NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

North Carolina Medicaid Quality Measurement Technical Specifications Manual

Measurement Year 2026

Version 2026.1[1]

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2026 Technical Specifications Summary of Updates:

- Modified the following measures:
  - Switch *Adults Access to Preventive/Ambulatory Health Services (AAP*) to plan-reported for Standard Plans and Behavioral Health and Intellectual/Developmental Disabilities (I/DD) Tailored Plans (subsequently referred to as Tailored Plans)
  - Switch the USC measure *Continuity of Pharmacotherapy for Opioid Use Disorder* with the HEDIS measure *Pharmacotherapy for Opioid Use Disorder (POD)*
  - Switch *Initiation and Engagement in Substance Use Disorder (IET)* measure to plan-reported for Tailored Plans
  - Switch *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)* measure to Department-calculated for Prepaid Inpatient Health Plans (PIHPs)
  - Switch *Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E*) measure to Department-calculated for PIHPs
- Added the following measures:
  - *Rate of Screening for Health-Related Resource Needs (HRRN)* to the PIHP measure set
  - *Eye Exam for Patients with Diabetes (EED)* to the Tailored and Standard Plan measure sets
  - *Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)* to the Tailored Plan measure set
  - *MLTSS 6, 7, and 8* to the Standard and Tailored Plan measure sets
- Removed the following measures:
  - *Inpatient Utilization (IPU)* from the Standard Plan, Tailored Plan, and CCNC measure sets
  - *Sealant Receipt on Permanent First Molars (SMF)* from the Standard and Tailored Plan measure sets
  - *Antibiotic Utilization for Respiratory Conditions (AXR)* from the Standard and Tailored Plan measure sets
  - *Asthma Medication Ratio (AMR)* from the Standard and Tailored Plan measure sets
  - *Admission to a Facility from the Community (AIF)* from the Standard Plan, CCNC, PIHP, and Tailored Plan measure sets
  - *PDI 16: Pediatric Gastroenteritis Admission Rate* from the Standard and Tailored Plan measure sets
  - *PDI 18: Pediatric Urinary Tract Infection Admission Rate* from the Standard and Tailored Plan measure sets
  - *Live Births Weighing Less than 2,500 Grams (CMS)* from the Standard and Tailored Plan measure sets
  - *Total Cost of Care (TCOC) from the Standard, Tailored Plan, and PIHP measure sets due to the decommissioning of the Health Partners' TCOC dashboard.*

I. Introduction

The North Carolina Department of Health and Human Services (hereafter referred to as "The Department", specifically the Division of Health Benefits (DHB), unless otherwise noted) is dedicated to operating a comprehensive NC Medicaid managed care program that optimizes health and well-being for all North Carolinians. Central to this effort is a commitment to the delivery of high-quality health care through the development of a data-driven, outcomes-based, continuous quality improvement process that focuses on rigorous measurement against relevant benchmarks and appropriately rewards Standard Plans, Behavioral Health and I/DD Tailored Plans (hereafter referred to as "Tailored Plans"), Prepaid Inpatient Health Plans (PIHPs) and other plan types operating in the state and providers for advancing quality goals.[2] This document provides an overview of the Department's approach to quality improvement, with a specific focus on quality measurement, reporting and incentives for improved quality performance. The document includes:

- The Department's vision for advancing quality across NC Medicaid.
- Detailed information about how the Department will measure managed care plan (commonly referred to as "health plans") quality and promote quality improvement.
- Appendices containing technical specifications for all quality measures that Standard Plans, Tailored Plans and other managed care entities are required to report as well as those that the Department will calculate.

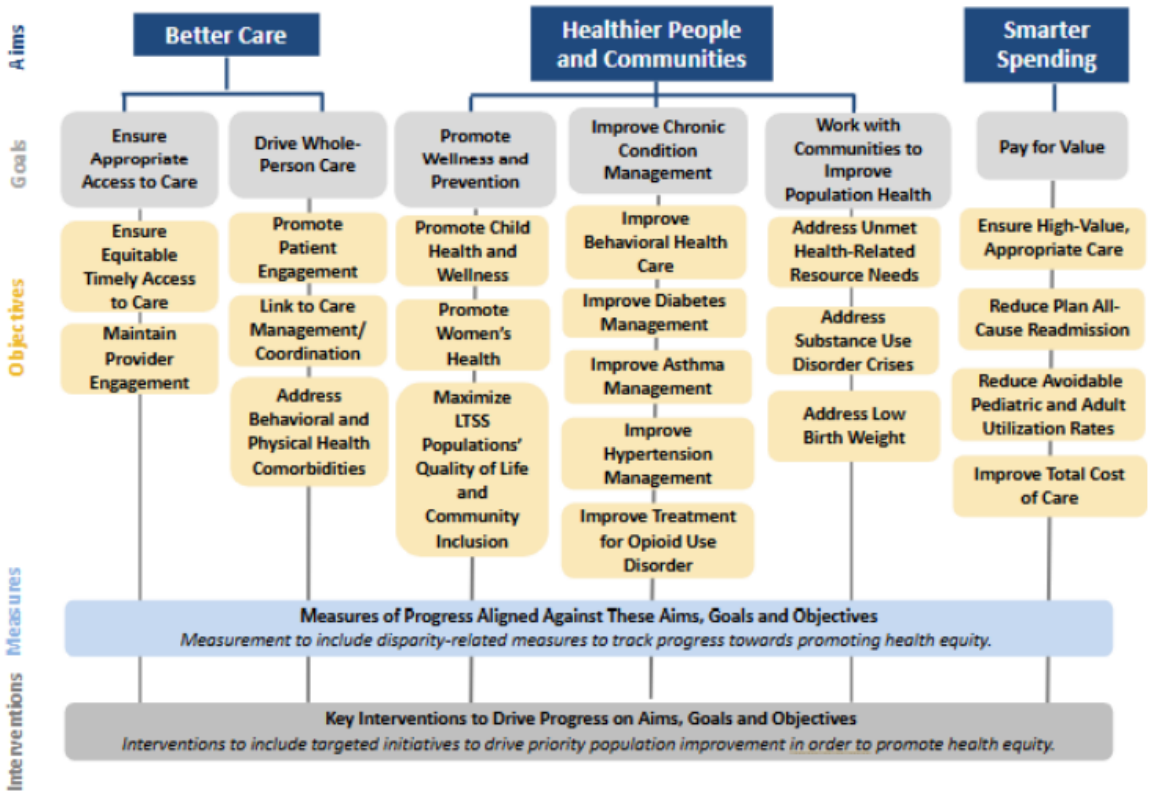
This document will be updated annually and on an as-needed basis to reflect changes in the quality improvement and measurement approach, including updates to measure requirements.

II. Vision for Advancing Quality Through Managed Care

As noted in the Quality Strategy,[3] the Department seeks to develop a data-driven, outcomes-based continuous quality improvement process in the NC Medicaid program that supports the three central Aims: 1) Better Care Delivery; 2) Healthier People, Healthier Communities; and 3) Smarter Spending (see Figure 1). Goals and Objectives are tied to each of these Aims, along with a series of interventions, including but not limited to Advanced Medical Homes (AMHs), Tailored Care Management and NC Integrated Care for Kids (InCK), which are specifically designed to improve quality outcomes in North Carolina.

[2] While this document incorporates quality measurement and improvement efforts for a variety of entities serving Medicaid members, there is a specific focus on Standard Plans and Tailored Plans.
[3] Available here.

Figure 1: North Carolina's Medicaid Managed Care Quality Strategy Framework

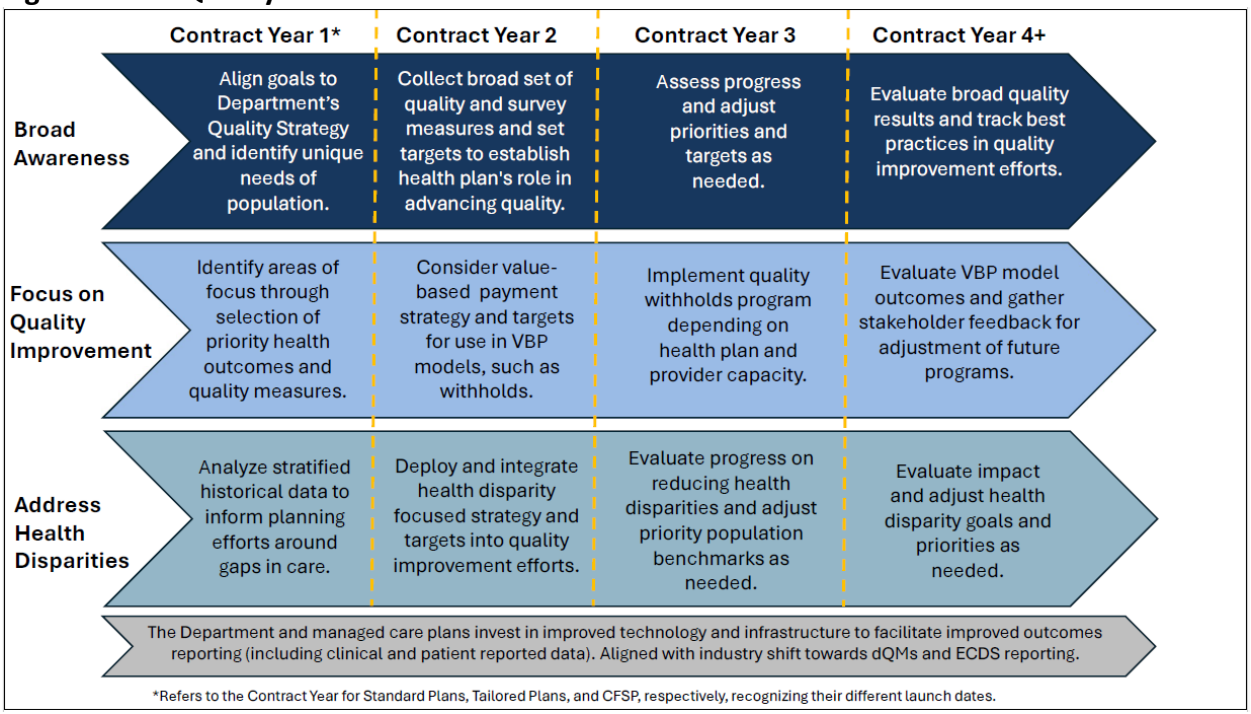


The Department is committed to rewarding health plans serving NC Medicaid members that accurately report and demonstrate meaningful improvement against specified quality benchmarks. The Department collects a robust set of quality data to paint a clear picture of service delivery and clinical care at statewide and regional levels and across demographic strata, such as age, gender, disability status, geography, race and ethnicity (see Table 2 for the full list). The Department requires health plans, such as Standard Plans and Tailored Plans, to quickly establish working relationships with providers and other community stakeholders to support accurate plan- and provider-level reporting for quality measures, including selected clinical outcomes. Health plans are expected to build on these relationships to reach specific targets for priority outcomes specified by the Department (see Figure 2). The Department also tracks select public health measures to link plan quality improvement efforts to larger state public health initiatives and goals.

The Department will support the vision outlined in the Quality Strategy through investments in initiatives to improve health outcomes. The Department will support efforts to address upstream social drivers of health and support the development of infrastructure needed to facilitate public reporting of quality performance and assessment of state-level health improvements resulting from improved care delivery in the NC Medicaid program.

Each year the Department will reassess its role in calculating certain quality measures directly, to manage the health plans' reporting burden. In turn, the Department expects plans to: 1) establish the staffing plans, tools, information technology (IT) infrastructure and analytic capabilities required to measure quality performance, 2) embed continuous quality improvement efforts to improve outcomes and 3) possess the capabilities to execute successful strategies to promote health equity. The Department intends to invest in improved technology and infrastructure to support plan reporting and will further streamline reporting requirements when feasible, based on the results of when reporting.

Figure 2: The Quality Vision Over Time



Programmatic Requirements for Quality Improvement

The Department uses a variety of programmatic requirements to ensure managed care plans move toward plan-level accountability for health outcomes and offers resources to support plans and providers in their quality improvement efforts. Most directly, the Department sets targets for plan quality improvement efforts through the establishment of quality measure sets.

What is a Quality Measure?

Quality measures are tools that help quantify health care processes, outcomes, patient perceptions and organizational structure and/or systems that are associated with the ability to provide high-quality health care. Quality measures help the Department identify successes and areas for opportunity, so that NC Medicaid and the health plans can prioritize efforts to achieve better outcomes for beneficiaries.

Each health plan is assigned and held accountable for the quality metrics in their measure set. These measure sets include both plan-reported and Department-calculated measures. The Department shares historical rates and performance benchmarks for the measures that are reported by the Department directly and for the Advanced Medical Home (AMH) measure set. Plans will focus on performance improvement for these measures, both for overall and for priority population performance improvement.

Program elements related to quality improvement in the Standard Plan and Tailored Plan programs include:

- The Department expects Standard Plans and Tailored Plans to work with their contracted providers to improve quality through Performance Improvement Projects (PIPs), for which the Department will provide broad guidelines. Standard Plans and Tailored Plans are required to submit an annual Quality Assessment and Performance Improvement (QAPI) plan, delineating their plans for PIPs and other quality improvement efforts (see section V (E) for more details on PIPs).

- The Department requires engagement with 1) external entities to improve quality, including through an accrediting body that will assess quality management processes and offer additional guidance; and 2) an External Quality Review Organization (EQRO) that will validate quality performance, assess quality improvement efforts and provide feedback to Standard Plans and Tailored Plans. The Department has established requirements for plan deployment of Value-based payments (VBP) and PIPs to incentivize quality improvement among contracting providers.

- The Department expects Standard Plans and Tailored Plans, contracting providers, enrollees and other community stakeholders to share feedback on quality improvement and offer suggestions that can lead to better processes and outcomes through the state Consumer and Family Advisory Committee, Medicaid Advisory Council (MAC) and the Beneficiary Advisory Council (BAC). [4]

Many of these elements have been described in detail in other documents. Further information regarding VBP can be found here. Further information regarding PIPs and QAPI plans, as well as additional details on the EQRO and accreditation, is provided in the accompanying Quality Strategy.

The remainder of this document focuses on quality measure reporting, the Department's use of quality measures to assess plan performance, and Standard Plans' and Tailored Plans' use of

[4] In April 2024, the Centers for Medicare & Medicaid (CMS) announced a new rule, "Ensuring Access to Medicaid Services," to improve Medicaid. The new rule requires NC Medicaid and other State Medicaid agencies to create two new groups, a Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) by July 2025.The MAC/BAC are designed to center the lived experience of beneficiaries, their families and caregivers and these will replace the Medicaid Medical Care Advisory Committee (MCAC).

these measures in their respective contracts with primary care practices (e.g., AMHs) and organizations that provide Tailored Care Management (e.g., certified AMH practices (called AMH+s) and care management agencies (CMAs)).[5]

III. Quality Measurement and Improvement

To ensure that all NC Medicaid Managed Care members receive high-quality care, Standard Plans and Tailored Plans are expected to report on, and ultimately be held accountable for, performance against measures aligned to a range of specific goals and objectives used to drive quality improvement and operational excellence. The Department's use of specific quality requirements to advance toward these goals and objectives will evolve as Standard Plans, Tailored Plans and providers' infrastructure and experience increase, with rewards for excellence and penalties for poor performance.

The Department monitors a wide range of processes and outcomes relevant to managed care, which are shown in Appendix A, Table 1. The Department has identified a subset of measures as the priority focus for health plan accountability. These measures make up the set from which plans can draw for required quality improvement initiatives such as PIPs. In addition, the Department calculates and monitors a separate set of measures related to health care delivery and outcomes in the broader NC Medicaid program.

Tailored Plans will also be responsible for a set of measures to assess the quality of state-funded services, which address the unique needs of individuals receiving state and non-Medicaid federally funded services for mental health, I/DD, traumatic brain injury and substance use (see Appendix A, Table 1). State-funded services include beneficiaries served by the Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMHDDSUS) using state allocated funding, federal block grants and other funds. Funding is administered by the Local Management Entity/Managed Care Organization (LME/MCOs). The measures in the State-Funded measure set are submitted by the plans or calculated by DMHDDSUS on monthly or quarterly cycles. To learn more about these measures visit the DMHDDSUS webpage.

Plan-level performance on Standard Plan and Tailored Plan measures will be tracked and shared with health plans for performance improvement processes. These results may be used in public-facing quality reports and deliverables. Plan-level performance on the Tailored Plan State-funded measures may also be publicly reported (see Appendix A, Table 1). [6]

Considering stakeholder (health plan) feedback, the Department's Quality and Health Outcomes Committee (QHO) reviews quality measure performance results and updates the Technical Specifications Manual at least once a year to inform annual quality measure set monitoring and updates. These quality measures are meant to provide the Department with a standardized view of the health plans' processes and performance. Measures are selected from a variety of

[5] More information on Tailored Plans and Tailored Care Management can be found here.
[6] The EQRO will report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures at the plan level.

sources, including the Healthcare Effectiveness Data and Information Set (HEDIS®); National Committee for Quality Assurance (NCQA) health plan accreditation,[7] including a requirement for Long-Term Services and Supports (LTSS) accreditation; and the Centers for Medicare & Medicaid Services (CMS) Adult and Child Core Measure Sets. The Department will update all quality measures annually to reflect changes made by these measure stewards and as the foci of the Department's quality improvement efforts evolve.

Measure Reporting Methodologies

The Department has emphasized inclusion of plan-reported measures that can be reported using only administrative data but will accept a hybrid reporting approach when appropriate as indicated in a measure's specifications.[8]

Electronic Clinical Data Systems Reporting

NCQA HEDIS is moving towards Electronic Clinical Data Systems (ECDS) reporting methodology, which gives health plans a method for collecting and reporting standard electronic clinical data for HEDIS quality measurement and improvement. Data systems that may be eligible for HEDIS ECDS reporting include, but are not limited to, member eligibility files, electronic health records (EHRs), clinical registries, health information exchanges (HIEs), administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.[9]

As NCQA HEDIS moves toward a fully digital state, they plan to phase out the hybrid method by MY2029. Some hybrid measures will revert to an administrative-only method, while others will transition to being ECDS measures (see more details on NCQA's proposed timeline below).

- MY2025
  - *Childhood Immunization Status (CIS), Immunizations for Adolescents (IMA) and Cervical Cancer Screening (CCS)*—Transitioned to ECDS
- MY2026
  - *Lead Screening in Children (LSC)*—Will be Administrative Only
- MY2027
  - *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)*—Will be Administrative Only
- MY2028
  - *Prenatal and Postpartum Care (PPC)*—Will be Administrative Only
  - *Controlling High Blood Pressure (CBP)*—Will transition to ECDS
  - *Blood Pressure Control for Patients with Diabetes (BPD)*—Will transition to ECDS

[7] Standard Plans and Tailored Plans will be required to secure NCQA accreditation. Standard Plans must be accredited by July 1, 2025.
[8] The hybrid reporting method involves the use of both administrative data (such as claims/encounter data) and medical record review.
[9] Learn more about ECDS reporting here.

Note of ECDS Transitions Impact on Quality Measure Target Setting:

Beginning in MY2025, NCQA retired administrative and hybrid reporting methods for Cervical Cancer Screening (CCS) and Immunizations for Adolescents (IMA) Combination 2, leaving only the Electronic Clinical Data Systems (ECDS) reporting methodology. For these measures, MY2025 and MY2026 Standard Plan performance will be calculated using ECDS data, while the MY2023 and MY2024 baseline were calculated based on administrative data. The Department does not anticipate any negative impact on the Standard Plan Withhold Program with this transition to ECDS, as it will only expand potential data sources for numerator compliance by incorporating administrative data along with additional electronic sources such as EHRs, HIEs and immunization registries. This approach was reviewed and approved by NCQA.

For MY2026, the Department is requiring that all plans adopt a hybrid reporting approach for Glycemic Status Assessment for Patients with Diabetes (GSD) (formerly Hemoglobin A1c (HbA1c) Control for Patients with Diabetes (HBD)) and Controlling High Blood Pressure (CBP). These measures were selected because certain elements, such as clinical data that are not always available in claims and encounters, are needed to provide complete and accurate data. However, the Department reserves the right to suspend hybrid reporting as necessary, such as in the case of a disaster or state of emergency. The Department encourages the health plans to develop consistent approaches to collecting clinical data that minimizes administrative burden for providers.

DHB & NC HIEA

The Department is working with the state's HIE, NC HealthConnex, to create a clinical data conduit for NC Medicaid Managed Care. The Department envisions Standard Plans and Tailored Plans will access clinical data needed for quality measurement via NC HealthConnex instead of collecting data directly from providers. This will significantly reduce providers' workload as they will only need to adhere to existing requirements to submit clinical data to NC HealthConnex, rather than reporting clinical data to multiple managed care plans and to the Department. NC HealthConnex data will be used to improve the Department's understanding of specific care needs, such as maternal care pathways, and to identify risk factors for poor maternal and birth outcomes, such as maternal mortality, low birth weight and infant mortality. Additionally, NC HealthConnex will serve as a central point for providers and plans to access beneficiaries' clinical records, particularly during transitions in care, to ensure that beneficiaries do not have interruptions in essential services.

The Department is currently working with NC HealthConnex to:

1. Evaluate and standardize the clinical data in the HIE to ensure it is complete and accurate enough to be used in quality measurement by conducting internal data assessments and by leveraging NCQA's Data Aggregator Validation program.
2. Expand the extract of clinical data elements utilized for quality measures. NC HealthConnex sends these priority data elements to the Department and plans monthly

to be used for population health monitoring, beneficiary outreach and production of HEDIS measures (once certified).

3. Foster a hub for exchanging essential population health data for care management including care plans, clinical assessments, patient risk lists, patient registries and patient attribution lists.
4. Develop the capacity to collect and exchange from and to providers health-related resource needs screening data.
5. Ensure that all NC Medicaid providers with the capacity to do so, including labs, registries and long-term care facilities, are submitting complete and accurate data to the HIE.
6. Develop the capacity to join beneficiary health information, such as clinical data submitted by providers, with NC Medicaid claims, encounters and enrollment data provided by the Department to produce Digital Quality Measures (dQMs). This aligns with CMS' goal of transitioning all quality measures used in reporting programs to dQMs.[10] Transitioning to dQMs will allow measure performance and gaps in care to be exchanged with providers, plans and the Department in real time, thereby reducing the burden associated with manual reporting. dQMs can be used to close gaps in care and improve performance by providing patient-specific information at the point of care. The initial focus of this strategy will be on the following measures:
    - Controlling High Blood Pressure (CBP)
    - Glycemic Status Assessment for Patients with Diabetes (GSD)
    - Screening for Depression and Follow-Up Plan (CDF)

Quality Measure Sets & Reporting

The Standard Plan and Tailored Plan measure sets are aligned with North Carolina's Quality Aims, Goals and Objectives. Measures in these sets can be used for performance improvement projects and value-based arrangements. For example, the Standard Plan Withhold Program holds Standard Plans financially accountable for their performance on a set of priority performance measures from within the Standard Plan measure set (see Section V (D) for more information on the Withhold Program).

