NEW YORK STATE OF OPPORTUNITY. Department of Health

Value Based Payment Arrangements for Adults with Intellectual or Developmental Disabilities (IDD)

Progress Report of the IDD Value Based Payment Advisory Group

December 2016

NYS Medicaid Value-Based Payment

Introduction

Delivery System Reform Incentive Payment (DSRIP) Program & Value-Based Payment (VBP) Overview

The New York State DSRIP program aims to fundamentally restructure New York State's healthcare delivery system, reducing avoidable hospital use by 25 percent, and improving the financial sustainability of New York State's safety net.

To further stimulate and sustain this delivery reform, at least 80 – 90 percent of all payments made from Managed Care Organizations (MCOs) to providers will be captured within VBP arrangements by 2020. The goal of converting to VBP arrangements is to develop a sustainable system, which incentivizes value over volume. The Centers for Medicare & Medicaid Services (CMS) has approved the State's multiyear VBP Roadmap, which details the menu of options and different levels of VBP that the MCOs and providers can select and also outlines how the State sets quality measures per VBP arrangement.

The NYS VBP Roadmap outlines two types of VBP arrangements:

- Population-based VBP arrangements
- Episode-based VBP arrangements

This document describes the population-based IDD VBP arrangement.

The Intellectually/Developmentally Disabled VBP Advisory Group

Introduction

New York State's Office for People With Developmental Disabilities (OPWDD) has launched a comprehensive effort to transform its services in partnership with CMS. The joint goals of the transformation effort include:

- Developing new service options to better meet the needs of individuals and families in a truly person-centered way, including allowing for more self-direction of services;
- Creating a specialized managed care system that recognizes the unique needs of people with disabilities, and is focused on a habilitation model of services and supports;
- Ensuring that people live in the most integrated community settings;
- Increasing the number of individuals who are competitively employed;
- Focusing on a quality system that values personal outcome goals for people, such as an improved life or access to meaningful activities; and
- Working to make funding in the system sustainable and transparent.

As part of the effort, a diverse group of stakeholders was called together by OPWDD to examine the challenges of implementing the Transformation Agenda, which is focused on programmatic goals in the areas of community integration, employment and self-direction, as well as the transition to managed care. The panel was asked to shape clear and actionable recommendations to guide implementation. People with intellectual and developmental disabilities and their families, as well as advocates and providers were engaged throughout the process. A series of public meetings was convened at various locations around the state to gain the input of stakeholders through an unprecedented level of outreach. The results of the

Panel's work are contained in the Transformation Panel Report, *Raising Expectations, Changing Lives,* which lays out their process, vision and recommendations.[1]

One of the key questions posed by the Transformation Panel related to the implementation of managed care and VBP in the OPWDD system was how to use Managed Care and Value-Based Payment models to increase the accountability and flexibility of the system by rewarding providers for good performance. Managed care and VBP were identified as key platforms for change upon which other needed structural changes could be built using tools unavailable through the fee for service Medicaid system. In addition to the establishment of conflict-free Care Coordination Organizations in the OPWDD system, a plan for the transition to managed care is under development. This plan will be thoroughly vetted by stakeholders to ensure it meets the needs of the individuals and families supported by OPWDD. Managed care is the foundation for VBP, and in order to realize the full benefits of VBP for OPWDD services, a timely transition to managed care is essential.

To begin considering the question of how to implement VBP for individuals with IDD, OPWDD and DOH jointly convened an IDD VBP Advisory Group comprised of more than 40 stakeholder representatives including advocates, parents, individuals with IDD, and providers. Over the course of four meetings, the Advisory Group discussed key components of potential VBP arrangements, including the nature of the VBP arrangement for IDD as outlined in the New York State Roadmap, central values and tenets to be upheld in VBP for individuals with IDD, and quality and performance benchmarking and measurement appropriate for OPWDD services. For a full list of meeting dates and agendas, please see Appendix A.

