Agenda

1. Welcome and Introductions
2. The Role of the Subcommittee / CAG
3. Overview of Children’s MRT and VBP
4. Review of Existing Data
5. Identification and Prioritization of Key Principles for Children’s VBP (Discussion)
6. Preview and Next Steps
Welcome & Introductions

Co-chairs

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Now let us have the group’s members introduce themselves!
2. Role of the Subcommittee / CAG
Opening Platform to Inform Our Work

- **Children Are Not Just Mini Adults!**

  - Early childhood development, social determinants of health, parental health, and clinical care all play a part in children’s wellbeing.
  - Ensuring that all children have access to high quality primary health care is important.
  - Early Interventions can have profound, long-term positive effects on children’s lifetime outcomes.
  - Value from improving child outcomes will accrue over a longer time frame and to society at large.
  - Cross-system collaboration is important as children follow their developmental trajectory.

October 2016
Children’s Health VBP Subcommittee / Clinical Advisory Group (CAG) Composition: A Dual Approach

**Subcommittee**
Focus: to create recommendations to the State on VBP design

**CAG**
Focus: to develop quality measures for VBP Arrangements

- Clinical Experts
- Providers
- Universities
- Health Plans
- State Agencies
- Medical Societies
- Medical Centers

Comprehensive Stakeholder Engagement
Children’s Health VBP Subcommittee / Clinical Advisory Group: Objectives

- Understand the State’s vision for the Roadmap to Value Based Payment
- Review VBP arrangements for children’s services
- Develop a plain language value statement for the health and well-being of New York’s child and adolescent Medicaid beneficiaries
- Make recommendations to the State that reflect the value statement on:
  - Overall design for children’s VBP, including populations / subpopulations
  - Pertinent quality measures for children’s VBP arrangements
  - Data and other support required for providers to be successful
  - Implementation details related to VBP
## Tentative Meeting Schedule

<table>
<thead>
<tr>
<th>Meeting #1</th>
<th>October 20 - Albany</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Introductions and Explanation of Roles</td>
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<tr>
<td>• Overview of VBP and Children’s MRT</td>
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<tr>
<td>• Review of Children’s Medicaid Data and population distinctions</td>
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<tr>
<td>• Identification and Prioritization of Key Principles for Children’s VBP</td>
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<table>
<thead>
<tr>
<th>Meeting #2</th>
<th>November 18 - NYC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recap of Meeting #1</td>
<td></td>
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<tr>
<td>• Children’s VBP Design</td>
<td></td>
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<tr>
<td>• Model Options for Children’s VBP</td>
<td></td>
</tr>
<tr>
<td>• Group to discuss Model Recommendations</td>
<td></td>
</tr>
<tr>
<td>• Group to discuss Key Implementation Considerations</td>
<td></td>
</tr>
<tr>
<td>• Preview of Quality Measures</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Meeting #3</th>
<th>December 12 - Albany</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recap of Meetings #1 &amp; 2</td>
<td></td>
</tr>
<tr>
<td>• Quality Measures Overview</td>
<td></td>
</tr>
<tr>
<td>• Detailed Measure Review and Discussion</td>
<td></td>
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<tr>
<td>• Pediatric Health</td>
<td></td>
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<tr>
<td>• Pediatric BH</td>
<td></td>
</tr>
<tr>
<td>• Other (e.g. life outcomes; school readiness)</td>
<td></td>
</tr>
<tr>
<td>• Quality Measure Selection and Recap</td>
<td></td>
</tr>
<tr>
<td>• Connection to Principles of Children’s VBP</td>
<td></td>
</tr>
</tbody>
</table>

By the end of 2016, the recommendations put forth by the Subcommittee / CAG will be submitted and written into the recommendation report.
3. Overview of Children’s MRT and VBP
Overview of Medicaid Redesign Team (MRT)

- In 2011, Governor Cuomo created the Medicaid Redesign Team (MRT).
  - Made up of 27 stakeholders representing every sector of healthcare delivery system
  - Developed a series of recommendations to lower immediate spending and propose reforms
  - Major reforms included cost control; global spending cap; care management for all, Patient Centered Medical Homes (PCMH), and Health Homes (HH)
- Part of the MRT plan was to obtain a 1115 Waiver which would reinvest MRT generated federal savings back into New York’s health care delivery system
- In April 2014, New York State and CMS finalized agreement Waiver Amendment
  - Allows the State to reinvest $8 billion of $17.1 billion in Federal savings generated by MRT reforms
  - $6.4 billion is designated for Delivery System Reform Incentive Payment Program (DSRIP)
Delivery Reform and Payment Reform: Two Sides of the Same Coin

• A thorough transformation of the delivery system can only become and remain successful when the payment system is transformed as well.

