



**Department  
of Health**

Medicaid  
Redesign Team

# Medicare Access and CHIP Reauthorization ACT of 2015 (MACRA) and NYS VBP Alignment

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March 1, 2019

# Agenda

- I. Introduction, NYS Department of Health, Office of Health Insurance Programs**
- II. Center for Medicare & Medicaid Innovation Overview of Advanced Alternative Payment Models (AAPM) in the Quality Payment Program (QPP)**
- III. Overview of MACRA alignment with NYS Medicaid's Valued Based Payment (VBP) Roadmap**
- IV. Summary and Q&A**

# I. Introductions & Purpose of Webinar

# Purpose of Webinar

- Provide an overview of the MACRA program, explain how MACRA and the NYS Medicaid VBP model align, and demonstrate the opportunity this presents for clinicians across the State.
- This webinar will also describe the benefits of the Advanced Alternative Payment Model track and explain what providers may want to consider as they pursue alternative payment arrangements for Medicare and Medicaid.

## II. CMMI Overview of Provider Initiated Process for Advanced Alternative Payment Model Track

*Richard Jensen, MPP; Senior Policy Advisor | Center for Medicare & Medicaid Innovation*



# Advanced Alternative Payment Models (APMs)

Pathways to Qualifying APM Participant (QP) Status



Richard Jensen

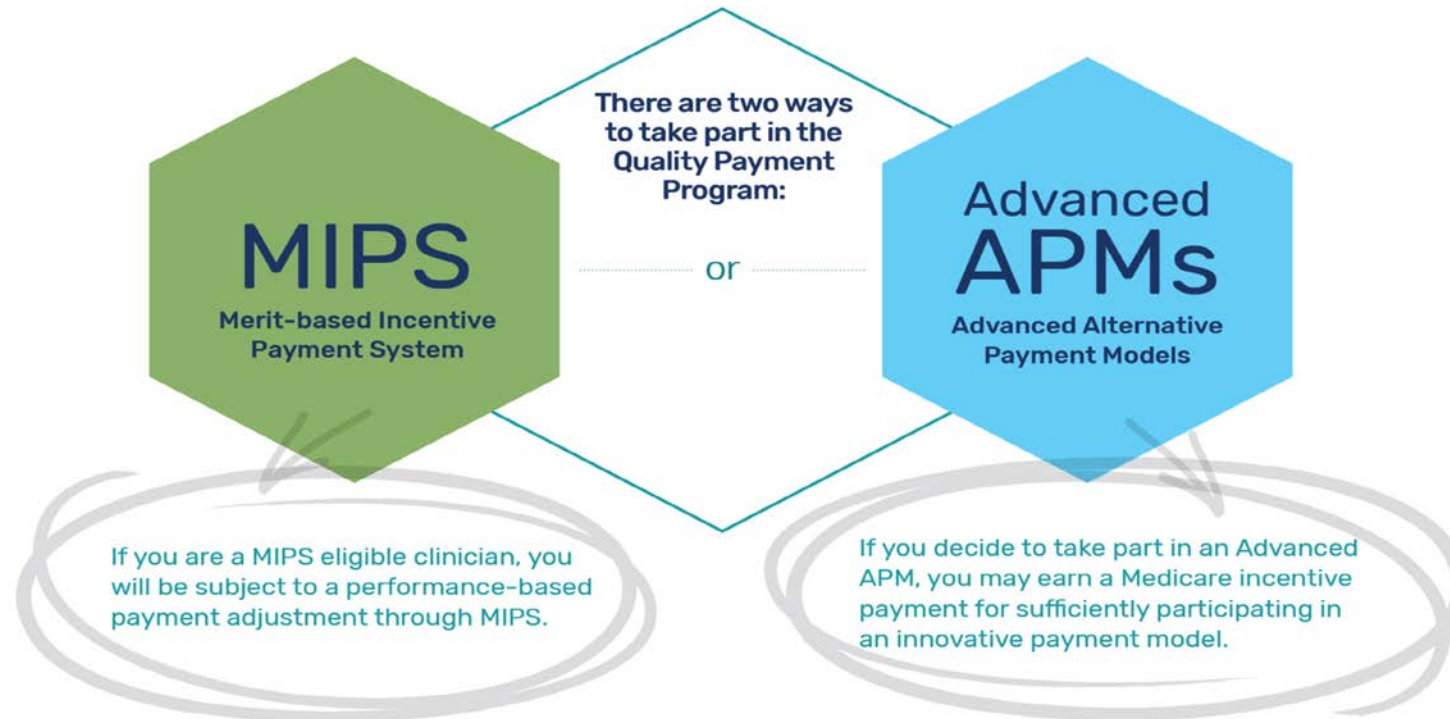
**Senior Policy Advisor  
Center for Medicare &  
Medicaid Innovation (CMMI)**



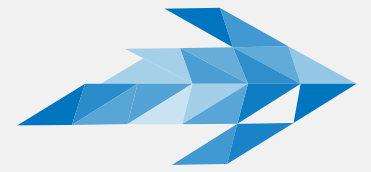


## The Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides for two participation tracks:





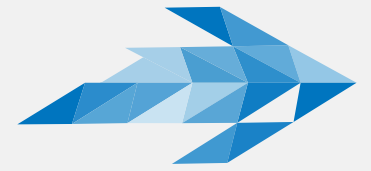


## Alternative Payment Model (APM) Overview

APMs are new approaches to paying for medical care through Medicare that often incentivize quality and value. The CMS Innovation Center develops new payment and service delivery models. Additionally, Congress has defined—both through the Affordable Care Act and other legislation—a number of demonstrations to be conducted by CMS.

As defined by  
MACRA,  
**APMs**  
include:

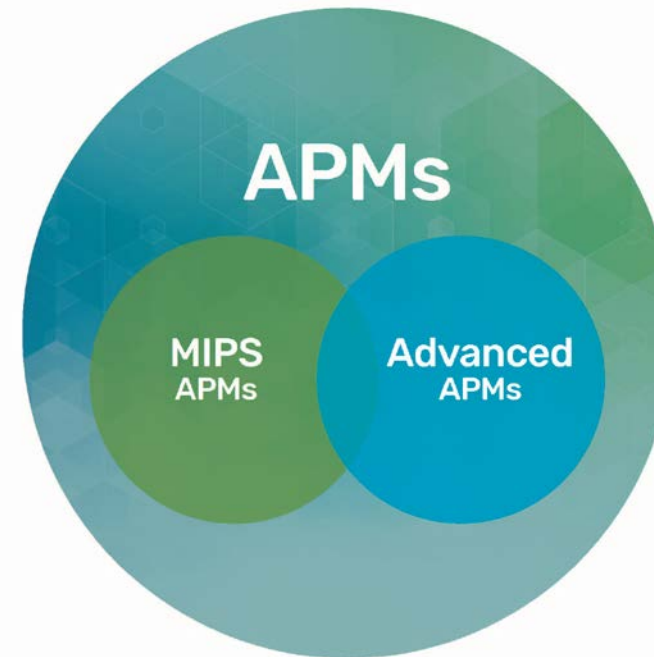
- ✓ CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- ✓ Shared Savings Program
- ✓ Demonstration under the Health Care Quality Demonstration Program
- ✓ Demonstration required by federal law

