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 #7

Subcommittee/CAG Recommendations & Measures Consensus

July 10, 2017, 11:00 am – 3:00 pm

In-Person at DOH – 99 Washington Ave, CR 1613, Albany

Call In: (844) 799-2451; Participant Passcode: 37157165

July 10, 2017

Meeting Agenda

Agenda Items	Time	Duration
1. Welcome and Introductions	11:00 AM	15 mins
2. Brief Progress Update	11:15 AM	15 mins
3. Presentation of Quality Measures and Consensus Process	11:30 AM	60 mins
Lunch	12:30 PM	30 mins
4. Presentation of Recommendations and Consensus Process	1:00 PM	90 mins
5. North Star goals, Indicators and Primary Care Strategies	2:30 PM	15 mins
6. Aspirational Outcomes	2:45 PM	10 mins
7. Next Steps and Adjourn	2:55 PM	5 minutes

Subcommittee/CAG Progress

- Feedback on recommendations from June 9 webinar
- Feedback on measures from June 14 webinar
- Appear to be very near consensus on both with a few outstanding questions/issues
- Additional conversations on complex populations
- Streamlining and visualizing the “Matrix”
- Gathering measures beyond the current consensus set for future consideration
- Co-chair change

Consensus Process

Kate Breslin and Jeff Kaczorowski, Co-Chairs
Chad Shearer and Suzanne Brundage, UHF

Consensus Process for Measures & Recommendations

- Discussion of changes and outstanding issues after June webinars
- Walkthrough of each recommendation and measure
  - Full agreement with recommendation or measure as written
  - Not in full agreement, but not opposed to inclusion
  - Opposed to inclusion as written
    - Any changes that would get to or
- Phone participants or – email sbrundage@uhfnyc.org

Measures Outstanding Issues Discussion

Kate Breslin and Jeff Kaczorowski, Co-Chairs
Suzanne Brundage and Chad Shearer, UHF

Maternity Bundle and TCGP #5

#	Measure (NQF #)	Steward	Data Source	Category
5	**Behavioral risk assessment for pregnant women**	AMA-PCPI	EMR	recommend to Maternity CAG without consensus on categorization as Cat 1 P4R or Cat 2
	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.			

Behavioral risk assessment for pregnant women: The Subcommittee discussed the overall importance of this measure to child health and well-being, and fully recommends its inclusion in the Maternity Bundle and TCGP measure sets. The Subcommittee could not reach consensus on whether the measure should be categorized as Category 2, due to its data being sourced from the EMR and limited experience with the measure, or a Category 1 P4R measure in order to incentivize its use.

Universal Child Set #7 (TCGP, IPC, PPCC)

#	Measure (NQF #)	Steward	Data Source	Category
7	**Discharges, for patients ages 6 - 17, that meet the inclusion and exclusion rules for the numerator in any of the following PDIs:** **● #14 Asthma Admission Rate** **● #15 Diabetes Short-Term Complications Admission Rate** **● #16 Gastroenteritis Admission Rate** **● #18 Urinary Tract Infection Admission Rate**	AHRQ	Hospital discharge data	1 P4P
	Rate of inpatient admissions of children for four ambulatory care sensitive conditions.			

Rate of inpatient admissions for any of four conditions: asthma, diabetes, gastroenteritis, or UTI (PDI #90):
The Subcommittee debated whether to use this composite measure (PDI #90) or whether to only use the underlying measures for asthma (PDI #14) and/or gastroenteritis (PDI #16). While the age range for the composite measure (PDI #90) is 6 – 17, the age range for the asthma admission rate (PDI #14) is 2 – 17. For gastroenteritis (PDI #16) the age range is 3 months to 17 years.

The Subcommittee can decide to:

- Adopt PDI #90 (composite measure) as is
- Adopt PDI #90 (composite measure) but change it to a Category 2 measure
- Substitute PDI #90 for PDI #14 and/or PDI #16 and select the appropriate categorization
- Remove PDI #90 (composite measure)

The Subcommittee could also choose to selectively include measures for the diabetes short-term complications rate (PDI #15) or Urinary Tract Infection admission rate (PDI #18) – although no one spoke in favor of doing so during the 6/14/17 webinar.

