NY State’s Value Based Payment Initiative: A Means to Improved Sexual Health Care
The Need For Better Sexual Health Care

Nationwide
People 15 to 24 year of age

Gonorrhea

- Diagnosed & reported
- Estimated total new infections

Chlamydia

- Diagnosed & reported
- Estimated total new infections

March 7, 2018
The Need For Better Sexual Health Care

New York State Cascade of HIV Care, 2014

- Estimated HIV Infected Persons: 123,000
- Persons Living w/ Diagnosed HIV Infection: 113,000, 92% of infected
- Cases w/ any HIV Care during the year*: 91,000, 74% of infected, 81% of PLWHI
- Cases w/ continuous care during the year**: 77,000, 62% of infected, 68% of PLWHI
- Virally suppressed (n.d. or ≤200/μl) at test closest to end-of-year: 77,000, 62% of infected, 68% of PLWHI, 84% of cases w/ any care

HIV Care Continuum, United States, 2014

- Diagnosed: 85%
- Receiving Care: 62%
- Retained in Care: 48%
- Virally Suppressed: 49%

An estimated 1.1 million people are living with HIV in the United States.
Current Challenges in Sexual Health Care

- Large system with wide range of provider services and expertise
- Heavy reliance on fee-for-service (FFS) payment methodology that incentivizes volume and may not pay for what is really needed
- Lack of accountability for high-need patients
- Few incentives to support sexual health - Primary Care integration
- Barriers to information sharing within health and social services systems (MCO, criminal and juvenile justice, homeless systems)
- Stigma around sexual health care
- Low percentage of people engaged in care

Delivery System Reform Incentive Payment (DSRIP) goals align with improved sexual health care goals

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

- **DSRIP** as a transformation tool
- To transform the system, DSRIP will focus on the provision of high quality, integrated primary, specialty and BH care in the community setting with hospitals used primarily for emergent and tertiary level of services

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

- **DSRIP** Program’s holistic and integrated approach to healthcare transformation = Better Sexual Health Care delivery system.

[DSRIP delivery system changes → VBP Readiness](https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/)
Engagement

Care managed by a coordinated set of integrated providers

Delivery

Episodic care with unnecessary ER visits & hospitalizations

Outcome

Poor condition control & increased risk of complications/comorbidities

DSRIP Health Outcomes vs. Status quo Health Outcomes

Today

Patient in Medicaid with HIV

Engagement

Intermittent care provided by separate providers, as necessary

Delivery

High quality care with a focus on prevention & prompt intervention

Outcome

Good condition control & decreased risk of complications/comorbidities

= Unnecessary strain on the patient and the healthcare system

= Value to the patient and the healthcare system
How DSRIP & Value Based Payment Programs (VBP) Relate

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

New world:
- VBP arrangements
- Integrated care services for patients are anchor for financing and quality measurement
- Value over Volume

DSRIP: Restructuring effort to prepare for future success in changing environment
The New World: Paying for Outcomes not Inputs

- By DSRIP Year 5 (2020), all MCOs must employ VBP systems that reward value over volume for at least 80 – 90% of their provider payments.

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 Managed Care Organization (MCO) - VBP Contractor 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.
MCO and Contractors can Choose Different Levels of VBP

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

<table>
<thead>
<tr>
<th>Level 0 VBP*</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP (feasible after experience with Level 2; requires mature contractors)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>Prospective total budget payments</td>
</tr>
<tr>
<td>No Risk Sharing</td>
<td>Upside Only</td>
<td>Upside &amp; Downside Risk</td>
<td>Upside &amp; Downside Risk</td>
</tr>
</tbody>
</table>

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

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

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. June 2016 updated version approved by CMS March 2017
Upside and Down Side Risk Sharing Arrangements (Guideline)

- 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</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Upside when actual costs &lt; budgeted costs</strong></td>
</tr>
<tr>
<td>&gt; 50% of Quality Targets Met Met</td>
<td>50% of savings returned to VBP contractors</td>
<td>Up to 90% of savings returned to VBP contractors</td>
</tr>
<tr>
<td>&lt;50% of Quality Targets Met 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>
</tr>
<tr>
<td>Quality Worsens</td>
<td>No savings returned to VBP contractors</td>
<td>No savings returned to VBP contractors</td>
</tr>
</tbody>
</table>

