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

Update to Subcommittee

Webinar Date: August 21, 2018, 3:00 pm – 5:00 pm

August 21, 2018

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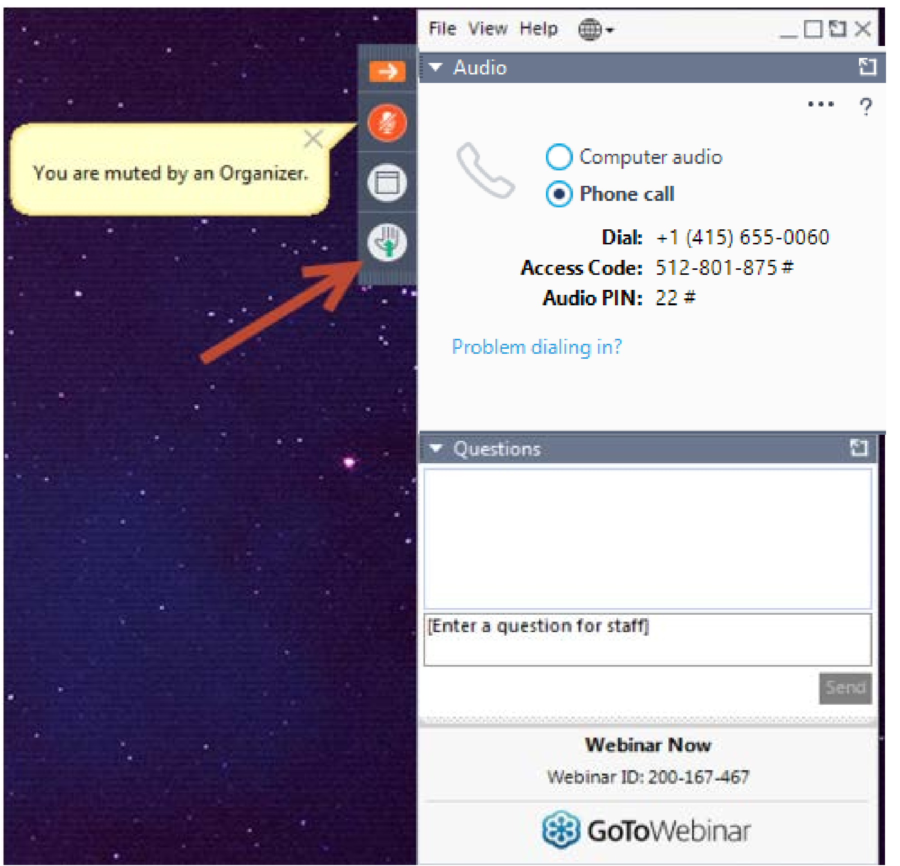

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  Sbrundage@uhfnyc.org

Webinar Agenda

Agenda Items	Time	Duration
1. Welcome and Agenda	3:00pm	10 mins
2. Co-Chairs' Welcome	3:10pm	15 mins
3. Payment Model Update from DOH	3:25pm	20 mins
4. Discussion	3:45pm	30 mins
5. Quality Measures Update from DOH	4:15pm	10 mins
6. Discussion	4:25pm	15 mins
7. Status of Other Report Recommendations	4:40pm	10 mins
8. State Timeline and Next Steps	4:50pm	5 mins
9. Discussion	4:55pm	5 mins
10. Adjourn	5:00pm	--

Co-Chairs' Welcome

Kate Breslin, Co-Chair
Jeff Kaczorowski, Co-Chair

Review of Subcommittee/CAG Work

This subcommittee/CAG met from Fall 2016 – Spring 2017. A final report with recommendations was submitted to DOH in September 2017.

The final report contained three products from the subcommittee:

1. North Star Framework intended to guide the State's future deliberations about value-based payment for children;

2. A set of recommendations pertaining to a child-specific VBP model, measures, and future work focused on children with complex needs; and

3. A specific set of measures which could be applied to VBP arrangements for children in 2018.

North Star Framework

Value-Based Payment for Kids: Goals, Indicators, & High-Value Primary Care Strategies, by Age

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	• On-target developmental and social-emotional screens • Reported cases of abuse and neglect	• On-target developmental and social-emotional screens • ED visits for unintentional injury • Expulsions/suspensions • Kindergarten readiness using standardized tool (aspirational) • Reported cases of abuse and neglect
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 **Co-located/integrated behavioral health services** **Screening/referrals for:** • Adverse Childhood Experiences (ACEs) • Social determinants of health • Domestic violence/personal safety • Maternal depression **Enhancing parental skills through evidence-based education/home visitation programs** **Seamless information exchange between women's health and child health providers**	**Regular well-child visits including:** • Developmental screenings in four domains: motor, language, cognitive, and social emotional • Weight/nutrition/physical activity counseling • Early Intervention referral **Co-located/integrated behavioral health services** **Screening/referrals for:** • ACEs • Social determinants of health • Domestic violence/personal safety • Maternal depression **Enhancing parental skills through evidence-based education/home visitation programs** **Seamless information exchange between women's health and child health providers (when mother is primary caregiver of child)**	**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 and hearing examination/referral • Vaccinations **Co-located/integrated behavioral health services** **Screening/referrals for:** • ACEs • Social determinants of health **Enhancing parental skills through evidence-based educational programs** **Management/treatment of chronic conditions**

