



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

North Carolina's Medicaid Quality
Measurement Technical Specifications
Manual for Standard Plans and
Behavioral Health
Intellectual/Developmental Disability
Tailored Plans
Version 1.6

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2023 Technical Specifications Summary of Updates:

- Added the following quality measures:
 - Lead Screening in Children (LSC)
 - Oral Evaluation, Dental Services (OEV)
 - Topical Fluoride for Children (TFL)
 - Sealant Receipt on Permanent First Molars (SFM)
 - EPSDT Screening Ratio
 - Developmental Screening in the First Three Years of Life (DEV)
 - Long-term Services and Supports Comprehensive Care Plan and Update (CPU)
 - Antibiotic Utilization for Respiratory Conditions (AXR)
 - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)
 - Colorectal Cancer Screening (COL)
- Updated background information and the measure set/specifications for the Integrated Care for Kids (InCK) initiative (See Section III (G)); the Departments work in collaboration with the Health Information Exchange (HIE) (Section III); gap reporting (Section IV(A)); and select measures of utilization (Section III(C)).
- Added new information related to the Standard Plan withhold program.
- Revised equations describing how performance improvement for quality measures will be calculated.
- Updated the descriptions for the Low Birth Weight and Pregnancy Risk Screening measures.
- Updated measure specifications to align with the 2023 HEDIS Specifications (see Appendices).
- Edited to align with the 2023 Adult and Child Core Sets.
- Provided links to additional programs' quality measure set specifications, where applicable.
- Added the Prenatal and Postpartum Care (PPC) measure to the AMH Measure Set.
- Replaced the Rate of Screening for Unmet Resource Needs with the Rate of Screening for Health-Related Resource Needs (HRRN)
- Updated the following measures in the Standard and Tailored Plan Measure Sets to be department-calculated:
 - Rate of Screening for Health-Related Resource Needs (HRRN)
 - Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]
 - Low Birth Weight
 - Rate of Screening for Pregnancy Risk
- Updated the specifications for Inpatient Utilization to align with NCQA's Inpatient Utilization – General Hospital/Acute Care (IPU) measure.
- Added information regarding the workaround for interim care gap reporting given 834 term dates.
- Provided more information on the geography strata in Table 2. Stratified Reporting Elements.
- Added explicit exclusion of members with dual commercial and Medicaid enrollment from quality measurement reports.

I. Introduction

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”) and providers for advancing quality goals. This document provides an overview of the Department’s approach to quality improvement, with a specific focus on quality measurement and reporting and incentives for improved quality performance. The document includes:

- The Department’s vision for advancing quality through Standard Plans and Tailored Plans.
- 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 and Tailored Plans are required to report as well as those that the Department will calculate.

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

II. Vision for Advancing Quality Through Managed Care

As noted in the Quality Strategy¹, the Department seeks to develop a data-driven, outcomes-based continuous quality improvement process that rewards Standard Plans and Tailored Plans for advancing quality outcomes in targeted areas that support three central Aims: 1) Better Care Delivery; 2) Healthier People, Healthier Communities; and 3) Smarter Spending. Goals and Objectives are tied to each of these Aims, along with a series of interventions, including 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.

The Department is committed to rewarding Standard Plans and Tailored Plans that accurately report and demonstrate meaningful improvement against specified quality benchmarks. Working with Standard Plans and Tailored Plans, the Department will collect a robust set of quality data, which will paint a clear picture of service delivery and clinical care at a statewide

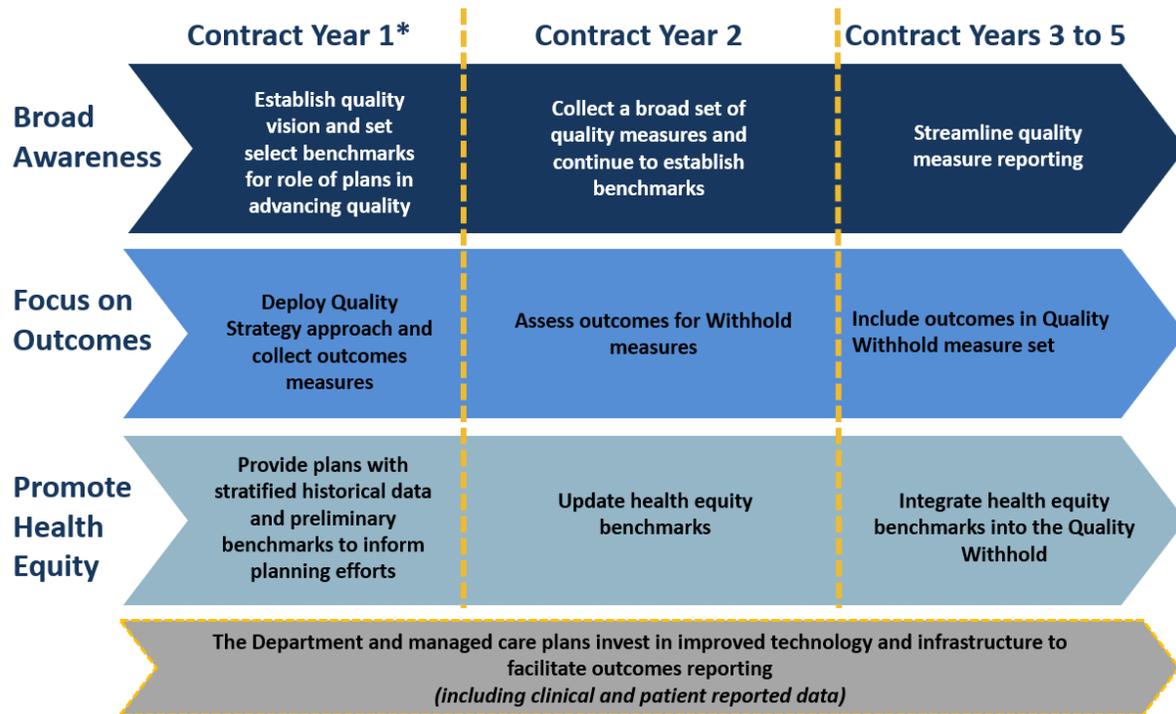
¹ Available [here](#).

