NEW YORK STATE | Department of Health | Medicaid Redesign Team

Technical Design II Subcommittee

Meeting #4

October 22, 2015

Agenda

Today's Agenda includes the following:

Agenda Item	Time
Welcome & Introductions	1.00
Review Draft Recommendations: 1. Financially Challenged Provider status: what does it mean? 2. What will be included in the planned assessment of progress made in VBP participation and market dynamics? 3. What should be the process for addressing impasse situations during contract negotiations? Continued Discussion: 1. What should be the criteria and policies for the VBP Innovator Program?	1:15
Break	2:30
Introduction to New Topics: 1. What should be the Quality and Outcome measures in the TCTP arrangement?	2:45

Agenda Item moved to next meeting: How should the workforce measures (generic level) be defined?

Technical Design II Tentative Agenda

Workgroup II (Quality/Support/ Design)	
Discussion	**Introduction to**
Meeting 1	
VBP Introduction	1. How to continue to incentivize preventive activities within VBP? (What activities/services should remain FFS and will be considered VBP?) 2. How will the technical assistance be provided to those providers that run into performance challenges in VBP arrangements?
Meeting 2	
Topics from previous meeting – Deep Dive	1. Should certain services or providers be excluded from VBP? 2. What should be the criteria and policies for the VBP Innovator Program?
Meeting 3	
Topics from previous meeting – Deep Dive	1. Financially challenged provider status: what does it mean? 2. What will be included in the planned assessment of the progress made in the VBP participation and market dynamics? 3. What should be the process for addressing impasse situations during VBP contract negotiations?
Meeting 4	
Topics from previous meeting – Deep Dive	1. What should be the Quality and Outcome measures in the TCTP arrangement? 2. How should the workforce measures (generic level) be defined? (Discussion postponed)
Meeting 5	
Topics from previous meeting – Deep Dive	1. How should the workforce measures (generic level) be defined? 2. TBD

Key Questions for all Topics

Per option, the Subcommittee should recommend whether the State should set a **Statewide Standard** or a **Guideline** for the methodologies employed between MCOs and the providers. The State will consistently employ a standard in its own approaches regarding methodologies and data dissemination to both MCOs and providers. The Subcommittee should recommend whether MCOs and providers should adopt the same standard or are free to vary, using the State's methods more as a guideline.

- A **Standard** is required when it is crucial to the success of the NYS Medicaid Payment Reform Roadmap that all MCOs and Providers follow the same method.
- A **Guideline** is sufficient when it is useful for Providers and MCOs to have a starting point for the discussion, but MCOs and Providers may deviate without that harming the overall success of the Payment Reform Roadmap.

Technical Design II Meeting Schedule

Meeting	Date	Time	Location
Meeting 1	7/20/15	2:00 pm	Albany
Meeting 2	8/17/15	2:30 pm	Albany
Meeting 3	9/29/15	1:00 pm	NYC
Meeting 4	**10/22/15**	**1:00 pm**	**NYC**
Meeting 5	11/18/15	1:00 pm	Albany School of Public Health

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Financially Challenged Provider status: what does it mean?

Recommendation

Recommendation

The Subcommittee recommends a *guideline* to be set for identifying Financially Challenged Providers (FCPs) and their participation in VBP arrangements.

It is recommended that the following definition be used to identify FCPs:

A provider(s), including safety net providers, is deemed financially challenged if the DOH determines that the provider is unlikely to be sustainable as a freestanding facility even with value based payment reform, and the provider is in the planning process with DOH to:

- Be absorbed under the umbrella of another health care system;
- Be transitioned to an outpatient facility; or
- Discontinue operations.

The proposed guideline also states that the following limitations will apply to FCPs:

- FCPs cannot enter a Level 2 or higher VBP arrangement in a VBP contractor role;
- FCPs can be part of a Level 2 or higher VBP arrangement as long as they are protected from any downside risk.

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What will be included in the planned assessment of progress made in VBP participation and market dynamics?

Recommendation

Recommendation

It is recommended that the design of the planned assessment be delayed for a six month period (ending approximately in June of 2016), shifting the decision-making to the VBP Workgroup.

Delay in the planned assessment design will allow for:

- Acquirement of a good understanding of the impact that will help guide the evaluation
- Alignment with decisions currently being made by other Subcommittees
  - Including decisions on reporting guidelines to reduce complexity and redundancy
- Finalization of amendments made to the Medicaid Model Contract.

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What should be the process for addressing impasse situations during contract negotiations?

Recommendation

Recommendation

The Subcommittee does not feel that the development of a State-supported process is warranted at this time.

- Though the contracting environment will change, it is difficult to predict what type of challenges might arise and what form of corresponding State support may be needed
- The State and the VBP Workgroup will monitor the experiences of the pilot groups for further insight into changes in the VBP contracting process.

Although the development of a standard or guideline is not recommended at this time, the State, MCOs and providers will collectively monitor whether action or additional guidelines may become necessary in the future.

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VBP Innovator Program Design

Continued Discussion

Innovator Program Components

Component	Options	Decision
1. Program Eligibility (slide 12)	(1) High risk Level 2 and 3 OR (2) Level 3 only TCTP or Subpopulation Arrangements	Must be decided
2. Applicant Review Process (slide 13)	Applicants must meet a set of minimum criteria OR strict program criteria	Must be decided
3. Criteria for Participation (slide 14)	Criteria include confirmation of network adequacy and proven success in VBP contracting	Additional decisions to be made
4. Appeals Process	Allow applicants to appeal decisions OR do not allow an appeals process	✓ No appeals process requested
5. Program Benefits (slide 15)	Differing percentages of premium pass-through sharing between plans and providers	Must be decided
6. Performance Measurements	Create additional performance measures for Innovators OR align with existing DSRIP performance measures	✓ Align with DSRIP and TCTP measures
7. Status Maintenance and Program Exit Criteria (slide 16)	Determine whether Innovators must meet performance requirements and clarify exit process	Must be decided
8. Cooling Off Periods	Include a cooling off period after contract termination OR do not include a cooling off period	✓ Include a cooling off period

IP Component 1: Program Eligibility

Which VBP risk arrangements are eligible for the Innovator Program?

