New York State’s Health Care Transformation: The Path to Medicaid Payment Reform through *Value-Based Payment Programs*

Douglas G. Fish, MD
Medical Director, Division of Program Development and Management
Office of Health Insurance Programs, NYSDOH
Medicaid Redesign Team (MRT) Waiver Amendment

• Part of the Medicaid Redesign Team (MRT) plan was to obtain a 1115 Waiver, which would reinvest MRT-generated, federal savings back into New York’s health care delivery system.

• In April 2014, Governor Andrew M. Cuomo announced that New York State and CMS finalized an agreement on the MRT Waiver Amendment.
  • Allowed the state to reinvest $8 billion of the $17.1 billion in federal savings generated by MRT reforms for 6.3 million members.

• The MRT Waiver Amendment goals are to:
  ✓ Transform the State’s Health Care System
  ✓ Bend the Medicaid Cost Curve
  ✓ Assure Access to Quality Care for all Medicaid members

• 1115 Waiver renewed for 5 years, as of December 2016
Delivery System Reform Incentive Payment (DSRIP) Program Objectives

**Goal:**
Reduce avoidable hospital use – Emergency Department and Inpatient – by 25% over 5+ years of DSRIP

- Develop Integrated Delivery Systems
- Enhance Primary Care and Community-based Services
- Remove Silos
- Integrate Behavioral Health and Primary Care

- DSRIP was built on the CMS and State goals in the Triple Aim:
  - Improving quality of care
  - Improving health
  - Reducing costs

- DSRIP Program’s holistic and integrated approach to healthcare transformation provides a template for integration of Behavioral Health (BH) initiatives into primary care and primary care into BH settings.

DSRIP delivery system changes → VBP Readiness

[https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/)
How DSRIP & Value Based Payment Programs (VBP) Relate

Old world:
- FFS
- Individual provider was anchor for financing and quality measurement
- Volume over Value

DSRIP:
Restructuring effort to prepare for future success in changing environment

New world:
- VBP arrangements
- Integrated care services for patients are anchor for financing and quality measurement
- Value over Volume
The New World: Paying for *Outcomes* not *Inputs*

Volume of Care (FFS) → Value of Care (VBP)

**Value Based Payment (VBP)**

- An approach to Medicaid reimbursement that rewards value over volume
- An approach to incentivize providers through shared savings and financial risk
- A method to directly tie payment to providers with quality of care and health outcomes
- A component of DSRIP that is key to the sustainability of the program


**VBP Transformation: Overall Goals and Timeline**

**Goal:** To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.

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**DSRIP Goals**

- **April 2017:** PPS requested to submit growth plan outlining path to 80-90% VBP
- **April 2018:** > 10% of total MCO expenditure in Level 1 VBP or above
- **April 2019:** > 50% of total MCO expenditure in Level 1 VBP or above. > 15% of total payments contracted in Level 2 or higher
- **April 2020:** 80-90% of total MCO expenditure in Level 1 VBP or above. > 35% of total payments contracted in Level 2 or higher

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**Acronym Definition:**
- New York State (NYS)
- Performing Provider System (PPS)
- Managed Care Organization (MCO)
Today’s discussion will focus on the Managed Care Organization (MCO) to VBP Contractor (Provider) relationship.

*A VBP Contractor is the entity that contracts the VBP arrangement with the MCO. This can be:

- Accountable Care Organization (ACO)
- Independent Practice Association (IPA)
- Individual provider (either assuming all responsibility and upside/downside risk or subcontracting with other providers)
- Individual providers brought together by an MCO to create a VBP arrangement through individual contracts with these providers.

Note: A PPS is not a legal entity and therefore cannot be a VBP Contractor. However, a Performing Provider System (PPS) can form one of the entities above to be considered a VBP Contractor.
MCO and Contractors can Choose Different Levels of VBP

In addition to choosing which integrated services to focus on, the MCOs and contractors can choose different levels of Value Based Payments:

<table>
<thead>
<tr>
<th>Level 0 VBP*</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP (feasible after experience with Level 2; requires mature contractors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/IPC, FFS may be complemented with PMPM subsidy)</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
<tr>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>Prospective total budget payments</td>
</tr>
<tr>
<td>No Risk Sharing</td>
<td>↑ Upside Only</td>
<td>↑↓ Upside &amp; Downside Risk</td>
<td>↑↓ Upside &amp; Downside Risk</td>
</tr>
</tbody>
</table>

Acronym Definition: Fee for Service (FFS); Per Member Per Month (PMPM)

Level 0 is not considered a sufficient move away from traditional fee-for-service incentives to be counted as value based payment in the terms of the NYS VBP Roadmap.