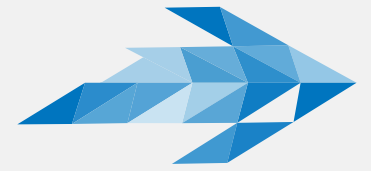


## Advanced APMs

- Clinicians and practices can receive **greater rewards** for taking on some risk related to patient outcomes
- Advanced APMs
  - Require participants to use certified EHR technology
  - Base payment for covered professional services on quality measures comparable to those in MIPS
  - Entities bear more than nominal financial risk, or APM is a Medical Home Model Expanded under Innovation Center authority

Advanced APMs are  
a Subset of APMs





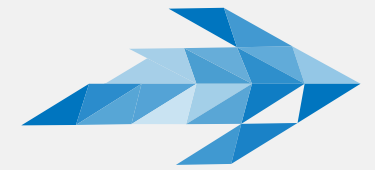
## Benefits of Participating in an Advanced APM as a Qualifying APM Participant (QP)

QPs:

Are excluded from the MIPS

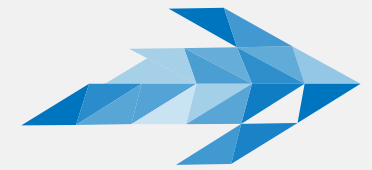
Receive a 5% incentive payment per payment year through 2024

Receive a higher Physician Fee Schedule update  
starting in 2026



## Qualifying APM Participant (QP): QP Status Thresholds

Requirements for Incentive Payments for Significant Participation in Advanced APMs (QP Status Thresholds) (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	<b>50%</b>	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	<b>35%</b>	35%	50%	50%



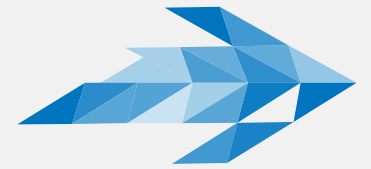
## Qualifying APM Participant (QP)

All Payer and Other APM Thresholds

All-Payer Combination Option (Could Exceed Thresholds with Medicare Only, But Must Meet the Medicare Minimum and Then Can Add Other Payer Participation)										
Payment Year	2017	2018	2019		2020		2021		2022 and later	
QP Payment Amount Threshold	N/A	N/A	50%	25%	50%	25%	75%	25%	75%	25%
QP Patient Count Threshold	N/A	N/A	35%	20%	35%	20%	50%	20%	50%	20%
			Total	Medicare	Total	Medicare	Total	Medicare	Total	Medicare

All-Payer  
Combination  
Option &  
Other Payer  
Advanced APMs





## All-Payer Combination Option

### Overview

The MACRA statute created two pathways to allow eligible clinicians to become QPs.



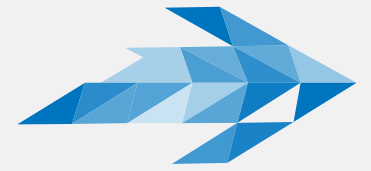
#### Medicare Option

- Available for all performance years.
- Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs with Medicare.



#### All-Payer Combination Option

- Available starting in Performance Year 2019.
- Eligible clinicians achieve QP status based on a combination of participation in:
  - Advanced APMs with Medicare;  
and
  - Other Payer Advanced APMs offered by other payers.



## All-Payer Combination Option

All-Payer Combination Option & Other Payer Advanced APMs

Other Payer Advanced APMs are non-Medicare payment arrangements that meet criteria that are similar to Advanced APMs under Medicare.

Payer types that may have payment arrangements that qualify as **Other Payer Advanced APMs** include:



✓ Title XIX (Medicaid)



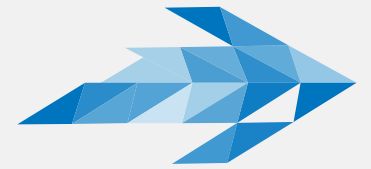
✓ Medicare Health Plans (including Medicare Advantage)



✓ Payment arrangements aligned with CMS Multi-Payer Models

✓ Other commercial and private payers





## All-Payer Combination Option

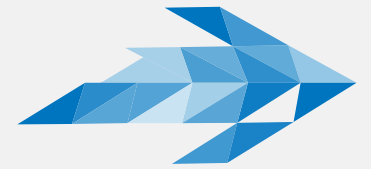
### Other Payer Advanced APM Criteria

The criteria for determining whether a payment arrangement qualifies as an Other Payer Advanced APM are similar, but not identical, to the comparable criteria used for Advanced APMs under Medicare:

**1** Requires at least 50 percent of eligible clinicians to **use certified EHR technology** to document and communicate clinical care information.

**2** Base payments on **quality measures that are comparable to those used in the MIPS** quality performance category.

**3** Either: (1) is a Medicaid Medical Home Model that meets criteria that are comparable to a **Medical Home Model expanded** under CMS Innovation Center authority, OR (2) requires **participants to bear more than nominal amount of financial risk if actual aggregate expenditures exceed expected aggregate expenditures.**



## All-Payer Combination Option

### Other Payer Advanced APM Criteria

The generally applicable nominal amount standard for an Other Payer Advanced APM will be applied in one of two ways depending on how the Other Payer Advanced APM defines risk.

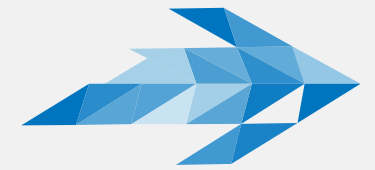
#### Expenditure-based Nominal Amount Standard

Nominal amount of risk must be:

- Marginal Risk of at least 30%;
- Minimum Loss Rate of no more than 4%; and
- Total Risk of at least 3% of the expected expenditures the APM Entity is responsible for under the APM.

#### Revenue-based Nominal Amount Standard

- Nominal amount of risk must be:
  - Marginal Risk of at least 30%;
  - Minimum Loss Rate of no more than 4%; and
- For QP Performance Periods 2019 and 2020, Total Risk of at least 8% of combined revenues from the payer of providers and other entities under the payment arrangement if financial risk is expressly defined in terms of revenue.



## All-Payer Combination Option

### Medicaid Medical Home Model

A Medicaid Medical Home Model is a payment arrangement under Medicaid (Title XIX) that has the following features:



Participants include primary care practices or multispecialty practices that include primary care physicians and practitioners and offer primary care services.



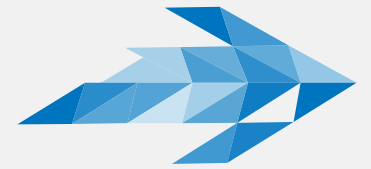
Empanelment of each patient to a primary clinician; and



At least four of the following additional elements:

- Planned coordination of chronic and preventive care.
- Patient access and continuity of care.
- Risk-stratified care management.
- Coordination of care across the medical neighborhood.
- Patient and caregiver engagement.
- Shared decision-making.
- Payment arrangements in addition to, or substituting for, fee-for-service payments.

Medicaid Medical Home Models are subject to different (more flexible) standards in order to meet the financial risk criterion to become an Other Payer Advanced APM.



## All-Payer Combination Option

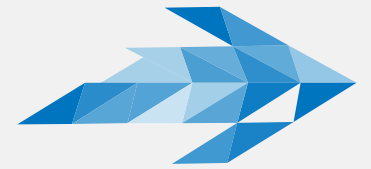
### Medicaid Medical Home Model Nominal Amount Standard

The Medicaid Medical Home Model must require that the total annual amount that an APM Entity potentially owes a payer or foregoes under the Medicaid Medical Home Model is at least:

- 3 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2019.
- 4 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2020.
- 5 percent of the average estimated total revenue of the participating providers or other entities under the payer in 2021 and later.