and, eventually, a regional level, and across demographic strata, such as age, gender, disability status, geography, race, and ethnicity (see Table 1 for the full list). The Department will require 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. In later years, plans will be expected to build on these relationships to attain quality withhold targets for priority outcomes specified by the Department (Figure 1). The Department will also collect and report 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.

The Department will also expand its role in calculating certain quality measures directly, to limit reporting burden on managed care plans. In turn, the Department expects Standard Plans and Tailored 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. Recognizing the substantial investments Standard Plans and Tailored Plans must make to meet quality reporting requirements, 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 1: 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 will use a variety of programmatic requirements to ensure Standard Plans and Tailored Plans move toward plan-level accountability for health outcomes and will offer resources to support plans and providers in their quality improvement efforts. Most directly, the Department will set goals for plan quality improvement efforts through the establishment of quality measure sets. Standard Plans and Tailored Plans will be required to report on the quality metrics in these measure sets, as well as calculate historical rates and performance benchmarks. The Department will also share historical rates and performance benchmarks for the measures that will be reported by the Department directly. These requirements are likely to be a major focus of plan efforts, and through the quality withhold program (described in greater detail in Section V), plans will have direct financial accountability for a subset of overall quality performance improvement and reduction or elimination of disparities.

The Department will require additional program elements related to quality improvement, including the following:

- 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 will submit an annual Quality Assessment and Performance Improvement (QAPI) plan, delineating their plans for PIPs and other quality improvement efforts.

- The Department requires Standard Plans and Tailored Plans to engage 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. Additionally, the EQRO will develop a separate report on health equity.
- 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 (MCAC) and the state Consumer and Family Advisory Committee (CFAC).

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)).²

III. Quality Measurement and Improvement

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

The Department will monitor a wide range of processes and outcomes relevant to managed care, which are shown in Appendix A. One subset of measures (shown in Appendix A, Tables 4 and 5 and Appendix D) is the priority focus for plan accountability. These measures, which are selected by the Department and will primarily be calculated by plans, comprise the set from which plans can draw for required quality improvement initiatives such as PIPs. Eventually, the

² More information on Tailored Plans and Tailored Care Management can be found [here](#).

Department will use a limited subset of these measures as part of its withhold program as well. In addition, the Department will calculate and monitor a separate, larger set of measures on health care delivery and outcomes in the Medicaid program (Appendix A, Table 7 and Appendix F).

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 6 and Appendix E). For several of these state-funded services measures, Tailored Plans will be held financially accountable starting in Contract Year 1, as Local Management Entities/Managed Care Organizations (LME/MCOs) are today.

Plan-level performance on measures shown in Appendix A, Tables 4 and 5 will be publicly reported, and plan-level performance on measures shown in Appendix A, Tables 6 and 7 may be publicly reported.³

The Department's Quality and Health Outcomes Committee (QHO) will review 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 that will be specified by the Department. Measures were selected from a variety of sources, including the Healthcare Effectiveness Data and Information Set (HEDIS®); National Committee for Quality Assurance (NCQA) health plan accreditation, 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.⁴ The Department will update all quality measures annually to reflect changes in these sets as the foci of the Department's quality improvement efforts evolve.

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

³ The EQRO will report the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures at the plan level.

⁴ Standard Plans and Tailored Plans will be required to secure NCQA accreditation. Standard Plans must be accredited by July 2025.