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. June 2016 updated version approved by CMS March 2017
Level 1 Agreement
50% Shared Savings (Upside Only)

<table>
<thead>
<tr>
<th>MCO Profit &amp; Loss</th>
<th>Provider Profit &amp; Loss</th>
<th>Shared Savings Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>[A] Revenue (Premium) $6,000</td>
<td>[B] Revenue (Claims) $4,600</td>
<td>[TB] Target Budget $5,500</td>
</tr>
<tr>
<td>[B] Cost (Claims) $4,600</td>
<td>[C] Provider Cost $4,000</td>
<td>[B] Claims $4,600</td>
</tr>
<tr>
<td>[A-B] Profit $1,400</td>
<td>[B-C] Profit $600</td>
<td>[TB - B] Shared Savings $900</td>
</tr>
<tr>
<td>[S] Shared Savings (50%) $450</td>
<td>[S] Shared Savings (50%) $450</td>
<td></td>
</tr>
<tr>
<td>[A – B + S] Total Profit / (Loss) $1,850</td>
<td>[B – C + S] Total Profit / (Loss) $1,050</td>
<td></td>
</tr>
</tbody>
</table>

**Coordinated care among team members**

**State**

$6,000

**Premium**

$4,600

MC FFS

**Payer/MCO**

**Provider**

**Forestland Care**

Payer Premium $6,000 ($500 PMPM)

**New York Medical Group (contracts a VBP arrangement)**

**2014 Claims**

Primary Care: $2,000
ER (Opioid overdose): $2,600

Total: $4,600

**Provider Cost** $4,000

**VBP Budget** $5,500

**50% Shared Savings (Upside Only)**

- 2014 Claims
  - Primary Care: $2,000
  - ER (Opioid overdose): $2,600
  - Total: $4,600

**Payer**

- Premium $6,000

**Provider**

- New York Medical Group (contracts a VBP arrangement)
- Provider Profit & Loss
  - Revenue (Claims) $4,600
  - Provider Cost $4,000
  - Shared Savings (50%) $450
  - Total Profit / (Loss) $1,050

**Shared Savings Calculation**

- Target Budget $5,500
- Claims $4,600
- Shared Savings $900
Standard: Implementation of Social Determinants of Health Intervention

“To stimulate VBP contractors to venture into this crucial domain, VBP contractors in Level 2 or Level 3 agreements will be required, as a statewide standard, to implement at least one social determinant of health intervention. Provider/provider networks in VBP Level 3 arrangements are expected to solely take on the responsibilities and risk.” (VBP Roadmap, p. 41)

The State has seen success with the following intervention types:
1. Housing
2. Nutrition
3. Education

Standard: Inclusion of at Least One, Tier 1 Community-Based Organization (CBO)

“Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community based organizations be supported and included in the transformation. It is therefore a requirement that starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO (VBP Roadmap, p. 42)

Description:

• VBP contractors in a Level 2 or 3 arrangement **MUST** include at least one, Tier 1 CBO.
  - A Tier 1 CBO is a non-profit, non-Medicaid billing, community-based social and human service organizations (e.g. housing, social services, religious organizations, food banks)

Measuring Performance for VBP Arrangements
Upside and Down Side Risk Sharing Arrangements

- While VBP encourages efficiency, **quality** is paramount!
- No savings will be earned without meeting minimum quality thresholds.

