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

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Medical Director, Division of Program Development and Management

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Agenda

• DSRIP Program to Value-Based Payment
• Terminology and VBP Levels
• Target Budget Adjustments & Distribution of Shared Savings
• Measuring Performance for VBP Arrangements
• VBP Quality Measurement in 2018
Terminology

- **Behavioral Health** – Encompasses Mental Health or Substance Use conditions

- **Efficiency** – defined as ACTUAL cost /EXPECTED cost, and determines if there are savings or losses

- **Fee-for-Service** – 2 Usages: 1) Claims are submitted by the provider and paid by the plan, vs 2) Medicaid members who are not yet in Managed Care

- **Medicaid MCO** – Managed Care Organization (MCO) in Medicaid Program

- **PCP** – may be Primary Care **Provider** or Primary Care **Practitioner**, depending on the setting or usage, so be careful.

- **Provider** – can be a practice, a hospital, nursing home, community-based organization or a practitioner, as examples.

- **VBP Contractor** – An entity, either a provider or groups of providers, engaged with a Medicaid Managed Care Organization in a VBP contract.

- **VBP Roadmap** – CMS-approved document of standards, guidelines and recommendations pertaining to VBP in New York State’s Medicaid Program
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

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

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.

**DSRIP Goals**
- **April 2017:** PPS requested to submit VBP Needs Assessment
- **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.
- **April 2020:** 80-90% of total MCO expenditure in Level 1 VBP or above

Acronyms: NYS = New York State; PPS = Performing Provider System; MCO = Managed Care Organization
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.
Target Budget Setting Components are Flexible

The VBP Roadmap outlines a recommended, but not required, method to establish a target budget.

**Baseline Setting**

- **Guideline: Historic claims data**
  - 3 year look back. Recent years are weighted more.

**Trend Determination**

- **Guideline: Growth Trend**
  - 1 year look back weighted evenly by two factors:
    - VBP contractor specific growth trend (50%)
    - Regional growth rate (50%)

**Risk Adjustment**

- **Guideline: Risk Adjustment Factor**
  - TCGP = 3M CRG methodology
  - Subpopulations = risk adjustment methodology used for Plan rate setting
  - Bundles of Care (IPC, Maternity) = Altarum’s episode severity adjustment

**Performance Adjustment**

- **Guideline: Performance Adjustments (Efficiency / Quality)**
  - Adjustment to target budget with combined range of -6% to 6% for quality and efficiency.

The State does not mandate a specific methodology to be used to calculate a target budget for an arrangement. However, contracts should specify that a target budget will be used.
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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retrospective Reconciliation</td>
<td>Retrospective Reconciliation</td>
<td>Prospective (requires mature contractors)</td>
<td></td>
</tr>
<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</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>

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

Acronym Definition: Fee for Service (FFS); Per Member Per Month (PMPM)
# Level 1 Agreement

50% Shared Savings (Upside Only)

If Quality Metrics met

## Coordinated care among team members

### MCO Profit & Loss

<table>
<thead>
<tr>
<th>[A]</th>
<th>Revenue (Premium)</th>
<th>$6,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>[B]</td>
<td>Cost (Claims)</td>
<td>$4,600</td>
</tr>
<tr>
<td>[A-B]</td>
<td>Profit</td>
<td>$950 + $450 = $1,400</td>
</tr>
<tr>
<td>[S]</td>
<td>Shared Savings (50%)</td>
<td>$(450)</td>
</tr>
<tr>
<td>[A – B + S]</td>
<td>Total Profit / (Loss)</td>
<td>$950</td>
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</tbody>
</table>

### Provider Profit & Loss

<table>
<thead>
<tr>
<th>[B]</th>
<th>Revenue (Claims)</th>
<th>$4,600</th>
</tr>
</thead>
<tbody>
<tr>
<td>[C]</td>
<td>Provider Cost</td>
<td>$4,000</td>
</tr>
<tr>
<td>[B-C]</td>
<td>Profit</td>
<td>$600</td>
</tr>
<tr>
<td>[S]</td>
<td>Shared Savings (50%)</td>
<td>$(450)</td>
</tr>
<tr>
<td>[B – C + S]</td>
<td>Total Profit / (Loss)</td>
<td>$1,050</td>
</tr>
</tbody>
</table>

### Shared Savings Calculation

- **[TB]** Target Budget: $5,500
- **[B]** Claims: $4,600
- **[S]** Shared Savings: $450
- **[TB - B]** Shared Savings: $900

## Payer/MCO

- **State**: Forestland Care
- **Payer Premium**: $6,000 ($500 PMPM)