Standard: Implementation of Social Determinants of Health Intervention

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

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

“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)

VBP Arrangements

There is no single path towards Value Based Payments. Rather, there are a variety of options from which MCOs and providers can jointly choose:

Arrangement Types

- **TCGP**: All costs and outcomes for care, excluding MLTC, HARP, HIV/AIDS, and I/DD* subpopulations.
- **Episodic Care**
  - **IPC**: All costs and outcomes associated with primary care, sick care, and a set of chronic conditions selected due to high volume and/or costs.
  - **Maternity Care**: Episodes associated with pregnancies, including delivery and first month of life of newborn and up to 60 days post-discharge for mother.
- **Total Care for Special Needs Subpopulations**: Costs and outcomes of total care for all members within a subpopulation exclusive of TCGP.
  - **HARP**: For those with Serious Mental Illness or Substance Use Disorders
  - **HIV/AIDS**
  - **Managed Long Term Care (MLTC)**
  - **I/DD***

VBP Contractors can contract TCGP as well as Subpopulations as appropriate; nothing mandates that the Roadmap-defined arrangement types must be handled in standalone contracts.

*Total Care for the I/DD Subpopulation will be available as an arrangement when the population is moved to managed care.

Acronyms: MLTC = Managed Long Term Care; HARP = Health and Recovery Plans; I/DD = Intellectually/Developmentally Disabled
Total Care for the General Population (TCGP)

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.

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

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.
Integrated Primary Care (IPC)

**Components of Care**

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

Similar to 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.

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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
Integrated Primary Care (IPC)

Goal: Improve the quality of preventive care, sick care and the most prevalent chronic and high-cost conditions.

- VBP contractor is at risk for that component that it most controls and where the potential savings are high.
  - The IPC arrangement limits the risk to those components of the costs of care within the scope of influence of the primary care professionals.
- IPC contractors may opt to also contract a Level 1 TCGP contract for their attributed population.
  - Contractors can share in the potential savings realized outside the scope of the IPC bundle without sharing in the downside risk.
- Four of the chronic care episodes are related to behavioral health.
  - Providers should focus on integration of physical and behavioral health.
  - Engage and include other providers that may provide behavioral health services.
Maternity Care

Components of Care

Prenatal Care
Includes all services associated with pregnancy care, such as pre-natal care and visits, lab tests, medication, ultrasound, etc.

Delivery & Post-partum Care
Includes all services associated with the delivery, whether vaginal or cesarean section, up to 60 days post-discharge for the mother. Services such as facility costs, professional services, and any associated complications for mother and child are included.

Newborn Care
Includes all services associated with the newborn's care up to 30 days post-discharge.
Maternity Care

Goal: Improve the quality of care for both the mother and the newborn.

- Dedicated incentive to streamline the total spectrum of maternity care.
  - Providers should focus on reducing unnecessary cesarean sections, emphasizing the “right care at the right place” and improving dedicated health education, low-birth weight, and teenage pregnancy prevention.
- Providers should consider risk: Bundles with a total cost above a certain threshold (“stop-loss”) have costs above the threshold excluded.
  - This protects the VBP contractor from the risk of high-cost NICU admissions and excludes stillbirths or multiple live births.

Episodes in Maternity Care:

1) Pregnancy
2) Vaginal Delivery
3) C-Section
4) Newborn
Total Care for the Special Needs Subpopulations

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

- All services covered by the associated Managed Care Organizations are included, and all members fulfilling the criteria for eligibility to such plans are included.
  - Identify who these specific members are and tailor approaches to reduce inefficiencies and Potentially Avoidable Complications.
- Specialized providers dedicated to serving these populations will be in a strong position to generate shared savings.
  - Collaborate with Community-Based Organizations and address Social Determinants of Health.