• Many of NYS system’s problems (fragmentation, high re-admission rates) are rooted in how the State pays for services.
  
  • Fee-for-Service (FFS) pays for inputs rather than outcome; an avoidable readmission is rewarded more than a successful transition to integrated home care.
  
  • Current payment systems do not adequately incentivize prevention, coordination, or integration.

Financial and regulatory incentives drive…

a delivery system which realizes…

cost efficiency and quality outcomes: value
Overview of Value Based Payments (VBP)

• A Five-Year Roadmap outlining New York State’s plan for Medicaid Payment Reform (MRT) was required by the MRT Waiver

• By DSRIP Year 5 (2019), all Managed Care Organizations (MCOs) must employ non fee-for-service payment systems that reward value over volume for at least 80-90% of their provider payments (outlined in the Special Terms and Conditions of the waiver)

• The State and CMS have committed to the Roadmap

• Core Stakeholders (providers, MCOs, unions, patient organizations) have actively collaborated in the creation of the Roadmap

• If Roadmap goals are not met, overall DSRIP dollars from CMS to NYS will be significantly reduced
Reforming the Payment System and Moving from Volume to Value

Value Based Payments (VBP)

- An approach to Medicaid reimbursement that rewards value over volume
- An approach to incentivize providers through shared savings and financial risk
- A method to directly tie payment to providers with quality of care and health outcomes
- A component of DSRIP that is key to the sustainability of the program

• VBP arrangements are not intended primarily to save money for the State, but to allow providers to increase their margins by realizing value.

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 March 2016.
How an Integrated Delivery System should Function

Integrated Physical & Behavioral Primary Care

*Includes social services interventions and community-based prevention activities*

Maternity Care (including first month of baby)

Chronic Care
(Asthma, Diabetes, Depression and Anxiety, Substance Use Disorder, Trauma & Stressors…)

HIV/AIDS

Managed Long Term Care

Severe Behavioral Health/Substance Use Disorders (HARP Population)

Intellectually/Developmentally Disabled Population

Sub-population focus on Outcomes and Costs *within* sub-population or episode

Population Health focus on overall Outcomes and *total* Costs of Care
MCOs and Contractors can Choose Different Levels of Value Based Payments

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

<table>
<thead>
<tr>
<th>Level 0 VBP*</th>
<th>Level 1 VBP</th>
<th>Level 2 VBP</th>
<th>Level 3 VBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFS with bonus and/or withhold based on quality scores</td>
<td>FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/IPC, FFS may be complemented with PMPM subsidy)</td>
<td>FFS with risk sharing (upside available when outcome scores are sufficient)</td>
<td>Prospective capitation PMPM or Bundle (with outcome-based component)</td>
</tr>
<tr>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>FFS Payments</td>
<td>Prospective total budget payments</td>
</tr>
<tr>
<td>No Risk Sharing</td>
<td>Upide Risk Only</td>
<td>Upide &amp; Downside Risk</td>
<td>Upide &amp; Downside Risk</td>
</tr>
</tbody>
</table>

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

• Arrangement Types*
  - Total Care General Population (TCGP)
  - Integrated Primary Care (includes Chronic Bundle) (IPC)
  - Maternity Bundle - episodic
  - Health and Recovery Plans (HARP)
  - HIV/AIDS
  - Managed Long Term Care (MLTC)

*Arrangements do not yet include Dually Eligible members

• Two VBP implementation subcommittees were created to focus on:
  - Social Determinants of Health (SDH) and CBOs
  - Advocacy and Engagement

The full recommendations that came from these Subcommittees are available in the DOH VBP Resource Library: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/index.htm
Important Platform of Managed Care

• Managed care is the vehicle for VBP

The **State** will adjust MCO premiums based on value delivered to their total membership per VBP arrangement type (whether actually contracted or not) and on meeting yearly targets to move to 80-90% VBP.

**MCOs** will subsequently drive providers to improve this value of care. VBP arrangements and insight in the potential performance of providers will be actionable entry point for MCOs.

**Feedback-loop facilitates control of the overall Medicaid spend**

**Providers**: Deliver better quality and efficient care for Medicaid beneficiaries, allowing for further re-investment into the delivery system.

