



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

North Carolina's Medicaid Quality Measurement  
Technical Specifications Manual  
*Measurement Year 2025*

Version 2025.0

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## 2025 Technical Specifications Summary of Updates:

- Modified the following measures:
  - Modified the technical specifications for the Rate of Screening for Health-Related Resource Needs (HRRN) measure
- Updated the following metrics to ECDS-only reporting to align with NCQA:
  - Childhood Immunization Status (CIS-E) Combination 10
  - Adolescent Immunization Status (IMA-E) Combination 2
  - Cervical Cancer Screening (CCS-E)
- Added the following measures:
  - Adult’s Access to Preventive/Ambulatory Health Services (AAP) to the Standard Plan and Tailored Plan Measure Sets
  - Prenatal Immunization Status (PRS-E) to the Standard Plan and Tailored Plan Measure Sets
  - Oral Evaluation During Pregnancy (OEVF) to the CCNC Measure Set
  - Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A) to the CCNC Measure Set
  - Childhood Immunization Status (CIS-E) Combination 7 to the Standard Plan, Tailored Plan and CCNC Measure Sets
- Retired or removed the following measures:
  - Antidepressant Medication Management (AMM)
  - Pharmacotherapy Management of COPD Exacerbation (PCE)
  - Ambulatory Care: Emergency Department Visits (AMB)
- Added new information related to the Department’s benchmarking approach
- Added new information related to the Standard Plan Withhold Program
- Updated measure specifications to align with the 2025 HEDIS Specifications (see Appendices)
- Edited to align with the 2025 CMS Adult and Child Core Sets
- Added reference to the Prepaid Inpatient Health Plan (PIHP), Community Care of North Carolina (CCNC) and Eastern Band of Cherokee Indians (EBCI) Tribal Option Measure Sets (see Appendix A)
- Updated information on Medicaid Expansion as it relates to quality measurement
- Updated reference to the Department’s *Technical Specifications Strata Crosswalk* document for detailed guidance on quality measurement stratification elements
- Added requirement for Standard Plans to report applicable measures using both the administrative methodology and hybrid methodology
- Updated information on: The Rate of Screening for Pregnancy Risk measure & NCDHHS’ modified Low Birth Weight metric

## I. Introduction

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The North Carolina Department of Health and Human Services (hereafter referred to as “The Department”) is dedicated to operating a comprehensive 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 Intellectual/Developmental Disability (I/DD) Tailored Plans (hereafter referred to as “Tailored Plans”), other plan types operating in the state and providers for advancing quality goals.<sup>1</sup> 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 broadly in the Medicaid program.
- Detailed information about how the Department will measure plan 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

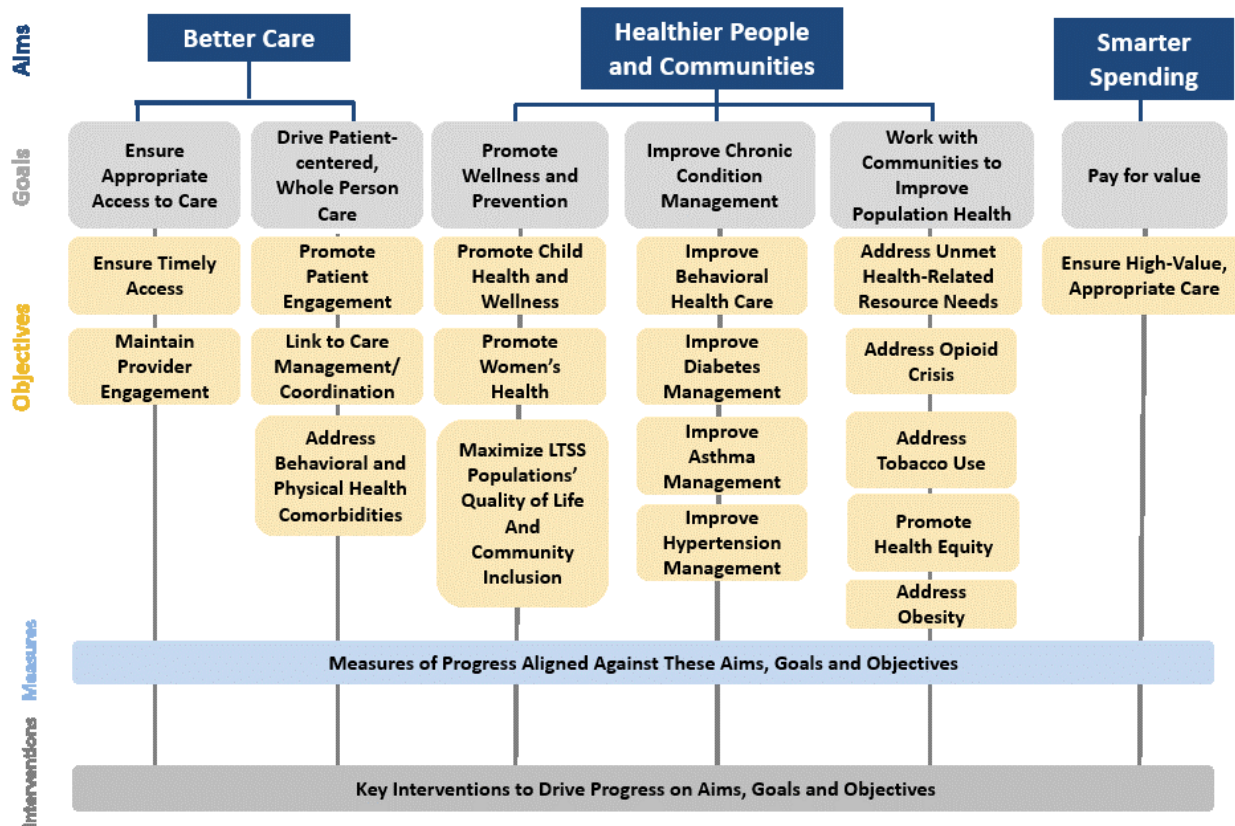
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As noted in the Quality Strategy,<sup>2</sup> the Department seeks to develop a data-driven, outcomes-based continuous quality improvement process in the Medicaid program that supports three central Aims: 1) Better Care Delivery; 2) Healthier People, 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, NC Integrated Care for Kids (InCK) and the Healthy Opportunities Pilots, which are outlined in more detail in previous papers, and specifically designed to improve quality outcomes in North Carolina.

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<sup>1</sup> 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.

<sup>2</sup> Available [here](#).



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

The Department is committed to rewarding health plans serving 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. Plans are expected to build on these relationships to attain specific targets for priority outcomes specified by the Department (see Figure 2). The Department also collects and reports on select public health measures to link plan quality improvement efforts to larger state public health initiatives and goals.

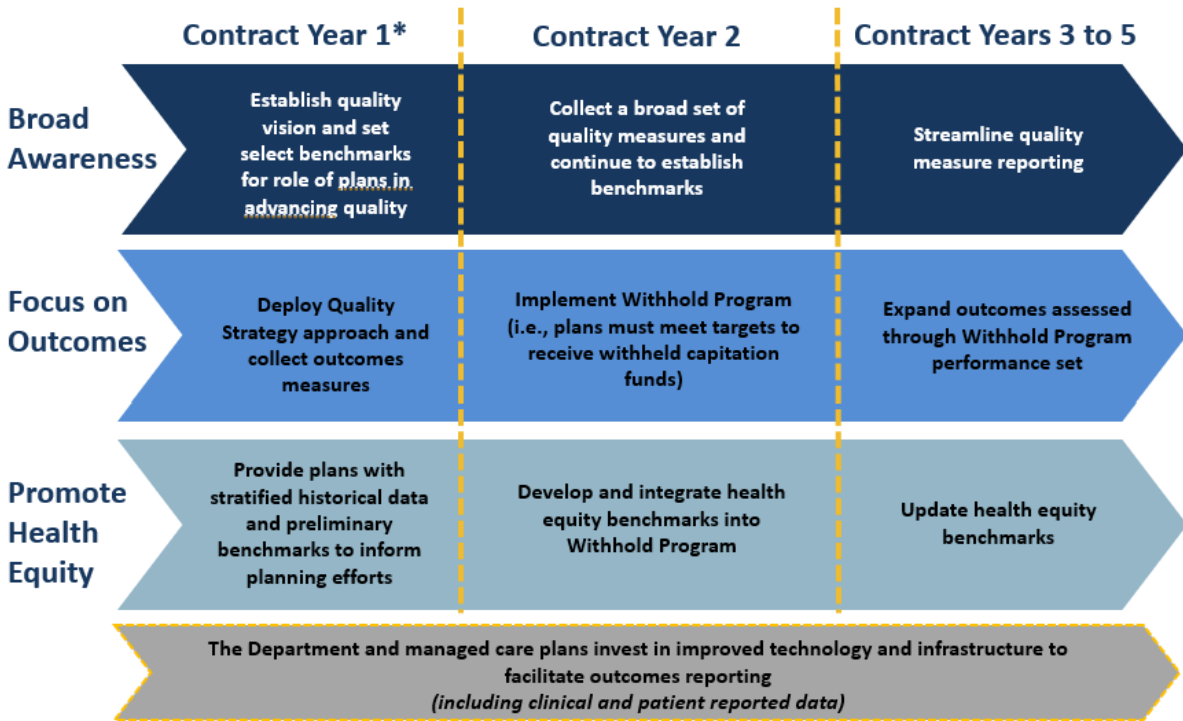
The Department will support the vision outlined in the Quality Strategy through investments in initiatives to improve health outcomes. The Healthy Opportunities Pilots and other efforts to address upstream social drivers of health, support the development of infrastructure needed to facilitate public reporting of quality performance and assessment of state-level health improvements that will result from improved care 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 reporting in the early years of Medicaid managed care implementation.

**Figure 2: The Quality Vision Over Time**



\*Refers to the Contract Year for Standard Plans and Tailored Plans, respectively, recognizing their different launch dates. Each Contract Year will run from July 1 to June 30.

**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 goals for plan quality improvement efforts through the establishment of quality measure sets. Managed care plans are required to report on the quality metrics in these measure sets, as well as calculate historical rates and performance benchmarks. The Department also shares historical rates and performance benchmarks for the measures that are reported by the Department directly. These requirements are likely to be a major focus of plan efforts, and through the quality Standard Plan Withhold Program (described in greater detail in Section V (D)), plans will have direct financial accountability for a subset of performance measures. Plans will focus on performance improvement for these measures, particularly for priority populations.

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 contracting 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.
- 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 Medical Care Advisory Committee and the state Consumer and Family Advisory Committee.

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 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)).<sup>3</sup>

### III. Quality Measurement and Improvement

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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,

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<sup>3</sup> More information on Tailored Plans and Tailored Care Management can be found [here](#).

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 plan accountability. These measures, which are selected by the Department and will primarily be calculated by plans, to include Standard Plans, Tailored Plans and other entities serving Medicaid members, comprise the set from which plans can draw for required quality improvement initiatives such as PIPs. In addition, the Department calculates and monitors a separate, larger set of measures on health care delivery and outcomes in the 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 abuse (see Appendix A, Table 1). State-funded services include beneficiaries served by the Division of Mental Health, Developmental Disabilities, and Substance Use Services (DMH/DD/SUS) 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 calculated by DMH/DD/SUS on a state fiscal year (SFY) cycle. To learn more about these measures visit the DMH/DD/SUS [webpage](#).

