NEW YORK STATE | Department of Health | Medicaid Redesign Team

# Value Based Payment Advisory Group - Children's Health Subcommittee / Clinical Advisory Group (CAG)

Children's Health VBP Advisory Group Meeting #4

Meeting Date: May 2, 2017, 10:00 am – 2:00 pm

# Meeting #4 Agenda

| Agenda Items | | Time | Duration |
|---|---|---|---|
| Morning Session | 1. Welcome and Introductions | 10:00 AM | 10 mins |
| | 2. DOH Update | 10:10 AM | 10 mins |
| | 3. Review and Update on Winter Progress | 10:20 AM | 10 mins |
| | 4. Matrix Feedback | 10:30 AM | 30 mins |
| | 5. Draft Recommendations Discussion | 11:00 AM | 60 mins |
| Break | Lunch | 12:00 PM | 30 mins |
| Afternoon Session | 6. Draft Measures Discussion | 12:30 PM | 80 mins |
| | 7. Next Steps and Closing | 1:50 PM | 10 mins |

# 1. Welcome and Introductions

Jeanne Alicandro and Kate Breslin, Co-Chairs

# 2. DOH Update

Jason Helgerson, NYS Medicaid Director

# 3. Meetings #1-3 Review and Update

Jeanne Alicandro and Kate Breslin, Co-Chairs
Chad Shearer, UHF

# Children's Health VBP Subcommittee / Clinical Advisory Group: Progress to Date

Meeting #1 (October 20, 2016)
- Reviewed NY VBP Process and Goals
- Explored NY Medicaid's child and adolescent population by utilization and expenditures
- Established value statement for children

Meeting #2 (November 18, 2016)
- Identified key model elements of appropriate children's VBP design
  - Components of Bailit Health model that should be incorporated
  - Discussion of subpopulations
- Explored quality measurement opportunities and challenges, and how other States/Providers/Plans have approached quality measurement

Meeting #3 (December 12, 2016)
- Outlined a "North Star" approach at each developmental stage to guide overall VBP approach, including measure selection.

Meeting #4 (Today: May 2, 2017)
- Review draft recommendations on VBP models and measures
- Define process for finalization of models and measures and reports to the VBP Workgroup

# SC/CAG Winter Progress

- Matrix development and refinement
  - North Star goals: What are we trying to achieve for every child?
  - North Star indicators: How do we know if we are making progress toward those goals?
  - Primary Care strategies: Which evidence-based approaches contribute to those goals?
  - Healthcare measures: Which existing measures correlate to those strategies?
- Measure review and discussion with OHIP and OQPS on VBP appropriateness
- Initiation of VBP options for behaviorally and medically complex children
- Draft recommendations based on meeting notes and off-line comments

# 4. Matrix Review

Jeanne Alicandro and Kate Breslin, Co-Chairs
Suzanne Brundage, UHF

# Matrix Purpose

To guide New York's VBP approaches for children by identifying goals for child health and development, and by identifying some of the strategies that high-value child-serving primary care could adopt – if enabled through supportive payment and quality measurement strategies – to improve health and developmental trajectories at each developmental stage.

This approach reflects the subcommittee's value statement, which states "Focusing on the healthy growth and development of children will improve their quality of life. Children require a value based payment approach that acknowledges the specific needs attendant to each developmental stage and the unique opportunity to improve health and life trajectories."

# Matrix Structure

3. What evidence-based primary care approaches contribute to those goals?

| Developmental Stage | Overarching "North Star" Goals & Key Indicators | Primary Care Strategies | Healthcare Measures |
|---|---|---|---|

1. What are we trying to achieve for every child?

2. How would we know if we were making progress toward those goals?

4. Which existing measures correlate to those strategies?

# Matrix Part 1

| Developmental Stage | Overarching "North Star" Goals & Key Indicators | Primary Care Strategies | Healthcare Measures |
|---|---|---|---|
| Prenatal through first month of age | Optimal birth outcomes for mother and child<br><br>• Pre-term birth rate<br>• Birthweight <2500 grams | Early and regular prenatal care visits<br><br>Screen and treat for risks, including preterm birth, tobacco/substance abuse<br><br>Encourage breastfeeding<br><br>Encourage birth spacing and counsel on contraceptive use | Timeliness and frequency of prenatal and postpartum care visits<br><br>(NQF #1391* and 1517*)<br><br>Behavioral risk assessment for pregnant women (AMA-PCPI*)<br><br>Rate of live births with weight less than 2500 grams (NQF #1382* )<br><br>Percentage of infants exclusively breastfed in the hospital (NYS vital stats)<br><br>Post-partum contraceptive uptake (NQF #2902)<br><br>Percentage of newborns screened prior to hospital discharge (NQF #1354) |