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North Star Framework (part 2)

	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 • Obesity • Positive screens for depression/anxiety • 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 **Co-located/integrated behavioral health services** **Screening/referrals for:** • ACEs • Social determinants of health • Behavioral health risks **Enhancing parental skills through evidence-based educational programs** **Management/treatment of chronic conditions**	**Regular adolescent visits including:** • Weight/nutrition/physical activity counseling • Health care self-management/health literacy education • Vaccinations **Co-located/integrated behavioral health services** **Screening/counseling/referrals for:** • ACEs • Social determinants of health • Behavioral health risks **Enhancing parental skills through evidence-based educational programs** **Management/treatment of chronic conditions**	**Regular adolescent visits including:** • Weight/nutrition/physical activity counseling • Health care self-management/health literacy education • Vaccinations **Co-located/integrated behavioral health services** **Screening/counseling/referrals for:** • ACEs • Social determinants of health • Behavioral health risks **Management/treatment of chronic conditions**

First 1,000 Days on Medicaid

Final Rank	Proposal Description
1	Proposal 17 - Braided Funding for Early Childhood Mental Health Consultations
2	Proposal 10 - Statewide Home Visiting
3	Proposal 1 - Create a Preventive Pediatric Clinical Advisory Group
4	Proposal 4 - Expand Centering Pregnancy
5	Proposal 2 - Promote Early Literacy through Local Strategies
6	Proposal 14 - Require Managed Care Plans to have a Kids Quality Agenda
7	Proposal 5 - New York State Developmental Inventory Upon Kindergarten Entry
8	Proposal 20 - Pilot and Evaluate Peer Family Navigators in Multiple Settings
9	Proposal 18 - Parent/Caregiver Diagnosis as Eligibility Criteria for Dyadic Therapy
10	Proposal 16 - Data System Development for Cross-Sector Referrals

Goals for Today’s Discussion

- Ask clarifying questions about DOH’s approach to incorporating children’s value-based payment model/measures into the VBP Roadmap.
- Provide guidance to DOH on refining it’s approach.
- Understand next steps in DOH’s timeline and alignment with other DOH pediatric initiatives.
- Review Quality Measurement recommendations.

Payment Model Update

Ryan Ashe, Director of Medicaid Payment Reform, Office of Health Insurance Programs
Doug Fish, Medical Director, Office of Health Insurance Programs

How DSRIP & Value Based Payment Programs (VBP) Relate

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

DSRIP:
Restructuring effort to prepare for future success in changing environment

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

2013 2014 2015 2016 2017 2018 2019 2020

How is VBP Different from the Current Payment Structure?

1) Efficiency component - A **target budget** is set at the beginning of the year, against which costs (expenditures) are reconciled at the end of the year.

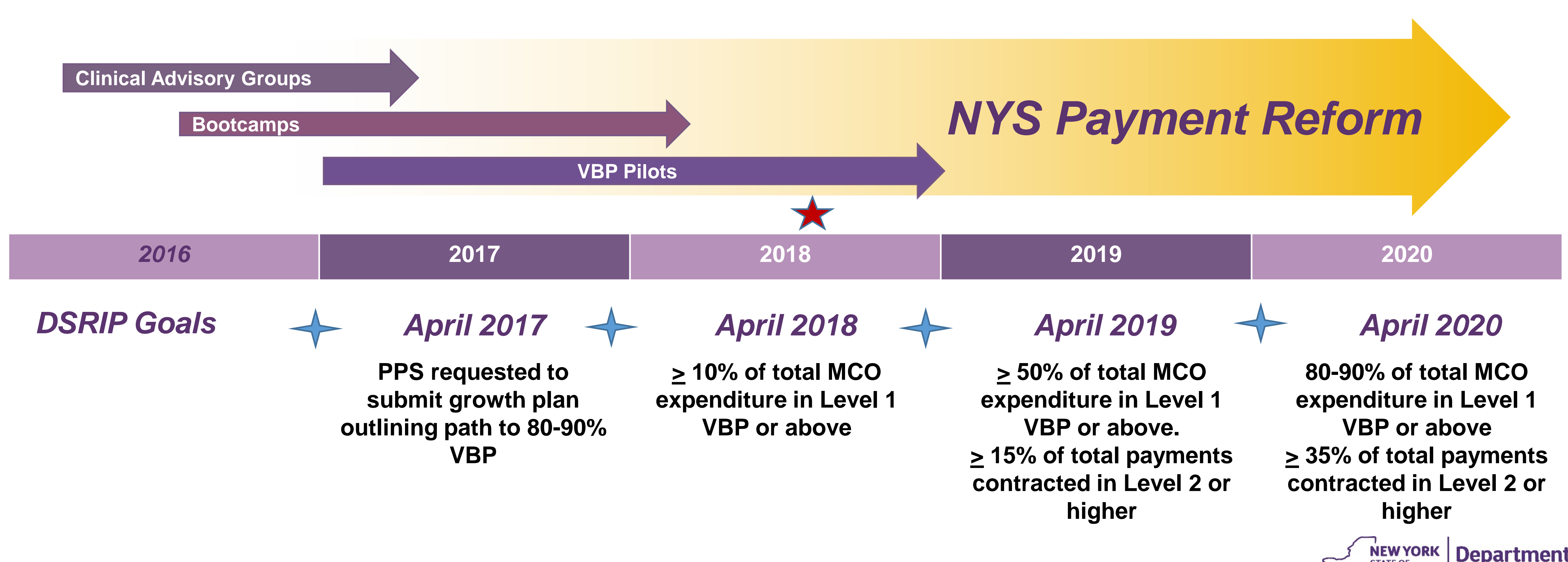
- Services may be reimbursed as *fee-for-service* as they are now, or as a *per member per month (PMPM)* prospective payment.

