



**Department
of Health**

**Medicaid
Redesign Team**

Chronic Pulmonary, Heart, Diabetes, and Primary Care Clinical Advisory Group (CAG) Meeting

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September 17, 2018

Agenda

1. Introduction 15 min
2. Recap of May 2018 VBP CAG meeting 15 min
3. National Quality Measure Updates 10 min
4. New York State (NYS) Core Quality Measurement Strategy 40 min
5. Overview of TCGP/ IPC Logic 10 min
6. MY 2018 Priority Clinical and Care Delivery Goals 20 min
7. Summary and Next Steps 10 min
8. Appendix

Section 1: Introduction

Roll Call

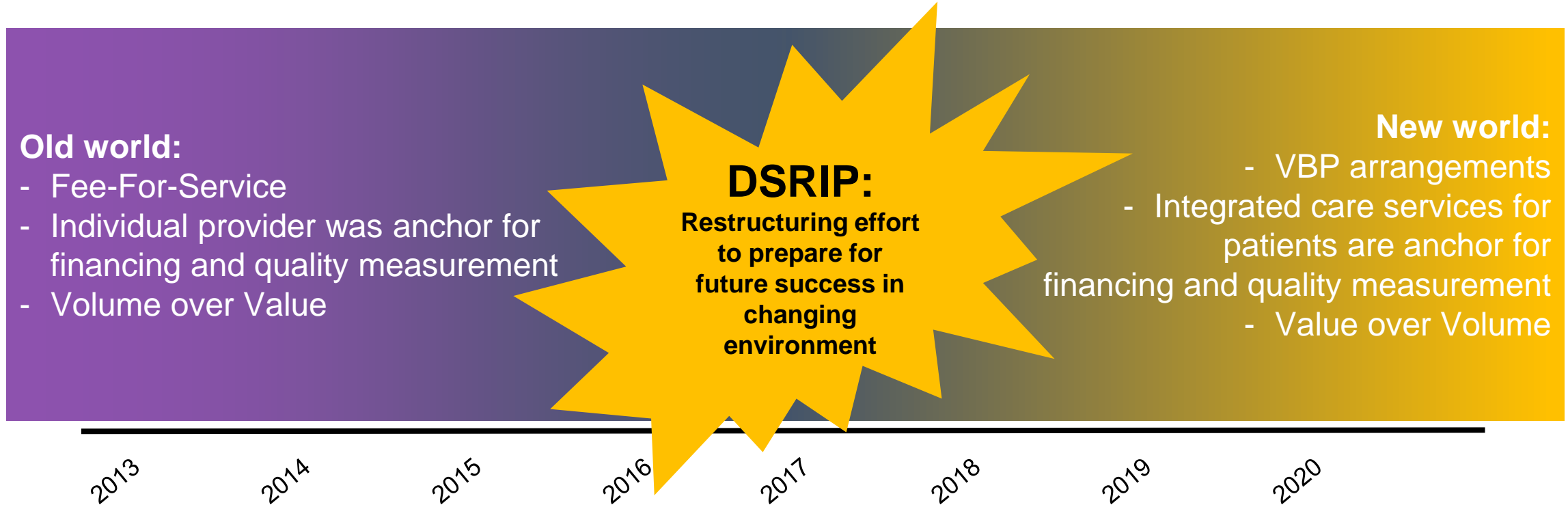
DSRIP → VBP Relationship

VBP Structure

Risk & Quality relationship

Timelines and Expectations

How DSRIP & Value Based Payment Programs (VBP) Relate



How is VBP Different from the Current Payment Structure?

- 1) Efficiency component - A **target budget** is set at the beginning of the year, against which costs (expenditures) are reconciled at the end of the year.
 - Services may be reimbursed as *fee-for-service* as they are now, or as a *per member per month (PMPM)* prospective payment.

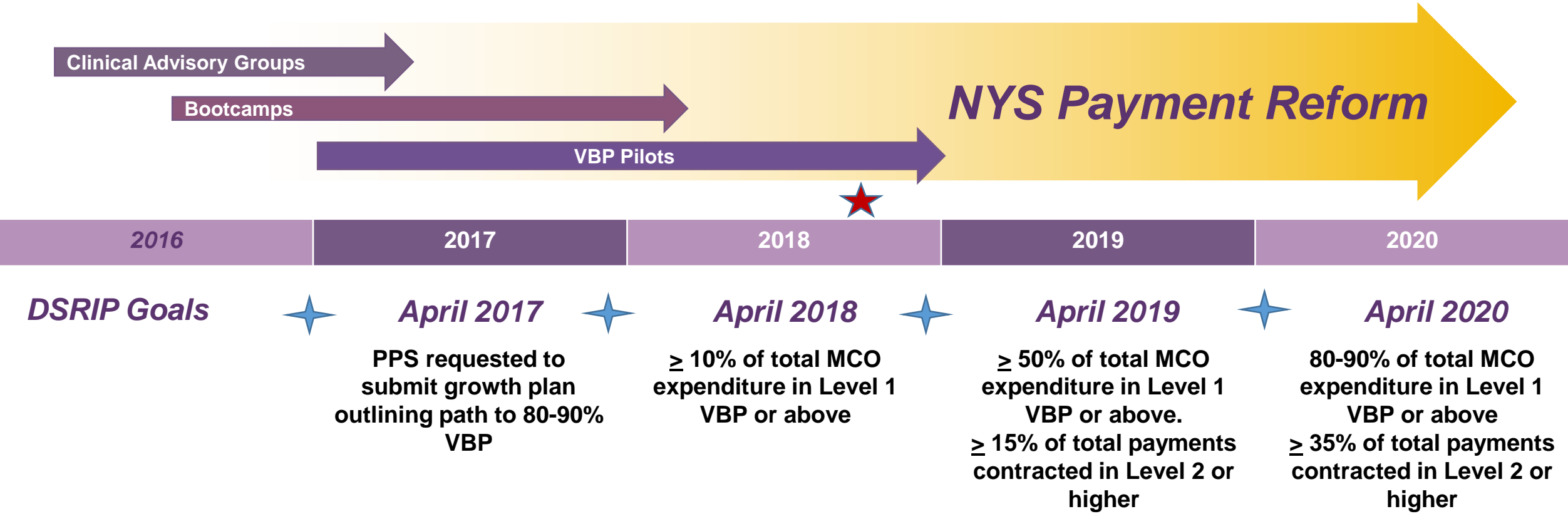
- 2) Quality component - A **percentage of performance measures** on the attributed population (those included in the arrangement) **must be passed** to share in any savings (or to determine the percentage of losses that must be made up).