It is important to note that additional meetings will be needed as the transition to managed care progresses. This interim progress report includes quality measures and concepts that are under development. The quality measures in particular should be viewed as conveying the desired direction and are indicative of a system endeavoring to advance more flexible, person-centered and community-oriented options.

Progress Report Content Overview

The Progress Report is contains two sections.

1. A Description of the IDD VBP Arrangement as Envisioned in the NYS Roadmap

This section provides an overview of the VBP arrangement design, which is envisioned as a total cost of care arrangement for designated IDD members.

2. IDD Quality Measure Discussion Summary

This section provides a description of the quality measures discussed by the Advisory Group to date and the initial criteria used to categorize and prioritize them. A preliminary list of measures recommended by the Advisory Group is included.

[1] The full report is available at https://opwdd.ny.gov/sites/default/files/documents/TransformationPanelReport-RaisingExpectationsChangingLives.pdf

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A Description of the IDD VBP Arrangement as Envisioned in the NYS Roadmap

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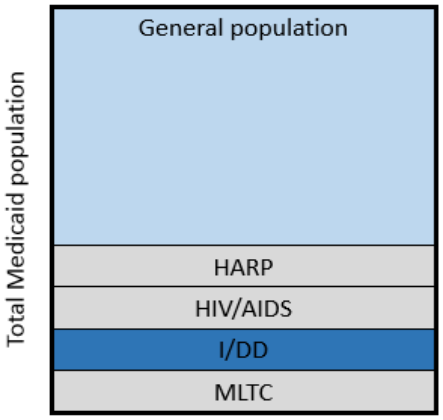
IDD VBP Arrangement Overview

New York State's VBP Roadmap[2] describes how the State will transition 80-90% of all payments from Managed Care Organizations to providers from Fee for Service (FFS) to VBP. The Roadmap identifies a range of VBP options and a menu of options for providers and plans seeking to transition to VBP. These include episodes and bundles of care such as maternity and integrated primary care, as well as total cost of care arrangements for designated member populations, called "subpopulation" arrangements. These total cost of care arrangements for designated populations are designed to incentivize maximum gains from care coordination across the multiple care "silos" with whom these members interact. There are four groups identified for this type of VBP arrangement, including IDD members:



- Members diagnosed with HIV/AIDS;
- Members in Health and Recovery Plans (HARP);
- Members in Managed Long-Term Care plans (MLTC); and
- Members with IDD, receiving OPWDD services.

Value based payments are designed to complement a managed care system, and as the timeframe for OPWDD's transition to managed care is finalized the design for value-based payments will also be finalized.

Members Included in the Total Cost of Care IDD VBP Arrangement

OPWDD is responsible for the provision of services to more than 128,000 New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, and other neurological impairments. It provides services directly and through a network of approximately 750 nonprofit service providing agencies, with about 80 percent of services provided by the private nonprofits and 20 percent provided by state-run agencies. Supports and services include Medicaid funded long-term care services such as habilitation and clinical services, as well as residential supports and services, and are primarily provided in community settings across the state. Largely because of intensive treatment needs, about 270 people continue to reside in institutional settings such as developmental centers. OPWDD services are provided to individuals with qualifying intellectual and/or development disabilities who meet eligibility criteria as defined in New York State law.

IDD members to be included in total cost of care IDD VBP arrangements receive OPWDD services funded by Medicaid. Support needs for IDD members and their families vary and conditions such as behavioral health or chronic physical health conditions may also be present and have an impact on lifetime health status. Regardless of the degree of support needed by any individual with developmental disabilities receiving services from OPWDD, the goal of OPWDD and its provider agencies is to maximize the capability of every individual to achieve personal goals, exercise choice, and live a full, meaningful life.

Services to be Included in the IDD VBP Arrangement

The IDD VBP arrangement is envisioned as a total cost of care arrangement. This type of arrangement is designed to maximize care coordination opportunities across multiple care "silos." The individual member forms the center of the arrangement and all the agencies and support services are arrayed around the individual. The total budget allows for maximum opportunity to respond to individual needs in flexible, creative ways and generate shared savings by streamlining services and developing more cost effective care options.