# Matrix Part 2

| | | | |
|---|---|---|---|
| One month of age to first birthday | Optimal physical health and a secure attachment with a primary caregiver<br><br>• An assessment of whether there is a gap between developmental and biological age. | Provision of regular well-child visits that incorporate developmental screenings, including for social-emotional health, and identification of social determinants of health<br><br>Provision of evidence-based home visitation programs<br><br>Screen for maternal depression and facilitate access to treatment<br><br>Screen for domestic violence/personal safety<br><br>Enhance parenting skills (e.g. Incredible Years, Screening for parental ACEs; SEEK screen and program; Healthy Steps) | Frequency of well-child visits during first 15 months (NQF 1392*)<br><br>Developmental screening using standardized screening tool (OHSU*)<br><br>Maternal depression screening during first six months of child's life (CMS MIPS set)<br><br>CAHPS experience of care survey, including items relevant to children with chronic conditions (NCQA*) |

# Matrix Part 3

| | | | |
|---|---|---|---|
| Ages 1 through 5 years | Developmentally on track at school entry<br><br>• Rates of children considered kindergarten ready using standardized tool<br>• Rates of referrals to Early Intervention | Provision of regular well-child visits that incorporate developmental screenings, including for social-emotional health, and identification of social determinants of health<br><br>Effective referral to Early Intervention treatment and community social service supports<br><br>Provision of age-appropriate dental screens and treatment<br><br>Enhance parenting skills (e.g. Incredible Years, Screening for parental ACEs; SEEK screen and program; Healthy Steps)<br><br>Provision of appropriate immunizations<br><br>Effective management of chronic conditions | Well-child visits, ages 3 to 6 (NQF 1516*)<br><br>Developmental screening through 36 months of life using standardized screening tool (OHSU*)<br><br>Children at elevated risk of carries who received fluoride varnish applications (NQF 2528)<br><br>Children ages 2 – 18 having annual dental visit<br><br>(NYS)<br><br>Child immunization status measure at age 2 (NQF 0038*)<br><br>Incidence of hospital admissions for any of two conditions: asthma, and gastroenteritis (AHRQ)<br><br>CAHPS experience of care survey, including items relevant to children with chronic conditions (NCQA*) |

# Matrix Part 4

| | | | |
|---|---|---|---|
| Ages 6 through 10 | Staying healthy and strengthening social, emotional and intellectual skills<br><br>• Scores on standard 3rd grade reading and math tests<br>• School attendance rates | Receipt of well-child visits<br><br>Counseling provided re weight, nutrition, and physical activity needs<br><br>Receipt of appropriate preventative dental care<br><br>Effective management and treatment of chronic conditions<br><br>Screening for behavioral health risks | BMI assessment and counseling (NQF 0024*)<br><br>Medication management for children with asthma, ages 5-11 (NQF 1799*)<br><br>Follow-up care for children prescribed ADHD Rx (NQF 0108*)<br><br>Suicide risk assessment (NQF 1365*) (MIPS)<br><br>CAHPS experience of care survey, including items relevant to children with chronic conditions (NCQA*)<br><br>Children ages 2 – 18 having annual dental visit (NYS) |

# Matrix Part 5

| | | | |
|---|---|---|---|
| Ages 11-14 | Staying healthy and coping effectively with challenges of early adolescence<br><br>• Scores on standards 8th grade reading and math tests<br>• School attendance rates<br>• Incidence of tobacco and substance abuse<br>• Incidence of positive screens for depression/anxiety<br>• Incidence of obesity | Receipt of adolescent well-care visits<br><br>Effective management of chronic conditions<br><br>Screening and counseling for depression, anxiety, use of tobacco, substance abuses, and sexual activity<br><br>Receipt of age-appropriate vaccines<br><br>Begin health care self-management /health literacy education | Rate of adolescent well-care visits (HEDIS*)<br><br>Med. Mgt. measure for teens with asthma ages 12-18 (NQF 1799*)<br><br>Assessment and counseling for adolescents on sexual activity, tobacco, depression and substance abuse (four NYS QARR measures)<br><br>BMI assessment and counseling (NQF 0024*)<br><br>Suicide risk assessment (NQF 1365*) (MIPS)<br><br>Follow-up care for children prescribed ADHD Rx (NQF 0108*)<br><br>Adolescent immunization rate, including rate for HPV (NQF 1407*) (MIPS)<br><br>Depression screening and follow-up plan, ages 12 and older (NQF 0418) (MIPS)<br><br>CAHPS experience of care survey, including items relevant to children with chronic conditions (NCQA*)<br><br>Children ages 2 – 18 having annual dental visit (NYS) |