Upside and Downside Risk-sharing Arrangements (NYS Guideline)

- While VBP encourages efficiency, **quality** is paramount!
- No savings will be earned without meeting minimum quality thresholds.
- NY State Medicaid's CMS-approved VBP Roadmap recommends that 50% of Pay-for-Performance (P4P) measures should be “passed” to qualify for any shared savings or to determine the proportion of any losses to be shared.
 - Other measures are required to be reported (Pay-for-Reporting (P4R)), but are not used for performance payments.

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.



CAG Timeline & Expectations for 2018

2018 CAG Goals

- Conduct annual review of the quality measure sets
- Identify and analyze clinical and care delivery gaps in current measure sets
- Propose recommendations for 2019

Timeline

- CAGs will convene in **spring and summer.**
- Based on CAG feedback, the State will present the proposed measure set to the VBP Workgroup for approval in **October**
- The final Measurement Year (MY) 2019 Quality Measure Sets will be released in **October/early November.**
- The MY 2018 VBP Reporting Requirements Technical Specifications Manual will be released in **October/early November.**

VBP Quality Measure Integration Timeline

Summary of 2017 Measure Readiness by VBP Measure Set

In February of 2017, a total of **76** unique quality measures were approved by the VBP Workgroup for further review and incorporation into the 2017 VBP Program. Of the unique measures approved by the VBP workgroup, the following were approved for reporting as Cat 1 or Cat 2 in 2017 through the following VBP arrangements:

TCGP/IPC Measure Set (40 Total Measures)	HARP Measure Set (41 Total Measures)	HIV/AIDS Measure Set (44 Total Measures)	Maternity Care Measure Set (18 Total Measures)
<ul style="list-style-type: none"> • 5 measures are unique to the TCGP/IPC Arrangements • 35 measures are shared with at least one of the other measure sets. 	<ul style="list-style-type: none"> • 9 measures unique to the HARP Arrangement • 32 measures that are also included in the TCGP/IPC Arrangement 	<ul style="list-style-type: none"> • 10 measures unique to the HIV/AIDS Arrangement • 34 measures that are also included in the TCGP/IPC Arrangement 	<ul style="list-style-type: none"> • 17 measures unique to the Maternity Care Arrangement • 1 measure that is also included in the TCGP/IPC Arrangement

2017 TCGP/IPC VBP Arrangement Summary

2017 TCGP/IPC VBP Quality Measure Set	2017 Measure Feasibility Review				Anticipated Integration			
	Feasible in 2017		Not Feasible in 2017		2018	2019	2020	Integration Date Unknown
Measure Set Total*	All Measures	Unique to TCGP/IPC	All Measures	Unique to TCGP/IPC				
40	23/40	14/35	17/40	21/35	+2 <i>(1 unique)</i>	+5 <i>(0 unique)</i>	+5 <i>(1 unique)</i>	5 <i>(1 unique)</i>
Category 1								
P4P	16/18	2/16	2/18	14/16	1	1	0	0
P4R	4/11	6/10	7/11	4/10	1	2	4	0
Category 2								
	3/11	6/9	8/11	3/9	0	2	1	5

*35 measures within the set are also included in the HARP, HIV/AIDS, or Maternity Care Measure Sets

Acronyms: P4R = Pay-for-Reporting; P4P = Pay-for-Performance

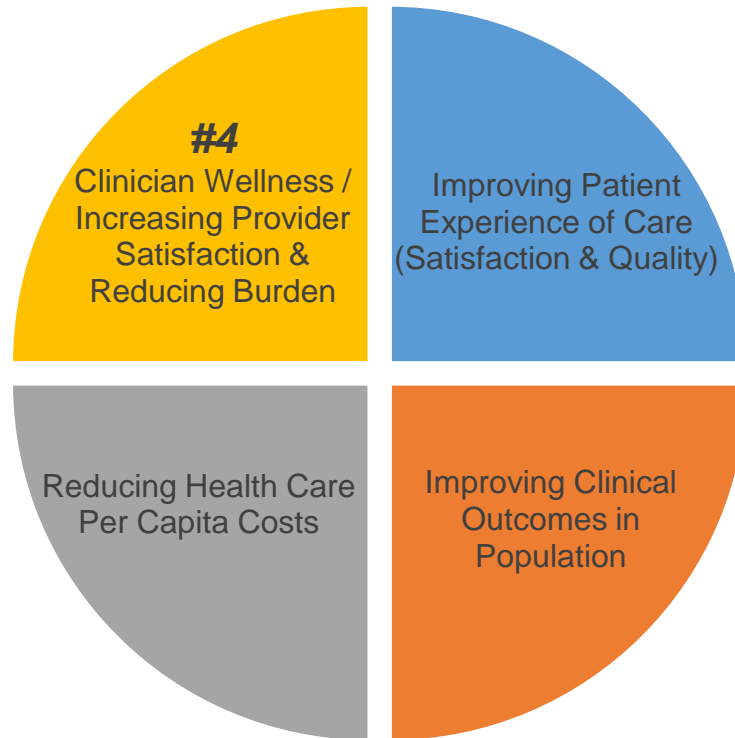
TCGP/ IPC VBP Arrangement Anticipated Measure Integration