<table>
<thead>
<tr>
<th>Quality Targets % Met goal</th>
<th>Level 1 VBP Upside Only</th>
<th>Level 2 VBP Up - and downside when actual costs &lt; budgeted costs</th>
<th>Level 2 VBP Up - and downside when actual costs &gt; budgeted costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 50% of Quality Targets Met</td>
<td>50% of savings returned to VBP contractors</td>
<td>Up to 90% of savings returned to VBP contractors</td>
<td>VBP contractors are responsible for up to 50% losses</td>
</tr>
<tr>
<td>&lt;50 % of Quality Targets Met</td>
<td>Between 10 – 50% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)</td>
<td>Between 10 – 90% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)</td>
<td>VBP contractors responsible for 50-90 % of losses (sliding scale in proportion with % of Quality Targets met)</td>
</tr>
<tr>
<td>Quality Worsens</td>
<td>No savings returned to VBP contractors</td>
<td>No savings returned to VBP contractors</td>
<td>VBP contractors responsible for up to 90% of losses</td>
</tr>
</tbody>
</table>

VBP Arrangements

• Arrangement **Types**
  ➢ Total Care for the General Population (TCGP)
  ➢ Integrated Primary Care (IPC)
  ➢ Maternity Care
  ➢ Health and Recovery Plans (HARP)
  ➢ HIV/AIDS Care
  ➢ Managed Long Term Care (MLTC)

  *Arrangements do not yet include Dually Eligible members

• Two VBP implementation subcommittees were created to focus on:
  ➢ Social Determinants of Health and CBOs
  ➢ Advocacy and Engagement
  ➢ The full recommendations that came from these Subcommittees are available in the DOH VBP Resource Library - NYS DOH VBP website ([Link](#))
Total Care for Special Needs Subpopulations

Goal: Improve population health through enhancing the quality care for specific subpopulations that often require highly specific and costly care needs.

- Subpopulations include:
  - HIV/AIDS
  - Health and Recovery Plans (HARP)
  - Managed Long Term Care (MLTC)*
  - Intellectual and Developmental Disabilities (I/DD)*

- All services covered by the associated managed care plans are included, and all members fulfilling the criteria for eligibility to such plans are included.

In this arrangement the VBP Contractor assumes responsibility for the care of the specific population, where co-morbidity or disability may require specific and costly care needs, so that the majority (or all) of the care is determined by the specific characteristic of these members.

* Arrangements are still being developed as of 4/6/17.
Value Based Payment Program
Measurement Year 2017 Quality Measure Sets

The MY 2017 Quality Measure Sets for TCGP/IPC, Maternity, HIV/AIDS and HARP VBP arrangements have been finalized and posted to the NYS DOH VBP website (Link)
HIV/AIDS Complete Measure Set

- Measures recommended by the HIV/AIDS CAG were aligned with measures included in the NYS DOH portfolio of programs including the Delivery System Reform Incentive Payment (DSRIP) Program, the Quality Improvement Program (QIP), Quality Assurance Reporting Requirements (QARR), and the State’s HIV/AIDS care measures.

- The final HIV/AIDS Category 1 measure set includes a subset of the Total Care General Population (TCGP)/Integrated Primary Care (IPC) Arrangement.
Categorizing and Prioritizing Quality Measures

CATEGORY 1
Approved quality measures that are felt to be both clinically relevant, reliable and valid, and feasible.

CATEGORY 2
Measures that are clinically relevant, valid, and probably reliable, but where the feasibility could be problematic. These measures should be investigated during the 2016/2017 pilot program.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible.
Category 1 Measures

• Category 1 quality measures as identified by the Stakeholders and accepted by the State are to be reported by VBP Contractors.

The State classified each Category 1 measure as P4P or P4R:

**Pay for Performance (P4P)**

• Measures designated as P4P are intended to be used in the determination of shared savings amounts for which VBP Contractors are eligible.

• Performance on the measures can be included in both the determination of the target budget and in the calculation of shared savings for VBP Contractors.

**Pay for Reporting (P4R)**

• Measures designated as P4R are intended to be used by MCOs to incentivize VBP Contractors for reporting data to monitor quality of care delivered to members under the VBP contract.

• MCOs and VBP Contractors will be incentivized based on timeliness, accuracy & completeness of data reporting.

• Measures can move from P4R to P4P through the annual CAG and State review process or as determined by the MCO and VBP Contractor.