2) Quality component - A **percentage of performance measures** on the attributed population (those included in the arrangement) **must be passed** to share in any savings (or to determine the percentage of losses that must be made up).

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYS DOH VBP website (Link) *June 2016 updated version approved by CMS March 2017.*

VBP Transformation: Overall Goals and Timeline

Goal: To improve population and individual health outcomes by creating a sustainable system through integrated care coordination and rewarding high value care delivery.



Acronyms: NYS = New York State; PPS = Performing Provider System; MCO = Managed Care Organization

CAG Timeline & Expectations for 2018

2018 CAG Goals

- Conduct annual review of the quality measure sets
- Identify and analyze clinical and care delivery gaps in current measure sets
- Propose recommendations for 2019

Timeline

- CAGs will convene in **spring and summer.**
- Based on CAG feedback, the State will present the proposed measure set to the VBP Workgroup for approval in **October**
- The final Measurement Year (MY) 2019 Quality Measure Sets will be released in **October/early November.**
- The MY 2018 VBP Reporting Requirements Technical Specifications Manual will be released in **October/early November.**

DOH Process for Considering Subcommittee Recommendations

- Conduct series of meetings to refine recommendations to establish a VBP arrangements that are appropriate for the children's population.
- Engage Managed Care Organizations and providers to understand current approaches and models that address the children's population.
- Present the final Subcommittee recommendations to the Value Based Payment Workgroup (VBP Workgroup).
- Receive feedback from the VBP Workgroup.
- Finalize the Children's VBP arrangement (design and associated quality measures) and update report.
- Update the VBP Roadmap with the Children's Arrangement design.
- Submit the VBP Roadmap for public comment.
- Finalize the VBP Roadmap based on public comment.
- Submit the VBP Roadmap (including the design of the Children's arrangement) to CMS for approval.

Principles Informing DOH Approach

- Children represent a unique population and with that, have a unique set of needs that will inform development of a child and their trajectory over the next critical phases of their life.
- Healthy growth and development of children today will bring long-term value to Medicaid and other public systems, including but not limited to education, child welfare, and juvenile justice. For these reasons a longer horizon for assessing cost savings must be considered.
- The payment model must allow and enable subcapitated type arrangements to support pediatricians and providers.
- Access to specialty care, especially for maternal and child behavioral health, should be integrated into primary care settings to ensure appropriate access.
  - Community based organizations play a critical role in child care.
- Children with complex medical needs require highly specialized care.
  - This cohort would require a separate VBP arrangement.

Challenges That Informed Path Forward

- Children are not “little adults.”
  - They tend to be healthier than adults, which impacts opportunity for quality and efficiency improvements.
- VBP arrangements must be feasible, but must account for the complete spectrum of care.
  - Helps to ensure that pediatric providers are at the core of care delivery.
- Savings are often hard to realize in the short term, which impacts the availability of resources to providers.
- Innovative and evidence-based strategies that address the root causes of poor health among children can result in efficiencies across multiple public domains.
  - These efficiencies are often difficult to calculate.
- Relying on a strictly fee-for-service model limits upfront support for pediatricians.
  - The model should allow for capitated arrangements.

A children's VBP arrangement would:

- Take the shape of a population-based arrangement;
- Must account for the unique nature of children, i.e. healthy population where savings can be realized over the long term;
- Risk – needs further discussion, but perhaps not tie to efficiency measure.
  - Dental and Mental Health care context
- Include a capitation option – Level 3; and,
- Exclude children with complex medical needs.
  - Stakeholders have recommended these children be considered for a separate, physician-specialist type of arrangement.