#	Options	Pros	Cons
1	Level 2 (high risk) & 3 TCTP and Subpopulations Arrangements	Broader eligibility would allow more groups to apply for Innovator status. Greater support of Level 2 groups may expedite their movement to Level 3.	Could dilute the group of Innovators.
2	Level 3 only TCTP and Subpopulations Arrangement	This would make the VBP Innovator program more selective and focused on a smaller core group of innovators. Allowing for only Level 3 would help establish more uniform criteria.	May exclude provider groups who have proven their ability to manage total cost of care arrangements but are not ready for Level 3.

The Innovator Program will be on an open enrollment basis starting in Q1 2016, and the Program could start first by accepting only Level 3 groups and then include Level 2 arrangements once program efficacy Is established.

IP Component 2: Applicant Review Process

What is the review process for the Innovator Program?

The review process will be dependent on the Program Eligibility. The below options were the two options favored by the Subcommittee during the last meeting.

#	Options	Pros	Cons
1	Program applicants must meet a set of minimum predetermined criteria for Program consideration (before applying). If minimum criteria are met then they are qualified to undergo a readiness assessment for program entrance approval.	A smaller amount of providers will apply because the initial assessment will become a responsibility of the provider. This option can save resources that would be expended if there were more applications to review. The providers that are approved will have a better chance at program acceptance since minimum criteria have been satisfied.	Additional resources will still be expended during the assessment process.
2	Each applicant must meet strict predetermined Program criteria. If met, acceptance is granted into Program.	This option would greatly reduce the expense of assessment resources as the review would be minimal compared to the other options.	Depending on the predetermined criteria set, the amount of providers able to participate in the Program might be limited.

IP Component 3: Criteria for Participation

What are the criteria for participating in the Innovator Program?

- Confirmation of provider network adequacy based on the appropriate provisions of the NYS Laws and regulations;
- Maturity level and proven success in VBP contracting for TCTP and Subpopulations.
  - Option 1: A standard criteria based on timeline applies, e.g. minimum of X months of successful VBP contracting is required
  - Option 2: Timeline is considered but each provider is reviewed on an individual basis.
- Number of patients:
  - **<u>Selected Option 1:</u>** Minimum number of Medicaid Patients (e.g. DSRIP defines a meaningful presence as a minimum of 5,000 Medicaid patients for a PPS); or
  - Option 2: Percentage of Medicaid patients in a particular region (e.g. DSRIP currently measures as a minimum of 5% of attributed Medicaid members in a county)

Should there be other/additional criteria?

IP Component 5: Program Benefits

The VBP Roadmap lists the potential Innovator Program benefit as rewarding providers with up to 95% of premium pass-through for total risk arrangements. The below matrix outlines how delegation of administrative functions could be used to determine the pass-through percentage.

Not delegable?

Innovator		No Delegation		Maximum delegation		Max share of all F's		Optimum		Example Scenario	
#	MCO Administrative Functions*	MCO	Provider	MCO	Provider	MCO	Provider	MCO	Provider	MCO	Provider
1	Utilization Review (UR)	●			●	○	○		●		●
2	Utilization and Care Management (UM)	●			●	○	○		●		●
3	Drug Utilization Reviews (DUR)	●			●	○	○	○	○		●
4	Appeals and Grievances	●			●	○	○	○	○	○	○
5	Quality	●			●	○	○	○	○		●
6	Member Enrollment/Advertising	●			●	○	○	●		○	○
7	Claims Administration	●			●	○	○		●	○	○
8	Member/Customer Service	●			●	○	○	○	○	○	○
9	Network Management	●			●	○	○	○	○		●
10	Risk Adjustment & Reinsurance	●			●	○	○	○	○		●
11	Disease Management	●			●	○	○		●	●	
12	Member/Provider Services Helpdesk	●			●	○	○	○	○	●	
13	Provider Relations	●			●	○	○	○	○	●	
14	Medicaid Management & UM Metrics	●			●	○	○		●	●	
15	Credentialing	●			●	○	○		●	●	
16	Fraud, Waste and Abuse	●		●		●		●		●	
17	Legal	●		●		●		●		●	
18	Compliance	●		●		●		●		●	

IP Component 7: Status Maintenance and Program Exit Criteria

What is the status maintenance and contract termination/program exit criteria?

Status maintenance: In order for Innovators to remain in the Program it is necessary to meet performance measurements during the contracting period. If performance measurements are not met there are two (2) possible options:

a. Option 1: The participant is placed on a probation period and with a set time line to improve performance; or
b. Option 2: The participant exits from the Program.

Program exit criteria: An Innovator may need to exit the program due to poor performance or loss of confidence in ability to participate. In order for the Innovator to exit the Program, it should be determined if one or both parties must give consent to exit.

During the last SC meeting, it was determined that a transition plan will be critical if Innovator status is terminated. There may be differences in the transition plan requirements based on Program Eligibility decisions made on Component 1.

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Break 15 mins

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What should be the Quality and Outcome measures in the TCTP arrangement?

Introduction to New Topic

In each level of VBP arrangements Quality Measures are necessary to ensure that real patient value is rewarded

The MCOs and PPSs can choose different levels of Value Based Payments:

Level 0 VBP	Level 1 VBP	Level 2 VBP	Level 3 VBP (only feasible after experience with Level 2)
FFS with bonus and/or withhold based on quality scores	FFS with upside-only shared savings available when outcome scores are sufficient (For PCMH/APC, FFS may be complemented with PMPM subsidy)	FFS with risk sharing (upside available when outcome scores are sufficient)	Prospective capitation PMPM or Bundle (with outcome-based component)

- Incorporating quality measures in those arrangements ensure focus on quality of care, rather than only on efficiency

How Are the Quality Measures Going to be Used?