All Payer Combination  
Option:  
Determination of  
Other Payer  
Advanced APMs





## All-Payer Combination Option

Determinations of Other Payer Advanced APMs

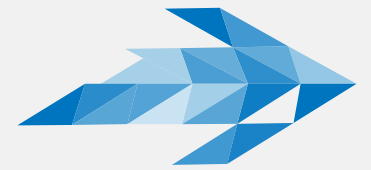
There are two pathways through which a payment arrangement can be determined to be an Other Payer Advanced APM.

### Payer Initiated Process

- Voluntary.
- Deadline is **before** the QP Performance Period.
- Specific deadlines and mechanisms for submitting payment arrangements vary by payer type in order to align with pre-existing processes and meet statutory requirements.

### Eligible Clinician Initiated Process

- Deadline is **after** the QP Performance Period, **except** for eligible clinicians participating in Medicaid payment arrangements.
- Overall process is similar for eligible clinicians across all payer types, except for the submission deadlines.



## All-Payer Combination Option

Determinations of Other Payer Advanced APMs

### Overview – Payer Initiated Process

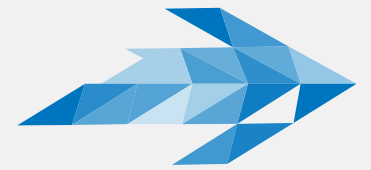
Prior to each QP Performance Period, CMS will make Other Payer Advanced APM determinations based on information voluntarily submitted by payers.

This Payer Initiated Process will be available for Medicaid, Medicare Health Plans (e.g., Medicare Advantage, PACE plans, etc.) and payers participating in CMS Multi-Payer Models beginning in 2018 for the 2019 QP Performance Period. We intend to add remaining payer types in future years.

Guidance materials and the Payer Initiated Submission Form will be made available prior to each QP Performance Period.

CMS will review the payment arrangement information submitted by each payer to determine whether the arrangement meets the Other Payer Advanced APM criteria.

CMS will post a list of Other Payer Advanced APMs on a CMS website prior to the QP Performance Period.



## All-Payer Combination Option

Determinations of Other Payer Advanced APMs

### Overview – Eligible Clinician Initiated Process

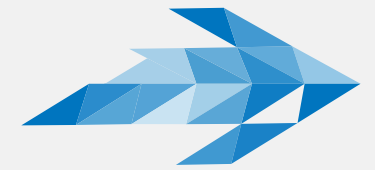
If CMS has not already determined that a payment arrangement is an Other Payer Advanced APM under the Payer Initiated Process, then eligible clinicians (or APM Entities on their behalf) may submit this information and request a determination. CMS would then use this information to determine whether the payment arrangement is an Other Payer Advanced APM.

Guidance materials and the Eligible Clinician Initiated Submission Form will be provided during the QP Performance Period with submission due after the QP Performance Period.

- Note, eligible clinicians or APM Entities participating in Medicaid payment arrangements will be required to submit information for Other Payer Advanced APM determinations for those Medicaid payment arrangements only prior to the QP Performance Period.

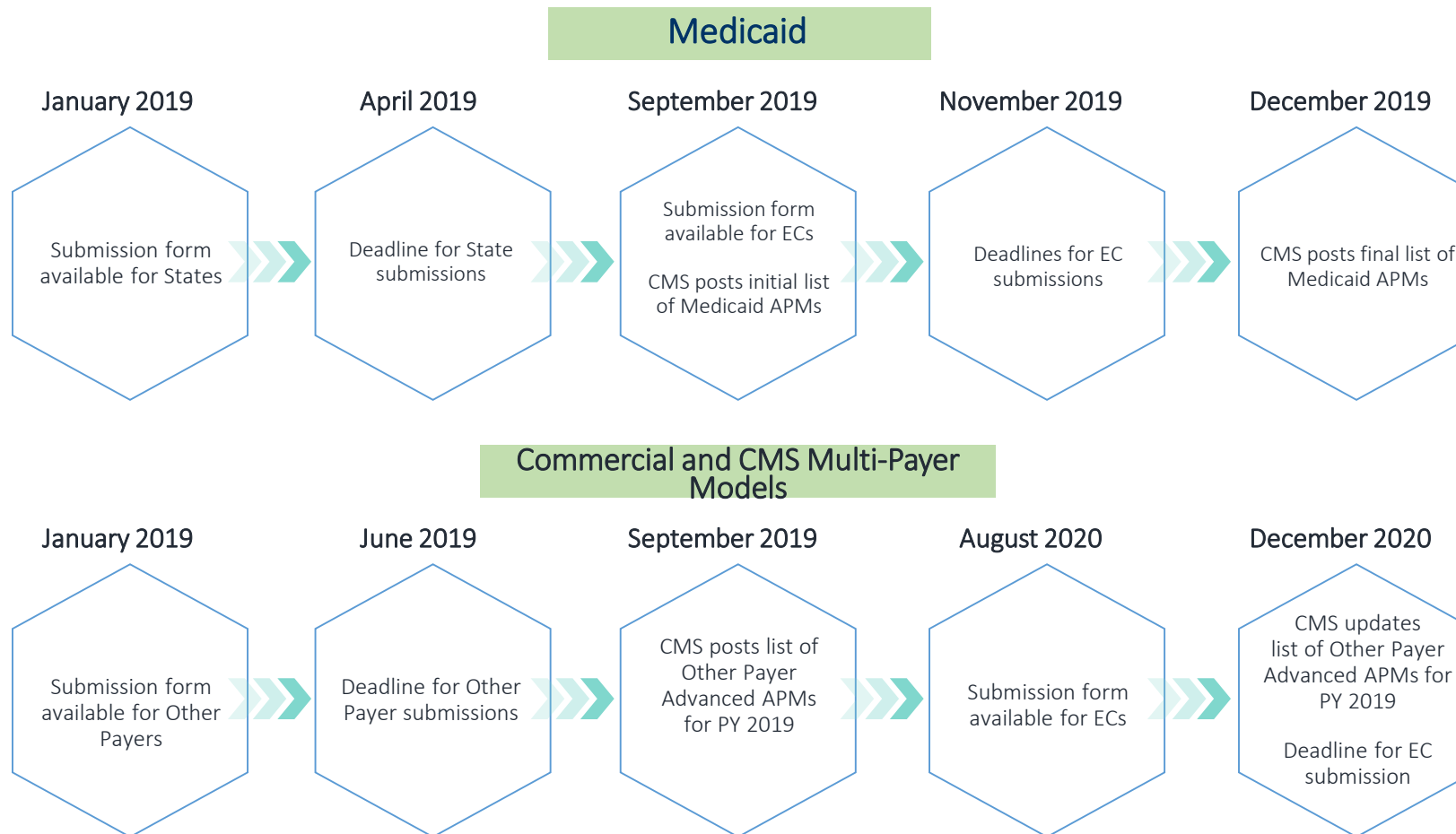
CMS will review the payment arrangement information submitted by APM Entities or eligible clinicians to determine whether the payment arrangement meets the Other Payer Advanced APM criteria.

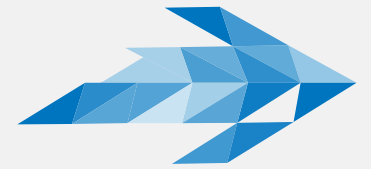




## All-Payer Combination Option

Timeline for Determinations of Other Payer Advanced APMs for 2020





## All-Payer Combination Option

Medicaid Eligible Clinicians

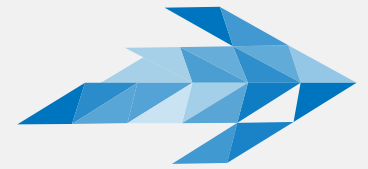
### Eligible Clinician Initiated Process -- Medicaid

A list of Medicaid Other Payer Advanced APMs determined for the 2019 QP Performance Period through the Payer Initiated Process was posted September 1, 2018.