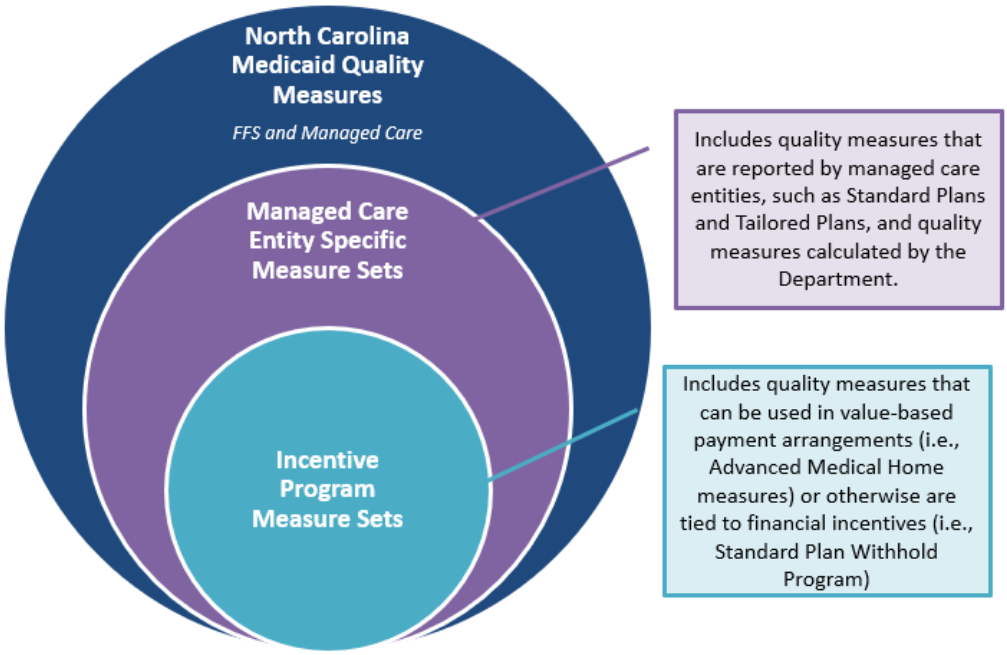
Each year, the Department will seek feedback from the health plans on which measures, if any, they would like to add, modify or retire from their measure sets. The sets will also be updated to align with any changes made to the measure's technical specifications by the measure steward.

The Department has established a list of measures that the Standard Plans and Tailored Plans must use as the basis for performance incentive payments to AMH practices. In the future, AMH+s and CMAs serving Tailored Plan members may also receive incentive payments for improvement against a limited set of measures.

[10] More information on CMS's Digital Quality Measurement Strategic Roadmap is available here.

Standard Plans and Tailored Plans are expected to draw from their respective reporting measures for any PIPs and non-AMH value-based contracting arrangements.

Figure 3: Quality and Administrative Measure Reporting Framework



The Department considers alignment with nationally recognized measure sets such as CMS' Universal Foundation Measure Set,[11] the Medicaid Child and Adult Core Sets[12] and the State Transformation Collaborative priority measures[13] when selecting measures for incentive program measure sets. In addition, the Department promotes alignment within measure sets used for NC Medicaid quality measurement efforts where appropriate and feasible, recognizing that different measure sets must address the different needs, characteristics and challenges specific to each plan's member population.

The Department aims to include any revisions or additions to the AMH measure set in this document at least six months prior to the calendar year for which qualifying services will be delivered. For example, if a measure were included in this document in June 2026, the effective date would be the claims-year running from January 2027 through December 2027.

For non-AMH measures and non-Withhold Program measures, announcement of a measure could be effective immediately. The Department does not plan to announce non-standard measures for immediate reporting unless unusual or extreme circumstances warrant immediate implementation (e.g., in the event of a new public health emergency requiring rapid adjustment of care delivery priorities). The Department will engage plans before implementing a measure

[11] More information on CMS' Universal Foundation Measure Set can be found here.
[12] More information on the Medicaid Child and Adult Core Sets can be found here.
[13] More information on the State Transformation Collaborative measures can be found here.

that would require additional development and will ensure all plan feedback is considered before the new measure is announced and an initial measurement year is determined.

The following subsections outline quality measures of particular interest to stakeholders, including measures that are unique to North Carolina, measures that have changed based on public and stakeholder feedback and select measures that Standard Plans and Tailored Plans will be required to report.

Modified Measures

The Department seeks to understand how babies are faring under the transition to managed care and to monitor plans' efforts to decrease rates of low birth weight in their assigned populations.

The UNC Sheps Center for Health Services Research modified an existing quality measure to account for health plans' role in addressing low birth weight rates. The Live Births Weighing Less than 2,500 Grams measure (Consensus Based Entity (CBE) #1382) is a widely used metric that assesses rates of low and very low birth weight at the geographic level, such as a county or state.[14,15] The Department selected this measure because low birth weight is an important cause of morbidity for North Carolina children. In 2023, North Carolina ranked 41st for its rate of low-birth-weight babies (9.4%), reflecting the unacceptably high rate of low birth weight in the state.[16,17] These high rates, in turn, are associated with higher rates of poor health outcomes and higher health care spending.[18] While the common quality measures of low birth weight are assessed at the state level, the Department modified this measure to assess at the plan- and member-level to better monitor and support plan efforts in this area.

This modified measure assesses rates of low birth weight (<2,500 grams) and very low birth weight (<1,500 grams) at the member- and plan-level, considering only singleton, live birth deliveries because multiple gestations are more likely to have low birth weight for reasons unrelated to health care delivery.[19] The measure also excludes babies born weighing less than 300 grams (to exclude births that are pre-viable but may be classified as live births) or with an unknown birthweight. For plan-level assessment, this measure only considers deliveries where

[14] An alternative measure of low birth weight rate, CBE #0278 (Prevention Quality Indicator (PQI) #9), measures a similar concept, but uses claims data to identify cases of low birth weight. The Department has elected to use CBE #1382 because it uses vital statistics data. In future years, the Department intends to compare the accuracy of claims data against birth certificate data in identifying low birth weight and may transition to a claims-based measure.

[15] To modify the Percentage of Low Birth Weight Births measure so that it can be used to measure plan accountability, the Department convened a short-term workgroup comprising physicians, researchers, epidemiologists and state staff. Because the Department sought to modify an existing measure rather than develop an entirely new measure, the Department used a limited adaptation of the CMS Measures Management System (MMS) Blueprint process involving a series of structured expert workgroups to address key issues, with a particular focus on ensuring the eventual measure retained face validity and did not put beneficiaries at risk.

[16] Centers for Disease Control, Percentage of Babies Born Low Birth Weight by State: North Carolina, 2022. Available here.

[17] Lower rates indicate better performance on the Live Births Weighing Less than 2,500 Grams measure.

[18] March of Dimes, Low Birthweight. Available here.

[19] Kalikkot Thekkeveedu, R., Dankhara, N., Desai, J. *et al.* Outcomes of multiple gestation births compared to singleton: analysis of multicenter KID database. *matern health, neonatol and perinatol* 7, 15 (2021). https://doi.org/10.1186/s40748-021-00135-5

the mother has had continuous coverage with the same health plan from 16 weeks gestation or earlier, to ensure that plans and providers have opportunities to intervene where possible (see Appendix C for further information).

While the measure focuses on members who are already pregnant, the Department believes that an effective approach to reducing low birth weight risk involves interventions prior to conception and encourages Standard Plans and Tailored Plans to consider addressing health risks that contribute to low birth weight for members who expect to become pregnant.

Measures of Utilization

The Department has added measures of utilization to the quality measure sets to assess the degree to which plans' care management and related efforts are able to reduce avoidable acute care utilization. The Department will calculate results for the following measures and share results with plans:

- Hospital readmissions (measured using CBE #1768*,* Plan All-Cause Readmissions): The Plan All-Cause Readmissions (PCR) measure in the Medicaid Adult and Health Home Core Sets assesses the percentage of acute inpatient hospital discharges resulting in an unplanned hospital readmission within 30 days. The Department calculates the observed versus expected ratio for this measure, which is the ratio of the actual (observed) count of readmissions in relation to the risk-adjusted (expected) count of readmissions. The count of expected readmissions is a prediction of the state's performance based on its demographic and clinical case mix in the NC Medicaid Managed Care population. It is typically calculated by classifying the state's case mix and applying risk weights to each eligible hospital stay.

- Total Cost of Care: The Department previously produced a TCOC dashboard in partnership with HealthPartners. The interactive dashboard was used by plans and providers to analyze TCOC data for enrolled members and detect causes of overutilization.[20] The dashboard allowed plans and providers to stratify TCOC data by aid category (e.g., Aged, Blind and Disabled, Temporary Assistance for Needy Families), NC Integrated Care for Kids (InCK) participation age, race, ethnicity, geography, Standard Plan region and health conditions to gain a deeper understanding of utilization patterns. This dashboard was decommissioned September 2025 due to funding shortages. Although TCOC has been removed from the quality measure sets, plans must continue quarterly cost of care reporting through the Financial Reporting Template for fiscal monitoring purposes only. These data will not be scored for quality performance.

- PDI/PQIs: PQIs use data from hospital discharges to identify admissions that might have been avoided through access to high-quality outpatient care. Similarly, The Pediatric Quality Indicators (PDIs) focus on potentially preventable complications for pediatric

[20]More information on the HealthPartners measures can be found here and here.

patients treated in hospitals and on preventable hospitalizations among pediatric patients.

Standard Plans and Tailored Plans may elect to calculate additional measures of avoidable utilization as part of their internal processes at any time with the provision that these measures should not be used to adjudicate the appropriateness of specific emergency department visits and hospital admissions, as they are not validated for this purpose, nor used in any PIP.

Select Homegrown Measures

Rate of Screening for Health-Related Resource Needs (HRRN)

This measure assesses whether health plans are screening all members to determine if they have needs in the areas of housing/utilities, safety from interpersonal violence, transportation and food insecurity. The HRRN measure assesses total number of unique members with a successful social determinants of health (SDOH) screening in the calendar year.[21] The denominator includes all NC Medicaid Managed Care members in a health plan's enrolled population in the calendar year. The measure will track SDOH screenings completed between January 1 and December 31 of the measurement year. Plans are required to use the NCDHHS Standardized SDOH screening questions.[22]

To report on this measure, Standard Plans and Tailored Plans will report all relevant data for their eligible population in their quarterly BCM026 operational report. This report will capture the dates that screenings are completed to calculate the number of successful screenings completed in the calendar year. (See Appendix E for additional information required to calculate this measure.)

Rate of Screening for Pregnancy Risk

This measure captures the degree to which beneficiaries are receiving pregnancy risk screenings in a timely manner. These risk assessments help to predict an individual's likelihood of experiencing adverse health events, enabling providers to administer risk-appropriate perinatal care. Upon completion, the standardized pregnancy risk screening forms are submitted to the Care Management for High-Risk Pregnancies (CMHRP) staff at the local health department in the member's county of residence. The Department works with Community Care of North Carolina (CCNC) to collect this information on a quarterly basis. Data is used for internal monitoring of NC Medicaid's pregnant population and calculation of the Rate of Screening for Pregnancy Risk measure.

For plan-level reporting, the measure denominator includes all members that were pregnant during the measurement year in a plan's enrolled population. The numerator is all members for

[21] HRRN measure assesses successful screenings completed in the calendar year and is not aligned with the contract requirement of 90 days within enrollment or re-enrollment. This is due to difficulties with identifying accurate enrollment and re-enrollment dates within the current data set.
[22] Screening questions are available here.

whom the plan's contracted providers (including obstetricians, local health departments or other designated providers) administer the standardized pregnancy risk screening and submit the completed form to the appropriate care management entity (e.g., the local health department). (See Appendix E for additional information required to calculate this measure.) The Department is actively working to calculate this measure. Once available, the Department will report this measure with appropriate guidance for interpreting results reflecting small population sizes.

Select Survey-based Measures

Provider Survey: The Department, in partnership with a third party, distributes an annual survey to unique provider organizations that care for NC Medicaid patients to assess their experience with each plan. The survey focuses on primary care, obstetrical/gynecological care and behavioral health care providers.

Patient-reported Outcomes Measures: The Department uses tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult and Child surveys, Home and Community Based Services (HCBS) CAHPS Survey, Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey, North Carolina Treatment Outcomes & Program Performance System (NC-TOPPS), National Core Indicators (NCI) I/DD Surveys and NCI Aging and Disabilities (AD) Surveys and other surveys to assess beneficiaries' experience in receiving care.

The Department will focus on evaluating CAHPS survey responses related to:

- Beneficiaries' ability to obtain needed care
- Beneficiaries' ability to get care quickly
- Coordination of care
- How well doctors communicate
- Health Plan Customer service
- Beneficiaries' rating of their health plan
- Beneficiaries' rating of their personal doctor
- Beneficiaries' rating of the specialist they see most frequently
- Beneficiaries' rating of all health care
- Medical assistance with smoking and tobacco use cessation (adult population only)

The Department may include up to 10 supplemental items in both the adult and child CAHPS survey annually. CAHPS reporting requirements may change to reflect changes in the way NCQA

constructs and analyzes the CAHPS survey, for example, by retiring certain survey elements. Reporting requirements may change to capture results for historically marginalized subpopulations.

The 2024 NC Medicaid CAHPS Survey Report can be viewed here: https://medicaid.ncdhhs.gov/2024-cahps-survey-three-years-managed-care-full-report/download?attachment

Public Health Measures

The Department envisions Standard Plans and Tailored Plans serving as active partners in meeting Healthy North Carolina 2030 goals. [23] To advance this vision, the Department will review a select set of public health population-level outcome measures expected to be affected by the activities of Standard Plans and Tailored Plans. These measures are meant to assess the association between plan-level efforts around Healthy North Carolina 2030 priorities and health improvements at the population level.

The Department will track select survey-based public health measures at the NC Medicaid population level and will review progress against related plan performance on quality measures. The Department may reach out to plans to discuss performance improvement opportunities related to these select public health measures.

For MY2026, the Department has selected the following survey items from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) Survey for the NC Medicaid Population. These measures were selected to align with the Healthy North Carolina 2030 goals. NC Medicaid will review the following rates to track performance over time:

- Percentage of adults who are current smokers
- Percentage of adults who use multiple tobacco products
- Percentage of adults with any leisure time physical activity or exercise in the past 30 days
- Percentage of adults with diabetes
- Percentage of adults with depression
- Percentage of adults who ranked their general health as excellent/very good/good and fair/poor

[23] More information about Healthy North Carolina 2030 can be found here.

Integrated Care for Kids (InCK) Initiative

The NC InCK model is a child-centered local service delivery and state payment model in Alamance, Orange, Durham, Granville and Vance counties. The program is supported by funding from CMS and aims to reduce expenditures and improve the quality of care for children through age 21 covered by NC Medicaid through prevention, early identification and treatment of behavioral and physical health needs. The NC InCK Model is designed to build and support the infrastructure needed to integrate health and human services for NC Medicaid beneficiaries, from birth through age 20, and covers approximately 95,000 children across the five-county model service area. Children identified through NC InCK as likely to benefit from additional care management support are offered enhanced care management from Care Managers. Care Managers are often existing staff members at health plans, AMHs or CCNC. Care Managers work with participating practices to integrate care and care management across physical health, behavioral health and 10 core child service areas to help meet health, education and social needs of children and families.

NC InCK has a seven-year model period, which includes a two-year planning period that began in January 2020 and ended in December 2021 and a five-year implementation period that began in January 2022 and runs through December 2026. To support its goal of aligning provider payments with meaningful measures of child well-being, NC InCK includes an alternative payment model (APM). The NC InCK APM is a four-year targeted incentive program that began in January 2023 and runs through December 2026.

The NC InCK APM includes both standard health care measures (e.g., proportion of children receiving well-child checks) and novel cross-sector well-being measures (e.g., kindergarten readiness, food insecurity, housing instability). In calendar year 2026, only two measures, indicated in the table below, will be linked to incentive payments. More information on these measures can be found in the NC InCK Performance Measure Technical Specifications Manual.[24]

Table 1: InCK Quality Measures

CBE#	CMIT	Measure Name	Steward	Frequency
N/A	N/A	Ambulatory Care: ED visits (AMB-CH)	NCQA	Annually
N/A	N/A	Food Insecurity Rate**	NC InCK	Annually
N/A	N/A	Housing Instability Rate**	NC InCK	Annually
N/A	N/A	Kindergarten Readiness Rate**	NC Department of Public Instruction	Annually

[24] The full quality measure specifications for the InCK program are available here.

CBE#	CMIT	Measure Name	Steward	Frequency
N/A	N/A	Primary Care Kindergarten Readiness Bundle+	NC InCK	Annually
0418/0418e	672	Screening for Clinical Depression and Follow-Up Plan (CDF)	CMS*	Annually
N/A	N/A	Food Insecurity and Housing Instability Screening+	NC InCK	Annually
N/A	N/A	Shared Action Plan for Children in SIL-2 and SIL-3	NC InCK	Annually
N/A	N/A	Total Cost of Care (TCOC)**	Health Partners	Annually
1392	761	Well-Child Visits in the First 30 Months of Life (Disparity Measure) (W30) [25]	NCQA	Annually

**Please note that NC InCK's approach will differ from the CMS Child Core Set Measure in that Health Information Exchange data will be used in combination with claims and encounters.*
***These measures are shared with providers for awareness only and are not linked to an incentive payment.*
+These measures will be linked to incentive payments in performance year 2026. Other measures may be provided for awareness only.

IV. Required Reporting Activities for Standard Plans and Tailored Plans

Standard Plans and Tailored Plans are required to report on select quality measures as part of their contractual obligations under NC Medicaid Managed Care, including annual and gap reporting described below (see Appendix A, Table 1). These reports are intended to support a wide range of activities including ongoing Department quality monitoring and state submission of quality measure sets to CMS. The Department will combine data and narrative reports submitted by Standard Plans and Tailored Plans in addition to internal Department-calculated data to develop and release public-facing reports.

Quality measure reporting began with the launch of NC Medicaid Managed Care. Quality measures are typically measured on a calendar year (January–December), while the Department will contract with Standard Plans and Tailored Plans on a contract year (July–June).

At the end of each contract year (June), health plans submit quality performance data for the previous calendar year (Example: Plans submitted their QAV007 quality report in June 2025, which covered measurement year 2024).

[25] The InCK program uses the W30 sub-measure (first 15 months) as a disparity measure, and only collects the second sub-measure (15–30 months) for awareness.

- Standard Plans' first QAV007 reporting year is MY2022
- Tailored Plans' first QAV007 reporting year is MY2025
- Children and Families Specialty Plan's (CFSP) first QAV007 reporting year is MY2026

When reporting quality measure performance, health plans should exclude members with dual commercial and Medicaid enrollment.

The remainder of this section discusses timing and types of required reporting.

Gap Reporting Requirements for AMH, AMH+s and CMAs

Standard Plans and Tailored Plans are expected to provide gap reports to AMHs and AMH+/CMAs that cover, at least, the measures included in any VBP arrangements the plan has with the respective provider. Because gap reports may contain protected health information, Standard Plans and Tailored Plans are expected to identify secure modes of transmission and to notify the Department immediately in the event of a privacy breach. The Department is working with plans to increase usability of gap reports and may request data or other participation.

North Carolina's 834 file provides enrollment period end dates that represent the end of the period for which the respective member's Medicaid eligibility has been certified. These dates are almost always updated, but counties have until the last day of the month to determine eligibility. HEDIS engines developed based on 834s from other markets read North Carolina's nearer-term end dates as termination dates and remove the members from interim care gap reports that are sent to providers. To promote consistency in interim care gap reporting, the Department requires plans to use the following approach to prevent the exclusion of members from care gap reports for projected gaps in enrollment that are avoided due to subsequent renewal of eligibility:

1. On a monthly basis (February–October) create a pseudo copy of the monthly enrollment file, ensuring the naming convention of the file reflects "Pseudo" to differentiate between the altered and non-altered file.
    a. On a monthly basis (February–October), pull a fully updated enrollment file from the system with the latest enrollment segment.
    b. On a monthly basis (February–October) apply the following logic:
        i. Find each unique member with a max term date.
        ii. Set the max term date to a high date (e.g., 12/31/9999) if a term date is in the measurement year and is greater than the current month. [26]

[26] Members' term dates are sometimes extended retroactively. To account for this, plans can allow for a runout period of up to 65 days before reverting to the unaltered term date. For example, if Step 1.b.ii above were altered to include a 65-day runout period, it would read "*Set the max term date to a high date (e.g., 12/31/9999) if a term date is in the measurement year and is greater than the current month minus 65 days.*" Including a runout period will reduce the likelihood that members whose term dates are extended retroactively are dropped from gap reports in the intervening period.

2. Load the Pseudo Enrollment File into a separate HEDIS engine prospective environment (project) to ensure the Pseudo Enrollment File does not impact the annual HEDIS and PMV reporting in alignment with HEDIS specifications. [27]
3. Transition from the Pseudo Enrollment File to the originating member enrollment file to allow for annual/full year measurement.

	Prospective	Annual
Jan.		x
Feb.	X	x
March	X	x
April	X	x
May	X	x
June	X	x
July	X	
Aug.	X	
Sept.	X	
Oct.	X	
Nov.	X	
Dec.		x

Implementing this workaround will make interim care gap reports more complete. However:

- Some members listed may not be impactable.
- Some members listed may not end up in the annual measure.
- Interim care gap reports should not be leveraged for population-level analyses (i.e., the data should not be aggregated to develop a rate for comparison against benchmarks.)

In addition to the approach outlined above, the Department encourages plans to employ additional analyses (e.g., modified continuous enrollment, rolling year, year to date) to understand which of their members have impactable gaps in care and to share their findings with providers strategically to close those gaps. For its part, the Department will work with plans, providers and other partners to develop more accurate systems that identify gaps in members' care closer to real time and deliver that information to providers at the point of care. More information on the Department's strategy to leverage NC HealthConnex for quality measurement and care gap reporting is described above.

[27] During the February–June timeframe, maintain two environments—annual and prospective projects—running concurrently. The Pseudo Enrollment File is to be loaded into the prospective environment only to ensure there is no impact to the annual environment. In November, maintain the prospective environment and in December, maintain the annual environment. Compare November results with December results to make sure December results are as expected.

Stratified Reporting Requirements

The Department aims to promote equitable health outcomes for NC Medicaid enrollees. In cases where Standard Plans and Tailored Plans are expected to analyze and act upon population-level results that are stratified, where applicable, they will use the stratified reporting details indicated in each measure's technical specification.

HEDIS measures meet rigorous development and evaluation criteria. As such, entities using HEDIS measures may not alter, enhance or otherwise modify HEDIS measures and specifications in ways that are not consistent with the HEDIS Rules for Allowable Adjustment. Entities seeking to modify HEDIS measure specifications should consult the Rules for Allowable Adjustment to determine whether these modifications are permissible.

For measures lacking stratification details, Standard Plans and Tailored Plans should use the distinctions outlined in Table 2. Consistent with the Rules for Allowable Adjustment, Standard Plans and Tailored Plans should only use Department-defined measure stratifications shown in Table 2 if a measure's specification does not include stratification or the measure's specification does not explicitly prohibit use of additional stratifications.

For plan-reported measures the plan should align with the stratifications designated in each measure's specification, in addition to the stratification listed in Table 2. Additionally, the Department added a table to the Technical Specifications Crosswalk to map NC Tracks 834-I race and ethnicity stratified reporting elements to the NCQA HEDIS reporting requirements. If a measure specification includes stratifications for some elements listed in the Department-defined stratification (e.g., race) shown in Table 2, but lacks stratification for others, the plan should report according to the Department-defined stratification.

In alignment with CMS' small cell suppression policy, the Department will not report any cell containing a value between 1 and 10. A value of zero does not violate the small cell policy. In addition, the Department will not report cells that allow a value of 1 to 10 to be derived from other reported cells or information.[28] The Department will consider the effects of small sample size in its evaluation of Standard Plans' and Tailored Plans' stratified performance rates.

When strata elements are not available, they will be categorized as "asked but not answered." More detailed information about mapping stratification elements for quality measurement can be found in the Department's Technical Specifications Strata Crosswalk document.

Table 2. Stratified Reporting Elements

Stratification Element	Strata (In cases where measure technical specifications differ from these strata, plans should report both)	Source
Age	Age stratifications are applied when described by the measure's specifications. If specific age	NCDHHS enrollment data

[28] More information about CMS's Cell Suppression Policy can be found here.