• Populations transitioning to managed care will need an approach to VBP to be developed in a commensurate timeline
  • Contract and reward high value care, and incentivize improvement
Medicaid Redesign Team (MRT)’s Vision, Goals and Principles for Transforming the Delivery of Health Care for Children

- Keep children on their developmental trajectory
- Focus on recovery and building resilience
- Identify needs early and intervene
- Maintain child at home with support and services
- Maintain the child in the community in least restrictive settings
- Prevent escalation and longer term need for higher end services
- Maintain accountability for outcomes and quality
- Maintain access to services for children without Medicaid as a “Household of One”
Children and Behavioral Health Initiatives in the MRT

- Expansion of Co-located BH and Primary Care (PC)
- Expansion of Health Homes (HH) to Children
- Expansion of Home and Community Based Services for children
- Children’s Workgroup
- HH Children’s Workgroup
PPS DSRIP Projects that Impact Children Healthcare

DSRIP Project Organization

Domain 1: Organizational Components

Domain 2: System Transformation
3.a.i: Integration of primary care services and behavioral health
3.a.ii: Behavioral health community crisis stabilization services
4.a.i: Promote mental, emotional, and behavioral well-being in communities

Domain 3: Clinical Improvement
3.d.ii: Expansion of asthma home-based self-management programs
4.a.iii: Strengthen mental health and substance use infrastructure across systems

Domain 4: Population Health
3.d.iii: Evidence based medicine guidelines for asthma treatment
4.d.i: Reduce premature births
3.f.i: Increase support programs for maternal & child health

Source: New York State DSRIP Project Toolkit, NYSDOH DSRIP Website.
DSRIP Health Outcomes for Children: An Example

Today
- Child in Medicaid with a chronic health condition

After DSRIP
- Intermittent care provided by separate providers, as necessary
- Care managed by a coordinated set of integrated providers

Engagement

Delivery
- Unnecessary ER visits & hospitalizations in childhood
- Preventive healthcare provides the resources the child requires

Outcome
- Unnecessary ER visits & hospitalizations throughout adulthood
- Integrated care follows through adolescence into adulthood

Value to the child, the family, and the healthcare system

Unnecessary strain on the child, the family, and the healthcare system
Coverage of Children Under Existing VBP Arrangements

• Currently, children are covered in 3 types of arrangements:
  • Total Care for the General Population (TCGP)
  • Integrated Primary Care (IPC)
  • Existing Subpopulation Arrangements
    - HIV/AIDS
    - I/DD (under development)

Key to Consider:
• Are there gaps in VBP coverage that should be addressed?
• Is the volume sufficient to support a specialized arrangements?
• What are the unintended consequences (if any) of a particular approach?
Coverage of Children Total Care for the General Population (TCGP)

- Larger providers that are focused on population health may be interested in TCGP arrangements that cover at least 10,000 members
  - Children are currently included in TCGP
  - Attribution follows PCP assignment (PCP may include pediatricians or family practice doctors)

- Quality measures for TCGP include a range of pediatric measures (see Appendix)
Coverage of Children in Integrated Primary Care (IPC)

Preventive Care
(ages 0 -65)

Includes e.g.:
- Wellness visits
- Immunizations, vaccinations (Medicaid-covered)
- Screening
- Routine diagnostics

Routine Sick Care
(age range depends on condition)

Includes e.g.:
- ages 0-65 Routine Sick Care
- ages 2-65 Rhinitis/Sinusitis, Upper Respiratory Infection, Tonsillectomy

Chronic Care
(age range depends on condition)

Includes 14 chronic conditions:
- ages 2-65 Asthma
- ages 5-65 Diabetes
- ages 12-65 Lower Back Pain, Bipolar, Depression and Anxiety, Substance Use Disorder, Trauma and Stressors
- ages 18-65 COPD, CHF, CAD, Arrhythmia, Heart Block/Conduction Disorders, Hypertension, Osteoarthritis and Gastro-Esophageal Reflux

Note: Patients that are attributed to subpopulations are excluded.
Coverage of Children in Existing Subpopulation Arrangements

- **HIV/AIDs** – Includes cohort of Medicaid members who are HIV-positive or have AIDS, regardless of age
  - Includes all care for the total subpopulation

- **Intellectually/Developmentally Disabled (I/DD)**
  - Under Development
  - I/DD advisory group convened; 4 meetings completed; quality measures in discussion