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.⁵ 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 minimize 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:

1. Validate the extent to which the data it receives are complete and accurate enough to be used in quality measurement by potentially 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 to run hybrid 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 exchange of essential population health data for care management including care plans, clinical assessments, patient risk lists, patient registries, and patient attribution lists.
4. Ensure that all Medicaid providers with the capacity to do so, including labs, registries, and long-term care facilities, are submitting complete, accurate data to the HIE.
5. 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

⁵ The hybrid reporting method involves the use of both administrative data (such as claims/encounter data) and medical record review.

dQMs.⁶ 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)
- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CDF)

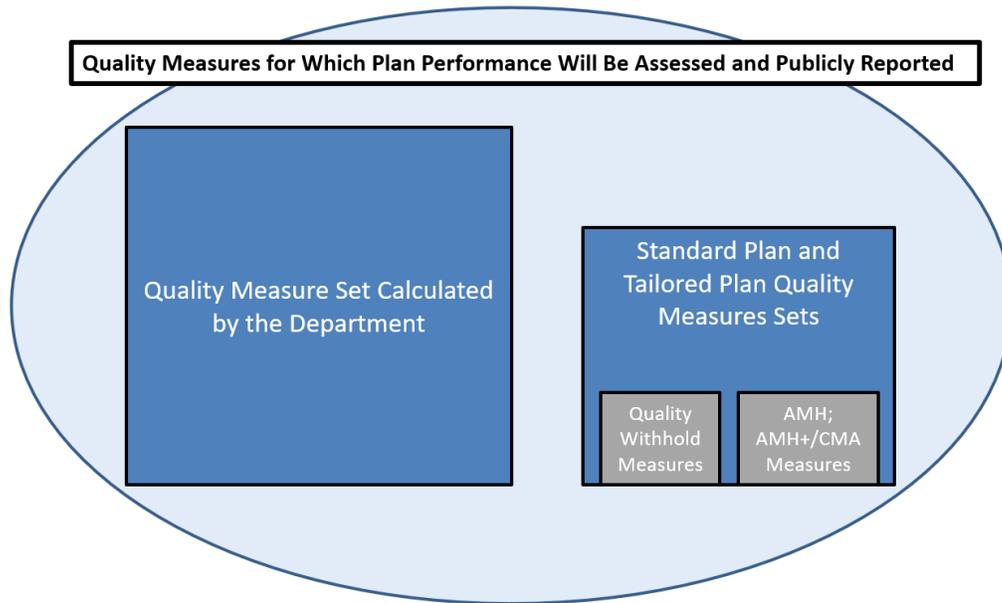
A. Quality and Administrative Measure Reporting

The Standard Plan and Tailored Plan measure sets are aligned with North Carolina’s Aims, Goals, and Objectives. The Department may hold Standard Plans and Tailored Plans financially accountable for their performance on a set of **quality withhold measures**. The Department will draw from their respective measure sets in the corresponding calendar year. See Section V for further information on the timing of financial accountability.

The Department has established a list of measures that Standard Plans and Tailored Plans must use as the basis for performance incentive payments to AMH practices. In the future, AMH+s and CMAs may also have the opportunity to receive incentive payments for improvement against a limited set of measures (described further in Section V (E)). Standard Plans and Tailored Plans should draw from their respective measure sets (see Appendix A, Tables 4 and 5) for any non-AMH PIPs and value-based contracting arrangements.

⁶ More information on CMS’ Digital Quality Measurement Strategic Roadmap is available [here](#).

Figure 2: Quality and Administrative Measure Reporting Framework



The Department aims to include any revisions or additions to the AMH measure set or quality measures subject to withholds in this document approximately 11 months prior to the calendar year for which qualifying services will be delivered. For example, if a measure were included in this document in January 2023, the effective date would be the claims-year running from January 2024 through December 2024 and retrospectively reported to the Department by health plans in 2025. 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 (National Quality Forum (NQF #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.^{7,8} The Department selected this measure because low birth weight is an important cause of morbidity for North Carolina children. In 2021, North Carolina ranked 40th among the 50 states for its rate of low birth weight babies (9.3%), reflecting the unacceptably high rate of low birth weight in the state each year.⁹ These high rates, in turn, are associated with higher rates of poor health outcomes and higher health care spending.¹⁰ 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 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 below, 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. The Department will coordinate with Standard Plans, Tailored Plans, and the North Carolina Department of Health and Human Service'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 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.¹¹ 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. The 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

⁷ An alternative measure of low birth weight rate, NQF #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 NQF #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.

⁸ 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. Developing technical specifications for a new measure according to the full process recommended in the CMS Measures Management System (MMS) Blueprint typically requires more than a year and substantial investment of resources. Because the Department sought to modify an existing measure rather than develop an entirely new measure, the Department used a limited adaptation of the MMS 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.

⁹ United Health Foundation. America's Health Rankings: North Carolina, 2021. Available [here](#).

¹⁰ March of Dimes, Low Birthweight. Available [here](#).

¹¹ 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>

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.