Stratification Element	Strata (In cases where measure technical specifications differ from these strata, plans should report both)	Source
	strata are not specified by the measure's specs, then age strata can be applied on an as-needed basis.	
Race	Black, White, American Indian/Alaskan Native, Asian, Hawaiian/Pacific Islander, Multiracial, Other In addition to comparing individual groups, the Department will separately calculate the following strata: Black or African American, Non-Black or African American American Indian/Alaskan Native, Non-American Indian/Alaskan Native	NCDHHS enrollment data (self-reported where possible)
Ethnicity	Hispanic/Latino, Non-Hispanic/Latino	NCDHHS enrollment data (self-reported where possible)
Gender	Male, Female[29]	NCDHHS enrollment data (self-reported where possible)
Primary Language	English, Spanish, Other	NCDHHS enrollment data (self-reported where possible)
LTSS Needs Status[30]	Methodology is still in the works[31]	
Disability Status	Disability, No Disability	NCDHHS enrollment data
Transitions to Community Living (TCL)[32]	Housed or planning for transition to TCL supportive housing, Receiving In-Reach or referred for Diversion, Housed in the Community without a TCL Housing Slot, All Other Adults (>17 years old)	NCDHHS and Tailored Plan program data; Transitions to Community Living Database (TCLD)

[29] At this time, only Male and Female values are allowable, but the Department intends to add a Third Gender (Other) value option for future reporting years.
[30] The Department's previous methodology for LTSS Needs Status identified individuals that are eligible for LTSS services, not individuals receiving LTSS services.
[31] DHB is working to develop a standardized methodology to identify beneficiaries who utilize long-term services and supports (LTSS)
[32] The TCL strata will only be applied to Behavioral Health I/DD Tailored Plan measures (Please refer to Appendix A, Tables 3 and 4).

Stratification Element	Strata (In cases where measure technical specifications differ from these strata, plans should report both)	Source
Geography[33]	Rural, Urban, Other	NCDHHS enrollment data
Service Region[34]	Standard Plans: 1–6	NCDHHS enrollment data

V. Assessing Performance

The Department assesses quality measure performance in several ways. This section details how Standard Plans and Tailored Plans will be held accountable, as well as the measures that plans will be able to deploy to reward providers for high-quality outcomes. It also describes the Department's public reporting process, which supports statewide engagement (including with plans) around population health goals.

A. How the Department will Assess Standard Plans and Tailored Plans Performance on Quality Measures

Standard Plans and Tailored Plans will be given historical rates, calculated by the Department, for all measures where comparable historical data are available at the state level. The Department will also calculate performance benchmarks, representing improved performance levels, for all measures. These performance benchmarks are meant to support plans' quality improvement efforts. Over time, performance benchmarks are meant to help the Department identify high-performing Standard Plans and Tailored Plans.

Beginning in Contract Year 1 for Standard Plans and Tailored Plans, respectively, the Department has monitored progress toward meeting performance benchmarks each year. The Department expects to see annual progress toward meeting measure performance benchmarks. Measure performance improvement will serve as the focus of Standard Plans and Tailored Plans QAPI programs and PIPs.

The Department has adopted a two-decimal place policy for rounding and reporting quality measure rates.

B. Benchmarking Approach

Performance benchmarks are used to drive plan and Department conversations around quality and performance and serve as the basis for the targets set in the Standard Plan Withhold Program.

[33] Geography is based on a member's residential county (as reported in the 834 member file) and the National Center for Health Statistics (NCHS) Urban-Rural Classification Scheme for Counties. More information about the classification scheme can be found here.

[34] Service region is determined based on a member's administrative county as reported in the 834 member file.

For measurement years 2023 through 2025 targets, the Department used a 105% relative improvement benchmarking approach. For this benchmarking approach, the Department set a benchmark for each measure (except for measures related to contraceptive care) of 105% of the prior year line-of-business overall performance for the measure (or 95% for measures for which a lower rate indicates better performance).[35] Please see MY2024 NC Medicaid Managed Care Quality Measurement Technical Specifications, or other archived versions, of the technical specifications for more details on this benchmarking approach.

Beginning with MY2026 targets, the Department will use an updated benchmarking approach referred to as "gap-to-goal" to set performance benchmarks for quality measures (see figure 4). Benchmarks will be set based on a 10% gap reduction between baseline performance and an external benchmark. For example, MY2026 targets would be set by looking at the gap between MY2024 baseline performance and the selected MY2024 national goal. The Department will consider implementing an alternate methodology to set targets for a measure that has experienced persistent national declines, called "beat the trend." In this methodology, plan targets are set based on outperforming the national benchmark's relative change (more details below).

Figure 4: Timeline for Benchmarking Methodology Transition

<table>
<tr><th></th><th>MY2023</th><th>MY2024</th><th>MY2025</th><th>MY2026 Onwards</th></tr>
<tr><td>Targets</td><td colspan="3">105% Relative Improvement</td><td>Gap-To-Goal</td></tr>
<tr><td>Baseline</td><td>105% Relative Improvement</td><td colspan="3">Gap-To-Goal</td></tr>
</table>

The gap-to-goal benchmarking methodology is as follows:

- *Goals*: The Department will set goals for each measure[36] using aggregate line of business performance; all plans for a particular Line of Business (e.g., Standard Plans, Tailored Plans) will have the same goal[37] for a given measure.
    - The NCQA Quality Compass National 50th percentile will serve as the goal for measures where baseline plan aggregate performance is below the 50th percentile.

[35] Prior year performance refers to the most recent year for which six months' claims runout can be accounted for and measure production can be completed.
[36] For measures of contraceptive care, the Department will not apply an external performance benchmark, reflecting the preference-sensitive nature of contraceptive care. The Department will, however, monitor measure results to assess where barriers to contraceptive care may exist.
[37] Goals used to set targets for NCQA HEDIS measures are based on NCQA Quality Compass national Medicaid HMO percentiles (50th and 90th percentiles) for the same year as the Standard Plan baseline performance (2024 Quality Compass data will be used to set 2026 goals).

- The NCQA Quality Compass National 90th percentile will serve as the goal for measures where baseline plan aggregate performance is at or above the 50th percentile.

- The Department wants to encourage continued improvement even for measures whose performance is above the 90th percentile. In these scenarios, the Department will set targets using 1% relative improvement.

- *Percentiles:* The Department will use the NCQA Quality Compass' national percentiles as goals for this methodology. There are two different national percentiles the Department will use based on the plan type.

- For any managed care line of business (e.g., Standard Plans), the Department will use the percentiles for the *National Medicaid HMOs.*

- For any other line of business (e.g., Total NC Medicaid or NC Medicaid Direct) the Department will use the percentiles for the *National All Lines of Business.*

- For measures without a HEDIS benchmark, the Department will consider other external benchmarks or develop a custom benchmark. [38]

- *Targets*: Plan targets will be set based on individual plan performance and will be calculated using a 10% gap reduction between the plan's baseline performance and the goal.[39] The following formula is used to calculate improvement targets:

    - Target = Baseline + [(goal - baseline) * 0.10]

- *Improvement Corridors*: Targets will have a floor and a ceiling to adjust for cases when gap-to-goal targets result in either very small or very large improvement levels for some plans. The minimum relative improvement required is 2% and will only apply to measures with the 50th percentile goal. The maximum relative improvement required is 10%. The following steps can be used to determine whether improvement corridors will be applied to plan targets for specific measures and to calculate plan targets in these cases.

    - *Step 1.* Calculate whether the measure's gap-to-goal improvement target is below 2% relative improvement (only for measures with 50th percentile goals) or above 10% relative improvement to determine whether improvement corridor adjustments are required. This can be done using the following formula:

[38] Measures that are non-HEDIS but are part of a CMS Core Set will use the 50th / 90th percentiles reported via the CMS Core Set Data Dashboard.

[39] Baselines will continue to be the latest calendar year for which complete data is available (e.g., MY2024 will be the baseline for MY2026).

        - % Relative improvement = [(Gap-to-goal target – baseline) / baseline] * 100
    - *Step 2.* Calculate adjusted targets for measures when plan gap-to-goal targets are below 2% relative improvement (only for measures with 50th percentile goals) or above 10% relative improvement.
        - Formulas to calculate targets with minimum improvement adjustments
            - When higher rates indicate better performance: baseline * 1.02
            - When lower rates indicate better performance: baseline * 0.98
        - Formulas to calculate targets with maximum improvement adjustments
            - When higher rates indicate better performance: baseline * 1.10
            - When lower rates indicate better performance: baseline * 0.90
- A detailed example demonstrating improvement target calculations under the new gap-to-goal benchmarking methodology is included in Appendix B of this document.

Timelines Across Managed Care Plans
The new gap-to-goal benchmarking methodology will be used to set Standard Plan Aggregate and plan-level targets, along with PIHP, NC Medicaid Direct and total NC Medicaid targets, starting with MY2026 targets and using MY2024 as the baseline.

The new gap-to-goal benchmarking methodology will also be applied to Tailored Plan targets to ensure an aligned approach to quality measurement across the Department's managed care delivery systems. The new methodology will be used to set Tailored Plan Aggregate targets starting in MY2026 and using MY2024 as the baseline. This data will be caveated with the fact that Tailored Plans launched July 2024. Individual Tailored Plan-level targets will be set using the new methodology starting with MY2027 targets, once the first full year of Tailored Plan performance data (MY2025) is available.

Target Adjustments for Measures with Declining National Performance

The Department will consider implementing an alternate "beat the trend" methodology to set targets for specific measures when a measure has experienced national decline. If national performance (national median) on a measure has declined by at least 1% over two consecutive measurement periods, the Department will consider applying a beat the trend methodology for the measure. However, the Department will also review internal quantitative and qualitative performance data and consider local drivers of declining trends prior to designating a "beat the trend" methodology for any measure.

Under the “beat the trend” methodology, plan targets are set based on outperforming the national benchmark’s relative change during the current measurement year by a specified margin. For example, if a measure’s national benchmark has a 10% relative decrease between MY2026 and MY2027, plans must achieve a relative change from MY2026 to MY2027 that is favorable to a 10% relative decrease by a specified margin. This margin will be set based on an analysis of national and state data, including comparison of North Carolina’s trends to national trends in prior years, as well as consideration of trends in other states or for similar measures.

The Department will consider switching measures using the "beat the trend" methodology back to "gap-to-goal" after seeing any level of improvement in the national median over two years.

The Department will share any measures subject to a “beat the trend” methodology with details on parameters for outperforming national trends in annual January updates of this document for the measurement year in which it applies (e.g., if the “beat the trend” designation is shared in the MY2026 technical specifications it would apply to the MY2026 targets for that measure). Withhold Program measures subject to a “beat the trend” approach will be shared in the updated Standard Plan Withhold Program Guidance document prior to the start of each performance period. [40]

C. Promoting Equity in Care and Outcomes

The Department expects Standard Plans and Tailored Plans to ensure improvements in quality are equitably distributed across all populations. In support of this goal, the Department requires Standard Plans and Tailored Plans to participate in activities promoting health equity and can leverage withholds to hold them financially accountable for ensuring improvements in the population of interest’s performance for select measures.

The Department develops a Health Disparities Report that tracks health disparities across a large set of quality measures for the entire NC Medicaid population. The Department uses this report to guide the development of subpopulation specific quality improvement strategies. The report will ensure the systematic identification of disparities in the NC Medicaid program, allowing the Department to strategize around programs and policies that incentivize the reduction of health disparities and improvement of priority population quality performance.

Identification of Disparities

The Department identifies select measures with significant disparities, defined as an equal to or greater than 10% relative difference in performance between the group of interest and the reference group.[41]

[40] For example, the 2025 North Carolina Standard Plan Withhold Program Guidance (pages 13-14) sets targets for the Combo 10 measure using a beat the trend approach.

[41] When analyzing quality measurement data for health disparities the Department most commonly stratifies by Black and African American binary, American Indian and Alaskan Native binary and Hispanic/Latin binary. See Table 2 for more information.

- For quality measures where a higher rate indicates better performance, a disparity exists when: ((Reference Group Performance % – Group of Interest Performance %) ÷ Reference Group Performance %) is greater than or equal to 10%.

- For quality measures where a lower rate indicates better performance, the inverse equation is used and a disparity exists when: ((Group of Interest Performance % - Reference Group Performance %) ÷ Reference Group Performance %) is greater than or equal to 10%.

- For CAHPS measures, disparities based on race are identified by performing statistical tests of significance. Stratifications are based on self-reported responses to race questions within the CAHPS survey instrument. Race categories of interest are first compared to the aggregate of all other categories. Specifically, Black respondents are compared to non-Black respondents, multi-racial respondents are compared to non-multi-racial respondents, Native American respondents are compared to non-Native American respondents, other respondents are compared to non-other respondents and White respondents are compared to non-White respondents. For this analysis, the other category includes Asian, Native Hawaiian or other Pacific Islander, and Other. If there are sufficient data, the race categories that comprise the Other category will be broken out and reported as their own category at the aggregate level. Then, to determine significance, a global F test and a t-test are performed and tested against a p-value of 0.05.

- For CAHPS measures, disparities based on ethnicity are identified by performing statistical tests of significance. Stratifications are based on self-reported responses to ethnicity questions within the CAHPS survey instrument. Ethnicity categories of Hispanic and Non-Hispanic are compared to each other. Then, to determine significance, a global F test and a t-test are performed and tested against a p-value of 0.05.

Benchmarking Approach

Starting with MY2026 targets, the Department will apply the gap-to-goal benchmarking approach described above in Section V(B) to set priority population performance targets.[42] When a disparity, as defined above, is identified, targets for the group of interest will be set as follows:

- *Goal*s: Goals for the group of interest will be the same as overall population goals under the gap-to-goal benchmarking methodology described above in Section V(B).

- *Targets* = Group of interest baseline + [(goal – group of interest baseline) * 0.10]

[42] MY2025 priority population targets were set using the old benchmarking methodology of 110% relative improvement over the priority population 's own performance from two years earlier.

- *Improvement Corridors:* Improvement targets for the group of interest will be subject to the same improvement corridors as the overall population under the gap-to-goal benchmarking methodology described in Section V(B). To determine the necessity of improvement corridor adjustments and calculate adjusted targets, the same steps described in Section V(B) for overall population targets are followed for the group of interest.

D. Withhold Program

Withhold programs are a tool used by many state Medicaid agencies to encourage Managed Care plans to improve performance on select quality measures. Under NC Medicaid's Standard Plan Withhold Program, a portion of each plan's capitation rate is withheld and paid when the plan meets reasonably achievable performance targets on priority measures set by the Department.

The first measurement year for the Standard Plan Withhold Program was 2024. Measures used in the withhold program each year are listed in Table 3. A withhold program is only in place for Standard Plans at this time. The Department may utilize withholds for other prepaid health plans in the future.

The Standard Plan Withhold Program for 2026 uses the following metrics:

- Cervical Cancer Screening (CCS)
- Immunizations for Adolescents (IMA) Combination 2
  - Rate One: Overall population rate
  - Rate Two: Black/African American priority population rate
- Prenatal and Postpartum Care (PPC)
  - Sub-Measure: Timeliness of Prenatal Care
  - Sub-Measure: Postpartum Care
- Rate of Screening for Health-Related Resource Needs (HRRN)[43]
- Well-Child Visits in the First 30 Months of Life (W30)
  - Sub-Measure: 0-15 months, priority population (Black/African American)
  - Sub-Measure: 15-30 months, priority population (Black/African American)
- Child and Adolescent Well-Care Visits (WCV)

Under the 2026 Standard Plan Withhold Program, the Department will withhold 2% of each Standard Plan's total risk-adjusted capitation during the July 2026 – June 2027 contract year. Receiving these withheld funds is tied to Standard Plan performance on these measures for the 2026 quality measurement year.

The 2026 Standard Plan Withhold Program will utilize the Department's gap-to-goal benchmarking methodology to set targets (see section V(B) for more details). All measures

[43] This measure was scored according to pay for reporting in Years 1 and 2 of the Withhold Program but is moving to pay for performance in year 3.

included in the 2026 Standard Plan Withhold Program are NCQA HEDIS measures, except HRRN, which is a homegrown metric. Without a national Medicaid Health Maintenance Organization (HMO) benchmark available, the Department will use a 20% screening rate as the goal for the gap-to-goal methodology for HRRN based on analysis of past Standard Plan performance data.

Additional details on the Standard Plan Withhold Program can be found in the NC Medicaid Standard Plan Withhold Program Guidance documents for each measurement year, available on the Quality Management and Improvement webpage.

To guide potential changes to the Standard Plan Withhold Program each year, the Department has implemented an annual process that includes engaging internal and external stakeholders to select measures to be included or excluded from the program.[44] The Department will share a final set of measures and full details on the upcoming year's Standard Plan Withhold Program NC Medicaid Standard Plan Withhold Program Guidance document.

Table 3. Standard Plan Withhold Program Measures by Performance Period

CBE #	CMIT #	Measure	Steward	2024 Withhold Measure	2025 Withhold Measure	2026 Withhold Measure
0032	118	Cervical Cancer Screening (CCS-E)	NCQA			**X**
1516	123	Child and Adolescent Well-Care Visits (WCV)	NCQA			**X**
0038	124	Childhood Immunization Status (CIS-E)–Combination 10	NCQA	**X**	**X**	
1407	363	Immunizations for Adolescents (IMA-E)– Combination 2	NCQA			**X**
1517	582/ 581	Prenatal and Postpartum Care (PPC)	NCQA	**X**	**X**	**X**
N/A	N/A	Rate of Screening for Health-Related Resource Needs (HRRN)	NC DHHS	**X***	**X***	**X**
1392	761	Well-Child Visits in the First 30 Months of Life (W30)	NCQA			**X**

*Indicates pay-for-reporting measures in 2024 and 2025. HRRN is pay-for-performance in 2026.

E. Practice-level Quality Measurement for Advanced Medical Homes

AMHs

The Department requires Standard Plans to monitor the performance of AMHs in all tiers to ensure delivery of high-quality care. Practice-level monitoring must be sensitive to limitations such as population size. Standard Plans are required to offer opportunities for Performance

[44] NC Medicaid Standard Plan Withhold Program Measure Set Decision-Making Rubric. (April 2024). https://medicaid.ncdhhs.gov/documents/files/standard-plan-withhold-program-measure-set-decision-making-rubric/download?attachment.

Incentive Payments to Tier 3 AMHs based on the set of measures in Table 4, which were selected for their relevance to primary care and care coordination. These incentives are optional for Tier 1 and 2 AMHs.

Plans are not required to use all the AMH measures for such payments, but any quality measures they choose must be drawn from the set listed in Table 4. Incentive programs for non-AMH providers are not limited to this measure set. If plans and AMHs choose to use measures for which hybrid reporting is appropriate (e.g., Controlling High Blood Pressure), the Department encourages plans to use consistent reporting approaches that will minimize burden on AMH practices.

The NC Medicaid Quality Measure Performance and Targets for the AMH Measure Set, available here, includes baseline data for AMH measures and targets for the overall NC Medicaid population, Standard Plan Aggregate population and individual plans. For most overall and age stratified measures a target will be set each year, however, priority population targets are only set when a disparity is identified.[45] All measures in the AMH measure set may be stratified by three demographic strata: Black and African American binary, American Indian and Alaskan Native binary, and Hispanic and Latino binary. The Department updates the AMH Measure Set annually with the most recent performance data.

The Department collected feedback on the AMH Measure Set from health plans, providers and clinical subject matter experts in spring 2025. This feedback resulted in updates to the MY2026 AMH Measure Set, including the removal of three quality measures: *Plan-All Cause Readmissions (PCR), Total Cost of Care (TCOC) and Screening for Depression and Follow-Up (CDF)*.[46] The Department also added one measure to the set: *Adults' Access to Preventive/Ambulatory Health Services (AAP)*.

Table 4: Measures Selected for Use in Plan Assessments of AMH Practice Quality (AMH Measure Set)

CBE#	CMIT#	Measure Name	Steward	Frequency[47]
N/A	36	Adults' Access to Preventive/Ambulatory Health Services (AAP)[48]	NCQA	Annually
0032	118	Cervical Cancer Screening (CCS-E)	NCQA	Annually
1516	123	Child and Adolescent Well-Care Visits (WCV)	NCQA	Annually

[45] Not all measures will have targets set each year. For example, the Department has historically not set targets for measures that require additional clinical data for accurate reporting.
[46] The measures PCR, TCOC and CDF will have MY2024 performance reported in the AMH tables, but will not have MY2026 targets set, as they were retired from the AMH measure set beginning in measurement year 2026.
[47] Plans will also send monthly gap measure reports to AMHs.
[48] This measure was added to the AMH set in the 2025.2 version of this document. As such, the first measurement year in which this measure can be incentivized as an AMH measure is the claims-year running from January 2026 through December 2026. See Section III(A) for more details.

CBE#	CMIT#	Measure Name	Steward	Frequency[47]
N/A	36	Adults' Access to Preventive/Ambulatory Health Services (AAP)[48]	NCQA	Annually
0032	118	Cervical Cancer Screening (CCS-E)	NCQA	Annually
0038	124	Childhood Immunization Status (Combination 10) (CIS-E)	NCQA	Annually
0033	128	Chlamydia Screening (CHL)	NCQA	Annually
0034	139	Colorectal Cancer Screening (COL-E) [49]	NCQA	Annually
0018	167	Controlling High Blood Pressure (CBP)	NCQA	Annually
0059/0575	147/204	Glycemic Status Assessment for Patients with Diabetes (GSD)[50]	NCQA	Annually
1407	363	Immunizations for Adolescents (Combination 2) (IMA-E)	NCQA	Annually
1517	582/581	Prenatal and Postpartum Care (PPC)[51]	NCQA	Annually
1392	761	Well-Child Visits in the First 30 Months of Life (W30)	NCQA	Annually

Medicaid Expansion

As of September 2025, North Carolina has enrolled over 680,000 Expansion members since expanding NC Medicaid Dec. 1, 2023. As such, newly enrolled Expansion members who met continuous enrollment criteria for 2024 will be included in quality measure calculations. Research on states that have previously expanded Medicaid does not suggest systematic decreases in plan-level or safety-net hospital-level quality performance.[52,53] However, the Department recognizes practices may have concerns about having Expansion members included in their quality measure calculations for 2024 as they may have had less time in the first year to close care gaps for new members, who may not have received regular care in the past. To alleviate providers' concerns, the Department implemented a temporary policy for MY 2024

[49] This measure was added to the AMH set in the 2024 version of this document. As such, the first measurement year in which this measure can be incentivized as an AMH measure is the claims-year running from January 2025 through December 2025. See Section III(A) for more details.

[50] Previously known as Hemoglobin A1c Control for Patients with Diabetes (HBD), this measure title and its associated specifications have been slightly modified by the measure steward.

[51] This measure was added to the AMH set in the 2023 version of this document. As such, the first measurement year in which this measure can be incentivized as an AMH measure is the claims-year running from January 2024 through December 2024. See Section III(A) for more details.

[52] Ndumele CD, Schpero WL, Trivedi AN. Medicaid Expansion and Health Plan Quality in Medicaid Managed Care. Health Serv Res. 2018 Aug;53 Suppl 1(Suppl Supplhttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC6056574/ 1):2821-2838. doi: 10.1111/1475-6773.12814. Epub 2017 Dec 12. PMID: 29230801; PMCID: PMC6056574.

[53] Chatterjee P, Qi M, Werner RM. Association of Medicaid Expansion With Quality in Safety-Net Hospitals. JAMA Intern Med. 2021;181(5):590–597.

intended to: (1) create a quality measurement methodology that does not introduce a disincentive for practices to serve Expansion members; (2) encourage engagement with new Expansion members to close care gaps; and (3) promote continued participation in the Medicaid program by AMH providers.

AMH+/CMAs

The Department also seeks to monitor the performance of AMH+s/CMAs and promote improvement in patient outcomes through the delivery of Tailored Care Management. In future years, AMH+ and CMA practices will be eligible to earn performance incentive payments based on a limited set of metrics.