Guide for submitting Medicaid payment arrangements:

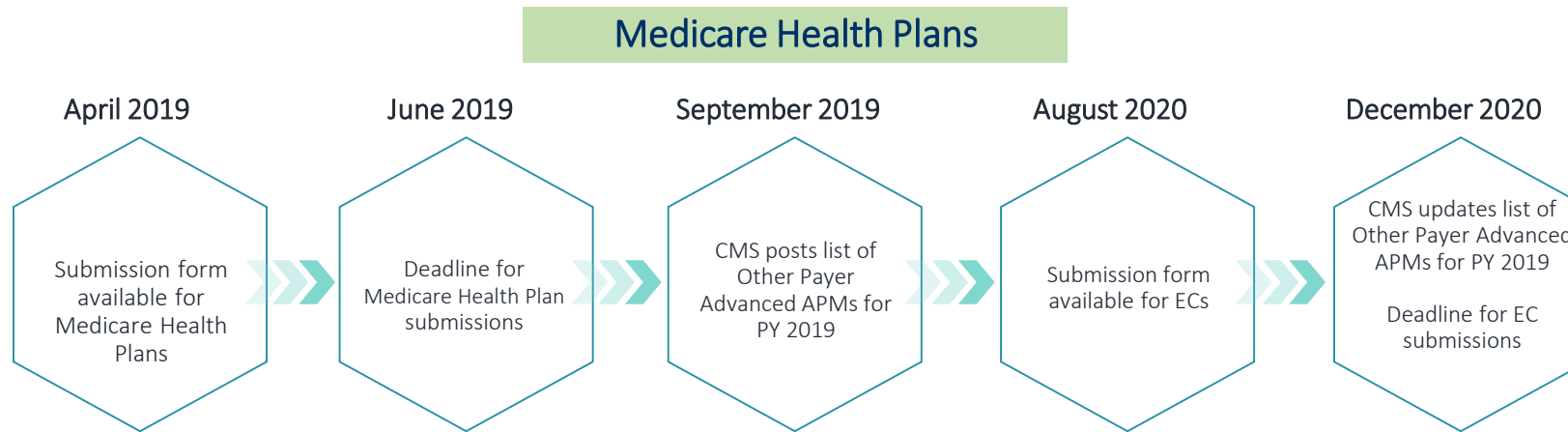
<https://qpp-cm-prod-content.s3.amazonaws.com/uploads/112/Payer%20Initiated%20Submission%20Form%202018%2001%2029.pdf>

Submission period for Eligible Clinicians to submit Medicaid payment arrangement for 2020 will be open from September 1, 2019 to November 1, 2019.



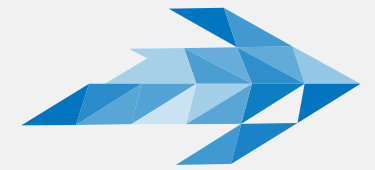
## All-Payer Combination Option

Timeline for Determinations of Other Payer Advanced APMs



All Payer Combination  
Option:  
QP Determinations



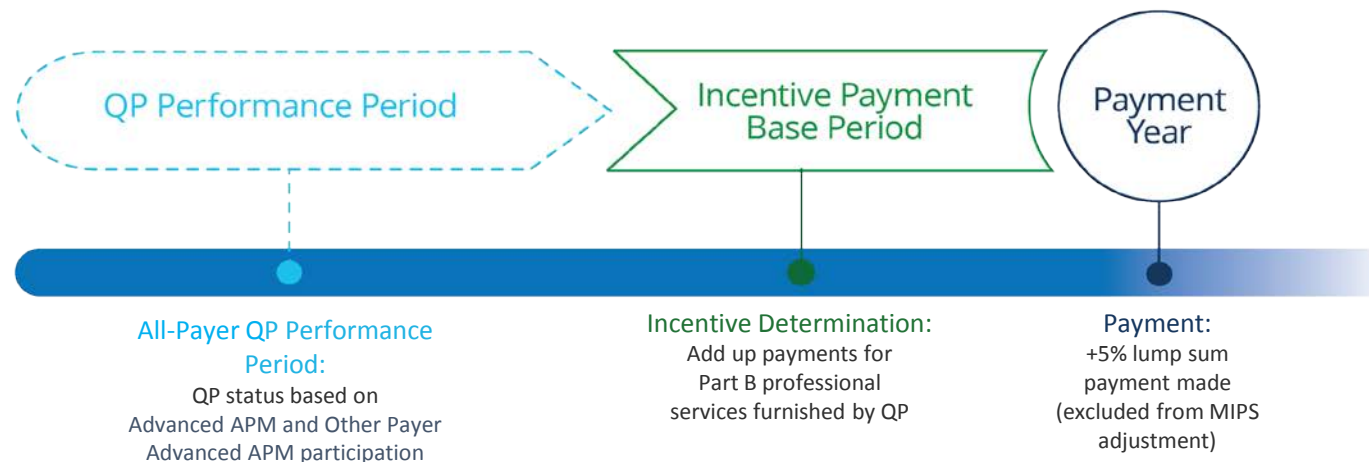


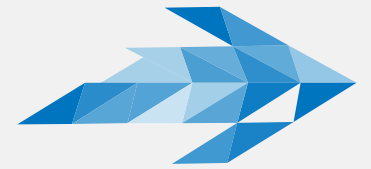
## All-Payer Combination Option

### QP Performance Period

The All-Payer QP Performance Period is the period during which CMS will assess eligible clinicians' participation in Advanced APMs and Other Payer Advanced APMs to determine if they will be QPs for the payment year.

The All-Payer QP performance Period will be from January 1 through June 30 of the year that is two years prior to the payment year. Under this proposal, CMS will make QP determinations under the All-Payer Combination Option from either January 1 - March 31, January 1 – June 30, or January 1 – August 31.





