NEW YORK STATE | Department of Health | Medicaid Redesign Team

New York State's Health Care Transformation: The Path to Medicaid Payment Reform through *Value-Based Payment Programs*

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Agenda

- DSRIP Program to Value-Based Payment
- Terminology and VBP Levels
- Target Budget Adjustments & Distribution of Shared Savings
- Measuring Performance for VBP Arrangements
- VBP Quality Measurement in 2018

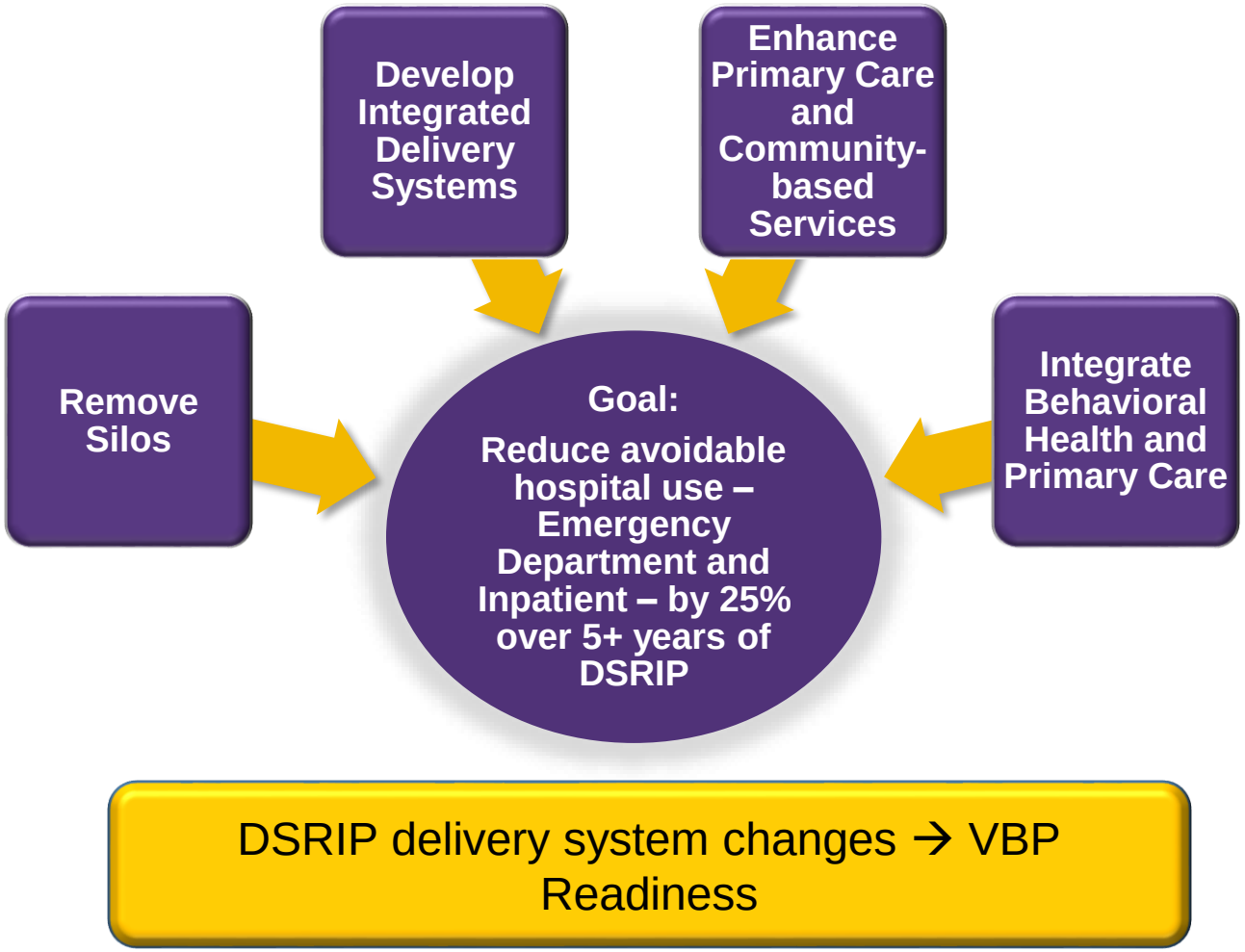
Terminology

- **Behavioral Health** – Encompasses Mental Health **or** Substance Use conditions
- **Efficiency** – defined as ACTUAL cost /EXPECTED cost, and determines if there are savings or losses
- **Fee-for-Service** – 2 Usages: 1) Claims are submitted by the provider and paid by the plan, vs 2) Medicaid members who are not yet in Managed Care
- **Medicaid MCO** – Managed Care Organization (MCO) in Medicaid Program
- **PCP** – may be Primary Care **Provider** or Primary Care **Practitioner**, depending on the setting or usage, so be careful.
- **Provider** – can be a practice, a hospital, nursing home, community-based organization or a practitioner, as examples.
- **VBP Contractor** – An entity, either a provider or groups of providers, engaged with a Medicaid Managed Care Organization in a VBP contract.
- **VBP Roadmap** – CMS-approved document of standards, guidelines and recommendations pertaining to VBP in New York State's Medicaid Program