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

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Total Population

TCGP

Subpopulations (HIV/AIDS, HARP, MLTC, I/DD*)

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*Total Care for the I/DD Subpopulation will be available as an arrangement when the population is transitioned into managed care.
The MY 2017 Quality Measure Sets for TCGP/IPC, Maternity, HIV/AIDS and HARP VBP arrangements have been finalized and posted to the NYS DOH VBP website (Link)
Background: Developing the Initial VBP Quality Measure Recommendations

**VBP Governance and Stakeholder Engagement**

1. **NYS DOH (OHIP)**
2. **VBPP Workgroup**
3. **Subcommittees (SCs)**
4. **Clinical Advisory Groups (CAGs)**
5. **Recommendations**

**Background:** Developing the Initial VBP Quality Measure Recommendations

**VBP Governance and Stakeholder Engagement**

1. **The VBP Workgroup** is a governing body that consists of NYS Health Plans, MCOs, and representative organizations (including physicians, health plan associations, hospital associations, legal firms specializing in health care contracting, NYS HHS Agencies, CBOs, patient advocates, PPSs, and other industry experts). **Its goal is to develop strategy and monitor the implementation of VBP in NYS.**

2. **The VBP CAGs and SCs** were created to address the larger VBP design questions. Their charge was to produce initial recommendations for design solutions to the VBP Workgroup and to the State. As a result, a number of VBP standards and guidelines were developed (included in the current version of the Roadmap) by the Subcommittees. The scope of work for the CAG included the recommendation of an initial set of quality measures for each of the VBP arrangements.
Determining Feasibility of Quality Measures Reporting

Measure Feasibility focused on 9 factors:

- **Specification** – Does the measure have clear specification for data sources and methods for data collection and reporting?
- **Reasonable Cost** – Does the measure impose an inappropriate burden on health care systems?
- **Confidentiality** – Does the data collection violate accepted standards of member confidentiality?
- **Logistical Feasibility** – Is the required data available for the specified reporting source?
- **Auditability** – Is the measure susceptible to manipulation or “gaming” that would be undetectable in an audit?
- **NYS Guidelines** – Does the measure conflict with current accepted NYS guidelines?
- **Duplicate Measures** – Does the measure conflict with, or is a duplicate of, other measures in the same or related set?
- **High Performance** – Has statewide performance already topped out on this measure?
- **Sample Size** – Is there sufficient sample size at the VBP contractor level?
Categorizing and Prioritizing Quality Measures

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

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

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

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

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

**Pay for Performance (P4P)**

- Measures designated as P4P are intended to be used in the determination of shared savings amounts for which VBP Contractors are eligible.
- Performance on the measures can be included in both the determination of the target budget and in the calculation of shared savings for VBP Contractors.

**Pay for Reporting (P4R)**

- Measures designated as P4R are intended to be used by MCOs to incentivize VBP Contractors for reporting data to monitor quality of care delivered to members under the VBP contract.
- MCOs and VBP Contractors will be incentivized based on timeliness, accuracy & completeness of data reporting.

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

Category 2

- Category 2 measures have been accepted by the State based on agreement of measure importance, but flagged as presenting concerns regarding implementation feasibility.
- The State requires that VBP Pilots make a good faith effort to explore reporting feasibility for Category 2 measures by including them in their contracting arrangements where possible.
- Plans participating in the Pilot Program were required to include a minimum of two Category 2 measures per arrangement to report on in their contracting arrangements, or have a State and Plan approved alternative.
- VBP Pilot participants will be expected to share meaningful feedback on the feasibility of Category 2 measures when the CAGs reconvene. The State will discuss measure testing approach, data collection, and reporting requirements with VBP pilots at a future date.

Category 3

- Category 3 measures were identified as unfeasible at this time or as presenting additional concerns including accuracy or reliability when applied to the attributed member population for the VBP arrangement. These measures will not be tested in pilots or included in VBP at this time.
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)
VBP Contracting, Measure Implementation and Reporting Timeline

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>VBP MY 2017 Provider VBP Contract Year</td>
<td>Data Capture</td>
<td>Final MCO Data Submission to DOH</td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>Biannual CAG Meeting</td>
<td>VBP Workgroup Meeting</td>
<td>Provider VBP Contract Year</td>
<td>Data Capture</td>
</tr>
<tr>
<td>2019</td>
<td>Annual CAG Meeting</td>
<td>VBP Workgroup Meeting</td>
<td>Provider VBP Contract Year</td>
<td>Data Capture</td>
</tr>
<tr>
<td>2020</td>
<td>Annual CAG Meeting</td>
<td>VBP Workgroup Meeting</td>
<td>Provider VBP Contract Year</td>
<td>Data Capture</td>
</tr>
</tbody>
</table>
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 and has been published for Measurement Year 2018. ([Link](#))