	2018	2019	2020	Integration Date Unknown
Total New Measures	+ 1 <i>(1 unique)</i>	+ 6 <i>(0 unique)</i>	+ 5 <i>(1 unique)</i>	5 <i>(1 unique)</i>
Category 1 Measures				
P4P	Controlling High Blood Pressure	-	-	-
		Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	-	-
P4R	-	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow – Up Plan	Preventive Care and Screening: Influenza Immunization	-
	-	<i>Potentially Avoidable Complications in Routine Sick Care or Chronic Care</i>	Preventive Care and Screening: Screening for Clinical Depression and Follow–Up Plan	-
	-	-	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	-
	-	-	Comprehensive Diabetes Care: Foot Exam	-
Category 2 Measures				
	-	Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence	<i>Topical Fluoride for Children at Elevated Caries Risk, Dental Services</i>	Asthma: Assessment of Asthma Control – Ambulatory Care Setting
	-	Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence	-	Continuity of Care from Inpatient Detox or Inpatient Care to Lower Level of Care
	-	Use of Opioid Dependence Pharmacotherapy	-	<i>Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver</i>
	-	-	-	Lung Function/Spirometry Evaluation (Asthma)
	-	-	-	Patient Self–Management and Action Plan (Asthma)

Section 2: RECAP: May 2018 CAG Meeting Takeaways

Triple Aim → Quadruple Aim
Addressing Provider Satisfaction
Roadmap Review

Triple Aim → Quadruple Aim in Health Care



- Improving Patient Experience of Care
- Improving Clinical Outcomes in Population
- Reducing Health Care Per Capita Costs
- Increasing Provider Satisfaction

Addressing Provider Burnout

Some Good News: Provider burnout down 9% from 2017 to 42% of respondents reporting burnout. However, approximately 15% admitted to experiencing either clinical or colloquial forms of depression.
– AMA Wire, August 3, 2018

Leading Causes of Provider Burnout

- Physicians claims of too many bureaucratic tasks
- Less than desirable work schedule/ hours
- Lack of respect from patients
- Attitudes of colleagues
- Depression

Solutions & Ways VBP addresses *Provider Burnout*

- Developing and implementing workforce redesign strategies reduces administrative burden for those on the front lines including LMSW's, LCSW's, Nurse Practitioners of Psychiatry and Psychiatrists in Behavioral Health, *and*, Nurses, Nurse Practitioners and Physicians, and for all those in direct service.
- Adoption of Wellness programs.
- Seeking out new opportunities for education/professional growth.
- Limiting social isolation in work; increasing opportunities for social connectedness to combat increased time spent in documentation.

ROADMAP REVIEW AT A HIGH LEVEL: New York State's Medicaid VBP Plan...

“Is Not an attempt to make providers do more for less.”

In fact, under the State's VBP approach, **reducing lower value care** and **increasing higher value care** in equal proportions should lead to higher margins rather than lower margins.



*“Often, payment reform initiatives initially seem to increase the administrative burden; they necessarily constitute a change from the way current administrative processes and systems operate. They may require upfront investment for redesign and may require providers to temporarily straddle different payment systems simultaneously. Yet well-executed payment reform can significantly offset this complexity by reducing the need for micro-accountability (**such as the need for utilization review throughout the care process**), by not only standardizing rules and incentives across providers, but also by increasing transparency.”*

[2017 VBP Roadmap - Link](#)

Section 3: National Quality Measurement Updates

*Chronic Pulmonary, Heart, Diabetes and Primary Care
Mental Health and Substance Use*

National Quality Measurement Updates

Chronic Pulmonary, Heart, Diabetes and Primary Care

HEDIS 2019

- Measure Change – Controlling High Blood Pressure
 - Update the blood pressure target to <140/90 mm Hg for all hypertensive patients 18–85 years of age.
 - Remove the medical record confirmation requirement and use two outpatient encounters to identify the denominator.
 - Add administrative numerator specifications.
 - Allow use of telephone, videoconferencing, and asynchronous telehealth encounters to satisfy one of two required outpatient visits in the denominator.
 - Allow remote monitoring device readings directly transmitted to and interpreted by the provider to satisfy the numerator.

National Quality Measurement Updates

Mental Health

HEDIS 2019

- Follow-up after ED Visit for Mental Illness
 - Include members with a principal diagnosis indicating *intentional self-harm*:
 - Suicide attempt
 - Poisoning by drugs, medicaments and biological substances due to intentional self-harm
 - Toxic effects of nonmedicinal substances due to intentional self-harm
 - Asphyxiation due to intentional self-harm

Substance Use

HEDIS 2019

- New Measure – Risk of Chronic Opioid Use

Section 4: NYS Quality Measurement Strategy

Quality Measure Prioritization

Discussion of Measure Consolidation

Proposed Measure Changes for 2019

Quality Measure Prioritization: Goals for MY 2019

- Prioritize a focused list of high value quality measures for VBP in MY 2019.
- Key Principles in measure prioritization:
 - Process → Outcome;
 - Gather feedback from stakeholders on what are the “right” outcomes; and
 - Focus on efficient measurement
- Reduce the number of measures in use for VBP to focus on a core set and minimize administrative burden for providers where possible.
- Focus on measures compiled from clinical, rather than claims, data to allow for feedback loops from the measure back into clinical decision making.
- Align quality measurement efforts across stakeholder communities and State and Federal-led quality programs.