[2] https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_roadmap_final.pdf

Total cost of care for IDD would include primary and acute care, as well as OPWDD specialty services such as supported employment, day services, residential supports, Home and Community Based Services (HCBS), and care coordination. Other services relevant to IDD members and families may be included as the arrangement evolves.

It is also important to note that Medicare is an important potential source of support for IDD members, as nearly half of members are dually eligible for Medicaid and Medicare. Efforts to align New York's Medicaid VBP program with Medicare are underway, and will continue. For providers to fully realize the potential benefits of avoiding hospitalization and providing better primary care, Medicare participation is essential. In the meantime, however, the State will pursue the development of quality incentive initiatives to reward providers for generating savings that would otherwise accrue to Medicare.

Data limitations for dually eligible IDD members are also a factor, as Medicare data is not yet available in the Medicaid Data Warehouse (MDW). Although efforts are underway to link Medicare data in the MDW, total cost of care budget creation is hampered by the lack of claims data in the near term.

Member Attribution to the IDD VBP Arrangement

For the purposes of VBP, members are "attributed" to a provider group and a managed care plan. The cost of their care collectively then forms the basis for the creation of a VBP budget. Each member is attributed to only one arrangement, and for total cost of care "subpopulation" arrangements, designated members are not included in any other arrangements. The attribution assignment also helps to define which of the care partners will take primary responsibility for organizing or coordinating the care. In principle, the provider group that assumes attribution should also have control over the lion's share of resources available to provide the necessary care and supports for the member. This helps to align the opportunity for shared savings with the primary contracting provider(s).

Although attribution logic was discussed briefly with the IDD VBP Advisory Group, no decisions were made about how to attribute members. Network development among providers was identified as a key area of concern.

In order to help develop the kinds of provider networks needed to support managed care and total cost of care VBP arrangements, OPWDD is working with the provider community to develop Care Coordination Organizations (CCOs). A primary goal of the CCOs will be to coordinate services across multiple service systems including medical, behavioral health, and long-term support services. In addition to a focus on holistic care, the CCOs will have added information technology capabilities to support pay for performance through value-based payments. CCOs are expected to become a logical nexus for member attribution; their exact role in VBP arrangements will be finalized as they evolve.

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IDD VBP Arrangement Quality Measure Summary

December 2016

NYS Medicaid Value-Based Payment

IDD VBP Advisory Group

Quality Measure Discussion Summary

Over the course of four meetings the IDD VBP Advisory Group discussed how to appropriately measure quality for a total cost of care arrangement for members with IDD. One key area of focus for the group was on the potential for nontraditional measures to capture the unique aspects of OPWDD supports and services. Many of the supports and services provided by OWPDD fall outside the realm of healthcare. Clinical treatment and condition improvement measures are also not appropriate in many instances.

In order to identify the quality elements most valued among stakeholders, the group completed a brainstorming exercise. Each member was tasked with articulating a number of important indicators of quality to be upheld across the OPWDD system. The "frequency" of the occurrence of the various words among the lists was then charted. Not surprisingly, the most frequently used words were community, people, choice, relationships, employment, life, and staff. A graphic depiction – a "word cloud" – of the frequency of the words appears on the next page.

The measurement challenge is translating these values into tangible quality indicators while also capturing the important role that high quality traditional healthcare services play in the lives of individuals. One possible alternative source for person-centered measures for persons supported by OPWDD are Personal Outcome Measures®, or POMs.[3] POMs focus on a person's perception of the quality of his or her life, what he or she defines as important, and whether these preferences and goals have been achieved. POMs cover three domains with twenty-one individual measure. The three domains are: *My Self*, *My World*, and *My Dreams*. The *My Self* domain is captured with nine measures focusing on the individual's personal identity, experiences, and choices. The *My World* domain is comprised of seven outcome measures. These explore where the individual works, lives, socializes, and belongs. The third domain, *My Dreams*, includes five measures that cover the individual's goals and desires. (A full list of the POMS measures is provide in the Appendix.) The measures are collected through structured interviews by accredited, trained interviewers.