Proposed Payment Model Overview

- **Total Cost of Care Arrangement:** VBP Contractor assumes responsibility for the total cost of care for its attributed population. All services included in Medicaid mainstream managed care are thus included in this arrangement.
- **Attribution**: The plan-assigned Primary Care Provider (PCP) is the attribution-driving provider. Members assigned to a pediatrician are "captured" in the VBP arrangement, if the pediatrician is included in the provider network.
- **Risk:** In risk arrangements, the pediatric provider would only assume risk for the costs attributed to the services the pediatrician provides. This would also include specialty care.

  In sub-capitated arrangements, pediatric providers assume risk for the costs attributed to the services covered in their sub-capitation payment.
- **Performance Measurement:** VBP Contractor quality would be measured across the total spectrum of care of the member. Unlike typical Level 1 arrangements, the children's Level 1 arrangement is based only on quality performance.
- **Capitation:** VBP Contractors may enter into Level 3 arrangements, which are based on prepaid capitation (sub-capitation).

Proposed Payment Model Example

Pediatric provider adopts a Level 3 sub-capitated arrangement with an MCO

- The arrangement has an attributed population of 3,000 members
- Quality outcomes are measured across all 3,000 members
- For discussion - The pediatric provider would be at financial risk for only the costs attributed to the services covered in the sub-capitation, including specialty care services.
  - Specialty care services include, e.g., pulmonology, neurology, & endocrinology, among others.
- The sub-capitation is adjusted based on quality outcomes (Ex. retrospective reconciliation)

Pediatric provider adopts a Level 1 arrangement with an MCO

- The arrangement has an attributed population of 3,000 members
- Quality outcomes are measured across all 3,000 members
- The pediatric provider does not assume any financial risk.
- The pediatric provider is eligible for quality bonus (based purely on quality outcomes)

Feedback from MCOs and Providers

- Some MCOs and providers have capitated arrangements for pediatricians.
- Some MCOs have included care management fees as an upfront payment, within their models.
- MCOs and providers also maintain quality bonus type structures in their children arrangements.
- Some MCOs stratify based on age cohorts within their attributed, pediatric population.

Outstanding Questions

- Can risk be effectively limited to PCP activities in a total cost arrangement?
- Would an Integrated Primary Care episode-based arrangement serve this function better, since this arrangement limits accountable services to those directly impactable by the PCP?
  - If so, how would we deal with the chronic conditions not as relevant for children?
  - Or should DOH seek to build a specific, pediatric arrangement with kids-specific episodes?

Discussion

Quality Measures Update

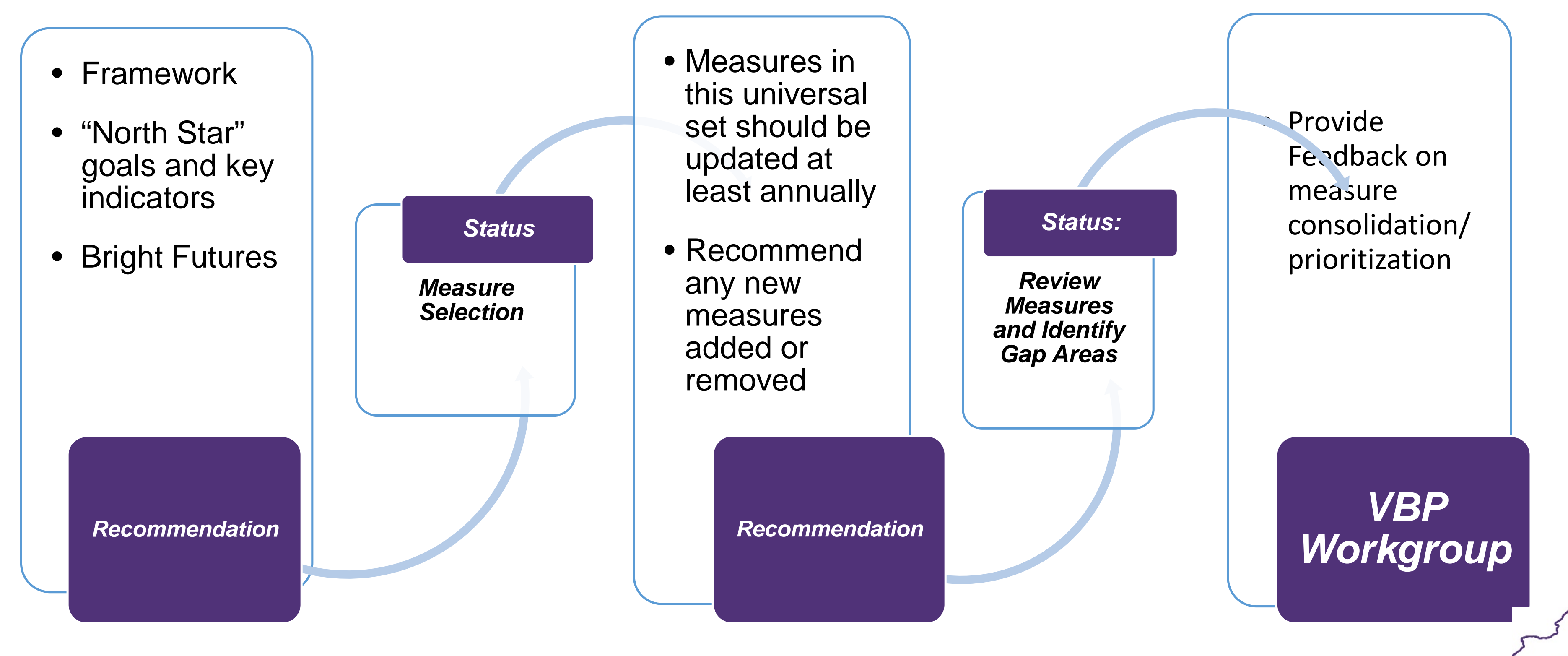
Lindsay Cogan, Director, Division of Quality Measurement, Office of Patient Quality and Safety