Medicaid Redesign Team (MRT) Waiver Amendment

- Part of the Medicaid Redesign Team (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, Governor Andrew M. Cuomo announced that New York State and CMS finalized an agreement on the MRT Waiver Amendment.
  - Allowed the state to reinvest $8 billion of the $17.1 billion in federal savings generated by MRT reforms for 6.3 million members.
- The MRT Waiver Amendment goals are to:
  - ✓*Transform the State's Health Care System*
  - ✓ *Bend the Medicaid Cost Curve*
  - ✓ *Assure Access to Quality Care for all Medicaid members*
- 1115 Waiver renewed for 5 years, as of December 2016

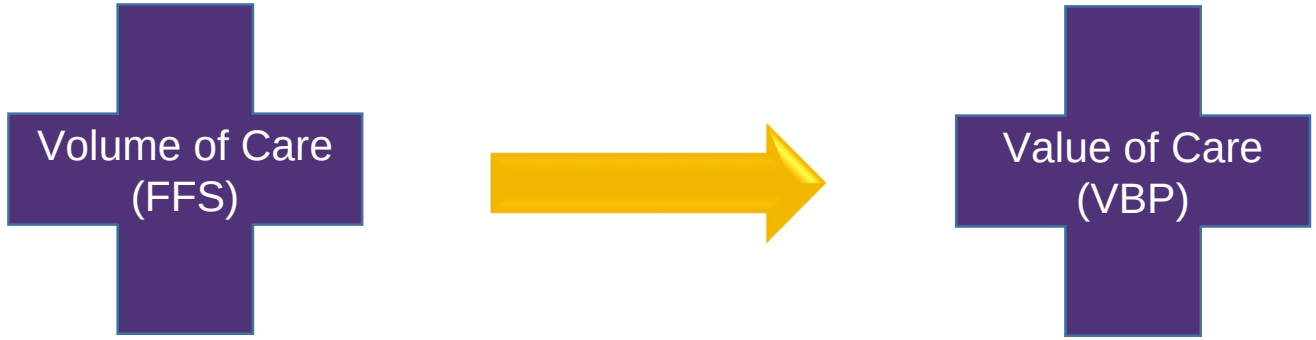
Delivery System Reform Incentive Payment (DSRIP) Program Objectives



- DSRIP was built on the CMS and State goals in the Triple Aim:
  - Improving quality of care
  - Improving health
  - Reducing costs

Source: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/. Accessed May 5, 2016.

The New World: Paying for *Outcomes* not *Inputs*



FFS - Fee for Service

Value Based Payment (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

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. New York State Department of Health (NYS DOH) DSRIP Website. Originally Published June 2015.Updated and approved by CMS March 2017.
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/2017-03-30_cms_vbp_roadmap_approval_letter.htm
https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/2016-06_vbp_roadmap_final.pdf

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	April 2017	April 2018	April 2019	April 2020
	PPS requested to submit VBP Needs Assessment	≥ 10% of total MCO expenditure in Level 1 VBP or above	≥ 50% of total MCO expenditure in Level 1 VBP or above. ≥ 15% of total payments contracted in Level 2 or higher	80-90% of total MCO expenditure in Level 1 VBP or above ≥ 35% of total payments contracted in Level 2 or higher

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

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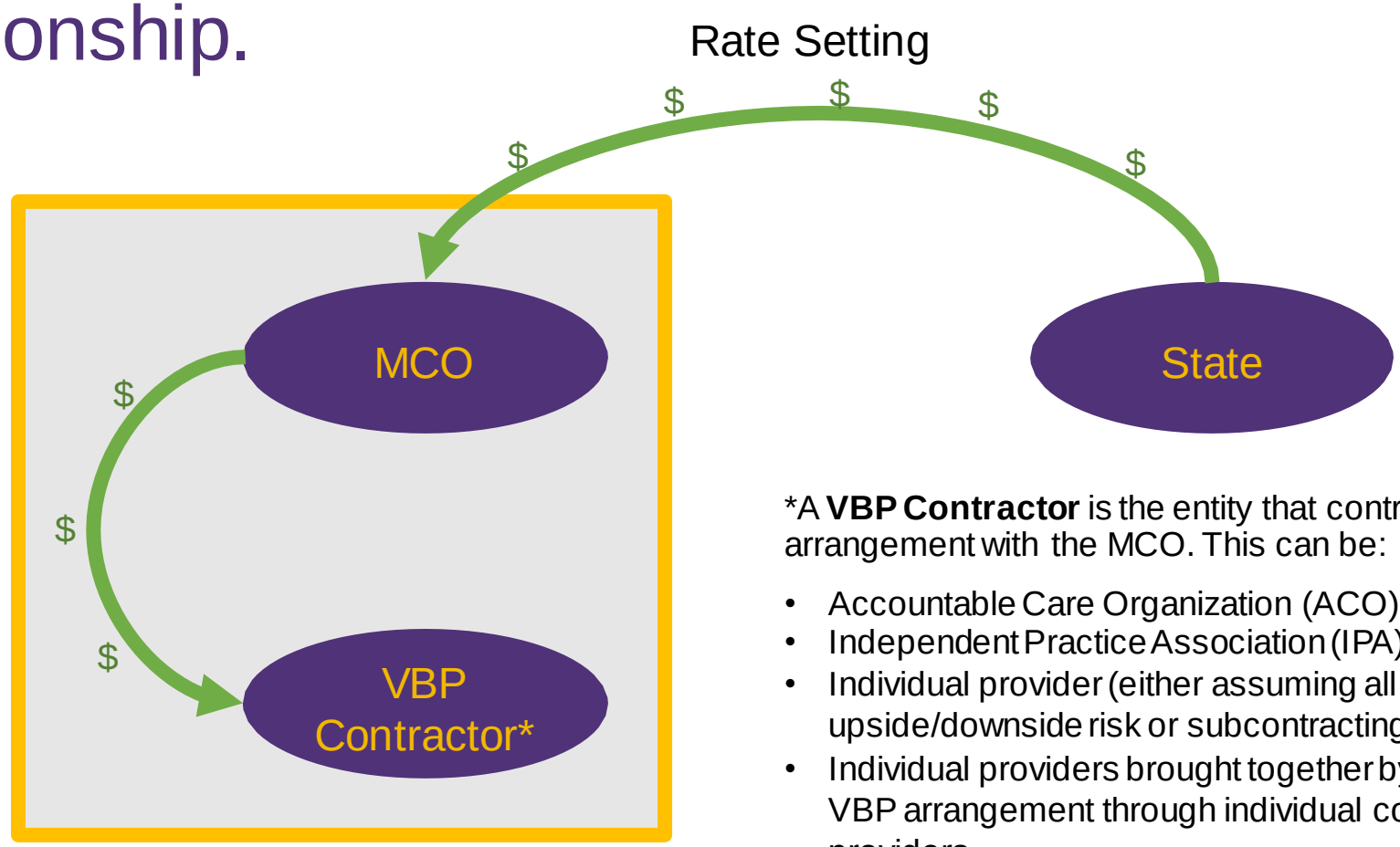
Today's discussion will focus on the Managed Care Organization (MCO) to VBP Contractor (Provider) relationship.