Prior to the release of AMH+ and CMA metrics, Tailored Plans may, but are not required to, make performance incentive payments to AMH+ or CMAs for Tailored Care Management. The Department encourages Tailored Plans to base any performance incentive payment on the Tailored Plan measure set and NC Medicaid Quality Strategy. Following the release of AMH+ and CMA metrics, Tailored Plans must offer performance incentive payments to AMH+s and CMAs using the Department-specified measure set.

More information on the measure set and scoring approach is forthcoming.

F. Public Reporting of Performance

The Department intends to report Standard Plans' and Tailored Plans' quality performance publicly where feasible and appropriate, as this is an important step in promoting high-quality care and increasing stakeholder awareness. The Department will produce several reports to appraise the public of plan performance and promote transparency in the overall quality of the NC Medicaid Managed Care program. These reports include:

- *Accreditation Progress and Results*—All Standard Plans and Tailored Plans are required to receive plan accreditation through NCQA. The Department will track plan progress toward receiving accreditation and will report the accreditor's findings for each plan during its accreditation process.

- *Health Disparities Report*—The Department will assess disparities in care and outcomes across the demographics described in Section IV(B) and produce a report summarizing areas of care in which disparities have improved, persisted or developed.

- *Quality Report* – The Department will assess performance on various quality measures to evaluate access to care, utilization of services and health outcomes among beneficiaries. Performance is assessed both across years and compared to national medians. The report will identify strengths, areas of concern, and growth opportunities linked to the goals identified in the NC Medicaid Managed Care Quality Strategy.

- *Provider Survey Results*—As noted in Section III(E), the Department, in partnership with a third party, will field a survey to providers assessing their experience with the plan(s) they have contracted with. The Department will track experience ratings and other findings from this survey.

- *CAHPS Survey Results*—As noted in Section III(E), the Department, in partnership with a third party, will field the CAHPS Health Plan surveys to assess beneficiaries' health care experience. The Department will publish experience ratings by aggregate-level and plan-level populations in addition to other findings from this survey.

- *Other Surveys*—The Department may report the results of other surveys and instruments.

- *Access to Care Report*—The Department, in partnership with a third party, will biennially produce a report that will track year-over-year trends for measures concerning health care access for NC Medicaid recipients. Access to care focuses on two key dimensions: Geographic Distribution and Access and Availability of Services. Geographic distribution will be assessed utilizing time/distance geographical (geo) access reports. The Access and Availability of Services Dimension will use data from grievances due to access-related issues, NCQA HEDIS® quality measures, CAHPS® surveys, provider directory validation and provider access call studies.

Additional NC Medicaid Quality Reporting—The Department also issues a variety of reports that provide visibility into aggregate NC Medicaid performance. These reports include:

- *NC Medicaid Quality Fact Sheet Series*—These reports are produced on an ad-hoc basis, and the series outlines NC Medicaid performance across key areas, providing information on quality measure performance and improvement initiatives for a broad public audience.

- *Access Monitoring and Review Plan*—This report (completed every three years) analyzes access to care for NC Medicaid Direct beneficiaries by examining provider availability and accessibility, members' utilization of services, health care performance measures and patient experience measures.

E. Performance Improvement Projects

In compliance with 42 CFR 438.330(d), and as part of each QAPI, health plans are required to conduct PIPs that:

- Are designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction;
- Include measurement of performance using objective quality indicators;
- Include implementation of interventions to achieve improvement in access to and quality of care;
- Include planning and initiation of activities for increasing or sustaining improvement; and

- Include evaluation of the effectiveness of the interventions.

Prepaid Health Plans (PHPs) are required to conduct at least three PIPs annually, which must be approved by the Department. Clinical and Non-Clinical PIPs are required by each PHP type. Clinical PIPs refer to managing member health outcomes and typically utilize HEDIS measures. Non-Clinical PIPs are considered administrative and focus on improving processes and support efforts for the members. Non-Clinical PIPs frequently need to be created and defined by the Department. Standard Plans, PIHPs, Behavioral Health I/DD Tailored Plans and the Children and Families Specialty Plan (CFSP) are required to report on the status and results of each PIP conducted no less than once annually, as specified; these results will be validated by the EQRO and reviewed by the Department. As part of required PIP reporting, health plans must describe the details of interventions used, including a description of how improvement strategies/interventions will address gaps in access or outcomes. Quarterly PIP Progress reports will be conducted to ensure health plans are on track for the annual PIP reporting.

Table 5: List of 2026 PIP Measures by Line of Business

Plan	Measures
Standard Plans	• Childhood Immunization Status (Combo 10) (CIS) • Prenatal and Postpartum Care (PPC) • Glycemic Status Assessment (GSD) • Rate of Screening for Health-Related Resource Needs (HRRN)
PIHPs	• Follow-Up After Emergency Department Visit for Mental Illness (FUM) • Follow-Up After Hospitalization for Mental Illness (FUH) • Rate of Screening for Health-Related Resource Needs (HRRN)
Tailored Plans	• Follow-Up After Hospitalization for Mental Illness (FUH) • Initiation and Engagement of Substance Use Disorder Treatment (IET) • Rate of Screening for Health-Related Resource Needs (HRRN)
CFSP	• Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) • Child and Adolescent Well-Care Visits (WCV) • Improving CFSP Network Expertise • Juvenile Justice Entry

VI. Conclusion and Next Steps

The Department will engage with Standard Plans, Tailored Plans and other entities serving managed care enrollees as their quality measurement approach develops to inform future refinements to the Department's selection of quality measures. The Department's selection of quality measures will likely change annually, reflecting new quality priorities, alignment with federal measure sets, stakeholder feedback and a dynamic process as the transformation to managed care continues. The Department will consider emerging challenges in NC Medicaid Managed Care performance, as well as areas where performance has improved, when selecting or retiring measures during its annual review process. In addition, the Department's annual evaluation of its quality measure sets is informed by nationally recognized measure sets and the NC Medicaid Managed Care Quality Strategy's aims of Better Care Delivery, Healthier People, Healthier Communities and Smarter Spending. The Department aims to maintain a measure set that reflects state-of-the-art quality measurement for NC Medicaid Managed Care-enrolled populations and will update measures to reflect the evolving needs of members.

VII. Appendices

Appendix A: Table of Quality and Administrative Measures[54]

The tables in this section list the quality measures used to monitor quality improvement in NC Medicaid. Entities[55] reflected below are:

- Standard Plan
- Tailored Plan
- Tailored Plan State-Funded Measure Set
- Community Care of North Carolina (CCNC)
- Prepaid Inpatient Health Plan (PIHP)
- Eastern Band of Cherokee Indians (EBCI) Tribal Option
- Children and Families Specialty Plan (CFSP)

Measures included in the AMH measure set, described in Section V(E) are followed by an asterisk (*). Table 1 provides measures across all lines-of-business for cross-program comparison. Tables 2–8 provide separate measure sets for each managed care entity.

The following tables use CMS Measures Inventory Tool (CMIT) and Consensus-Based Entity (CBE) numbers to help identify quality measures. Note that not all measures have assigned numbers.

- The Centers for Medicare and Medicaid Services' (CMS) CMIT numbers are unique identifiers assigned to health care quality measures and search for measures that CMS uses for various quality programs and initiatives.

[54] To view the full measure specifications for all NCQA measures, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.
[55] More information for each entity is available in the Quality Strategy, linked here.

- The Partnership for Quality Measurement's (PQM) CBE numbers are identifiers used for health care quality measures that have been endorsed by the Consensus-Based Entity (CBE) working with CMS. Battelle currently serves as the CMS CBE and uses PQM to incorporate feedback from interested parties to endorse measures fostering health care quality improvement.

Appendix A Table 1: NC Medicaid Quality Measures Across All Lines-Of-Business

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
N/A	18	*Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)*	NCQA		**X**					
N/A	36	*Adults' Access to Preventive/Ambulatory Health Services (AAP)**	NCQA	**X**	**X**					
3620	26	*Adult Immunization Status (AIS-E)*	NCQA	**X**	**X**					
N/A	N/A	*Alcohol and Drug Abuse Treatment Center (ADATC) Readmissions within 30 days and 180 days*	NCDHHS			**X**				
N/A	1784	*Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)*	Dental Quality Alliance (DQA)				**X**			

[56] Measures in the Tailored Plan State-Funded Measure Set are calculated by DMH/DD/SUS.

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
N/A	N/A	*Antibiotic Utilization for Respiratory Conditions (AXR)*	NCQA				**X**			
N/A	N/A	*Average Length of Stay in Community Hospitals (mental health treatment & substance use disorder treatment)*	NC DHHS			**X**				
0272/ 0275/ 0277/ 0283	577/578/ 579/580	*Avoidable Adult Utilization* *PQI 01: Diabetes Short-term Complication Admission Rate* *PQI 05: COPD or Asthma in Older Adults Admission Rate* *PQI 08: Heart Failure Admission Rate* *PQI 15: Asthma in Younger Adults Admission Rate*	Agency for Healthcare Research and Quality (AHRQ)	**X**	**X**		**X**			
0728/ N/A	N/A	*Avoidable Pediatric Utilization:* *PDI 14: Asthma Admission Rate*	AHRQ	**X**	**X**		**X**			

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
		PDI 15: Diabetes Short-term Complications Admission Rate								
0727 / N/A	N/A	*Avoidable Pediatric Utilization:* *PDI 16: Gastroenteritis Admission Rate* *PDI 18: Urinary Tract Infection Admission Rate*	AHRQ				**X**			
0058	84	*Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)*	NCQA	**X**						
N/A	N/A	*Blood Pressure Control for Patients with Diabetes (BPD)*	NCQA	**X**	**X**		**X**			
2372	93	*Breast Cancer Screening (BCS-E)*	NCQA	**X**	**X**					
0032	118	*Cervical Cancer Screening (CCS-E) **	NCQA	**X**	**X**		**X**			**X**
1516	123	*Child and Adolescent Well-Care Visits (WCV)**	NCQA	**X**	**X**		**X**			**X**

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
0038	124	*Childhood Immunization Status (Combination 10) (CIS-E)**	NCQA	**X**	**X**		**X**		**X**	**X**
0038	124	*Childhood Immunization Status (Combination 7) (CIS-E)*	NCQA	**X**	**X**		**X**			
0033	128	*Chlamydia Screening (CHL)**	NCQA	**X**	**X**		**X**			**X**
0034	139	*Colorectal Cancer Screening (COL-E) **	NCQA	**X**	**X**					
N/A	N/A	*Community Mental Health Inpatient Readmissions within 30 Days*	NCDHHS			**X**				
N/A	N/A	*Community Substance Use Disorder Inpatient Readmission within 30 Days*	NCDHHS			**X**				
3389	150	*Concurrent Use of Prescription Opioids and Benzodiazepines (COB)*	PQA	**X**	**X**			**X**		**X**
N/A	N/A	*Pharmacotherapy for Opioid Use Disorder (POD)*	NCQA		**X**			**X**		**X**
2903/ 2904	1002	*Contraceptive Care: All Women (CCW)*	US Office of	**X**	**X**		**X**			

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
			Population Affairs							
2902	166	*Contraceptive Care: Postpartum (CCP)*	US Office of Population Affairs	**X**	**X**		**X**			
0018	167	*Controlling High Blood Pressure (CBP)[57]**	NCQA	**X**	**X**		**X**		**X**	**X**
2607	196	*Diabetes Care for People with Serious Mental Illness: Glycemic Status > 9.0% (>9.0%) (HPCMI)*	NCQA		**X**					
1932	202	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	NCQA		**X**			**X**		**X**
1448	1003	*Developmental Screening in the First Three Years of Life (DEV)*	OHSU	**X**	**X**		**X**			
N/A	N/A	*Engagement in Mental Health Services*	NCDHHS			**X**				

[57] The Department requires Standard Plans to complete both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
N/A	N/A	*Engagement in Substance Use Disorder Services*	NCDHHS			**X**				
N/A	N/A	*EPSDT Screening Ratio*	NCDHHS	**X**	**X**			**X**		**X**
N/A	203	*Eye Exam for Patients with Diabetes (EED)*	NCQA	**X**	**X**					
N/A	N/A	*Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility-based Crisis Services for Mental Health Treatment (7 days and 30 days)*	NCDHHS			**X**				
N/A	N/A	*Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services for substance use disorder (SUD) Treatment (7 days and 30 days)*	NCDHHS			**X**				
3489	265	*Follow-Up After Emergency Department Visit for Mental Illness (FUM)*	NCQA	**X**	**X**			**X**		

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
3488	264	*Follow-Up After Emergency Department Visit for Substance Use (FUA)*	NCQA		**X**			**X**		**X**
N/A	N/A	*Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)*	NCQA		**X**					
0576	268	*Follow-Up After Hospitalization for Mental Illness (FUH)*	NCQA	**X**	**X**			**X**		**X**
0108	271	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)*	NCQA	**X**	**X**			**X**		**X**
0059/0057	147/204	*Glycemic Status Assessment for Patients with Diabetes (GSD)*[58]*	NCQA	**X**	**X**		**X**		**X**	**X**
1407	363	*Immunizations for Adolescents (Combination 2) (IMA-E) **	NCQA	**X**	**X**		**X**			**X**
N/A	N/A	*Improving CFSP Network Expertise*	NCDHHS							**X**

[58] The Department requires Standard Plans to complete both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
0004	394	*Initiation and Engagement of Substance Use Disorder Treatment (IET)*	NCQA		**X**			**X**		
N/A	N/A	*Initiation of Mental Health Services*	NCDHHS			**X**				
N/A	N/A	*Initiation of Substance Use Disorder Services*	NCDHHS			**X**				
N/A	N/A	*Juvenile Justice Entry*	NCDHHS							**X**
N/A	1775	*Lead Screening in Children (LSC)*	NCQA	**X**	**X**		**X**			
N/A	N/A	*Low Birth Weight (LBW)*[59]	NCDHHS	**X**	**X**					**X**
N/A	N/A	Tobacco Use Screening and Cessation Intervention (TSC-E)	NCQA	**X**	**X**					**X**
2800	448	*Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)*	NCQA		**X**			**X**		**X**
N/A	20	*Managed LTSS Admission to a Facility from the Community (MLTSS 6)*	CMS	**X**	**X**					

[59] Plans will submit a quarterly operational report that contains all live singleton births during the measurement year to date to support the production of this measure. See Appendix C for more information about this measure.

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
N/A	968	*Managed LTSS Minimizing Facility Length of Stay (MLTSS 7)*	CMS	**X**	**X**					
N/A	414	*Managed LTSS Successful Transition After Long-Term Facility Stay (MLTSS 8)*	CMS	**X**	**X**					
2517	897	*Oral Evaluation, Dental Services (OEV)*	DQA	**X**	**X**		**X**			
N/A	1783	*Oral Evaluation During Pregnancy (OEVP)*	DQA				**X**			
1768	561	*Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*	NCQA	**X**	**X**		**X**			**X**
N/A	N/A	*Prenatal Depression Screening and Follow-Up (PND-E)*	NCQA	**X**	**X**		**X**			
3484	1782	*Prenatal Immunization Status (PRS-E)*	NCQA	**X**	**X**					
1517	582/581	*Prenatal and Postpartum Care (PPC)[60]**	NCQA	**X**	**X**		**X**			**X**

[60] This measure is a 2026 Standard Plan Withhold measure. The Department requires Standard Plans to complete both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
N/A	N/A	*Rate of Screening for Pregnancy Risk*[61]	NCDHHS	**X**	**X**		**X**			**X**
N/A	N/A	*Rate of Screening for Health-Related Resource Needs (HRRN)*[62]	NCDHHS	**X**	**X**			**X**		**X**
0418/ 0418e [63]	672	*Screening for Depression and Follow-Up Plan (CDF)*	CMS	**X**	**X**					**X**
N/A	830	*Sealant Receipt on Permanent First Molars (SFM)*	DQA				**X**			
N/A	N/A	*State Psychiatric Hospital Readmissions within 30 Days and 180 Days*	NCDHHS			**X**				
N/A	700	*Statin Therapy for Patients with Cardiovascular Disease (SPC)*	NCQA	**X**	**X**		**X**			
2528/ 3700/ 3701	1672	*Topical Fluoride for Children (TFL)*	DQA	**X**	**X**		**X**			

[61] The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.
[62] This measure is a 2026 Standard Plan Withhold measure.
[63] Plans must report to the Department whether they are using the standard or electronic measure.

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) [56]	CCNC	PIHP	EBCI Tribal Option	CFSP
2801	743	*Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)*	NCQA	**X**	**X**			**X**		**X**
2940	748	*Use of Opioids at High Dosage in Persons Without Cancer (OHD)*	PQA		**X**			**X**		**X**
2950	N/A	*Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)*	PQA		**X**			**X**		**X**
3400	750	*Use of Pharmacotherapy for Opioid Use Disorder (OUD)*	CMS		**X**			**X**		
0024	760	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	NCQA	**X**	**X**		**X**			
1392	761	*Well-Child Visits in the First 30 Months of Life (W30)**	NCQA	**X**	**X**		**X**			**X**

** Measure is included in the AMH measure set*

Appendix A Table 2: Standard Plan Measure Set

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
3620	26	*Adult Immunization Status (AIS-E)*	NCQA	**X**	
N/A	36	*Adults' Access to Preventive/Ambulatory Health Services (AAP)**	NCQA	**X**	
0272/ 0275/ 0277/ 0283	577/578/ 579/580	*Avoidable Adult Utilization:* • *PQI 01: Diabetes Short-term Complication Admission Rate* • *PQI 05: COPD or Asthma in Older Adults Admission Rate* • *PQI 08: Heart Failure Admission Rate* • *PQI 15: Asthma in Younger Adults Admission Rate*	AHRQ		**X**
0728/ N/A/	N/A	*Avoidable Pediatric Utilization:* • *PDI 14: Asthma Admission Rate* • *PDI 15: Diabetes Short-term Complications Admission Rate*	AHRQ		**X**
0058	84	*Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)*	NCQA	**X**	
N/A	N/A	*Blood Pressure Control for Patients with Diabetes (BPD)*	NCQA		**X**
2372	93	*Breast Cancer Screening (BCS-E)*	NCQA	**X**	
0032	118	*Cervical Cancer Screening (CCS-E) **	NCQA	**X**	
1516	123	*Child and Adolescent Well-Care Visits (WCV)**	NCQA	**X**	
0038	124	*Childhood Immunization Status (Combination 10) (CIS-E)**	NCQA	**X**	

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
0038	124	*Childhood Immunization Status (Combination 7) (CIS-E)*	NCQA	**X**	
0033	128	*Chlamydia Screening (CHL)**	NCQA	**X**	
0034	139	*Colorectal Cancer Screening (COL-E)**	NCQA	**X**	
3389	150	*Concurrent Use of Prescription Opioids and Benzodiazepines (COB)*	PQA	**X**	
2903/ 2904	1002	*Contraceptive Care: All Women (CCW)*	US Office of Population Affairs		**X**
2902	166	*Contraceptive Care: Postpartum (CCP)*	US Office of Population Affairs		**X**
0018	167	*Controlling High Blood Pressure (CBP)[64]**	NCQA	**X**	
1448	1003	*Developmental Screening in the First Three Years of Life (DEV)*	OHSU		**X**
N/A	N/A	*EPSDT Screening Ratio*	NCDHHS		**X**
N/A	203	*Eye Exam for Patients with Diabetes (EED)*	NCQA	**X**	
3489	265	*Follow-Up After Emergency Department Visit for Mental Illness (FUM)*	NCQA	**X**	
0576	268	*Follow-Up After Hospitalization for Mental Illness (FUH)*	NCQA	**X**	

[64] The Department requires both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
0108	271	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)*	NCQA	**X**	
0059/ 0057	147/204	*Glycemic Status Assessment for Patients with Diabetes (GSD)*[65]*	NCQA	**X**	
1407	363	*Immunizations for Adolescents (Combination 2) (IMA-E)**	NCQA	**X**	
N/A	1775	*Lead Screening in Children (LSC)*	NCQA		**X**
N/A	N/A	*Low Birth Weight (LBW)*[66]	NCDHHS		**X**
N/A	20	*Managed LTSS Admissions to a Facility from the Community (MLTSS 6)*	CMS		**X**
N/A	968	*Managed LTSS Minimizing Facility length of Stay (MLTSS 7)*	CMS		**X**
N/A	414	*Managed LTSS Successful Transition After Long-Term Facility Stay (MLTSS 8)*	CMS		**X**
2517	897	*Oral Evaluation, Dental Services (OEV)*	DQA		**X**
1768	561	*Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*	NCQA		**X**
1517	581/582	*Prenatal and Postpartum Care (PPC)*[67]**	NCQA	**X**	
N/A	N/A	*Prenatal Depression Screening and Follow-Up (PND-E)*	NCQA		**X**
3484	1782	*Prenatal Immunization Status (PRS-E)*	NCQA		**X**

[65] The Department requires both administrative and hybrid reporting for this measure.
[66] See Appendix C for more information about this measure.
[67] This measure is a 2026 Standard Plan Withhold measure. The Department requires both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
N/A	N/A	*Rate of Screening for Pregnancy Risk*[68]	NCDHHS		**X**
N/A	N/A	*Rate of Screening for Health-Related Resource Needs (HRRN)*[69]	NCDHHS		**X**
0418/ 0418e[70]	672	*Screening for Depression and Follow-Up Plan (CDF)*	CMS	**X**	
N/A	700	*Statin Therapy for Patients with Cardiovascular Disease (SPC)*	NCQA		**X**
N/A	N/A	Tobacco Use Screening and Cessation Intervention (TSC-E)	NCQA		**X**
2528/ 3700/ 3701	1672	*Topical Fluoride for Children (TFL)*	DQA		**X**
2801	743	*Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)*	NCQA	**X**	
0024	760	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	NCQA		**X**
1392	761	*Well-Child Visits in the First 30 Months of Life (W30)**	NCQA	**X**	

** Measure is included in the AMH measure set*

[68] The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.
[69] This measure is a 2026 Standard Plan Withhold measure.
[70] Plans must report to the Department whether they are using the standard or electronic measure.

Appendix A Table 3: Tailored Plan Measure Set

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
N/A	18	*Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)*	NCQA	**X**	
3620	26	*Adult Immunization Status (AIS-E)*	NCQA	**X**	
N/A	36	*Adults' Access to Preventive/Ambulatory Health Services (AAP)**	NCQA	**X**	
0272/ 0275/ 0277/ 0283	577/578/ 579/580	*Avoidable Adult Utilization* • *PQI 01: Diabetes Short-term Complication Admission Rate* • *PQI 05: COPD or Asthma in Older Adults Admission Rate* • *PQI 08: Heart Failure Admission Rate* • *PQI 15: Asthma in Younger Adults Admission Rate*	AHRQ		**X**
0728/ N/A/	N/A	*Avoidable Pediatric Utilization:* • *PDI 14: Asthma Admission Rate* • *PDI 15: Diabetes Short-term Complications Admission Rate*	AHRQ		**X**
N/A	N/A	*Blood Pressure Control for Patients with Diabetes (BPD)*	NCQA		**X**
2372	93	*Breast Cancer Screening (BCS-E)*	NCQA	**X**	
0032	118	*Cervical Cancer Screening (CCS-E) **	NCQA	**X**	
1516	123	*Child and Adolescent Well-Care Visits (WCV)**	NCQA	**X**	

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
0038	124	*Childhood Immunization Status (Combination 10) (CIS-E) **	NCQA	**X**	
0038	124	*Childhood Immunization Status (Combination 7) (CIS-E)*	NCQA	**X**	
0033	128	*Chlamydia Screening (CHL)**	NCQA	**X**	
0034	139	*Colorectal Cancer Screening (COL-E) **	NCQA	**X**	
3389	150	*Concurrent Use of Prescription Opioids and Benzodiazepines (COB)*	PQA	**X**	
2903/ 2904	165	*Contraceptive Care: All Women (CCW)*	US Office of Population Affairs		**X**
2902	166	*Contraceptive Care: Postpartum (CCP)*	US Office of Population Affairs		**X**
0018	167	*Controlling High Blood Pressure (CBP)*[71]*	NCQA	**X**	
2607	196	*Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI)*	NCQA		**X**
1932	202	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	NCQA	**X**	
1448	1003	*Developmental Screening in the First Three Years of Life (DEV)*	OHSU		**X**

[71] The Department requires both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
N/A	N/A	*EPSDT Screening Ratio*	NCDHHS		**X**
N/A	203	*Eye Exam for Patients with Diabetes (EED)*	NCQA	**X**	
3489	265	*Follow-Up After Emergency Department Visit for Mental Illness (FUM)*	NCQA	**X**	
3488	264	*Follow-Up After Emergency Department Visit for Substance Use (FUA)*	NCQA		**X**
0576	268	*Follow-Up After Hospitalization for Mental Illness (FUH)*	NCQA	**X**	
N/A	N/A	*Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)*	NCQA	**X**	
0108	271	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)*	NCQA	**X**	
0059/ 0057	147/204	*Glycemic Status Assessment for Patients with Diabetes (GSD)*[72]*	NCQA	**X**	
1407	363	*Immunizations for Adolescents (Combination 2) (IMA-E)**	NCQA	**X**	
0004	394	*Initiation and Engagement of Substance Use Disorder Treatment (IET)*	NCQA	**X**	
N/A	1775	*Lead Screening in Children (LSC)*	NCQA		**X**
N/A	N/A	*Low Birth Weight (LBW)*[73]	NCDHHS		**X**

[72] The Department requires both administrative and hybrid reporting for this measure.
[73] The health plans will submit a quarterly operational report that contains all live singleton births during the measurement year to date to support the production of this measure. See Appendix C for more information about this measure.