Quality Measure Prioritization: Goals for 2018

- Prioritize a focused list of high value quality measures for VBP in MY 2019.
- Key Principles in measure prioritization:
  - Process → Outcome
  - Gather feedback from stakeholders on what are the “right” outcomes
  - Focus on efficient measurement
- Align quality measurement efforts across stakeholder communities and State and Federal-led quality programs
- Reduce the number of measures in use for VBP

Recommendation: Child Measure Consolidation

- The current number of quality measures and the reporting challenges across programs place a significant reporting burden on providers.
  - We are recommending **no** measures be removed from Category 1; Child VBP Quality Measurement set remain the same for 2018/2019



M3 Recommendation and Status – Category 1

- **Recommendation:**
  - A group of maternity measures were recommended based on their relevance to child health quality.
  - These are applicable to TCGP as well as the Maternity arrangement, given Maternity is part of TCGP.
- **Status:**
  - Discussed with both the Maternity CAG and TCGP/IPC CAG
  - Low Birth Weight (LBW) was put forward as a recommended measure to add to TCGP.
    - LBW is the only outcome measure among these measures.

Recommended Measure	Description	Category	Classification	Measure Steward	NQF Endorsed?
Infants exclusively fed with breast milk in hospital	The number of newborns exclusively fed with breast milk during the newborn´s entire hospitalization.	Cat 1	P4R	The Joint Commission	Y
Low Birth Weight Rate (PQI 9)	**The number of Low birth weight (< 2,500 grams) infants per 1,000 newborns.**	**Cat 1**	**P4R**	**Agency for Healthcare Research and Quality**	**N**
Prenatal and postpartum care visits	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.	Cat 1	P4P	National Center for Quality Assurance	N
Contraception care- Postpartum	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, or a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.	Cat 1	P4R	Office of Population Affairs	Y

M3 Recommendation and Status – Category 2

- **Recommendation:**
  - A measure was recommended to be added to the Maternity Care Measure set based on its relevance to child health quality.
- **Status:**
  - Discussed with the Maternity CAG.
  - Behavioral risk assessment for pregnant women was not added as a Category 2 measure to the Maternity Care measure set.
    - Removed from Child Core set
    - Seeking more appropriate measure

Recommended: Child Health Measure Prioritization

Child Health Priority Measures			
Measure	Category	Claims Based	Non-Claims Based
Outcome / Intermediate Outcome Measures			
Pediatric Quality Indicator (PDI) #14 Asthma Admission Rate, Ages 2 Through 17 Years	1	Yes	
Depression Remission or Response for Adolescents and Adults- *Prioritized by IPC CAG*	2 ?	No	
Low Birth Weight Rate (PQI 9)– *Prioritized by Maternity CAG*	1	Yes	
Priority Evidence Based Process Measures			
Childhood Immunization Status , Combination 3	1	No	Claims, Electronic Health Data, Immunization registry
Immunization for Adolescents, Combination 2	1	Yes	
Medication Management for People with Asthma	1	Yes	

- Looking for feedback on which of these measures or others to include
- Which measure(s) 1 (2 max) should we include as Child Health priority measure:
    - Childhood Immunization Status, Combination 3
    - Immunization for Adolescents, Combination 2
    - Pediatric Quality Indicator (PDI) #14 Asthma Admission Rate, Ages 2 Through 17 Years
    - Medication Management for People with Asthma

Recommended: 2019 CAT 1 Child Measure Set

Maternity Measure	Category	Classification	Measure Steward	NQF Endorsed?
Outcome/Intermediate Outcome Measures				
Pediatric Quality Indicator (PDI) #14 Asthma Admission Rate, Ages 2 Through 17 Years	Cat 1	P4R	AHRQ	N
Process Measures				
Adolescent Well-Care Visits	Cat 1	P4R	NCQA	N
Adolescent preventive care – assessment and counseling of adolescents on sexual activity, tobacco use, alcohol and drug use, depression	Cat 1	P4R	NYS	N
Annual dental visit	Cat 1	P4R	NCQA	Y
Childhood Immunization Status, Combination 3	Cat 1	P4P	NCQA	Y
Follow-up care for children prescribed ADHD medication	Cat 1	P4R	NCQA	Y
Immunizations for adolescents, Combination 2	Cat 1	P4P	NCQA	Y
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Cat 1	P4P	NCQA	Y
Well child visits in the first 15 months of life	Cat 1	P4P	NCQA	N
Well child visits in the third, fourth, fifth, and sixth year of life	Cat 1	P4R	NCQA	N