# Matrix Part 6

| | | | |
|---|---|---|---|
| Ages 15 to 21 | Staying healthy and able to succeed in the world of work, school, and other adult responsibilities<br>• School drop-out rates<br>• High school graduation rates<br>• Adolescent pregnancy rates ages 15-17<br>• Incidence of tobacco and substance abuse<br>• Incidence of positive screens for depression/anxiety<br>• Incidence of obesity | Receipt of adolescent well-care visits<br><br>Effective management of chronic conditions<br><br>Screening and counseling for depression, anxiety, use of tobacco, substance abuses, and sexual activity<br><br>Receipt of age-appropriate vaccines<br><br>Continue health care self-management /health literacy education | Rate of adolescent well-care visits (HEDIS*)<br><br>Med. Mgt. measure for teens with asthma ages 12-18 (NQF 1799*)<br><br>Assessment and counseling for adolescents on sexual activity, tobacco, depression and substance abuse (four NYS QARR measures)<br><br>BMI assessment and counseling (NQF 0024*)<br><br>Suicide risk assessment (NQF 1365*) (MIPS)<br><br>Depression screening and follow-up plan, ages 12 and older (NQF 0418) (MIPS)<br><br>Adolescent immunization rate (NQF 1407*) (MIPS)<br><br>Screen for chlamydia, ages 16 – 21 (NQF 0033*)<br><br>CAHPS experience of care survey, including items relevant to children with chronic conditions (NCQA*)<br><br>Children ages 2 – 18 having annual dental visit (NYS) |

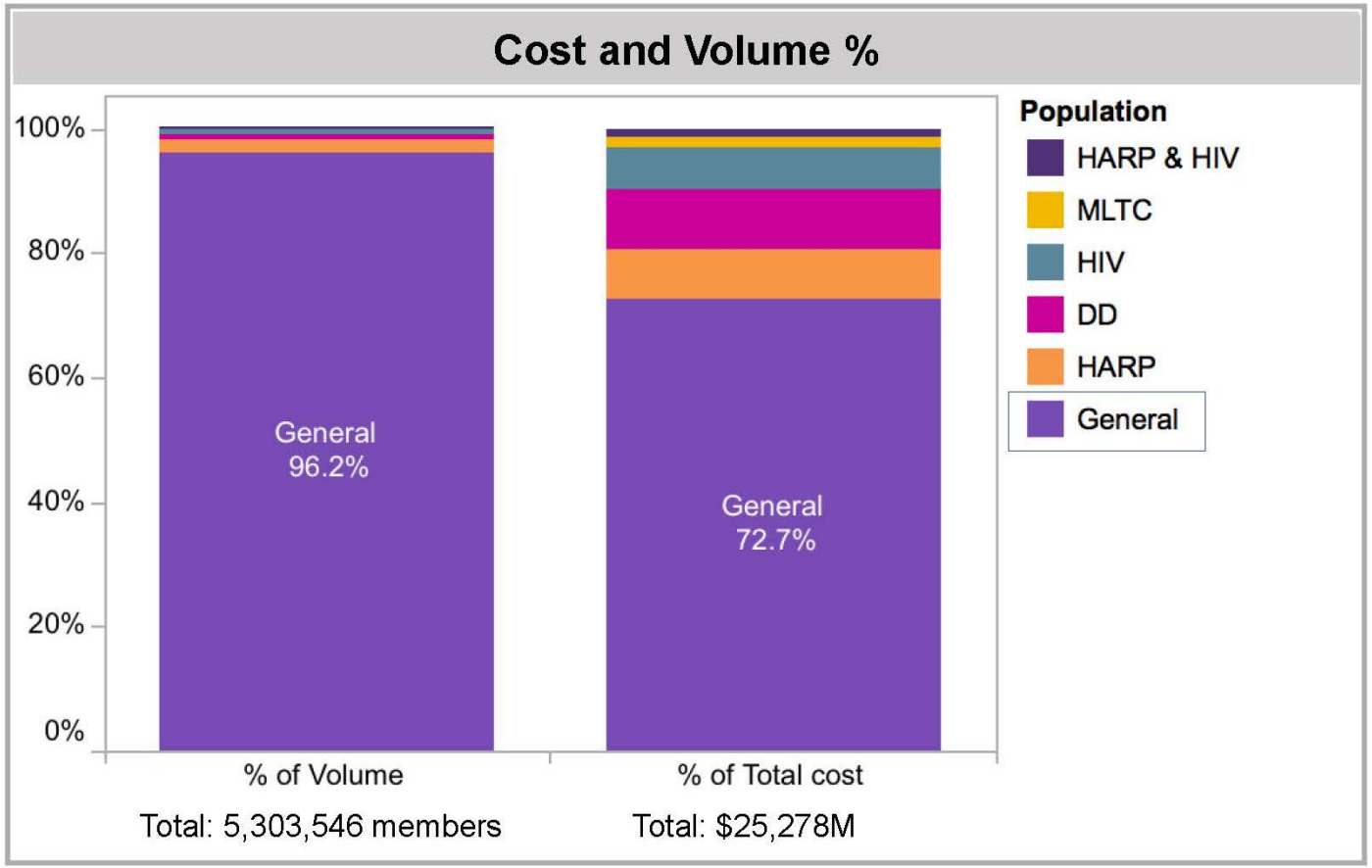
# Matrix Review Questions

1. Are the North Star goals right?
2. Are there better indicators available?
3. Are there missing primary care strategies?

