medicare where Medicare pays health care providers directly for Part A and/or Part B benefits on a service-specific basis under the specific statutory payment rules that apply to payment for services furnished by each type of provider.

Glossary of Terms

- **Gainsharing** – Payments shared among providers that represent a portion of the gains achieved due to more coordinated, efficient, higher quality care. It can enable cooperative engagement by physicians, hospitals, and/or post-acute providers. Experience from Medicare demonstrations led CMS to conclude that it can result in savings for both providers and the Medicare program through increases in efficiency without affecting beneficiaries' clinical outcomes. (CMS)

- **Global Payment** – A fixed payment to a provider for all care provided to a patient during a specified time period (e.g., one month). Global payments differ from bundled payments in that a bundled payment is payment for all services provided for a specific clinical condition during an episode. (CMS)

- **Health Home** – Expand(s) the traditional medical home models to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care, in keeping with the needs of persons with multiple chronic illnesses. (CMS)

- **Learning Health Care System** – A health care system that is designed to generate and apply the best evidence for the collaborative healthcare choices of each patient and provider; to drive the process of discovery as a natural outgrowth of patient care; and to ensure innovation, quality, safety, and value in health care .

Glossary of Terms

- **Patient Centered Medical Home (PCMH) –** model for care, provided by physician – led practices, that seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and individuals' complaints with coordinated care for all life stages (acute, chronic, preventive, and end of life) and long-term therapeutic relationship. The physician-led care team is responsible for coordinating all of the individual's health care needs, and arranges for appropriate care with other qualified physicians and support services. (CMS)

- **Post-Episode Monitoring** – A mechanism to detect those services/expenditures expected to be included in an episode of care that are furnished/paid outside of the episode (before or after), thereby potentially increasing total Medicare spending for services related to the episode. Typically this will compare the actual Medicare spending to a historical baseline to detect overall increased expenditures despite the discount provided through the target price or prospective bundled payment for the episode.

- **Post-Episode Monitoring Period –** The length of time after the episode of care during which Medicare Part A and Part B spending for included beneficiaries is monitored to ensure no increase in aggregate expenditures for included beneficiaries occurs. In this initiative, this period of time is 30 days.

- **Prospective Episode Payment** – The payment mechanism whereby the bundle of services and a target price would be defined in advance and paid as one sum. The amount would be paid to a single entity at the time an episode-defining claim is submitted for the episode (e.g., hospital discharge). That entity would be responsible for payment of any other providers whose services are included in the episode.

Glossary of Terms

- **Retrospective Episode Payment** –Payment mechanism whereby the bundle of services and a target price would be defined in advance, but operationally, hospital, physician, and post-acute provider claims would be paid using existing FFS payment systems for the duration of the episode of the care. A retrospective reconciliation process would compare the actual total payment of FFS claims for the included services during the episode with the predetermined target price. If the total FFS payment is less than the target price, the awardee would be paid the difference at reconciliation.

- **Shared Savings** – An agreement between a payer and another entity to share a specified percentage of savings or losses that result from a care intervention that reduces payments. (CMS)

- **Waiver –** The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose, and distinct requirements.

- **Waiver: Research & Demonstration Projects (1115)** – This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

- **Waiver: Managed Care/Freedom of Choice (1915(b))** – This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

- **Waiver: Home and Community-Based Services (1915(c))** – This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care service to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

Reduce Utilization Associated with Avoidable Inpatient Stays: Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
Ambulatory Care Sensitive Conditions **OR** Preventable Quality Indicators	Claims	(National Quality Measures Clearinghouse NQMC – Rosenthal) Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, (per 100,000 population) under age 75 years. The rate of acute care hospitalizations for ambulatory care sensitive conditions per 1,000 member years	Acute care discharges will be identified from administrative claims. We will use data analytics to aggregate results by health homes and compare to peers. Information on performance will be shared with the health homes.
Hospital Readmission **OR** Potentially Preventable Readmissions	Claims	(Rosenthal) Hospital or health home specific risk standardized readmission rates (RSRR). RSRR is calculated as the ratio of predicted to expected readmissions, multiplied by the national unadjusted rate. The ratio of readmissions is the number of readmissions for each health home adjusting for the observed case mix.	Acute care admissions occurring within 30 days of discharge from acute care inpatient stays will be identified using administrative data. We will use data analytics to determine aggregate results and a case mix adjustment. The expected to observed ratios will be used to adjust the result and compare to the unadjusted overall readmission rates for health homes.