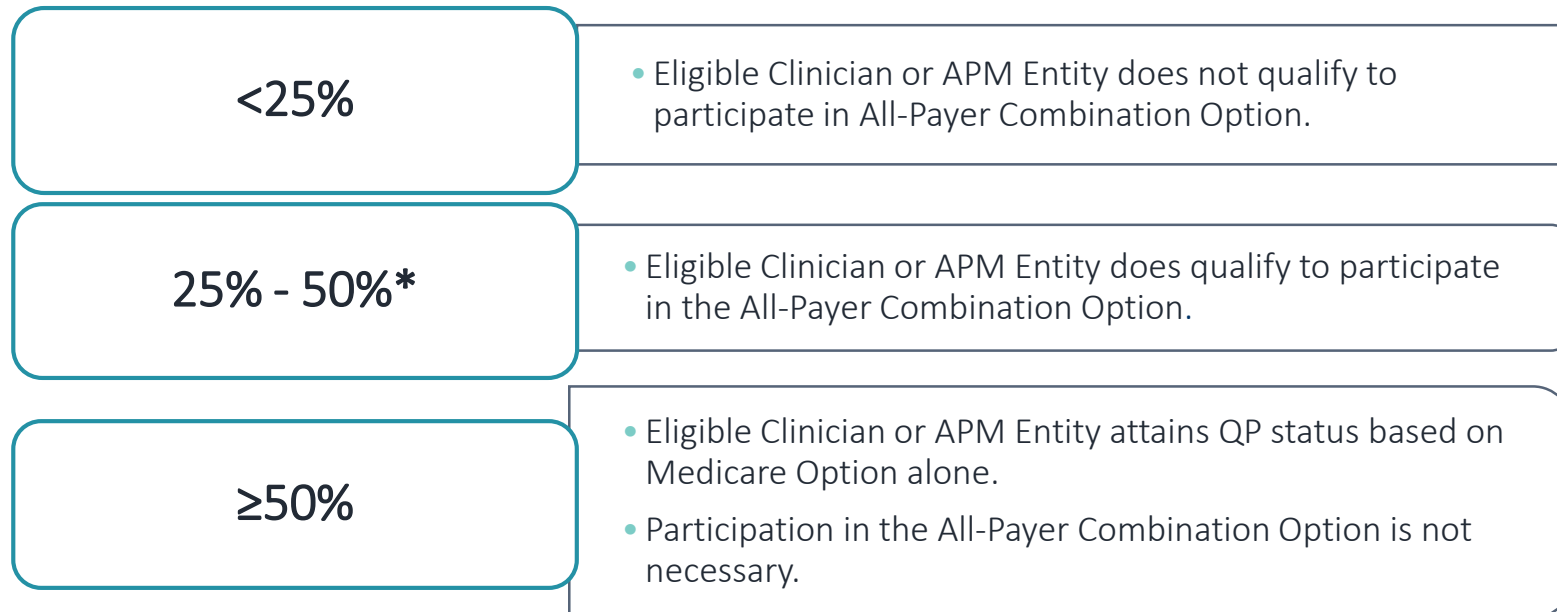
## All-Payer Combination Option

### QP Determination Process

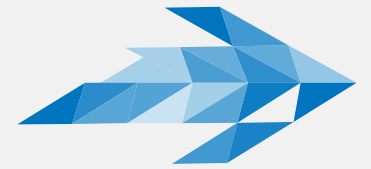
1

An Eligible Clinician or APM Entity needs to participate in an Advanced APM with Medicare to a sufficient extent to qualify for the All-Payer Combination Option.

For performance year 2019, based on the payment amount method, sufficient means:



\*Eligible clinicians must have greater than or equal to 25% and less than 50% of payments through an Advanced APM(s).



## All-Payer Combination Option

### QP Determination Process

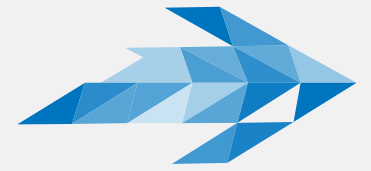
2

Under the All-Payer Combination Option, an Eligible Clinician or APM Entity needs to be in at least one Other Payer Advanced APM during the relevant QP Performance Period.

Eligible clinicians or APM Entities seeking a QP Determination under the All-Payer Combination Option will\*\*:

1. Inform CMS that they are in a payment arrangement that CMS has determined is an Other Payer Advanced APM; and
2. Submit information to CMS on a payment arrangement where CMS will make an Other Payer Advanced APM determination.

\*\*Note that eligible clinicians in Medicaid payment arrangements only would have the option to submit their payment arrangement information prior to the relevant QP Performance Period.



## All-Payer Combination Option

### QP Determination Process

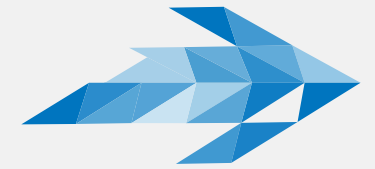
3

Between August 1 and December 1 after the close of the QP Performance Period, eligible clinicians or APM Entities seeking QP determinations under the All-Payer Combination Option would submit the following information:

- Payments and patients through Other Payer Advanced APMs, aggregated between January 1 – March 31, January 1 – June 30, and January 1 – August 31.
- All other payments and patients through other payers except those excluded, aggregated between January 1 – March 31, January 1 – June 30, and January 1 – August 31.

Eligible clinicians may submit information on payment amounts or patient counts for any or all of the 3 snapshot periods. Information can be submitted at either the individual level or the APM Entity level.





## All-Payer Combination Option

### QP Determination Process

4

#### QP Determinations under the All-Payer Combination Option:

Eligible clinicians and APM Entities will have the option to request All-Payer QP determinations. Eligible clinicians can request at either the individual level, and APM Entities can request at the APM Entity level.

CMS will calculate Threshold Scores under both the payment amount and patient count methods, applying the more advantageous of the two:



#### Payment Amount Method

\$\$\$ through Advanced APMs and Other Payer Advanced APMs

\$\$\$ from all payers (except excluded \$\$\$)

= Threshold Score %

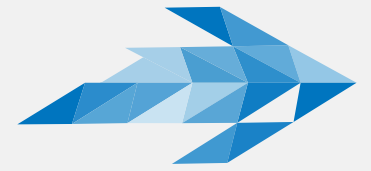


#### Patient Count Method

# of patients furnished services under Advanced APMs and Other Payer Advanced APMs

# of patients furnished services under all payers (except excluded patients)

= Threshold Score %



## All-Payer Combination Option

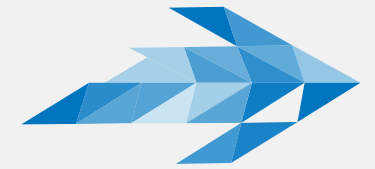
### QP Determination Process

4

The MACRA statute directs us to exclude certain types of payments (and we will for associated patients).