Plan-level performance on Standard Plan and Tailored Plan measures will be publicly reported, and plan-level performance on Tailored Plan State-funded and Department-calculated measures may be publicly reported (see Appendix A, Table 1).<sup>4</sup>

The Department's Quality and Health Outcomes Committee (QHO) is responsible for reviewing quality measure performance results, updates to technical specifications and stakeholder feedback (including from managed care plans) at least annually to inform annual quality measure set monitoring and updates. These quality measures are meant to provide the Department with a view of the Standard Plans' and Tailored Plans' processes and performance in a format specified by the Department. Measures are selected from a variety of sources, including the Healthcare Effectiveness Data and Information Set (HEDIS®); National Committee for Quality Assurance (NCQA) health plan accreditation<sup>5</sup>, 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 in these sets and as the foci of the Department's quality improvement efforts evolve.

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<sup>4</sup> The EQRO will report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures at the plan level.

<sup>5</sup> Standard Plans and Tailored Plans will be required to secure NCQA accreditation. Standard Plans must be accredited by July 1, 2025.

The sections below discuss the Department’s overall approach to quality and administrative reporting, followed by a review of approaches to specific areas of measurement the Department would like to highlight. Those areas include:

- Modified Measures
- Utilization Management Measures
- Select Administrative Measures
- Survey-based Measures
- Public Health Measures

The Department has emphasized inclusion of plan-reported measures that can be reported using only administrative data but will accept a hybrid reporting approach for measures when appropriate as indicated in the measure’s specifications.<sup>6</sup> For the 2025 measurement year, 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)), Prenatal and Postpartum Care (PPC) and Controlling High Blood Pressure (CBP). These measures were selected because certain elements, such as clinical data, not always available in claims and encounters, are needed to provide complete and accurate rates. 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 Standard Plans and Tailored Plans to develop consistent approaches to collecting clinical data that minimizes administrative burden for providers.

The Department aims to work with the state’s designated Health Information Exchange (HIE), NC HealthConnex, to create a clinical data conduit for NC Medicaid Managed Care. Through NC HealthConnex, the Department envisions that Standard Plans and Tailored Plans will access clinical data needed for quality measurement 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:

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<sup>6</sup> The hybrid reporting method involves the use of both administrative data (such as claims/encounter data) and medical record review.

1. Validate the extent to which the data it receives are complete and accurate enough to be used in quality measurement by leveraging NCQA’s Data Aggregator Validation program, utilizing the Department’s EQRO’s Performance Measure Validation process and continuing internal efforts to reconcile measures and monitoring produced with NC HealthConnex data.
2. Produce an extract that contains clinical data elements needed for clinical quality measures. NC HealthConnex sends these priority data elements to the Department and plans monthly so they can be used for population health monitoring and evaluation, beneficiary outreach and the production of annual HEDIS measures.
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 health-related resource needs screening data.
5. Ensure that all 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.<sup>7</sup> 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)

#### **A. Quality and Administrative Measure Reporting**

The Standard Plan and Tailored Plan measure sets are aligned with North Carolina’s Aims, Goals, and Objectives. The Department launched in 2024 a Standard Plan Withhold Program that holds Standard Plans financially accountable for their performance on a set of priority performance measures and intends to implement a withhold program for Tailored Plans. See Section V (D) for more information on withholds.

The Department will seek feedback from the health plans each year on the measures in their measure sets to inform which measures, if any, to add, modify or retire. The sets will also be

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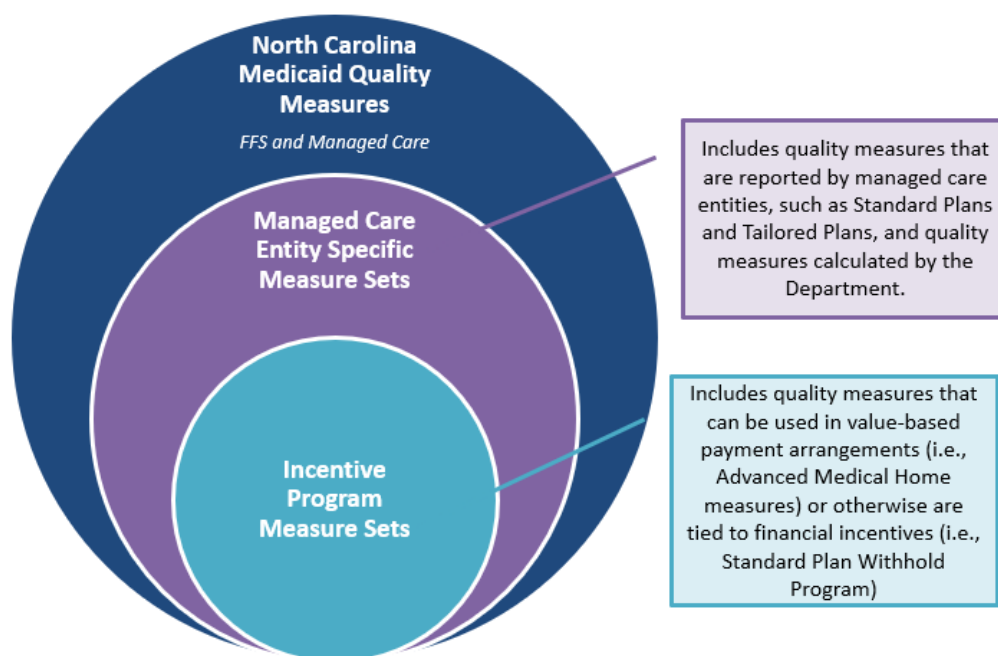
<sup>7</sup> More information on CMS’ Digital Quality Measurement Strategic Roadmap is available [here](#).

updated to align with the measure stewards', NCQA HEDIS and non-HEDIS, technical specification updates.

The Department has established a list of measures that Standard 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 (described further in Section V (E)).

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's Universal Foundation Measure Set,<sup>8</sup> the Medicaid Child and Adult Core Sets,<sup>9</sup> the State Transformation Collaborative priority measures<sup>10</sup> and the Medicare Making Care Primary (MCP) Performance Incentive Payment Measure Set<sup>11</sup> when selecting measures for Incentive Program Measure Sets. In addition, the Department promotes alignment within measure sets used for North Carolina Medicaid quality measurement efforts, where appropriate and feasible, recognizing that different measure sets must be designed to address different needs and challenges related to the specific enrollee populations involved, population sizes of the entities being measured and other characteristics.

<sup>8</sup> More information on CMS' Universal Foundation Measure Set can be found [here](#).

<sup>9</sup> More information on the Medicaid Child and Adult Core Sets can be found [here](#).

<sup>10</sup> More information on the State Transformation Collaborative measures can be found [here](#).

<sup>11</sup> More information on the Medicare MCP Performance Incentive Payment Measure Set can be found [here](#).

The Department aims to include any revisions or additions to the AMH measure set or quality measures subject to a withhold in this document at least six months prior to the calendar year for which qualifying services will be delivered. This will allow for more time to collect stakeholder feedback on changes. For example, if a measure were included in this document in June 2025, the effective date would be the claims-year running from January 2026 through December 2026 and retrospectively reported to the Department by health plans in 2027.

For non-AMH measures and non-withhold 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 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.

## **B. Modified Measures**

As part of the NC Medicaid Managed Care transformation process, the Department is requiring Standard Plans' and Tailored Plans' participation in reporting low birth weight. 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 Department modified an existing quality measure to account for 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.<sup>12,13</sup> The Department selected this measure because low birth weight is an important cause of morbidity for North Carolina children. In 2022, North Carolina ranked 41<sup>st</sup> among the 50 states for its rate of low-birth-weight babies (9.4%), reflecting the unacceptably high rate of low birth weight in the state.<sup>14,15</sup> These high rates, in turn, are associated with higher rates of poor health outcomes and higher health

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<sup>12</sup> 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.

<sup>13</sup> 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.

<sup>14</sup> Centers for Disease Control, Percentage of Babies Born Low Birth Weight by State: North Carolina, 2022. Available [here](#).

<sup>15</sup> Lower rates indicate better performance on the Live Births Weighing Less than 2,500 Grams measure.

care spending.<sup>16</sup> 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.

The Department expects Standard Plans and Tailored Plans to report the measure elements requested, including the measure's denominator and number of exclusions, both overall and based on the required stratifications, and to respond to supplemental requests for data the Department may issue.<sup>17</sup> The Department will coordinate with Standard Plans, Tailored Plans and The Department's division of Vital Records (Vital Records) to calculate the measure.

This modified measure assesses rates of low birth weight (<2,500 grams) and very low birth weight (<1500 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.<sup>18</sup> 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 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 B 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.

### **C. 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

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<sup>16</sup> March of Dimes, Low Birthweight. Available [here](#).

<sup>17</sup> Plans will submit information on live, singleton births quarterly via the "Eligible Mothers for Low Birth Weight Measure" Report (QAV008).

<sup>18</sup> Kalikkot Thekkevedu, 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>



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 (HealthPartners):** The HealthPartners' Total Cost of Care measure is a person-centered tool that accounts for 100% of the care provided to a patient. The Department includes all administrative claims (e.g., inpatient, outpatient, clinic, ancillary, pharmacy and all other types of services) for continuously enrolled members to calculate Total Cost of Care. Members' total costs (or paid amounts) are then divided by total member months, providing an average per-member per-month (PMPM) sum that reflects population-level costs. PMPM costs are risk adjusted to account for member characteristics (i.e., members are grouped based on diagnoses, age and gender) and facilitate comparisons on health care utilization across plans and providers. The Department will also report Total Cost Relative Resource Values, which evaluates resource use across all medical services, procedures and places of service instead of cost.<sup>19</sup> In 2024, the Department developed an interactive dashboard for plans and providers to analyze total cost of care data for enrolled members and detect causes of overutilization. The dashboard allows plans and providers to stratify total cost of care data based on 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.

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.

#### **D. Select Administrative Measures**

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

This measure assesses whether Standard Plans and Tailored 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. Standard Plans and Tailored Plans are required to conduct a screening on all members within 90 days of enrollment (expedited for Aged/Blind/Disabled (ABD) and high-acuity individuals enrolled in Tailored Plans). This applies to both newly enrolled and re-enrolling members if the re-enrolling member had at least a 90-day gap in coverage. If a member is transferring health plans, the plan the member is transferring from is also required to submit the most recent screening to the new health plan. However, the new health plan is still responsible for completing a screening.

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<sup>19</sup>More information on the HealthPartners measures can be found [here](#) and [here](#).

The HRRN measure assesses total number of unique members with a successful screening in the calendar year.<sup>20</sup> The denominator includes all NC Medicaid Managed Care members in a health plan's enrolled population in the calendar year. The measure will track screenings completed between January 1<sup>st</sup> and December 31<sup>st</sup> of the measurement year. Plans are required to use the NC DHHS Standardized SDOH screening questions.<sup>21</sup>

To report on this measure, Standard Plans and Tailored Plans will report all relevant data for their eligible population in their 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 D 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 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 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 D 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.

### **E. Select Survey-based Measures**

*Provider Survey:* The Department, in partnership with a third party, distributes an annual survey to providers assessing their experience with each plan.

*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

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<sup>20</sup> 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.

<sup>21</sup> Screening questions are available [here](#).