# 4. Draft Recommendations Discussion

Jeanne Alicandro and Kate Breslin, Co-Chairs
Chad Shearer, UHF

# Total Care for General Population (TCGP) Definition




Total Population

Subpopulations*

Total Care for General Population

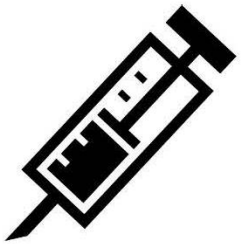
In this arrangement the VBP Contractor assumes responsibility for the care of the entire attributed population. Members attributed to this arrangement cannot be covered by a different arrangement.

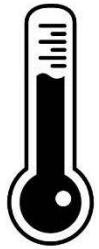
***Disclaimer:*** *Preliminary Data, work in progress; 2014, real-priced data*

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

# Integrated Primary Care

IPC = Preventive Care + Routine Sick Care + Chronic Care





*Note: Patients that are attributed to subpopulations are excluded.*

# Where Children Currently Factor in New York's Systemic Approach to VBP

## TCGP — Large-Scale Population Health Focused Providers

- About 2.1 million kids, ages 0-18, eligible to be included in these arrangements
- Measures from Advanced Primary Care (APC) preventive care set included, some with relevance for pediatric care, as well as chronic condition measures selected by CAGs & NYS

## IPC — Professional Practices Focused on Primary Care

- Covers preventive care, routine sick care, and chronic condition management for 14 conditions (e.g. diabetes and asthma) for designated age ranges depending on episode parameters
- Measures include APC preventive care set as well as measures specific to chronic conditions, some with pediatric relevance

## Subpopulation — Total Cost of Care for Designated Specialty Populations

- Covers all eligible services, care coordination is deemed a central value, and all general population as well as specialty measures (CAG & NYS selected) apply
- Example - HIV/AIDS includes about 1,600 children

# Recommendation Considerations

- The role of “North Star” goals across all recommendations
- The intersection of children’s recommendations with existing VBP models and measures
- Recommendation Type
  - A ***Standard*** is required when it is crucial to the success of the VBP Roadmap that all MCOs and providers follow the same method.
  - A ***Guideline*** is sufficient when it is useful for providers and MCOs to have a starting point for the discussion, but MCOs and providers may deviate as local flexibility may contribute to the overall success of the VBP Roadmap.
  - A ***Suggestion*** is a recommendation directed at the state that is not directly related to MCO and provider standards and guidelines.

# 3 Categories of Recommendations

1. VBP Principles and Payment Models
2. Measures
3. Additional Work/Deliberation

# Principles & Payment Models Recommendation #1

- **Type –** Suggestion
- **Description –** Children are not “little adults.” Focusing on the healthy growth and development of children will improve their quality of life. Children require a VBP approach that acknowledges the specific needs attendant to each developmental stage and the unique opportunity to improve health and life trajectories, as well as the importance of responding to immediate health needs. Support and recognition of families and caregivers is central to improving children’s lives.
- **Draft Recommendation –** The State should adopt the Matrix and it’s “North Star” goals as the guiding framework which recognizes the unique needs of children at different developmental stages, and the overarching role of primary care in both the delivery of healthcare services to children and the promotion of overall child well-being. Adoption of current and future payment models should be guided by this framework and the American Academy of Pediatrics Bright Futures Guidelines.

# Principles & Payment Models Recommendation #2

- **Type –** Suggestion
- **Description –** The vast majority of children are low-cost and not ideally served by VBP models that rely on shared savings/risk. Additional investment in child primary care services is necessary to maximally contribute to the Matrix goals. A wholly separate VBP model should be available to MCOs and providers that voluntarily wish to develop unique VBP contracts for the pediatric population.
- **Draft Recommendation –** The State should consider creating an additional on-menu option in the VBP Roadmap that allows MCOs and providers to enter into pediatric primary care capitation (PPCC) arrangements consistent with the sub-recommendations that follow. The model would be deemed a Level 3 VBP arrangement under the Roadmap.

# Principles & Payment Models Recommendation #2.1

- **Type –** Standard
- **Description –** PPCC arrangements are not ideal for medically and behaviorally complex children because they are insufficient to address the specialized needs and service utilization of these children.
- **Draft Recommendation 2.1 –** MCOs and providers should be allowed to enter into PPCC arrangements only for children who are in the bottom 80$^{th}$ percentile of the MCO's overall cost/utilization distribution among all its child members.

# Principles & Payment Models Recommendation #2.2

- **Type –** Guideline
- **Description –** The capitation rate in PPCC agreements must reflect the role of providers in screening and coordinating care for social and developmental threats to health, in addition to medical needs. The capitation should include enhancements sufficient to support all necessary screenings, risk-adjusted care coordination, and new workflows to address developmental needs and social determinants. The enhanced rate should incorporate behavioral health services for primary care practices with co-located and operational integrated behavioral healthcare. The capitation rate should exclude services where there may be a serious concern for underutilization.
- **Draft Recommendation 2.2 –** The capitation rate should include nearly all primary care service needs for children. MCOs and providers can agree to exclude services where there are underutilization concerns (e.g., vaccinations, developmental screenings). Parties may also agree to exclude pediatric services provided by some, but not all providers that are party to the PPCC arrangement (e.g., suturing).