• The VBP Measure Specification and Reporting Manual will be released alongside the QARR reporting manual in October of the measurement year and has been published for Measurement Year 2017. ([Link](#))
<table>
<thead>
<tr>
<th>Measure</th>
<th>Arrangement Type(s)</th>
<th>Measure Steward</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Viral Load Suppression</td>
<td>HIV/AIDS</td>
<td>HRSA</td>
<td>1</td>
</tr>
<tr>
<td>Linkage to HIV Medical Care</td>
<td>HIV/AIDS</td>
<td>HRSA</td>
<td>2</td>
</tr>
<tr>
<td>Sexually Transmitted Diseases: Screening for Chlamydia, Gonorrhea, and Syphilis</td>
<td>HIV/AIDS</td>
<td>NCQA</td>
<td>2</td>
</tr>
<tr>
<td>Proportion of Patients with HIV/AIDS that have a Potentially Avoidable Complication during a Calendar Year</td>
<td>HIV/AIDS</td>
<td>Altarum Institute (Formerly HCI3)</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis C Screening</td>
<td>HIV/AIDS</td>
<td>HRSA</td>
<td>2</td>
</tr>
<tr>
<td>Prescription of HIV Antiretroviral Therapy</td>
<td>HIV/AIDS</td>
<td>HRSA</td>
<td>2</td>
</tr>
<tr>
<td>Sexual History Taking: Anal, Oral, and Genital</td>
<td>HIV/AIDS</td>
<td>NYS DOH AIDS Institute</td>
<td>2</td>
</tr>
<tr>
<td>Chlamydia Screening in Women</td>
<td>TCGP/IPC, HARP</td>
<td>NCQA</td>
<td>1</td>
</tr>
<tr>
<td>Adolescent Preventive Care– Assessment and Counseling of Adolescents on Sexual Activity, Tobacco Use, Alcohol and Drug Use, Depression</td>
<td>TCGP/IPC</td>
<td>NYS</td>
<td>1</td>
</tr>
</tbody>
</table>
## SUD Measures in VBP Arrangements