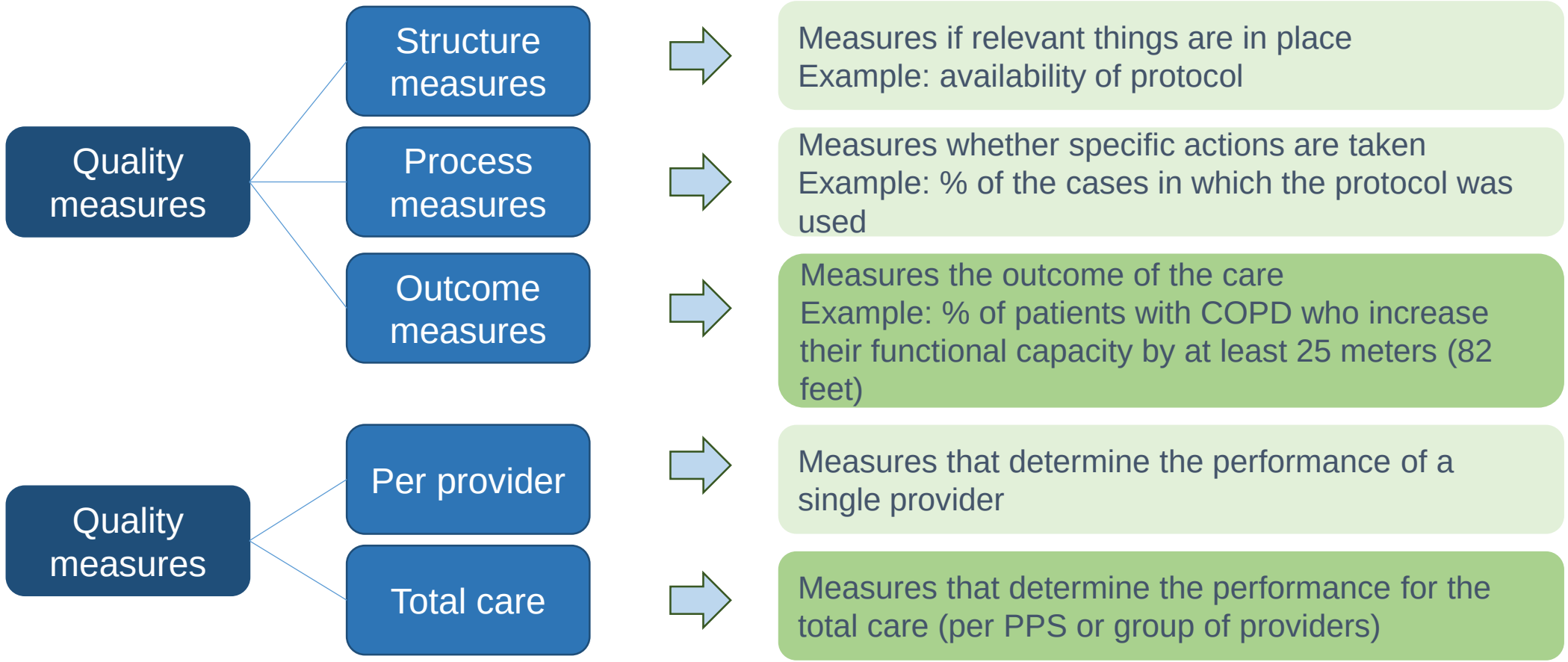
NY State / MCO relationship

- MCO's will be held accountable for the quality measures, and will get upward or downward adjustments based on the value of the care their network.
- The State will make the outcomes of the recommended measures transparent to all stakeholders. The quality measures set by the CAG and accepted by the State will be mandatory for the VBP arrangement involved.

MCO / Provider relationship

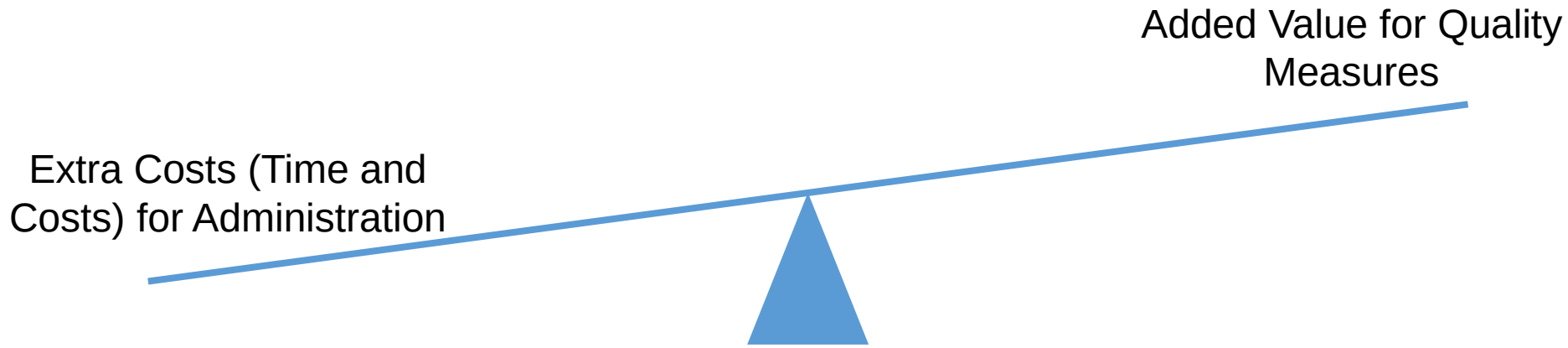
- How the providers and MCO's translate the quality measures into financial consequences, and which measure(s) they want to focus on primarily, is left to these stakeholders.
- Improvement of quality measures could affect payment in different ways:
  - A higher or lower score leading to a higher or lower percentage of savings respectively available for the providers
  - A higher or lower score leading to a higher or lower negotiated rate respectively

To Assess Value, a Small Key Set of Quality Measures is Needed. Focus Should Be on the *Performance* of the Overall Care.