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**General population**  
**HARP (adults only)**  
**HIV/AIDS**  
**I/DD**  
**MLTC (adults only)**

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October 2016
4. Review of Existing Data for Children’s Health

Presentation by Chad Shearer from United Hospital Fund (UHF)
5. Identification and Prioritization of Key Principles for Children’s VBP
Many Factors Impact Children’s Health

- Early Childhood Development
- Social Determinants of Health
- Parental Health and Wellbeing
- Experience in the Education System
Early intervention with children can pay long-lasting, broad-based dividends

- Future benefits accrue not just to individuals or the healthcare system but to society more broadly
- Research has shown that preventing/reducing exposure to adverse life events improves the overall lifetime trajectory for children
Children’s Health Needs are Dynamic

- Health needs change as children age
- Some symptoms and conditions are not as prevalent in older children as they are in younger children (e.g. asthma / pulmonary conditions)
- Some physical and behavioral health conditions can present during adolescence
Others?

- Group Discussion
Prioritization Discussion

The prioritization and categorization of our key principles will provide structure as we create recommendations.

What key principles are most critical to address first? Do these key principles reflect the groups’ *value statement*?
Examples of Specific VBP Questions to Consider

In some cases a key principle may link directly to a VBP design question. These will be explored during the next meeting. Examples include:

• Are there specific child and adolescent preventive services that should remain fee-for-service in order to incentivize volume?

• How can the most relevant SDH for children be encouraged through value based payment models?

• How the importance of family network to care outcomes be explicitly recognized in VBP?

• How can public investment from other systems (e.g. school) be factored into VBP arrangements?

• How can VBP address a longer timeframe for savings?
Starting Points for Quality Measurement

The quality measure selection process can begin using the following sources:

- Relevant DSRIP Domain 2 and 3 measures
- Relevant NYS Quality Assurance Reporting Requirements (QARR) measures
- Advanced Primary Care (APC) measure set (State Heath Innovation Plan – SHIP)
- Relevant measures from CMS measure sets
- National Quality Forum (NQF) measures
- National Committee for Quality Assurance (NCQA)

*Key starting point: no reinventing of the wheel!*

* Please refer to Appendix A for a listing of pediatric-specific quality measures

7. Preview and Next Steps
Preview of Children’s Health VBP Advisory Group Meeting #2

<table>
<thead>
<tr>
<th>Topics covered</th>
<th>Featured Presenters</th>
<th>Date &amp; Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children’s VBP design</td>
<td>• Michael Bailit, <em>Bailit Health</em></td>
<td>November 18th</td>
<td>NYC - TBD</td>
</tr>
<tr>
<td>• Model options for consideration</td>
<td>• Marc Berg, <em>KPMG</em></td>
<td></td>
<td></td>
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<tr>
<td>• Develop model recommendations</td>
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<tr>
<td>• Discuss key implementation considerations</td>
<td></td>
<td></td>
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<tr>
<td>• Preview quality measures</td>
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</table>
Recommended Reading

- VBP Roadmap (2016 update)
- Value-Based Payment Models for Medicaid Child Health Services (Bailit Health)
- Poverty and Child Health in the United States
- Effects of Social Needs Screening and In-Person Service Navigation on Child Health
- You Get What You Pay For: Measuring Quality in Value-Based Payment for Children’s Health Care
- Understanding Medicaid Utilization for Children in New York State: Data Brief and Chartbook
- Shifting the Care and Payment Paradigm for Vulnerable Children
- Accounting for Kids in Accountable Care: A Policy Perspective
- Transformation of Child Health in the United States
Additional Information:

DOH Website:
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/

Contact Us:
DSRIP Email:
dsrip@health.ny.gov
Appendix A – Sample Pediatric Quality Measures
Measures with a Pediatric focus in the IPC and Total Care for the General Population Measure set

All measures developed by the Advanced Primary Care (APC) Integrated Care Workgroup as part of the State Health Innovation Plan (SHIP) are included in this set.
## Primary Prevention Measure Relevant to Pediatric Population (0-65 age range)

### Advanced Primary Care Measure set

<table>
<thead>
<tr>
<th>No.</th>
<th>Measure</th>
<th>Reporting Source</th>
<th>State Recommended Category</th>
<th>P4R</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Topical Fluoride for Children at Elevated Caries Risk, Dental Services</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Childhood Immunization Status</td>
<td>VBP Contractor</td>
<td>1</td>
<td>No</td>
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<tr>
<td>3</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
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<tr>
<td>5</td>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
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<tr>
<td>6</td>
<td>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
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</tbody>
</table>
# Asthma measures (2-65 age range)