Reduce Utilization Associated with Avoidable Inpatient Stays: Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Care Transitions: Reconciled Medication List	Claims (Denom.) Survey/ EMR (Num.)	(National Quality Measures Clearinghouse) Percentage of patients or caregivers who were discharged from inpatient acute care to home or any other site of care who received a reconciled medication list at the time of discharge which includes: meds taken prior to admission, meds given in the hospital, and meds to be taken upon discharge.	Acute Care admissions will be determined from administrative claims. Health homes will use EMRs if available or will audit a sample of inpatient records each quarter to report an aggregate result for the quarter. Health homes will submit aggregated information at specified intervals. We will summarize data across health homes and share overall peer performance.
Care Transitions: Transition Record Transmitted to Health Care Professional	Claims (Denom.) Survey/EMR (Num.)	(National Quality Measures Clearinghouse) Percentage of patients who are discharged from an acute inpatient setting to home or any other site of care for whom a transition record (Diagnosis/problem list, medication list with OTC and allergies, identified follow up provider, cognitive status, and test results or pending results) was transmitted to the accepting facility or to the designated follow up provider within 24 hours of discharge.	Acute Care admissions will be determined from administrative claims. Health homes will audit a sample of inpatient and follow up provider records each quarter to determine transmission or transition records within 24 hours. Health homes will submit aggregated information at specified intervals. We will summarize data across health homes and share overall peer performance.

Reduce Utilization Associated with Emergency Room Visits: Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
Mental Health Utilization	Claims	(HEDIS 2012 – Use of Services) The number and percentage of members receiving the following mental health services during the measurement year. Any service Inpatient Intensive outpatient or partial hospitalization Outpatient or ED	Mental health services will be identified by data analysis of administrative claims. Results of aggregated results will be shared with health homes including their results and benchmarking to the overall peer results.
Identification of Alcohol and Other Drug Services	Claims	(HEDIS 2012 – Use of Services) This measure summarizes the number and percentage of members with an alcohol and other drug (AOD) claim who received the following chemical dependency services during the measurement year. Any service Inpatient Intensive outpatient or partial hospitalization Outpatient or ED	Alcohol and other drug services will be identified by data analysis of administrative claims. Results of aggregated results will be shared with health homes including their results and benchmarking to the overall peer results.

Reduce Utilization Associated with Emergency Room Visits: Clinical Outcomes

Measures	Data Source	Specifications	HIT Utilization
Follow Up After Hospitalization for Mental Illness	Claims	(HEDIS 2012 - Effectiveness of Care) Percentage of discharges for treatment of selected mental illness disorders who had an outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health provider within 7 days and within 30 days of discharge. In addition, 'retention' in services, defined as at least five qualifying visits (see above) with mental health providers within 90 days of discharge.	The transition of care HEDIS indicator is developed from treatment guidelines. The State's Office of Mental Health added quantification standards for retention to capture quality of ongoing care for a persistently severe mentally ill population targeted by NYS SPA for Health Home. The follow up visits will be identified from vendor data and claims. We will use data analytics to aggregate results by health home and compare to peers.
Follow up After Hospitalization for Alcohol and Chemical Dependency Detoxification	Claims	(New York State Specific) The percentage of discharges for specified alcohol and chemical dependency conditions that are followed up with visits with chemical treatment and other qualified providers within 7 days and within 30 days and who have ongoing visits within 90 days of the discharges	The transition of care is patterned after the HEDIS indicator for mental health. The State's Office of Alcohol and Substance Abuse Services added quantification standards for retention to capture quality of ongoing care for a chemically dependent population targeted By NYS SPA for Health Home. The follow up visits will be identified from vendor data and claims. We will use data analytics to aggregate results by health home and compare to peers.