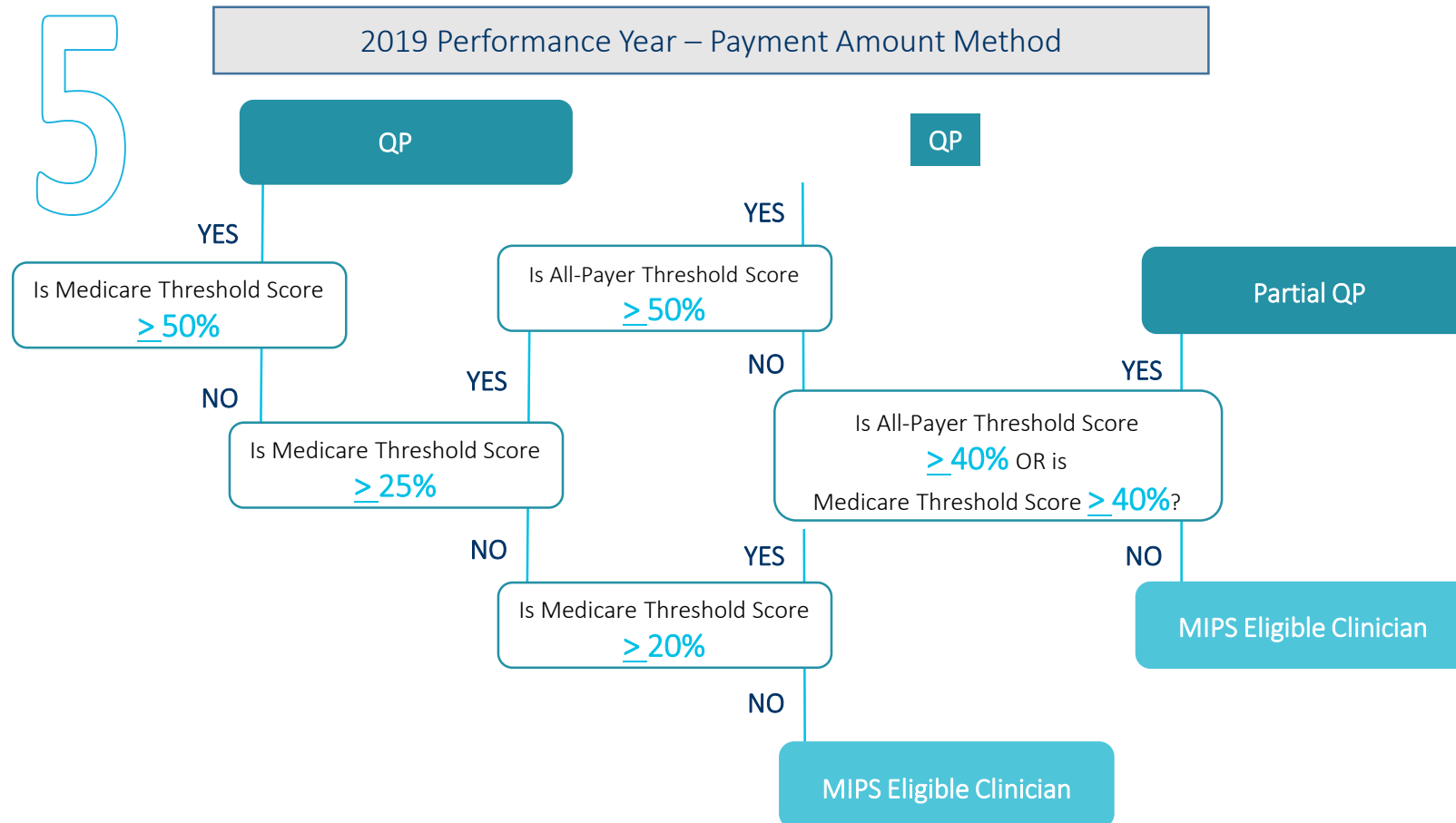
Specifically, that list of excluded payments includes, but is not limited to, Title XIX (Medicaid) payments where no Medicaid APM (which includes a Medicaid Medical Home Model that is an Other Payer Advanced APM) is available under that state program.

In the case where the Medicaid APM is implemented at the sub-state level, Title XIX (Medicaid) payments and associated patients will be excluded unless CMS determines that there is at least one Medicaid APM available in the county where the eligible clinician sees the most patients and that eligible clinician is eligible to participate in the Other Payer Advanced APM based on their specialty.



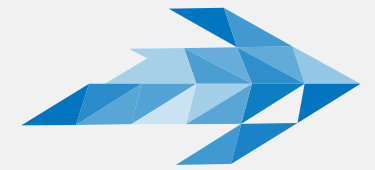
## All-Payer Combination Option

### QP Determination Process



# Resources






# Technical Assistance

CMS has free resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

### PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative


- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact [TCPI.ISCMail@us.ibm.com](mailto:TCPI.ISCMail@us.ibm.com) for extra assistance.


 [Locate the PTN\(s\) and SAN\(s\) in your state](#)

### SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
- Assistance will be tailored to the needs of the clinicians.
- There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
- For more information or for assistance getting connected, contact [QPPSURS@IMPAQINT.COM](mailto:QPPSURS@IMPAQINT.COM).






### LARGE PRACTICES

Quality Innovation Networks-  
Quality Improvement Organizations (QIN-QIO)




- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit-Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

 [Locate the QIN-QIO that serves your state](#)

Quality Innovation Network (QIN) Directory

### TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

-  **Quality Payment Program Website: [qpp.cms.gov](http://qpp.cms.gov)**  
Serves as a starting point for information on the Quality Payment Program.
-  **Quality Payment Program Service Center**  
Assists with all Quality Payment Program questions.  
1-866-288-8292 TTY: 1-877-715-6222 [QPP@cms.hhs.gov](mailto:QPP@cms.hhs.gov)
-  **Center for Medicare & Medicaid Innovation (CMMI) Learning Systems**  
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

To learn more, view the Technical Assistance Resource Guide: <https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf>

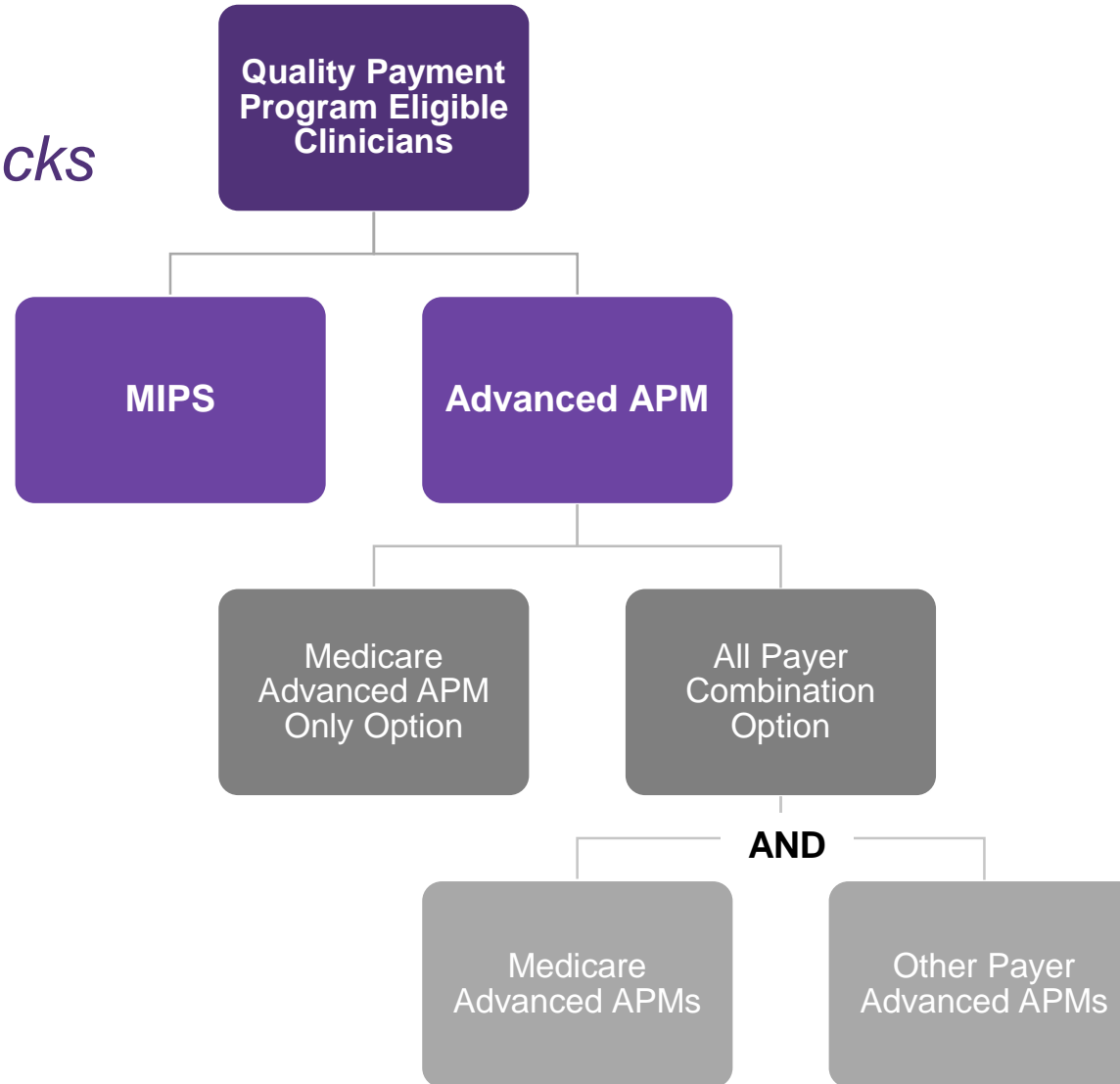


### III. NYS Overview on MACRA Alignment with NYS Value Based Payment

*Douglas Fish, MD, Medical Director, Division of Medical & Dental Directors |  
New York State Department of Health*

# Review

## *QPP Participation Tracks*



- Title XIX (Medicaid and Medicaid Medical Home Models)
- Medicare Health Plans (including Medicare Advantage)
- Payment arrangements aligned with CMS Multi-Payer Models
- Other Commercial and Private Payers



# 1 – CEHRT Requirements

## Other Payer Advanced APM Criteria

- To become a Qualifying Participant for an advanced alternative payment model in 2019, 75% of practices need to be using certified EHR Technology within the Advanced APM entity.