<table>
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<th>Measure</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Lung Function/Spirometry Evaluation</td>
<td>State</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Medication management</td>
<td>State</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Potentially Avoidable Complications</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Assessment of Asthma Control – Ambulatory Care Setting</td>
<td>State</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Patient Self-Management and Action Plan</td>
<td>VBP Contractor</td>
<td>2*</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>PDI #14 Pediatric Admission Rate</td>
<td>State</td>
<td>3**</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>PQI #15 Younger Adults Admission Rate</td>
<td>State</td>
<td>3**</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver (process)</td>
<td>VBP Contractor</td>
<td>2</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* Measure managed by private registry that charges for use. Inclusion in this list does not imply endorsement by the State.

** Incidence too low in Medicaid population for reliable measurement. PQIs are included in the Potentially Avoidable Complications (PAC) measure.
## Diabetes Measures (5-65 age range)

Children’s Health SC / CAG to recommend which of these measures are relevant for the pediatric population

<table>
<thead>
<tr>
<th>No.</th>
<th>Measure</th>
<th>Reporting Source</th>
<th>State Recommended Category</th>
<th>P4R</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical Attention for Nephropathy</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Hemoglobin A1c (HbA1c) testing performed</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>Hemoglobin A1c (HbA1c) Poor Control (&lt;8.0 or &gt;9.0%)</td>
<td>State</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Eye Exam (retinal) performed</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>5</td>
<td>Foot Exam</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>6</td>
<td>Composite measure: Comprehensive Diabetes Care (combination of Diabetes measures above)</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>Optimal Diabetes Care (Composite Measure)</td>
<td>State</td>
<td>3**</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Controlling Blood Pressure</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Statin Therapy</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>10</td>
<td>Proportion of Days Covered (PDC): three rates by therapeutic category (RAS antagonists, diabetes medication or statins)</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>Angiotensin-Converting Enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy</td>
<td>VBP Contractor</td>
<td>2</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* Measures recommended by more than 1 CAG are not (see slide 4). For prevention measures see Appendix.
** Measure not in APC or QARR. Large overlap with existing measures.
*** Incidence too low to be reliable. Is also included in PAC measure.
Recommended Maternity Measures 
(Mother 60 days post partum; infant 30 
days post partum)
Maternity – Category 1 Measures

The CAG recommends the following quality measures for use in the Maternity VBP Arrangement.

<table>
<thead>
<tr>
<th>No.</th>
<th>Category 1 Measure</th>
<th>Reporting Source</th>
<th>State Recommended Category</th>
<th>P4R</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Frequency of Ongoing Prenatal Care</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>2</td>
<td>Prenatal and Postpartum Care (PPC)</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>% of Vaginal Deliveries with Episiotomy</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Vaginal Birth After Cesarean (VBAC) Delivery Rate</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>C-Section for Nulliparous Singleton Term Vertex (NSTV) (risk adjusted)</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>% of Early Elective Deliveries</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Maternity – Category 2 Measures

The CAG recommends the following quality measures for use in the Maternity VBP Arrangement.

<table>
<thead>
<tr>
<th>No.</th>
<th>Category 2 Measure</th>
<th>Reporting Source</th>
<th>State Recommended Category</th>
<th>P4R</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Birth Trauma Rate – Injury to Neonate</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>8</td>
<td>Live Births Weighing Less than 2,500 Grams (risk adjusted)</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>% Preterm Births</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Under 1500g Infant Not Delivered at Appropriate Level of Care</td>
<td>State</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>LARC Uptake</td>
<td>VBP Contractor</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>Neonatal Mortality Rate</td>
<td>VBP Contractor</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>13</td>
<td>Hepatitis B Vaccine Coverage Among All Live Newborn Infants Prior to Discharge</td>
<td>VBP Contractor</td>
<td>2</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>% of Babies Who Were Exclusively Fed with Breast Milk During Stay</td>
<td>VBP Contractor</td>
<td>1</td>
<td>Yes</td>
</tr>
<tr>
<td>15</td>
<td>Monitoring and Reporting of NICU Referral Rates</td>
<td>VBP Contractor</td>
<td>2</td>
<td>Yes</td>
</tr>
</tbody>
</table>