Reduce Utilization Associated with Emergency Room Visits: Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Antidepressant Medication Management	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who had a new diagnosis of depression and treated with an antidepressant medication who remained on the antidepressant for acute phase and recovery phase of treatment	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Follow Up Care for Children Prescribed ADHD Medication	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of children newly prescribed ADHD medication who had appropriate follow up in the initial 30 days and in the continuation and maintenance phase	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

Reduce Utilization Associated with Emergency Room Visits: Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Adherence to Antipsychotics for Individuals with Schizophrenia	Claims and Pharmacy	(RAND section 2701 ACA proposed measure) Percentage of patients with a schizophrenia diagnosis who received an antipsychotic medication that had a proportion of days covered (PDC) for antipsychotic medication ≥0.8 during the measurement period.	This medication adherence indicator is based on the RAND measure and includes advice from the State's mental health agency to better reflect the standards of quality of care for a persistently severe mentally ill population targeted for Health Home. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Claims and Pharmacy	(RAND section 2701 ACA proposed measure) Percentage of patients with bipolar I disorder who received a mood stabilizer medication that had a proportion of days covered (PDC) for mood stabilizer medication ≥0.8 during the measurement period.	This medication adherence indicator is based on the RAND measure and includes advice from the State's mental health agency to better reflect the standards of quality of care for a persistently severe mentally ill population targeted for Health Home. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

Improve Disease Related Care for Chronic Conditions: Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Use of Appropriate Medications for People with Asthma	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who are identified with persistent asthma and who were appropriately prescribed preferred asthma medication	The medication adherence HEDIS indicator is developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Medication Management for People With Asthma	Claims and Pharmacy	(HEDIS 2012 – Effectiveness of Care) The percentage of members who were identified as having persistent asthma and were dispensed appropriate medications in amounts to cover: 1) at least 50% of their treatment period and 2) at least 75% of their treatment period.	The medication adherence HEDIS indicator is developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

Improve Disease Related Care for Chronic Conditions: Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Comprehensive Diabetes Care (HbA1c test and LDL-c test)	Claims, Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members with diabetes who had at least one HbA1c test and at least one LDL-C test	The service-related HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Persistence of Beta-Blocker Treatment after Heart Attack	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who were hospitalized and discharged alive with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge	The medication adherence HEDIS indicators are developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

Improve Disease Related Care for Chronic Conditions: Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Cholesterol Testing for Patients with Cardiovascular Conditions	Claims, Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of members who were discharged alive for AMI, CABG or PCI or who have a diagnosis of IVD and who had at least one LDL-C screening	The service-related HEDIS indicators were developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Comprehensive Care for People Living with HIV/AIDS	Claims and Pharmacy	(NYS Specific QARR 2010) Percentage of members living with HIV/AIDS who received the following services: (A) two outpatient visits with primary care with one visit in the first six months and one visit in the second six months, (B) viral load monitoring, and (C) Syphilis screening for all who 18 and older	The service-related HEDIS indicators were developed from treatment guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

Improve Preventative Care: Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Adult Weight Screening	EMR	(CMS and National Quality Measures Clearinghouse) Percentage of patients aged 18 years and older with a calculated BMI documented in the medical record AND if the most recent BMI is outside the parameters, a follow up plan is documented. Parameters: age 65 and older BMI > or = 30 or < 22; age 18-64 BMI > or = 25 or< 18.5	The service related HEDIS indicator was developed from treatment guidelines. Health homes will audit a sample of EMRs or provider records each quarter to determine BMI calculation and documentation of follow up if the calculation is in the indicated parameter. Health homes will submit aggregated information at specified intervals. We will summarize data will be shared with the health homes and will include benchmarks to peers.
Screening for Clinical Depression and Follow-up Plan	EMR	(National Quality Forum) Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up documented	Health homes will audit a sample of EMRs or provider records each quarter to determine screening for depression with a standardized tool and documentation of follow up if the tool results indicate positive findings. Health homes will submit aggregated information at specified intervals. We will summarize data across health homes and share overall peer performance.

Improve Preventative Care: Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Chlamydia Screening in Women	Claims and Pharmacy	(HEDIS 2012 - Effectiveness of Care) Percentage of women who were identified as sexually active and who had at least one test for Chlamydia	The preventive care HEDIS indicator was developed from preventive care guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.
Colorectal Cancer Screening	Claims (administrative method only)	(HEDIS 2012 - Effectiveness of Care) Percentage of member 50 and older who had appropriate screening for colorectal cancer	The preventive care HEDIS indicator was developed from preventive care guidelines. We will use data analytics with administrative claims data to calculate the results which will be shared with the health homes and will include benchmarks to peers.