Recommended: TCGP/IPC 2018 Priority Measures

TCGP/IPC 2018 Outcome Measures

Outcome / Intermediate Outcome Measures

1

Priority Evidence Based Process Measures

- These measures represent the only outcome measures in the TCGP/IPC measure set
- BH CAG recommended two areas for measure prioritization
 1. Adding IET to address lack of outcome measures for SUD
 2. Depression outcome measures should be prioritized over screening for depression (Not currently included in the set)
- Looking for feedback on these measures

How does the 2018 TCGP/IPC Measure set align with the Advanced APM quality measure criteria?

Included on the 2018 MIPS List of Measures

- 21 measures in both the 2018 MIPS and TCGP/IPC measure sets
- 19 process measures (18 Cat 1, 1 Cat 2)
- 2 outcome /intermediate outcome measures (both Cat 1)

Endorsed by a "consensus-based entity" (i.e. NQF)

- 20 NQF endorsed measures in both the 2018 MIPS and TCGP/IPC measure sets (all Cat 1)
- 11 NQF endorsed measures in TCGP/IPC but not on the MIPS list (8 Cat 1, 3 Cat 2)

Other TCGP/IPC Measures

- 21 measures in the TCGP/IPC measure set that are not on the MIPS list and are not NQF endorsed (9 Cat 1, 12 Cat 2)

2018 VBP TCGP/IPC Measures Included in MIPS Measure Set

TCGP/IPC Measure	Category	Classification	Measure Steward	NQF Endorsed?	MIPS Measure?
<i>Outcome / Intermediate Outcome Measures</i>					
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Cat 1	P4P	NCQA	Y	Y
Controlling High Blood Pressure	Cat 1	P4P	NCQA	Y	Y
<i>Process Measures</i>					
Anti-Depressant Medication Management	Cat 1	P4P	NCQA	Y	Y
Breast Cancer Screening	Cat 1	P4P	NCQA	Y	Y
Cervical Cancer Screening	Cat 1	P4P	NCQA	Y	Y
Childhood Immunization Status	Cat 1	P4P	NCQA	Y	Y
Chlamydia Screening for Women	Cat 1	P4P	NCQA	Y	Y
Colorectal Cancer Screening	Cat 1	P4P	NCQA	Y	Y
Diabetes Foot Care	Cat 1	P4R	NCQA	Y	Y
Diabetes: Eye Exam	Cat 1	P4P	NCQA	Y	Y
Diabetes: Medical Attention for Nephropathy	Cat 1	P4P	NCQA	Y	Y
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Cat 1	P4R	NCQA	Y	Y
Immunizations for Adolescents	Cat 1	P4P	NCQA	Y	Y
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Cat 1	P4P	NCQA	Y	Y
Medication Management for People with Asthma	Cat 1	P4P	NCQA	Y	Y
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Cat 1	P4R	NCQA	N	Y
Preventive Care and Screening: Influenza Immunization	Cat 1	P4R	AMA-PCPI	Y	Y
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Cat 1	P4R	CMS	Y	Y
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Cat 1	P4R	AMA-PCPI	Y	Y
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Cat 1	P4P	NCQA	Y	Y

2018 VBP TCGP/IPC Measures *Not* Included in MIPS

TCGP/IPC Measure	Category	Classification	Measure Steward	NQF Endorsed?	MIPS Measure?
<i>Outcome / Intermediate Outcome Measures</i>					
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Cat 1	P4R	NCQA	Y	N
Potentially Avoidable Complications in Routine Sick Care or Chronic Care	Cat 1	P4R	Altarum	N	N
<i>Process Measures</i>					
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	Cat 1	P4P	CMS	Y	N
Adolescent Preventative Care	Cat 1	P4R	NYS	N	N
Adolescent Well-Care Visits	Cat 1	P4R	NCQA	N	N
Annual Dental Visit	Cat 1	P4R	NCQA	Y	N
Asthma Admission Rate – ages 2-17	Cat 1	P4P	AHRQ	Y	N
Comprehensive Diabetes Care: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	Cat 1	P4P	NCQA	Y	N
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]	Cat 1	P4P	NCQA	Y	N
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Cat 1	P4P	NCQA	Y	N
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence	Cat 1	P4R	NYS	N	N
Use of Pharmacotherapy for Alcohol Abuse or Dependence	Cat 1	P4R	NYS	N	N
Statin Therapy for Patients with Cardiovascular Disease	Cat 1	P4R	NCQA	N	N *
Statin Therapy for Patients with Diabetes	Cat 1	P4R	NCQA	N	N
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	Cat 1	P4R	NCQA	Y	N
Well-Child Visits in the First 15 Months of Life	Cat 1	P4P	NCQA	N	N
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	Cat 1	P4P	NCQA	N	N

* There is another MIPS measure looking at Statin Therapy for Cardiovascular Disease

Recommended: 2019 VBP TCGP/IPC Measures to be removed

TCGP/IPC Measure	Category	Classification	Measure Steward	NQF Endorsed?	MIPS Measure?
<i>Outcome / Intermediate Outcome Measures</i>					
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	Cat 1	P4R	NCQA	Y	N
<i>Process Measures</i>					
Comprehensive Diabetes Care: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	Cat 1	P4P	NCQA	Y	N
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]	Cat 1	P4P	NCQA	Y	N
Diabetes Foot Care	Cat 1	P4R	NCQA	Y	Y *
Statin Therapy for Patients with Diabetes	Cat 1	P4R	NCQA	N	N