# Principles & Payment Models Recommendation #2.3

- **Type –** Standard/Guideline
- **Description –** In a PPCC model, providers are paid a per-member / per-month payment for an attributed population of children. In order to ensure providers do not unduly limit child health utilization or reduce the quality of care provided under this model, a percentage withhold and periodic improvement/performance payment based on agreed to measures is necessary.
- **Draft Recommendation 2.3 –**
  - Standard – MCOs shall implement a withhold from the PPCC rate to be disbursed at least annually based on both improvement and high performance on all Category 1 P4P measures, and complete and accurate reporting of all Category 1 P4R measures.
  - Guideline – MCOs and providers shall agree upon a percentage withhold and the weighting by which performance payments from the withhold are disbursed based on improvement and high performance. In weighting, MCOs and providers should take into account measures of particular relevance to the population being served, and current provider performance on those measures.

# Principles & Payment Models Recommendation #2.4

- **Type –** Suggestion
- **Description –** While PPCC is not an entirely new payment approach to some MCOs and providers, it is not widespread as described in these recommendations. It also may introduce currently unforeseeable impacts as it intersects with TCGP/IPC arrangements or where individual providers are pursuing a multitude of Medicaid and commercial VBP approaches for pediatric populations.
- **Draft Recommendation 2.4 –** The state should consider offering pilot opportunities for the PPCC VBP model similar to the pilots offered for the existing VBP Roadmap models.

# Principles & Payment Models Recommendation #3

- **Type –** Guideline for TCGP and IPC Arrangements
- **Description –** Not all children will be served through a PPCC arrangement. Many will be covered by broader TCGP or IPC arrangements that include shared savings/risk that are not generally appropriate for the PPCC target population as previously defined. In TCGP or IPC arrangements with large pediatric populations with substantial avoidable hospital utilization it may be appropriate for shared savings/risk to apply to the child population for a limited time period to reduce avoidable utilization.
- **Draft Recommendation –** MCOs and providers in TCGP and IPC arrangements should consider excluding PPCC eligible populations from shared savings/risk calculations in order to ensure that pediatric primary care providers are not penalized for appropriate additional investments in child services that are unlikely to generate one-year savings opportunities.

# Measures Recommendation #1

- **Type –** Suggestion
- **Description –** Standard health measures alone are insufficient to fully assess outcomes of high-value well-child care. Cross-sector measures of child development and well-being may be good proxy measures. While it is not currently feasible or appropriate to hold providers accountable for such cross-sector measures of appropriate child development, the State should not lose sight of these larger goals as it advances VBP for children.
- **Draft Recommendation –** The state should adopt the “North Star” goals and key indicators at each developmental stage, and the American Academy of Pediatrics Bright Futures Guidelines as the guiding framework by which the success of VBP for children is measured, and for consideration of all future children’s measure development and implementation for VBP purposes and beyond.

# Measures Recommendation #2

- **Type –** Suggestion
- **Description –** Many children will be covered by TCGP/IPC arrangements regardless of the availability of the PPCC VBP model. The current TCGP/IPC measure set does not include sufficient pediatric focused measures to ensure providers are striving to improve and achieve high performance for children under those VBP models.
- **Draft Recommendation –** Measures developed for the PPCC model should be integrated with existing measures to create a universal TCGP/IPC/PPCC measure set for 2018 and beyond. PPCC measures in this universal set should be updated at least annually consistent with the processes used to update TCGP/IPC measures.

# Measures Recommendation #3

- **Type –** Suggestion
- **Description –** Maternal health has a major impact on child health, especially pre- and post-natal and during the first year of a child's life. Maternity costs are included in the TCGP VBP model and excluded from the IPC model. Births are likely to occur both under the maternity bundle and TCGP VBP models, but there are no maternity measures in the TCGP measure set. There are also a small number of additional pre- and post-natal measures identified as especially relevant to child health that are not included in the maternity bundle measure set.
- **Draft Recommendation* –** Four specific measures in the current maternity bundle that are especially relevant for child health should be added to the TCGP measure set for 2018 and beyond. The maternity CAG should consider the addition of one new maternity bundle measure identified by the Children's CAG as particularly relevant to children's health. That measure should be added to the TCGP measure set for 2018 and beyond as adopted for the maternity bundle.

*Recommendation subject to adjustment pending specific measures CAG discussion and additional clarification on maternity bundle and TCGP intersection.

# Measures Recommendation #4

- **Type –** Standard
- **Description –** The pediatric population is more diverse than the adult population and disparities in care are especially troubling for children. Tracking VBP measures for children with race-ethnicity breakdowns would provide a unique opportunity to assess disparities and identify future opportunities for improved equity through appropriate disparity reduction targets.
- **Draft Recommendation –** VBP arrangements, regardless of model, should require providers and MCOs to report and track performance on all pediatric VBP measures at the most detailed level of race/ethnicity breakdown possible.