The Department will publicly report plan performance on the modified low birth weight outcome measure for the first full measurement year of NC Medicaid Managed Care (i.e. CY 2022), with explanatory language describing the pilot nature of the measure and providing appropriate guidance for interpreting results associated with small sample sizes. Based on Standard Plans' and Tailored Plans' respective performance in the first two years of measure reporting, the Department may elect to modify this measure.

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 will share results with plans:

- Hospital readmissions (measured using NQF #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 will calculate the observed versus expected ratio for this measure, which is the ratio of the actual (observed) count of readmissions in relation to the risk-adjusted (expected) count of readmissions. The count of expected readmissions is a prediction of the state's performance based on its demographic and clinical case mix in the NC Medicaid Managed Care population. It is typically calculated by classifying the state's case mix and applying risk weights to each eligible hospital stay.
- Total Cost of Care (HealthPartners): The HealthPartners' Total Cost of Care measure is a person-centered tool that accounts for 100% of the care provided to a patient. All administrative claims—for inpatient, outpatient, clinic, ancillary, pharmacy, and all other types of services—contribute to the total cost measure for continuously-enrolled members. Population-level costs therefore reflect an average per-member per-month (PMPM) sum, estimated by dividing members' total costs (or paid amounts) by total member months. Costs PMPM are adjusted to account for member characteristics (i.e., members are grouped based on diagnoses, age, and gender). The Department will also report Total Cost Relative Resource Values (TCRRV), which evaluate resource use across all medical services, procedures, and places of service. The Department is developing an interactive dashboard for plans and providers to access total cost of care information and is conducting stakeholder engagement in Spring 2023 to inform rollout in Fall/Winter 2023.¹²

¹² More information on the HealthPartners measures can be found [here](#).

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. The Department may calculate additional measures or different measures of avoidable utilization in future years.

D. Select Administrative Measures

Rate of Screening for Health-Related Resource Needs

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.

This measure has three rates. The denominator includes all NC Medicaid Managed Care members in a health plan's enrolled population with at least 90 consecutive days of continuous enrollment during the measurement year. The measure will track screenings completed between January 1st and December 31st of the measurement year. The eligible population will be those members enrolled from October 1st of the previous calendar year through September 30th of the current calendar year.¹³

Rate one captures the percent of all NC Medicaid Managed Care enrollees that the plans attempted to screen within 90 days of health plan enrollment, or re-enrollment, as per contract requirements. Rate two captures the percent of all enrollees who successfully completed a screening within 90 days of health plan enrollment, or re-enrollment.¹⁴ Rate three captures all members who have successfully completed a screening within the calendar year (January 1st-December 31st). Plans are required to use the NC DHHS Standardized SDOH screening questions.¹⁵

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 in order to calculate the number of days' difference between

¹³ For members who were not enrolled at least 90 days before the end of the measurement year (October 1st), the PHP would not have sufficient opportunity to provide the screening within 90 days. To account for this, the measure will track screenings completed between Jan 1st and December 31st of the measurement year. The eligible population will be those members enrolled from October 1st of the previous measurement year through September 30th of the current measurement year.

¹⁴ Completed screenings are defined as beneficiaries who received a screening and answered at least one question or beneficiaries who received a screening and actively declined to respond.

¹⁵ Screening questions are available [here](#).

member enrollment and successful screening completion for rate one. While NC Medicaid Managed Care contracts require plans make at least three attempts to screen within the 90-day period, this measure also captures how many screenings the plan has successfully completed, both within the required 90-day period and the calendar year. (See Appendix D for additional information required to calculate this measure.)

Screening for Pregnancy Risk

This measure captures whether Standard Plans' and Tailored Plans' contracted pregnancy care providers are administering 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. The denominator includes all members in a plan's enrolled population with a claim/encounter for prenatal services. 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 bill the plan. (See Appendix D for additional information required to calculate this measure.) The Department will report this measure with appropriate guidance in interpreting results reflecting small population sizes.

E. Select Survey-based Measures

Provider Survey: The Department, in partnership with a third party, will distribute an annual survey to providers assessing their experience with each plan. The Department may request Standard Plans' and Tailored Plans' support in developing a sampling frame and conducting outreach for this survey.

Patient-reported Outcomes Measures: The Department will use tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult and Child surveys, Mental Health Statistics Improvement Program (MHSIP) Consumer Satisfaction Survey, North Carolina Treatment Outcomes & Program Performance System (NC-TOPPS), National Core Indicators (NCI), 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, their ability to get care quickly, coordination of care, customer service, their rating of the health plan, rating of their personal doctor, and rating of the specialist seen most frequently. 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.¹⁶ To advance this vision, the Department will

¹⁶ More information about Healthy North Carolina 2030 can be found [here](#).