Program (MHSIP) Consumer Satisfaction Survey, North Carolina Treatment Outcomes & Program Performance System (NC-TOPPS), National Core Indicators (NCI) Intellectual and Developmental Disabilities (IDD) Surveys and NCI Aging and Disabilities (AD) Surveys and other surveys to assess members' experience in receiving care.

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

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

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.

## **F. Public Health Measures**

The Department envisions Standard Plans and Tailored Plans serving as active partners in meeting Healthy North Carolina 2030 goals.<sup>22</sup> 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.

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<sup>22</sup> More information about Healthy North Carolina 2030 can be found [here](#).

The Department may reach out to plans to discuss performance improvement opportunities related to these select public health measures.

For MY2025, 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.

### **G. 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 under 21 years of age covered by 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 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 Family Navigators. Family Navigators are often existing staff members at health plans, AMHs or CCNC. Family Navigators work with participating practices to integrate care and care management across physical health, behavioral health and ten 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). More information on these measures can be found in the NC InCK Performance Measure Technical Specifications Manual.<sup>23</sup>

**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
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) <sup>24</sup>	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.*

<sup>23</sup> The full quality measure specifications for the InCK program are available [here](#).

<sup>24</sup> 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.

## IV. Required Reporting Activities for Standard Plans and Tailored Plans

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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 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), Standard Plans and Tailored Plans submit quality performance data for the previous calendar year (Example: Plans submitted their QAV007 quality report in June of 2024, which covered measurement year 2023).

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.

### A. 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.<sup>25</sup>
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.<sup>26</sup>
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
Mar	x	x
Apr	x	x
May	x	x
Jun	x	x
Jul	x	
Aug	x	
Sep	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.

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<sup>25</sup> 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.

<sup>26</sup> 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.

- 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.

## **B. 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.

The plan should use the stratifications listed in each measure's specification, if any, in addition to the stratification listed in Table 2. In addition, 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., age or race) shown in Table 2, but lacks stratification for others, the plan should report according to the Department-defined stratification. In alignment with CMS's small cell suppression policy, the Department will not directly report a cell containing a value of 1 to 10. A value of zero does not violate the minimum 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. <sup>27</sup> 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 <sup>28</sup>	<p>For pediatric measures: 0 through 1, 2 through 3, 4 through 6, 7 through 10, 11 through 14, 15 through 18, 19 through 20, 21</p> <p>For maternal health: &lt;19, 19 through 20, 21, 22 through 24, 25 through 34, 35+</p> <p>For adult/full pop. measures: 0 through 18, 19 through 20, 21, 22 through 44, 45 through 64, 65+</p>	DHHS enrollment data
Race	<p>Black, White, American Indian/Alaskan Native, Asian, Hawaiian/Pacific Islander, Multiracial, Other</p> <p>In addition to comparing individual groups, the Department will separately calculate the following strata:</p> <p>Black or African American, Non-Black or African American</p> <p>American Indian/Alaskan Native, Non-American Indian/Alaskan Native</p>	DHHS enrollment data (self-reported where possible)
Ethnicity	Hispanic/Latino, Non-Hispanic/Latino	DHHS enrollment data (self-reported where possible)

<sup>27</sup> More information about CMS’s Cell Suppression Policy can be found [here](#).

<sup>28</sup> Not all pediatric, maternal health and adult measures include all of the respective age strata listed in Table 2. Denominators for some measures may only include a subset of the pediatric, maternal, and adult age groups (e.g., the denominator for Childhood Immunization Status only includes children aged 0 through 2).

Stratification Element	Strata (In cases where measure technical specifications differ from these strata, plans should report both)	Source
Gender	Male, Female <sup>29</sup>	DHHS enrollment data (self-reported where possible)
Primary Language	English, Spanish, Other	DHHS enrollment data (self-reported where possible)
LTSS Needs Status <sup>30</sup>	Aged, Blind, Disabled (ABD), Non-ABD	DHHS enrollment data (self-reported where possible)
Disability Status	Disability, No Disability	DHHS enrollment data
Transitions to Community Living (TCL) <sup>31</sup>	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)	DHHS and Tailored Plan program data; Transitions to Community Living Database (TCLD)
Geography <sup>32</sup>	Rural, Urban, Other	DHHS enrollment data
Service Region <sup>33</sup>	Standard Plans: 1–6	DHHS 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.

<sup>29</sup> 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.

<sup>30</sup> The Department’s current methodology for LTSS Needs Status identifies individuals that are eligible for LTSS services, not individuals receiving LTSS services.

<sup>31</sup> The TCL strata will only be applied to Behavioral Health I/DD Tailored Plan measures (Please refer to Appendix A, Tables 3 and 4).

<sup>32</sup> 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](#).

<sup>33</sup> Service region is determined based on a member’s administrative county as reported in the 834 member file.

## **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. Standard Plans and Tailored Plans can be held financially accountable for performance measured against a different performance benchmark, designated as the withhold target, for a smaller subset of measures for their respective enrolled populations. These withhold targets reflect a performance level that ensures meaningful improvement for NC Medicaid Managed Care enrollees. Further discussion of these measures and performance benchmarks can be found in Section V (B and D).

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

## **B. Benchmarking Approach**

The Department is maintaining the benchmarking approach used in the 2024 measurement year, and previous measurement years, for measurement year 2025. Performance benchmarks are used to drive plan and Department conversations around quality and performance and may form the basis of Withhold program targets.

The 2025 measurement year performance benchmarking approach is as follows:

- The Department will set a benchmark for each measure (except for measures of contraceptive care) of 105% of prior year line-of-business overall performance for the measure (or 95% for measures for which a lower rate indicates better performance).<sup>34</sup> Prior year performance refers to the most recent year of measure results that allow for 90 days of claims runout and 90 days for measure production/reporting, as of the outset of the measurement year. For example, measurement year 2023 data is used to set 2025 targets. This target represents a 5% relative increase (or decrease) in the performance rate. If the plan's performance has worsened during the prior year, the previous benchmark will be carried forward rather than adopting a new, less rigorous,

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<sup>34</sup> 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.

standard. Standard Plans and Tailored Plans will each be compared against their respective program's historical performance (i.e., Medicaid Managed Care plan-level targets will be a 5% relative increase (or decrease for select measures) from the previous year's line-of-business-wide rate).

- 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.

In the 2026 measurement year, the Department plans to implement an updated benchmarking approach using a gap-to-goal methodology. Statewide and plan performance targets would be set based on a specified gap reduction between previous performance and an external benchmark. NCQA HEDIS Quality Compass data on national Medicaid managed care organization performance may be used to set performance goals for some measures. More detailed information on the Department's planned gap-to-goal benchmarking methodology for MY2026 is forthcoming.

### **C. Promoting Equity in Care and Outcomes**

The Department expects Standard Plans and Tailored Plans to ensure improvements in quality are equitably distributed with no segments of the population ignored. 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 interests' performance for select measures.

The Department develops an annual 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. With the systematic identification of disparities in the NC Medicaid Managed Care program The Department can incentivize Standard Plans and Tailored Plans that generate more equitable improvement in outcomes for their enrolled members.

The Department identifies selected measures with significant disparities, defined as greater than 10% relative difference in performance between the group of interest and the reference group. For the 2025 measurement year, disparity-specific targets will be set for the group of interest at a 10% relative improvement in performance. In the evaluation of plan performance on these measures, the Department will assess whether disparities have narrowed through performance improvement, specifically for the subpopulation experiencing the disparity. Additionally, the Department will consider overall performance improvement for each plan's respective enrolled population as compared to their Standard Plan or Tailored Plan peers.

The Department's approach to analyzing performance improvement for quality measures overall and with respect to disparities can be captured by the following steps:

Step 1. Measure plan performance overall.

- For measures where a higher rate indicates better performance: The overall target for each measure, where prior-year statewide performance is available, will be: (Prior Year Statewide Line-of-Business Performance % \* 1.05);
- For measures where a lower rate indicates better performance: The overall target for each measure, where prior-year statewide performance is available, will be: (Prior Year Statewide Line-of-Business Performance % \* 0.95);
- If the updated benchmark is worse than the previous year's benchmark, the previous year's benchmark will be used.

Step 2. Identify disparities.

- For quality measures where a higher rate indicates better performance, a disparity exists when:  $((\text{Reference Group Performance \%} - \text{Group of Interest Performance \%}) \div \text{Reference Group Performance \%})$  is greater than 10%.
- For quality measures where a lower rate indicates better performance, the inverse equation is used, and a disparity exists when:  $((\text{Group of Interest Performance \%} - \text{Reference Group Performance \%}) \div \text{Reference Group Performance \%})$  is greater than 10%.
- For CAHPS measures, disparities based on race are identified by performing 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, White respondents are compared to non-White respondents, 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, and other respondents are compared to non-other 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 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.

Step 3. Set disparity-specific targets. When a disparity, as defined in Step 2 above, is identified, the associated target for the group of interest is set at a 10% relative improvement in performance.

- For measures where a higher rate indicates better performance, the disparity-specific target for each measure will be: (Group of Interest's Performance % \* 1.10);
- For measures where a lower rate indicates better performance, the disparity-specific target for each measure will be: (Group of Interest's Performance % \* 0.9);
- If the updated disparity-specific target is worse than the previous year's target, the previous year's target will be used.

Step 4. In subsequent years, plan-level calculations of performance against disparity-specific targets for groups of interest will be included.

For the 2026 measurement year, the Department plans to implement the gap-to-goal benchmarking approach described above to set priority population performance targets. More detailed information on how the Department's updated gap-to-goal benchmarking methodology would apply to priority population performance targets in MY2026 is forthcoming.

#### **D. Withhold Program**

Standard Plans and Tailored Plans are required to meet several reporting thresholds (which may be met through hybrid or digital reporting where appropriate) to remain in compliance with Department contract provisions. Failure to achieve these minimum performance thresholds may result in sanctions. Additionally, the Department may encourage plans to perform beyond compliance thresholds through a withhold program, in which a portion of each plan's capitation rate is withheld and paid when the plan meets reasonably achievable performance targets on priority measures.

The first measurement year for the Standard Plan Withhold Program was 2024. The Department is currently planning to launch a Tailored Plan Withhold Program no sooner than the 2027 measurement year and will communicate proposed performance measures in an update of this document.

The Department will maintain the same quality measures as used in Year 1 (2024) of the Standard Plan Withhold Program for the Standard Plan Withhold Program Year 2 (2025). The metrics are:

- Childhood Immunization Status (CIS-E) (CBE #0038)–Combination 10 (Combo 10)

- Prenatal and Postpartum Care (PPC) (CBE #1517)<sup>35</sup>
- Rate of Screening for Health-Related Resource Needs (HRRN)<sup>36</sup>

Additional details on the 2025 Standard Plan Withhold Program can be found in the updated [North Carolina Medicaid Standard Plan Withhold Program Guidance](#). Specific information on Withhold amounts, scoring and targets across all performance measures is included in the Program Guidance, which the Department will update prior to the start of each measurement year.

Standard Plan Withhold Program performance measure targets will be informed by the Department’s overall Quality benchmarking approach wherever appropriate. 2025 Standard Plan Withhold Program performance measure targets align with the 2025 Quality benchmarking approach, with the exception of Combo 10 performance targets, which the Department has set using an alternate methodology to account for national performance measure trends.<sup>37</sup> The Department intends for 2026 Standard Plan Withhold Program targets would align with the Department’s planned gap-to-goal benchmarking approach for 2026.<sup>38</sup>

The Department is closely monitoring the potential impact of Hurricane Helene on Standard Plan Withhold measure performance. As more information becomes available, the Department may consider updates to parameters of the 2024 and 2025 Standard Plan Withhold Program.