Measurement Year 2017
HIV / AIDS Measure Classification and Categorization
# HIV/AIDS – Specific Measures

## 2017 Value Based Payment Quality Measure Set

### Category 1

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Description</th>
<th>Steward</th>
<th>VBP Category</th>
</tr>
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<tbody>
<tr>
<td>HIV Viral Load Suppression</td>
<td>The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.</td>
<td>HRSA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Linkage to HIV Medical Care</td>
<td>Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis</td>
<td>HRSA</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases: Screening for Chlamydia, Gonorrhea, and Syphilis</td>
<td>Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Substance Abuse Screening</td>
<td>Percentage of new patients with a diagnosis of HIV who have been screened for substance use (alcohol &amp; drugs) in the measurement year</td>
<td>HRSA</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year</td>
<td>Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year</td>
<td>Altarum</td>
<td>Cat 1 P4R</td>
</tr>
</tbody>
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Acronyms: HRSA - Health Resources and Services Administration, NCQA - National Committee for Quality Assurance
### HIV/AIDS VBP Arrangement – 2017 Measure Set included in the TCGP/ IPC Measure Set (1 of 5)

#### Category 1

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<tbody>
<tr>
<td>Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder</td>
<td>Percentage of individuals at least 18 years of age as of the beginning of the measurement period with bipolar I disorder who had at least two prescription drug claims for mood stabilizer medications and had a Proportion of Days Covered (PDC) of at least 0.8 for mood stabilizer medications during the measurement period (12 consecutive months).</td>
<td>CMS</td>
<td>Cat 1 P4P</td>
</tr>
</tbody>
</table>
| Antidepressant Medication Management - Effective Acute Phase Treatment & Effective Continuation Phase Treatment | The percentage of patients 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.  
  a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 84 days (12 weeks).  
  b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated patients who remained on an antidepressant medication for at least 180 days (6 months). | NCQA | Cat 1 P4P |
| Breast Cancer Screening | Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months | NCQA | Cat 1 P4P |
| Cervical Cancer Screening | Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:  
  - Women age 21–64 who had cervical cytology performed every 3 years.  
  - Women age 30–64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years. | NCQA | Cat 1 P4P |
| Colorectal Cancer Screening | Percentage of patients 50 - 75 years of age who had appropriate screening for colorectal cancer | NCQA | Cat 1 P4P |

Acronyms: CMS – Centers for Medicare and Medicaid Services, NCQA - National Committee for Quality Assurance
### HIV/AIDS VBP Arrangement – 2017 Measure Set included in the TCGP/ IPC Measure Set (2 of 5)

**Category 1**

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</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care: Eye Exam (retinal) performed</td>
<td>Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Foot Exam</td>
<td>Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period</td>
<td>NCQA</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</td>
<td>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is &lt;8.0% during the measurement year.</td>
<td>NCQA</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%)</td>
<td>Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c &gt; 9.0% during the measurement period</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]</td>
<td>The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
<td>The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Comprehensive Diabetes Screening: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)</td>
<td>NQF #s 0055, 0062, 0057 Number of people (18-75) who received at least one of each of the following tests: HbA1c test, , diabetes eye exam, and medical attention for nephropathy</td>
<td>AHRQ</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90 mmHg) during the measurement period</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
</tbody>
</table>
## HIV/AIDS VBP Arrangement – 2017 Measure Set included in the TCGP/ IPC Measure Set (3 of 5)

### Category 1

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</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</td>
<td>The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>HIV Viral Load Suppression</td>
<td>The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.</td>
<td>HRSA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)</td>
<td>Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Initiation of Pharmacotherapy for Alcohol Dependence</td>
<td>The percentage of individuals who initiate pharmacotherapy with at least 1 prescription for alcohol treatment medication within 30 days following an index visit with a diagnosis of alcohol abuse or dependence.</td>
<td>OASAS</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Initiation of Pharmacotherapy for Opioid Use Disorder</td>
<td>The percentage of individuals who initiate pharmacotherapy with at least 1 prescription or visit for opioid treatment medication within 30 days following an index visit with a diagnosis of opioid abuse or dependence.</td>
<td>OASAS</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Linkage to HIV Medical Care</td>
<td>Percentage of patients who attended a routine HIV medical care visit within 3 months of HIV diagnosis</td>
<td>HRSA</td>
<td>Cat 1 P4R</td>
</tr>
</tbody>
</table>

Acronyms: NCQA - National Committee for Quality Assurance, HRSA - Health Resources and Services Administration, OASAS - Office of Alcoholism and Substance Abuse Services
### Mediation Management for Patients with Asthma

The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.

1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period.
2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.