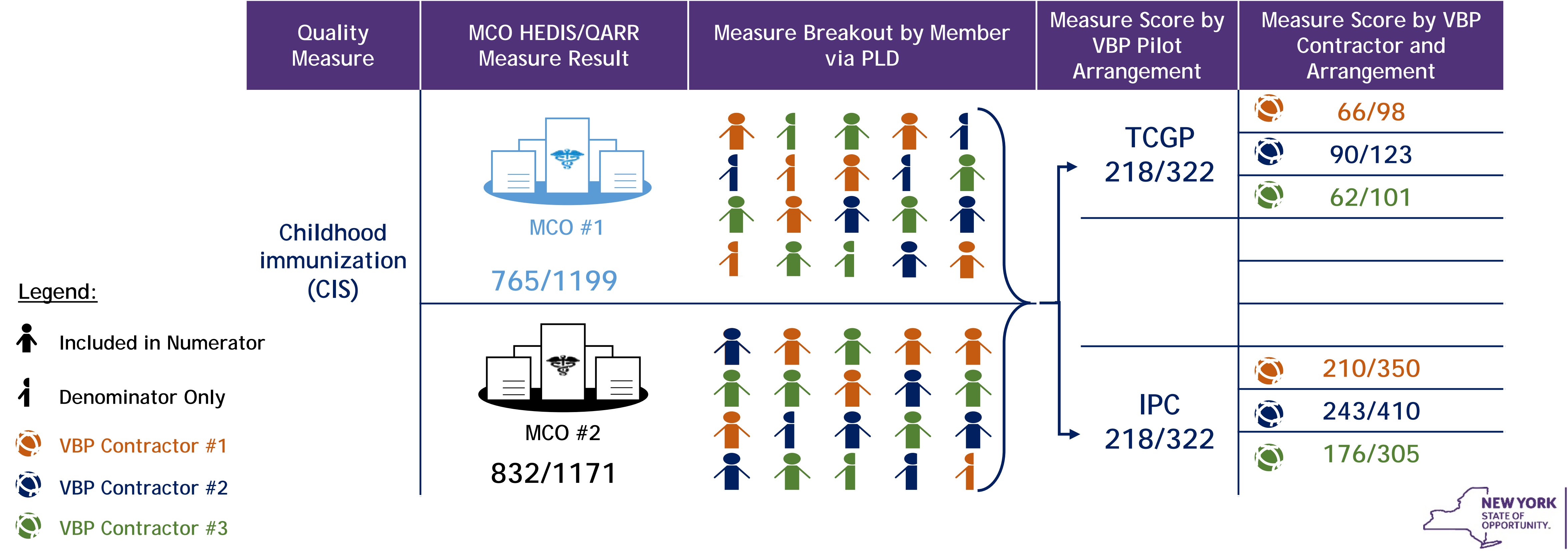
Acronyms: NQF = National Quality Forum; Cat = Category; P4R = Pay-for-Reporting; AHRQ = Agency for Healthcare Research & Quality; TJC = The Joint Commission; NYS = New York State; NCQA = National Committee for Quality Assurance; CMS = Centers for Medicare and Medicaid Services

Recommended: 2019 Category 2 Child Measure Set

Measure	State Category	Final
Developmental screening in the first three years of life	2	P4R
Follow-up after ED visit for mental illness	2	
Follow-up after ED visit for alcohol and other drug dependence	2	P4R
Maternal depression screen done during child's first 6 months of life	2	P4R
Screening for reduced visual acuity and referral in children	2	P4R
Use of first line psycho-social care for children and adolescents on antipsychotics	2	P4R

Quality Measurement Reporting- Interim Strategy

- VBP is leveraging the APC Scorecard method to require health plans to modify the Patient Level Detail (PLD) files submitted for HEDIS/QARR to include provider attribution fields to calculate measure results at the VBP Contractor level across all arrangements.



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Level Set: Problems and Challenges

- **What is the problem that needs to be solved?**
  - Several Category 1 Quality Measures for VBP are not reportable by Managed Care Organizations (MCOs) at the VBP Contractor Level
    - **Controlling High Blood Pressure (HEDIS: CBP)**
    - Adolescent preventive care
    - Screening for Clinical Depression and Follow-up
    - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents
- **Challenges:**
  - MCOs do not report all Category 1 VBP Measures for HEDIS/QARR and may not have the capacity to report new VBP measures without additional support.
  - MCOs do not currently report most Category 2 VBP measures, and most will need additional work to operationalize the reporting of these measures.