As noted above, the Department aims to include any potential changes to Standard Plan Withhold Program performance measures in the update of this document released approximately six months prior to the start of each new measurement year. To guide potential changes to the Standard Plan Withhold Program in the 2026 performance period and beyond, the Department has implemented an annual process that includes engaging internal and external stakeholders to solicit nominations for new performance measures and applying a framework for performance measure selection or retirement.<sup>39</sup> Candidate measures for the for the 2026 performance period will be shared in an update of this document released no later than June 2025.

## E. Practice-level Quality Measurement for Advanced Medical Homes

### AMHs

<sup>35</sup> 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 could be incentivized as an AMH measure was the claims-year running from January 2024 through December 2024. See Section III(A) for more details.

<sup>36</sup> This measure is scored according to pay for reporting in Years 1 and 2 of the Withhold Program.

<sup>37</sup> This approach is only planned for the 2025 performance period. The Department will evaluate national performance trends as MY2024 data becomes available to inform Combo 10 scoring for the 2026 performance period.

<sup>38</sup> See Section V(B) for more details on the Department’s 2025 and 2026 measurement year benchmarking approaches.

<sup>39</sup> 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>

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. All Tier 3 AMH practices will be eligible to earn negotiated Performance Incentive Payments based on the set of measures in Table 3, which were selected for their relevance to primary care and care coordination. These incentives are optional for Tier 1 and 2 AMHs.

Standard Plans are required to offer opportunities for Performance Incentive Payments to Tier 3 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 3 below. 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. The Department updates this document annually with the most recent performance data.

**Table 3: AMH Measure Set, Measures Selected for Use in Plan Assessments of AMH Practice Quality**

CBE#	CMIT#	Measure Name	Steward	Frequency <sup>40</sup>
0032	118	Cervical Cancer Screening (CCS-E)	NCQA	Annually
1516	123	Child and Adolescent Well-Care Visits (WCV)	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) <sup>41</sup>	NCQA	Annually
0018	167	Controlling High Blood Pressure (CBP)	NCQA	Annually

<sup>40</sup> Plans will also send monthly gap measure reports to AMHs.

<sup>41</sup> 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.



CBE#	CMIT#	Measure Name	Steward	Frequency <sup>40</sup>
0059/0575	147/204	Glycemic Status Assessment for Patients with Diabetes (GSD) <sup>42</sup>	NCQA	Annually
1407	363	Immunizations for Adolescents (Combination 2) (IMA-E)	NCQA	Annually
1768	561	Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]	NCQA	Annually
1517	582/581	Prenatal and Postpartum Care (PPC) <sup>43</sup>	NCQA	Annually
0418/ 0418e	672	Screening for Depression and Follow-Up Plan (CDF)	CMS	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 (W30)	NCQA	Annually

Within the AMH measure set, 8 out of 13 measures are expected to include significant numbers of members of the Expansion population in MY2024 performance rates (See section F below for more details on the Expansion). The remaining measures are limited to previously eligible/enrolled populations (i.e., children and pregnant enrollees). The eight measures include: CCS, CHL, COL, CBP, GSD, PCR, CDF and TCOC. For MY 2024, the Department implemented a temporary policy to minimize the impact of VBP arrangements entered into prior to the launch of Medicaid Expansion. This policy prohibits Standard Plans from refusing to make applicable incentive payments otherwise owed to AMHs or their networks for the eight “expansion sensitive” measures, if the sole basis for the provider failing to meet the performance targets is caused by the inclusion of Medicaid Expansion members. These requirements apply specifically to determining performance for VBP arrangements with AMHs or CINs for the quality measurement year 2024 and will not be carried over into the 2025 measurement year.

#### *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

<sup>42</sup> 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.

<sup>43</sup> 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.

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 Medicaid Quality Strategy. Following the release of AMH+ and CMA metrics, Tailored Plans must offer performance incentives payments to AMH+s and CMAs using the Department-specified measure set.

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

## **F. Medicaid Expansion**

As of December 2024, North Carolina has enrolled over 608,000 Expansion members since expanding Medicaid on December 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 do not suggest systematic decreases in plan-level or safety-net hospital-level quality performance.<sup>44, 45</sup> 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 is implementing a temporary policy (described above) for MY 2024 that: (1) creates a quality measurement methodology that does not introduce a disincentive for practices to serve Expansion members; (2) encourages engagement with new Expansion members to close care gaps; and (3) promotes continued participation in the Medicaid program by AMH providers.

## **G. 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 publish 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 publish plan progress

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<sup>44</sup>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 Suppl <https://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.

<sup>45</sup>Chatterjee P, Qi M, Werner RM. Association of Medicaid Expansion With Quality in Safety-Net Hospitals. JAMA Intern Med. 2021;181(5):590-597.

toward receiving accreditation and will report the accreditor’s findings for each plan during its accreditation process.

- *Annual Plan-Level Quality Measures*—The Department will share plan-level rates for the quality measures described in Appendix A, to facilitate comparison among plans. Members and the public should have access to a reliable report on how plans are performing on specific elements. To that end, the Department will produce a report that will share plan-level quality measures. Over time, plan performance may be used to inform other state actions (e.g., auto-assignment).
- *Health Disparities Report*—The Department will assess disparities in care and outcomes across the demographics described in Section IV (B) and publish a report summarizing areas of care in which disparities have improved, persisted, or developed.
- *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 publish 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 surveys to assess members’ experience in receiving care. The Department will publish experience ratings by aggregate-level and plan-level populations in addition to other findings from this survey. The Department is considering other methods of sharing plan performance data, including plan report cards with aggregate quality data collected from each plan. The Department will share additional details should it introduce these reports.
- *Other Surveys*—The Department may report the results of other surveys and instruments, particularly those related to quality of life or functional status.
- *Access to Care Report*—The Department, in partnership with a third party, will issue a report that will track year-over-year trends for measures concerning healthcare access for North Carolina (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 Annual Quality Report*—This report evaluates NC Medicaid performance on quality measures related to access, utilization of services and member health outcomes.

It includes comparisons across years and national medians and highlights strengths, areas of concern and growth opportunities related to the NC Medicaid Managed Care Quality Strategy goals.

- *NC Medicaid Quality Fact Sheet Series*—This series of reports 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 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.

## VI. Conclusion and Next Steps

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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

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### **Appendix A: Table of Quality and Administrative Measures<sup>46</sup>**

The tables in this section list the quality measures that will be used to monitor quality improvement in the Medicaid program. Entities<sup>47</sup> 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

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 2–7 provide separate measure sets for each managed care entity.<sup>48</sup>

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<sup>46</sup> To view the full measure specifications for all NCQA measures, please refer to the HEDIS® Measurement Year 2023 & Measurement Year 2024 Volume 2 Technical Specifications for Health Plans.

<sup>47</sup> More information for each entity is available in the Quality Strategy, linked [here](#).

<sup>48</sup> There will be a separate quality measure set for the Children and Families Specialty Plan (CFSP) once launched. More information on the CFSP will be included in a future version of this document.

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

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
N/A	18	<i>Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)</i>	NCQA		X				
N/A	20	<i>Admission to a Facility from the Community (AIF)</i>	CMS	X	X		X	X	
N/A	36	<i>Adults' Access to Preventive/Ambulatory Health Services (AAP)</i>	NCQA	X	X				
3620	26	<i>Adult Immunization Status (AIS-E)</i>	NCQA	X	X				
N/A	N/A	<i>Alcohol and Drug Abuse Treatment Center (ADATC) Readmissions within 30 days and 180 days</i>	DHHS			X			
N/A	1784	<i>Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)</i>	DQA (ADA)				X		
N/A	N/A	<i>Antibiotic Utilization for Respiratory Conditions (AXR)</i>	NCQA	X	X				

<sup>49</sup> 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) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
1800	80	<i>Asthma Medication Ratio (AMR)</i>	NCQA	X	X				
N/A	N/A	<i>Average Length of Stay in Community Hospitals (mental health treatment &amp; substance use disorder treatment)</i>	DHHS			X			
0272/0275/0277/0283	577/578/579/580	<i>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</i>	AHRQ	X	X		X		
0728/ N/A/ 0727/ N/A	N/A	<i>Avoidable Pediatric Utilization: PDI 14: Asthma Admission Rate PDI 15: Diabetes Short-term Complications Admission Rate</i>	AHRQ	X	X		X		

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
		<i>PDI 16: Gastroenteritis Admission Rate</i> <i>PDI 18: Urinary Tract Infection Admission Rate</i>							
0058	84	<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)</i>	NCQA	X	X				
N/A	N/A	<i>Blood Pressure Control for Patients with Diabetes (BPD)</i>	NCQA	X	X		X		
2372	93	<i>Breast Cancer Screening (BCS-E)</i>	NCQA	X	X				
0032	118	<i>Cervical Cancer Screening (CCS-E) *</i>	NCQA	X	X		X		
1516	123	<i>Child and Adolescent Well-Care Visits (WCV)*</i>	NCQA	X	X		X		
0038	124	<i>Childhood Immunization Status (Combination 10) (CIS-E) <sup>50*</sup></i>	NCQA	X	X		X		X
0038	124	<i>Childhood Immunization Status (Combination 7)</i>	NCQA	X	X		X		

<sup>50</sup> This measure is a 2025 Standard Plan Withhold measure.



CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
0033	128	<i>Chlamydia Screening (CHL)*</i>	NCQA	X	X		X		
0034	139	<i>Colorectal Cancer Screening (COL-E) *</i>	NCQA	X	X				
N/A	N/A	<i>Community Mental Health Inpatient Readmissions within 30 Days</i>	DHHS			X			
N/A	N/A	<i>Community Substance Use Disorder Inpatient Readmission within 30 Days</i>	DHHS			X			
3389	150	<i>Concurrent Use of Prescription Opioids and Benzodiazepines (COB)</i>	PQA	X	X			X	
3175	N/A	<i>Continuity of Pharmacotherapy for Opioid Use Disorder</i>	USC		X			X	
2903/2904	1002	<i>Contraceptive Care: All Women (CCW)</i>	US Office of Population Affairs	X	X		X		
2902	166	<i>Contraceptive Care: Postpartum (CCP)</i>	US Office of Population Affairs	X	X		X		

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
0018	167	<i>Controlling High Blood Pressure (CBP)<sup>51*</sup></i>	NCQA	X	X		X		X
2607	196	<i>Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) (HPCMI)</i>	NCQA		X			X	
1932	202	<i>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</i>	NCQA		X			X	
1448	1003	<i>Developmental Screening in the First Three Years of Life (DEV)</i>	OHSU	X	X		X		
N/A	N/A	<i>Engagement in Mental Health Services</i>	DHHS			X			
N/A	N/A	<i>Engagement in Substance Use Disorder Services</i>	DHHS			X			
N/A	N/A	<i>EPSDT Screening Ratio</i>	DHHS	X	X			X	