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
2800	448	*Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)*	NCQA	**X**	
N/A	20	*Managed LTSS Admissions to a Facility From the Community (MLTSS 6)*	CMS		**X**
N/A	968	*Managed LTSS Minimizing Facility length of Stay (MLTSS 7)*	CMS		**X**
N/A	414	*Managed LTSS Successful Transition After Long-Term Facility Stay (MLTSS 8)*	CMS		**X**
2517	897	*Oral Evaluation, Dental Services (OEV)*	DQA		**X**
N/A	N/A	*Pharmacotherapy for Opioid Use Disorder (POD)*	NCQA		**X**
1768	561	*Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*	NCQA		**X**
N/A	N/A	*Prenatal Depression Screening and Follow-Up (PND-E)*	NCQA		**X**
1517	581/582	*Prenatal and Postpartum Care (PPC)*[74]*	NCQA	**X**	
3484	1782	*Prenatal Immunization Status (PRS-E)*	NCQA		**X**
N/A	N/A	*Rate of Screening for Pregnancy Risk*[75]	NCDHHS		**X**
N/A	N/A	*Rate of Screening for Health-Related Resource Needs (HRRN)*	NCDHHS		**X**
0418/ 0418e[76]	672	*Screening for Depression and Follow-Up Plan (CDF)*	CMS	**X**	

[74] The Department requires both administrative and hybrid reporting for this measure.
[75] The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.
[76] Plans must report to the Department whether they are using the standard or electronic measure.

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
N/A	700	*Statin Therapy for Patients with Cardiovascular Disease (SPC)*	NCQA		**X**
N/A	N/A	Tobacco Use Screening and Cessation Intervention (TSC-E)	NCQA		**X**
2528/ 3700/ 3701	1672	*Topical Fluoride for Children (TFL)*	DQA		**X**
2801	743	*Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)*	NCQA	**X**	
2940	748	*Use of Opioids at High Dosage in Persons Without Cancer (OHD)*	PQA		**X**
2950	N/A	*Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)*	PQA		**X**
3400	750	*Use of Pharmacotherapy for Opioid Use Disorder (OUD)*	CMS		**X**
0024	760	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	NCQA		**X**
1392	761	*Well-Child Visits in the First 30 Months of Life (W30)**	NCQA	**X**	

** Measure is included in the AMH measure set*

Appendix A Table 4: Tailored Plan State-Funded Measure Set[77]

CBE #	CMIT #	Measure	Steward	Tailored Plan (State Funded) Reported	Department Calculated
N/A	N/A	*Alcohol and Drug Abuse Treatment Center (ADATC) Readmissions within 30 days and 180 days*	NCDHHS	**X**	
N/A	N/A	*Average Length of Stay in Community Hospitals (mental health treatment & substance use disorder treatment)*	NCDHHS	**X**	
N/A	N/A	*Community Mental Health Inpatient Readmissions within 30 Days*	NCDHHS	**X**	
N/A	N/A	*Community Substance Use Disorder Inpatient Readmission within 30 Days*	NCDHHS	**X**	
N/A	N/A	*Engagement in Mental Health Services*	NCDHHS	**X**	
N/A	N/A	*Engagement in Substance Use Disorder Services*	NCDHHS	**X**	
N/A	N/A	*Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility-based Crisis Services for Mental Health Treatment (7 days and 30 days)*	NCDHHS		**X**
N/A	N/A	*Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services for substance use disorder (SUD) Treatment (7 days and 30 days)*	NCDHHS		**X**
N/A	N/A	*Initiation of Mental Health Services*	NCDHHS	**X**	
N/A	N/A	*Initiation of Substance Use Disorder Services*	NCDHHS	**X**	

[77] The plan-reported measures for the state-funded measure set are reported in the QAV010-T on a quarterly basis. The department-calculated measures are calculated by DMH/DD/SUS, and are shared with plans no less than quarterly.

CBE #	CMIT #	Measure	Steward	Tailored Plan (State Funded) Reported	Department Calculated
N/A	N/A	*State Psychiatric Hospital Readmissions within 30 Days and 180 Days*	NCDHHS	**X**	

Appendix A Table 5: Community Care of North Carolina (CCNC) Measure Set

CBE #	CMIT #	Measure	Steward	CCNC Reported	Department Calculated
N/A	1784	*Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)*	DQA		**X**
N/A	N/A	*Antibiotic Utilization for Respiratory Conditions (AXR)*	NCQA		**X**
0272/ 0275/ 0277/ 0283	577/578/ 579/580	*Avoidable Adult Utilization* • *PQI 01: Diabetes Short-term Complication Admission Rate* • *PQI 05: COPD or Asthma in Older Adults Admission Rate* • *PQI 08: Heart Failure Admission Rate* • *PQI 15: Asthma in Younger Adults Admission Rate*	AHRQ		**X**
0728/ N/A/ 0727/ N/A	N/A	*Avoidable Pediatric Utilization:* • *PDI 14: Asthma Admission Rate* • *PDI 15: Diabetes Short-term Complications Admission Rate* • *PDI 16: Gastroenteritis Admission Rate*	AHRQ		**X**

CBE #	CMIT #	Measure	Steward	CCNC Reported	Department Calculated
		• *PDI 18: Urinary Tract Infection Admission Rate*			
N/A	N/A	*Blood Pressure Control for Patients with Diabetes (BPD)*	NCQA		**X**
0032	118	*Cervical Cancer Screening (CCS-E)**	NCQA	**X**	
1516	123	*Child and Adolescent Well-Care Visits (WCV)**	NCQA	**X**	
0038	124	*Childhood Immunization Status (Combination 10) (CIS-E)**	NCQA	**X**	
0038	124	*Childhood Immunization Status (Combination 7) (CIS-E)*	NCQA	**X**	
0033	128	*Chlamydia Screening (CHL)**	NCQA	**X**	
2903/ 2904	1002	*Contraceptive Care: All Women (CCW)*	US Office of Population Affairs		**X**
2902	166	*Contraceptive Care: Postpartum (CCP)*	US Office of Population Affairs		**X**
0018	167	*Controlling High Blood Pressure (CBP)**	NCQA	**X**	
1448	1003	*Developmental Screening in the First Three Years of Life (DEV)*	OHSU		**X**
N/A	N/A	*EPSDT Screening Ratio*	NCDHHS		**X**
0059/ 0057	147/204	*Glycemic Status Assessment for Patients with Diabetes (GSD)**	NCQA	**X**	
1407	363	*Immunizations for Adolescents (Combination 2) (IMA-E)**	NCQA	**X**	
N/A	1775	*Lead Screening in Children (LSC)*	NCQA		**X**

CBE #	CMIT #	Measure	Steward	CCNC Reported	Department Calculated
2517	897	*Oral Evaluation, Dental Services (OEV)*	DQA		**X**
N/A	1783	*Oral Evaluation During Pregnancy (OEVP)*	DQA		**X**
1768	561	*Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*	NCQA		**X**
1517	582/581	*Prenatal and Postpartum Care (PPC)**	NCQA		**X**
N/A	N/A	*Prenatal Depression Screening and Follow-Up (PND-E)*	NCQA		**X**
N/A	N/A	*Rate of Screening for Pregnancy Risk*[78]	NCDHHS		**X**
N/A	830	*Sealant Receipt on Permanent First Molars (SFM)*	DQA		**X**
N/A	700	*Statin Therapy for Patients with Cardiovascular Disease (SPC)*	NCQA		**X**
2528/ 3700/ 3701	1672	*Topical Fluoride for Children (TFL)*	DQA		**X**
0024	760	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	NCQA		**X**
1392	761	*Well-Child Visits in the First 30 Months of Life (W30)**	NCQA	**X**	

** Measure is included in the AMH measure set*

[78] The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.

Appendix A Table 6: Prepaid Inpatient Health Plan (PIHP) Measure Set

CBE #	CMIT #	Measure	Steward	PIHP Reported	Department Calculated
3389	150	*Concurrent Use of Prescription Opioids and Benzodiazepines (COB)*	PQA	**X**	
N/A	N/A	*Pharmacotherapy for Opioid Use Disorder (POD)*	NCQA		**X**
1932	202	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	NCQA	**X**	
N/A	N/A	*EPSDT Screening Ratio*	NCDHHS		**X**
3489	265	*Follow-Up After Emergency Department Visit for Mental Illness (FUM)*	NCQA	**X**	
3488	264	*Follow-Up After Emergency Department Visit for Substance Use (FUA)*	NCQA		**X**
0576	268	*Follow-Up After Hospitalization for Mental Illness (FUH)*	NCQA	**X**	
0108	271	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)*	NCQA		**X**
0004	394	*Initiation and Engagement of Substance Use Disorder Treatment (IET)*	NCQA		**X**
2800	448	*Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)*	NCQA		**X**
N/A	N/A	*Rate of Screening for Health-Related Resource Needs (HRRN)*	NCDHHS		**X**
2801	743	*Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)*	NCQA	**X**	
2940	748	*Use of Opioids at High Dosage in Persons Without Cancer (OHD)*	PQA		**X**

CBE #	CMIT #	Measure	Steward	PIHP Reported	Department Calculated
2950	N/A	*Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)*	PQA		**X**
3400	750	*Use of Pharmacotherapy for Opioid Use Disorder (OUD)*	CMS		**X**

** Measure is included in the AMH measure set*

Appendix A Table 7: EBCI Tribal Option Measure Set

CBE #	CMIT #	Measure	Steward	EBCI Reported	Department calculated
0038	124	*Childhood Immunization Status (Combination 10) (CIS-E)**	NCQA	**X**	
0018	167	*Controlling High Blood Pressure (CBP)**	NCQA	**X**	
0059/ 0057	147/204	*Glycemic Status Assessment for Patients with Diabetes (GSD)**	NCQA	**X**	

** Measure is included in the AMH measure set*

Appendix A Table 8: CFSP Measure Set

CBE #	CMIT #	Measure	Steward	CFSP Reported	Department calculated
0032	118	*Cervical Cancer Screening (CCS-E)**	NCQA	**X**	
1516	124	*Child and Adolescent Well-Care Visits (WCV)**	NCQA	**X**	
0038	124	*Childhood Immunization Status (Combination 10) (CIS-E)**	NCQA	**X**	
0033	128	*Chlamydia Screening (CHL)**	NCQA	**X**	
3389	150	*Concurrent Use of Prescription Opioids and Benzodiazepines (COB)*	PQA	**X**	
N/A	N/A	*Pharmacotherapy for Opioid Use Disorder (POD)*	NCQA		**X**
0018	167	*Controlling High Blood Pressure (CBP)**	NCQA	**X**	

CBE #	CMIT #	Measure	Steward	CFSP Reported	Department calculated
1932	202	*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	NCQA	**X**	
N/A	N/A	*EPSDT Screening Ratio*	CMS		**X**
3488	264	*Follow-Up After Emergency Department Visit for Substance Use (FUA)*	NCQA		**X**
0576	268	*Follow-Up After Hospitalization for Mental Illness (FUH)*	NCQA	**X**	
0108	271	*Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)*	NCQA	**X**	
0059	204	*Glycemic Status Assessment for Patients with Diabetes (GSD)**	NCQA	**X**	
1407	363	*Immunizations for Adolescents (IMA-E) Combination 2**	NCQA	**X**	
N/A	N/A	*Improving CFSP Network Expertise*	NCDHHS	**X**	
N/A	N/A	*Juvenile Justice Entry*	NCDHHS	**X**	
N/A	N/A	*Low Birth Weight (LBW)*[79]	NCDHHS		**X**
N/A	N/A	*Tobacco Use Screening and Cessation Intervention (TSC-E)*	NCQA		**X**
2800	448	*Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)*	NCQA	**X**	
1768	561	*Plan All-Cause Readmission (PCR)*	NCQA		**X**
1517	581/582	*Prenatal and Postpartum Care (PPC)**	NCQA	**X**	
N/A	N/A	*Rate of Screening for Health-Related Resource Needs (HRRN)*	NCDHHS		**X**
N/A	N/A	*Rate of Screening for Pregnancy Risk*	NCDHHS		**X**
0418/0418e	672	*Screening for Depression and Follow-Up Plan (CDF)*	CMS	**X**	
2801	743	*Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)*	NCQA	**X**	

[79] See Appendix C for more information on this measure.

CBE #	CMIT #	Measure	Steward	CFSP Reported	Department calculated
2940	748	*Use of Opioids at High Dosage in Persons Without Cancer (OHD)*	NCQA		**X**
2950	N/A	*Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)*	NCQA		**X**
1392	761	*Well-Child Visits in the First 30 Months of Life (W30)**	NCQA	**X**	

** Measure is included in the AMH measure set*

Appendix A Table 9. Additional Measure Set Specifications

The following table lists additional measure specifications for programs within NC Medicaid.

Measure Set	Specifications Location
InCK	https://medicaid.ncdhhs.gov/nc-inck-tools-resources
Transitions to Community Living (TCL)	https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living
Innovations 1915(c) Medicaid Home and Community-Based	https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/nc-innovations-waiver

Measure Set	Specifications Location
Services Waiver (HCBS) Waiver	
TBI 1915(c) Medicaid HCBS Waiver	https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/traumatic-brain-injury
CMHRP and CMARC	Please refer to the Program Guide, available here, for more information on quality measures that must be reported as part of Care Management for High Risk Pregnancy and Care Management for At-Risk Children Programs.

Appendix B: Gap-to-Goal Benchmarking Methodology Example

Appendix B Table 10. Hypothetical Gap-to-Goal Target Calculation Example for Measure with 50th Percentile Goal

Plan	Plan Baseline	Goal: 50th Percentile	Gap-to-Goal Target	Relative Improvement Required [80]	Improvement Corridor Adjustment Required?	Adjusted Target
Plan A	40%	52%	40% + [(52% – 40%) * 0.10] = **41.20%**	[(41.20% – 40%) / 40%] *100 = 3%	No	N/A
Plan B	51%	52%	51% + [(52% – 51%) * 0.10] = 51.10%	[(51.10% – 51%) / 51%] *100 = 0.2%	Yes, 2% minimum improvement	51% * 1.02 = **52.02%**

[80] A 2% minimum improvement adjustment is required when gap-to-goal targets result in less than 2% relative improvement (only for measures with 50th percentile goals); 10% maximum improvement adjustments are used when gap-to-goal targets result in greater than 10% relative improvement.

Plan	Plan Baseline	Goal: 50th Percentile	Gap-to-Goal Target	Relative Improvement Required [80]	Improvement Corridor Adjustment Required?	Adjusted Target
Plan C	25%	52%	25% + [(52% – 25%) * 0.10] = 27.70%	[(27.70% – 25%) / 25%] *100 = 10.8%	Yes, 10% maximum improvement	25% * 1.10 = **27.50%**

Appendix B Table 11. Hypothetical Gap-to-Goal Target Calculation Example for Measure with 90th Percentile Goal

Plan	Plan Baseline	Goal: 90th Percentile	Gap-to-Goal Target	Relative Improvement Required	Improvement Corridor Adjustment Required?	Adjusted Target
Plan A	60%	70%	60% + [(70% – 60%) * 0.10] = **61.00%**	[(61% – 60%) / 60%] *100 = 1.7%	No	N/A
Plan B	33%	70%	33% + [(70% – 33%) * 0.10] = 36.70%	[(36.70% – 33%) / 33%] *100 = 11.2%	Yes, 10% maximum improvement	33% * 1.10 = **36.30%**

Appendix C: Measure Modifications: Low Birth Weight

UNC Sheps Center for Health Services Research ("Sheps") will report the low-birth-weight outcome measure. The calculation of the low-birth-weight outcome measure will be completed as follows:

7. Using birth certificate records, births in the measurement year are identified with child and parent linked via name, gender, birth date, address etc.
8. From the linked records, identify those where the birthing parent had Medicaid eligibility at the time of the delivery OR the child was enrolled within a month of delivery to capture births where Medicaid paid.[81]
9. Sheps next identifies live births by removing non-live births identified by diagnosis codes in the claims data and allowing for a 30-day period of the delivery date to account for any discrepancies between claims delivery dates and birth certificate records. A flag will also be created for singleton births, removing those that are multi-gestational.
10. Sheps will remove babies with an unknown or unreported birth weight from the numerator and denominator, as well as exclude those who had a weight less than 300 grams.
11. Sheps identifies births in which the parent was enrolled in a PHP by 16 weeks' gestation, creating a "minimum enrollment date" based on the gestational age from the date of birth on the birth certificate record. They also identify babies whose parent had continuous coverage for the same health plan from the minimum enrollment date through the delivery date. If parent does not meet criteria, they are excluded.

To ensure the implementation and use of this measure does not create incentives for plans to avoid high-risk members, the Department will monitor potential plan avoidance of high-risk members via strategies that may include monitoring plan enrollment and disenrollment patterns for pregnant members, specifically with respect to the 90-day choice period[82]; monitoring practice referral patterns and plan contracting with practices specializing in low-income or high-risk populations; and reporting at the plan and regional levels to address region-driven variations in populations. In addition, the Department will not publicly report measure performance at the provider or practice level, and plans will not be permitted to use the measure in value-based and performance incentive contracting due to concerns that provider-level samples will be small and unreliable, and providers may be discouraged from treating high-risk members.

[81] This was updated July 2025 to account for inaccurate Medicaid coverage information on birth certificates.

[82] All NC Medicaid Managed Care members—whether they select or are assigned to a Standard Plan or Tailored Plan—have a 90-day period following the effective coverage date or date of notice of new plan enrollment (referred to as the choice period) to switch plans "without cause." After the completion of the 90-day period, most beneficiaries must remain enrolled in their plan for the remainder of their eligibility period unless they can demonstrate a "with cause" reason for switching. Certain special populations may switch plans "without cause" at any time, including members of a federally recognized tribe and beneficiaries receiving long-term services and supports in institutional or community-based settings. All beneficiaries will have the option to switch plans annually at the time of eligibility redetermination.

Appendix D: Key to Technical Specifications

Measure Name

Descriptive Information

Measure Type

Indicates whether the measure is a process, outcome or a cost/resource use measure.

CBE/CMIT Number and Measure Steward

CBE/CMIT number and measure steward.

Brief Description of Measure

Short description of the measure focus, target population and timeframe.

Numerator Statement

A brief, narrative description of the measure focus or what will be measured within the target population. If an outcome measure, state the outcome being measured.

Denominator Statement

A brief, narrative description of the target population being measured. If an outcome measure, states the target population for the outcome.

Denominator Exclusions

A brief narrative description of exclusions from the target population.

Appendix E: Specifications for Measures

The following measure descriptions contain high-level information about quality measures and are not meant to replace the measure steward's official technical specification. For example, when calculating NCQA HEDIS measures, the official NCQA HEDIS technical specifications should be utilized.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CMIT# 18, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 18 and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.

Numerator Statement

The number of members who achieved a proportion of days covered (PDC) of at least 80% for their antipsychotic medications during the measurement year.

Denominator Statement

Members ages 18 and older as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement year.

Denominator Exclusions

Members with any diagnosis of dementia during the measurement period.

Members who did not have at least two antipsychotic medication dispensing events. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.

- Claim/encounter data. An antipsychotic medication.
- Pharmacy data. Dispensed an antipsychotic medication.

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Adult Immunization Status (AIS-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 3620, CMIT# 26, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 19 and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, pneumococcal, hepatitis B and coronavirus disease 2019 (COVID-19).

Numerator Statements

Numerator 1 – Immunization Status: Influenza

- Members who received an influenza vaccine on or between July 1 of the year prior to the measurement period and June 30 of the measurement period, or
- Members with anaphylaxis due to the influenza vaccine any time before or during the measurement period.

Numerator 2 – Immunization Status: Td/Tdap

- Members who received at least one Td vaccine or one Tdap vaccine between nine years prior to the start of the measurement period and the end of the measurement period, or
- Members with a history of anaphylaxis or encephalitis due to the diphtheria, tetanus or pertussis vaccine any time before or during the measurement period.

Numerator 3 – Immunization Status: Zoster

- Members who received two doses of the herpes zoster recombinant vaccine at least 28 days apart Oct. 20, 2017, through the last day of the measurement period, or

- Members with anaphylaxis due to the herpes zoster vaccine any time before or during the measurement period.

Numerator 4 – Immunization Status: Pneumococcal

- Members who were administered at least one dose of an adult pneumococcal vaccine on or after their 19th birthday and before or during the measurement period, or

- Members with anaphylaxis due to the pneumococcal vaccine any time before or during the measurement period.

Numerator 5 – Immunization Status: Hepatitis B

- Members who received at least three doses of the childhood hepatitis B vaccine with different dates of service on or before their 19th birthday, or

- Members who received a hepatitis B vaccine series on or after their 19th birthday, before or during the measurement period, or

- Members who had a hepatitis B surface antigen, hepatitis B surface antibody or total antibody to hepatitis B core antigen test, with a positive result any time before or during the measurement period, or

- Members with a history of hepatitis B illness any time before or during the measurement period, or

- Members with anaphylaxis due to the hepatitis B vaccine any time before or during the measurement period.

Numerator 6: Immunization Status: COVID-19

- Members who received at least one dose of a COVID-19 vaccine that occurred both on or between July 1 of the year prior to the measurement period and on or after their 65th birthday.

- Members with a history of anaphylaxis or encephalitis due to the COVID-19 vaccine any time before or during the measurement period.

Denominator Statements

Denominator 1: Influenza—Members ages 19 and older at the start of the measurement period who also meet the criteria for participation.

Denominator 2: Td/Tdap—Members ages 19 and older at the start of the measurement period who also meet the criteria for participation.

Denominator 3: Zoster—Members ages 50 and older at the start of the measurement period who also meet the criteria for participation.

Denominator 4: Pneumococcal—Members ages 65 and older at the start of the measurement period who also meet the criteria for participation.

Denominator 5: Hepatitis B—Members ages 19 through 59 at the start of the measurement period who also meet the criteria for participation.

Denominator 6: COVID-19-- Members ages 65 and older at the start of the measurement period who also meet the criteria for participation.

Denominator Exclusions

Members who use hospice or elect to use a hospice benefit any time during the measurement period.

Members who die any time during the measurement period.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

ADATC Readmissions within 30 Days and 180 Days

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

This measure provides the number and percentage of persons discharged during the measurement period readmitted to any State Alcohol and Drug Abuse Treatment Center (ADATC) within 30 days and within 180 days of discharge.