Addressing Problems and Challenges

Opportunities to leverage existing work to inform Quality Measurement:

- VBP Pilots- HARP and TCGP
  - Controlling High Blood pressure and reporting of clinical data on population level
- School Readiness VBP Pilot
  - Developmental screening working on tracking screening and ensuring follow-up
- First 1,000 Days
  - TBD. Blood lead level testing and follow-up, Newborn hearing screening
- Health Information Technology (Health IT) Enabled Quality Measurement
  - Controlling High Blood Pressure, Comprehensive Diabetes Care
- NYS Advanced Primary Care Scorecard

Quality Measure Resources

- Issue 1. Statewide Executive Summary of Managed Care in New York State
  - 2017 Executive Summary (PDF, 535KB)
- Issue 2. Health Plan Comparison in New York State
  - 2017 Report
  - Health Data NY- QARR
- Issue 3. Regional Consumer Guides
  - 2017 Regional Consumer Guides
- Issue 4. Health Plan Service Use in New York State
  - 2017 Report
- Issue 5. Health Care Disparities in New York State*
  - 2017 Report
  - Health Data NY - Health Disparities

*** Relates to M4 recommendation to stratify child measures by race/ethnicity**

Discussion

Status of Other Report Recommendations

Doug Fish, Medical Director, Office of Health Insurance Programs

M1 Recommendation and Status

Recommendation M1: 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. These frameworks should be considered as part of all future children’s measure development and implementation for VBP purposes and beyond.

Status: The “North Star” goals and framework have become the focus and work of the First 1000 Days Preventive Care Pediatric Clinical Advisory Group.

M2 Recommendation and Status

Recommendation M2: 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.

Status: The following Category 1 (mandatory) measures **were added** to the TCGP/IPC measure set for 2018 at the recommendation of the Children's Subcommittee:

- Adolescent well-care visits
- Adolescent preventive care – assessment and counseling of adolescents on sexual activity, tobacco use, alcohol and drug use, depression
- Annual dental visit
- Follow-up care for children prescribed ADHD medication
- Immunizations for adolescents – Combination 2
- PDI #14 – asthma admission rate, ages 2 – 17
- Well child visits in the first 15 months of life
- Well child visits in the third, fourth, fifth, and sixth year of life

M2 Status - Continued

Status: The following Category 2 (optional) measures were added to the TCGP/IPC measure set for 2018 at the recommendation of the Children's Subcommittee:

- Developmental screening in the first three years of life
- Follow-up after ED visit for alcohol and other drug dependence
- Follow-up after ED visit for mental illness
- Maternal depression screen done during child's first 6 months of life
- Screening for reduced visual acuity and referral in children
- Use of first line psycho-social care for children and adolescents on antipsychotics

M3 Recommendation and Status

Recommendation M3: Four specific measures for the current Maternity Care VBP arrangement that are especially relevant for child health should be added to the TCGP measure set as soon as feasible. Relatedly, the maternity CAG should consider adding one new maternity care measure identified by the children's CAG as particularly relevant to children's health: behavioral risk assessment for pregnant women. That measure should be added to the TCGP measure set as soon as feasible, as adopted for the Maternity Care arrangement.

Status: Addressed by Lindsay Cogan in earlier slides.

M4 Recommendation

Recommendation M4: VBP arrangements, regardless of model, should require providers and MCOs to report and track performance on pediatric VBP measures at the most detailed disaggregation of race/ethnicity possible.

Status: The State envisions a QM dashboard for VBP in a future version of the Mediciad Analytics Performance Portal (MAPP).

M5 Recommendation and Status

Recommendation M5: 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 24 Children's Health Subcommittee and Clinical Advisory Group: Report to the NYS Medicaid VBP Workgroup federal grant, and other related efforts, in order 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, Massachusetts, Minnesota, North Carolina, 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.

Status: The State will summarize lessons learned from the Connections (Albany Promise) pilot. A new steward is being sought for the Developmental Screening measure.

Timeline and Next Steps for DOH

Ryan Ashe, Director of Medicaid Payment Reform, Office of Health Insurance Programs
Doug Fish, Medical Director, Office of Health Insurance Programs

Timeline

Activity	Timeframe
Review of Subcommittee/CAG comments	Late August/early September
Finalization of proposed VBP payment model and VBP measure set for 2019	Mid to late September
Update to VBP Workgroup	Early October 2018
The final Measurement Year (MY) 2019 Quality Measure Sets	October/early November

Thank you!