The Effort of Collecting Additional Data for Quality Measurement Must Be Weighed Against the Added Value

- For TCTP, quality measures can be derived from claims, but only partially so.
- There might be other relevant measures that include patient surveys and assessments. Incorporating these data will require standardized collection efforts. Identification of key measures is important.
  - *The extra costs (in time and money) of collecting the additional data has to be weighed against the added value that the measure brings.*



Methodology for Selecting Initial TCTP Measures

Aggregate quality measures from relevant sources	**Carve out relevant measures, based on the following criteria**	**Categorize remaining quality measures**
1. DSRIP 2. QARR/HEDIS 2015 3. CMS 2015 ACO Measures	1. Measures that are generic (not condition specific) 2. Measures that help evaluate the functionality of the entire system (TCTP) 3. Measures focusing on conditions not covered in the current bundles and subpopulations	1. Preventive Care 2. Screening 3. Access/Availability of Care 4. Outcomes of Care 5. Patient Experience 6. Other

For Categorizing and Prioritization of TCTP Measures We Use Three Categories (or 'Buckets')

CATEGORY 1
Approved quality measures that are felt to be both clinically relevant, reliable and valid, and feasible in regards to capturing TCTP.

CATEGORY 2
Measures that are most likely clinically relevant, valid and probably reliable for TCTP, but where the feasibility could be problematic.

CATEGORY 3
Measures that are insufficiently relevant, valid, reliable and/or feasible for TCTP.

Criteria for Selecting Quality Measures

CLINICAL RELEVANCE

- **Focused on key outcomes of integrated care process**

  I.e. outcome measures are preferred over process measures; outcomes of the total care process are preferred over outcomes of a single component of the care process (i.e. the quality of one type of professional's care).

- **For process measures: crucial evidence-based steps in integrated care process that may not be reflected in the patient outcome measures**

- **Existing variability in performance and/or possibility for improvement**

RELIABILITY AND VALIDITY

- **Measure is well established by reputable organization**

  By focusing on established measures (owned by e.g. NYS Office of Quality and Patient Safety (OQPS), endorsed by the National Quality Forum (NQF), HEDIS measures and/or measures owned by organizations such as the Joint Commission, the validity and reliability of measures can be assumed to be acceptable.

- **Outcome measures are adequately risk-adjusted**

  Measures without adequate risk adjustment make it impossible to compare outcomes between providers.

Criteria for Selecting Quality Measures

FEASIBILITY

- **Claims-based measures are preferred over non-claims based measures (clinical data, surveys)**
- **When clinical data or surveys are required, existing sources must be available**

  I.e. the link between the Medicaid claims data and this clinical registry is already established.

- **Preferably, data sources be patient-level data**

  This allows drill-down to patient level and/or adequate risk-adjustment. The exception here is measures using samples from a patient panel or records. When such a measure is deemed crucial, and the infrastructure exists to gather the data, these measures could be accepted.

- **Data sources must be available without significant delay**

  I.e. data sources should not have a lag longer than the claims-based measures (which have a lag of six months).

Quality Measure Stewards and Sources

- DSRIP Measure Specification Manual (Attachment J)
- QARR/HEDIS (National Committee for Quality Assurance)
- Accountable Care Organization (ACO) 2015 Program Analysis Quality Performance Standards Narrative Measure Specifications (Centers for Medicare & Medicaid Services)

Selection of TCTP Measures* – Preventive Care

	#	Quality Measure**	Measure Steward	Type of Measure	QARR/HEDIS	DSRIP	CMS ACO	Availability			TCTP Categorization
								Medicaid Claims Data	Clinical data	Survey Data	
Preventive Care	1	Immunizations for adolescents: percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	
	2	Adolescent well-care visits: percentage of enrolled members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	
	3	Preventive care and screening: percentage of patients who received an influenza immunization during the one-year measurement period.	QARR/HEDIS (NCQA)	Process			X	NO	YES	NO	

*For Measurement specification please refer to the Appendix.

**Measures found in QARR and/or DSRIP measures are marked green.

Selection of TCTP Measures – Screening

	#	Quality Measure	Measure Steward	Type of Measure	QARR/HEDIS	DSRIP	CMS ACO	Availability			TCTP Categorization
								Medicaid Claims Data	Clinical data	Survey Data	
Screening	4	Preventive care and screening: body mass index screening and follow-up	CMS	Process			X	YES	YES	NO	
	5	Adult body mass index (BMI) assessment: percentage of patients 18 to 74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	
	6	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	
	7	Lead screening in children: percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	
	8	Annual Monitoring for Patients on Persistent Medications	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	
	9	Preventive care and screening: tobacco use: screening and cessation intervention	AMA/PCPI	Process			X	YES	YES	NO	
	10	Falls: Screening for Fall Risk	AMA/PCPI	Process			X	YES	YES	NO	

Selection of TCTP Measures – Access/Availability of Care (1/2)