Universal Child Set #11 (TCGP, IPC, PPCC)

#	Measure (NQF #)	Steward	Data Source	Category
11	**Maternal depression screen done during child's first six months of life**	NCQA	EMR, CMS eCQM #82	1 P4R
	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.			

Maternal depression screen done during child's first six months of life
The Subcommittee debated the disconnect of the payment policy (screen during the first year of life) and the available measure which only captures a screen during the first six months of life. Questions remain about the viability of collecting this measure.

Universal Child Set #20 (TCGP, IPC, PPCC)

#	Measure (NQF #)	Steward	Data Source	Category
20	**Follow-Up After Hospitalization for Mental Illness: 7-Day and 30-Day (NQF 0576)**	NCQA	Claims	TBD
	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: *- The percentage of discharges for which the patient received follow-up within 30 days of discharge* *- The percentage of discharges for which the patient received follow-up within 7 days of discharge.*			

Follow-Up After Hospitalization for Mental Illness: 7-Day and 30-Day (NQF 0576):

This measure was recommended for inclusion in the Universal Set by a Subcommittee member. It is currently included in the HARP (Health and Recovery Plans) measure set as a Category 1 P4P measure.

Universal Child Set #21 (TCGP, IPC, PPCC)

#	Measure (NQF #)	Steward	Data Source	Category
21	**Screening for Reduced Visual Acuity and Referral in Children** **(NQF 2721 - approved for trial use)**	NCQA	Claims	TBD
	The percentage of children who received visual acuity screening at least once by their 6th birthday; and if necessary, were referred appropriately.			

Screening for Reduced Visual Acuity and Referral in Children (NQF 2721 - approved for trial use): The Subcommittee has had several discussions about the importance of eye examinations for overall health and promoting school readiness.* This measure is for vision screening, not eye examinations, and is currently only in trial phase. The American Optometric Association has voiced concerns about this measure. However, it is the only measure related to vision that could be found.

*Similar concerns have been raised regarding hearing measure(s)

Universal Child Set #22 (TCGP, IPC, PPCC)

#	Measure (NQF #)	Steward	Data Source	Category
22	**Follow-Up after Emergency Department Visits for Dental Caries in Children (NQF 2695)**	ADA	Claims	TBD
	The percentage of caries-related emergency department visits among children 0 through 20 years for which the member visited a dentist within 7 days and 30 days.			

Follow-Up after Emergency Department Visits for Dental Caries in Children (NQF 2695):

Subcommittee members requested a measure related to follow-up after Emergency Department visits for a chronic disease such as asthma. While there is no matching chronic disease measure, the Subcommittee could choose to adopt this measure as dental caries are the most common chronic condition in children. Subcommittee members should note there are already two dental measures recommended for inclusion in the Universal Set, both of which are more preventative in nature, and it is unclear to what extent this measure is amenable to primary care intervention.

Measures Consensus

Kate Breslin and Jeff Kaczorowski, Co-Chairs
Suzanne Brundage and Chad Shearer, UHF

* In the measures that follow indicates CMS Child Core Set measures

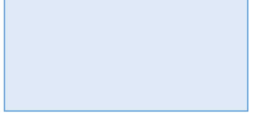
Reading the Measure Sets

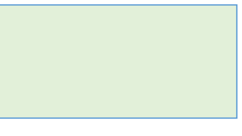
- Two sets:

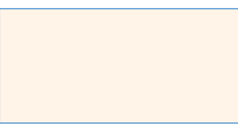
  "Maternity Set": applicable to Total Care for General Population and Maternity Bundle arrangements

  "Universal Child Set": applicable to Total Care for General Population, Integrated Primary Care, and proposed Pediatric Primary Care Capitation VBP arrangements

- Color Coding:


= Measure already included in the maternity set, recommend broader inclusion in TCGP but not PPCC


= Measure already included in TCGP/IPC set, we recommend inclusion in a TCGP/IPC/PPCC child set


= New measure recommended by Children's CAG

Maternity Set

#	Measure (NQF #)	Steward	Data Source	Category
1	**Infants exclusively fed with breast milk in hospital (NQF 480)***	Joint Commission	Claims, Medical Record	1 P4R
	The number of newborns exclusively fed with breast milk during the newborn´s entire hospitalization.			
2	**Live births less than 2500 grams (NQF 1382)***	CDC	Vital Statistics	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.			
3	**Timeliness and frequency of prenatal and postpartum care visits (NQF 1391)***	NCQA	Claims, Medical Record	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. *Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.*			