<table>
<thead>
<tr>
<th>Measure</th>
<th>Arrangement Type(s)</th>
<th>Measure Steward</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)</td>
<td>HARP, TCGP/IPC, HIV/AIDS</td>
<td>NCQA</td>
<td>1</td>
</tr>
<tr>
<td>Initiation of Pharmacotherapy for Alcohol Dependence</td>
<td>HARP, TCGP/IPC, HIV/AIDS</td>
<td>NYS Office of Alcoholism and Substance Abuse Services (OASAS)</td>
<td>1</td>
</tr>
<tr>
<td>Initiation of Pharmacotherapy for Opioid Use Disorder</td>
<td>HARP, TCGP/IPC, HIV/AIDS</td>
<td>NYS OASAS</td>
<td>1</td>
</tr>
<tr>
<td>Substance Abuse Screening</td>
<td>HARP, HIV/AIDS</td>
<td>Health Resources Services Administration, HIV/AIDS Bureau</td>
<td>1</td>
</tr>
<tr>
<td>Continuing Engagement in Treatment (CET) Alcohol and other Drug Dependence</td>
<td>HARP, TCGP/IPC, HIV/AIDS</td>
<td>NYS OASAS</td>
<td>2</td>
</tr>
<tr>
<td>Continuity of Care (CoC) within 14 Days of Discharge from Any Level of SUD Inpatient Care</td>
<td>HARP, TCGP/IPC, HIV/AIDS</td>
<td>NYS OASAS</td>
<td>2</td>
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<tr>
<td>Utilization of Pharmacotherapy for Alcohol Dependence</td>
<td>HARP, TCGP/IPC, HIV/AIDS</td>
<td>NYS OASAS</td>
<td>2</td>
</tr>
<tr>
<td>Utilization of Pharmacotherapy for Opioid Use Disorder</td>
<td>HARP, TCGP/IPC, HIV/AIDS</td>
<td>NYS OASAS</td>
<td>2</td>
</tr>
<tr>
<td>Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence</td>
<td>HARP</td>
<td>NCQA</td>
<td>1</td>
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<tr>
<td>Measure</td>
<td>Arrangement Type(s)</td>
<td>Measure Steward</td>
<td>Category</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<tr>
<td>Follow-up After Hospitalization for Mental Illness (within 7 and 30 days)</td>
<td>HARP</td>
<td>NCQA</td>
<td>1</td>
</tr>
<tr>
<td>Percentage of Members Enrolled in a Health Home</td>
<td>HARP</td>
<td>OMH/OASIS</td>
<td>1</td>
</tr>
<tr>
<td>Percentage of Mental Health Discharges Followed by Two or More Mental Health Outpatient Visits within 30 days</td>
<td>HARP</td>
<td>OMH</td>
<td>2</td>
</tr>
<tr>
<td>Rate of Readmission to Inpatient Mental Health Treatment within 30 days</td>
<td>HARP</td>
<td>OMH</td>
<td>1</td>
</tr>
<tr>
<td>Percentage of Members who Receive PROS or HCBS for at Least 3 months in Reporting Year</td>
<td>HARP</td>
<td>OMH/OASIS</td>
<td>1</td>
</tr>
<tr>
<td>Percentage of Members Who Maintained/Obtained Employment or Maintained/Improved Higher Education Status</td>
<td>HARP</td>
<td>OMH/OASIS</td>
<td>1</td>
</tr>
<tr>
<td>Percentage of Members with Maintenance of Stable or Improved Housing Status</td>
<td>HARP</td>
<td>OMH/OASIS</td>
<td>1</td>
</tr>
<tr>
<td>Percentage of Members with Reduced Criminal Justice Involvement</td>
<td>HARP</td>
<td>OMH/OASIS</td>
<td>1</td>
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<tr>
<td>Antidepressant Medication Management – Effective Acute Phase Treatment &amp; Effective Continuation Phase Treatment</td>
<td>TCGP/IPC, HIV/AIDS</td>
<td>NCQA</td>
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### Behavioral Health Measures in VBP Arrangements

Continued

<table>
<thead>
<tr>
<th>Measure</th>
<th>Arrangement Type(s)</th>
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<th>Category</th>
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</thead>
<tbody>
<tr>
<td>Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder</td>
<td>HARP, TCGP/IPC, HIV/AIDS</td>
<td>CMS</td>
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<tr>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow–Up Plan</td>
<td>TCGP/IPC, HIV/AIDS</td>
<td>CMS</td>
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</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>TCGP/IPC, HIV/AIDS</td>
<td>AMA PCPI</td>
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<tr>
<td>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</td>
<td>HARP, TCGP/IPC, HIV/AIDS</td>
<td>NCQA</td>
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### Conclusion: VBP = Better Sexual Health

<table>
<thead>
<tr>
<th>FFS / Status Quo</th>
<th>VBP</th>
</tr>
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<tbody>
<tr>
<td>PCP refers individual to HIV specialist for HIV care, and other sites for Behavioral Health care</td>
<td>Primary care, infectious disease specialist care, and behavioral health care are all virtually integrated</td>
</tr>
<tr>
<td>Acute care is given as next available appointments</td>
<td>Increased access to same day appointments to accommodate acute care needs</td>
</tr>
<tr>
<td>Care mostly delivered around acute illness episodes (IP hospital stays and ER visits)</td>
<td>Emphasis on preventive care, and shift in focus to member wellness in their communities</td>
</tr>
<tr>
<td>Primacy care and care management are distinct</td>
<td>Primacy care and care management are integrated</td>
</tr>
<tr>
<td>Care mostly directed by a single practitioner</td>
<td>Care coordinated by a multidisciplinary team, each member working to the full extent of her/his scope of practice</td>
</tr>
<tr>
<td>Medicaid member (or guardian) informs practitioner about what happened when hospitalized in another city</td>
<td>Integrated electronic network enables the practitioner to see the other providers’ labs, imaging studies and discharge summary</td>
</tr>
</tbody>
</table>
Additional Information:

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

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