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 report on select survey-based public health measures at both the population level and level of the NC Medicaid Managed Care program and will review progress against related plan performance measures. The Department may reach out to plans to discuss performance improvement opportunities related to these select public health measures. For Year 1, the Department will report the following rates, based on the Centers for Disease Control and Prevention’s Behavioral Risk Factor Surveillance System Survey (BRFSS):

- Percentage of adults who are current smokers;
- Percentage of high school students using tobacco;
- Percentage of women who smoke during pregnancy;
- Exposure to secondhand smoke in the workplace;
- Fruit and vegetable consumption among adults;
- Percentage of adults getting the recommended amount of physical activity; and
- Unintentional poisoning mortality rate.

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 and the Children’s Health Insurance Program (CHIP) 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- and CHIP-enrolled beneficiaries, from birth through age 20, and covers approximately 95,000 children across the five-county model service area. Work on NC InCK began in January 2020 with a two-year planning period. NC InCK officially launched in January 2022 and will run through December 2026. To support its goal of aligning provider payments with meaningful measures of child well-being, NC InCK will include an alternative payment model (APM), called InCK Foundation. The initial quality measurement period will begin in January 2023 and run through December 2023. InCK Foundation 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.¹⁷

Table 1: InCK Quality Measures

| NQF# | Measure Name | Steward | Frequency |
|------------|--|-------------------------------------|-----------|
| N/A | Ambulatory Care: ED visits (AMB-CH) | NCQA | Annually |
| N/A | Food Insecurity Rate | NC InCK | Annually |
| N/A | Housing Instability Rate | NC InCK | Annually |
| N/A | Kindergarten Readiness Rate | NC Department of Public Instruction | Annually |
| N/A | Primary Care Kindergarten Readiness Bundle | NC InCK | Annually |
| 0418/0418e | Screening for Clinical Depression and Follow-Up Plan (CDF) | CMS* | Annually |
| N/A | Food Insecurity and Housing Instability Screening | NC InCK | Annually |
| N/A | Shared Action Plan for Children in SIL-2 and SIL-3 | NC InCK | Annually |
| N/A | Total Cost of Care (TCOC) | Health Partners | Annually |
| 1392 | Well-Child Visits in the First 30 Months of Life (Disparity Measure) (W30) | 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.*

IV. Required Reporting Activities for Standard Plans and Behavioral Health I/DD Tailored Plans

Standard Plans and Tailored Plans will be required to report on measures in each plan type’s respective measure sets (listed in Appendix A) as part of their contractual obligations under NC Medicaid Managed Care, including annual and gap reporting described below. These reports will 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, while the Department will contract with Standard Plans and Tailored Plans on a contract year.

¹⁷ The full quality measure specifications for the InCK program are available [here](#).

Each contract year, Standard Plans and Tailored Plans submit quality performance data collected during the calendar year that began immediately before the contract year.

Note: 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 required 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 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 (Feb to Oct) 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 (Feb to Oct), pull a fully updated enrollment file from the system with the latest enrollment segment.
 - b. On a monthly basis (Feb to Oct) 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.¹⁸

¹⁸ 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. E.g., if step 1.b.ii above were altered to include a 65-day runout period, it would read 'Set the max term date to a high date (e.g., 12/31/9999) if a term date is in the measurement year and is greater than the current month minus 65 days.' Including a runout period will reduce the likelihood that members whose term dates are extended retroactively are dropped from gap reports in the intervening period.

2. Load the Pseudo Enrollment File into a separate HEDIS engine prospective environment (project) to ensure the Pseudo Enrollment File does not impact the annual HEDIS and PMV reporting in alignment with HEDIS specifications.¹⁹
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 patients listed may not be impactable.
- Some patients listed may not end up in the annual measure.
- Interim care gap reports should not be leveraged for population-level analyses, i.e., the data should not be aggregated to develop a rate for comparison against benchmarks.

In addition to the approach outlined above, the Department encourages plans to employ additional analyses (e.g., modified continuous enrollment, rolling year, year to date) to understand which of their members have impactable gaps in care and to share their findings with providers strategically to close those gaps. For its part, the Department will work with plans, providers, and other partners to develop more accurate systems that identify gaps in members' care in closer to real time and deliver that information to providers at the point of care. For more information on the Department's strategy to leverage NC HealthConnex for quality measurement and care gap reporting, see page 15.

¹⁹ During the February to 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.

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. Further, 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. The Department will suppress small cell sizes before publicly reporting stratified results and will consider the effects of small sample size in its evaluation of Standard Plans’ and Tailored Plans’ stratified performance rates.