Legend:
VBP stakeholder
Funds flow

*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.

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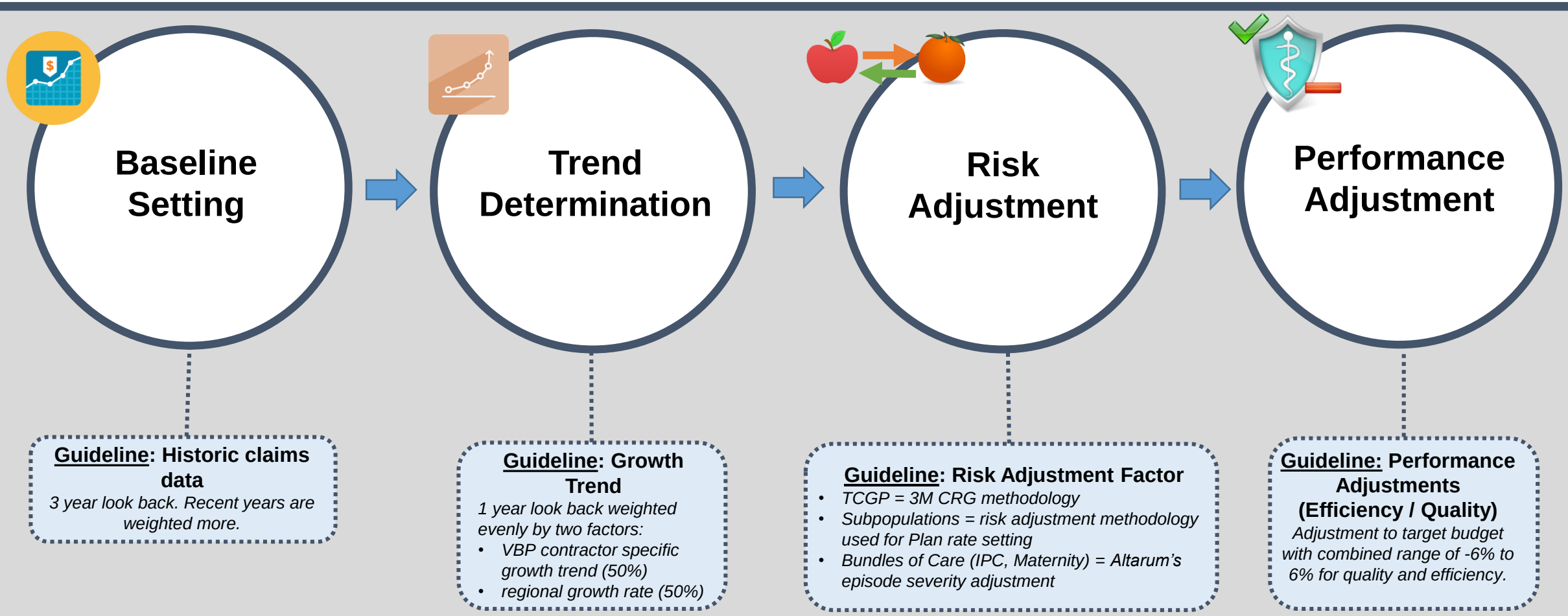
Target Budget Adjustments & Distribution of Shared Savings

Target Budget Setting Components are Flexible

The VBP Roadmap outlines a recommended, but not required, method to establish a target budget.

The State does not mandate a specific methodology to be used to calculate a target budget for an arrangement. However, contracts should specify that a target budget will be used.