	#	Quality Measure	Measure Steward	Type of Measure	QARR/HEDIS	DSRIP	CMS ACO	Availability			TCTP Categorization
								Medicaid Claims Data	Clinical data	Survey Data	
Access/Availability of Care	11	Adults' access to preventive/ambulatory health services: percentage of members 20 years and older who had an ambulatory or preventive care visit.	QARR/HEDIS (NCQA)	Process	X			NO	YES	NO	
	12	Children and adolescents' access to primary care practitioners (PCP): percentage of members 12 months to 19 years of age who had a visit with a PCP.	QARR/HEDIS (NCQA)	Process	X			NO	YES	NO	
	13	CAHPS Measures: - Getting Care Quickly (routine and urgent care appointments as soon as member thought needed) - Getting Care Needed (access to specialists and getting care member thought needed) - Access to Information After Hours - Wait Time (days between call for appointment and getting appoint for urgent care)	AHRQ	Process		X		NO	NO	YES	
	14	Well-Child Visits in the First 15 Months of Life	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	
	15	Well-Child Visits in the 3rd, 4th, 5th & 6th Year	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	
	16	Adolescent well-care visits: percentage of enrolled members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	

Selection of TCTP Measures – Access/Availability of Care (2/2)

	#	Quality Measure	Measure Steward	Type of Measure	QARR/HEDIS	DSRIP	CMS ACO	Availability			TCTP Categorization
								Medicaid Claims Data	Clinical data	Survey Data	
Access/Availability of Care	17	Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits and ED visits.	QARR/HEDIS (NCQA)	Process	X			NO	YES	NO	
	18	Use of primary and preventive care services-- Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year (For NU and LU Medicaid Members)	NYS	Process		X		YES	NO	NO	
	19	Emergency department use by uninsured persons as measured by percent of Emergency Medicaid emergency department claims compared to same in baseline year. (Uninsured only)	NYS	Process		X		YES	NO	NO	
	20	Medical Assistance with Smoking Cessation	QARR/HEDIS (NCQA)	Process	X			NO	NO	YES	
	21	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	QARR/HEDIS (NCQA)	Process	X			YES	YES	NO	
	22	Annual dental visit: percentage of members 2 to 21 years of age who had at least one dental visit during the measurement year.	QARR/HEDIS (NCQA)	Process	X			NO	YES	NO	

Selection of TCTP Measures – Outcomes of Care

	#	Quality Measure	Measure Steward	Type of Measure	QARR/HEDIS	DSRIP	CMS ACO	Availability			TCTP Categorization
								Medicaid Claims Data	Clinical data	Survey Data	
Outcomes of Care	23	PQI Suite – Composite of all measures	AHRQ	Outcome		X		YES	YES	NO	
	24	PDI Suite – Composite of all measures	AHRQ	Outcome		X		YES	YES	NO	
	25	Percentage of adults who are obese	BRFSS	Outcome		X		NO	YES	NO	
	26	Percentage of children and adolescents who are obese	BRFSS	Outcome		X		NO	YES	NO	
	27	Age-adjusted percentage of adult binge drinking during the past month	BRFSS	Outcome		X		NO	YES	NO	
	28	Percentage of cigarette smoking among adults	BRFSS	Outcome		X		NO	YES	NO	
	29	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	BRFSS	Outcome		X		NO	YES	NO	
	30	Percentage of premature death (before age 65 years)	NYS NYSDOH Vital Statistics	Outcome		X		YES	YES	NO	
	31	Age-adjusted suicide death rate per 100,000	NYS NYSDOH Vital Statistics	Outcome		X		YES	YES	NO	
	32	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	SPARCS	Outcome		X		YES	YES	NO	
	33	Potentially Avoidable Emergency Room Visits	3M	Outcome		X		YES	YES	NO	
	34	Potentially Avoidable Readmissions	3M	Outcome		X		YES	YES	NO	
	35	All-cause readmissions: the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission, for patients 18 years of age and older.	QARR	Outcome	X			YES	YES	NO	

Selection of TCTP Measures – Patient Experience

	#	Quality Measure	Measure Steward	Type of Measure	QARR/HEDIS	DSRIP	CMS ACO	Availability			TCTP Categorization
								Medicaid Claims Data	Clinical data	Survey Data	
Patient Experience	36	Getting Timely Care, Appointments, and Information	AHRQ	Outcome			X	NO	NO	YES	
	37	How Well Your Doctors Communicate	AHRQ	Outcome			X	NO	NO	YES	
	38	Patients' Rating of Doctor	AHRQ	Outcome			X	NO	NO	YES	
	39	Access to Specialists	CMS	Outcome			X	NO	NO	YES	
	40	Health Promotion and Education	CMS	Outcome			X	NO	NO	YES	
	41	Shared Decision Making	CMS	Outcome			X	NO	NO	YES	
	42	Health Status/Functional Status	CMS	Outcome			X	NO	NO	YES	

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Appendix

Definitions of TCTP Measures – Prevention (1/1)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
1	Immunizations for adolescents: percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday.	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	This measure is used to assess the percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday. The Immunizations for Adolescents (IMA) measure calculates a rate for each vaccine and one combination rate. This measure summary represents the overall rate.	Adolescents who received one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday	Adolescents who turn 13 years of age during the measurement year (see the related "Denominator Inclusions/Exclusions" field)
2	Adolescent well-care visits: percentage of enrolled members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	This measure is used to assess the percentage of enrolled members 12 to 21 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year.	At least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year	Members age 12 to 21 years as of December 31 of the measurement year
3	Preventive care and screening: per centage of patients who received an influenza immunization during the one-year measurement period.	AMA-PCPI (CMS ACO Measures)	Process	Clinical data	This measure is used to assess the percentage of patients aged greater than or equal to 50 years who received an influenza immunization during the one-year measurement period.	Patients who received an influenza immunization	All patients aged greater than or equal to 50 years of age at the beginning of the one-year measurement period

Definitions of TCTP Measures – Screening (1/4)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
4	Preventive care and screening: body mass index screening and follow-up	CMS	Process	Claims data and clinical data	Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter. Normal Parameters: Age 65 years and older BMI > or = 23 and < 30 Age 18 – 64 years BMI > or = 18.5 and < 25	Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters	All patients aged 18 years and older
5	Adult body mass index (BMI) assessment: percentage of patients 18 to 74 years of age who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year.	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	This measure is used to assess the percentage of patients 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	Body mass index (BMI) during the measurement year or the year prior to the measurement year	Patients age 18 years as of January 1 of the year prior to the measurement year to 74 years as of December 31 of the measurement year who had an outpatient visit during the measurement year or the year prior to the measurement year