## Provider

- **Provider**: New York Medical Group
- **Provider Premium**: $4,000

## 2014 Claims

- **Primary Care**: $2,000
- **ER (Opioid Overdose)**: $2,600

Total: $4,600
Level 2 Agreement

90% Shared Savings (Upside)
50% Shared Losses (Downside)
If Quality Metrics Met

Coordinated care among team members

<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 $590 + $810 = $1,400</td>
<td>[B - C] Profit $600</td>
<td>[TB - C] Shared Savings $900</td>
</tr>
<tr>
<td>[S] Shared Savings (10%) $(810)</td>
<td>[S] Shared Savings (90%) $810</td>
<td></td>
</tr>
<tr>
<td>[A – B + S] Profit / (Loss) $590</td>
<td>[B – C + S] Profit / (Loss) $1,410</td>
<td></td>
</tr>
</tbody>
</table>

Payer

Forestland Care
Payer Premium $6,000 ($500 PMPM)
Provider New York Medical Group
contracts a VBP arrangement
2014 Claims Primary Care: $2,000
ER (Bench Press Accident): $2,600
Total: $4,600
Provider Cost $4,000
TCGP Budget $5,500

Shared Savings Calculation

Target Budget $5,500
Claims $4,600
Shared Savings $900

If Quality Metrics Met

Level 2 Agreement
## Level 3 Agreement

**Full Capitation**

### Coordinated care among team members

**State**

**Payer**
- **Payer**:
  - **Payer**:
    - **Premium**:
      - **Forestland Care**:
        - **Premium**: $6,000 ($500 PMPM)
  - **Provider**:
    - **New York Medical Group (contracts a VBP arrangement)**
  - **2014 Claims**:
    - **Primary Care**: $2,000
    - **ER (Bench Press Accident)**: $2,600
    - **Total**: $4,600
  - **Provider Cost**: $4,000
  - **TCGP Budget**: $5,500

### MCO Profit & Loss

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>[A]</td>
<td>Revenue (Premium)</td>
<td>$6,000</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>$5,500</td>
</tr>
<tr>
<td>[A – B]</td>
<td>Profit / (Loss)</td>
<td>$500</td>
</tr>
</tbody>
</table>

### Provider Profit & Loss

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>[B]</td>
<td>Revenue (Target Budget)</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>$5,500</td>
</tr>
<tr>
<td>[C]</td>
<td>Provider Cost</td>
<td>$4,000</td>
</tr>
<tr>
<td>[B – C]</td>
<td>Profit / (Loss)</td>
<td>$1,500</td>
</tr>
</tbody>
</table>
“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.” (VBP Roadmap, p. 41)

The State has seen success with the following intervention types:

1. Housing
2. Nutrition
3. Education
“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 ≤ 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
VBP Quality Measurement in 2018
TCGP/IPC Measures & Annual Review Process
Combined TCGP/IPC Measure Set

• The TCGP/IPC Quality Measure Set was created in collaboration with the Diabetes, Chronic Heart Disease, Pulmonary, Behavioral Health, and Children’s Health Clinical Advisory Groups (CAGs), as well as the NYS VBP Workgroup

• This aligned measure sets recommended for the Advanced Primary Care initiative by the Integrated Care Workgroup, the DSRIP Program, and Quality Assurance Reporting Requirements (QARR)

• The TCGP/IPC measure set includes both physical and behavioral health measures
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)
Key Challenges & Opportunities

**Challenges**

- Practitioner comfort with VBP
- Performance measurement on a VBP contractor, population level
- Reporting on non-claims-based measures

**Opportunities**

- Higher quality providers can negotiate higher target budgets.
- VBP creates opportunity to reward efficiency and quality in meaningful ways not available before.
- Level 3 VBP eliminates need for prior authorization and other administrative burdens.
What do VBP Contractors Need to Do to Succeed in VBP?

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.**
  - VBP Contractors will need to have the capability to invest in and focus on population health efforts.
  - VBP Contractors 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 serves, are included in TCGP.**
  - VBP Contractors will likely need to invest in care coordination, referral patterns and discharge management.

*Note: VBP Contractors and MCOs are free to add one or more subpopulations to their TCGP contracts.*
What do PCPs Need to Do to Succeed in VBP?

PCPs are core to the achievement of value based payment program goals.

- PCP patient relationships drive attribution for the majority of VBP arrangements

- PCPs may group together to form legal contracting entities, but must consider…
  - How will the total spectrum of care for the patient population be addressed?
  - What is the level of risk that can feasibly and practically be taken on?