* Public comment from CMS to remove from MIPS

Children's Health CAG Recommendations

- The Children's Health CAG was tasked with selecting child-focused quality measures for inclusion in VBP arrangements beginning in 2018.
- A group of maternity measures were recommended based on their relevance to child health quality.
- These are applicable to TCGP as well as the Maternity arrangement, given Maternity is part of TCGP.
- The TCGP/IPC CAG is asked to review these measures (see table below) and consider which (if any) measures should be added to the TCGP/IPC measure set.
 - The Maternity CAG recommended Low Birth Weight, do you agree?
 - Any thoughts on the inclusion of Prenatal and Postpartum Care Visits?

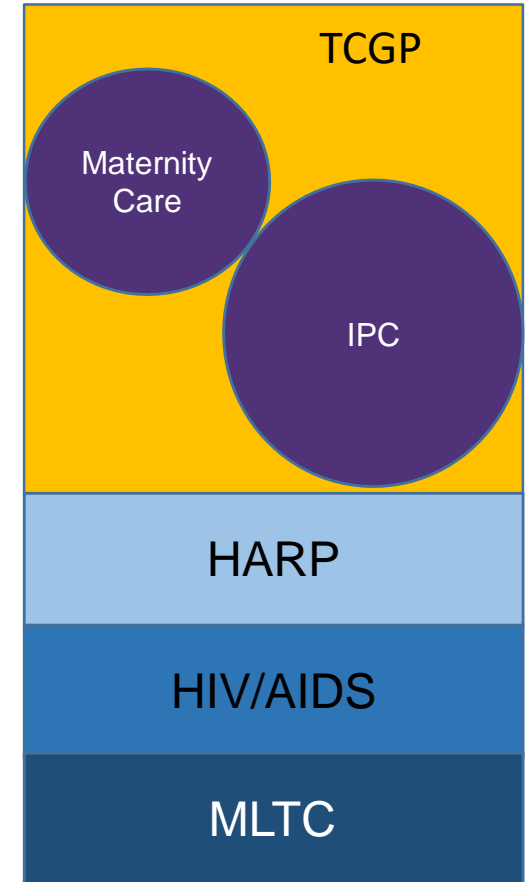
Recommended Measure	Description	Category	Classification	Measure Steward	NQF Endorsed?
Infants exclusively fed with breast milk in hospital	The number of newborns exclusively fed with breast milk during the newborn's entire hospitalization.	Cat 1	P4R	The Joint Commission	Y
Low Birth Weight Rate (PQI 9)	The number of Low birth weight (< 2,500 grams) infants per 1,000 newborns.	Cat 1	P4R	Agency for Healthcare Research and Quality	N
Prenatal and postpartum care visits	Prenatal Care: The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	Cat 1	P4P	National Center for Quality Assurance	N
Contraception care- Postpartum	Among women aged 15-21 who had a live birth, the percentage that is provided a most effective (sterilization, contraceptive implants, intrauterine devices or systems (IUD/IUS)) or moderately (injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery, or a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.	Cat 1	P4R	Office of Population Affairs	Y



Section 5: Overview of TCGP/ IPC Logic

VBP Arrangements

- Arrangement **Types***
 - Population:
 - Total Care for the General Population (TCGP)
 - Episode-based
 - Integrated Primary Care (IPC)
 - Maternity Care
 - Subpopulations
 - Health and Recovery Plans (HARP)
 - HIV/AIDS Care
 - Managed Long Term Care (MLTC)
- Department of Health (DOH) VBP Resource Library website ([Link](#))

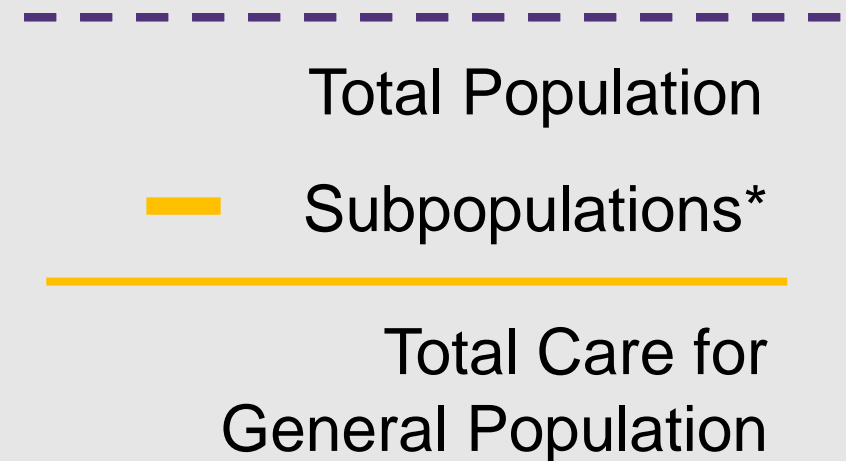


Total Care for the General Population

Goal: Improve population health through enhancing the quality of the total spectrum of care.

- Maximum impact for health systems focusing on both population health and streamlining specialty and inpatient care
 - This means providers will need to have the capability to invest in and focus on population health efforts.
 - Providers should focus efforts on addressing inefficiencies and potentially avoidable complications throughout the entire spectrum of care.
- All patients attributed to the arrangement, not just the patients a provider services, are included in TCGP.
 - Providers will likely need to invest in care coordination, referral patterns and discharge management.