Managed Care Organization and Provider can Choose Different Levels of VBP

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

Level 0 VBP*	**Level 1 VBP** **Retrospective Reconciliation**	**Level 2 VBP** **Retrospective Reconciliation**	**Level 3 VBP** **Prospective** (requires mature contractors)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available **when outcome scores are sufficient**	FFS with risk sharing (upside available **when outcome scores are sufficient**)	Prospective capitation PMPM or Bundle (**with outcome-based component**)
FFS Payments	FFS Payments	FFS Payments	Prospective total budget payments
No Risk Sharing	↑ **Upside Only**	↑↓ **Upside** & **Downside Risk**	↑↓ **Upside** & **Downside Risk**

Acronym Definition: Fee for Service (FFS); Per Member Per Month (PMPM)

Source: New York State Department of Health Medicaid Redesign Team. A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform. June 2016 updated version approved by CMS March 2017

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Level 1 Agreement

50% Shared Savings (Upside Only)
If Quality Metrics met

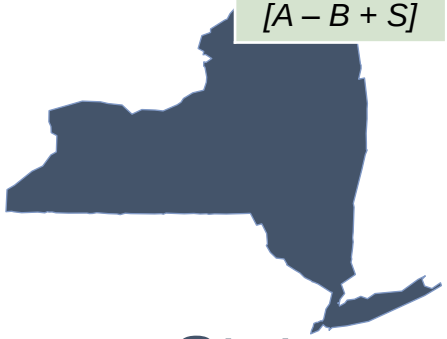
Coordinated care among team members

Payer	Forestland Care
Payer Premium	$ 6,000 ($ 500 PMPM)
Provider	New York Medical Group *(contracts a VBP arrangement)*
2014 Claims	Primary Care: $ 2,000 ER (Opioid overdose): $ 2,600 **Total: $ 4,600**
Provider Cost	$ 4,000
VBP Budget	$ 5,500

MCO Profit & Loss		
[A]	Revenue *(Premium)*	$ 6,000
[B]	Cost *(Claims)*	$ 4,600
[A-B]	*Profit*	$ 950 + $ 450 = $ 1,400
[S]	Shared Savings (50%)	$ (450)
[A – B + S]	**Total Profit / (Loss)**	**$ 950**

Provider Profit & Loss		
[B]	Revenue *(Claims)*	$ 4,600
[C]	Provider Cost	$ 4,000
[B-C]	Profit	$ 600
[S]	Shared Savings (50%)	$ 450
[B – C + S]	**Total Profit / (Loss)**	**$ 1,050**

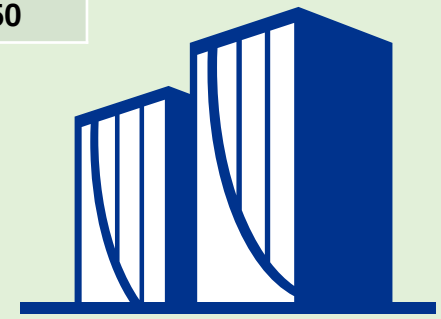
Shared Savings Calculation		
[TB]	Target Budget	$ 5,500
[B]	Claims	$ 4,600
[TB - B]	Shared Savings	$ 900



State

$6,000

Premium



Payer/MCO

$4,600

MC FFS

Provider

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Level 2 Agreement

90% Shared Savings (Upside)
50% Shared Losses (Downside)
If Quality Metrics Met

Coordinated care among team members

Payer	Forestland Care
Payer Premium	$ 6,000 ($ 500 PMPM)
Provider	New York Medical Group *(contracts a VBP arrangement)*
2014 Claims	Primary Care: $ 2,000 ER (Bench Press Accident): $ 2,600 **Total: $ 4,600**
Provider Cost	$ 4,000
TCGP Budget	$ 5,500

MCO Profit & Loss		
[A]	Revenue *(Premium)*	$ 6,000
[B]	Cost *(Claims)*	$ 4,600
[A - B]	*Profit*	$590 + $810 = $1,400
[S]	Shared Savings (10%)	$ (810)
[A – B + S]	**Profit / (Loss)**	**$ 590**

Provider Profit & Loss		
[B]	Revenue *(Claims)*	$ 4,600
[C]	Provider Cost	$ 4,000
[B - C]	Profit	$ 600
[S]	Shared Savings (90%)	$ 810
[B – C + S]	**Profit / (Loss)**	**$ 1,410**

Shared Savings Calculation		
[TB]	Target Budget	$ 5,500
[B]	Claims	$ 4,600
[TB - C]	Shared Savings	$ 900

State

$6,000

Premium

Payer

$4,600

MC FFS

Provider

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Level 3 Agreement

Full Capitation

Coordinated care among team members

Payer	Forestland Care
Payer Premium	$ 6,000 ($ 500 PMPM)
Provider	New York Medical Group *(contracts a VBP arrangement)*
2014 Claims	Primary Care: $ 2,000 ER (Bench Press Accident): $ 2,600 **Total: $ 4,600**
Provider Cost	$ 4,000
TCGP Budget	$ 5,500

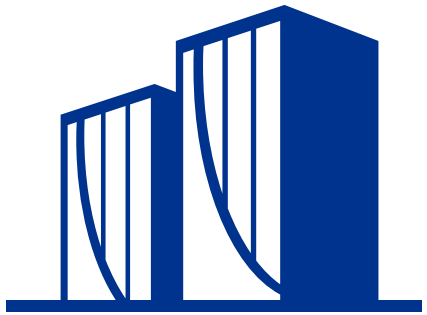
MCO Profit & Loss		
[A]	Revenue *(Premium)*	$ 6,000
[B]	Cost *(Target Budget)*	~~$ 4,600~~ $ 5,500
[A – B]	**Profit / (Loss)**	**$ 500**

Provider Profit & Loss		
[B]	Revenue *(Target Budget)*	~~$ 4,600~~ $ 5,500
[C]	Provider Cost	$ 4,000
[B – C]	**Profit / (Loss)**	**$ 1,500**