The POMs measures are developed and maintained by The Council on Quality and Leadership (CQL), a nonprofit organization dedicated to helping create "a world of dignity, opportunity, and community inclusion for all people".[4] CQL is focused on defining, measuring, and improving the quality of life for older adults, people with disabilities, and people with mental illness and/or substance use disorders. CQL started as an accreditation council of the Joint Commission on Accreditation of Hospitals but now offers its own independent accreditations in quality assurance and person-centered excellence. POMS are fairly widely used by agencies in the OPWDD system and CQL has certified and trained many POMs interviewers in New York. However, the adoption of POMs is not mandatory for OPWDD agencies and additional feasibility studies would be needed in incorporating POMs or other outcome measures in the VBP structure.

In addition to the nontraditional POMs measures the Advisory Group also reviewed and discussed other measure sets in use in the IDD field. These included:

- 33 Medicare ACO measures;
- The quality framework submitted to CMS for the Fully Integrated Duals Advantage (FIDA) IDD demonstration;
- National Quality Forum (NQF); and
- OPWDD system-wide performance and agency measures.

Preventive care was identified as a high priority, as members with IDD may experience difficulty undergoing routine examinations and procedures. Yet these examinations and procedures are essential for maintaining good physical health. Behavioral health needs were also flagged as especially important. Hospitalization and over medication are more common for individuals with IDD, and particularly those with significant communication challenges. Hence the group recommended several medication reconciliation measures.

[3] POMs are a version of the Patient Reported Outcome Measures, which are key outcome measures because they put the member's perspective as a central information source to define outcomes of care. See the Roadmap.
[4] http://www.thecouncil.org/about/cql-history

Although a complete list of recommended measures has not yet been finalized by the Advisory Group, a preliminary list of recommended measures is included in this report.

Figure 1: Results of the Group Exercise – A Word Cloud

The word cloud below is a visual presentation of qualitative data—words with greater prominence are words that were used more frequently in the written submissions from the Advisory Group.

Selecting Quality Measures: Criteria Used to Determine Relevance

The standard criteria for measure selection, used by all CAGs and not specific to I/DD, are presented below along with general examples.

Clinical relevance

Focused on key outcomes of integrated care process

- *Outcome measures (e.g., postpartum depression) are preferred over process measures (e.g., screening for postpartum depression);*
- *Outcomes of the total care process are preferred over outcomes of a single component of the care process (e.g., the quality of one type of professional's care)*

For process measures: crucial evidence-based steps in integrated care process that may not be reflected in the patient outcomes measured should be reflected *(e.g., focus on postpartum contraceptive care is key but will not be captured in outcomes of current maternity episode).*

Existing variability in performance and/or possibility for improvement *(e.g., blood pressure measurement during pregnancy is unlikely to be lower than >95% throughout the State).*

Reliability and Validity

Measure is well established by reputable organization

By focusing on established measures – those collected by the. NYS Office of Patient Quality and Safety (OQPS), endorsed by the National Quality Forum (NQF), part of the Healthcare Effectiveness Data and Information Set (HEDIS) measures, for example – validity and reliability of measures are assumed acceptable.

Outcome measures are adequately risk-adjusted *(e.g., measuring '% preterm births' without adequate risk adjustment makes it impossible to compare performance among providers).*

Feasibility

Claims-based measures are preferred over non-claims based measures (e.g. clinical data, surveys)

- *Ease of data collection data is an important consideration and measures should not place undue burden on providers.*

Existing sources are preferable when clinical data or surveys are required *(e.g., the vital statistics repository based on birth certificates).*

Patient-level data sources are preferable

- *Measures that require random samples (e.g. sampling patient records or using surveys) are not ideal because they do not drill down to the patient level and/or allow for adequate risk adjustment, and may add to the data collection burden. An exception is made for measures that are already part of DSRIP/QARR.*

Data must be available without significant delay

- *In general, measure data sources should not have a longer lag than claims-based measures (about six months). This is an issue with the vital statistics repository, for example, which has a one-year lag for New York City data.*

Meaningful and actionable to provider improvement in general

Measures should not only be related to the goals of care but be usable by the provider to improve care.