## Medicaid VBP

- The NYS VBP Roadmap does not have any specific requirement governing the use of CEHRT.
- If a provider meets the AAPM requirements, this is satisfactory for the NYS VBP model, specifically governing the use of CEHRT.

*Key Takeaway:* This is one of the largest differences between Medicaid VBP and the QPP requirements to meet Other Payer Advanced APM criteria; **VBP contractors will need to include additional terms outside of the state's criteria.**

## 2 – Quality Measurement Tied to Payment

### Other Payer Advanced APM Criteria

- Contract must specify payment based on quality measures comparable to those in the MIPS quality performance category, including at least one outcome measure.

### Medicaid VBP

- Quality measures must be incorporated into the payment arrangement and used to determine the amount of shared savings for which VBP contractors are eligible.
- State will not define or enforce what quality measures are selected or the approach used to evaluate performance/reward providers.
- Many of the AAPM measures are contained in the VBP measure sets. See Appendix.

*Key Takeaways:* To meet Other Payer Advanced APM criteria, VBP contractors must select and incorporate MIPS comparable quality measures into the VBP contract.

# 3 – Financial Risk

	Marginal Risk	Minimum Loss Rate	Total Risk
<b>MACRA All Payer Combination Option Risk Requirements</b>	<p>Marginal Risk of <math>\geq 30\%</math></p> <p>Marginal risk defines the percentage for which the contracted provider entity is liable for if actual expenditures are higher than expected (higher than the benchmark).</p>	<p>Minimum Loss Rate of <math>\leq 4\%</math></p> <p>A percentage by which actual expenditures may exceed expected expenditures without triggering financial risk.</p>	<p>Based on Other Payer Advanced APM definition of risk; Total Risk of <math>\geq 3\%</math> expected Expenditures or <math>\geq 8\%</math> of Contracted Provider Revenues</p> <p>Defined as the maximum potential payment for which an APM Entity could be liable under a payment</p>
<b>NYS VBP Risk Requirements</b>	<p>A provider that meets MACRA risk standard would also meet NYS VBP risk standard</p>	<p>In the NYS VBP model, the minimum percentage of potential losses to be allocated to a provider is 20%, and where stop loss is capped, at least 3% of the target budget.</p>	<p>The NYS VBP model aligns with the expenditure based model. In the NYS model, providers must adopt risk of at least 3% of the target budget based on expenditure In year 2, the amount of risk increases to at least 5% of the target budget based on expenditure .</p>

**Key Takeaways:** To meet Other Payer Advanced APM requirements, VBP contractors must define financial risk in VBP contracts to meet both State- and CMS-defined criteria.

# VBP Alignment with QPP Quality Measure Requirements

## QPP Requirements

- The Advanced APM Track: In order to be deemed an Advanced APM, **the contractual arrangement must include MIPS-comparable\* quality measures tied to payment, including 1 outcome measure on the MIPS Measure List.**

- **How do the State's VBP Quality Measure sets align?**

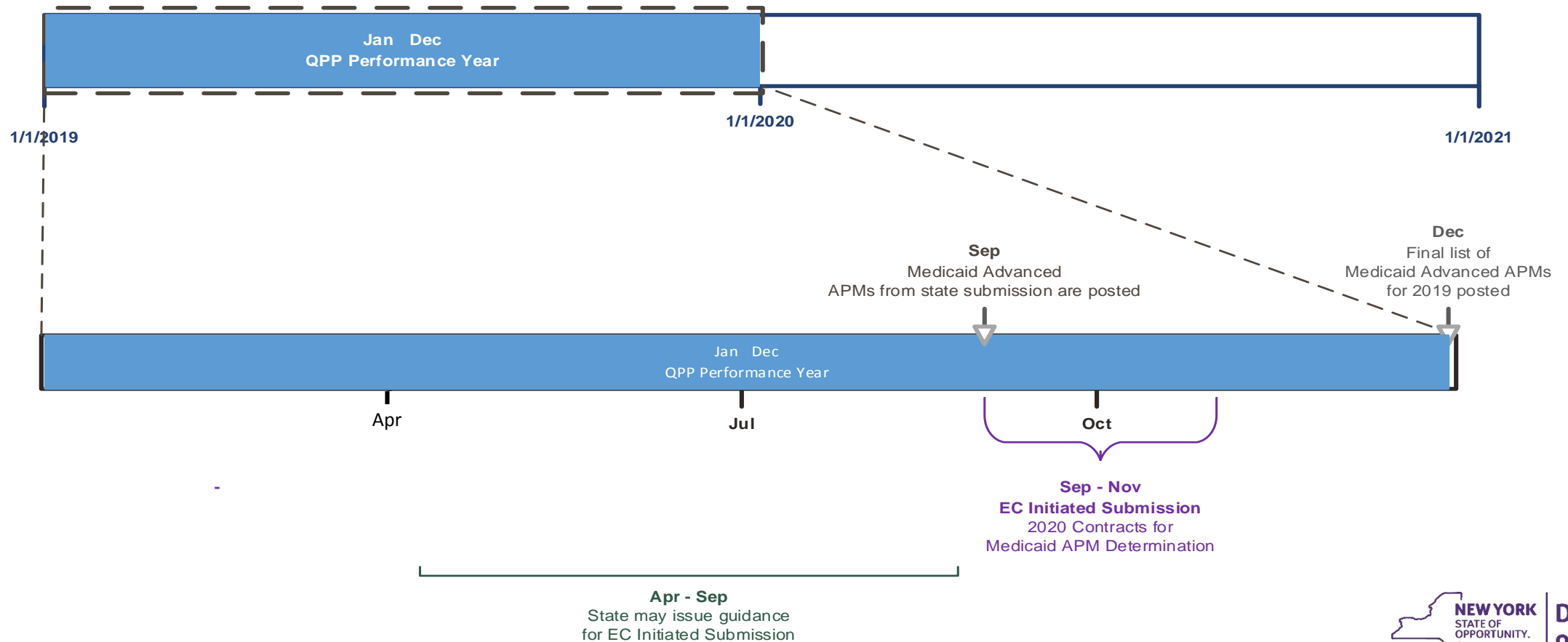
	Category 1 VBP Measures included on the 2018 MIPS Measure List			
	Total Cat 1 Measures in MIPS Measure List	Total Cat 1 Measures Not in MIPS	Process Measures	Outcome Measures
TCGP/IPC	19	28	17	2
HARP	15	14	12	3
HIV/AIDS	15	7	12	3
Maternity Care	1	7	1	0