In this arrangement, the VBP Contractor assumes responsibility for the care of the entire attributed population. Members attributed to this arrangement cannot be covered by a different arrangement.



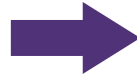
*Note: VBP Contractors and MCOs are free to add one or more subpopulations to their TCGP contracts.

Integrated Primary Care (IPC)

Components of Care



Preventive Care



Includes care activities such as wellness visits, checkups, immunizations, screening and routine tests.



Similar to Affordable Care Act (ACA) list of preventive care activities.



Sick Care



Includes care for symptoms such as headache or abdominal pain and minor acute conditions such as rhinitis, etc.



Chronic Care*



Consists of care related to 14 physical and behavioral chronic conditions that have been prioritized on the basis of prevalence and total costs.

14 episodes included in Chronic care:

- 1) Hypertension
- 2) Coronary Artery Disease (CAD)
- 3) Arrhythmia, Heart Block and Conductive Disorders
- 4) Congestive Heart Failure (CHF)
- 5) Asthma
- 6) Chronic Obstructive Pulmonary Disease (COPD)
- 7) Bipolar Disorder
- 8) Depression & Anxiety
- 9) Trauma & Stressor
- 10) Substance Use Disorder (SUD)
- 11) Diabetes
- 12) Gastro-esophageal reflux disease
- 13) Osteoarthritis
- 14) Lower Back Pain

Note: Patients who are attributed to subpopulations are excluded.

*Given the prevalence of chronic co-morbidities, VBP Contractors, by default, include the 14 chronic conditions as a whole within IPC, rather than selecting one or more of the individual chronic conditions.

Source: NYS Department of Health website: VBP Bootcamp – Session 1

Section 6: MY 2018 Priority Clinical and Care Delivery Goals

*Recap of 2017 CAG Feedback
Next Steps*

2017 Clinical Advisory Group Feedback Process

Work to Date



- The initial set of Priority Clinical and Care Delivery Goals presented to the CAGs in July 2017 and May 2018 was based on a review of the CAG and Integrated Care Workgroup (ICWG) Measure Set recommendations
- Following the July 2017 and May 2018 CAG meetings, members were asked to submit their feedback on the priority clinical and care delivery goals and sub-goals for each arrangement’s measure set.
- Responses were aggregated and used to update the goals and sub-goals targeted by each arrangement.

June 30, 2017 DRAFT 30

Worksheet: Recommendation of Additional Priority Goals

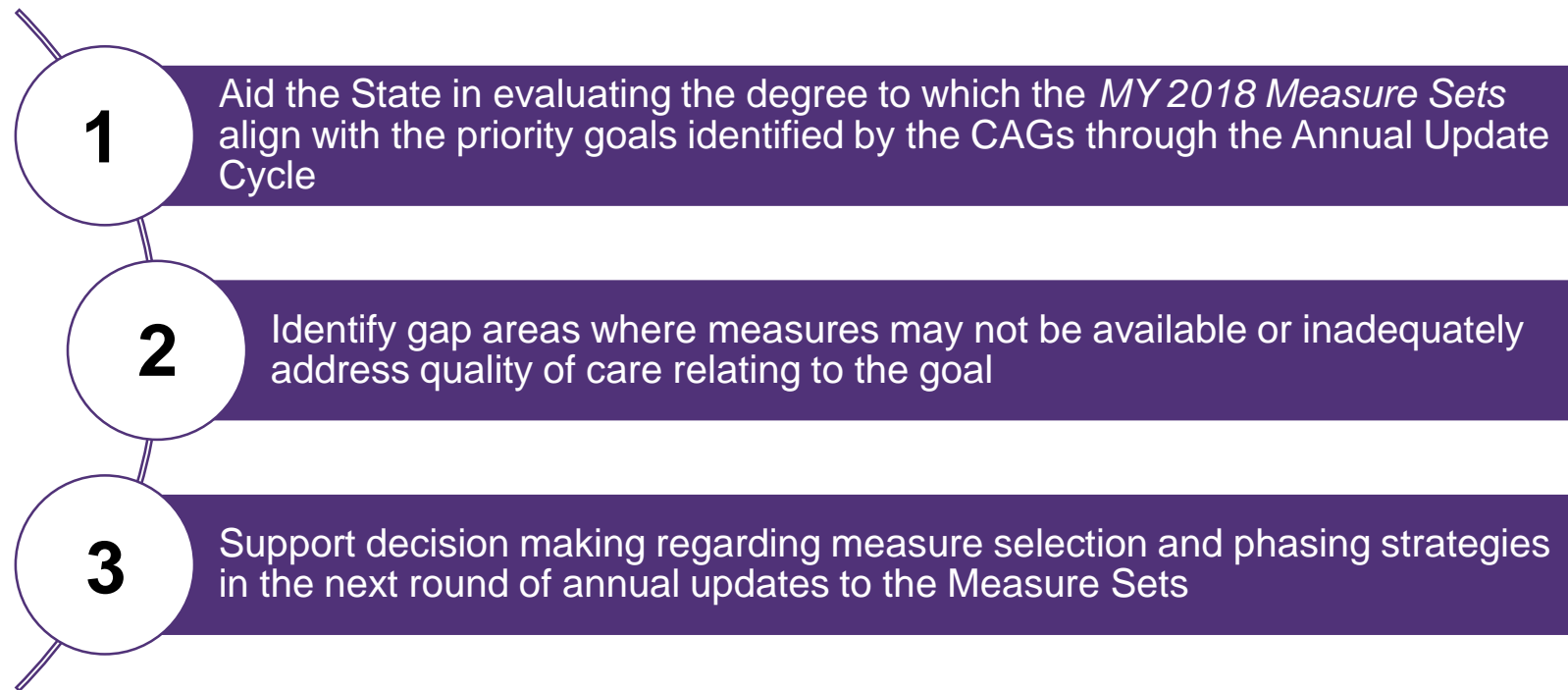
Phase	Clinical and Care Delivery Goals	Description	Additional Subgoals
	<i>Suggested Priority Goal 1</i>	<i>Description</i>	<i>(No Subgoals)</i>
1) Phase of Care	<i>Suggested Priority Goal 2</i>	<i>Description</i>	<ul style="list-style-type: none"> • <i>Subgoal 1</i> • <i>Subgoal 2</i>
2) Phase of Care			
3) Phase of Care			
4) Phase of Care			

**Further instructions on how to submit additional recommendations will be sent to the CAG members following this meeting.

