



**Department
of Health**

Medicaid
Redesign Team

Maternity Clinical Advisory Group (CAG) Meeting

*Review of Quality Measures for Value Based Payment (VBP)
Arrangements*

Douglas G. Fish, MD

Medical Director, Division of Program Development & Management

New York State Department of Health

Office of Health Insurance Programs

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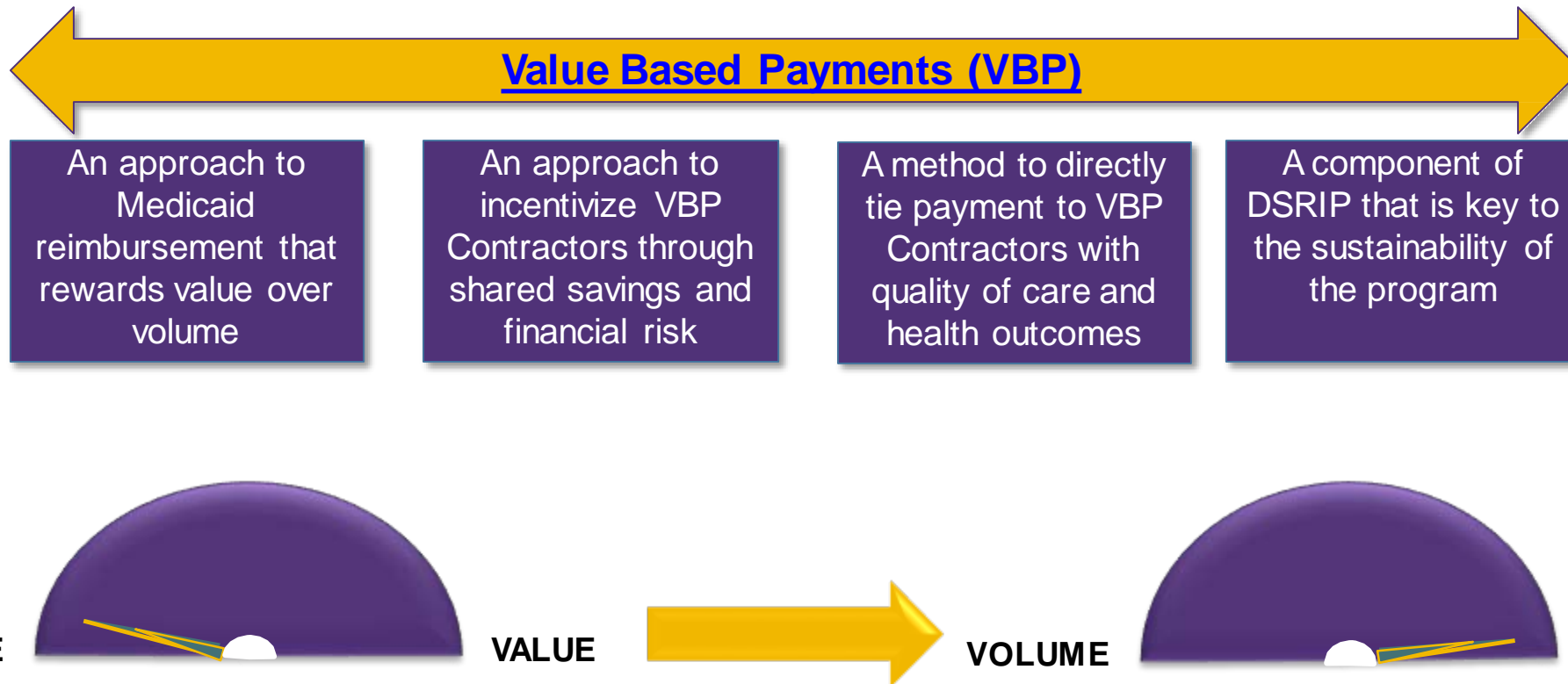
Agenda

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|---|--------|
| 1. Welcome and Meeting Agenda | 5 min |
| 2. NYS Healthcare Reform and Value Based Payment Program Background | 5 min |
| 3. VBP Quality Measure Sets | 20 min |
| 4. Next Steps | 5 min |
| 5. Questions, Feedback, and Suggestions | 20 min |

Background

Value Based Payments: Why is this important?