Maternity Set

#	Measure (NQF #)	Steward	Data Source	Category
4	**Women provided most or moderately effective methods of contraceptive care within 3 to 60 days of delivery (NQF 2902)***	OPA	Claims	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.			
5	**Behavioral risk assessment for pregnant women**	AMA-PCPI	EMR	Cat 1 or Cat 2 - Defer to Maternity CAG
	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.			
N/A	**Hearing screen prior to hospital discharge (NQF 1354)**	CDC	EMR	3
	Percentage of newborns who were screened for hearing loss prior to hospital discharge.			

Universal Child Set Category 1 Measures

#	Measure (NQF #)	Steward	Data Source	Category
1	**Adolescent well-care visit rate**	NCQA	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.			
2	**Assessment and counseling of adolescents on sexual activity, tobacco use, alcohol and drug use, depression (four-part measure)**	NYS	Claims, Medical Record	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.			

Universal Child Set Category 1 Measures

#	Measure (NQF #)	Steward	Data Source	Category
3	**BMI assessment and counseling (NQF 0024)***	NCQA	Medical Record	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. - *Percentage of patients with height, weight, and body mass index (BMI) percentile documentation* - *Percentage of patients with counseling for nutrition* - *Percentage of patients with counseling for physical activity*			
4	**Child immunization status, age 2 (combo 3) (NQF 0038)***	NCQA	Claims, Medical Record	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.			

Universal Child Set Category 1 Measures

#	Measure (NQF #)	Steward	Data Source	Category
5	**Children ages 2-20 having annual dental visit**	NYS	Dental Claims	1 P4R
	Percentage of children ages 2-20 who have at least one dental visit during the year.			
6	**Chlamydia screening, ages 16 – 21 (NQF 0033)***	NCQA	Claims	1 P4P
	The percentage of women 16–20 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.			
7	**Discharges, for patients ages 6 - 17, that meet the inclusion and exclusion rules for the numerator in any of the following PDIs:** ● **#14 Asthma Admission Rate** ● **#15 Diabetes Short-Term Complications Admission Rate** ● **#16 Gastroenteritis Admission Rate** ● **#18 Urinary Tract Infection Admission Rate**	AHRQ	Hospital discharge data	1 P4P
	Rate of inpatient admissions of children for four ambulatory care sensitive conditions.			

Universal Child Set Category 1 Measures

#	Measure (NQF #)	Steward	Data Source	Category
8	**Follow-up care for children prescribed Rx for ADHD (NQF 0108)** **Two part measure: initiation phase and continuation phase**	NCQA	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.			
9	**Frequency of well child visits, ages 3 to 6 (NQF 1516)**	NCQA	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.			
10	**Frequency of well-child visits during the first 15 months of life (NQF 1392)**	NCQA	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.			

Universal Child Set Category 1 Measures

#	Measure (NQF #)	Steward	Data Source	Category
11	**Maternal depression screen done during child's first six months of life**	NCQA	EMR, CMS eCQM #82	1 P4R
	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.			
12	**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. *1. The percentage of patients who remained on an asthma controller medication for at least 50% of their treatment period.* *2. The percentage of patients who remained on an asthma controller medication for at least 75% of their treatment period.*			

Universal Child Set Category 1 Measures

#	Measure (NQF #)	Steward	Data Source	Category
13	**Screen for depression using age appropriate tool and follow-up, ages 12+ (NQF 0418)***	CMS	Claims, registry	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.			

Universal Child Set Category 2 Measures

#	Measure (NQF #)	Steward	Data Source	Category
14	**Adolescent immunization rate, including rate for HPV (NQF 1407)**	NCQA	Claims	2
	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.			
15	**Children at elevated risk of caries who received fluoride varnish applications (NQF 2528)***			2
	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.			
16	**Developmental screening using standardized tool, first 36 months of life (NQF 1448)**	Oregon HSU	Claims or Medical Record	2
	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.			

Universal Child Set Category 2 Measures

#	Measure (NQF #)	Steward	Data Source	Category
17	**Follow-up after ED visit for mental illness, ages 6 and older**	NCQA	Claims	2
	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.			
18	**Follow-up after ED visit for alcohol and other drug dependence, ages 13 and older**	NCQA	Claims	2
	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.			
19	**Use of first-line psychosocial care for children and adolescents on antipsychotics**	NCQA	Claims	2
	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.			