Definitions of TCTP Measures – Screening (2/4)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
6	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	Percentage of patients 3-17 years of age who had an outpatient visit with a primary care physician (PCP) or an OB/GYN and who had evidence of the following during the measurement year: - Body mass index (BMI) percentile documentation* - Counseling for nutrition - Counseling for physical activity	The percentage of patients who had evidence of a Body mass index (BMI) percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.	Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or OB-GYN during the measurement year.
7	Lead screening in children: percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	This measure is used to assess the percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	At least one capillary or venous blood test on or before the child's second birthday	Children who turn 2 years old during the measurement year

Definitions of TCTP Measures – Screening (3/4)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
8	Annual Monitoring for Patients on Persistent Medications	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	This measure assesses the percentage of patients 18 years of age and older who received a least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. - Angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB): At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. - Digoxin: At least one serum potassium, one serum creatinine and a serum digoxin therapeutic monitoring test in the measurement year. - Diuretics: At least one serum potassium and a serum creatinine therapeutic monitoring test in the measurement year. - Total rate (the sum of the three numerators divided by the sum of the three denominators)	This measure is reported as three rates and a total rate. For annual monitoring for patients on ACE inhibitors or ARBs: the number of patients with at least one serum potassium and serum creatinine therapeutic monitoring test in the measurement year. For annual monitoring for patients on digoxin: the number of patients with at least one serum potassium, one serum creatinine, and a serum digoxin therapeutic monitoring test in the measurement year. For annual monitoring for patients on diuretics: the number of patients with at least one serum potassium and serum creatinine therapeutic monitoring test in the measurement year. For the total rate: sum of the 3 numerators.	Patients age 18 and older as of the end of the measurement year (e.g., December 31) who are on selected persistent medications (ACE Inhibitors/ARB, Digoxin or Diuretics.)
9	Preventive care and screening: tobacco use: screening and cessation intervention	AMA-PCPI	Process	Claims data and clinical data	Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user	Patients who were screened for tobacco use at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Definitions of TCTP Measures – Screening (4/4)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
10	Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls	AMA-PCPI/NCQA	Process	Claims data and clinical data	This is a clinical process measure that assesses falls prevention in older adults. The measure has three rates: A) Screening for Future Fall Risk: Percentage of patients aged 65 years of age and older who were screened for future fall risk at least once within 12 months B) Falls: Risk Assessment: Percentage of patients aged 65 years of age and older with a history of falls who had a risk assessment for falls completed within 12 months C) Plan of Care for Falls: Percentage of patients aged 65 years of age and older with a history of falls who had a plan of care for falls documented within 12 months.	This measure has three rates. The numerators for the three rates are as follows: A) Screening for Future Fall Risk: Patients who were screened for future fall* risk** at last once within 12 months B) Falls: Risk Assessment: Patients who had a risk assessment*** for falls completed within 12 months C) Plan of Care for Falls: Patients with a plan of care**** for falls documented within 12 months. *A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of a sudden onset of paralysis, epileptic seizure, or overwhelming external force. **Risk of future falls is defined as having had had 2 or more falls in the past year or any fall with injury in the past year. ***Risk assessment is comprised of balance/gait assessment AND one or more of the following assessments: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months. ****Plan of care must include consideration of vitamin D supplementation AND balance, strength and gait training.	A) Screening for Future Fall Risk: All patients aged 65 years and older. B & C) Risk Assessment for Falls & Plan of Care for Falls: All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year).

Definitions of TCTP Measures – Access/Availability of Care (1/6)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
11	Adults' access to preventive/ambulatory health services: percentage of members 20 years and older who had an ambulatory or preventive care visit.	QARR/HEDIS (NCQA)	Process	Clinical data	This measure is used to assess the percentage of members 20 years and older who had an ambulatory or preventive care visit. The organization reports three separate percentages for each product line: Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year Commercial members who had an ambulatory or preventive care visit during the measurement year or the two years prior to the measurement year	Medicaid and Medicare: One or more ambulatory or preventive care visits during the measurement year Commercial: One or more ambulatory or preventive care visits during the measurement year or the two years prior to the measurement year	Members age 20 years and older as of December 31 of the measurement year
12	Children and adolescents' access to primary care practitioners (PCP): percentage of members 12 months to 19 years of age who had a visit with a PCP.	QARR/HEDIS (NCQA)	Process	Clinical data	This measure is used to assess the percentage of members 12 months to 19 years of age who had a visit with a primary care practitioner (PCP). The organization reports four separate percentages for each product line: -Children 12 to 24 months and 25 months to 6 years who had a visit with a PCP during the measurement year -Children 7 to 11 years and adolescents 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year	For 12 to 24 months, 25 months to 6 years: One or more visits with a primary care practitioner (PCP) during the measurement year For 7 to 11 years, 12 to 19 years: One or more visits with a PCP during the measurement year or the year prior to the measurement year	Members age 12 months to 19 years as of December 31 of the measurement year