<sup>51</sup> 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) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
N/A	N/A	<i>Follow-Up After Discharge from Community Hospitals, State Psychiatric Hospitals, and Facility-based Crisis Services for Mental Health Treatment (7 days and 30 days)</i>	DHHS			<b>X</b>			
N/A	N/A	<i>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)</i>	DHHS			<b>X</b>			
3489	265	<i>Follow-Up After Emergency Department Visit for Mental Illness (FUM)</i>	NCQA	<b>X</b>	<b>X</b>			<b>X</b>	
3488	264	<i>Follow-Up After Emergency Department Visit for Substance Use (FUA)</i>	NCQA		<b>X</b>			<b>X</b>	
0576	268	<i>Follow-Up After Hospitalization for Mental Illness (FUH)</i>	NCQA	<b>X</b>	<b>X</b>			<b>X</b>	

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
0108	271	<i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)</i>	NCQA	X	X			X	
0059/0057	147/204	<i>Glycemic Status Assessment for Patients with Diabetes (GSD)<sup>52</sup>*</i>	NCQA	X	X		X		X
1407	363	<i>Immunizations for Adolescents (Combination 2) (IMA-E) *</i>	NCQA	X	X		X		
0004	394	<i>Initiation and Engagement of Substance Use Disorder Treatment (IET)</i>	NCQA		X			X	
N/A	N/A	<i>Initiation of Mental Health Services</i>	DHHS			X			
N/A	N/A	<i>Initiation of Substance Use Disorder Services</i>	DHHS			X			
N/A	397	<i>Inpatient Utilization (IPU)</i>	NCQA	X	X		X		
N/A	1775	<i>Lead Screening in Children (LSC-CH)</i>	NCQA	X	X		X		

<sup>52</sup> 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) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
1382	413	<i>Live Births Weighing Less Than 2,500 Grams</i> <sup>53</sup>	CDC	X	X				
N/A	N/A	<i>Low Birth Weight</i> <sup>54</sup>	DHHS	X	X				
0027	432	<i>Medical Assistance with Smoking and Tobacco Use Cessation (MSC)</i> <sup>55</sup>	NCQA	X	X				
2800	448	<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)</i>	NCQA		X			X	
2517	897	<i>Oral Evaluation, Dental Services (OEV)</i>	DQA (ADA)	X	X		X		
N/A	1783	<i>Oral Evaluation During Pregnancy (OEVp)</i>	DQA (ADA)				X		
1768	561	<i>Plan All-Cause Readmissions (PCR) [Observed versus expected ratio] *</i>	NCQA	X	X		X		

<sup>53</sup> This measure is calculated at the state-level for all states by CMS using natality data compiled by the National Center for Health Statistics (NCHS).

<sup>54</sup> 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 B for more information about this measure.

<sup>55</sup> Note: this measure may not be stratified by all sub-strata listed Table 2 in Section IV (B).

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
N/A	N/A	<i>Prenatal Depression Screening and Follow-Up (PND-E)</i>	NCQA	X	X		X		
3484	1782	<i>Prenatal Immunization Status (PRS-E)</i>	NCQA	X	X				
1517	582/581	<i>Prenatal and Postpartum Care (PPC)<sup>56*</sup></i>	NCQA	X	X		X		
N/A	N/A	<i>Rate of Screening for Pregnancy Risk<sup>57</sup></i>	DHHS	X	X		X		
N/A	N/A	<i>Rate of Screening for Health-Related Resource Needs (HRRN)<sup>58</sup></i>	DHHS	X	X				
0418/ 0418e <sup>59</sup>	672	<i>Screening for Depression and Follow-Up Plan (CDF)*</i>	CMS	X	X				
N/A	830	<i>Sealant Receipt on Permanent First Molars (SFM)</i>	DQA (ADA)	X	X		X		

<sup>56</sup> This measure is a 2025 Standard Plan Withhold measure. The Department requires Standard Plans to complete both administrative and hybrid reporting for this measure.

<sup>57</sup> The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.

<sup>58</sup> This measure is a 2025 Standard Plan Withhold measure.

<sup>59</sup> 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) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
N/A	N/A	<i>State Psychiatric Hospital Readmissions within 30 Days and 180 Days</i>	DHHS			X			
N/A	700	<i>Statin Therapy for Patients with Cardiovascular Disease (SPC)</i>	NCQA	X	X		X		
2528/ 3700/ 3701	1672	<i>Topical Fluoride for Children (TFL)</i>	DQA (ADA)	X	X		X		
N/A	N/A	<i>Total Cost of Care (TCOC)*</i>	Health Partners	X	X		X	X	
2801	743	<i>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)</i>	NCQA	X	X			X	
2940	748	<i>Use of Opioids at High Dosage in Persons Without Cancer (OHD)</i>	PQA		X			X	
2950	N/A	<i>Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)</i>	PQA		X			X	
3400	750	<i>Use of Pharmacotherapy for Opioid Use Disorder (OUD)</i>	CMS		X			X	

CBE #	CMIT #	Measure	Steward	Standard Plan	Tailored Plan	Tailored Plan (State Funded) <sup>49</sup>	CCNC	PIHP	EBCI Tribal Option
0024	760	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i>	NCQA	X	X		X		
1392	761	<i>Well-Child Visits in the First 30 Months of Life (W30) *</i>	NCQA	X	X		X		

\* Measure is included in the AMH measure set

**Appendix Table 2: Standard Plan Measure Set**

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
N/A	20	<i>Admission to a Facility from the Community (AIF)</i>	CMS		X
3620	26	<i>Adult Immunization Status (AIS-E)</i>	NCQA	X	
N/A	36	<i>Adults' Access to Preventive/Ambulatory Health Services (AAP)</i>	NCQA		X
N/A	N/A	<i>Antibiotic Utilization for Respiratory Conditions (AXR)</i>	NCQA	X	
1800	80	<i>Asthma Medication Ratio (AMR)</i>	NCQA	X	
0272/ 0275/ 0277/ 0283	577/578/ 579/580	<i>Avoidable Adult Utilization</i> <ul style="list-style-type: none"> <li><i>PQI 01: Diabetes Short-term Complication Admission Rate</i></li> <li><i>PQI 05: COPD or Asthma in Older Adults Admission Rate</i></li> </ul>	AHRQ		X



CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
		<ul style="list-style-type: none"> <li>• <i>PQI 08: Heart Failure Admission Rate</i></li> <li>• <i>PQI 15: Asthma in Younger Adults Admission Rate</i></li> </ul>			
0728/ N/A/ 0727/ N/A	N/A	<i>Avoidable Pediatric Utilization:</i> <ul style="list-style-type: none"> <li>• <i>PDI 14: Asthma Admission Rate</i></li> <li>• <i>PDI 15: Diabetes Short-term Complications Admission Rate</i></li> <li>• <i>PDI 16: Gastroenteritis Admission Rate</i></li> <li>• <i>PDI 18: Urinary Tract Infection Admission Rate</i></li> </ul>	AHRQ		<b>X</b>
0058	84	<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)</i>	NCQA	<b>X</b>	
N/A	N/A	<i>Blood Pressure Control for Patients with Diabetes (BPD)</i>	NCQA		<b>X</b>
2372	93	<i>Breast Cancer Screening (BCS-E)</i>	NCQA	<b>X</b>	
0032	118	<i>Cervical Cancer Screening (CCS-E) *</i>	NCQA	<b>X</b>	
1516	123	<i>Child and Adolescent Well-Care Visits (WCV) *</i>	NCQA	<b>X</b>	
0038	124	<i>Childhood Immunization Status (Combination 10) (CIS-E) <sup>60</sup>*</i>	NCQA	<b>X</b>	
0038	124	<i>Childhood Immunization Status (Combination 7)</i>	NCQA	<b>X</b>	
0033	128	<i>Chlamydia Screening (CHL) *</i>	NCQA	<b>X</b>	

<sup>60</sup> This measure is a 2025 Standard Plan Withhold measure.

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
0034	139	<i>Colorectal Cancer Screening (COL-E)*</i>	NCQA	X	
3389	150	<i>Concurrent Use of Prescription Opioids and Benzodiazepines (COB)</i>	PQA	X	
2903/ 2904	1002	<i>Contraceptive Care: All Women (CCW)</i>	US Office of Population Affairs		X
2902	166	<i>Contraceptive Care: Postpartum (CCP)</i>	US Office of Population Affairs		X
0018	167	<i>Controlling High Blood Pressure (CBP)<sup>61*</sup></i>	NCQA	X	
1448	1003	<i>Developmental Screening in the First Three Years of Life (DEV)</i>	OHSU		X
N/A	N/A	<i>EPSDT Screening Ratio</i>	DHHS		X
3489	265	<i>Follow-Up After Emergency Department Visit for Mental Illness (FUM)</i>	NCQA	X	
0576	268	<i>Follow-Up After Hospitalization for Mental Illness (FUH)</i>	NCQA	X	
0108	271	<i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)</i>	NCQA	X	
0059/ 0057	147/204	<i>Glycemic Status Assessment for Patients with Diabetes (GSD)<sup>62*</sup></i>	NCQA	X	

<sup>61</sup> The Department requires both administrative and hybrid reporting for this measure.

<sup>62</sup> The Department requires both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
1407	363	<i>Immunizations for Adolescents (Combination 2) (IMA-E)*</i>	NCQA	<b>X</b>	
N/A	397	<i>Inpatient Utilization (IPU)</i>	NCQA		<b>X</b>
N/A	1775	<i>Lead Screening in Children (LSC-CH)</i>	NCQA		<b>X</b>
1382	413	<i>Live Births Weighing Less Than 2,500 Grams</i>	CDC		<b>X</b>
N/A	N/A	<i>Low Birth Weight<sup>63</sup></i>	DHHS		<b>X</b>
0027	432	<i>Medical Assistance with Smoking and Tobacco Use Cessation (MSC)<sup>64</sup></i>	NCQA		<b>X</b>
2517	897	<i>Oral Evaluation, Dental Services (OEV)</i>	DQA (ADA)		<b>X</b>
1768	561	<i>Plan All-Cause Readmissions (PCR) [Observed versus expected ratio] *</i>	NCQA		<b>X</b>
1517	581/582	<i>Prenatal and Postpartum Care (PPC)<sup>65</sup>*</i>	NCQA	<b>X</b>	
N/A	N/A	<i>Prenatal Depression Screening and Follow-Up (PND-E)</i>	NCQA		<b>X</b>
3484	1782	<i>Prenatal Immunization Status (PRS-E)</i>	NCQA		<b>X</b>
N/A	N/A	<i>Rate of Screening for Pregnancy Risk<sup>66</sup></i>	DHHS		<b>X</b>
N/A	N/A	<i>Rate of Screening for Health-Related Resource Needs (HRRN)<sup>67</sup></i>	DHHS		<b>X</b>

<sup>63</sup> See Appendix B for more information about this measure.

<sup>64</sup> Note: this measure may not be stratified by all sub-strata listed Table 2 in Section IV (B).

<sup>65</sup> This measure is a 2025 Standard Plan Withhold measure. The Department requires both administrative and hybrid reporting for this measure.

<sup>66</sup> The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.

<sup>67</sup> This measure is a 2025 Standard Plan Withhold measure.