Universal Child Set Category 3 Measure

#	Measure (NQF #)	Steward	Data Source	Category
N/A	**Experience with care survey using CAHPS Clinician and Group survey 3.0, Child version, including supplemental questions re children with chronic conditions**	AHRQ	Survey	3
	Information collected using this standardized survey instrument on parents' experiences with their child's doctors during the year.			

Universal Child Set – Inclusion/Category TBD

#	Measure (NQF #)	Steward	Data Source	Category
20	**Follow-Up After Hospitalization for Mental Illness: 7-Day and 30-Day (NQF 0576)**	NCQA	Claims	TBD
	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: *- The percentage of discharges for which the patient received follow-up within 30 days of discharge* *- The percentage of discharges for which the patient received follow-up within 7 days of discharge.*			
21	**Screening for Reduced Visual Acuity and Referral in Children** **(NQF 2721 - approved for trial use)**	CMS	EMR	TBD
	The percentage of children who received visual acuity screening at least once by their 6th birthday; and if necessary, were referred appropriately.			
22	**Follow-Up after Emergency Department Visits for Dental Caries in Children** **(NQF 2695)**	ADA	Claims	TBD
	The percentage of caries-related emergency department visits among children 0 through 20 years for which the member visited a dentist within 7 days and 30 days.			

Recommendations Changes & Consensus

Kate Breslin and Jeff Kaczorowski, Co-Chairs
Chad Shearer and Suzanne Brundage, UHF

Recommendation Considerations and Terminology

- 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 holistic 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 physical and behavioral health needs. Support and recognition of families and caregivers is central to improving children's lives.
- **Draft Recommendation 1–** The State should adopt the Matrix and it's "North Star" goals as the guiding framework which recognizes the: (1) unique needs of children at different developmental stages; (2) the overarching role of primary care in both the delivery of healthcare services to children and the promotion of overall child well-being; and (3) **the role of caregivers and nonmedical factors in shaping long-term health**. 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 therefore may be better served by VBP models that do not 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 2–** The State should consider creating an additional on-menu option in the VBP Roadmap that allows (but does not require) 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 –** Guideline
- **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 enter into PPCC arrangements only for children who are in the bottom 90th percentile of the MCO's overall cost/utilization distribution among its child members. Plans and providers should be granted discretion in determining the attributed child population below the 90th percentile, particularly taking into account the share of members that would be considered part of a complex population that should be excluded from the PPCC arrangement. The attributed population methodology should be subject to State review and approval.

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, behavioral and developmental threats to health, in addition to medical needs.
- **Draft Recommendation 2.2 –** The risk-adjusted primary care capitation should include enhancements sufficient to support all necessary screenings, risk-adjusted care coordination, and new workflows to address developmental and behavioral health needs and social determinants. An additional enhancement should be provided to primary care practices with co-located and operational integrated behavioral health care, **taking into account differential operational and staffing costs of various models**. While the capitation rate should include nearly all primary care service needs for children, including the previously described enhancements, MCOs and providers can agree to exclude services where there are underutilization concerns (e.g. vaccine costs). 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. In those arrangements pediatric providers should not be disadvantaged because low-cost children generally do not generate savings. Pediatric providers should also receive any pediatric enhancements envisioned under PPCC.
- **Draft Recommendation 3 –** MCOs and providers in TCGP and IPC arrangements should consider appropriate children's utilization and cost (including any potential additional enhancements added to MCO rates via a PPCC related increase) in determining baseline pediatric spending targets in these shared savings/risk arrangements. The State should review this methodology as part of the VBP contract review process 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 1 –** 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 *(Strongly Recommended)*
- **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 2 –** 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 *(Strongly Recommended)*
- **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 3 –** 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.

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 4 –** 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.