Categorizing and Prioritizing Quality Measures

Based on the above criteria, the CAG discussed the quality measures in the framework of three categories:

- **Category 1 –** Category 1 comprises approved quality measures that are felt to be clinically relevant, reliable, valid, and feasible.
- **Category 2 –** Category 2 quality measures were felt to be clinically relevant, valid, and probably reliable, but the feasibility could be problematic. These quality measures will likely be investigated during pilots but will likely not be implementable in the immediate future.
- **Category 3 –** Category 3 measures were decided to be insufficiently relevant, valid, reliable, and/or feasible.

Conclusion

Members of the IDD VBP Advisory Group participated in a broad ranging discussion of the key values and quality opportunities within the OPWDD system, and developed a preliminary list of quality measures. As the transition to managed care for OPWDD services begins to gain momentum, the group will likely need to be reassembled to make final recommendations.

Intellectually/Developmentally Disabled CAG Recommended Quality Measures – Category 1 and 2

It should be noted that the POMs measures included below reflect potential measures within the domains considered in the deliberations of the IDD VBP CAG to date in establishing priority outcomes for the OPWDD system. However, as OPWDD advances the use of outcome measures for VBP it may be necessary to substitute process measures to facilitate service providers' adoption of the performance measure subsets ultimately decided upon in the finalization of the VBP framework.

	No.	Measure	Measure Steward/Source
Category 1	1	People Choose Where and With Whom they Live	POMs®
	2	People Choose Where they Work	POMs®
	3	People Use their Environments (*has maximum access to each physical environment s/he frequents)*	POMs®
	4	People Participate in the Life of the Community	POMs®
	5	People have the Best Possible Health	POMs®
	6	People Interact with Other Members of the Community	POMs®
	7	People Perform Different Social Roles	POMs®
	8	Annual Dental Visit (ADV)	NCQA
	9	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	CMS
	10	Proportion of Adults who had blood pressure screened in past 2 years	CMS
	11	Colorectal Cancer Screening	NCQA
	12	Diabetes Composite: Hemoglobin A1c Control (HbA1c) (<8 percent)	NCQA
	13	Statin Therapy for Patients With Cardiovascular Disease	NCQA
	14	Diabetes Composite: Blood Pressure (BP) < 140/90	NCQA
	15	Diabetes Composite: Tobacco Non Use	NCQA
	16	Diabetes Composite: Aspirin Use	CMS
	17	Emergent Care for Improper Medication Administration or Medication Side Effects	CMS
Category 2	18	Antipsychotic Polypharmacy Monitoring of three or more agents	OPWDD – Under Development
	19	Psychotropic polypharmacy Monitoring	OPWDD – Under Development