# Additional Work/Deliberation Recommendation #1

- **Type –** Suggestion
- **Description –** The Subcommittee discussed a number of options for addressing the unique needs of complex children through VBP and worked with a subset of members to brainstorm potential models. Given time and data constraints, and the recognition that many complex children are not yet in managed care and/or relevant services remain carved-out, additional deliberation is required.
- **Draft Recommendation –** The state should utilize this subcommittee, a subgroup thereof, or develop a new advisory group to make recommendations on payment models and measures for complex children. This process should specifically consider:
  - The definition of complex children for VBP purposes and the issue of small and unique complex population subsets and substantial regression to the mean.
  - Whether a complex family subpopulation that includes payment for children and their caretakers on Medicaid is viable and feasible.
  - What measures from the TCGP/IPC/PPCC measure set should apply to complex children and what additional measures are required.

# Additional Work/Deliberation Recommendation #2

- **Type –** Suggestion
- **Description –** Ongoing measure review, development, and implementation is required to continue to push the envelope for improvement and to ensure the measures being utilized are valid and appropriate. Outside of the current CAGs there is no obvious venue for this vital ongoing work.
- **Draft Recommendation –** The state should utilize the existing CAG expertise but consider a centralized and streamlined process for: 1) annual reconsideration of VBP measures; 2) inclusion of new measures; 3) encouraging further development of Category 1 P4R and Category 2 measures so that they can become P4P; and 4) developing additional measures that are important to VBP goals, but not currently feasible. This group or a subgroup thereof could be charged with refinement of the pediatric “North Star” goals and indicators and developing pathways for cross-sector measurement.* The Oregon Metrics and Scoring Committee is an example the State should consider as a model.

*See slide 60 for potential next steps related to North Star indicators.

# Additional Work/Deliberation Recommendation #3

- **Type –** Suggestion
- **Description –** There are multiple efforts underway to transform the delivery system broadly and primary care specifically. None of those efforts specifically focus on the unique needs of pediatric patients or pediatric primary care practices.
- **Draft Recommendation –** The State should build on its early efforts (e.g., All Albany Kids Ready) to develop additional pilots, programs and/or technical assistance efforts that test, evaluate and spread optimum pediatric primary care delivery models that are focused on the “North Star” goals.

# Lunch Break

# 5. Measures Discussion

Jeanne Alicandro and Kate Breslin, Co-Chairs
Suzanne Brundage, UHF

# Preparing Measures for Subcommittee Consideration

- Assessment of relationship between proposed pediatric primary care capitation VBP model and the existing VBP models and their associated measure sets.
- Review of the matrix, specifically the primary care strategies and existing quality measures related to those strategies. Assess connection between the measures, primary care strategies and identified “North Star” goals.
- Develop library of 70 potential measures used across the nation with a focus on existing use in New York (VBP, DSRIP, QARR, APC, etc.).
- Multiple discussions with medical directors at OHIP and OQPS on a subset of the 70 measures most aligned with the Matrix to develop draft recommendations for the Subcommittee to consider.

# Starting Points for Selection of Quality Measures

- Alignment with DSRIP (avoidable hospital use)
- Reduce ‘drowning’ in measures phenomenon: outcome measures have priority
- Measuring the quality of the total cycle of care of the VBP arrangement
- Relevance for patients and providers
- Alignment with Medicare: linking to point of care registration (EHR)
- Alignment with State Heath Innovation Plan’s Advanced Primary Care measure set
- Transparency of process, of measures, of outcomes

# Quality Measures – Roadmap Language

*"The Category 1 quality measures recommended by each CAG and accepted by the State are to be reported by the VBP contractors. The measures are also intended to be used to determine the amount of shared savings that VBP contractors are eligible for … "* [1]


CAG recommends measure categories → State accepts or re-categorizes measures → VBP Contractors report on measures

# 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.

# Three Types of Measures

- **Existing Maternity Bundle –** These measures are relevant to child health and are currently included in the maternity bundle, but not in TCGP measure set. They are not appropriate for the PPCC measure set, but arguably should be included in TCGP.
- **Existing TCGP/IPC –** These child specific measures are already included in the TCGP/IPC measure set and should form the base child measures in the new universal TCGP/IPC/PPCC measure set.
- **New Child Focused Measures –** Additional measures that should apply to all VBP arrangements serving children via the new universal TCGP/IPC/PPCC measure set. This group includes two maternity related measures that should be considered for the maternity bundle and TCGP measure sets (but not the TCGP/IPC/PPCC universal set).