State

$6,000

Premium



Payer

$ 5,500

Capitation

Provider

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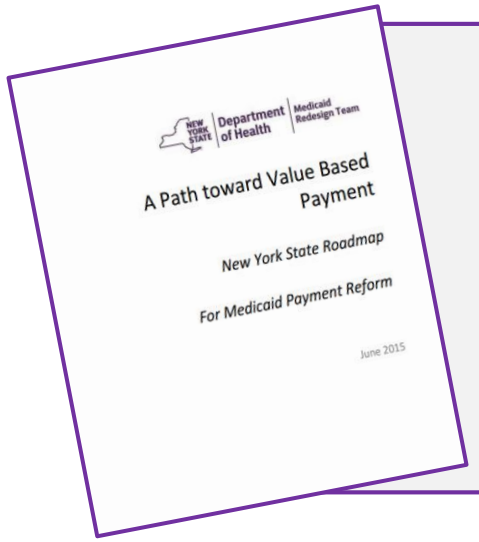
Standard: Implementation of Social Determinants of Health Intervention



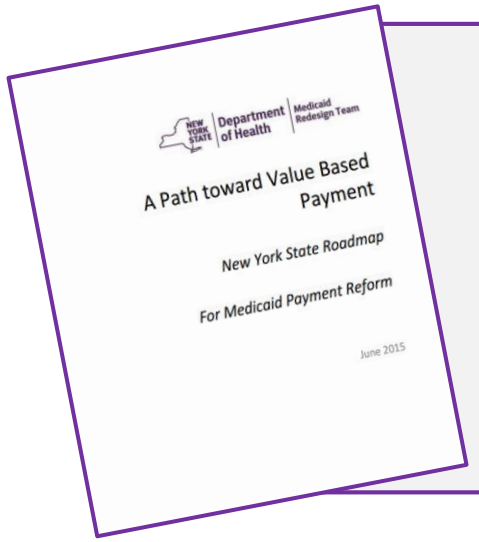
"To stimulate VBP contractors to venture into this crucial domain, VBP ***contractors in Level 2 or Level 3 agreements*** *will be* ***required****, as a statewide standard,* ***to implement*** *at least* ***one social determinant of health intervention****." (VBP Roadmap, p. 41)*

The State has seen success with the following intervention types:

1. Housing
2. Nutrition
3. Education

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. June 2016 updated version, approved by CMS March 2017.

Standard: Inclusion of at Least One, Tier 1 Community-Based Organization (CBO)



*"Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, **it is also critical that community based organizations be supported and included in the transformation**. It is therefore a requirement that starting January 2018, all Level 2 and 3 VBP arrangements include a minimum of one Tier 1 CBO (VBP Roadmap, p. 42)*

Description:

- VBP contractors in a Level 2 or 3 arrangement **MUST** include at least one, Tier 1 CBO.
  - A Tier 1 CBO is a non-profit, non-Medicaid billing, community-based social and human service organizations (e.g. housing, social services, religious organizations, food banks)

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. June 2016 updated version, approved by CMS March 2017.

Measuring Performance for VBP Arrangements

Upside and Down Side Risk Sharing Arrangements

- While VBP encourages efficiency, quality is paramount!
- No savings will be earned without meeting minimum quality thresholds.

Quality Targets % Met goal	Level 1 VBP Upside Only	Level 2 VBP Up - and downside when actual costs < budgeted costs	Level 2 VBP Up - and downside when actual costs > budgeted costs
> 50% of Quality Targets Met	50% of savings returned to VBP contractors	Up to 90% of savings returned to VBP contractors	VBP contractors are responsible for up to 50% losses
<50 % of Quality Targets Met	Between 10 – 50% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	Between 10 – 90% of savings returned to VBP contractors (sliding scale in proportion with % of Quality Targets met)	VBP contractors responsible for 50-90 % of losses (sliding scale in proportion with % of Quality Targets met)
Quality Worsens	No savings returned to VBP contractors	No savings returned to VBP contractors	VBP contractors responsible for up to 90% of losses

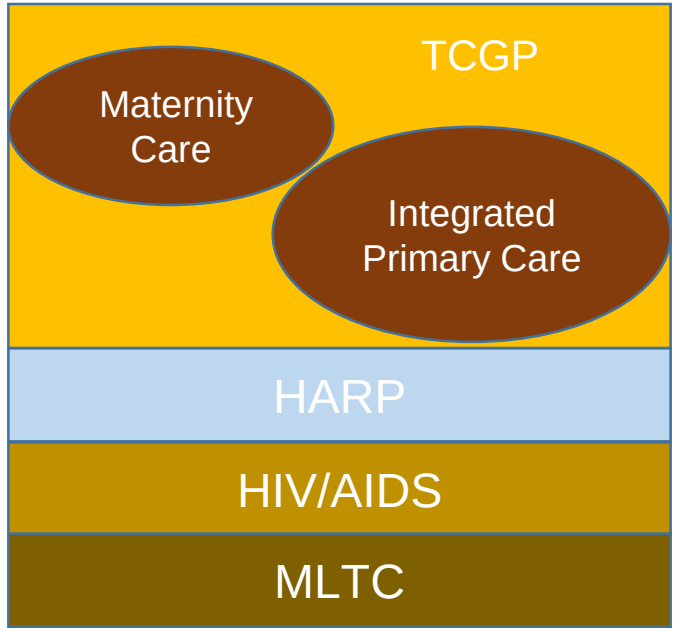
Source: New York State Department of Health Medicaid Redesign Team, *A Path Towards Value Based Payment, New York State Roadmap for Medicaid Payment Reform*, NYS DOH VBP website, June 2016 updated version approved by CMS March 2017.