Numerator Statement

For individuals in the denominator, the number of discharges that were readmitted to an ADATC within 30 calendar days and within 180 days of discharge. The readmission does not have to be to the same facility from which the person was originally discharged.

Denominator Statement

The number of allowable discharges, as defined below, from a state ADATC during the measurement quarter, that fall within the responsibility of an LME/MCO to coordinate services.

Denominator Inclusions/Exclusions

Discharges include only those coded as “direct” discharges or “program completion” to sources that fall within the responsibility of an LME/MCO to coordinate services (e.g., to other outpatient and residential non-state facility, self/no referral, unknown, community agency, private physician, other health care, family or friends, nonresidential treatment/habilitation program, other).

Discharges for other reasons (e.g., transfers to other facilities, deaths, discharges to medical visits); to other referral sources (e.g., court, correctional facilities, nursing homes, state facilities, VA); and out of state are not included in the numerator and denominator.

Treat transfers as a continuous inpatient episode. In these cases, count only the discharge from the last facility. For individuals with multiple admissions to an ADATC during the measurement quarter, count all discharges.

Note: Measure calculated quarterly aligned with the SFY.

State Psychiatric Hospital Readmissions within 30 Days and 180 Days

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

This measure provides the number and percentage of persons discharged during the measurement period readmitted to any State Psychiatric Hospital within 30 days and within 180 days of discharge.

Numerator Statement

For individuals in the denominator, the number of discharges that were readmitted to any State Psychiatric Hospital within 30 calendar days and within 180 days of discharge. The readmission does not have to be to the same facility from which the person was originally discharged.

Denominator Statement

The number of allowable discharges, as defined below, from a State Psychiatric Hospital during the measurement quarter that fall within the responsibility of an LME/MCO to coordinate services.

Denominator Inclusions/Exclusions

Discharges include only those coded as "direct" discharges or "program completion" to sources that fall within the responsibility of an LME/MCO to coordinate services (e.g., to other outpatient and residential non-state facility, self/no referral, unknown, community agency, private physician, other health care, family or friends, nonresidential treatment/habilitation program, other).

Discharges for other reasons (e.g., transfers to other facilities, deaths, discharges to medical visits); to other referral sources (e.g., court, correctional facilities, nursing homes, state facilities, VA); and out of state are not included in the numerator and denominator.

Treat transfers as a continuous inpatient episode. In these cases, count only the discharge from the last facility. For individuals with multiple admissions to State Psychiatric Hospital during the measurement quarter, count all discharges.

Note: Measure calculated quarterly aligned with the SFY.

Adults Access to Preventive/Ambulatory Health Services (AAP)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CMIT#36, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 20 and older who had an ambulatory or preventive care visit.

Numerator Statement

Number of members with one or more ambulatory or preventive care visits during the measurement year.

Denominator Statement

Members ages 20 and older.

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who die any time during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Antibiotic Utilization for Respiratory Conditions (AXR)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCQA

Brief Description of Measure

The percentage of episodes for members 3 months and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.

Numerator Statement

Dispensed prescription for an antibiotic medication from the AXR Antibiotic Medications List on or three days after the episode date.

Denominator Statement

Members months of age or older with a diagnosis of a respiratory condition.

Denominator Exclusions

Visits that resulted in an inpatient stay.

Episode dates when the member had a claim/encounter with any diagnosis for a comorbid condition during the 12 months prior to or on the episode date.

Episode dates where a new or refill prescription for an antibiotic medication (AXR Antibiotic Medications List) was dispensed 30 days prior to the episode date or was active on the episode date.

Episode dates where the member had a claim/encounter with a competing diagnosis on or three days after the episode date.

Members in hospice or using hospice services anytime during the measurement year.

Members who die any time during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Average Length of Stay in Community Hospitals for Mental Health Treatment and Substance Use Disorder Treatment

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

The measure provides the average length of stay for persons with a principal mental health diagnosis who were discharged during the measurement period from a community psychiatric hospital or a psychiatric unit of a general community hospital for acute mental health care.

Numerator Statement

Total number of inpatient days associated with discharges that occurred during the measurement period. This is the sum of the lengths of stay for all discharges during the measurement period, as defined below.

Denominator Statement

Total number of allowable discharges during the measurement period, as defined below.

Numerator and Denominator Inclusions/Exclusions

The number of days is calculated as the date of discharge minus the date of admission unless the two dates are the same. In that case, the number of days will be 1 (cannot have “0” days).

Do not include the last day of the stay (unless the last day of the stay is also the admit day).

Calculate length of stay only for persons discharged during the measurement period. Total days include all days associated with the inpatient stay including days before the first day of the measurement period for discharge dates occurring during the measurement period.

Total days do not include days during the measurement period that are associated with discharge dates after the last day of the measurement period. Therefore, do not include days for persons still in the hospital on the last day of the measurement period.

For transfers between inpatient units or facilities to the same service or level of care, be sure to count all days for both units and facilities.

Exclude days associated with intermediate care or partial hospitalization.

Avoidable Adult Utilization – Prevention Quality Indicators (PQI)

Descriptive Information

Measure Type

Rate/Proportion

CBE Number and Measure Steward

CBE# 0272/0275/0277/0283, CMIT# 577/578/579/580, Measure Steward: AHRQ

Brief Description of Measure

The department will calculate the following measures of avoidable adult hospitalization:

- PQI 01 Diabetes Short-term Complication Admission Rate.
- PQI 05 COPD or Asthma in Older Adults Admission Rate.
- PQI 08 Heart Failure Admission Rate.
- PQI 15 Asthma in Younger Adults Admission Rate.

A lower rate indicates better performance.

Numerator Statement

Discharges, for members ages 18 and older, that meet the inclusion and exclusion rules for the numerator in any of the following PQIs:

- PQI 01 Diabetes Short-term Complication Admission Rate.
- PQI 05 COPD or Asthma in Older Adults Admission Rate.
- PQI 08 Heart Failure Admission Rate.
- PQI 15 Asthma in Younger Adults Admission Rate.

Denominator Statement

Population ages 18 and older in a metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of residence, not the metropolitan area or county of the hospital where the discharge occurred.

Denominator Exclusions

See each component measure for exclusions.

More information is available here and full specifications are available here.

Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0058, CMIT# 84, Measure Steward: NCQA

Brief Description of Measure

The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.

Numerator Statement

Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List) on or 3 days after the episode date.

Denominator Statement

Episodes for members ages 3 months and older with a diagnosis of acute bronchitis or bronchiolitis during the intake period.

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Blood Pressure Control for Patients with Diabetes (BPD)

Descriptive Information

Measure Type

Outcome: Intermediate Clinical Outcome

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 18 through 75 with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Numerator Statement

Members whose most recent blood pressure level was <140/90 mm Hg during the measurement year.

Denominator Statement

Members ages 18 through 75 by the end of the measurement year who had a diagnosis of diabetes (type 1 or 2) during the measurement year or the year prior to the measurement year.

Denominator Exclusions

Members who use hospice services or elect to use a hospice benefit any time during the measurement year.

Members who died anytime during the measurement year. Members receiving palliative care any time during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Breast Cancer Screening (BCS-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 2372, CMIT# 93, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 40 through 74 who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer in the past two years.

Numerator Statement

Women who received at least one mammogram to screen for breast cancer in the past two years.

Denominator Statement

Women ages 42 through 74 by the end of the measurement period who were recommended for routine breast cancer screening and also meet the criteria for participation.

Denominator Exclusions

Members who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the member's history through the end of the measurement period.

Members who use hospice services or are enrolled in an institutional special needs plan or are living long-term in an institution anytime during the measurement year.

Members who die any time during the measurement period.

Members who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the member's history through the end of the measurement year.

Members receiving palliative care any time during the measurement period.

Reporting for this measure transitioned to Electronic Clinical Data Systems (ECDS)-only in measurement year 2023. Health plans should follow the BCS-E methodology outlined in HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans, which includes all exclusion criteria.

Cervical Cancer Screening (CCS-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0032, CMIT# 118, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 21 through 64 who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members ages 21 through 64 who were recommended for routine cervical cancer screening and had cervical cytology performed within the last three years.
- Members ages 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Members ages 30 through 64 who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) co-testing within the last five years.

Numerator Statement

The number of members recommended for routine cervical cancer screening who were screened for cervical cancer.

Denominator Statement

Members, recommended for routine cervical cancer screening, ages 24 through 64 as of the end of the measurement year.

Denominator Exclusions

Members who had a hysterectomy with no residual cervix, cervical agenesis or acquired absence of cervix anytime during the member's history through December 31 of the measurement year.

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

Members receiving palliative anytime during the measurement year.

Members with Sex Assigned at Birth of Male at any time in the patient's history.

Reporting for this measure transitioned to Electronic Clinical Data Systems (ECDS)-only in measurement year 2024. Health plans should follow the CCS-E methodology outlined in HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans, which includes all exclusion criteria.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Child and Adolescent Well-Care Visits (WCV)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 1516, CMIT# 123, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 3 through 21 who had at least one comprehensive well-care visit with a primary care provider (PCP) or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement year.

Numerator Statement

One or more well-care visits during the measurement year. The well-care visit must occur with a PCP or an OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the member.

Denominator Statement

Members ages 3 through 21 as of December 31 of the measurement year.

Denominator Exclusions

Members in hospice or using hospice services at any time during the measurement year.

Members who died during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Childhood Immunization Status (CIS-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0038, CMIT# 124, Measure Steward: NCQA

Brief Description of Measure

The percentage of children 2 years old who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenzae type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two combination rates.

Appendix E Table 11: Childhood Immunization Status (CIS) Combinations

Combination	DTaP	IPV	MMR	HiB	HepB	VZV	PCV	HepA	RV	Influenza
Combination 7	X	X	X	X	X	X	X	X	X	
Combination 10	X	X	X	X	X	X	X	X	X	X

Numerator Statement

Children who received the recommended vaccines on or before their second birthday.

Denominator Statement

Children who turn 2 during the measurement year.

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who died during the measurement year.

Members who have a contraindication to a childhood vaccine on or before their second birthday.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Chlamydia Screening (CHL)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0033, CMIT# 128, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 16 through 24 who were recommended for routine chlamydia screening, were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Numerator Statement

At least one chlamydia test during the measurement year.

Denominator Statement

Members ages 16 through 24 who were recommended for routine chlamydia screening and had a claim or encounter indicating sexual activity.

Denominator Exclusions

Members who received a pregnancy test during the measurement year and a prescription for isotretinoin on the date of the pregnancy test of six days after the pregnancy test.

Members who received a pregnancy test during the measurement year and an x-ray on the date of the pregnancy test or six days after the pregnancy test.

Members in hospice or using hospice services during the measurement year.

Members who died during the measurement year.

Members with a Sex Assigned at Birth of Male any time in the member's history through the last day of the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Colorectal Cancer Screening (COL-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0034, CMIT# 139, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 45 through 75 who had appropriate screening for colorectal cancer. This includes any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every five years, colonoscopy every ten years, computed tomography colonography every five years, stool DNA test every three years.

Numerator Statement

Members who received one or more screenings for colorectal cancer according to clinical guidelines.

Denominator Statement

Members ages 45 through 75.

Denominator Exclusions

Members who had colorectal cancer anytime during the member's history through the end of the measurement year.

Members who had a total colectomy any time during the member's history through December 31 of the measurement year.

Members in hospice or using hospice services during the measurement year.

Members who died anytime during the measurement year.

Members receiving palliative care any time during the measurement year.

Reporting for this measure transitioned to Electronic Clinical Data Systems (ECDS)-only in measurement year 2024. Health plans should follow the COL-E methodology outlined in HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans, which includes all exclusion criteria.

Community Mental Health Inpatient Readmissions within 30 Days

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

This measure provides the number and percentage of consumers discharged during the measurement period with a principal mental health diagnosis readmitted to inpatient care in an acute inpatient hospital within 30 calendar days of the discharge.

Numerator Statement

Total number of discharges in the denominator readmitted within 30 days (inclusive) for a mental health, I/DD or substance use disorder (SUD) diagnosis after the discharge. The readmission does not have to be to the same facility from which the person was originally discharged.

Denominator Statement

Total number of discharges from an acute inpatient hospital setting with a principal mental health diagnosis during the measurement period.

Denominator Exclusions

None.

Measurement

The measure is reported separately for discharges from acute inpatient hospitals and for discharges from facility-based crisis services.

Note: Measure calculated quarterly with the SFY.

Community Substance Use Disorder Inpatient Readmissions within 30 Days

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

This measure provides the number and percentage of consumers discharged during the measurement period with a principal SUD diagnosis readmitted to inpatient care in an acute inpatient hospital within 30 calendar days of the discharge.

Numerator Statement

Total number of discharges in the denominator readmitted within 30 days of the discharge (inclusive) for an MH, I/DD or SUD diagnosis. The readmission does not have to be to the same facility from which the person was originally discharged.

Denominator Statement

Total number of discharges from an acute inpatient hospital service with a principal SUD diagnosis during the measurement period.

Denominator Exclusions

None.

Measurement

Note: Measure calculated quarterly with the SFY.

Concurrent Use of Prescription Opioids and Benzodiazepines (COB)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 3389, CMIT# 150, Measure Steward: PQA

Brief Description of Measure

The percentage of individuals ages 18 and older with concurrent use of prescription opioids and benzodiazepines during the measurement year.

A lower rate indicates better performance.

Numerator Statement

The number of members with both of the following:

- Two or more prescription claims for any benzodiazepines with different dates of service.
- Concurrent use of opioids and benzodiazepines for 30 or more cumulative days.

Denominator Statement

Members ages 18 and older with two or more prescription claims for opioid medications on different dates of service and with 15 or more cumulative days' supply during the measurement year.

Denominator Exclusions

Members in hospice or with a cancer or sickle cell disease diagnosis at any point during the measurement year are excluded from the denominator.

More information on the Pharmacy Quality Alliance (PQA) measures can be found here. For full measure specifications, please refer to the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) and Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manuals.

Continuity of Pharmacotherapy for Opioid Use Disorder

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 3175, Measure Steward: University of Southern California (USC)

Brief Description of Measure

Percentage of adults ages 18 through 64 with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment.

Numerator Statement

Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days.

Denominator Statement

Individuals ages 18 through 64 who had a diagnosis of OUD and at least one claim for an OUD medication.

Denominator Exclusions

None.

Contraceptive Care: All Women (CCW)

Descriptive Information

Measure Type

Outcome: Intermediate Clinical Outcome

CBE Number and Measure Steward

CBE# 2903/2904, CMIT# 1002, Measure Steward: U.S. Office of Population Affairs

Brief Description of Measure

Among women ages 15 through 44 at risk of unintended pregnancy, the percentage that:

1. Were provided a most effective or moderately effective method of contraception.
2. Were provided a long-acting reversible method of contraception (LARC).

Numerator Statement

Most or moderately effective method of contraception: Women ages 15 through 44 at risk of unintended pregnancy who are provided a most (i.e., sterilization, intrauterine device or system (IUD/IUS) or contraceptive implant) or moderately (i.e., oral pill, patch, ring, injectable or diaphragm) effective method of contraception.

LARC: Women ages 15 through 44 at risk of unintended pregnancy who are provided contraceptive implants or intrauterine devices or systems (IUD/IUS).

Denominator Statement

Women ages 15–44 years who are at risk of unintended pregnancy.

Denominator Exclusions

Members who meet the following criteria:

- Those who are infecund for non-contraceptive reasons (unable to bear children).
- Those who had a live birth in the last two months of the measurement year.
- Those who were still pregnant, or their pregnancy outcome was unknown at the end of the measurement year.

For full measure specifications, please refer to the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) and Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manuals.

Contraceptive Care: Postpartum (CCP)

Descriptive Information

Measure Type

Outcome: Intermediate Clinical Outcome

CBE Number and Measure Steward

CBE# 2902, CMIT# 166, Measure Steward: U.S. Office of Population Affairs

Brief Description of Measure

Among women ages 15 through 44 who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within three and 90 days of delivery.

2. Were provided a long-acting reversible method of contraception (LARC) within three and 90 days of delivery.

Numerator Statement

Most or moderately effective method of contraception within three days: Women ages 15 through 44 years who had a live birth and are provided a most (i.e., sterilization, intrauterine device or system (IUD/IUS) or contraceptive implant) or moderately (i.e., oral pill, patch, ring, injectable or diaphragm) effective method of contraception within three days of delivery.

Most or moderately effective method of contraception within 90 days: Women ages 15 through 44 who had a live birth and are provided a most (i.e., sterilization, intrauterine device or system (IUD/IUS) or contraceptive implant) or moderately (i.e., oral pill, patch, ring, injectable or diaphragm) effective method of contraception within 90 days of delivery.

LARC within three days: Women ages 15 through 44 who had a live birth and are provided contraceptive implants or intrauterine devices or systems (IUD/IUS) within three days of delivery.

LARC within 90 days: Women ages 15 through 44 years who had a live birth and are provided contraceptive implants or intrauterine devices or systems (IUD/IUS) within 90 days of delivery.

Denominator Statement

Women ages 15 through 44, as of December 31 of the measurement year, who had a live birth during the measurement year.

Denominator Exclusions

Members who meet the following criteria:

- Deliveries that did not end in a live birth (i.e., miscarriage, ectopic, stillbirth or induced abortion). Deliveries that occurred during the last three months of the measurement year.

For full measure specifications, please refer to the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) and Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manuals.

Controlling High Blood Pressure (CBP)

Descriptive Information

Measure Type

Outcome

CBE Number and Measure Steward

CBE# 0018, CMIT# 167, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 18 through 85 who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement year.

Numerator Statement

The number of members in the denominator whose most recent blood pressure was adequately controlled during the measurement year. For a patient's blood pressure to be controlled, both the systolic and diastolic blood pressure must be <140/90 mm Hg (adequate control). To determine whether a patient's blood pressure was adequately controlled, the representative blood pressure must be identified.

Note: Supplemental blood pressure data from NC HealthConnex can be used to identify numerator compliance.

Denominator Statement

Members ages 18 through 85 by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension during the first six months of the measurement year.

Denominator Exclusions

Members with evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant anytime during the member's history on or prior to December 31 of the measurement year.

Members with a diagnosis of pregnancy during the measurement year.

Members who had an admission to a non-acute inpatient setting during the measurement year.

Members receiving palliative care anytime during the measurement year.

Members in hospice or using hospice services anytime during the measurement year.

Members who died during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Diabetes Care for People with Serious Mental Illness: Glycemic Status > 9.0% (HPCMI)

Descriptive Information

Measure Type

Outcome

CBE Number and Measure Steward

CBE# 2607, CMIT# 196, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 18 through 75 with a serious mental illness and diabetes (type 1 or 2) whose most recent HbA1c level during the measurement year is >9.0%.

A lower rate indicates better performance.

Numerator Statement

Members whose most recent HbA1c level is greater than 9.0% (poor control) during the measurement year.

Denominator Statement

Members ages 18 through 75 as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least

one inpatient visit for major depression during the measurement year and diabetes (type 1 or 2) during the measurement year or the year before.

Denominator Exclusions

Members who do not have a diagnosis of diabetes and meet one of the following criteria:

- Members with a diagnosis of polycystic ovaries.
- Members with gestational or steroid-induced diabetes.

Beneficiaries in hospice or using hospice services anytime during the measurement year.

Beneficiaries receiving palliative care during the measurement year.

Summary of Updates to HPCMI for MY2025

NCQA made multiple updates to the HPCMI measure in MY2025. These updates included:

- Changing the measure title from *Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (Hba1c) Poor Control (> 9.0%)* to *Diabetes Care for People with Serious Mental Illness: Glycemic Status > 9.0%;*
- Updating the event/diagnosis criteria for identifying beneficiaries with diabetes; and
- Removing the required exclusion for beneficiaries who did not have a diagnosis of diabetes.

Click here to view all the updates made to HPCMI for MY2025.

For full measure specifications, please refer to the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Technical Specifications and Resource Manual.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 1932, CMIT# 202, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 18 through 64 with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Numerator Statement

Among members ages 18 through 64 with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Denominator Statement

Members ages 18 through 64 as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

Denominator Exclusions

Members who use hospice services or elect to use a hospice benefit anytime during the measurement year, regardless of when the services began.

Members with diabetes during the measurement year or the year prior to the measurement year.

Members who had no antipsychotic medications dispensed during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Developmental Screening in the First Three Years of Life (DEV)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 1448, CMIT# 1003, Measure Steward: Oregon Health and Sciences University (OHSU)

Brief Description of Measure

The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second or third birthday. This is a composite measure of screening in the first three years of life that includes

three, age-specific indicators assessing whether children are screened in the 12 months preceding or on their first, second or third birthday.

Numerator Statements

Children who were screened for risk of developmental, behavioral and social delays using a standardized tool. This measure will be calculated with four performance rates:

1. *Screened by 12 Months:* Percentage of children who turned 1 during the performance period who were screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report within 12 months preceding or on their birthday.

2. *Screened by 24 Months:* Percentage of children who turned 2 during the performance period who were screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report within 12 months preceding or on their birthday.

3. *Screened by 36 Months:* Percentage of children who turned 3 during the performance period who were screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report within 12 months preceding or on their birthday.

4. *Combined Rate:* Percentage of children who turned 1, 2 or 3 during the performance period who were screened for risk of developmental, behavioral and social delays using a standardized tool with interpretation and report within 12 months preceding or on their birthday (the sum of numerators one, two or three).

Denominator Statements

Screened by 12 Months: The children in the eligible population who turned 1 during the measurement year.

Screened by 24 Months: The children in the eligible population who turned 2 during the measurement year.

Screened by 36 Months: The children in the eligible population who turned 3 during the measurement year.

Combined Rate: All children in the eligible population who turned 1, 2, or 3 during the measurement year, e.g., the sum of denominators one, two or three.

Denominator Exclusions

None.

For full measure specifications, please refer to the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Screening Ratio

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: CMS

Brief Description of Measure

Indicates the extent to which EPSDT eligibles received the number of initial and periodic screening services required by the state's periodicity schedule, prorated by the proportion of the year for which they were EPSDT eligible.

Numerator Statement

Actual number of initial and periodic screening services received.

Denominator Statement

Expected number of initial and periodic screening services.

Denominator Exclusions

Undocumented individuals who are eligible only for emergency Medicaid services.

Members in separate state Children's Health Insurance Program (CHIP) programs.

Other groups of individuals under age 21 who are eligible only for limited services as part of their Medicaid eligibility (for example, pregnancy-related services).

For more detailed instructions, please see the CMS-416 Instructions.

Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, CMIT# 1784, Steward: DQA

Brief Description of Measure

Number of emergency department (ED) visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 member months for adults

A lower rate indicates better performance.

Numerator Statement

Number of ED visits with an ambulatory care sensitive non-traumatic dental condition diagnosis code among individuals ages 18 and older

Denominator Statement

All member months for individuals ages 18 and older during the reporting year

Denominator Exclusions

For more detailed instructions, please see the DQA technical specification.

Engagement in Mental Health Services

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

The percentage of children and adults with a new episode of mental health treatment who initiated treatment (through an inpatient mental health admission, outpatient visits, telehealth, intensive outpatient encounter or partial hospitalization) and who had two or more additional services with a mental health diagnosis within 34 days of the initiation visit.

Numerator Statement

Initiation of mental health treatment, as defined above, and two or more inpatient admissions, outpatient visits, telehealth visits, intensive outpatient encounters or partial hospitalizations with any mental health diagnosis within 34 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with

different providers to be counted. For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 34-day engagement period. If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 34 days of the initiation encounter (inclusive).

Denominator Statement

The eligible population(s) with a new episode of mental health treatment during the measurement period.

Denominator Exclusions

Do not count engagement encounters that include detoxification codes (including inpatient detoxification).