Table 2. Stratified Reporting Elements

| Stratification Element | Strata | Source |
|------------------------|--|---|
| Age | For pediatric measures: 0–1, 2–3, 4–6, 7–10, 11–14, 15–18, 19–20, 21 For maternal health: <19, 19–20, 21, 22–24, 25–34, 35+ For adult/full pop. measures: 0–18, 19–20, 21, 22–44, 45–64, 65+ | DHHS enrollment data |
| Race | Black, White, American Indian/Alaska Native, Asian, Hawaiian/Pacific Islander, Multiracial, Other | DHHS enrollment data (self-reported where possible) |

| Stratification Element | Strata | Source |
|---|---|--|
| | In addition to comparing individual groups, the Department will separately calculate the following strata: Black, Not-Black American Indian/Alaska Native (AIAN), Not-AIAN | |
| Ethnicity | Hispanic, Non-Hispanic | DHHS enrollment data (self-reported where possible) |
| Gender | Male, Female ²⁰ | DHHS enrollment data (self-reported where possible) |
| Primary Language | English, Spanish, Other | DHHS enrollment data (self-reported where possible) |
| LTSS Needs Status | 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)²¹ | 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) |
| Geography²² | Rural, Urban | DHHS enrollment data |
| Service Region²³ | Standard Plans: 1–6, Tailored Plans: 1–7 | DHHS enrollment data |

²⁰ 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.

²¹ The TCL strata will only be applied to Behavioral Health I/DD Tailored Plan measures (Please refer to Appendix A, Tables 5 and 6).

²² 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](#).

²³ Service region is determined based on a member's administrative county as reported in the 834 member file.

V. Assessing Performance

The Department will assess 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 will support statewide engagement (including with plans) around population health goals.

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

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

Beginning in Contract Year 1 for Standard Plans and Tailored Plans, respectively, the Department will monitor progress toward meeting performance benchmarks each contract 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. In future years, Standard Plans and Tailored Plans may 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 will reflect a performance level to ensure 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 has developed a performance benchmarking approach for use in quality measurement. Performance benchmarks are used to drive plan and Department conversations around performance.

The updated performance benchmarking approach is as follows:

- For the first two years of Standard Plan and Tailored Plan implementation, respectively, 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). For example, measurement year 2022 data will be used to set measurement year 2024

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, 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 the third plan year and beyond, the Department will monitor performance and may adjust the benchmarking methodology.

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.

The Department will use quality scores in the managed care plan auto-enrollment algorithm, allowing Standard Plans and Tailored Plans with higher quality scores to be assigned proportionally more new beneficiaries. If quality performance is unacceptably low over a continued period, the Department may terminate or decline to renew a managed care contract.

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 will require Standard Plans and Tailored Plans to participate in activities promoting health equity, and may use withholds to hold them financially accountable for ensuring equity in improvements for select measures.

Standard Plans and Tailored Plans are expected to engage with the Department's designated EQRO, which will develop an annual health equity report. The Department will use this report to guide development of subpopulation specific quality improvement strategies. This will start with systematic identification of disparities in the NC Medicaid Managed Care program and progress to rewarding Standard Plans and Tailored Plans that generate more equitable improvement in outcomes for their enrolled members. In Contract Year 1 for Standard Plans and Tailored Plans, respectively, the requirement is limited to stratified reporting.

The Department will identify selected measures with significant disparities, defined as greater than 10% relative difference in performance between the group of interest and the reference group. 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: $(\text{Prior Year Statewide Line-of-Business Performance \%} * 1.05)$;
- For measures where a lower rate indicates better performance: The overall target for each measure, where prior-year statewide performance is available, will be: $(\text{Prior Year Statewide Line-of-Business Performance \%} * 0.95)$;
- If the updated benchmark is worse than the previous year's benchmark, the previous years' benchmark will be used.

Step 2. Identify disparities.

- For measures where a higher rate indicates better performance, a disparity exists when: $((\text{Reference Group Performance \%} - \text{Group of Interest Performance \%}) / \text{Reference Group Performance \%})$ is greater than 10%;
- For measures where a lower rate indicates better performance, the inverse equation is used, and a disparity exists when: $((\text{Group of Interest Performance \%} - \text{Reference Group Performance \%}) / \text{Reference Group Performance \%})$ is greater than 10%.

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

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 Standard Plan withholds will be 2024. Potential timing for Tailored Plan withholds is under development. (Per S.L. 2018-49, the withhold program cannot be initiated until at least 18 months after managed care launch.)²⁴

The Department has identified a set of quality measures to be subject to withholds for implementation the first year of the Standard Plan withhold program. The metrics are:

- Childhood Immunization Status (CIS) (NQF #0038) – Combination 10
- Prenatal and Postpartum Care (PPC) (NQF #1517)²⁵
- Rate of Screening for Health-Related Resource Needs²⁶

For the Childhood Immunization Status (CIS) – Combination 10 measure, withholds performance will be assessed both on overall plan performance and priority population performance improvement. Withholds for the Prenatal and Postpartum Care (PPC) measure will be assessed on overall plan performance for the two submeasures (Timeliness of Prenatal Care and Postpartum Care). The Rate of Screening for Health-Related Resource Needs withhold measure will be based on submitting validated data for this measure ("pay for reporting") and not on performance rate, although bonuses beyond the withheld funds may be available for higher performance.