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



Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. NYSDOH DSRIP Website. Published June 2015.

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.

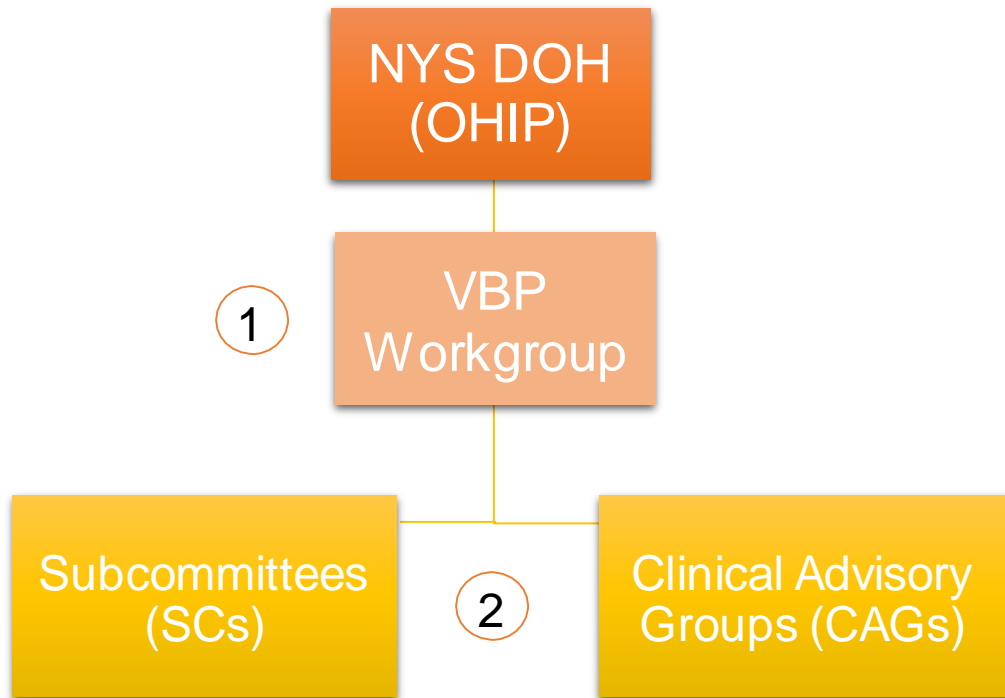


DSRIP Goals

Year	Key Milestone / Goal
2017	April 2017 PPS requested to submit growth plan outlining path to 80-90% VBP
2018	April 2018 ≥ 10% of total MCO expenditure in Level 1 VBP or above
2019	April 2019 ≥ 50% of total MCO expenditure in Level 1 VBP or above. ≥ 15% of total payments contracted in Level 2 or higher
2020	April 2020 80-90% of total MCO expenditure in Level 1 VBP or above ≥ 35% of total payments contracted in Level 2 or higher

Acronym Definition:
 New York State (NYS)
 Performing Provider System (PPS)
 Managed Care Organization (MCO)

VBP Governance and Stakeholder Engagement



Additional CAGs and Subcommittees may be created as the need arises.

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

2 The **VBP CAGs and SCs** were created to address the larger VBP design questions. Their charge is to produce recommendations to the VBP Workgroup and to the State with their best design solutions. As a result, a number of VBP standards and guidelines were developed (included in the current version of the Roadmap) by the Subcommittees. The CAGs' scope of work included selecting Quality Measures for specific arrangements.