HOMEWORK: Priority Clinical and Care Delivery Goals Analysis

- The *MY 2018 Measure Sets* have been reviewed against the priority clinical and care delivery goals identified by the CAGs through the MY 2018 Annual Update Cycle.
- The resulting report, *Measurement Year (MY) 2018 Priority Clinical and Care Delivery Goals: Supporting Measure and Gap Analysis*, aims to:



- The CAG is asked to review this document in advance of the next CAG meeting in late summer.

Summary of Feedback

Clinical and Care Delivery Goals

Recommendations for updates and modification of the four Clinical and Care Delivery Goal tables were extracted from both the July 2017 and May 2018 CAG meeting member discussion and the worksheets subsequently submitted to the Department of Health (DOH).

Feedback was analyzed to create a summary of key themes and incorporate recommendations into the existing priority clinical and care delivery goals.

Key Themes

1**General Primary and Secondary Prevention**

Recommendations fell into two core themes related to the addition of clinical and care delivery goals addressing control of modifiable risk factors to prevent the occurrence of chronic disease and the addition of goals focused on screening and early detection of disease.

2**Diabetes**

Feedback included emphasis on the importance of goals for patient self-management, optimal health behaviors, and psychosocial health, including depression and stress management, supporting optimal diabetes management and prevention of diabetes-related complications

3**Chronic Heart Disease**

Recommendations for additional goals related to psychosocial health and optimal lifestyle/health behaviors supporting self-management of chronic heart disease, slow disease progression, and prevent acute cardiovascular events.

4**Chronic Pulmonary Disease**

Recommendations supporting the addition of goals related to assessment of environmental exposures, self-management of asthma, and obesity screening/weight management for patients with chronic pulmonary disease.

Clinical and Care Delivery Goals

General Primary and Secondary Prevention

Based on feedback received, the Clinical and Care Delivery Goals table for General Primary and Secondary Prevention has been modified to include:

- Goals focusing on prevention and early detection of chronic diseases including diabetes, cardiovascular disease, and obesity.
- Additional goals for optimal health behaviors and psychosocial health including goals related to physical activity and stress management.
- Additional reproductive and sexual health goals related to HIV risk assessment and screening based on recommendations from the HIV/AIDS CAG.

Care Focus	Priority Clinical and Care Delivery Goals	
1) Immunizations/ Vaccinations	Childhood Immunizations	Prevention and Control of Seasonal Influenza with Vaccinations
2) Optimal Health Behaviors/ Lifestyle	Active Living / Regular Physical Activity Healthy Weight Nutrition	Screening and Prevention of Drug Abuse and Excessive Alcohol Use Tobacco Avoidance and Cessation Addiction Treatment
3) Prevention and Early Detection of Disease	Cancer Screening <ul style="list-style-type: none"> - Breast Cancer - Cervical Cancer - Colorectal Cancer Chronic Disease Screening <ul style="list-style-type: none"> - Pre-Diabetes - Cardiovascular Risk Assessment - Hypertension - Dyslipidemia - Obesity 	Medication Management <ul style="list-style-type: none"> - Daily Aspirin use as cardiovascular prophylaxis for those at elevated risk for cardiovascular disease/events [^]
4) Psychosocial Health	Depression Screening <ul style="list-style-type: none"> - Early Identification, Initiation of Treatment, and Management 	Psychosocial Stress Management
5) Reproductive and Sexual Health	Sexually Transmitted Infection Prevention <ul style="list-style-type: none"> - HIV Risk Assessment (Identification of at-risk patients) - HIV Pre-Exposure Prophylaxis (PrEP) 	Sexually Transmitted Infection Early Detection <ul style="list-style-type: none"> - Hep B Screening - Chlamydia Screening - HIV Screening - HIV Re-screening for at-risk patients (high-risk negatives)

Red text indicates goals that were added based on feedback

[^] Source: <https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/aspirin-to-prevent-cardiovascular-disease-and-cancer>

Clinical and Care Delivery Goals

Diabetes

Based on feedback received, the Clinical and Care Delivery Goals table for Diabetes has been modified to include:

- Incorporation of diabetes self-management.
- Inclusion of regular physical activity and exercise for diabetes management and prevention of cardiovascular comorbidities.
- Assessment and management of depression and psychosocial stressors in patients with diabetes.