CAG Categorization and Discussion of Measures – Category 1 & 2

Topic	#	Quality Measure (*= NQF Endorsed)	Type of Measure	Measure Steward/ Source	Data Required		Quality Measure Categorization and Notes	
					Medicaid Claims Data	Clinical Data	Category	Notes
POMs®	1	People choose where and with whom they live	Process	POMs®	No	Yes	1	This measure scores high on all criteria.
	2	People choose where they work	Process	POMs®	No	Yes	1	This measure scores high on all criteria.
	3	People use their environments	Process	POMs®	No	Yes	1	This measure scores high on all criteria.
	4	People participate in the life of the community	Process	POMs®	No	Yes	1	This measure scores high on all criteria.
	5	People have the best possible health	Process	POMs®	No	Yes	1	This measure scores high on all criteria.
	6	People interact with other members of the community	Process	POMs®	No	Yes	1	This measure scores high on all criteria.
	7	People perform different social roles	Process	POMs®	No	Yes	1	This measure scores high on all criteria.
Preventive Health	8	Annual Dental Visit (ADV)	Process	NCQA	Yes	Yes	1	This measure scores high on all criteria.
	9	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Process	CMS	Yes	Yes	1	This measure scores high on all criteria.
	10	Proportion of Adults who had blood pressure screened in past 2 years	Process	CMS	Yes	Yes	1	This measure scores high on all criteria.
	11	Colorectal Cancer Screening	Process	NCQA	Yes	Yes	1	This measure scores high on all criteria.
Diabetes Composite	12	Hemoglobin A1c Control (HbA1c) (<8 percent)	Process	NCQA	Yes	Yes	1	The advisory group felt that a diabetes composite was a valuable quality measure framework.
	13	Statin Therapy for Patients With Cardiovascular Disease	Process	NCQA	Yes	Yes	1	The advisory group felt that a diabetes composite was a valuable quality measure framework.
	14	Blood Pressure (BP) < 140/90	Process	NCQA	Yes	Yes	1	The advisory group felt that a diabetes composite was a valuable quality measure framework.
	15	Tobacco Non Use	Process	NCQA	Yes	Yes	1	The advisory group felt that a diabetes composite was a valuable quality measure framework.
	16	Aspirin Use	Process	CMS	Yes	Yes	1	The advisory group felt that a diabetes composite was a valuable quality measure framework.

Topic	#	Quality Measure (*= NQF Endorsed)	Type of Measure	Measure Steward/ Source	Data Required		Quality Measure Categorization and Notes	
					Medicaid Claims Data	Clinical Data	Category	Notes
Medication	17	Emergent Care for Improper Medication Administration or Medication Side Effects	Process	CMS	No	Yes	1	This measure scores high on all criteria.
	18	Antipsychotic Polypharmacy Monitoring of three or more agents	OPWDD – Under Development				2	Will need to work with OPWDD to define numerator & denominator to be vetted during pilots.
	19	Psychotropic Polypharmacy Monitoring	OPWDD – Under Development				2	Will need to work with OPWDD to define numerator & denominator to be vetted during pilots.

Additional CAG Requested Measures

During the quality measure, selection discussion the CAG identified additional measurement domains to be reviewed for consideration in a VBP Pilot arrangement.

Quality Measure (*= NQF Endorsed)	Measure Description	Type of Measure	Measure Steward/ Source	Data Required		Quality Measure Categorization and Notes	
				Medicaid Claims Data	Clinical Data	Category	Notes
Medication Reconciliation	Measure would need development						
Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient	This measure assesses the actual quality of the medication reconciliation process by identifying errors in admission and discharge medication orders due to problems with the medication reconciliation process. The target population is any hospitalized adult patient. The time frame is the hospitalization period.	Outcome	Brigham and Women´s Hospital	No	Yes		NQF # 2456
Medication Reconciliation Post-Discharge	The percentage of discharges for patients 18 years of age and older for whom the discharge medication list was reconciled with the current medication list in the outpatient medical record by a prescribing practitioner, clinical pharmacist or registered nurse.	Process	NCQA	Yes	Yes		NQF # 0097 This measure could be adapted to the I/DD population in the pilot phase.
Avoidable Hospitalization w/BH diagnosis	Measure would need development						
Hospital-Wide All-Cause Unplanned Readmission Measure	The measure estimates a hospital-level risk-standardized readmission rate (RSRR) of unplanned, all-cause readmission after admission for any eligible condition within 30 days of hospital discharge.	Outcome	CMS	Yes	No		NQF # 1789
Care Coordination	Measures connectivity among servicing providers would need development						

CAG Categorization and Discussion of Measures – Category 3

The following quality measures were considered to be insufficiently relevant, valid, reliable, and/or feasible.