- Most common method of PCP engagement in VBP = partnership with ACOs or IPAs

- Build internal capacity and competencies to transform into a high performing practice
  - Redesign workflows to perform better on key quality metrics
  - Operate more efficiently and incorporate evidence-based practices
  - Identify high risk patients using registries or other data sources
  - Involve care team members to coordinate care and address the social determinants of health
  - Partner with care management services through Medicaid Health Homes
  - Receive NYS Patient-Centered Medical Home (PCMH) recognition
Appendix
VBP Quality Measurement in 2018
TCGP/IPC Measure Classification and Categorization
Categorizing and Prioritizing Quality Measures

**Category 1** – Approved quality measures felt to be clinically relevant, reliable, valid, & feasible.

**Category 2** – Measures that are clinically relevant, valid and probably reliable, but where feasibility could be problematic.

**Category 3** – Measures that are insufficiently relevant, reliable, valid, 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.

Annual Update Cycle

Final VBP Arrangement Measure Sets and Reporting Guidance

• The VBP Quality Measure Sets for each arrangement will be finalized and posted to the NYS DOH VBP website by the end of October of the year preceding the measurement year. ([Link](#))

• The VBP Measure Specification and Reporting Manual will be released alongside the QARR reporting manual in October of the measurement year. ([Link](#))
TCGP/IPC Arrangement Measure Set for 2018
TCGP/IPC Arrangement Measure Set for 2018

- Beginning in the summer of 2017, the Diabetes, Chronic Heart Disease, Pulmonary, Behavioral Health, and Children’s Health CAGs made recommendations to the State on quality measures, with further feedback on measure feasibility provided by the VBP Measure Support Task Force and its arrangement-level Sub-teams.

- Based on these recommendations, the DOH approved 53 Category 1 and 2 quality measures (including both P4P and P4R measures) for the 2018 TCGP/IPC measure set.

- The following changes were made to the TCGP/IPC measure set based on the feedback received by the DOH from the CAGs and Measure Feasibility Task Force and Sub-teams.

<table>
<thead>
<tr>
<th>Measure Disposition</th>
<th>Rationale for Change</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Added to Cat 1</td>
<td>Recommended by Children’s Health CAG</td>
<td>8</td>
</tr>
<tr>
<td>Change from Cat 1 to Cat 2</td>
<td>Measure demoted because timeframe for measurement is too narrow</td>
<td>1</td>
</tr>
<tr>
<td>Change from Cat 2 to Cat 1</td>
<td>Timeframe for measurement is sufficiently broad</td>
<td>1</td>
</tr>
<tr>
<td>Added to Cat 2</td>
<td>Recommended by Children’s Health CAG</td>
<td>6</td>
</tr>
<tr>
<td>Change from Cat 2 to Cat 3</td>
<td>Measure specification change</td>
<td>2</td>
</tr>
<tr>
<td>Unchanged between MY 2017 and MY 2018</td>
<td></td>
<td>35</td>
</tr>
</tbody>
</table>
## 2018 TCGP/IPC VBP Quality Measure Set (1/4)
### Category 1

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Steward</th>
<th>NQF Measure Identifier</th>
<th>Classification</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder</td>
<td>CMS</td>
<td>1880</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
<tr>
<td>Adolescent Preventative Care – Assessment and Counselling of Adolescents on Sexual Activity, Tobacco Use, Alcohol and Drug Use, Depression</td>
<td>NYS</td>
<td>-</td>
<td>Cat 1 P4R</td>
<td>Recommended by Children’s Health CAG</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits</td>
<td>NCQA</td>
<td>-</td>
<td>Cat 1 P4R</td>
<td>Recommended by Children’s Health CAG</td>
</tr>
<tr>
<td>Annual Dental Visit</td>
<td>NCQA</td>
<td>-</td>
<td>Cat 1 P4R</td>
<td>Recommended by Children’s Health CAG</td>
</tr>
<tr>
<td>Antidepressant Medication Management - Effective Acute Phase Treatment &amp; Effective Continuation Phase Treatment</td>
<td>NCQA</td>
<td>0105</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>NCQA</td>
<td>2372</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>NCQA</td>
<td>0032</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
<tr>
<td>Childhood Immunization Status – Combination 3</td>
<td>NCQA</td>
<td>0038</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>NCQA</td>
<td>0033</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>NCQA</td>
<td>0034</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
</tbody>
</table>

**Acronyms:** CMS = Centers for Medicare and Medicaid Services; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; NYS = New York State
### 2018 TCGP/IPC VBP Quality Measure Set (2/4)