- **A** ages 5-18
- **B** ages 19-64

<table>
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<tr>
<td>Medication management for patients with asthma</td>
<td>The percentage of patients 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported. 1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period. 2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period. <strong>A</strong> ages 5-18 <strong>B</strong> ages 19-64</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td>Potentially Avoidable Complications (PAC) in routine sick care or chronic care</td>
<td>Percent of proxy-priced costs associated with Potentially Avoidable Complications (PACs) in the chronic bundle and in routine sick care. Expressed as the ratio of actual/expected costs. Costs is used as a proxy for the severity of the PAC.</td>
<td>Altarum</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.</td>
<td>CMS</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization</td>
<td>AMA PCPI</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented</td>
<td>CMS</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user</td>
<td>AMA PCPI</td>
<td>Cat 1 P4R</td>
</tr>
</tbody>
</table>

**Acronyms:** NCQA - National Committee for Quality Assurance, CMS – Centers for Medicare and Medicaid Services, AMA – American Medical Association, PCPI - Physician Consortium for Performance Improvement
### HIV/AIDS VBP Arrangement – 2017 Measure Set included in the TCGP/ IPC Measure Set (5 of 5)

**Category 1**

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</thead>
<tbody>
<tr>
<td><strong>Sexually Transmitted Diseases:</strong> Screening for Chlamydia, Gonorrhea, and Syphilis</td>
<td>The percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea and syphilis screenings were performed at least once since the diagnosis of HIV infection</td>
<td>NCQA</td>
<td>Cat 1 P4P</td>
</tr>
<tr>
<td><strong>Statin Therapy for Patients with Cardiovascular Disease</strong></td>
<td>The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: (1) Statin Therapy. Members who were dispensed at least one high or moderate-intensity statin medication during the measurement year. (2) Statin Adherence 80%. Members who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.</td>
<td>NCQA</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td><strong>Statin Therapy for Patients with Diabetes</strong></td>
<td>The percentage of members 40 to 75 years of age during the measurement year with diabetes who do not have ASCVD who remained on a statin medication of any intensity for at least 80% of the treatment period.</td>
<td>NCQA</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td><strong>Substance Abuse Screening</strong></td>
<td>The percentage of new patients with a diagnosis of HIV who have been screened for substance use (alcohol &amp; drugs) in the measurement year.</td>
<td>HRSA</td>
<td>Cat 1 P4R</td>
</tr>
<tr>
<td><strong>Use of spirometry testing in the assessment and diagnosis of COPD</strong></td>
<td>The percentage of patients 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.</td>
<td>NCQA</td>
<td>Cat 1 P4R</td>
</tr>
</tbody>
</table>

**Acronyms:** NCQA - National Committee for Quality Assurance
## HIV/AIDS VBP Arrangement – 2017 Measure Set included in the TCGP/ IPC Measure Set (1 of 2)

### Category 2

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Description</th>
<th>Steward</th>
<th>VBP Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma: Assessment of Asthma Control – Ambulatory Care Setting</td>
<td>Percentage of patients aged 5 years and older with a diagnosis of asthma who were evaluated for asthma control (comprising asthma impairment and asthma risk) at least once during the measurement period</td>
<td>AAAAI</td>
<td>Cat 2</td>
</tr>
<tr>
<td>Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence</td>
<td>New Measure: Percentage of individuals undergoing initiation and engagement of alcohol and other drug dependence treatment (IET) who have three (3) or more same- or lower-level SUD service visits/claims between 45 days post the IET Index Episode Start Date (IESD) and 180 days post the IESD.</td>
<td>OASAS</td>
<td>Cat 2</td>
</tr>
</tbody>
</table>
| Continuity of Care (CoC) within 14 days of discharge from any level of SUD inpatient care | 1. Continuity of Care from Inpatient Detox to Lower Level of Care. The percentage of inpatient detox discharges for members 13 years of age and older with a diagnosis of alcohol and other drug (AOD) dependence, who had a follow-up lower level visit for AOD within 14 days of the discharge date.  
2. Continuity of Care from Inpatient Rehabilitation to Lower Level of Care. The percentage of inpatient discharges for members 13 years of age and older for alcohol and other drug abuse or dependence treatment (AOD), who had a follow-up lower level AOD visit within 14 days of the discharge date. | OASAS           | Cat 2        |
| Diabetes Screening (HIV/AIDS)                                             | Percentage of patients with any random blood sugar > 100 mg/dL who received diabetes screening.                                                                                                             | NYSDOH AIDS Institute | Cat 2        |
| Hepatitis C Screening                                                     | Percentage of patients for whom Hepatitis C (HCV) screening was performed at least once since the diagnosis of HIV                                                                                           | HRSA            | Cat 2        |
| Housing Status                                                            | Percentage of patients with an HIV diagnosis who were homeless or unstably housed in the 12-month measurement period                                                                                       | HRSA            | Cat 2        |
| Lung Function/Spirometry Evaluation (asthma)                              | Percentage of patients aged 5 years and older with asthma and documentation of a spirometry evaluation, in the medical record within the last 24 months                                                          | AAAAI           | Cat 2        |