Topic	#	Quality Measure (*= NQF Endorsed)	Type of Measure	Measure Steward/ Source	Data Required		Quality Measure Categorization and Notes	
					Medicaid Claims Data	Clinical Data	Category	Notes
POMs®	20	People are connected to support networks	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	21	People have intimate relationships	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	22	People are safe	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	23	People exercise rights	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	24	People are treated fairly	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	25	People are free from abuse and neglect	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	26	People experience continuity and security	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	27	People decide when to share personal information	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	28	People choose personal goals	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	29	People realize personal goals	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	30	People have friends	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	31	People are respected	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	32	People live in integrated environments	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.
	33	People choose services	Process	POMs®	No	Yes	3	The advisory group selected a subset of POMs® that they felt correlated with better overall care.

Topic	#	Quality Measure (*= NQF Endorsed)	Type of Measure	Measure Steward/ Source	Data Required		Quality Measure Categorization and Notes	
					Medicaid Claims Data	Clinical Data	Category	Notes
Avoidable Hospitalization	34	Acute Care Hospitalization	Outcome	CMS	Yes	No	3	The advisory group selected an Emergent Care measure and would like to look into a broad avoidable hospitalization measure
	35	Emergency Department Use without Hospitalization	Outcome	CMS	No	Yes	3	The advisory group selected an Emergent Care measure and would like to look into a broad avoidable hospitalization measure
	36	Emergency Department Use with Hospitalization	Outcome	CMS	No	Yes	3	The advisory group selected an Emergent Care measure and would like to look into a broad avoidable hospitalization measure
	37	Potentially Avoidable Hospitalizations: Primary Diagnosis: respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection	Outcome	CMS/NYS DOH	Yes	No	3	The advisory group selected an Emergent Care measure and would like to look into a broad avoidable hospitalization measure
Other At-Risk population measures	38	Percent of beneficiaries with hypertension whose BP < 140/90	Process	CMS/NCQA	Yes	Yes	3	The advisory group selected a diabetes composite measure set.
	39	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	Process	CMS/NCQA	Yes	Yes	3	The advisory group selected a diabetes composite measure set.
	40	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	Process	CMS/NCQA	Yes	Yes	3	The advisory group selected a diabetes composite measure set.
	41	Beta-Blocker Therapy for LVSD	Process	CMS/NCQA	Yes	Yes	3	The advisory group selected a diabetes composite measure set.
	42	ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	Process	CMS/NCQA	Yes	Yes	3	The advisory group selected a diabetes composite measure set.
Medical	43	Development of Urinary Tract Infection	Outcome	CMS	No	Yes	3	
	44	Increase in Number of Pressure Ulcers	Outcome	CMS	No	Yes	3	
Dental	45	Oral Evaluation, Dental Services	Process	American Dental Association on behalf of the Dental Quality Alliance	Yes	No	3	The advisory group selected Annual Dental Visit (ADV) as the quality measure for dental care.
	46	Children Who Have Dental Decay or Cavities	Process	The Child and Adolescent Health	Yes	No	3	The advisory group selected Annual Dental Visit (ADV) as the quality measure for dental care.