# Maternity Bundle measures recommended for addition to the TCGP measure set because of importance for child health.

| # | Measure (NQF #) | Category | P4P / P4R |
|---|---|---|---|
| 1 | Timeliness and frequency of prenatal and postpartum care visits (NQF 1391) | 1 | P4P |
| | *Prenatal Care: The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization.*<br><br>*Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.* | | |
| 2 | Live births less than 2500 grams (NQF 1382) | 1 | P4R |
| | *The adjusted rate for live infants weighing less than 2500 grams among all deliveries by women continuously enrolled in a plan for 10 or more months.* | | |

# Maternity Bundle measures recommended for addition to the TCGP measure set because of importance for child health. (Continued)

| # | Measure (NQF #) | Category | P4P / P4R |
|---|---|---|---|
| 3 | Infants exclusively fed with breastmilk in hospital (NQF 480) | 1 | P4R |
| | *The number of newborns exclusively fed with breast milk during the newborn´s entire hospitalization.* | | |
| 4 | Women provided most or moderately effective methods of contraceptive care within 3 to 60 days of delivery (NQF 2902) | 1 | P4R |
| | *Among women aged 15-21 who had a live birth, the percentage that is provided a most effective (sterilization, contraceptive implants, intrauterine devices or systems (IUD/IUS)) or moderately (injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery.* | | |

# Existing TCGP/IPC measures that will carry over into the universal TCGP/IPC/PCCC measure set.

| # | Measure (NQF #) | Category | P4P / P4R |
|---|---|---|---|
| 1 | Children at elevated risk of caries who received fluoride varnish applications (NQF 2528) | 2 | N/A |
| | *Percentage of enrolled children aged 1–21 years who are at "elevated" risk (i.e. "moderate" or "high") who received at least 2 topical fluoride applications as a dental OR oral health service within the reporting year.* | | |
| 2 | Child immunization status, age 2 (combo 3) (NQF 0038) | 1 | P4P |
| | *Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates.* | | |

# Existing TCGP/IPC measures that will carry over into the universal TCGP/IPC/PCCC measure set. (Continued)

| # | Measure (NQF #) | Category | P4P / P4R |
|---|---|---|---|
| 3 | BMI assessment and counseling (NQF 0024) | 1 | P4P |
| | *Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported.*<br>- *Percentage of patients with height, weight, and body mass index (BMI) percentile documentation*<br>- *Percentage of patients with counseling for nutrition*<br>- *Percentage of patients with counseling for physical activity* | | |

# Existing TCGP/IPC measures that will carry over into the universal TCGP/IPC/PCCC measure set. (Continued)

| # | Measure (NQF #) | Category | P4P / P4R |
|---|---|---|---|
| 4 | Medication management for children with asthma, ages 5 – 18 (NQF 1799) | 1 | P4P |
| | *2 part measure: The percentage of patients 5-18 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported.*<br>*1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period.*<br>*2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.* | | |
| 5 | Screen for depression using age appropriate tool and follow-up, ages 12+ (NQF 0418) | 1 | P4R |
| | *Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.* | | |

# Existing TCGP/IPC measures that will carry over into the universal TCGP/IPC/PCCC measure set. (Continued)

| # | Measure (NQF #) | Category | P4P / P4R |
|---|---|---|---|
| 6 | Chlamydia screening, ages 16 – 21 (NQF 0033) | 1 | P4P |
| | *The percentage of women 16–21 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.* | | |

# Additional maternity measure(s) recommended for inclusion in TCGP and maternity bundle measure sets because of importance for child health.

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 1 | Behavioral risk assessment for pregnant women | AMA-PCPI | | Yes | EMR | 2 | N/A |
| | *Percentage of women who gave birth during a 12-month period who were seen at least once for prenatal care and who were screened for depression, alcohol use, tobacco use, drug use, and intimate partner violence.* | | | | | | |
| 2 | Hearing screen prior to hospital discharge (NQF 1354) | CDC | | | EMR | 3 | N/A |
| | *Percentage of newborns who were screened for hearing loss prior to hospital discharge.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set.

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 1 | Frequency of well-child visits during the first 15 months of life (NQF 1392) | NCQA | Yes 80% | Yes | Claims | 1 | P4P |
| | *Percentage of children 15 months old who had the recommended number of well-child visits with a primary care provider during their first 15 months of life.* | | | | | | |
| 2 | Developmental screening using standardized tool, first 36 months of life (NQF 1448) | Oregon HSU | | Yes | Claims or medical record | 2 | N/A |
| | *Percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. The measure includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and 36 months of age.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set. (Continued)

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 3 | Maternal depression screen done during child's first six months of life | NCQA | | | EMR, CMS eCQM #82 | 2 | N/A |
| | *Percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during the child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.* | | | | | | |
| 4 | Frequency of well child visits, ages 3 to 6 (NQF 1516) | NCQA | Yes 84% | Yes | Claims | 1 | P4P |
| | *Percentage of children 3-6 years of age who had one or more well-child visits with a Primary Care Practitioner during the measurement year.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set. (Continued)