Acronyms: AAAAI - The American Academy of Allergy, Asthma & Immunology, OASAS - Office of Alcoholism and Substance Abuse Services, HRSA - Health Resources and Services Administration
# HIV/AIDS VBP Arrangement – 2017 Measure Set included in the TCGP/ IPC Measure Set (2 of 2)

## Category 2

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Description</th>
<th>Steward</th>
<th>VBP Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Case Management: Care Plan</td>
<td>Percentage of medical case management patients, regardless of age, with a diagnosis of HIV who had a medical case management care plan developed and/or updated two or more times in the measurement year.</td>
<td>HRSA</td>
<td>Cat 2</td>
</tr>
<tr>
<td>Patient Self-Management and Action Plan</td>
<td>Percentage of patients aged 5 years and older with asthma and documentation of an asthma self management plan.</td>
<td>AAAAI</td>
<td>Cat 2</td>
</tr>
<tr>
<td>Prescription of HIV antiretroviral therapy</td>
<td>Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year. A medical visit is any visit in an outpatient/ambulatory care setting with a nurse practitioner, physician, and/or a physician assistant who provides comprehensive HIV care.</td>
<td>HRSA</td>
<td>Cat 2</td>
</tr>
<tr>
<td>Sexual History Taking: Anal, Oral, and Genital (HIV/AIDS)</td>
<td>Percentage of patients who were asked about sexual activity (3 sub-measures)</td>
<td>NYSDOH AIDS Institute</td>
<td>Cat 2</td>
</tr>
<tr>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis. The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher score indicates appropriate treatment of low back pain (i.e., the proportion for whom imaging studies did not occur).</td>
<td>NCQA</td>
<td>Cat 2</td>
</tr>
<tr>
<td>Utilization of Pharmacotherapy for Alcohol Dependence</td>
<td>The percentage of individuals with any encounter associated with alcohol use or dependence, with at least 1 prescription for appropriate pharmacotherapy at any time during the measurement year.</td>
<td>OASAS</td>
<td>Cat 2</td>
</tr>
<tr>
<td>Utilization of Pharmacotherapy for Opioid Use Disorder</td>
<td>The percentage of individuals with any encounter associated with opioid dependence, with at least 1 prescription or visit for appropriate pharmacotherapy at any time during the measurement year.</td>
<td>OASAS</td>
<td>Cat 2</td>
</tr>
</tbody>
</table>

Acronyms: HRSA - Health Resources and Services Administration, AAAAI - The American Academy of Allergy, Asthma & Immunology, OASAS - Office of Alcoholism and Substance Abuse Services, NCQA - National Committee for Quality Assurance, OASAS - Office of Alcoholism and Substance Abuse Services
VBP Quality Measure Set Annual Review

**Annual Review**

*Clinical Advisory Groups* will convene to evaluate the following:
- Feedback from VBP Contractors, MCOs, and stakeholders
- Any significant changes in evidence base of underlying measures and/or measurement gaps
- Categorization of measures and make recommended changes

**State Review Panel**
- Review data, technical specification changes or other factors that influence measure inclusion/exclusion*
- Review measures under development to test reliability and validity
- Review measure categorizations from CAG and make recommendations where appropriate (Cat. 1 vs. Cat. 2; P4P vs. P4R)
Thank you!

Questions?

Additional Information:
DOH Website:
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/providers_professionals.htm

Contact Us:
dsrip@health.ny.gov
vbp@health.ny.gov