CBE #	CMIT #	Measure	Steward	Standard Plan Reported	Department Calculated
0418/ 0418e <sup>68</sup>	672	<i>Screening for Depression and Follow-Up Plan (CDF)*</i>	CMS	<b>X</b>	
N/A	830	<i>Sealant Receipt on Permanent First Molars (SFM)</i>	DQA (ADA)		<b>X</b>
N/A	700	<i>Statin Therapy for Patients with Cardiovascular Disease (SPC)</i>	NCQA		<b>X</b>
2528/ 3700/ 3701	1672	<i>Topical Fluoride for Children (TFL)</i>	DQA (ADA)		<b>X</b>
N/A	N/A	<i>Total Cost of Care (TCOC)*</i>	Health Partners		<b>X</b>
2801	743	<i>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)</i>	NCQA	<b>X</b>	
0024	760	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i>	NCQA		<b>X</b>
1392	761	<i>Well-Child Visits in the First 30 Months of Life (W30)*</i>	NCQA	<b>X</b>	

\* Measure is included in the AMH measure set

<sup>68</sup> Plans must report to the Department whether they are using the standard or electronic measure.

**Appendix Table 3: Tailored Plan Measure Set**

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
N/A	18	<i>Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)</i>	NCQA	<b>X</b>	
N/A	20	<i>Admission to a Facility from the Community (AIF)</i>	CMS		<b>X</b>
3620	26	<i>Adult Immunization Status (AIS-E)</i>	NCQA	<b>X</b>	
N/A	36	<i>Adults' Access to Preventive/Ambulatory Health Services (AAP)</i>	NCQA		<b>X</b>
N/A	N/A	<i>Antibiotic Utilization for Respiratory Conditions (AXR)</i>	NCQA	<b>X</b>	
1800	80	<i>Asthma Medication Ratio (AMR)</i>	NCQA	<b>X</b>	
0272/ 0275/ 0277/ 0283	577/578/ 579/580	<p><i>Avoidable Adult Utilization</i></p> <ul style="list-style-type: none"> <li><i>PQI 01: Diabetes Short-term Complication Admission Rate</i></li> <li><i>PQI 05: COPD or Asthma in Older Adults Admission Rate</i></li> <li><i>PQI 08: Heart Failure Admission Rate</i></li> <li><i>PQI 15: Asthma in Younger Adults Admission Rate</i></li> </ul>	AHRQ		<b>X</b>
0728/ N/A/ 0727/ N/A	N/A	<p><i>Avoidable Pediatric Utilization:</i></p> <ul style="list-style-type: none"> <li><i>PDI 14: Asthma Admission Rate</i></li> <li><i>PDI 15: Diabetes Short-term Complications Admission Rate</i></li> <li><i>PDI 16: Gastroenteritis Admission Rate</i></li> <li><i>PDI 18: Urinary Tract Infection Admission Rate</i></li> </ul>	AHRQ		<b>X</b>

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
0058	84	<i>Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)</i>	NCQA	X	
N/A	N/A	<i>Blood Pressure Control for Patients with Diabetes (BPD)</i>	NCQA		X
2372	93	<i>Breast Cancer Screening (BCS-E)</i>	NCQA	X	
0032	118	<i>Cervical Cancer Screening (CCS-E) *</i>	NCQA	X	
1516	123	<i>Child and Adolescent Well-Care Visits (WCV)*</i>	NCQA	X	
0038	124	<i>Childhood Immunization Status (Combination 10) (CIS-E) *</i>	NCQA	X	
0038	124	<i>Childhood Immunization Status (Combination 7)</i>	NCQA	X	
0033	128	<i>Chlamydia Screening (CHL)*</i>	NCQA	X	
0034	139	<i>Colorectal Cancer Screening (COL-E) *</i>	NCQA	X	
3389	150	<i>Concurrent Use of Prescription Opioids and Benzodiazepines (COB)</i>	PQA	X	
3175	N/A	<i>Continuity of Pharmacotherapy for Opioid Use Disorder</i>	USC	X	
2903/ 2904	165	<i>Contraceptive Care: All Women (CCW)</i>	US Office of Population Affairs		X
2902	166	<i>Contraceptive Care: Postpartum (CCP)</i>	US Office of Population Affairs		X
0018	167	<i>Controlling High Blood Pressure (CBP)<sup>69*</sup></i>	NCQA	X	

<sup>69</sup> The Department requires both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
2607	196	<i>Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) (HPCMI)</i>	NCQA		<b>X</b>
1932	202	<i>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</i>	NCQA	<b>X</b>	
1448	1003	<i>Developmental Screening in the First Three Years of Life (DEV)</i>	OHSU		<b>X</b>
N/A	N/A	<i>EPSDT Screening Ratio</i>	DHHS		<b>X</b>
3489	265	<i>Follow-Up After Emergency Department Visit for Mental Illness (FUM)</i>	NCQA	<b>X</b>	
3488	264	<i>Follow-Up After Emergency Department Visit for Substance Use (FUA)</i>	NCQA		<b>X</b>
0576	268	<i>Follow-Up After Hospitalization for Mental Illness (FUH)</i>	NCQA	<b>X</b>	
0108	271	<i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)</i>	NCQA	<b>X</b>	
0059/ 0057	147/204	<i>Glycemic Status Assessment for Patients with Diabetes (GSD)<sup>70*</sup></i>	NCQA	<b>X</b>	
1407	363	<i>Immunizations for Adolescents (Combination 2) (IMA-E)*</i>	NCQA	<b>X</b>	
0004	394	<i>Initiation and Engagement of Substance Use Disorder Treatment (IET)</i>	NCQA		<b>X</b>
N/A	397	<i>Inpatient Utilization (IPU)</i>	NCQA		<b>X</b>
N/A	1775	<i>Lead Screening in Children (LSC-CH)</i>	NCQA		<b>X</b>

<sup>70</sup> The Department requires both administrative and hybrid reporting for this measure.

CBE #	CMIT #	Measure	Steward	Tailored Plan Reported	Department Calculated
1382	413	<i>Live Births Weighing Less Than 2,500 Grams</i>	CDC		<b>X</b>
N/A	N/A	<i>Low Birth Weight<sup>71</sup></i>	DHHS		<b>X</b>
0027	432	<i>Medical Assistance with Smoking and Tobacco Use Cessation (MSC)<sup>72</sup></i>	NCQA		<b>X</b>
2800	448	<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)</i>	NCQA	<b>X</b>	
2517	897	<i>Oral Evaluation, Dental Services (OEV)</i>	DQA (ADA)		<b>X</b>
1768	561	<i>Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*</i>	NCQA		<b>X</b>
N/A	N/A	<i>Prenatal Depression Screening and Follow-Up (PND-E)</i>	NCQA		<b>X</b>
1517	581/582	<i>Prenatal and Postpartum Care (PPC)<sup>73</sup>*</i>	NCQA	<b>X</b>	
3484	1782	<i>Prenatal Immunization Status (PRS-E)</i>	NCQA		<b>X</b>
N/A	N/A	<i>Rate of Screening for Pregnancy Risk<sup>74</sup></i>	DHHS		<b>X</b>
N/A	N/A	<i>Rate of Screening for Health-Related Resource Needs (HRRN)</i>	DHHS		<b>X</b>
0418/ 0418e <sup>75</sup>	672	<i>Screening for Depression and Follow-Up Plan (CDF)*</i>	CMS	<b>X</b>	
N/A	830	<i>Sealant Receipt on Permanent First Molars (SFM)</i>	DQA (ADA)		<b>X</b>

<sup>71</sup> 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 B for more information about this measure.

<sup>72</sup> Note: this measure may not be stratified by all sub-strata listed in Table 2 in Section IV (B).

<sup>73</sup> The Department requires both administrative and hybrid reporting for this measure.

<sup>74</sup> The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.

<sup>75</sup> Plans must report to the Department whether they are using the standard or electronic measure.



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

\* Measure is included in the AMH measure set

**Appendix Table 4: Tailored Plan State-Funded Measure Set<sup>76</sup>**

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

<sup>76</sup> Measures in the Tailored Plan State-Funded Measure Set are calculated by DMH/DD/SUS.

CBE #	CMIT #	Measure	Steward	Tailored Plan (State Funded) Reported	Department Calculated
N/A	N/A	<i>State Psychiatric Hospital Readmissions within 30 Days and 180 Days</i>	DHHS	<b>X</b>	

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

CBE #	CMIT #	Measure	Steward	CCNC Reported	Department calculated
N/A	20	<i>Admission to a Facility from the Community (AIF)</i>	CMS		<b>X</b>
N/A	1784	<i>Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-A-A)</i>	DQA (ADA)		<b>X</b>
0272/ 0275/ 0277/ 0283	577/578/ 579/580	<i>Avoidable Adult Utilization</i> <ul style="list-style-type: none"> <li>• <i>PQI 01: Diabetes Short-term Complication Admission Rate</i></li> <li>• <i>PQI 05: COPD or Asthma in Older Adults Admission Rate</i></li> <li>• <i>PQI 08: Heart Failure Admission Rate</i></li> <li>• <i>PQI 15: Asthma in Younger Adults Admission Rate</i></li> </ul>	AHRQ		<b>X</b>
0728/ N/A/ 0727/ N/A	N/A	<i>Avoidable Pediatric Utilization:</i> <ul style="list-style-type: none"> <li>• <i>PDI 14: Asthma Admission Rate</i></li> <li>• <i>PDI 15: Diabetes Short-term Complications Admission Rate</i></li> <li>• <i>PDI 16: Gastroenteritis Admission Rate</i></li> </ul>	AHRQ		<b>X</b>

CBE #	CMIT #	Measure	Steward	CCNC Reported	Department calculated
		<ul style="list-style-type: none"> <li>PDI 18: Urinary Tract Infection Admission Rate</li> </ul>			
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)	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	DHHS		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	397	Inpatient Utilization (IPU)	NCQA		X

CBE #	CMIT #	Measure	Steward	CCNC Reported	Department calculated
N/A	1775	<i>Lead Screening in Children (LSC-CH)</i>	NCQA		<b>X</b>
2517	897	<i>Oral Evaluation, Dental Services (OEV)</i>	DQA (ADA)		<b>X</b>
N/A	1783	<i>Oral Evaluation During Pregnancy (O EVP)</i>	DQA (ADA)		<b>X</b>
1768	561	<i>Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*</i>	NCQA		<b>X</b>
1517	582/581	<i>Prenatal and Postpartum Care (PPC)</i>	NCQA		<b>X</b>
N/A	N/A	<i>Prenatal Depression Screening and Follow-Up (PND-E)</i>	NCQA		<b>X</b>
N/A	N/A	<i>Rate of Screening for Pregnancy Risk<sup>77</sup></i>	DHHS		<b>X</b>
N/A	830	<i>Sealant Receipt on Permanent First Molars (SFM)</i>	DQA (ADA)		<b>X</b>
N/A	700	<i>Statin Therapy for Patients with Cardiovascular Disease (SPC)</i>	NCQA		<b>X</b>
2528/ 3700/ 3701	1672	<i>Topical Fluoride for Children (TFL)</i>	DQA (ADA)		<b>X</b>
N/A	N/A	<i>Total Cost of Care (TCOC)*</i>	Health Partners		<b>X</b>
0024	760	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i>	NCQA		<b>X</b>
1392	761	<i>Well-Child Visits in the First 30 Months of Life (W30)*</i>	NCQA	<b>X</b>	

\* Measure is included in the AMH measure set

<sup>77</sup> The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.