VBP Arrangements

Arrangement **Types***

- Total Care for the General Population (TCGP)
- Integrated Primary Care (IPC)
- Maternity Care
- Health and Recovery Plans (HARP)
- HIV/AIDS Care
- Managed Long Term Care (MLTC)

**Arrangements do not yet include Dually Eligible members*



VBP Quality Measurement in 2018

TCGP/IPC Measures & Annual Review Process

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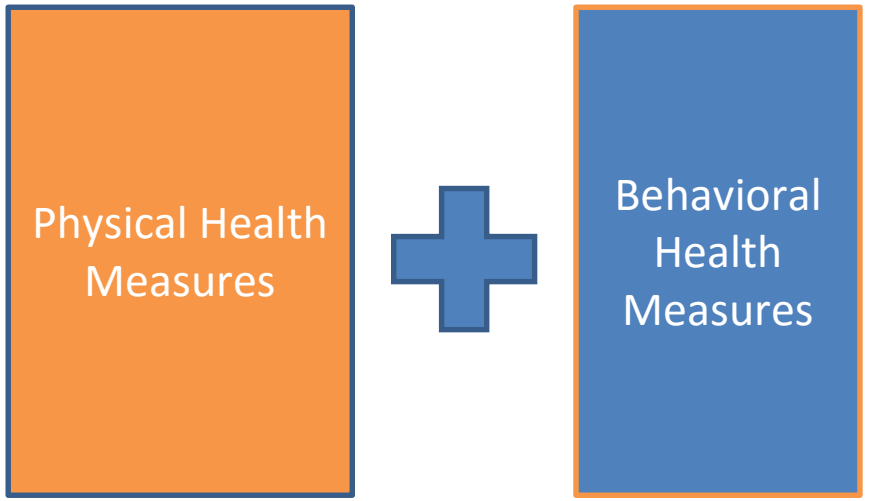
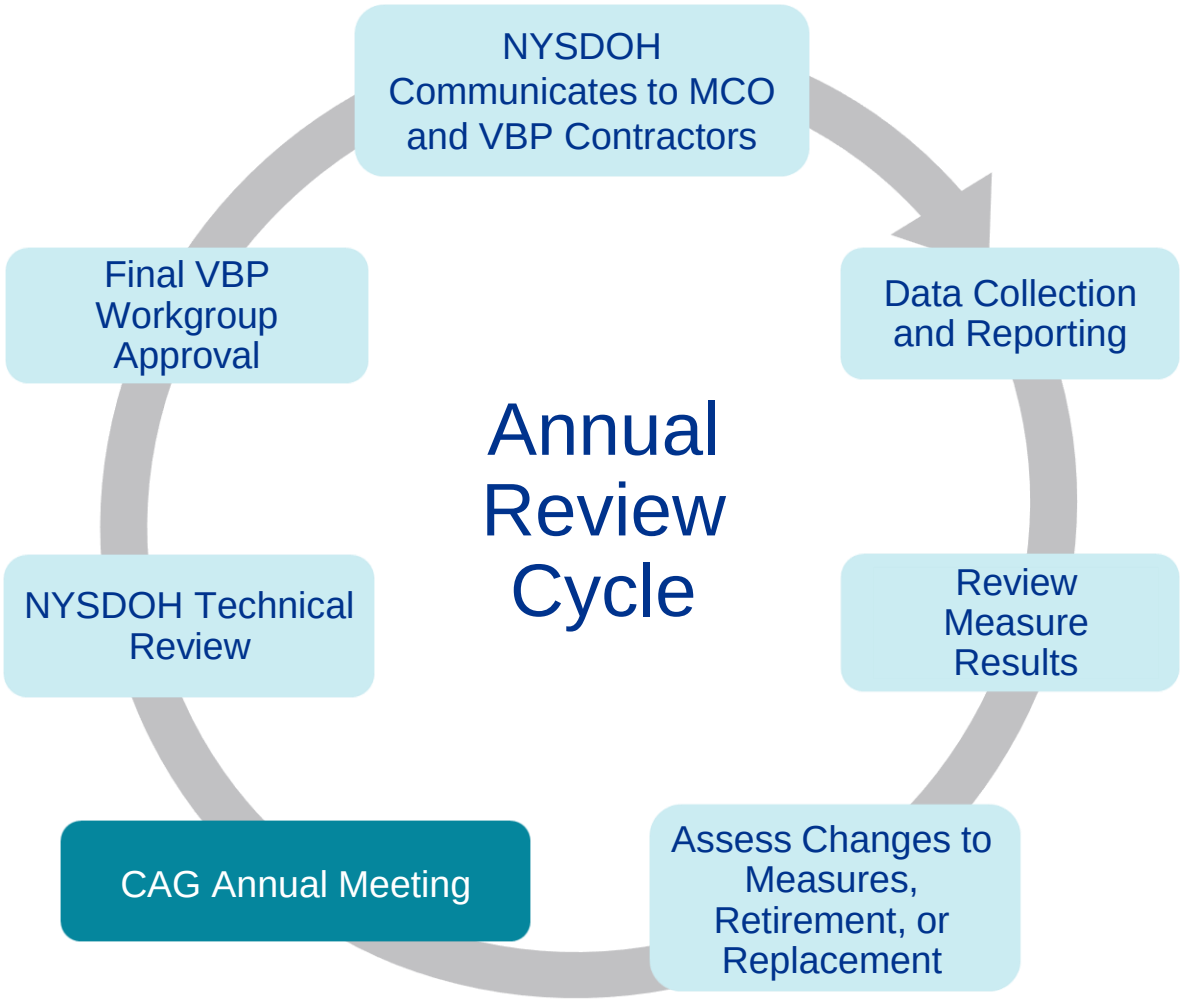
Combined TCGP/IPC Measure Set