# Application Timeline & Determination

# Key Dates & Timeline for Determination – Program Year 2019

**Legend**

- CMS milestones
- Submission milestones
- Key decision points for State



# Thank you!

***Please send questions and feedback to:***

**[vbp@health.ny.gov](mailto:vbp@health.ny.gov)**

- *For more information on the NYS VBP Program:*  
**[VBP Resource Library](#)**

# Appendix



## Category 1 2019 Medicaid VBP Measures by Arrangement

Measure Type	TCGP	IPC	Maternity	HARP	HIV/AIDs	Children's
All VBP CAT 1 Measures	35	33	10	30	24	14
VBP CAT 1/MIPS Measures	20	20	3	16	17	7
VBP CAT 1/NON-MIPS Measures	15	13	7	14	7	7
VBP CAT 1 - Process Measures	30	29	5	27	21	13
VBP CAT 1 - Outcome Measures	5	4	3	3	3	1
VBP CAT 1 - MIPS & Process	18	18	3	13	14	7
VBP CAT 1 - MIPS & Outcome	2	2	0	3	3	0

# Quality Measures in VBP & MACRA

Measure Name	NQF # *	Class	TCGP	IPC	Maternity	HARP	HIV/AIDs	Children's	Aligned?	Measure Type
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NQF 1879	P4P				x			Y	Intermediate Outcome
Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	NQF 1880	P4P	x	x			x		N	Process
Adolescent Preventive Care Measures		P4R	x	x				x	N	Process
Adolescent Well-Care Visits		P4R	x	x				x	N	Process
Annual Dental Visit	NQF 1388	P4R	x	x				x	N	Process
Antidepressant Medication Management	NQF 0105	P4P	x	x			x		Y	Process
Asthma Medication Ratio	NQF 1800	P4P	x	x		x	x	x	N	Process
Breast Cancer Screening	NQF 2372	P4P	x	x		x	x		Y	Process
Cervical Cancer Screening	NQF 0032	P4P	x	x		x	x		Y	Process
Childhood Immunization Status – Combination 3	NQF 0038	P4P	x	x				x	Y	Process
Chlamydia Screening in Women	NQF 0033	P4P	x	x		x		x	Y	Process
Colorectal Cancer Screening	NQF 0034	P4P	x	x		x	x		Y	Process
Comprehensive Diabetes Care: Eye Exams	NQF 0055	P4P	x	x		x	x		Y	Process

- \* If applicable
- All measures listed are CAT 1
- “x” indicates inclusion in arrangement

Measure Name	NQF # *	Class	TCGP	IPC	Maternity	HARP	HIV/AIDs	Children's	Aligned?	Measure Type
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NQF 0059	P4P	x	x		x	x		Y	Intermediate Outcome
Comprehensive Diabetes Care: Medical Attention for Nephropathy	NQF 0062	P4P	x	X		x	x		Y	Process
Continuity of Care from Inpatient Detox to Lower Level of Care		P4P				x			N	Process
Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care		P4P				x			N	Process
Contraceptive Care – Postpartum	NQF 2902	P4R			x				N	Intermediate Outcome
Controlling High Blood Pressure	NQF 0018	P4P	x	x		x	x		Y	Intermediate Outcome
C-Section for Nulliparous Singleton Term Vertex (NSTV)	NQF 0471	P4R			x				N	Outcome
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	NQF 1932	P4P	x	x		x	x		N	Process

- \* If applicable
- All measures listed are CAT 1
- “x” indicates inclusion in arrangement

Measure Name	NQF # *	Class	TCGP	IPC	Maternity	HARP	HIV/AIDs	Children's	Aligned?	Measure Type
Exclusive Breast Milk Feeding	NQF 0480	P4R			X				N	Process
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence	NQF 2605	P4P				x			N	Process
Follow-Up After Emergency Department Visit for Mental Illness	NQF 2605	P4P				x			N	Process
Follow-Up After Hospitalization for Mental Illness	NQF 0576	P4P				x			Y	Process
Follow-Up Care for Children Prescribed ADHD Medication	NQF 0108	P4R	x	x				x	Y	Process
HIV Viral Load Suppression	NQF 2082	P4P					x		Y	Outcome
Immunizations for Adolescents – Combination 2	NQF 1407	P4P	x	x				x	Y	Process
Incidence of Episiotomy	NQF 0470	P4R			X				N	Process
Initiation and Engagement of Alcohol & Other Drug Abuse or Dependence Treatment	NQF 0004	P4P	x	x	x	x	x		Y	Process
Initiation of Pharmacotherapy upon New Episode of Opioid Dependence		P4P	x	x		x	x		N	Process

- \* If applicable
- All measures listed are CAT 1
- “x” indicates inclusion in arrangement

Measure Name	NQF # *	Class	TCGP	IPC	Maternity	HARP	HIV/AIDs	Children's	Aligned?	Measure Type
Low Birth Weight [Live births weighing less than 2,500 grams (preterm v. full term)]	NQF 0278	P4R	x		x				N	Outcome
Maintaining/Improving Employment or Higher Education Status		P4R				x			N	Process
Maintenance of Stable or Improved Housing Status		P4R				x			N	Process
Medication Management for People with Asthma	NQF 1799	P4P	x	x		x	x	x	Y	Process
No or Reduced Criminal Justice Involvement		P4R				x			N	Process
PDI #14 Asthma Admission Rate	NQF 0728	P4P	x	x				x	N	Outcome
Percentage of Members Enrolled in a Health Home		P4R				x			N	Process
Percentage of Preterm Births		P4R			x				N	Process
Potentially Avoidable Complication (PAC) in Patients with HIV/AIDS		P4R					x		N	Process

- \* If applicable
- All measures listed are CAT 1
- “x” indicates inclusion in arrangement

Measure Name	NQF # *	Class	TCGP	IPC	Maternity	HARP	HIV/AIDs	Children's	Aligned?	Measure Type
Potentially Avoidable Complications (PAC) in Routine Sick Care or Chronic Care		P4R	x	x					N	Outcome
Potentially Preventable Mental Health Related Readmission Rate 30 Days		P4P				x			N	Process
Prenatal and Postpartum Care	NQF 1517	P4P	x		x				N	Process
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	NQF 0421	P4R	x	x	x	x	x		Y	Process
Preventive Care and Screening: Influenza Immunization	NQF 0041	P4R	x	x		x	x		Y	Process
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	NQF 0418	P4R	x	x	x		x	x	Y	Process
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	NQF 0028	P4R	x	x		x	x		Y	Process
Sexually Transmitted Infections: Screening for Chlamydia, Gonorrhea, and Syphilis		P4P					x		Y	Process

- \* If applicable
- All measures listed are CAT 1
- “x” indicates inclusion in arrangement

Measure Name	NQF # *	Class	TCGP	IPC	Maternity	HARP	HIV/AIDs	Children's	Aligned?	Measure Type
Statin Therapy for Patients with Cardiovascular Disease		P4R	x	x		x	x		Y	Process
Use of Pharmacotherapy for Alcohol Abuse or Dependence		P4R	x	x		x	x		N	Process
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	NQF 0577	P4R	x	x		x	x		N	Process
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NQF 0024	P4P	x	x				x	Y	Process
Well-Child Visits in the First 15 Months of Life	NQF 1392	P4P	x	x				x	N	Process
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life	NQF 1516	P4P	x	x				x	N	Process

- \* If applicable
- All measures listed are CAT 1
- “x” indicates inclusion in arrangement