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

<b>CBE #</b>	<b>CMIT #</b>	<b>Measure</b>	<b>Steward</b>	<b>PIHP Reported</b>	<b>Department calculated</b>
N/A	20`	<i>Admission to a Facility from the Community (AIF)</i>	CMS		<b>X</b>
3389	150	<i>Concurrent Use of Prescription Opioids and Benzodiazepines (COB)</i>	PQA	<b>X</b>	
3175	N/A	<i>Continuity of Pharmacotherapy for Opioid Use Disorder</i>	USC	<b>X</b>	
2607	196	<i>Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%) (HPCMI)</i>	NCQA		<b>X</b>
1932	202	<i>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)</i>	NCQA	<b>X</b>	
N/A	N/A	<i>EPSDT Screening Ratio</i>	DHHS		<b>X</b>
3489	265	<i>Follow-Up After Emergency Department Visit for Mental Illness (FUM)</i>	NCQA	<b>X</b>	
3488	264	<i>Follow-Up After Emergency Department Visit for Substance Use (FUA)</i>	NCQA		<b>X</b>
0576	268	<i>Follow-Up After Hospitalization for Mental Illness (FUH)</i>	NCQA	<b>X</b>	
0108	271	<i>Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)</i>	NCQA	<b>X</b>	
0004	394	<i>Initiation and Engagement of Substance Use Disorder Treatment (IET)</i>	NCQA		<b>X</b>
2800	448	<i>Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)</i>	NCQA	<b>X</b>	
N/A	N/A	<i>Total Cost of Care (TCOC)*</i>	Health Partners		<b>X</b>

<b>CBE #</b>	<b>CMIT #</b>	<b>Measure</b>	<b>Steward</b>	<b>PIHP Reported</b>	<b>Department calculated</b>
2801	743	<i>Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)</i>	NCQA	<b>X</b>	
2940	748	<i>Use of Opioids at High Dosage in Persons Without Cancer (OHD)</i>	PQA		<b>X</b>
2950	N/A	<i>Use of Opioids from Multiple Providers in Persons Without Cancer (OMP)</i>	PQA		<b>X</b>
3400	750	<i>Use of Pharmacotherapy for Opioid Use Disorder (OUD)</i>	CMS		<b>X</b>

\* Measure is included in the AMH measure set

**Appendix Table 7: EBCI Tribal Option Measure Set**

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

\* Measure is included in the AMH measure set

**Appendix Table 8. Additional Measure Set Specifications**

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

Measure Set	Specifications Location
<b>InCK</b>	<a href="https://medicaid.ncdhhs.gov/nc-inck-tools-resources">https://medicaid.ncdhhs.gov/nc-inck-tools-resources</a>
<b>Transitions to Community Living (TCL)</b>	<a href="https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living">https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living</a>
<b>Innovations 1915(c) Medicaid Home and Community-Based Services Waiver (HCBS) Waiver</b>	<a href="https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/nc-innovations-waiver">https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/nc-innovations-waiver</a>
<b>TBI 1915(c) Medicaid HCBS Waiver</b>	<a href="https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/traumatic-brain-injury">https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/traumatic-brain-injury</a>
<b>CMHRP and CMARC</b>	Please refer to the Program Guide, available <a href="#">here</a> , 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.



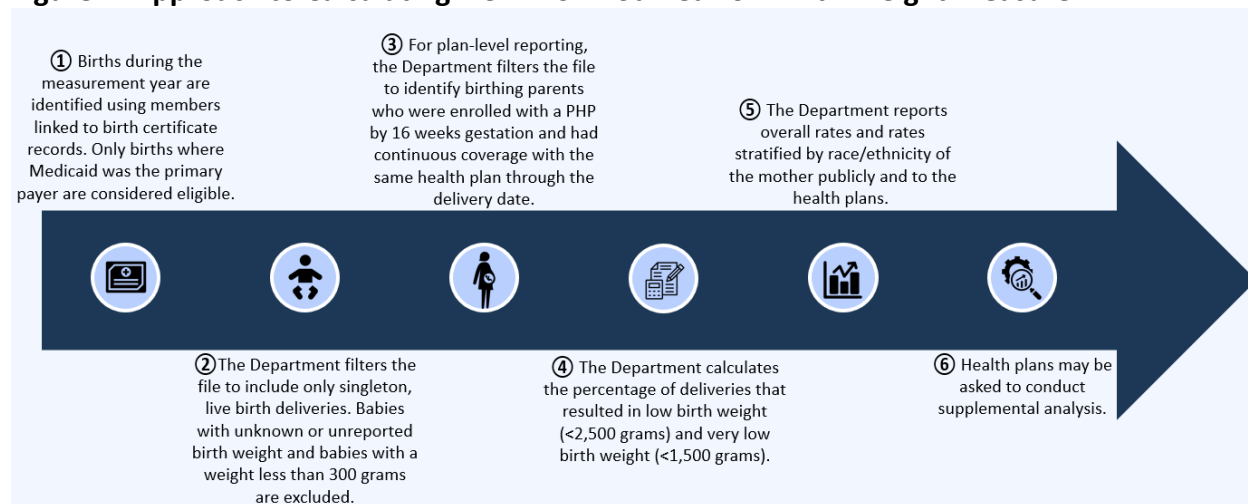
## Appendix B: Measure Modifications: Low Birth Weight

The low-birth-weight outcome measure will be reported collaboratively between the Department, Standard Plans and Tailored Plans. The Department expects collaboration with plans as follows:

1. The Department will work with Vital Records to obtain birth weights for all live, singleton deliveries weighing more than 300 grams during the measurement period using members linked to birth certificate records. Only births where Medicaid was the primary payer are considered eligible.
2. The Department will create a file with the birth weight status and identifier of each infant in the set. The file will not include live births with a birth weight that is “Unknown or Not Stated” or babies with a weight less than 300 grams.
3. For plan-level reporting, each plan provides the Department with a quarterly file representing live, singleton deliveries for the measurement-year-to-date. The Department uses this file and identifies mothers of infants who were continuously covered by the same health plan from 16 weeks’ gestation or earlier. This subset of infants will be considered eligible infants for the health plan.
4. The Department will calculate the rate of both low birth weight (<2,500 grams) and sub-rate of very low birth weight (<1,500 grams) among eligible infants in their population. The Department will report overall rates and rates stratified by race, ethnicity, and maternal age.
5. The Department may ask Standard Plans and Tailored Plans to conduct supplemental analyses to further refine measure specifications. Examples of such analyses may include comparing low birth weight as reported by V codes to low birth weight as reported by Vital Records data or calculating the measure incorporating additional potential exclusions.

See Figure 4 for a representation of the process for reporting the low-birth-weight outcome measure.

**Figure 4: Approach to Calculating NCDHHS’ Modified Low Birth Weight Measure**



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<sup>78</sup>; 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.

<sup>78</sup> All NC Medicaid Managed Care beneficiaries—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 C: 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 D: Specifications for Measures

### 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 18 years of age 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 at least 18 years of age 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 2025 Volume 2 Technical Specifications for Health Plans.*

## **Admission to a Facility from the Community (AIF)**

### *Descriptive Information*

#### **Measure Type**

Outcome

#### **CBE Number and Measure Steward**

CMIT# 20, Measure Steward: CMS

#### **Brief Description of Measure**

The number of admissions to a facility among enrollees, ages 18 and older, residing in the community for at least one month. The number of short-term, medium-term, or long-term admissions is reported per 1,000 enrollee months. Enrollee months reflect the total number of months each enrollee is enrolled in the program and residing in the community for at least one day of the month.

#### **Numerator Statement**

The following three performance rates are reported across four age groups (ages 18 to 64, ages 65 to 74, ages 75 to 84, and age 85 and older):

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

#### **Denominator Statement**

Number of enrollee months where the enrollee was residing in the community for at least one day of the month.

#### **Denominator Exclusions**

None.

*For full measure specifications, please refer to CMS' Health Home Resource Manual and Technical Specifications.*

## 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 19 years of age 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, and hepatitis B.

#### 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 at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine at least 28 days apart, any time on or after the member's 50<sup>th</sup> birthday and before or during 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 19<sup>th</sup> 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 (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set) with different dates of service on or before their 19<sup>th</sup> birthday, or
- Members who received a hepatitis B vaccine series on or after their 19<sup>th</sup> 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 (Hepatitis B Value set) 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.

**Denominator Statements**

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

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

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

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

*Denominator 5: Hepatitis B*—Members 19–59 years 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 2025 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: DHHS

#### 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: DHHS

#### 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

Outcome

### CBE Number and Measure Steward

CMIT#36 , Measure Steward: NCQA

### Brief Description of Measure

The percentage of members 20 years of age 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 of aged 20 years 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 2025 Volume 2 Technical Specifications for Health Plans.*

## Antibiotic Utilization for Respiratory Conditions (AXR)

### Descriptive Information

#### Measure Type

Outcome

#### CBE Number and Measure Steward

CBE# N/A, Measure Steward: NCQA

#### Brief Description of Measure

The percentage of episodes for members 3 months of age 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.

*For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2024 Volume 2 Technical Specifications for Health Plans.*

## Asthma Medication Ratio (AMR)

### Descriptive Information

#### Measure Type

Process

#### CBE Number and Measure Steward

CBE# 1800, CMIT# 80, Measure Steward: NCQA

#### Brief Description of Measure

The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

#### Numerator Statement

The number of members with persistent asthma who have a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.

#### Denominator Statement

All members 5–64 years of age as of December 31<sup>st</sup> of the measurement year who have persistent asthma and met at least one of the following criteria during both the measurement year and the year prior to the measurement year:

- At least one ED visit with asthma as the principal diagnosis.
- At least one acute inpatient encounter or discharge with asthma as the principal diagnosis (without telehealth).
- At least four outpatient visits, observation visits, telephone visits or online assessments on different dates of service, with any diagnosis of asthma AND at least two asthma medication dispensing events for any controller or reliever medication. Visit type need not be the same for the four visits.
- At least four asthma medication dispensing events for any controller medication or reliever medication.

#### Denominator Exclusions

Members who had any diagnosis from any of the following value sets, anytime during the member's history through December 31<sup>st</sup> of the measurement year:

- Emphysema Value Set.

- Other Emphysema Value Set.
- Chronic Obstructive Pulmonary Disease Value Set.
- Obstructive Chronic Bronchitis Value Set.
- Chronic Respiratory Conditions Due to Fumes or Vapors Value Set.
- Cystic Fibrosis Value Set.
- Acute Respiratory Failure Value Set.

Members who had no asthma medications (controller or reliever) dispensed during the measurement year.

Members in hospice or who used hospice services 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 2025 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: DHHS

#### 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 years 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 age 18 years 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 2025 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 18–75 years of age 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 18–75 years of age 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 receiving palliative care any time during the measurement year.



Members who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year and who did not have a diagnosis of diabetes. These members are sometimes pulled into the denominator via pharmacy data. They are then removed once no additional diagnosis of diabetes (type 1 or 2) is found.

*For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2025 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 50–74 years of age 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 52–74 years of age 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 2025 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 21–64 years of age who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria:

- Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last three years.
- Members 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 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting 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, 24–64 years of age 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<sup>st</sup> 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.

*For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2025 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 3–21 years of age 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 3–21 years of age as of December 31<sup>st</sup> 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 2025 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 of age 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.

**Table 9:** 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 by their second birthday.

#### Denominator Statement

Children who turn 2 years of age 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 had any of the following on or before their second birthday:

- Severe combined immunodeficiency.
- Immunodeficiency.
- HIV.
- Lymphoreticular cancer, multiple myeloma or leukemia.
- Intussusception.

*For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2025 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 16–24 years of age 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 16–24 years 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 or 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.

*For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2025 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 45–75 years of age 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 45–75 years of age.