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management	Access to Care Care Coordination Glycemic Control Cardiovascular Disease Diabetes Self-Management Eye Care Foot Care Kidney Disease Medication Management	Optimal Health Behaviors/Lifestyle <ul style="list-style-type: none"> - <i>Weight Management*</i> - <i>Nutrition*</i> - <i>Active Living/Regular Physical Activity*</i> - <i>Tobacco Avoidance and Cessation*</i> Psychosocial Health <ul style="list-style-type: none"> - <i>Depression Screening and Management*</i> - <i>Psychosocial Stress Management*</i>
2) Exacerbation and Complex Treatment	Access to Care Care Coordination	Clinical Outcomes

*Red text indicates goals that were added based on feedback.
 * Goals also included in General Primary and Secondary Prevention tables.*

Clinical and Care Delivery Goals

Chronic Heart Disease

Based on feedback received, the Clinical and Care Delivery Goals table for Chronic Heart Disease has been modified to include:

- Assessment and management of depression and psychosocial stress in patients with chronic heart disease.
- Inclusion of regular physical activity and exercise as part of the chronic heart disease management plan.

Care Focus	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management / Secondary Prevention	Access to Care Blood Pressure Control Cardiovascular Function (Ejection Fraction) Care Coordination Functional Status Assessment Lipid Control Medication Management Stroke Risk Assessment	Optimal Health Behaviours/ Lifestyle – <i>Weight Management*</i> – <i>Nutrition*</i> – <i>Active Living/Regular Physical Activity*</i> – <i>Tobacco Avoidance and Cessation*</i> Psychosocial Health – <i>Depression Screen and Management*</i> – <i>Psychosocial Stress Management*</i>
2) Acute / Hospitalization	Care Coordination Mortality	Outcomes
3) Post Acute / Rehab	Access to Care	Care Coordination
4) Cardiac Procedures	Cardiac Catheterization	

*Red text indicates goals that were added based on feedback.
 * Goals also included in General Primary and Secondary Prevention tables.*

Clinical and Care Delivery Goals

Chronic Pulmonary Disease

Based on feedback received, the Clinical and Care Delivery Goals table for Chronic Pulmonary Disease has been modified to include:

- Assessment of environmental exposures including indoor allergens and outdoor air pollution.
- Influenza and Pneumococcal vaccinations for chronic pulmonary disease patients at increased risk.
- Tobacco use assessment and cessation for patients with chronic pulmonary disease.
- Screening/management of obesity and weight management to support improvements in levels of pulmonary function and asthma control.

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Evaluation and Ongoing Management / Secondary Prevention	<p>Access to Care</p> <p>Asthma Severity Assessment and Monitoring</p> <p>Asthma Self-Management – <i>Management of Asthma Triggers</i></p> <p>Care Coordination</p> <p>Environmental Exposure – <i>Assessment of Environmental Exposures: Air Quality (indoor allergens; outdoor air pollution)</i></p>	<p>Immunizations/ Vaccinations – <i>Influenza</i> – <i>Pneumococcal</i></p> <p>Medication Management</p> <p>Optimal Health Behaviors/ Lifestyle – <i>Weight Management*</i> – <i>Tobacco Avoidance and Cessation*</i></p> <p>Obesity- Screening and Management</p> <p>Pulmonary Function</p>
2) Acute / Hospitalization	<p>Asthma Self-Management Mortality</p>	<p>Outcomes – <i>Utilization of Controller Medications</i></p>
3) Post Acute / Rehab	<p>Functional Status Assessment</p>	<p>Health Related Quality of Life</p>

Red text indicates goals that were added based on feedback.
 * Goals also included in General Primary and Secondary Prevention tables.

Children’s Health CAG

Priority Clinical and Care Delivery Goals – Maternity

The Children’s Health CAG met between October 2016 and July 2017. During deliberations the committee discussed maternity care and its impact on the newborn child. As a result, some of the clinical and care delivery goals underpinning the Maternity Quality Measure Set were also recommended for inclusion in Total Care for the General Population (TCGP).

All clinical and care delivery goals put forward by the Children's Health CAG are in alignment with the Maternity CAG goals.

Question: Do you agree that these clinical and care delivery goals (see table) should be included in TCGP arrangements?

Phase of Care	Priority Clinical and Care Delivery Goals	
1) Prenatal Care	Access to Care – Timely initiation of prenatal care Modifiable Risk Factors – Nutrition – Weight – Tobacco Avoidance and Cessation – Physical Activity/Exercise – Substance Use Disorder	Psychosocial Risk Assessment and Intervention – Depression, anxiety, and other mental illness – Drug and/or alcohol use – Stress management – Interpersonal violence Outcomes of Maternity Care – Low Birth Weight
2) Labor and Delivery	Breast Feeding Support Full Term Pregnancy	
3) Postpartum Care	Access to Care – Timely postpartum follow up	Postpartum Counseling/Education – Counseling on safe pregnancy spacing and family planning – Breastfeeding support – Social supports

Section 7: Summary & Next Steps

Request for Feedback / Submission of suggestions and recommendations

Summary / Takeaways

- Please provide any feedback on the evolving TGCP /IPC VBP Quality Measure set and send suggestions or recommendations.
- Consider the content of the *Closing Care Gaps* document and provide any recommendations of TCGP/IPC outcome measures that drive value.
- Provide any additional feedback and send your recommendations to Matt Reuter matthew.reuter@health.ny.gov by September 24, 2018.
- The final Measurement Year (MY) 2019 Quality Measure Sets will be released in **October/early November**.
- The MY 2018 VBP Reporting Requirements Technical Specifications Manual will be released in **October/early November**.

Thank you!

Section 8: Appendix

VBP Roadmap Levels in NYS

VBP Levels in New York State

- ✓ No financial risk to providers in Upside Only arrangements (Level1)
- ✓ In addition to choosing which integrated services to focus on, the MCOs and contractors can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)
FFS Payments	FFS Payments	FFS Payments	Prospective total budget payments
No Risk Sharing	↑ Upside Only	↑ Upside & ↓ Downside Risk	↑ Upside & ↓ Downside Risk