**Category 1**

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Steward</th>
<th>NQF Measure Identifier</th>
<th>Classification</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)</td>
<td>NCQA</td>
<td>0055, 0062, 0057</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Eye Exam (retinal) performed</td>
<td>NCQA</td>
<td>0055</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Foot Exam</td>
<td>NCQA</td>
<td>0056</td>
<td>Cat 1 P4R</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</td>
<td>NCQA</td>
<td>0575</td>
<td>Cat 1 P4R</td>
<td></td>
</tr>
<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%)</td>
<td>NCQA</td>
<td>0059</td>
<td>Cat 1 P4P</td>
<td></td>
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<tr>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]</td>
<td>NCQA</td>
<td>0057</td>
<td>Cat 1 P4P</td>
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<tr>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
<td>NCQA</td>
<td>0062</td>
<td>Cat 1 P4P</td>
<td></td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>NCQA</td>
<td>0018</td>
<td>Cat 1 P4P</td>
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</tr>
<tr>
<td>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</td>
<td>NCQA</td>
<td>1932</td>
<td>Cat 1 P4P</td>
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<tr>
<td>Follow-up Care for Children Prescribed ADHD Medication</td>
<td>NCQA</td>
<td>0108</td>
<td>Cat 1 P4R</td>
<td>Recommended by Children's Health CAG</td>
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<tr>
<td>Immunizations for Adolescents Combination 2</td>
<td>NCQA</td>
<td>1407</td>
<td>Cat 1 P4P</td>
<td>Recommended by Children's Health CAG</td>
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</table>

Acronyms: NCQA = National Committee for Quality Assurance
## 2018 TCGP/IPC VBP Quality Measure Set (3/4)

### Category 1

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Measure Steward</th>
<th>NQF Measure Identifier</th>
<th>Classification</th>
<th>Rationale for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)</td>
<td>NCQA</td>
<td>0004</td>
<td>Cat 1 P4P</td>
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<tr>
<td>Initiation of Pharmacotherapy upon New Episode of Opioid Dependence*</td>
<td>OASAS</td>
<td>-</td>
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<tr>
<td>Medication Management for Patients with Asthma (aged 5-64) – 50% and 75% of Treatment Days Covered</td>
<td>NCQA</td>
<td>1799</td>
<td>Cat 1 P4P</td>
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<tr>
<td>Pediatric Quality Indicator (PDI) #14 Asthma Admission Rate, Ages 2 Through 17 Years</td>
<td>AHRQ</td>
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<td>Recommended by Children’s Health CAG</td>
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<tr>
<td>Potentially Avoidable Complications in Routine Sick Care or Chronic Care</td>
<td>Altarum Institute (Formerly HCI3)</td>
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<td>Cat 1 P4R</td>
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<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>CMS</td>
<td>0421</td>
<td>Cat 1 P4R</td>
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<tr>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>AMA PCPI</td>
<td>0041</td>
<td>Cat 1 P4R</td>
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<tr>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>CMS</td>
<td>0418</td>
<td>Cat 1 P4R</td>
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<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>AMA PCPI</td>
<td>0028</td>
<td>Cat 1 P4R</td>
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<tr>
<td>Statin Therapy for Patients with Cardiovascular Disease</td>
<td>NCQA</td>
<td>-</td>
<td>Cat 1 P4R</td>
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* Measure name changed from MY2017.
Acronyms: AMA PCPI = American Medical Association Physician Consortium for Performance Improvement; AHRQ = Agency for Healthcare Research and Quality; CMS = Centers for Medicare and Medicaid Services; NCQA = National Committee for Quality Assurance; OASAS = Office of Alcoholism and Substance Abuse Services
## 2018 TCGP/IPC VBP Quality Measure Set (4/4)

**Category 1**

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<thead>
<tr>
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<th>Classification</th>
<th>Rationale for Change</th>
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</thead>
<tbody>
<tr>
<td>Statin Therapy for Patients with Diabetes</td>
<td>NCQA</td>
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<td>Cat 1 P4R</td>
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<tr>
<td>Use of Alcohol Abuse or Dependence Pharmacotherapy*</td>
<td>OASAS</td>
<td>-</td>
<td>Cat 1 P4R</td>
<td>Measure promoted because timeframe for measurement is sufficiently broad</td>
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<tr>
<td>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td>
<td>NCQA</td>
<td>0577</td>
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<td>Weight Assessment and Counselling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>NCQA</td>
<td>0024</td>
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<td>Well-Child Visits in the First 15 Months of Life</td>
<td>NCQA</td>
<td>1392</td>
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<tr>
<td>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life</td>
<td>NCQA</td>
<td>1516</td>
<td>Cat 1 P4P</td>
<td>Recommended by Children’s Health CAG</td>
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