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 5 | Experience with care survey using CAHPS Clinician and Group survey 3.0, Child version, including supplemental questions re children with chronic conditions | AHRQ | | | Survey responses; can be aggregated in multiple ways to measure performance | 3 | N/A |
| | *Information collected using this standardized survey instrument on parents' experiences with their child's doctors during the year.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set. (Continued)

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 6 | Children ages 2-18 having annual dental visit | NYS | Yes 60% | | Dental claims | 1 | P4R |
| | *Percentage of children ages 2-19 who have at least one dental visit during the year.* | | | | | | |
| 7 | Rate of inpatient admissions for any of four conditions: asthma, diabetes, gastroenteritis, or UTI (*PDI* #90) | AHRQ | | | Hospital discharge data | 1 | P4P |
| | *Rate of inpatient admissions of children for four ambulatory care sensitive conditions.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set. (Continued)

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 8 | Follow-up care for children prescribed Rx for ADHD (NQF 0108).<br>Two part measure: initiation phase and continuation phase | NCQA | Yes<br>58% init.<br><br>67% con. | Yes | Claims | 1 | P4R |
| | *Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period after the first ADHD medication was dispensed. The measure includes two separate rates: an initiation phase rate (follow-up visit within the 30 days after starting the medication) and a continuation and maintenance phase rate (children who remained on the medication for 7 months and who, in addition to the visit in the initiation phase had at least two follow-up visits in the 9 month period after the initiation phase ended.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set. (Continued)

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 9 | Assessment and counseling of adolescents on sexual activity, tobacco use, alcohol and drug use, depression (four-part measure) | NYS | Yes<br>65% sex<br>74% tob.<br>68% sub,<br>60% dep. | | Medicaid Record Review | 1 | P4R |
| | *Percentage of adolescents ages 12-17 who had at least one outpatient visit with a primary care provider or OB/GYN practitioner during the measurement year and received assessment, counseling or education on sexual activity, depression, tobacco use, and alcohol or other drug use.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set. (Continued)

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 10 | Adolescent immunization rate, including rate for HPV (NQF 1407) | NCQA | Yes | Yes | Claims | 2 | N/A |
| | *Percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one Tdap, and 3 doses of HPV by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.* | | | | | | |
| 11 | Adolescent well-care visit rate | NCQA | Yes 65% | Yes | Claims | 1 | P4R |
| | *Percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a primary care provider or an OB/GYN practitioner during the measurement year.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set. (Continued)

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 12 | Follow-up after ED visit for mental illness, ages 6 and older | NCQA | Yes-new 2017 | | Claims | 1 | P4R |
| | *Percentage of ED visits with a primary diagnosis of mental illness for which the patient received follow-up care with any practitioner within specified time frames. Reported in two separate rates: within 7 days of the ED visit and within 30 days of the visit.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set. (Continued)

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 13 | Follow-up after ED visit for alcohol and other drug dependence, ages 13 and older | NCQA | Yes-new 2017 | | Claims | 1 | P4R |
| | *Percentage of ED visits with a primary diagnosis of alcohol or other drug dependence for which the patient received follow-up care with any practitioner within specific time frames. Reported in two separate rates: within 7 days of the ED visit and within 30 days of the visit.* | | | | | | |

# Additional child focused measures recommended for inclusion in the universal TCGP/IPC/PPCC measure set. (Continued)

| # | Measure (NQF # if endorsed) | Steward | QARR/ 2015 Mean | CMS Child Core Set | Data Source | Category | P4P / P4R |
|---|---|---|---|---|---|---|---|
| 14 | Use of first-line psychosocial care for children and adolescents on antipsychotics | NCQA | Yes | Yes-new 2017 | Claims | 2 | N/A |
| | *Percentage of patients, ages 1-17, who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.* | | | | | | |

# Cross-Sector “North Star” Indicators

Potential next steps:

- Final selection and refinement of key indicators, particularly for North Star goals where clear indicators are lacking (e.g. optimal physical health and a secure attachment with a primary caregiver).
- Creation of one or two workgroups to outline at least two pathways for use of indicators:

(1) Inclusion of indicators in a Child Well-Being Dashboard used to partially assess whether child-focused VBP arrangements are achieving the population-level child health goals identified at the outset of the process;

(2) Development of a Medicaid pilot or “challenge award” that incentivizes MCOs and providers to develop data systems that enable them to track impact of traditional and non-traditional primary care services on one or more of the North Star goals and relevant indicators.

# 5. Next Steps

Jeanne Alicandro and Kate Breslin, Co-Chairs
Chad Shearer, UHF

# Timeline

| Activity | Due Date |
|---|---|
| Revised recommendations and measures circulated | 5/12 |
| Final feedback collected from subcommittee members | 5/19 |
| Draft subcommittee report circulated | June |
| Final PPCC VBP measure set released for public comment | June |
| Final subcommittee report presented to VBP Workgroup | July |

**THANK YOU!**

**For your participation to date, and in advance for your review and comments on the revised recommendations and measures and final report.**

**Please do not hesitate to contact the co-chairs and UHF if you have any questions or concerns as we finalize the recommendations and measures.**