Topic	#	Quality Measure (*= NQF Endorsed)	Type of Measure	Measure Steward/ Source	Data Required		Quality Measure Categorization and Notes	
					Medicaid Claims Data	Clinical Data	Category	Notes
				Measurement Initiative				
	47	Children Who Received Preventive Dental Care	Process	The Child and Adolescent Health Measurement Initiative	Yes	No	3	The advisory group selected Annual Dental Visit (ADV) as the quality measure for dental care.
Seizures	48	Seizure Type(s) and Current Seizure Frequency(ies)	Process	American Academy of Neurology	Yes	No	3	The CAG determined this measure should be category 3.
Feeding/Choking	49	Improvement in Eating	Outcome	CMS	No	yes	3	The CAG determined this measure should be category 3.
Preventive Health	50	Pneumococcal Vaccination	Process	CMS/NCQA	Yes	Yes	3	The CAG determined this measure should be category 3.
	51	Tobacco Use Assessment and Cessation Intervention	Process	CMS	Yes	yes	3	The CAG determined this measure should be category 3.
	52	Depression Screening	Process	CMS/NCQA	Yes	Yes	3	The CAG determined this measure should be category 3.
Weight Control/BMI	53	Body Mass Index (BMI) in adults > 18 years of age	Process	City of New York Department of Health and Mental Hygiene	No	Yes	3	The CAG determined this measure should be category 3.
OB/GYN	54	Mammography Screening	Process	NCQA	Yes	Yes	3	The CAG determined this measure should be category 3.
	55	Annual cervical cancer screening or follow-up in high-risk women	Process	Resolution Health, Inc.	Yes	Yes	3	The CAG determined this measure should be category 3.

Topic	#	Quality Measure (*= NQF Endorsed)	Type of Measure	Measure Steward/ Source	Data Required		Quality Measure Categorization and Notes	
					Medicaid Claims Data	Clinical Data	Category	Notes
Medication	56	Drug Education On All Medications Provided To Patient/Caregiver	Process	CMS	No	Yes	3	The CAG determined this measure should be category 3.
	57	Potential Medication Issues Identified And Timely Physician Contact	Process	CMS	No	Yes	3	The CAG determined this measure should be category 3.
Care Coordination	58	Care Transition Record Transmitted to Health Care Professional	Process	AMA-PCPI	No	Yes	3	The CAG determined this measure should be category 3.
	59	Real Time Hospital Admission Notifications	Process	CMS/State defined measure	No	Yes	3	The CAG determined this measure should be category 3.
	60	Risk stratification based on LTSS or other factors	Process	CMS/State defined measure	No	Yes	3	The CAG determined this measure should be category 3.
	61	Discharge follow –up	Process	CMS/State defined measure	No	Yes	3	The CAG determined this measure should be category 3.
	62	Long Term Care Overall Balance Measure	Process	State-specified measure	No	Yes	3	The CAG determined this measure should be category 3.
	63	Nursing Facility Diversion Measure	Process	CMS	No	Yes	3	The CAG determined this measure should be category 3.
	64	Long Term Care Rebalancing Measure	Process	State-specified measure	No	Yes	3	The CAG determined this measure should be category 3.

Appendix A:

Meeting Schedule

Date		Agenda
CAG #1	January 21, 2016	A. Intellectually/Developmentally Disabled VBP Advisory Group Overview B. The Role of VBP in Achieving Quality, Cost Effective Care C. I/DD Services in Transition - The Transformation Agenda D. System Platforms – Total care, total population models E. Questions / Open Discussion
CAG #2	March 23, 2016	A. Review themes from first meeting B. Introducing new themes C. Exercise: Reflections on Value D. Special considerations for measuring quality E. Previewing Quality Measures
CAG #3	May 17, 2016	A. VBP Overview B. Group Exercise – Recap and Reflections C. I/DD VBP---the larger picture D. Quality Measures E. The IDD-FIDA framework
CAG #4	July 6, 2016	A. CAG objectives review B. Value opportunities/pathways discussion C. Quality Measure review & selection

Appendix B:

Full List of CQL POMs

My Self | *Who I am as a result of my unique heredity, life experiences and decisions.*

- People are connected to natural support networks
- People have intimate relationships
- People are safe
- People have the best possible health
- People exercise rights
- People are treated fairly
- People are free from abuse and neglect
- People experience continuity and security
- People decide when to share personal information

My World | *Where I work, live, socialize, belong or connect.*

- People choose where and with whom they live
- People choose where they work
- People use their environments
- People live in integrated environments
- People interact with other members of the community
- People perform different social roles
- People choose services

My Dreams | *How I want my life (self and world) to be.*

- People choose personal goals
- People realize personal goals
- People participate in the life of the community
- People have friends
- People are respected