Definitions of TCTP Measures – Access/Availability of Care (2/6)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
13	CAHPS Measures: - Getting Care Quickly (routine and urgent care appointments as soon as member thought needed) - Getting Care Needed (access to specialists and getting care member thought needed) - Access to Information After Hours - Wait Time (days between call for appointment and getting appoint for urgent care)	AHRQ	Process	Survey	The CAHPS Health Plan Survey is a standardized survey instrument which asks enrollees to report on their experiences accessing care and health plan information, and the quality of care received by physicians. HP-CAHPS Version 4.0 was endorsed by NQF in July 2007 (NQF #0006). The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/hp/index.html. The survey's target population includes individuals of all ages (18 and older for the Adult version; parents or guardians of children aged 0-17 for the Child version) who have been enrolled in a health plan for a specified period of time (6 months or longer for Medicaid version, 12 months or longer for Commercial version) with no more than one 30-day break in enrollment. The CAHPS Adult Health Plan Survey has 39 items, and the CAHPS Child Health Plan Survey has 41 core items. Ten of the adult survey items and 11 of the child survey items are organized into 4 composite measures, and each survey also has 4 single-item rating measures. Each measure is used to assess a particular domain of health plan and care quality from the patient's perspective. Measure 1: Getting Needed Care (2 items) Measure 2: Getting Care Quickly (2 items) Measure 3: How Well Doctors Communicate (4 items in Adult survey & 5 items in Child survey) Measure 4: Health Plan Information and Customer Service (2 items) Measure 5: How People Rated Their Personal Doctor (1 item) Measure 6: How People Rated Their Specialist (1 item) Measure 7: How People Rated Their Health Care (1 item) Measure 8: How People Rated Their Health Plan (1 item)	We recommend that CAHPS Health Plan Survey items and composites be calculated using a top-box scoring method. The top-box score refers to the percentage of patients whose responses indicated that they "always" received the desired care or service for a given measure. The top box numerator for each of the four Overall Ratings items is the number of respondents who answered 9 or 10 for the item; with a 10 indicating the "Best possible."	The measure's denominator is the number of survey respondents who answered the question. The target population for the survey includes all individuals who have been enrolled in a health plan for at least 6 (Medicaid) or 12 (Commercial) months with no more than one 30-day break in enrollment. Denominators will vary by item and composite.

Definitions of TCTP Measures – Access/Availability of Care (3/6)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
14	Well-Child Visits in the First 15 Months of Life	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	The percentage of children 15 months old who had the recommended number of well-child visits with a PCP during their first 15 months of life.	Children who received the following number of well-child visits with a PCP during their first 15 months of life: - No well-child visits - One well-child visit - Two well-child visits - Three well-child visits - Four well-child visits - Five well-child visits - Six or more well-child visits	Children 15 months old during the measurement year.
15	Well-Child Visits in the 3rd, 4th, 5th & 6th Year	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	The percentage of children 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	Children who received at least one well-child visit with a PCP during the measurement year.	Children 3-6 years of age during the measurement year.
16	Adolescent well-care visits: percentage of enrolled members 12 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	This measure is used to assess the percentage of enrolled members 12 to 21 years of age who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year.	At least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrics and gynecology (OB/GYN) practitioner during the measurement year	Members age 12 to 21 years as of December 31 of the measurement year

Definitions of TCTP Measures – Access/Availability of Care (4/6)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
17	Ambulatory care: summary of utilization of ambulatory care in the following categories: outpatient visits and ED visits.	QARR/HEDIS (NCQA)	Process	Clinical data	This measure summarizes utilization of ambulatory services in the following categories: •Outpatient visits •Emergency department (ED) visits	Number of outpatient visits and emergency department (ED) visits	For commercial, Medicaid, and Medicare product lines, all member months for the measurement year, stratified by age
18	Use of primary and preventive care services-- Percent of attributed Medicaid members with no claims history for primary care and preventive services in measurement year compared to same in baseline year (For NU and LU Medicaid Members)	NYS					
19	Emergency department use by uninsured persons as measured by percent of Emergency Medicaid emergency department claims compared to same in baseline year. (Uninsured only)	NYS					

Definitions of TCTP Measures – Access/Availability of Care (5/6)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
20	Medical Assistance with Smoking Cessation	QARR/HEDIS (NCQA)	Process	Survey	Assesses different facets of providing medical assistance with smoking and tobacco use cessation: Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year. Discussing Cessation Medications: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who were current smokers or tobacco users who discussed or were provided smoking cessation methods or strategies during the measurement year.	Component 1: Advising Smokers and Tobacco Users to Quit (ASTQ) Patients who received advice to quit smoking or using tobacco from their doctor or health provider Component 2: Discussing Cessation Medications (DSCM) Patients who discussed or received recommendations on smoking or tobacco cessation medications from their doctor or health provider Component 3: Discussing Cessation Strategies (DSCS) Patients who discussed or received recommendations on smoking or tobacco cessation methods and strategies other than medication from their doctor or health provider	Patients 18 years and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users and had one or more visits during the measurement year or in the last 6 months for Medicaid and Medicare.

Definitions of TCTP Measures – Access/Availability of Care (6/6)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
21	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	QARR/HEDIS (NCQA)	Process	Claims data and clinical data	The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following. - Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. - Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. --- Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).
22	Annual dental visit: percentage of members 2 to 21 years of age who had at least one dental visit during the measurement year.	QARR/HEDIS (NCQA)	Process	Outcome	This measure is used to assess the percentage of members 2 to 21 years of age who had at least one dental visit during the measurement year. This measure applies only if dental care is a covered benefit in the organization's Medicaid contract.	One or more dental visits with a dental practitioner during the measurement year	Medicaid members age 2 to 21 years as of December 31 of the measurement year