Please send questions and feedback to:

vbp@health.ny.gov

Appendix:
Measures Recommended by Children’s Health Subcommittee/CAG (Sept 2017)

Universal Child Measure Set

Consistent with Recommendation M2, the final child measure set would be applicable to any TCGP, IPC or PPCC arrangement, because children will receive care under all VBP models

Category	Type	Already included in TCGP/IPC set	Newly Recommended	Total Measures
1	Pay for Performance	4	4	
1	Pay for Reporting	1	4	
1	*Category 1 subtotal*			*13*
2	Category 2 (all types)	1	6	
2	*Category 2 subtotal*			*7*
	TOTAL			**20**

Universal Child Measure Set – Category 1

#	Measure Name	Measure Steward	NQF Identifier	Classification	Existing TCGP/IPC
1	**Adolescent well-care visit rate** *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.*	NCQA		Cat 1 P4R	No
2	**Assessment and counseling of adolescents on sexual activity, tobacco use, alcohol and drug use, depression (four-part measure)** *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.*	NYS		Cat 1 P4R	No
3	**BMI assessment and counseling** *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*	NCQA	0024	Cat 1 P4P	Yes
4	**Child immunization status, age 2 (combo 3) (NQF 0038)*** *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.*	NCQA	0038	Cat 1 P4P	Yes

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Universal Child Measure Set – Category 1 (Con’t)

#	Measure Name	Measure Steward	NQF Identifier	Classification	Existing TCGP/IPC
5	**Children ages 2-20 having annual dental visit** *Percentage of children ages 2-20 who have at least one dental visit during the year.*	NYS		Cat 1 P4R	No
6	**Chlamydia screening, ages 16–21** *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.*	NCQA	0033	Cat 1 P4P	Yes
7	**PDI #14 asthma admission rate, ages 2 through 17 years** *Rate of inpatient admissions of children with a principal diagnosis of asthma per 100,000 population, ages 2 through 17 years.*	AHRQ		Cat 1 P4P	No
8	**Follow-up care for children prescribed Rx for ADHD** ***Two part measure: initiation phase and continuation phase:*** *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).*	NCQA	0108	Cat 1 P4R	No

Universal Child Measure Set – Category 1 (Con't)

#	Measure Name	Measure Steward	NQF Identifier	Classification	Existing TCGP/IPC
9	**Frequency of well-child visits, ages 3 to 6** *Percentage of children 3–6 years of age who had one or more well-child visits with a primary care provider during the measurement year.*	NCQA	1516	Cat 1 P4P	No
10	**Frequency of well-child visits during the first 15 months of life** *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.*	NCQA	1392	Cat 1 P4P	No
11	**Medication management for children with asthma, ages 5–18** *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.*	NCQA	1799	Cat 1 P4P	Yes
12	**Screen for depression using age appropriate tool and follow-up, ages 12+** *Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.*	CMS	0418	Cat 1 P4R	Yes
13	**Adolescent immunization rate, including rate for HPV (NQF 1407)** *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.*	NCQA	1407	Cat 1 P4P	No

Universal Child Measure Set – Category 2

#	Measure Name	Measure Steward	NQF Identifier	Classification	Existing TCGP/IPC
14	**Screening for Reduced Visual Acuity and Referral in Children** *The percentage of children who received visual acuity screening at least once by their 6th birthday; and if necessary, were referred appropriately.*	CMS	2721 (trial use)	Cat 2	No
15	**Maternal depression screen done during child's first 6 months of life** *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.*	NCQA		Cat 2	No
16	**Children at elevated risk of caries who received fluoride varnish applications** *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.*	American Dental Association (ADA)	2528	Cat 2	Yes
17	**Developmental screening using standardized tool, first 36 months of life** *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.*	Oregon Health & Science University	1448	Cat 2	No

Universal Child Measure Set – Category 2 (Con't)

#	Measure Name	Measure Steward	NQF Identifier	Classification	Existing TCGP/IPC
18	**Follow-up after ED visit for mental illness, ages 6 and older** *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.*	NCQA		Cat 2	No
19	**Follow-up after ED visit for alcohol and other drug dependence, ages 13 and older** *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.*	NCQA		Cat 2	No
20	**Use of first-line psychosocial care for children and adolescents on antipsychotics** *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.*	NCQA	2801	Cat 2	No

Maternity Measures

Consistent with Recommendation M3, the Advisory Group suggests the Maternity CAG consider 5 measures especially relevant for child health quality for inclusion in the TCGP measure set (including one measure not currently in the Maternity Care arrangement measure set).

Category	**Type**	**Already included in Maternity set**	**Newly Recommended**	**Total Measures**
1	Pay for Performance	1	0	
1	Pay for Reporting	3	0	
1	*Category 1 subtotal*			*4*
2	Category 2 (all types)	0	1	
2	*Category 2 subtotal*			*1*
	TOTAL			**5**

Maternity Measures for Child Health

#	Measure Name	Measure Steward	NQF Identifier	Classification	Existing Maternity
1	**Infants exclusively fed with breast milk in hospital** *The number of newborns exclusively fed with breast milk during the newborn´s entire hospitalization.*	Joint Commission	0480	Cat 1 P4R	Yes
2	**Live births less than 2500 grams** *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.*	AHRQ	1382	Cat 1 P4R	Yes
3	**Timeliness and frequency of prenatal and postpartum care visits*** *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.*	NCQA		Cat 1 P4P	Yes
4	**Women provided most or moderately effective methods of contraceptive care within 3 to 60 days of delivery** *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.*	OPA	2902	Cat 1 P4R	Yes
5	**Behavioral risk assessment for pregnant women** *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.*	No Current Steward		Cat 2	No

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