Measures Recommendation #5

NEW for June 14 Webinar

- **Type** – Suggestion
- **Description** – Developmental screening is widely recognized as an important clinical strategy for early identification of children experiencing developmental delays and challenges. When combined with access to appropriate interventions, developmental screening is a critical strategy for ensuring children are able to achieve their maximum potential. Developmental Screening in the First Three Years of Life (NQF #1448) is included in the CMS Child Core Set of quality measures, and currently 20 states annually report on developmental screening as part of that process. While acknowledging that there are concerns with developmental screening measure NQF# 1448, particularly the validity of using the billing code CPT 96110 to collect appropriate measurement data, the SC/CAG believes it is important to overcome these barriers in order to encourage developmental screening in clinical practice.
- **Draft Recommendation 5** - The State should expedite its efforts to work with providers and plans through its School Readiness VBP Pilot, New York's Early Childhood Comprehensive Systems federal grant, and other related efforts, to refine its approach to using Developmental Screening in the First Three Years of Life (NQF #1448). The State should consider lessons learned from other states that have modified their billing policies for this measure, including Maine, Minnesota, and Connecticut. The goal of this work should be on reasonably resolving concerns related to NQF #1448's measure specifications and updating related clinical guidance for providers and plans, in order to adopt a developmental screening measure as a Category 1 measure by Measurement Year 2019.

Additional Work/Deliberation Recommendation #1

- **Type –** Suggestion
- **Description –** The Subcommittee discussed a number of options for addressing the unique needs of complex children and families through VBP and worked with a subset of members to brainstorm potential models for the behaviorally complex subpopulation. Given time and data constraints, the heterogeneity of subpopulations within the group of complex children and families (e.g., medically complex, medically fragile, behaviorally complex, **foster care**), and the recognition that some portion of these children are not yet in managed care and/or relevant services remain carved-out, additional deliberation is required.

Additional Work/Deliberation Recommendation #1 (con't)

- **Draft Recommendation 1 –** The State should utilize this subcommittee, a subgroup thereof, or develop a new advisory group(s) to make recommendations on payment models and measures for complex children. This process should specifically consider:
  - The definition(s) of complex children for VBP purposes and the issue of feasibility of VBP models for small and unique complex population subsets (e.g., children with medically and/or behaviorally complex needs, children who fall under the State's definition of 'medically fragile', and **children in foster care**) and substantial regression to the mean.
  - Whether a payment model for a behaviorally complex family subpopulation that includes children and their caretakers on Medicaid is viable and feasible, and should be piloted.
  - What measures from the TCGP/IPC/PPCC measure set should apply to complex children (and/or redefined subsets thereof) and what additional measures are required.
  - Whether centers of excellence for very small subsets of complex children (e.g., medically fragile) could be a viable strategy for achieving VBP goals without creating unnecessary risk for providers and MCOs.

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 2–** 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, **particularly through engagement with the New York Department of Education**. The Oregon Metrics and Scoring Committee is an example the State should consider as a model.

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 3 –** 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.

Framework Used for Internal Deliberation and Proposed for Future Children’s VBP Considerations

Kate Breslin and Jeff Kaczorowski, Co-Chairs
Suzanne Brundage and Chad Shearer, UHF

VBP for Kids: Goals, Indicators, and High-Value Primary Care Strategies, by Age *(page 1 of 2)*

	Preterm to 1 Month	1 Month to 1 Year	1 Year to 5 Years
Overarching "North Star" Goals	**Optimal birth outcomes for mother and child**	**Optimal physical health and a secure attachment with a primary caregiver**	**Optimal physical health and developmentally on track at school entry**
Key Indicators	• Birthweight <2500 grams • Preterm births • Severe maternal morbidity	• Assessment of whether there is a gap between developmental and biological age (aspirational)	• ED visits for unintentional injury • Expulsions/suspensions • Kindergarten-readiness using standardized tool (aspirational)
High-Value, Often Underutilized Primary Care Strategies	**Early and regular prenatal care visits including:** • Birth spacing/contraceptive use counseling • Breastfeeding encouragement • Care transition plan for use by obstetrician, newborn nursery and primary care doctor • Screening/treatment for preterm birth risks and tobacco/substance use **Screening/referrals for:** • Adverse Childhood Experiences (ACEs) • Social determinants of health • Domestic violence/personal safety • Maternal depression **Enhancing parental skills through educational/home visitation programs**	**Regular well-child visits including:** • Developmental screenings in four domains: motor, language, cognitive, and social emotional • Weight/nutrition/physical activity counseling • Early Intervention referral **Screening/referrals for:** • ACEs • Social determinants of health • Domestic violence/personal safety • Maternal depression **Enhancing parental skills through educational/home visitation programs**	**Regular well-child visits including:** • Developmental screenings in four domains: motor, language, cognitive, and social emotional • Weight/nutrition/physical activity counseling • Early Intervention referral • Dental screening/treatment • Eye examination/referral • Vaccinations **Screening/referrals for:** • ACEs • Social determinants of health **Enhancing parental skills through educational programs** **Management/treatment of chronic conditions**