- The TCGP/IPC Quality Measure Set was created in collaboration with the Diabetes, Chronic Heart Disease, Pulmonary, Behavioral Health, and Children's Health Clinical Advisory Groups (CAGs), as well as the NYS VBP Workgroup
- This aligned measure sets recommended for the Advanced Primary Care initiative by the Integrated Care Workgroup, the DSRIP Program, and Quality Assurance Reporting Requirements (QARR)
- The TCGP/IPC measure set includes both physical and behavioral health measures



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)

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Key Challenges & Opportunities

Challenges

- Practitioner comfort with VBP
- Performance measurement on a VBP contractor, population level
- Reporting on non-claims-based measures

Opportunities

- Higher quality providers can negotiate higher target budgets.
- VBP creates opportunity to reward efficiency and quality in meaningful ways not available before.
- Level 3 VBP eliminates need for prior authorization and other administrative burdens.

What do VBP Contractors Need to Do to Succeed in VBP?

Goal: Improve population health through enhancing the quality of the total spectrum of care.

- *Maximum impact for health systems focusing on both population health and streamlining specialty and inpatient care.*
  - VBP Contractors will need to have the capability to invest in and focus on population health efforts.
  - VBP Contractors should focus efforts on addressing inefficiencies and Potentially Avoidable Complications throughout the entire spectrum of care.
- *All patients attributed to the arrangement, not just the patients a provider serves, are included in TCGP.*
  - VBP Contractors will likely need to invest in care coordination, referral patterns and discharge management.

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

Total Population

— Subpopulations*

Total Care for General Population

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

What do PCPs Need to Do to Succeed in VBP?

PCPs are core to the achievement of value based payment program goals.

- PCP patient relationships drive attribution for the majority of VBP arrangements
- PCPs may group together to form legal contracting entities, but must consider…
  - *How will the total spectrum of care for the patient population be addressed?*
  - *What is the level of risk that can feasibly and practically be taken on?*
- Most common method of PCP engagement in VBP = partnership with ACOs or IPAs
- Build internal capacity and competencies to transform into a high performing practice
  - Redesign workflows to perform better on key quality metrics
  - Operate more efficiently and incorporate evidence-based practices
  - Identify high risk patients using registries or other data sources
  - Involve care team members to coordinate care and address the social determinants of health
  - Partner with care management services through Medicaid Health Homes
  - Receive NYS Patient-Centered Medical Home (PCMH) recognition

Appendix

VBP Quality Measurement in 2018

TCGP/IPC Measure Classification and Categorization

Categorizing and Prioritizing Quality Measures

Category 1 – Approved quality measures felt to be clinically relevant, reliable, valid, & feasible.

Category 2 – Measures that are clinically relevant, valid and probably reliable, but where feasibility could be problematic.

Category 3 – Measures that are insufficiently relevant, reliable, valid, and/or feasible.

Category 1 Measures

- Category 1 quality measures as identified by the Stakeholders and accepted by the State are to be reported by VBP Contractors.

The State classified each Category 1 measure as P4P or P4R:

Pay for Performance (P4P)

- Measures designated as P4P are intended to be used in the determination of shared savings amounts for which VBP Contractors are eligible.
- Performance on the measures can be included in both the determination of the target budget and in the calculation of shared savings for VBP Contractors.

Pay for Reporting (P4R)

- Measures designated as P4R are intended to be used by MCOs to incentivize VBP Contractors for reporting data to monitor quality of care delivered to members under the VBP contract.
- MCOs and VBP Contractors will be incentivized based on timeliness, accuracy & completeness of data reporting.

- Measures can move from P4R to P4P through the annual CAG and State review process or as determined by the MCO and VBP Contractor.

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, June 2016 updated version, approved by CMS March 2017.

Annual Update Cycle

Final VBP Arrangement Measure Sets and Reporting Guidance

- The VBP Quality Measure Sets for each arrangement will be finalized and posted to the NYS DOH VBP website by the end of October of the year preceding the measurement year. (Link)
- The VBP Measure Specification and Reporting Manual will be released alongside the QARR reporting manual in October of the measurement year. (Link)

TCGP/IPC Arrangement Measure Set for 2018

TCGP/IPC Arrangement Measure Set for 2018

- Beginning in the summer of 2017, the Diabetes, Chronic Heart Disease, Pulmonary, Behavioral Health, and Children's Health CAGs made recommendations to the State on quality measures, with further feedback on measure feasibility provided by the VBP Measure Support Task Force and its arrangement-level Sub-teams
- Based on these recommendations, the DOH approved 53 Category 1 and 2 quality measures (including both P4P and P4R measures) for the 2018 TCGP/IPC measure set
- The following changes were made to the TCGP/IPC measure set based on the feedback received by the DOH from the CAGs and Measure Feasibility Task Force and Sub-teams