Note: Measure calculated quarterly aligned with the SFY.

Engagement in Substance Use Disorder Services

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who had two or more additional services with a diagnosis of AOD abuse or dependence within 34 days of the initiation visit.

Numerator Statement

Met initiation of alcohol and other drug treatment, as defined above, and received two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 34 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers to be counted as more than one event. For members who initiated treatment via an inpatient stay, use the discharge date as the start of the 34-day engagement period. If the engagement encounter is an inpatient admission, the admission date (not the discharge date) must be within 34 days of the initiation encounter (inclusive).

Denominator Statement

The eligible population(s) with a new episode of AOD abuse or dependence during the measurement period.

Denominator Exclusions

None.

Note: Measure calculated quarterly aligned with the SFY.

Eye Exam for Patients with Diabetes (EED)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, CMIT# 203, Measure Steward: NCQA

Measure Description

The percentage of persons ages 18 through 75 with diabetes (type 1 or type 2) who had a retinal eye exam.

Numerator Statement
Beneficiaries who received a retinal eye exam during the measurement year.

Denominator Statement
Beneficiaries ages 18 through 75 as of the last day of the measurement period, with a diagnosis of diabetes.

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

Members who received palliative care during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals and Facility-based Crisis Services for Mental Health Treatment

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

The percentage of discharges for individuals ages 3 through 64 who were admitted for mental health treatment in a community-based hospital, state psychiatric hospital or facility-based crisis service that received a follow-up visit with a behavioral health practitioner within one to seven and one to 30 days after discharge.

Numerator Statement

For discharges included in the denominator, a follow-up visit with a behavioral health practitioner within one to seven and one to 30 days after discharge. Do not include visits that occur on the date of discharge.

Denominator Statement

Discharged alive from a community-based hospital, state psychiatric hospital or a facility-based crisis service with a discharge date occurring within the measurement period, with a principal mental health diagnosis.

Community-based hospital includes:

- YP820 (inpatient hospital).
- YP821 (three-way contract – inpatient unit bed day).
- YP822 (three-way contract – enhanced inpatient unit bed day).

Facility-based crisis includes:

- S9484 (facility-based crisis service).
- S9484CR (facility-based crisis service) – flexibility.
- S9484HA (facility-based crisis service – child).

- S9484HA CR (facility-based crisis service – child) – flexibility.
- YP485 (facility-based crisis program – non-Medicaid).
- YP485CR (facility-based crisis program – non-Medicaid) – flexibility.

State psychiatric hospital includes:

Discharges coded as follows (all three fields must contain one of the listed values):

Discharge reason =

- Direct discharge to inpatient commitment.
- Direct to outpatient commitment.
- Direct to substance abuse commitment.
- Direct by court order.
- Direct with approval.
- Against medical advice (AMA).

And discharge referral to =

- Acute care hospital (inpatient).
- Other.
- Other outpatient and residential non-state facility.
- Outpatient services.
- Residential care.
- Self/no referral.
- Unknown.

And discharge living arrangement =

all arrangements except (not equal to)

- Correctional facility (prison jail training school).
- Psychiatric hospital.

- Developmental disability center.

Definition of date of discharge:

- Community hospital – the later of the statement coverage period through date or the last line service date + 1 day for bill types 111, 114 or 117 on the 837i.
- State psychiatric hospital – the date of discharge on the HEARTS extract.
- Facility-based crisis (S9484 and S9484HA) – the last date of service billed/paid.
- Facility-based crisis (YP485) – the last date of service billed/paid + 1 day.

Denominator Inclusions/Exclusions

Exclude state psychiatric hospital discharges coded as:

- Discharge aftercare LME = (blank) and discharge referral = "unknown."
- Responsible county or county discharged to = "out of state."
- Record does not have a valid CNDSID, or the record has a duplicate CNDSID and discharge date.

The denominator is based on discharges, not on individuals. If individuals have more than one discharge during the measurement period, include all discharges, except (re)admission or direct transfer within seven days.

If the discharge is followed by (re)admission* or direct transfer within seven days of discharge to a community-based hospital, state psychiatric hospital, ADATC or detox/facility-based crisis service for a principal mental health or principal substance use disorder diagnosis, treat the (re)admission or direct transfer as an extension of the original stay and count only the last discharge.

Use the principal diagnosis of the last discharge to determine which performance measure specifications to use to receive credit for the discharge and follow-up.

- If the principal diagnosis is mental health, continue to use the specifications for this measure.
- If the principal diagnosis is SUD, use the specifications for the Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs and Detox/Facility-based Crisis Services for SUD Treatment performance measure.

* To determine the date of (re)admission, use the earlier of the admission date or first line service date on the institutional claim or the first date of service on the professional claim.

Exclude the last discharge if it occurs after the end of the measurement period. In that case, the last discharge would be counted in the measurement period in which it occurs.

Exclude from the denominator any discharge followed by admission or direct transfer within the seven-day follow-up period to:

- Psychiatric residential treatment facility (YA230).
- Residential treatment level III/IV (H0019, H0019CR).
- Residential treatment level II program (H2020, H2020CR).

Note: Measure calculated quarterly aligned with the SFY.

Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, State ADATCs and Detox/Facility-based Crisis Services for SUD Treatment

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

The percentage of discharges for individuals ages 3 through 64 who were admitted for substance use disorder treatment in a community-based hospital, state psychiatric hospital, state ADATC or detox/facility-based crisis service and received a follow-up visit with a behavioral health practitioner within one to seven days and one to 30 days after discharge.

Numerator Statement

For discharges included in the denominator, a follow-up visit with a behavioral health practitioner within one to seven days after discharge. Do not include visits that occur on the date of discharge.

Denominator Statement

Discharged alive from a community-based hospital, state psychiatric hospital, ADATC or a detox/facility-based crisis service with a discharge date occurring during the measurement period and a principal substance use disorder diagnosis.

Community-based hospital includes:

- YP820 (inpatient hospital).
- YP821 (three-way contract – inpatient unit bed day).
- YP822 (three-way contract – enhanced inpatient unit bed day).

Detox/facility-based crisis includes:

- H0010 (non-hospital medical detox).
- H0010CR (non-hospital medical detox) – flexibility.
- H2036 (medically supervised detox crisis stabilization).
- H2036CR (medically supervised detox crisis stabilization) – flexibility.
- S9484 (facility-based crisis service).
- S9484CR (facility-based crisis service) – flexibility.
- S9484HA (facility-based crisis service – child).
- S9484HA CR (facility-based crisis service – child) – flexibility.
- YP485 (facility-based crisis program – non-Medicaid).
- YP485CR (facility-based crisis program – non-Medicaid) – flexibility.

State psychiatric hospital and ADATC:

Include discharges coded as follows (all three fields must contain one of the listed values):

Discharge reason =

- Direct discharge to inpatient commitment.
- Direct to outpatient commitment.
- Direct to substance abuse commitment.
- Direct by court order.
- Direct with approval.
- Against medical advice (AMA).
- Behavior problem discharge [ADATC].

- Therapeutic discharge [ADATC].
- Personal reasons (situational issue arises, and patient is discharged with treatment team approval, e.g., death in family, family emergency) [ADATC].

And discharge referral to =

- Acute care hospital (inpatient).
- Other.
- Other outpatient and residential non-state facility.
- Outpatient services.
- Residential.
- Self/no referral.
- Unknown.

And discharge living arrangement = all arrangements except (not equal to)

- Correctional facility (prison jail training school).
- Psychiatric hospital.
- Developmental disability center.

Date of discharge is defined as follows:

- Community hospital – the later of the statement coverage period through date or the last line service date + 1 day for bill types 111, 114 or 117 on the 837i.
- State psychiatric hospital and ADATC – the date of discharge on the HEARTS extract.
- Facility-based crisis (S9484 and S9484HA) – the last date of service billed/paid.
- Detox (H0010 and H2036) and facility-based crisis (YP485) – the last date of service billed/paid + 1 day.

Denominator Inclusions/Exclusions

Exclude state psychiatric hospital and ADATC discharges coded as:

- Discharge aftercare LME = (blank) **and** discharge referral = “unknown.”

- Responsible county or county discharged to = “out of state.”

- Record does not have a valid CNDSID, **or** the record has a duplicate CNDSID and discharge date.

Exclude ADATC discharges coded as the client did not provide consent to release information to an LME/MCO.

The denominator is based on discharges, not individuals. If individuals have more than one discharge during the measurement period, include all discharges, except (re)admission or direct transfer within seven days.

If the discharge is followed by (re)admission* or direct transfer within seven days of discharge to a community-based hospital, state psychiatric hospital, ADATC or detox/facility-based crisis service for a principal mental health or principal substance use disorder diagnosis, treat the (re)admission or direct transfer as an extension of the original stay and count only the last discharge.

Use the principal diagnosis of the last discharge to determine which performance measure specifications to use and to receive credit for the discharge and follow-up.

- If the principal diagnosis is SUD, continue to use the specifications for this measure.

- If the principal diagnosis is mental health, use the Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals and Facility-based Crisis Services for Mental Health Treatment measure.

* To determine the date of (re)admission, use the earlier admission date or first line service date on the institutional claim or the first date of service on the professional claim.

Exclude the last discharge if it occurs after the end of the measurement period. In that case, the last discharge would be counted in the measurement period in which it occurs.

Exclude from the denominator any discharge followed by admission or direct transfer within the seven day follow-up period to:

- Psychiatric residential treatment facility (YA230).

- Residential treatment level III/IV (H0019, H0019CR).

- Residential treatment level II (program) (H2020, H2020CR).

Note: Measure calculated quarterly aligned with the SFY.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 3489, CMIT# 265, Measure Steward: NCQA

Brief Description of Measure

The percentage of emergency department (ED) visits for members ages 6 and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are submitted:

5. The percentage of ED Visits for which the patient received follow-up within seven days after discharge.

6. The percentage of ED visits for which the patient received follow-up within 30 days after discharge.

Numerator Statement

Seven-Day Follow-Up: The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).

30-Day Follow-Up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

Denominator Statement

Emergency department (ED) visits for members ages 6 and older with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.

Denominator Exclusions

Multiple visits in a 31-day period: If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit.

ED visits followed by inpatient admission: Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission.

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Follow-Up After Emergency Department Visit for Substance Use (FUA)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 3488, CMIT# 264, Measure Steward: NCQA

Brief Description of Measure

The percentage of ED visits for members ages 13 and older with a principal diagnosis of substance use disorder, or any diagnosis of drug overdose, who had a follow-up visit for substance use disorder. Two rates are reported:

7. The percentage of ED visits for which the member received follow-up within seven days of the ED visit (eight total days).

8. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

Numerator Statements

Seven-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of SUD, within seven days after the ED visit (eight total days). Include visits that occur on the date of the ED visit.

30-Day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of SUD, within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

Denominator Statement

ED visits with a primary diagnosis of AOD abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 or older on the date of the visit. Includes ED visits for unintentional or undetermined overdose for commonly used drugs with addiction potential in “any” diagnosis position.

Denominator Exclusions

Multiple visits in a 31-day period: If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit.

ED visits followed by inpatient admission: Exclude ED visits that result in an inpatient stay. Exclude ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of the principal diagnosis for the admission.

ED visits followed by residential treatment: Exclude ED visits followed by residential treatment on the date of the ED visit or within 30 days after the ED visit.

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2025 Volume 2 Technical Specifications for Health Plans

Follow-Up After Hospitalization for Mental Illness (FUH)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0576, CMIT# 268, Measure Steward: NCQA

Brief Description of Measure

The percentage of discharges for members ages 6 and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within seven days of discharge.
- The percentage of discharges for which the patient received follow-up within 30 days of discharge.

Numerator Statements

Seven-Day Follow-Up: A follow-up service for mental health within seven days after discharge.

30-Day Follow-Up: A follow-up service for mental health within 30 days after discharge.

Denominator Statement

Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, during the first 11 months of the measurement year (i.e., January 1 to December 1) for members ages 6 and older.

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

Acute readmission or direct transfer: Exclude non-acute inpatient stays. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm, count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim), exclude both the original and the readmission/direct transfer discharge.

Non-acute readmission or direct transfer: Exclude discharges followed by readmission or direct transfer to a non-acute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for the readmission.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

Measure Steward: NCQA

Brief Description of Measure

The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among persons ages 13 and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:

- The percentage of visits or discharges for which the person received follow-up for substance use disorder within the 30 days after the visit or discharge.
- The percentage of visits or discharges for which the person received follow-up for substance use disorder within the seven days after the visit or discharge.

Numerator Statement

- **Numerator 1:** Beneficiaries with a follow-up visit or event with any practitioner for a diagnosis of substance use disorder within the 30 days after an episode for substance use disorder.

- **Numerator 2:** Beneficiaries with a follow-up visit or event with any practitioner for a diagnosis of substance use disorder within the seven days after an episode for substance use disorder.

Denominator Statement

Beneficiaries ages 13 and older as of date of the discharge, stay or event of high-intensity care for substance use disorder.

Denominator Exclusions

Members using hospice services during the measurement year.

Members who died during the measurement year.

Health plans should follow the FUI methodology outlined in HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans, which includes all exclusion criteria.

Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0108, CMIT# 271, Measure Steward: NCQA

Brief Description of Measure

The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported.

9. Initiation Phase. The percentage of members ages 6 through 12 with a prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase.

10. Continuation and Maintenance (C&M) Phase. The percentage of members ages 6 through 12 with a prescription dispensed for ADHD medication who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within 270 days (nine months) after the Initiation Phase ended.

Numerator Statement

Initiation Phase: A follow-up visit with a practitioner with prescribing authority within 30 days after the index prescription start date (IPSD).

Continuation and Maintenance Phase: A follow-up visit with a practitioner with prescribing authority within 30 days after the index prescription start date (IPSD); and at least two follow-up visits on different dates of service with any practitioner, from 31 to 300 days (nine months) after IPSD.

Denominator Statement

Children ages 6 through 12 newly prescribed ADHD medication.

Denominator Exclusions

Members who had an acute inpatient encounter for mental, behavioral or neurodevelopmental disorder or chemical dependency following the IPSD.

Members with a diagnosis of narcolepsy any time during their history through December 31 of the measurement year.

Members using hospice services during the measurement year.

Members who died during the measurement year.

Reporting for this measure transitioned to Electronic Clinical Data Systems (ECDS)-only in measurement year 2024. Health plans should follow the ADD-E methodology outlined in HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans, which includes all exclusion criteria.

Glycemic Status Assessment for Patients with Diabetes (GSD)

Descriptive Information

Measure Type

Outcome

CBE Number and Measure Steward

CBE# 0059, CMIT# 147/204, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 18 through 75 with diabetes (type 1 or type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

1. Glycemic Status <8.0%.

2. Glycemic Status >9.0%.

Numerator Statements

Glycemic Status <8.0%: Identify the most recent glycemic status assessment (HbA1c or GMI) during the measurement year. The member is numerator compliant if the most recent glycemic status assessment has a result of <8.0%. The member is not numerator compliant if the result of the most recent glycemic status assessment is ≥8.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. If there are multiple glycemic status assessments on the same date of service, use the lowest result.

Glycemic Status >9.0%: Identify the most recent glycemic status assessment (HbA1c or GMI) during the measurement year. The member is numerator compliant if the most recent glycemic status assessment has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. The member is not numerator compliant if the result for the most recent glycemic status assessment during the measurement year is ≤9.0%. If there are multiple glycemic status assessments on the same date, use the lowest results. *A lower rate indicates better performance for this indicator (i.e., low rates of Glycemic Status >9.0% indicate better care).*

Note: Supplemental glycemic status assessment data from NC HealthConnex can be used to identify numerator compliance.

Denominator Statement

Members ages 18 through 75 by the end of the measurement year who had a diagnosis of diabetes (type 1 or 2) during the measurement year or the year prior to the measurement year.

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

Members receiving palliative care or who had an encounter for palliative care any time during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Immunizations for Adolescents (IMA-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 1407, CMIT# 363, Measure Steward: NCQA

Brief Description of Measure

Percentage of adolescents age 13 who had one dose of meningococcal conjugate vaccine; had one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine; and completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and a combination rate (Combination 2: Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

Numerator Statement

Adolescents who had at least one dose of meningococcal vaccine; had one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap); and completed the HPV vaccination series by their 13th birthday.

Denominator Statement

Adolescents who turn 13 during the measurement year.

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who died during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0004, CMIT# 394, Measure Steward: NCQA

Brief Description of Measure

The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

1. Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days.

2. Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Numerator Statement

Initiation of SUD Treatment: Initiation of SUD treatment within 14 days of the Treatment Period Start Date.

Engagement of SUD Treatment: Initiation of SUD treatment and two or more additional SUD services or medication treatment within 34 days of the SUD treatment initiation.

Denominator Statement

Members ages 13 and older as of December 31 of the measurement year who were diagnosed with a new episode of SUD from November 15 of the year prior to the measurement year–November 14 of the measurement year.

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Initiation of Mental Health Services

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

The percentage of children and adults with a new episode of mental health treatment who initiate treatment through an inpatient mental health admission, outpatient visits, telehealth, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Numerator Statement

Initiation of the mental health treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.

- If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant.
- If the Index Episode was an outpatient, intensive outpatient, partial hospitalization or ED visit, the member must have an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health diagnosis within 14 days of the Index Episode start date (IESD) (inclusive).
- If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive).

Denominator Statement

The eligible population(s) with a new episode of mental health treatment during the measurement period.

Denominator Exclusions

Do not count Index Episodes that include detoxification codes (including inpatient detoxification) as beginning initiation of treatment.

Note: Measure calculated quarterly aligned with the SFY.

Improving CFSP Network Expertise

Descriptive Information

Measure Type

Non-Clinical PIP Measure

CBE Number and Measure Steward

N/A, NCDHHS

Brief Description of Measure

The percentage of Behavioral Health providers with one of the following trainings who were contracted with the CFSP PHP as of December 31 of the measurement year:

1. Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)
2. Child-Parent Psychotherapy (CPP)
3. Cognitive Processing Therapy (CPT)
4. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
5. Problematic Sexual Behavior Cognitive Behavioral Therapy (PSB-CBT)
6. Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
7. Parent-Child Interaction Therapy (PCIT)

Numerator Statement

The number of Behavioral Health providers from the denominator who were contracted with the CFSP PHP as identified through the Behavioral Health Services Providers Report (PRV033).

Denominator Statement

The number of Behavioral Health providers within the measurement year who have at least one of the active Evidence Based Treatment (EBT) certifications or trainings to support the CFSP population (listed above) identified on the Child Treatment Program Roster as of December 31 of the measurement year.

Denominator Exclusions

N/A

Note: This is a homegrown measure developed in partnership with the CFSP for their non-clinical PIP.

Initiation of Substance Use Disorder Services

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, detoxification, observation or telehealth visit within 14 days of the diagnosis.

Numerator Statement

Initiation of the AOD treatment within 14 days of the IESD.

- If the Index Episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the member is compliant.
- If the Index Episode was not an inpatient discharge, the member must initiate treatment for an AOD diagnosis on the IESD or in the 13 days after the IESD (14 total days). If the initiation encounter is an inpatient admission, the admission date (not the discharge date) must be within 14 days of the IESD (inclusive).

For all initiation events, initiation on the same day as the IESD must be with different providers in order to count.

Denominator Statement

The eligible population(s) with a new episode of AOD abuse or dependence during the measurement period.

Denominator Exclusions

None.

Note: Measure calculated quarterly aligned with the SFY.

Juvenile Justice Entry

Descriptive Information

Measure Type:

Outcome

CBE Number and Measure Steward:
N/A, NCDHHS

Brief Description of Measure
The percentage of CFSP members through age 17 who entered the juvenile justice system within the measurement year.

Numerator Statement
Members from the denominator who entered juvenile justice involvement (as defined by entering into a diversion plan or contract or level 1, 2 or 3 adjudication) at least once during the measurement year.

Denominator Statement
CFSP members ages 8 through 17 as of December 31 of the measurement year.

Denominator Exclusions
- Members in hospice or using hospice services anytime during the measurement year.
- Members who died anytime during the measurement year.
- Members involved in out-of-state juvenile justice systems.

Note: This is a homegrown measure developed in partnership with the CFSP for their non-clinical PIP.

Lead Screening in Children (LSC)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, CMIT# 1775, Measure Steward: NCQA

Brief Description of Measure

The percentage of children who had one or more capillary or venous lead blood tests to screen for lead poisoning by their second birthday.

Numerator Statement

At least one lead capillary or venous blood test on or before the child's second birthday.

Denominator Statement

Children who turn 2 during the measurement year.

Denominator Exclusions

Members in hospice or using hospice services during the measurement year.

Members who died during the measurement year.

Reporting for this measure transitioned to Electronic Clinical Data Systems (ECDS)-only in measurement year 2026. For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Live Births Weighing Less Than 2,500 Grams

Descriptive Information

Measure Type

Outcome

CBE Number and Measure Steward

CBE# 1382, CMIT# 413, Measure Steward: Centers for Disease Control and Prevention (CDC)

Brief Description of Measure

Percentage of live births that weighed less than 2,500 grams at birth during the measurement year.

A lower rate indicates better performance.

Numerator Statement

The number of Medicaid managed care live births weighing less than 2,500 grams at birth.

Denominator Statement

All NC Medicaid Managed Care live births during the measurement year.

Denominator Exclusions

Exclude resident live births from both the denominator and numerator with a birth weight that is “Unknown or Not Stated.”

For full measure specifications, please refer to the Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specification and Resource Manual.

Low Birth Weight (LBW)

Descriptive Information

Measure Type

Outcome

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

Percentage of live births, during the measurement year, where the baby weighed less than 2,500 grams and less than 1,500 grams at birth.

A lower rate indicates better performance.

Numerator Statement

Low Birth Weight: Percentage of live births that weighed less than 2,500 grams at birth during the measurement year.

Very Low Birth Weight: Percentage of live births that weighed less than 1,500 grams at birth during the measurement year.

Denominator Statement

All Medicaid managed care live births during the measurement year.

Denominator Exclusions

Exclude resident live births from both the denominator and numerator with a birth weight that is "Unknown or Not Stated."

To create the LBW measure, Live Births Weighing Less Than 2,500 Grams was modified to allow results to be stratified at the health plan level. See Appendix C to learn more about this measure.

Tobacco Use Screening and Cessation Intervention (TSC-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE#, CMIT, Measure Steward: NCQA

Brief Description of Measure

The percentage of persons ages 12 and older who were screened for commercial tobacco product use at least once during the measurement period, and who received tobacco cessation intervention if identified as a tobacco user. Two rates are reported:

- Tobacco Use Screening. The percentage of persons who were screened for tobacco use.
- Cessation Intervention. The percentage of persons who were identified as a tobacco user and who received tobacco cessation intervention.

Numerator Statements

- Tobacco Use Screening: Persons who were screened for tobacco use and identified as either a positive or negative tobacco user during the measurement period.
- Cessation Intervention: Persons who received tobacco cessation intervention during the measurement period or 180 days prior to the measurement period.

Denominator Statement

Beneficiaries ages 12 and older.

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who received palliative care during the measurement year.

Members who died anytime during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 2800, CMIT# 448, Measure Steward: NCQA

Brief Description of Measure

The percentage of children and adolescents ages 1 through 17 who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported:

1. The percentage of children and adolescents on antipsychotics who received blood glucose testing.

2. The percentage of children and adolescents on antipsychotics who received cholesterol testing.

3. The percentage of children and adolescents on antipsychotics who received both blood glucose and cholesterol testing.

Numerator Statement

Blood Glucose: Members ages 1 through 17 who received at least one test for blood or HbA1c during the measurement year.

Cholesterol: Members ages 1 through 17 who received at least one test for LDL-C or cholesterol during the measurement year.

Blood Glucose and Cholesterol: Members ages 1 through 17 who received both of the following during the measurement year on the same or different dates of service:

- At least one test for blood glucose or HbA1c.

- At least one test for LDL-C or cholesterol.