Acronym Definition:
 Health and Human Services (HHS)
 Community Based Organization (CBO)
 Performing Provider System (PPS)
 Department of Health, Office of Health Insurance Programs (DOH OHIP)

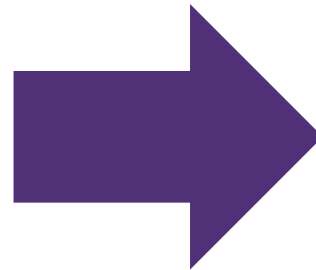
Multiple VBP Arrangement Options

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

Need for Contracting Flexibility

VBP Contractors and MCOs are able to address local population and organization characteristics:

- Different levels of *provider readiness*
- Different types of *outcomes* that are relevant
- Different roles for the *member/patient*
- Different *models of care*
- Different *organizational forms*
- Different *payment models*



Multiple Arrangement Options

- Total Care for General Population (TCGP)
- Integrated Primary Care (IPC)
- Maternity Bundle
- Total Care for Health and Recovery Plans (HARP) Subpopulation
- Total Care for HIV/AIDS Subpopulation
- Total Care for Managed Long Term Care (MLTC) Subpopulation
- Total Care for Intellectually or Developmentally Disabled (I/DD) Subpopulation

Initial VBP Implementation Efforts

The State is providing additional financial incentives and support for early adoption of Value Based Payment through the VBP Pilot Program.

VBP Pilot Program

The goal of the Pilots is to help the State and its participating organizations learn how VBP transformation will work in practice, as well as to incentivize early adoption of VBP. This is a voluntary, 2- year program. DOH reserves the right to restrict enrollment to those Pilots that it deems to be most relevant.

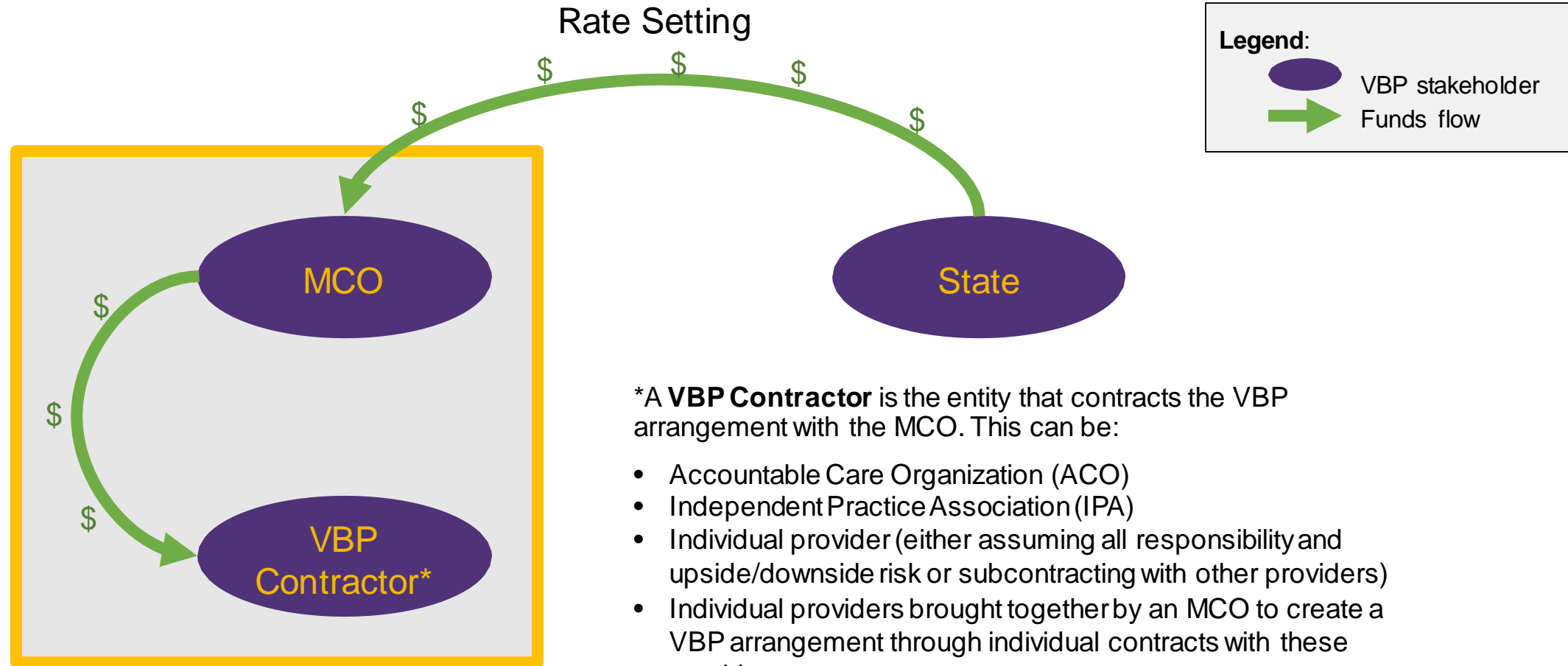
Pilot participants are required to:

- Adopt on-menu VBP arrangements, per NYS VBP Roadmap guidelines.
- Submit a VBP contract (or contract addendum) by April 14, 2017*, with an effective contract date of no later than January 1 (effective date may be retroactive, for contracts signed between January 1, 2017 and April 14, 2017).
- Report all Category 1 measures and a minimum of two (2) distinct Category 2 measures for each arrangement being contracted, or have a State and Plan approved alternative.
- Move to Level 2 VBP arrangements in Year 2 of the Pilot Program. Pilots that are unable to move to Level 2 in Year 2 (April 2018) will be disqualified from the Program.

* New deadline announced March 31, 2017

VBP Quality Measure Sets

Today's discussion will focus on the Managed Care Organization (MCO) to VBP Contractor relationship.



*A **VBP Contractor** is the entity that contracts the VBP arrangement with the MCO. This can be:

- Accountable Care Organization (ACO)
- Independent Practice Association (IPA)
- Individual provider (either assuming all responsibility and upside/downside risk or subcontracting with other providers)
- Individual providers brought together by an MCO to create a VBP arrangement through individual contracts with these providers.

Note: A PPS is not a legal entity and therefore cannot be a VBP Contractor. However, a Performing Provider System (PPS) can form one of the entities above to be considered a VBP Contractor.

Maternity Care

Maternity



Pregnancy Care



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



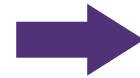
Delivery & Post-partum Care



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



Newborn Care



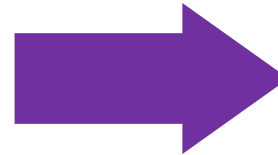
Includes all services associated with the newborn's care up to 30 days post-discharge.

High-Cost NICU Care and the Maternity Arrangement

- Original intent: exclude high-cost (Level 4) Neonatal Intensive Care Unit (NICU) cases from the Maternity Arrangement to avoid unacceptable insurance risk for Maternity Care Contractors. Concerns identified with this approach:
 - Analysis shows existence of significant inconsistencies in coding /registration across providers.
 - Excluding Level 4 creates potential incentive to 'upcode' neonates to Level 4 to exclude costs.
- The State recommends: Maternity episodes to include all levels of NICU care. Replace exclusion with explicit suggestion to include appropriate stop-loss provision to be negotiated between VBP Contractor and MCO.

Problem

The cost of newborn care can quickly escalate. A single case can have a significant negative impact on shared savings arrangements. Provider protection is required, but excluding all Level 4 NICU admissions could be incentive for upcoding.



State Recommendation

The State will not exclude Level 4 NICU admissions from Maternity Arrangement. To protect providers against insurance risk, the State suggests that Contractors and MCOs include stop-loss provisions for high cost cases in their contract.

*Maternity care episodes target Medicaid-only members and include three subcomponent episodes pregnancy, delivery, and newborn related care. These three episodes, along with the underlying services, provide a summary of care delivery from the onset of pregnancy to 60 days after discharge of the mother as well as 30 days after discharge of the newborn.

Maternity Measure Set

Measures recommended by the CAG were aligned with measures included in the NYS DOH portfolio of programs including the Delivery System Reform Incentive Payment (DSRIP) Program, the Quality Improvement Program (QIP), Quality Assurance Reporting Requirements (QARR) and the State's Vital Statistics maternity care measures.