	6 Years to 10 Years	11 Years to 14 Years	15 Years to 21 Years
Overarching "North Star" Goals	**Staying healthy and strengthening social, emotional and intellectual skills**	**Staying healthy and coping effectively with challenges of early adolescence**	**Staying healthy and able to succeed in the world of work, school, and other adult responsibilities**
Key Indicators	• Average daily school attendance • Hospitalization for asthma • Grade progression • Standard 3rd grade reading scores	• Average daily school attendance • Hospitalization for asthma • Obesity • Positive screens for depression/anxiety • Tobacco/substance use	• Algebra 1 Regent passing • Hospitalization for asthma • Obesity • Positive screens for depression/anxiety • Tobacco/substance use • Cohort graduation • Post-secondary enrollment • Pregnancy, ages 15-17
High-Value, Often Underutilized Primary Care Strategies	**Regular well-child visits including:** • Weight/nutrition/physical activity counseling • Dental screening/treatment **Screening/referrals for:** • ACEs • Social determinants of health • Behavioral health risks **Enhancing parental skills through educational programs** **Management/treatment of chronic conditions**	**Regular adolescent visits including:** • Weight/nutrition/physical activity counseling • Health care self-management/health literacy education • Vaccinations **Screening/counseling/referrals for:** • ACEs • Social determinants of health • Depression/anxiety • Tobacco/substance use • Sexual activity **Enhancing parental skills through educational programs** **Management/treatment of chronic conditions**	**Regular adolescent visits including:** • Weight/nutrition/physical activity counseling • Health care self-management/health literacy education • Vaccinations **Screening/counseling/referrals for:** • ACEs • Social determinants of health • Depression/anxiety • Tobacco/substance use • Sexual activity **Management/treatment of chronic conditions**

Aspirational Measures/Outcomes

Kate Breslin and Jeff Kaczorowski, Co-Chairs
Suzanne Brundage and Chad Shearer, UHF

Background

During its discussions the Committee identified several areas where the measure set needs to be broadened to support achieving the “North Star” goals. In a number of areas this will require actual development and testing of a measure before it can be recommended for use.

In two areas, hearing and vision testing, that work is already in progress. A measure of visual acuity screening of children under age 6 (NQF 2721) has been approved for trial use by the National Quality Forum and an infant hearing evaluation measure (NQF 1360) was added to the CMS Child Core set of recommended measures in 2016.

In most instances, however, much remains to be done, including working through complicated data-sharing relationships that will protect patient privacy but also permit enhanced learning and accountability.

Measures Wish List

The Sub-Committee / CAG's wish list of measures includes:

- Measures linked to school-based data sets, such as absence due to illness or suspension/expulsion, scores on kindergarten-ready assessments
- Measures related to family strengthening and reduction of toxic stress in a child's life
- Measures that can help evaluate impact of behavioral and substance abuse screens and treatment on juvenile justice system diversion initiatives (See NYS Juvenile Justice Advisory Group 2014 annual report p. 24 re incidence of high percentage of youth presenting mental health (50-60%) or substance abuse treatment (54-63%) need at intake into the system)
- Measures of care coordination quality for children with medically complex conditions, including measures based on patient or parent-reported data and measures that assess coordination among medical settings, schools, day care facilities, and community-based organizations
- Measures based on data derived from an adolescent's self-assessment of health status and capability of functioning successfully in school or workplace

Next Steps

Kate Breslin and Jeff Kaczorowski, Co-Chairs
Chad Shearer and Suzanne Brundage, UHF

Timeline

Activity	Date
Members send any final consensus related, framework and wish-list comments to Matlin Gilman at UHF – mgilman@uhfnyc.org	Monday, July 17
UHF and co-chairs draft final Subcommittee/CAG report	July/August
Draft report circulated for comments	August
Final report presented to VBP Workgroup	September