Denominator Statement

Children and adolescents ages 1 through 17 who had ongoing use of antipsychotic medications (at least two antipsychotic medication dispensing events of the same or different medications).

Denominator Exclusions

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

Reporting for this measure transitioned to Electronic Clinical Data Systems (ECDS)-only in measurement year 2024. Health plans should follow the APM-E methodology outlined in HEDIS®

Measurement Year 2026 Volume 2 Technical Specifications for Health Plans, which includes all exclusion criteria.

Managed LTSS Admission to a Facility from the Community (MLTSS 6)

Descriptive Information

Measure Type

Outcomes

CBE Number and Measure Steward

Measure Steward: CMS

Measure Description

The number of admissions to a facility among Medicaid MLTSS participants, ages 18and older, residing in the community for at least one month. Measure is presented as per 1,000 beneficiary months. Three rates are reported:

- Short-Term Stay
- Medium-Term Stay
- Long-Term Stay

Numerator Statements

- Short-Term Stay: The rate of admissions resulting in a short-term stay (1 to 20 days) per 1,000 Medicaid MLTSS participant months.
- Medium-Term Stay: The rate of admissions resulting in a medium-term stay (21 to 100 days) per 1,000 Medicaid MLTSS participant months.
- Long-Term Stay: The rate of admissions resulting in a long-term stay (greater than or equal to 101 days) per 1,000 Medicaid MLTSS participant months.

Denominator Statement

Eligible population includes beneficiaries ages 18 and older as of the first day of the measurement year.

Measure is presented as per 1,000 beneficiary months, so the denominator is the number of participant months where the participant was residing in the community for at least one day of the month.

Denominator Exclusions

Beneficiaries whose residence was identified within a facility, and who resided in a facility for an entire month.

Beneficiaries who died during the measurement year.

Health plans should refer to the CMS Long-Term Services and Supports (LTSS) Quality Measures Technical Specifications and Resource Manual available here.

Managed LTSS Minimizing Facility Length of Stay (MLTSS 7)

Descriptive Information

Measure Type

Outcomes

CBE Number and Measure Steward

Measure Steward: CMS

Measure Description

The proportion of admissions to a facility among Medicaid MLTSS participants, ages 18 years and older, that result in successful discharge to the community (community residence for 60 or more days) within 100 days of admission.

This measure is reported as an observed rate and a risk-adjusted rate.

Numerator Statement

The count of discharges from a facility to the community during the measurement year that occurred within 100 days or fewer of admission.

Discharges that result in death, hospitalization, or readmission to the facility within 60 days of discharge from the facility do not meet the element.

Denominator Statement

Number of facility admissions occurring during the measurement period.

Denominator Exclusions

Admissions associated with a transfer between facilities.

Beneficiaries who expired while admitted (or within one day of admission).

Health plans should refer to the CMS Long-Term Services and Supports (LTSS) Quality Measures Technical Specifications and Resource Manual available here.

Managed LTSS Successful Transition after Long-Term Facility Stay (MLTSS 8)

Descriptive Information

Measure Type

Outcomes

CBE Number and Measure Steward

Measure Steward: CMS

Measure Description

The proportion of long-term facility stays among Medicaid MLTSS participants, ages 18 years and older, that result in successful transitions to the community (community residence for 60 or more days).

This measure is reported as an observed rate and a risk-adjusted rate.

Numerator Statement

The count of discharges from a facility to the community from July 1 of the year prior to the measurement year through October 31 of the measurement year that result in a successful transition to the community for 60 consecutive days.

Discharges that result in death, hospitalization or readmission to the facility within 60 days of discharge from the facility do not meet the element.

Denominator Statement

Number of discharges occurring during the measurement period.

Denominator Exclusions

Admissions associated with a transfer between facilities.

Beneficiaries who expired while admitted (or within one day of admission).

Health plans should refer to the CMS Long-Term Services and Supports (LTSS) Quality Measures Technical Specifications and Resource Manual available here.

Oral Evaluation, Dental Services (OEV)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 2517, CMIT# 897 Measure Steward: ADA

Brief Description of Measure

The percentage of members through age 21 who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

Numerator Statement

Unduplicated number of enrolled members through age 21 who received a comprehensive or periodic oral evaluation as a dental service.

Denominator Statement

Unduplicated number of enrolled members through age 21.

Denominator Exclusions

Members who are in hospice or used hospice services during the measurement year.

Members who died anytime during the measurement year.

For more information, please refer to the Medicaid and CHIP Technical Assistance Resource available here.

Oral Evaluation During Pregnancy (OEVP)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# NA,CMIT# 1783, Measure Steward: DQA

Brief Description of Measure

Percentage of enrolled persons ages 15 through 44 with live-birth deliveries in the reporting year who received a comprehensive or periodic oral evaluation during pregnancy

Numerator Statement

Unduplicated number of enrolled persons with live-birth deliveries in the reporting year who received a comprehensive or periodic oral evaluation during pregnancy

Denominator Statement

Unduplicated number of enrolled persons ages 15 through 44 with live-birth deliveries in the reporting year

Denominator Exclusions

For more information on this measure visit the measure steward's technical specification here.

Plan All-Cause Readmissions (PCR)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 1768, CMIT# 561, Measure Steward: NCQA

Brief Description of Measure

For beneficiaries ages 18 to 64, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays). Data are reported in the following categories:

- Count of Index Hospital Stays (IHS)
- Count of Observed 30-Day Readmissions
- Count of Expected 30-Day Readmissions

Note: The observed-to-expected ratio (O/E Ratio) is calculated by taking the count of observed 30-day readmissions and dividing by the count of expected 30-day readmissions. The O/E ratio is interpreted as "lower-is-better":

- O/E ratio < 1.0 means the state had fewer readmissions than expected given the case mix.
- O/E ratio = 1.0 means that the number of readmissions was the same as expected given the case mix.
- O/E ratio > 1.0 means that the state had more readmissions than expected given the case mix.

Numerator Statement

At least one acute readmission for any diagnosis within 30 days of the date of discharge from the Index Hospital Stay that occurs on the second day of the measurement year or between that date and the end of the measurement year.

Denominator Statement

An acute inpatient or observation stay discharge between January 1 (or on that day) and December 1 of the measurement year among the eligible population.

Note: The denominator for this measure is based on discharges, not beneficiaries.

Denominator Exclusions

Discharges for death, pregnancy, perinatal condition or a discharge that is followed by a planned admission within 30 days.

Members in hospice or using hospice services anytime during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Prenatal Depression Screening and Follow-Up (PND-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCQA

Brief Description of Measure

The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care.

- Depression Screening. The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument.

- Follow-Up on Positive Screen. The percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding.

Numerator Statements

Depression Screening: Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized screening instrument, performed during pregnancy.

- Deliveries between January 1 and December 1 of the measurement period: Screening should be performed between the pregnancy start date and the delivery date (including on the delivery date).

- Deliveries between December 2 and December 31 of the measurement period: Screening should be performed between the pregnancy start date and December 1 of the measurement period.

Follow-Up on Positive Screen: Deliveries in which members received follow-up care on or up to 30 days after the date of the first positive screen (31 total days).

- Any of the following on or up to 30 days after the first positive screen:

    - An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.

    - A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.

    - A behavioral health encounter, including assessment, therapy, collaborative care or medication management.

    - A dispensed antidepressant medication.

OR

- Documentation of additional depression screening on a full-length instrument indicating either no depression or no symptoms that require follow-up (i.e., a negative screen) on the same day as a positive screen on a brief screening instrument.

Denominator Statements

Denominator 1: The eligible population, minus exclusions.

Denominator 2: All deliveries from numerator 1 with a positive finding for depression during pregnancy.

Denominator Exclusions

Deliveries that occurred at less than 37 weeks gestation.

Members who were in hospice or using hospice services during the measurement period.

Members who die any time during the measurement period.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Prenatal Immunization Status (PRS-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 3484; CMIT# 1782 Measure Steward: NCQA

Brief Description of Measure

The percentage of deliveries in the measurement period in which members received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

Numerator Statements

Numerator 1—Immunization Status: Influenza

- Deliveries where members received an adult influenza vaccine on or between July 1 of the year prior to the measurement period and the delivery date, ***or***
- Deliveries where members had anaphylaxis due to the influenza vaccine on or before the delivery date.

Numerator 2—Immunization Status: Tdap

- Deliveries where members received at least one Tdap vaccine during the pregnancy (including on the delivery date), ***or***
- Deliveries where members had anaphylaxis or encephalitis due to the diphtheria, tetanus or pertussis vaccine on or before the delivery date.

Numerator 3—Immunization Status: Combination

- Deliveries that met criteria for both numerator 1 and numerator 2.

Denominator Statement

Deliveries during the measurement period.

Denominator Exclusions

Deliveries that occurred at less than 37 weeks of gestation.

Members who use hospice services at any time during the measurement period.

Members who die any time during the measurement period.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Prenatal and Postpartum Care (PPC)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 1517, CMIT# 581/582 Measure Steward: NCQA

Brief Description of Measure

The measure assesses access to prenatal and postpartum care[83]:

1. *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

2. *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between seven and 84 days after delivery.

Numerator Statement

Timeliness of Prenatal Care: A prenatal visit during the required time frame.

[83] This measure looks at deliveries of live births on October 8 of the year prior to the measurement year or between that date and October 7 of the measurement year.

Postpartum Care: A postpartum visit on or between seven and 84 days after delivery.

Denominator Statement

The percentage of deliveries of live births delivered on October 8 of the year prior to the measurement year or between that date and October 7 of the measurement year.

Denominator Exclusions

Non-live births.

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

Remove multiple deliveries in a 180-day period, include only the first eligible delivery.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Avoidable Pediatric Utilization (PDIs)

Descriptive Information

Measure Type

Rate/Proportion

CBE Number and Measure Steward

CBE: 0728 / N/A / 0727 / N/A, Measure Steward: AHRQ

Brief Description of Measure

The department will calculate the following measures of avoidable pediatric hospitalization:

- PDI 14: Asthma Admission Rate
- PDI 15: Diabetes Short-term Complications Admission Rate
- PDI 16: Gastroenteritis Admission Rate
- PDI 18: Urinary Tract Infection Admission Rate

A lower rate indicates better performance.

Numerator Statement

Discharges, for members younger than 18 years old, that meet the inclusion and exclusion rules for the numerator in any of the following PDIs:

- PDI 14: Asthma Admission Rate
- PDI 15: Diabetes Short-term Complications Admission Rate
- PDI 16: Gastroenteritis Admission Rate
- PDI 18: Urinary Tract Infection Admission Rate

Denominator Statement

Eligible population dependent on specific PDI technical specification. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of residence, not the metropolitan area or county of the hospital where the discharge occurred.

Denominator Exclusions

See each component measure for exclusions.

More information is available here and full specifications are available here.

Rate of Screening for Pregnancy Risk

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

The *Rate of Screening for Pregnancy Risk* is an NCDHHS measure that assesses the proportion of pregnant beneficiaries who received a pregnancy risk screening (PRS).

Numerator Statement

Number of pregnant beneficiaries who received a pregnancy risk screening in the ten months prior to their delivery date.

Denominator Statement

Beneficiaries with evidence of a delivery.[84]

Denominator Exclusions

Exclude if any of the following were documented during the pregnancy at any time:

- Spontaneous Abortion
- Ectopic Pregnancy
- Molar Pregnancy

Rate of Screening for Health-Related Resource Needs (HRRN)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCDHHS

Brief Description of Measure

The percentage of enrollees who received and completed a health-related resource needs screening using the NCDHHS Standardized SDOH Screening Questions. This screening form includes four priority domains: food insecurity, housing/utilities instability, transportation needs and being at risk of, or experiencing, interpersonal violence/toxic stress.

Successful screening within the calendar year: Percent of enrollees who completed a screening within the calendar year (January 1–December 31).

Numerator Statement

Successful screening within the calendar year: All NC Medicaid Managed Care enrollees that completed* a SDOH screening within the calendar year. A completed screening must be administered by the health plan or their affiliated care manager.[85]
*Completed screenings are defined as:

[84] The Department continues to explore ways in which pregnant beneficiaries can be identified in order to have a more complete and accurate eligible population for this measure.
[85] Affiliated care manager refers to any contracted entity the health plan uses to conduct SDOH screening for the plan, not inclusive of provider-level screenings.

- Beneficiaries who received a screening and answered at least one SDOH screener question

Note: An N/A response or a refusal is not a completed screening. N/A responses should be entered in the dataset when screening attempts are unsuccessful and there is no response from the member.

Denominator Statement

All NC Medicaid Managed Care enrollees enrolled with the respective plan at any time during the measurement year. A beneficiary may be part of the eligible population for multiple plans in the same calendar year.

Denominator Exclusions

None.

Stratification

This measure will be stratified using the stratified reporting elements listed in Table 2. Stratifying this process measure will promote transparency into health plan performance by key demographic groups and help the state understand where disparities exist, so we can address care gaps. Plans will not be required to submit additional data to support stratification in the report template.

Submission Type

Plans will report all relevant data for their eligible population in their BCM026 operational report. Please note that health plans are required to use the NCDHHS Standardized SDOH screening questions. The Department will use the information reported in BCM026 to calculate this measure in partnership with the health plans.

Screening for Depression and Follow-Up Plan (CDF)[86]

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0418/0418e, CMIT# 672, Measure Steward: CMS

[86] Plans must report to the Department whether they are using the standard or electronic measure.

Brief Description of Measure

Percentage of members ages 12 and older who are screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND, if positive, for whom a follow-up plan is documented on the date of the eligible encounter. The numerator for this measure includes the following two groups:

1. Those beneficiaries with a positive screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool with a follow-up plan documented.

2. Those beneficiaries with a negative screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool.

Numerator Statement

Members who are screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized tool AND, if positive, for whom a follow-up plan is documented on the date of the eligible encounter.

Denominator Statement

All members ages 12 and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.

Denominator Exclusions

A member is not eligible if one or more of the following conditions are documented during the encounter during the measurement period:

- Member has an active diagnosis of depression prior to any encounter during the measurement period.

- Member has a diagnosed bipolar disorder prior to any encounter during the measurement period.

Members with a documented reason for not screening for depression:

- Member refuses to participate.

- Member is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

- Situations where the member's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example, certain court-appointed cases or cases of delirium.

For full measure specifications, please refer to the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) and Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manuals.

Sealant Receipt on Permanent First Molars (SFM)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, CMIT# 830, Measure Steward: ADA

Brief Description of Measure

Percentage of enrolled members who have ever received sealants on permanent first molar teeth. Two rates are reported: (1) at least one sealant and (2) all four molars sealed by the 10th birthday.

Numerator Statement

The unduplicated number of enrolled members who ever received a sealant on:

- At least one permanent first molar tooth.
- All four permanent first molars.

Denominator Statement

Members who turn 10 in the measurement year.

Denominator Exclusions

Members who have received treatment (restorations, extractions, endodontic, prosthodontic and other dental treatments) on all four permanent first molars in the 48 months prior to the 10th birthday.

For more information, please refer to the Medicaid and CHIP Technical Assistance Resource available here.

Statin Therapy for Patients with Cardiovascular Disease (SPC-E)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# N/A, CMIT# 700, Measure Steward: NCQA

Brief Description of Measure

The percentage of members ages 21 through 75 during the measurement period who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. Two rates are reported:

1. *Received Statin Therapy.*
2. *Statin Adherence 80%.*

Numerator Statement

Received Statin Therapy: Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.

Statin Adherence 80%: Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

Denominator Statement

The percentage of members ages 21 through 75 who during the measurement year or the year prior to the measurement year were either identified as having ASCVD or received at least two diagnoses of ASCVD on different dates of service.

Denominator Exclusions

Persons ages 66 or older by the last day of the measurement period with both frailty and advanced illness. Advanced illness can include in vitro fertilization, pregnancy, or a prescription of clomiphene, ESRD, cirrhosis, or dialysis, myalgia, myositis, myopathy or rhabdomyolysis, myalgia or rhabdomyolysis caused by statin.

Members in hospice or using hospice services anytime during the measurement year.

Members who died anytime during the measurement year.

Members receiving palliative care anytime during the measurement year.

Reporting for this measure transitioned to Electronic Clinical Data Systems (ECDS)-only in measurement year 2026. For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2025 Volume 2 Technical Specifications for Health Plans.

Topical Fluoride for Children (TFL)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 2528/3700/3701, CMIT# 1672, Measure Steward: ADA

Brief Description of Measure

The percentage of members ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year.

Numerator Statement

The unduplicated number of enrolled children who received at least two fluoride applications as the following during the measurement year:

- Dental or oral health services
- Dental services
- Oral health services

Fluoride applications must be provided on at least two unique dates of service.

Denominator Statement

Children ages 1 through 20 as of December 31 of the measurement year.

Denominator Exclusions

None.

For more information, please refer to the Medicaid and CHIP Technical Assistance Resource available here.

Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 2801, CMIT# 743, Measure Steward: NCQA

Brief Description of Measure

The percentage of children and adolescents ages 1 through 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Numerator Statement

Members who received psychosocial care or residential behavioral health treatment in the 121-day period from 90 days prior to the index prescription start date through 30 days after the index prescription start date.

Denominator Statement

Members ages 1 through 17 as of December 31 of the measurement year who had a new prescription of an antipsychotic medication.

Denominator Exclusions

Members with a diagnosis of a condition for which antipsychotic medications have FDA primary indication and are thus clinically appropriate during the measurement year: schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder.

Members in hospice or using hospice services anytime during the measurement year.

Members who died during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 3400, CMIT# 750, Measure Steward CMS

Brief Description of Measure

Percentage of Medicaid beneficiaries ages 18 through 64 with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:

- A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1)
- Four separate rates representing the following types of FDA-approved drug products:
    - Buprenorphine (Rate 2)
    - Oral naltrexone (Rate 3)
    - Long-acting, injectable naltrexone (Rate 4)
    - Methadone (Rate 5)

Numerator Statement

Total (Overall Rate 1): Identify beneficiaries with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication for OUD during the measurement year.

Note: The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count beneficiaries in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report beneficiaries with multiple drug products only once for the numerator for the total rate.

Buprenorphine (Rate 2): Identify beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year.

Oral Naltrexone (Rate 3): Identify beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year.

Long-acting, Injectable Naltrexone (Rate 4): Identify beneficiaries with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year.

Methadone (Rate 5): Identify beneficiaries with evidence of at least one dose of methadone at any point during the measurement year.

Denominator Statement

Beneficiaries ages 18 through 64 years of age as of January 1 of the measurement year, who had at least one encounter with a diagnosis of opioid abuse, dependence or remission (primary or other) at any time during the measurement year.

Denominator Exclusions

None.

For full measure specifications, please refer to the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) Technical Specifications and Resource Manuals.

Use of Opioids at High Dosage in Persons Without Cancer (OHD)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 2940, CMIT# 748, Measure Steward: PQA

Brief Description of Measure

The percentage of individuals ages 18 and older who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) over a period of ≥90 days.

A lower rate indicates better performance.

Numerator Statement

Individuals from the denominator with an average daily dosage ≥90 MME during the opioid episode.

Denominator Statement

Individuals ages 18 and older with ≥2 prescription claims for opioid medications on different dates of service and with a cumulative days' supply ≥15 during the measurement year.

Denominator Exclusions

Members in hospice.

Members who have cancer or sickle cell disease.

Members who died during the measurement year.

More information on the PQA measures can be found here. For full measure specifications, please refer to the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), Technical Specifications and Resource Manual.

Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 2950, Measure Steward: PQA

Brief Description of Measure

The percentage of individuals ages 18 and older who received prescriptions for opioids from at least four prescribers and at least four pharmacies within ≤180 days.

A lower rate indicates better performance.

Numerator Statement

Individuals from the denominator with opioid prescription claims from at least four prescribers **and** at least four pharmacies within ≤180 days during the opioid episode.

Denominator Statement

Individuals ages 18 and older with at least two prescription claims for opioid medications on different dates of service and with a cumulative days' supply of at least 15 during the measurement year.

Denominator Exclusions

Members in hospice.

Members who have cancer or sickle cell disease.

Members who died during the measurement year.

More information on the PQA measures can be found here.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 0024, CMIT# 760, Measure Steward: NCQA

Brief Description of Measure

Percentage of members ages 3 through 17 who had an outpatient visit with a primary care physician (PCP) or OB/GYN and had evidence of the following during the measurement year (three rates):

1. Body mass index (BMI) percentile documentation*
2. Counseling for nutrition.
3. Counseling for physical activity.

*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

Numerator Statement

BMI Percentile: BMI percentile documentation during the measurement year.

Counseling for Nutrition: Counseling for nutrition during the measurement year.

Counseling for Physical Activity: Counseling for physical activity during the measurement year.

Denominator Statement

Members ages 3 through 17 with at least one outpatient visit with a primary care physician (PCP) or obstetrician/gynecologist during the measurement year.

Denominator Exclusions

Members who have a diagnosis of pregnancy any time during the measurement year.

Members in hospice or using hospice services any time during the measurement year.

Members who died during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

Well-Child Visits in the First 30 Months of Life (W30)

Descriptive Information

Measure Type

Process

CBE Number and Measure Steward

CBE# 1392, CMIT# 761, Measure Steward: NCQA

Brief Description of Measure

The percentage of members who had the following number of well-child visits with a primary care provider (PCP) during the last 15 months. The following rates are reported:

1. Well-Child Visits in the First 15 Months. Members who turned 15 months old during the measurement year and had six or more well-child visits.

2. Well-Child Visits for Age 15–30 Months. Members who turned 30 months old during the measurement year and had two or more well-child visits.

Numerator Statement

Well-Child Visits in the First 15 Months: Members with six or more well-child visits on different dates of service on or before the 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Well-Child Visits for Age 15–30 Months: Two or more well-child visits on different dates of service between the child's 15-month birthday plus one day and the 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Denominator Statement

Well-Child Visits in the First 15 Months: Members who turned 15 months old during the measurement year.

Well-Child Visits in the First 30 Months: Members who turned 30 months old during the measurement year.

Denominator Exclusions

Members in hospice or using hospice services at any time during the measurement year.

Members who died during the measurement year.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2026 Volume 2 Technical Specifications for Health Plans.

CAHPS® Survey

Descriptive Information

Measure Type

Outcome

CBE Number and Measure Steward

CBE# 0006; Measure Steward: AHRQ

Brief Description of Measure

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey is a standardized survey instrument that asks beneficiaries to report on their experiences accessing care, their experiences with their health plan and the quality of care they receive, among numerous other measures.[i][87]

The survey's target population includes individuals of all ages (ages 18 and older for the adult version and parents or guardians of children through age 17 for the child version) who have been continuously enrolled in Medicaid, in the same plan or program, for the six-month measurement period (July 1 through December 31 of previous year) with no more than one 45-day gap in enrollment.

The CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set has 39 core items, and the CAHPS Child Health Plan Survey with the HEDIS supplemental item set has 41 core items. Ten of the adult survey items and 11 of the child survey items are organized into four composite measures. Each survey also has four single-item rating measures known as global ratings. Each measure is used to assess a particular domain of health plan and care quality from the beneficiary's perspective.

[87] The survey is part of the CAHPS family of patient experience surveys and is available in the public domain at https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html.

Appendix E Table 12: CAHPS survey measures the department will include [88]

Global Ratings	Composite Measures	Individual Item Measures	Effectiveness of Care Measures (Adult Population Only)
Rating of Health Plan	Getting Needed Care	Coordination of Care	Advising Smokers and Tobacco Users to Quit
Rating of All Health Care	Getting Care Quickly		Discussing Cessation Medications
Rating of Personal Doctor	How Well Doctors Communicate		Discussing Cessation Strategies
Rating of Specialist Seen Most Often	Customer Service		

[88] The Flu Vaccination for Adults measure has been retired for MY2024. The Department will survey this question to the adult and child CAHPS population as a supplemental item.