Clinical Care Delivery and Outcomes Addressed by the Maternity Measure Set

Pregnancy

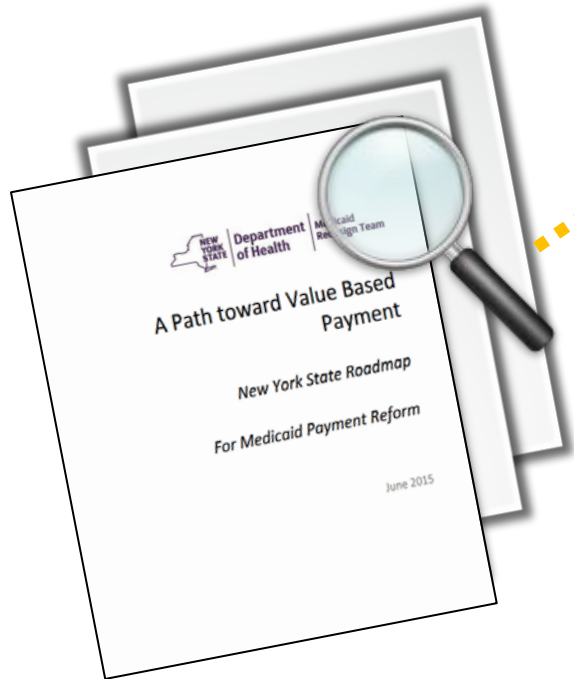
Delivery

- Vaginal Delivery
- C-Section Delivery

Newborn Care

Quality Measures – Process

“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 and VBP WG² approves measure categories



State accepts or re-categorizes measures



VBP Contractors report on measures



Final proposals are presented to the Workgroup for comment following the measure feasibility process.

¹ VBP Roadmap (June 2016), page 34

² WG= Workgroup

Measure Feasibility

Measure Feasibility focused on 9 factors:

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

Category 2 and 3 Measures

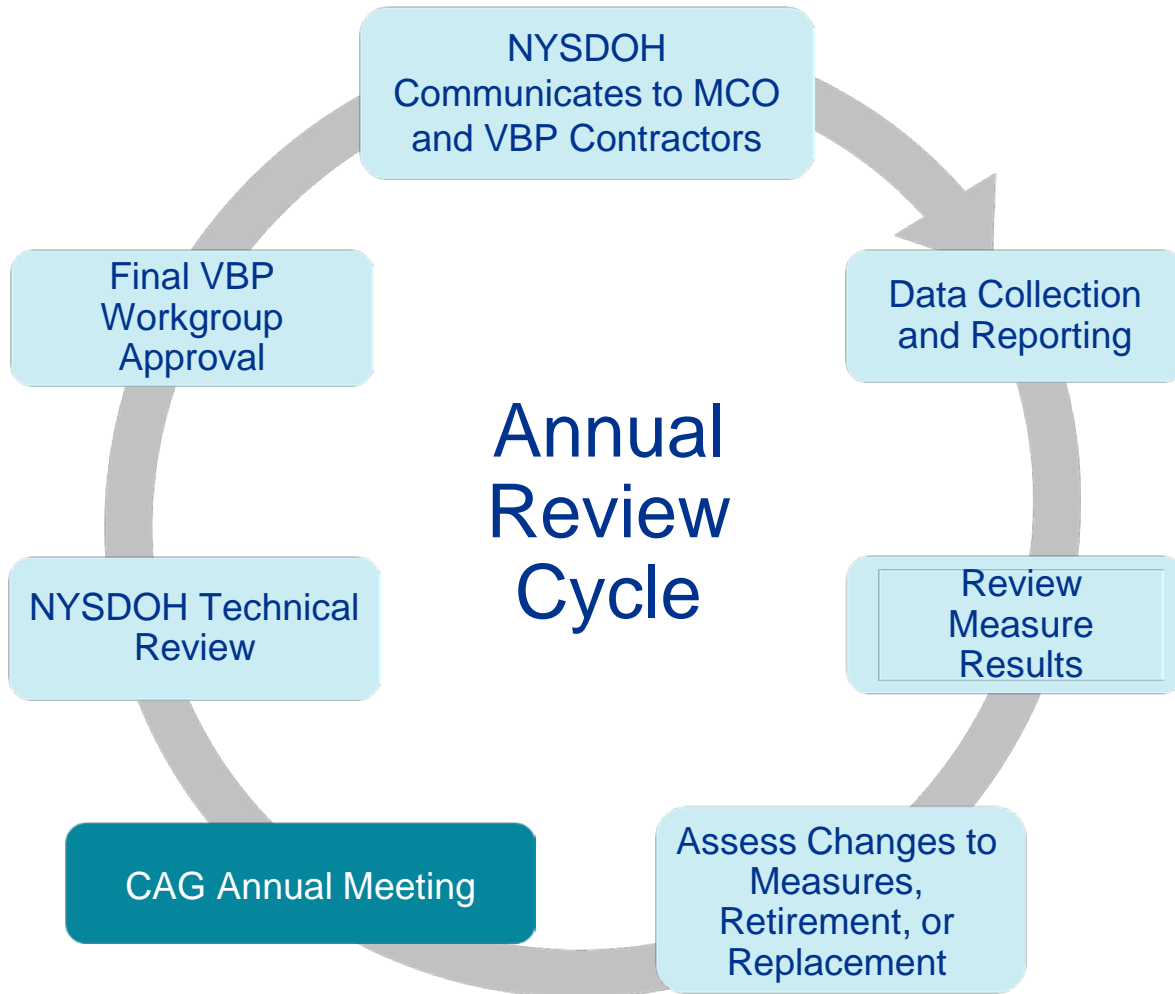
Category 2

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

Category 3

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

VBP Quality Measure Set Annual Review



Annual Review

Clinical Advisory Groups will convene to evaluate the following:

- Feedback from VBP Contractors, MCOs, and stakeholders
- Any significant changes in evidence base of underlying measures and/or measurement gaps
- Categorization of measures and make recommended changes

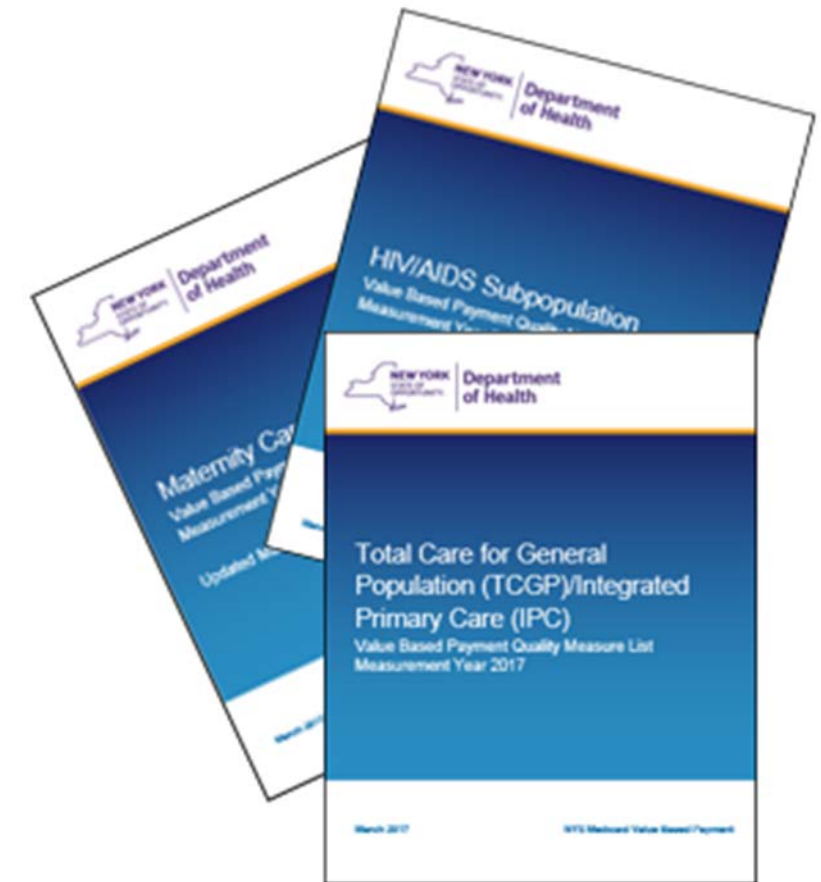
State Review Panel

- Review data, technical specification changes or other factors that influence measure inclusion/exclusion*
- Review measures under development to test reliability and validity
- Review measure categorizations from CAG and make recommendations where appropriate (Cat. 1 vs. Cat. 2; P4P vs. P4R)

Value Based Payment Program

Measurement Year 2017 Quality Measure Sets

The MY 2017 Quality Measure Sets for TCGP/IPC, Maternity, HIV/AIDS and HARP VBP Arrangements have been finalized and posted to the NYS DOH VBP website ([Link](#))



Measurement Year 2017

Maternity Measure Classification and
Categorization

Maternity – Measure Feasibility Summary

At the September 2016 VBP Workgroup meeting the committee identified 11 quality measures as **Category 1** (including both P4P and P4R measures). Workgroup feedback increased the measure set to a total of 13 Category 1 measures.