#### 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<sup>st</sup> 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 2025 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: DHHS

#### **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 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: DHHS

#### 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 18 years 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 18 years 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 18–64 years of age 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 18–64 years of age 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 to 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 15–44 years 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 aged 15–44 years 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 to 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 aged 15–44 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 aged 15–44 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 90 days of delivery.

*LARC within three days:* Women aged 15–44 years 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 aged 15–44 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 15–44, as of December 31<sup>st</sup> 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 18–85 years of age 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 (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 18–85 years of age 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<sup>st</sup> 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 2025 Volume 2 Technical Specifications for Health Plans.*

**Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>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 18–75 years of age 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 18–75 years of age as of December 31<sup>st</sup> 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.

*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 18–64 years of age 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 18–64 years old 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 18–64 years of age as of the end of the measurement year (e.g., December 31<sup>st</sup>) 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 2025 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 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 18 years and older

#### **Denominator Statement**

All member months for individuals 18 years 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: DHHS

#### **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: DHHS

### **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.

## **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: DHHS

### **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 1–7 and 1–30 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: DHHS

## **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 7 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 MH, 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 7-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 6 years of age 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:

1. The percentage of ED Visits for which the patient received follow-up within 7 days after discharge.
2. 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 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm on or between January 1<sup>st</sup> and December 1<sup>st</sup> 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 2025 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 13 years of age and older with a principal diagnosis of substance use disorder, who had a follow-up visit for substance use disorder. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (eight total days).
2. 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<sup>st</sup> and December 1<sup>st</sup> of the measurement year where the member was 13 years 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 6 years of age and older who were hospitalized for a principle 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<sup>st</sup> to December 1<sup>st</sup>) for members 6 years 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<sup>st</sup> 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 2025 Volume 2 Technical Specifications for Health Plans.*

## 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.

1. **Initiation Phase.** The percentage of members 6–12 years of age 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.
2. **Continuation and Maintenance (C&M) Phase.** The percentage of members 6–12 years of age 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 31–300 days (nine months) after IPSPD.

### **Denominator Statement**

Children 6–12 years of age newly prescribed ADHD medication.

### **Denominator Exclusions**

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

Members with a diagnosis of narcolepsy any time during their history through December 31<sup>st</sup> 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 2025 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 18–75 years of age with diabetes (types 1 and 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 18–75 years of age 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 2025 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 13 years of age 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 years of age 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 2025 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 13 years of age and older as of December 31<sup>st</sup> of the measurement year who were diagnosed with a new episode of SUD during the first 10.5 months of the measurement year (i.e., January 1<sup>st</sup>–November 15<sup>th</sup>).

**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 2025 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: DHHS

**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.*

## Initiation of Substance Use Disorder Services

### Descriptive Information

## Measure Type

Process

## CBE Number and Measure Steward

CBE# N/A, Measure Steward: DHHS

## 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.*

## Inpatient Utilization – General Hospital/Acute Care (IPU)

### Descriptive Information

## Measure Type

Process

## CBE Number and Measure Steward

CBE# N/A, CMIT# 397, Measure Steward: NCQA

## Brief Description of Measure

This measure summarizes utilization of acute inpatient care and services in the following categories:

1. Maternity.
2. Surgery.
3. Medicine.

4. Total inpatient (the sum of Maternity, Surgery and Medicine).

### **Numerator Statement**

Members with acute inpatient discharges (inpatient, maternity, surgery, medicine) on or between January 1<sup>st</sup> and December 31<sup>st</sup> of the measurement year.

Measure is reported in three sub-measures

1. Discharges per 1,000 member years
2. Days per 1,000 members years
3. Average length of stay

*Note: The Department prioritizes sub-measure #1 to align with other state's reporting*

### **Denominator Statement**

Eligible population.

### **Denominator Exclusions**

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

*This measure was retired by the measure steward for Measurement Year 2024. The Department intends to continue monitoring this measure until a new risk-adjusted utilization metric is developed for the Medicaid population. For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2025 Volume 2 Technical Specifications for Health Plans.*

## **Lead Screening in Children (LSC-CH)**

### *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 years of age during the measurement year.

**Denominator Exclusions**

Members in hospice or using hospice services 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 2025 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: 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 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: DHHS

**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 B to learn more about this measure.*

**Medical Assistance with Smoking and Tobacco Use Cessation (MSC)**  
*Descriptive Information*

**Measure Type**

Process



## **CBE Number and Measure Steward**

CBE# 0027, CMIT# 432, Measure Steward: NCQA

## **Brief Description of Measure**

The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

1. **Advising Smokers and Tobacco Users to Quit.** A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
2. **Discussing Cessation Medications.** A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.
3. **Discussing Cessation Strategies.** A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

## **Numerator Statement**

*Advising Smokers and Tobacco Users to Quit:* Members who indicated that they received advice to quit smoking or using tobacco from their doctor or health care provider.

*Discussing Cessation Medications:* Members who indicated that their doctor or health care provider recommended or discussed smoking or tobacco cessation medications.

*Discussing Cessation Strategies:* Members who indicated their doctor or health care provider discussed or provided smoking or tobacco cessation methods and strategies other than medication.

## **Denominator Statement**

Members 18 years of age and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users during the measurement year or in the past six months for Medicaid and Medicare.

## **Denominator Exclusions**

None.

For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2025 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 1–17 years of age 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 1–17 years of age received at least one test for blood or HbA1c during the measurement year.

*Cholesterol:* Members 1–17 years of age who received at least one test for LDL-C or cholesterol during the measurement year.

*Blood Glucose and Cholesterol:* Members 1–17 years of age 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 1–17 years of age 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 2025 Volume 2 Technical Specifications for Health Plans, which includes all exclusion criteria.*

## 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 under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider during the measurement year.

## Numerator Statement

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

## Denominator Statement

Unduplicated number of enrolled members under age 21 years.

## 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 (OEPV)

### *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 aged 15 through 44 years 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 aged 15 through 44 years 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 number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis

within 30 days and the predicted probability of an acute readmission. 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 county 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, unplanned 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<sup>st</sup> (or on that day) and December 1<sup>st</sup> 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 2025 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

*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<sup>st</sup> and December 1<sup>st</sup> 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<sup>nd</sup> and December 31<sup>st</sup> of the measurement period: Screening should be performed between the pregnancy start date and December 1<sup>st</sup> 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

*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.

*For full measure specifications, to include all exclusion criteria, please refer to the HEDIS® Measurement Year 2025 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 women received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.

### Numerator Statement

#### 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 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 2025 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<sup>79</sup>:

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 between seven and 84 days after delivery.

## **Numerator Statement**

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

*Postpartum Care:* A postpartum visit 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 2025 Volume 2 Technical Specifications for Health Plans.*

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<sup>79</sup> 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.

## 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: DHHS

#### Brief Description of Measure

The *Rate of Screening for Pregnancy Risk* is an NC DHHS 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.<sup>80</sup>

#### 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

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<sup>80</sup> 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.

## **CBE Number and Measure Steward**

CBE# N/A, Measure Steward: DHHS

## **Brief Description of Measure**

The percentage of enrollees who received and completed a health-related resource needs screening using the NC DHHS 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<sup>st</sup>–December 31<sup>st</sup>).

## **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.

\*Completed screenings are defined as:

- Beneficiaries who received a screening and answered at least one 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.

## **Continuous Enrollment Criteria**

## **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 NC DHHS 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)<sup>81</sup> *Descriptive Information*

### Measure Type

Process

### CBE Number and Measure Steward

CBE# 0418/0418e, CMIT# 672, Measure Steward: CMS

### Brief Description of Measure

Percentage of members ages 12 years 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 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period.

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<sup>81</sup> Plans must report to the Department whether they are using the standard or electronic measure.

## 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 10<sup>th</sup> 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 age 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 10<sup>th</sup> birthday.

*For more information, please refer to the Medicaid and CHIP Technical Assistance Resource available [here](#).*

## Statin Therapy for Patients with Cardiovascular Disease (SPC)

### Descriptive Information

## Measure Type

Process

## CBE Number and Measure Steward

CBE# N/A, CMIT# 700, Measure Steward: NCQA

## Brief Description of Measure

Assesses males 21–75 years of age and females 40–75 years of age who have clinical atherosclerotic cardiovascular disease (ASCVD) and who received and adhered to statin therapy. The following 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 males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having ASCVD.

### **Denominator Exclusions**

Members with a diagnosis of pregnancy during the measurement year or the year prior to the measurement year.

In vitro fertilization in the measurement year or the year prior to the measurement year.

Dispensed at least one prescription for clomiphene during the measurement year or the year prior to the measurement year.

ESRD or dialysis during the measurement year or the year prior to the measurement year.

Cirrhosis during the measurement year or the year prior to the measurement year.

Myalgia, myositis, myopathy or rhabdomyolysis during 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 care 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.*

## **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 1–20 years of age 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 age 1 through 20 as of December 31<sup>st</sup> of the measurement year.

### **Denominator Exclusions**

None.

*For more information, please refer to the Medicaid and CHIP Technical Assistance Resource available [here](#).*

### **Total Cost of Care (TCOC)**

*Descriptive Information*

*See information in Section III.C. Measures of Utilization*

### **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 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

### **Numerator Statement**

Documentation of psychosocial care 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**

Children and adolescents 1–17 years of age as of December 31<sup>st</sup> 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 2025 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 to 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 to 64 years as of January 1<sup>st</sup> 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 Dose 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  $\geq 18$  years of age who received prescriptions for opioids with an average daily dosage of  $\geq 90$  morphine milligram equivalents (MME) over a period of  $\geq 90$  days.

*A lower rate indicates better performance.*

### Numerator Statement

Individuals from the denominator with an average daily dosage  $\geq 90$  MME during the opioid episode.

### Denominator Statement

Individuals  $\geq 18$  years of age with  $\geq 2$  prescription claims for opioid medications on different dates of service and with a cumulative days' supply  $\geq 15$  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  $\geq 18$  years of age who received prescriptions for opioids from  $\geq 4$  prescribers and  $\geq 4$  pharmacies within  $\leq 180$  days.

*A lower rate indicates better performance.*

#### Numerator Statement

Individuals from the denominator with opioid prescription claims from  $\geq 4$  prescribers **and**  $\geq 4$  pharmacies within  $\leq 180$  days during the opioid episode.

#### Denominator Statement

Individuals  $\geq 18$  years of age with  $\geq 2$  prescription claims for opioid medications on different dates of service and with a cumulative days' supply  $\geq 15$  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 3–17 years of age 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 3–17 years of age 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 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 2025 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. Children 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. Children 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:* 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 2025 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 members to report on their experiences accessing care, their experiences with their health plan, and the quality of care they receive.<sup>i82</sup>

The survey’s target population includes individuals of all ages (ages 18 and older for the adult version and parents or guardians of children ages 0–17 for the child version) who have been continuously enrolled in Medicaid for the six-month measurement period (July 1<sup>st</sup> through December 31<sup>st</sup> 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 patient’s perspective.

**Table 10:** CAHPS survey measures the department will include <sup>83</sup>

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

<sup>82</sup> 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>.

<sup>83</sup> 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.



Global Ratings	Composite Measures	Individual Item Measures	Effectiveness of Care Measures (Adult Population Only)
Rating of Personal Doctor	How Well Doctors Communicate		Discussing Cessation Strategies
Rating of Specialist Seen Most Often	Customer Service		

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