Because managed care contracting occurs in the state fiscal year and quality measure reporting occurs in the calendar year, quality measure performance will be attributed to contract years on an offset basis, with 2024 as the first measurement year and State Fiscal Year 2025 as the first year in which funds will be withheld. Additional details on withhold scoring and targets will be released in a withholds specification document prior to the start of the measurement year.

²⁴ As per S.L. 2018-49 (available [here](#)), withholds cannot be implemented until at least 18 months after managed care launch. A methodology to determine the quality score required to receive a withhold target allocation will be released prior to the launch of a withhold program.

²⁵ This measure was added to the AMH set in the 2023 Tech Specs. 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.

²⁶ For Year 1 of the Withholds Program this measure is pay for reporting.

E. Practice-level Quality Measurement for Advanced Medical Homes

AMHs

The Department requires Standard Plans and Tailored 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 and Tailored Plans are required to offer opportunities for such payments to Tier 3 AMHs. Plans are not required to use all of the AMH measures, but any quality measures they choose must be drawn from the set 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.

Table 3: Measures Selected for Use in Plan Assessments of AMH Practice Quality

| NQF# | Measure Name | Steward | Frequency ²⁷ |
|---|---|---------|-------------------------|
| Pediatric Measures | | | |
| 1516 | Child and Adolescent Well-Care Visits (WCV) | NCQA | Annually |
| 0038 | Childhood Immunization Status (Combination 10) (CIS) | NCQA | Annually |
| 0033 | Chlamydia Screening in Women (CHL) – Ages 16 to 20 | NCQA | Annually |
| 1407 | Immunizations for Adolescents (Combination 2) (IMA) | NCQA | Annually |
| 0418/0418e | Screening for Depression and Follow-Up Plan (CDF) – Ages 12 to 17 | CMS | Annually |
| 1392 | Well-Child Visits in the First 30 Months of Life (W30) | NCQA | Annually |
| Adult Measures (Age 18 and Older Unless Otherwise Noted) | | | |
| 0032 | Cervical Cancer Screening (CCS) – Ages 21 to 64 | NCQA | Annually |
| 0033 | Chlamydia Screening in Women (CHL) – Ages 21 to 24 | NCQA | Annually |
| 0018 | Controlling High Blood Pressure (CBP) | NCQA | Annually |
| 0059/0575 | Hemoglobin A1c Control for Patients With Diabetes (HBD) | NCQA | Annually |

²⁷ Monthly gap measure reports are also required.

| NQF# | Measure Name | Steward | Frequency ²⁷ |
|----------------|--|-----------------|-------------------------|
| 1768 | Plan All-Cause Readmissions (PCR) [Observed versus expected ratio] | NCQA | Annually |
| 0418/ 0418e | Screening for Depression and Follow-Up Plan (CDF) | CMS | Annually |
| N/A | Total Cost of Care | Health Partners | Annually |
| 1517 | NEW: Prenatal and Postpartum Care (PPC) ²⁸ | NCQA | Annually |

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. All AMH+ and CMA practices will be eligible to earn performance incentive payments based on a limited set of metrics following the release of a Department measure set.

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, the Tailored Plan 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. 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 apprise the public of plan performance and promote transparency in the overall quality of the NC Medicaid Managed Care program. These reports will include:

- *Accreditation Progress and Results*—All Standard Plans and Tailored Plans will be required to receive plan accreditation through NCQA. The Department will publish plan progress 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. Beneficiaries and the public should have access to a reliable report on how plans are

²⁸ This measure was added to the AMH set in the 2023 Tech Specs. 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.

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 Equity 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 satisfaction with the plan(s) they have contracted. The Department will publish overall satisfaction rates and other findings from this survey.
- *CAHPS Survey Results*—The Department, in partnership with a third party, will field the CAHPS surveys to assess the patient care experience. The Department will publish overall ratings of plans and all care received 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 summarizing secret shopper findings and other metrics of access for each plan.

VI. Conclusion and Next Steps

The Department will engage with Standard Plans and Tailored Plans as their quality measurement approach develops. The Department's selection of quality measures will likely change annually, reflecting new quality priorities as the transformation to managed care continues. In addition, the Department's measure selection includes measures from several nationally recognized measure sets which are evaluated annually. Each year, the Department will release a new list of measures required for reporting and ask for public feedback. The Department aims to maintain a measure set that reflects state-of-the-art quality measurement for NC Medicaid Managed Care-enrolled populations and will update measures to reflect the evolving needs of members.