Definitions of TCTP Measures – Outcomes of Care (1/2)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
23	PQI Suite – Composite of all measures	AHRQ	Outcome	Claims data and clinical data	N/A	Number of admissions which were in the numerator of one of the adult prevention quality indicators	Number of people 18 years and older as of June 30 of measurement year
24	PDI Suite – Composite of all measures	AHRQ	Outcome	Claims data and clinical data	N/A	Number of admissions which were in the numerator of one of the pediatric prevention quality indicators	Number of people 6 to 17 years as of June 30 of measurement year
25	Percentage of adults who are obese	BRFSS	Outcome	Clinical data	N/A	Number of respondents 18 or older who are obese. Obesity is defined as having a body mass index (BMI) of 30.0 or greater.	Number of people age 18 or older
26	Percentage of children and adolescents who are obese	BRFSS	Outcome	Clinical data	N/A	Number of public school children who are obese. Obesity is defined as weight category greater than or equal to 95th percentile. Counties outside NYC: Grades K-12th; NYC counties: Grades K-8th.	Number of public school children
27	Age-adjusted percentage of adult binge drinking during the past month	BRFSS	Outcome	Clinical data	N/A	Number of respondents age 18 or older who reported binge drinking on one or more occasions in the past 30 days. Binge drinking is defined as men having 5 or more drinks or women having 4 or more drinks on one occasion.	Number of people age 18 or older
28	Percentage of cigarette smoking among adults	BRFSS	Outcome	Clinical data	N/A	Number of people age 18 or older who report currently smoking cigarettes	Number of people age 18 or older
29	Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month	BRFSS	Outcome	Clinical data	N/A	Number of respondents age 18 or older who reported experiencing poor mental health for 14 or more days in the last month	Number of people age 18 or older
30	Percentage of premature death (before age 65 years)	NYS NYSDOH Vital Statistics	Outcome	Claims and clinical data	N/A	Number of people who died before age 65 in the measurement period	Number of deaths in the measurement period

Definitions of TCTP Measures – Outcomes of Care (2/2)

#	36Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
31	Age-adjusted suicide death rate per 100,000	NYS NYSDOH Vital Statistics	Outcome	Claims and clinical data	N/A	Number of deaths of people age 18 or older with an ICD-10 primary cause of death code: X60-X84 or Y87.0	Number of people age 18 or older
32	Age-adjusted preventable hospitalizations rate per 10,000 - Aged 18+ years	SPARCS	Outcome	Claims and clinical data	N/A	Number of preventable hospitalizations for people age 18 or older	Number of people age 18 or older
33	Potentially Avoidable Emergency Room Visits	3M	Outcome	Claims and clinical data	N/A	Number of preventable emergency visits as defined by revenue and CPT codes	Number of people (excludes those born during the measurement year) as of June 30 of measurement year
34	Potentially Avoidable Readmissions	3M	Outcome	Claims and clinical data	N/A	Number of readmission chains (at risk admissions followed by one or more clinically related readmission within 30 days of discharge)	Number of people as of June 30 of the measurement year
35	All-cause readmissions: the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission, for patients 18 years of age and older.	QARR	Outcome	Claims data and clinical data	This measure is used to assess the number of acute inpatient stays for patients 18 years of age and older during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:	At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date	Acute inpatient discharges for commercial insurance patients age 18 to 64 years as of the Index Discharge Date who had one or more discharges on or between January 1 and December 1 of the measurement year Acute inpatient discharges for Medicare patients age 65 years and older as of the Index Discharge Date who had one or more discharges on or between January 1 and December 1 of the measurement year

Definitions of TCTP Measures – Patient Experience (1/2)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
36	Getting Timely Care, Appointments, and Information (**Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial**)	AHRQ	Outcome	Survey	The Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS) is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 12 months. The survey includes standardized questionnaires for adults and children. All questionnaires can be used in both primary care and specialty care settings. The adult survey is administered to patients aged 18 and over. The child survey is administered to the parents or guardians of pediatric patients under the age of 18. Patients who have had at least one visit during the past 12-months are eligible to be surveyed. CG-CAHPS Survey Version 1.0 was endorsed by NQF in July 2007 (NQF #0005). The development of the survey is through the CAHPS consortium and sponsored by the Agency for Healthcare Research and Quality. The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at https://cahps.ahrq.gov/surveys-guidance/cg/about/index.html. The Adult CG-CAHPS Survey includes one global rating item and39 items in which 13 items can be organized into three composite measures and one global item for the following categories of care or services provided in the medical office: 1. Getting Timely Appointments, Care, and Information (5 items) 2. How Well Providers Communicate With Patients (6 items) 3. Helpful, Courteous, and Respectful Office Staff (2 items) 4. Overall Rating of Provider (1 item)	We recommend that CG-CAHPS Survey items and composites be calculated using a top-box scoring method. The top box score refers to the percentage of patients whose responses indicated that they “always” received the desired care or service for a given measure. The top box numerator for the Overall Rating of Provider is the number of respondents who answered 9 or 10 for the item, with 10 indicating “Best provider possible”. For more information on the calculation of reporting measures, see How to Report Results of the CAHPS Clinician & Group Survey, available at https://cahps.ahrq.gov/surveys-guidance/cg/cgkit/HowtoReportResultsofCGCAHPS080610FINAL.pdf.	The measure’s denominator is the number of survey respondents. The target populations for the surveys are patients who have had at least one visit to the selected provider in the target 12-month time frame. This time frame is also known as the look back period. The sampling frame is a person-level list and not a visit-level list. For more information on the calculation of reporting measures, see How to Report Results of the CAHPS Clinician & Group Survey, available at https://cahps.ahrq.gov/surveys-guidance/cg/cgkit/HowtoReportResultsofCGCAHPS080610FINAL.pdf.

Definitions of TCTP Measures – Patient Experience (2/2)

#	Measure	Measure Steward	Measure Type	Data Source	Description	Numerator	Denominator
37	How Well Your Doctors Communicate	AHRQ	Outcome	Survey	See: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)		
38	Patients' Rating of Doctor	AHRQ	Outcome	Survey	See: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)		
39	Access to Specialists	CMS	Outcome	Survey	See: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)		
40	Health Promotion and Education	CMS	Outcome	Survey	See: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)		
41	Shared Decision Making	CMS	Outcome	Survey	See: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)		
42	Health Status/Functional Status	CMS	Outcome	Survey	See: Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey, Version 5.0 (Medicaid and Commercial)		