Care Management: Quality of Care

Measures	Data Source	Specifications	HIT Utilization
Engagement and Participation in Care Management	Care Management Data	(NYS DOH Care Management Data File Specifications) The percentage of members who have a comprehensive assessment and a care plan developed within 30 days of enrollment in the health home. The mean number of interventions conducted by the care manager or care management team per month (mail, telephonic, face-to-face).	This process efficiency measure was developed from several phases of case management measurement trials with health plans. Health homes will capture the individual data in case management systems and summarize results semi-annually. We will receive case management detailed files annually and will provide benchmarks based on overall peer data. In addition, we will provider process metrics of mean number of days from member enrollment in health home to engagement in case management.

QARR Measurements

Effectiveness of Care		
➢Adolescent Preventive Care Measures *(Sexual Activity, Depression, Tobacco and Substance Use)* ➢Adult BMI Assessment ➢Annual Monitoring for Patients on Persistent Medications *(ACE Inhibitors/ARBs, Diuretics, Digoxin, and Anticonvulsant)* ➢Antidepressant Medication Management ➢Appropriate Asthma Medications 3 or more controller dispensing events ➢Appropriate Testing for Children with Pharyngitis ➢Appropriate Treatment for Children with Upper Respiratory Infection ➢Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis ➢Breast Cancer Screening ➢Cervical Cancer Screening ➢Childhood Immunization Status ➢Chlamydia Screening in Women	➢Cholesterol Management for Patients with Cardiovascular Conditions *(Testing and Control)* ➢Colorectal Cancer Screening ➢Comprehensive Diabetes Care *(HbA1c test and control, LDL-C test and control, eye exam, nephropathy monitor, BP control)* ➢Controlling High Blood Pressure ➢Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis ➢Flu Shots for Adults Ages 50 - 64 ➢Follow-Up After Hospitalization for Mental Illness ➢Follow-Up Care for Children Prescribed ADHD Medication ➢HIV/AIDS Comprehensive Care *(Engaged in Care, Viral Load Monitoring, Syphilis Screening)* ➢HPV for Female Adolescents ➢Immunizations for Adolescents	➢Lead Screening in Children ➢Medical Assistance with Smoking Cessation ➢Medical Management for People with Asthma ➢Persistence of Beta-Blocker Treatment After a Heart Attack ➢Pharmacotherapy Management of COPD Exacerbation *(Corticosteroids and Bronchodilators)* ➢Use of Appropriate Medications for People with Asthma ➢Use of Imaging Studies for Low Back Pain ➢Use of Spirometry Testing in The Assessment and Diagnosis of COPD ➢Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (BMI Percentile, Nutrition and Physical Activity)

QARR Measurements

Access/Availability of Care	Health Plan Descriptive Information	Experience of Care (CAHPS Satisfaction Survey)
➢Adult Access to Preventive/Ambulatory Care ages 20 and Older ➢Annual Dental Visit ages 2 to 18 ➢Children's Access to PCPs ages 12 months to 19 years ➢Prenatal and Postpartum Care	➢Board Certification ➢Enrollment by Product Line	➢Care Coordination ➢Collaborative Decision Making ➢Customer Service ➢Doctor Communication ➢Getting Care Needed ➢Getting Care Quickly ➢Getting Needed Counseling or Treatment ➢Rating of Counseling or Treatment ➢Rating of Health Plan ➢Rating of Personal Doctor ➢Rating of Overall Health Care ➢Rating of Specialist ➢Wellness Discussion

QARR Measurements

Use of Services	Use of Services	NYS-Specific Prenatal Care Measures
➢Well-Child Visits in the First 15 Months of Life ➢Well-Child Visits in the 3rd, 4th, 5th & 6th Year ➢Adolescent Well-Care Visits ➢Ambulatory Care ➢Frequency of Ongoing Prenatal Care ➢Frequency of Selected Procedures Bariatric Weight Loss Surgery Tonsillectomy Hysterectomy, vaginal & abdominal Cholecystectomy, open & closed Back Surgery Percutaneous Coronary Intervention (PCI) Cardiac Catheterization Coronary Artery Bypass Graft (CABG) Prostatectomy Mastectomy Lumpectomy	➢Inpatient Utilization (General Hospital-Acute Care) ➢Mental Health Utilization ➢Antibiotic Utilization	➢Risk-Adjusted Low Birth Weight ➢Prenatal Care in the First Trimester ➢Risk Adjusted Primary C Section ➢Vaginal Births after C Section