The following proposed changes are based on DOH feasibility review:

Measure Disposition	Rationale for Change	Count
Unchanged		9
Move to Category 2	Applies to limited number of facilities	1
Move to Category 3	Numerator too small or measure topped out	2
Move to Category 3	NYS has another payment initiative in place	1
Total		13

P4R = Pay for Reporting
 P4P = Pay for Performance

Maternity: Final Measure List with Measure Changes

No.	Measure	State Category	Original	Final	Reasoning for Proposed Modification
1	Birth Trauma Rate- Injury to Neonate (PSI #17)	3	P4P		Sample size issues, very low incidence statewide.
2	C-Section for Nulliparous Singleton Term Vertex (NSTV)	1	P4R	P4R	
3	Frequency of Ongoing Prenatal Care	1	P4P	P4P	
4	Incidence of Episiotomy	1	P4R	P4R	
5	Long-Acting Reversible Contraception (LARC Uptake)*	1	P4R	P4R	
6	Percentage of Babies Who Were Exclusively Fed with Breast Milk During Stay	1	P4R	P4R	
7	Percentage of Early Elective Deliveries	3	P4R		NYS has another payment initiative in place
8	Percentage of preterm births	1	P4R	P4R	
9	Clinical Depression Screen*	1	P4R	P4R	

*Measure #5: Changed measure from Category 2 to Category 1 based on VBP Workgroup feedback Measure

*Measure #9: Added to the measure set based on VBP Workgroup feedback

Measure numbering is consistent with the March presentation to the VBP workgroup and does not reflect numbering included in the CAG recommendation reports.

Maternity: Final Measure List with Measure Changes (cont.)

No.	Measure	State Category	Original	Final	Reasoning for Proposed Modification
10	Prenatal & Postpartum Care (PPC)—Timeliness of Prenatal Care & Postpartum Visits	1	P4P	P4P	
11	Low Birth Weight [Live births weighing less than 2,500 grams (preterm v. full term)]	1	P4R	P4R	
12	Under 1500g infant Not Delivered at Appropriate Level of Care	3	P4P		Limited variability and topping out at high performance levels
13	Vaginal Births after Cesarean Section [Vaginal Birth After Cesarean (VBAC) Delivery Rate, Uncomplicated]	2	P4R	P4R	Limited to only birthing facilities able to perform VBAC

Measure numbering is consistent with the March presentation to the VBP workgroup and does not reflect numbering included in the CAG recommendation reports.

Category 2 Measures Not Reviewed by the VBP Workgroup

Measure	State Category	Original	Final	Reasoning for Proposed Modification
Antenatal Hydroxyprogesterone	2	P4R	P4R	No change
Antenatal Steroids	2	P4R	P4R	No change
Appropriate DVT Prophylaxis in Women Undergoing Cesarean Delivery	2	P4R	P4R	No change
Experience of Mother with Pregnancy Care	2	P4R	P4R	No change
Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Hospital or Birthing Facility Discharge	2	P4R	P4R	No change
Intrapartum Antibiotic Prophylaxis for Group B Streptococcus (GBS)	2	P4R	P4R	No change
Monitoring and Reporting of NICU Admission Rates	2	P4R	P4R	No change
Post Partum Blood Pressure Monitoring	2	P4R	P4R	No change

Moving Forward

- 2018 quality measure sets will need to be communicated to wider stakeholder community in October 2017.
- CAGs to be reconvened in the summer to kick off that process.
- More information to come!

Thank you!

Please send questions and feedback to:

vbp@health.ny.gov