Measure Disposition	Rationale for Change	Count
Added to Cat 1	Recommended by Children's Health CAG	8
Change from Cat 1 to Cat 2	Measure demoted because timeframe for measurement is too narrow	1
Change from Cat 2 to Cat 1	Timeframe for measurement is sufficiently broad	1
Added to Cat 2	Recommended by Children's Health CAG	6
Change from Cat 2 to Cat 3	Measure specification change	2
Unchanged between MY 2017 and MY 2018		35

2018 TCGP/IPC VBP Quality Measure Set (1/4)

Category 1

Measure Name	Measure Steward	NQF Measure Identifier	Classification	Rationale for Change
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	CMS	1880	Cat 1 P4P	
Adolescent Preventative Care – Assessment and Counselling of Adolescents on Sexual Activity, Tobacco Use, Alcohol and Drug Use, Depression	NYS	-	Cat 1 P4R	Recommended by Children's Health CAG
Adolescent Well-Care Visits	NCQA	-	Cat 1 P4R	Recommended by Children's Health CAG
Annual Dental Visit	NCQA	-	Cat 1 P4R	Recommended by Children's Health CAG
Antidepressant Medication Management - Effective Acute Phase Treatment & Effective Continuation Phase Treatment	NCQA	0105	Cat 1 P4P	
Breast Cancer Screening	NCQA	2372	Cat 1 P4P	
Cervical Cancer Screening	NCQA	0032	Cat 1 P4P	
Childhood Immunization Status – Combination 3	NCQA	0038	Cat 1 P4P	
Chlamydia Screening in Women	NCQA	0033	Cat 1 P4P	
Colorectal Cancer Screening	NCQA	0034	Cat 1 P4P	

Acronyms: CMS = Centers for Medicare and Medicaid Services; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; NYS = New York State

2018 TCGP/IPC VBP Quality Measure Set (2/4)

Category 1

Measure Name	Measure Steward	NQF Measure Identifier	Classification	Rationale for Change
Comprehensive Diabetes Care: All Three Tests (HbA1c, dilated eye exam, and medical attention for nephropathy)	NCQA	0055, 0062, 0057	Cat 1 P4P	
Comprehensive Diabetes Care: Eye Exam (retinal) performed	NCQA	0055	Cat 1 P4P	
Comprehensive Diabetes Care: Foot Exam	NCQA	0056	Cat 1 P4R	
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	NCQA	0575	Cat 1 P4R	
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NCQA	0059	Cat 1 P4P	
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing [performed]	NCQA	0057	Cat 1 P4P	
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NCQA	0062	Cat 1 P4P	
Controlling High Blood Pressure	NCQA	0018	Cat 1 P4P	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	1932	Cat 1 P4P	
Follow-up Care for Children Prescribed ADHD Medication	NCQA	0108	Cat 1 P4R	Recommended by Children's Health CAG
Immunizations for Adolescents Combination 2	NCQA	1407	Cat 1 P4P	Recommended by Children's Health CAG

Acronyms: NCQA = National Committee for Quality Assurance

2018 TCGP/IPC VBP Quality Measure Set (3/4)

Category 1

Measure Name	Measure Steward	NQF Measure Identifier	Classification	Rationale for Change
Initiation and Engagement of Alcohol and other Drug Dependence Treatment (IET)	NCQA	0004	Cat 1 P4P	
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence*	OASAS	-	Cat 1 P4P	
Medication Management for Patients with Asthma (aged 5-64) – 50% and 75% of Treatment Days Covered	NCQA	1799	Cat 1 P4P	
Pediatric Quality Indicator (PDI) #14 Asthma Admission Rate, Ages 2 Through 17 Years	AHRQ			Recommended by Children's Health CAG
Potentially Avoidable Complications in Routine Sick Care or Chronic Care	Altarum Institute (Formerly HCI3)	-	Cat 1 P4R	
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	CMS	0421	Cat 1 P4R	
Preventive Care and Screening: Influenza Immunization	AMA PCPI	0041	Cat 1 P4R	
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	CMS	0418	Cat 1 P4R	
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	AMA PCPI	0028	Cat 1 P4R	
Statin Therapy for Patients with Cardiovascular Disease	NCQA	-	Cat 1 P4R	

* Measure name changed from MY2017.

Acronyms: AMA PCPI = American Medical Association Physician Consortium for Performance Improvement; AHRQ = Agency for Healthcare Research and Quality; CMS = Centers for Medicare and Medicaid Services; NCQA = National Committee for Quality Assurance; OASAS = Office of Alcoholism and Substance Abuse Services

2018 TCGP/IPC VBP Quality Measure Set (4/4)

Category 1

Measure Name	Measure Steward	NQF Measure Identifier	Classification	Rationale for Change
Statin Therapy for Patients with Diabetes	NCQA	-	Cat 1 P4R	
Use of Alcohol Abuse or Dependence Pharmacotherapy*	OASAS	-	Cat 1 P4R	Measure promoted because timeframe for measurement is sufficiently broad
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NCQA	0577	Cat 1 P4R	
Weight Assessment and Counselling for Nutrition and Physical Activity for Children and Adolescents	NCQA	0024	Cat 1 P4P	
Well-Child Visits in the First 15 Months of Life	NCQA	1392	Cat 1 P4P	Recommended by Children's Health CAG
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	NCQA	1516	Cat 1 P4P	Recommended by Children's Health CAG

* Measure name changed from MY2017.
Acronyms: NCQA = National Committee for Quality Assurance; OASAS = Office of Alcoholism and Substance Abuse Services