VII. Appendices

Appendix A: Table of Quality and Administrative Measures²⁹

Table 4. Standard Plan Measure Set

This table lists quality measures that will be priority focus for Standard Plan accountability. These measures, which will primarily be calculated by Standard Plans, comprise the set that plans can draw measures for required quality improvement activities. An asterisk (*) indicates the measure is calculated by the Department.³⁰ Italicized measures are included in the AMH measure set, described in Section V (E).

| NQF# | Measure | Steward |
|--|---|---------|
| Pediatric Measures³¹ | | |
| 1800 | Asthma Medication Ratio (AMR) – Ages 5 to 18 Years | NCQA |
| 0058 | Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Ages 3 Months to 17 Years | NCQA |
| 1516 | <i>Child and Adolescent Well-Care Visits (WCV)</i> | NCQA |
| 0038 | <i>Childhood Immunization Status (Combination 10) (CIS)³²</i> | NCQA |
| 0033 | <i>Chlamydia Screening in Women (CHL) – Ages 16 to 20</i> | NCQA |
| 0576 | Follow-Up After Hospitalization for Mental Illness (FUH) – Ages 6 to 17 | NCQA |
| 0108 | Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD) | NCQA |
| 1407 | <i>Immunizations for Adolescents (Combination 2) (IMA)</i> | NCQA |
| 0418/0418e | <i>Screening for Depression and Follow-Up Plan (CDF) – Ages 12 to 17</i> | CMS |
| 2801 | Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) | NCQA |
| 1392 | <i>Well-Child Visits in the First 30 Months of Life (W30)</i> | NCQA |

²⁹ To view the full measure specifications for all NCQA measures, please refer to the HEDIS® Measurement Year 2022 & Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

³⁰ Please refer to the Program Guide, available [here](#), for more information on quality measures that must be reported as part of Care Management for High Risk Pregnancy and Care Management for At-Risk Children Programs.

³¹ Includes Adult measures with pediatric strata, where indicated.

³² 2024 Standard Plan Withhold measure.

| NQF# | Measure | Steward |
|--|--|-----------------|
| Adult Measures (Age 18 or Older Unless Otherwise Noted) | | |
| 1800 | Asthma Medication Ratio (AMR) | NCQA |
| 0058 | Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) | NCQA |
| 0032 | <i>Cervical Cancer Screening (CCS) – Ages 21 to 64</i> | NCQA |
| 0033 | <i>Chlamydia Screening in Women (CHL) – Ages 21 to 24</i> | NCQA |
| 0034 | Colorectal Cancer Screening (COL) – Ages 45 to 75 | NCQA |
| 3389 | Concurrent use of Prescription Opioids and Benzodiazepines (COB) | PQA |
| 0018 | <i>Controlling High Blood Pressure (CBP)</i> | NCQA |
| 0039 | Flu Vaccinations for Adults (FVA)* | NCQA |
| 0576 | Follow-Up After Hospitalization for Mental Illness (FUH) | NCQA |
| 0059/0575 | <i>Hemoglobin A1c Control for Patients with Diabetes (HBD)</i> | NCQA |
| N/A | Long-Term Services and Supports Comprehensive Care Plan and Update (CPU) | NCQA |
| 0027 | Medical Assistance with Smoking and Tobacco Use Cessation (MSC)* ³³ | NCQA |
| 1768 | <i>Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*</i> | NCQA |
| N/A | Rate of Screening for Health-Related Resource Needs (HRRN)* ³⁴ | DHHS |
| 0418 / 0418e ³⁵ | <i>Screening for Depression and Follow-Up Plan (CDF)</i> | CMS |
| N/A | <i>Total Cost of Care*</i> | Health Partners |
| Maternal Measures | | |
| N/A | Low Birth Weight* ³⁶ | DHHS |
| 1517 | <i>Prenatal and Postpartum Care (PPC)</i> ³⁷ <ul style="list-style-type: none"> • Timeliness of Prenatal Care • Postpartum Care | NCQA |
| N/A | Rate of Screening for Pregnancy Risk* ³⁸ | DHHS |

³³ Note: this measure may not be stratified by all sub-strata listed Table 2 in Section IV (B).

³⁴ The Department is exploring potential adoption of HEDIS' new Social Needs Screening and Intervention (SNS-E) [measure](#). In the interim, the PHPs will submit a quarterly operational report that includes beneficiary screening results that will be used to calculate this measure. See Appendix D for more specific information about this measure. This measure is a 2024 Standard Plan Withhold measure.

³⁵ Plans must report to the Department whether they are using the standard or electronic measure.

³⁶ The PHPs 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.

³⁷ 2024 Standard Plan Withhold measure.

³⁸ The Department will work jointly with plans and CCNC to collect pregnancy risk screening data and report this measure.

Table 5. Tailored Plan Medicaid Measure Set

This lists quality measures that will be the priority focus for Tailored Plan accountability; these measures, which will primarily be calculated by Tailored Plans, will comprise the set that plans can draw measures for required quality improvement activities. An asterisk (*) indicates that the measure is calculated by the Department. Italicized measures are included in the AMH measure set, described in V (E).

| NQF# | Measure Name | Steward |
|--|---|---------|
| Pediatric Measures³⁹ | | |
| 1800 | Asthma Medication Ratio (AMR) – Ages 5 to 18 Years | NCQA |
| 0058 | Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) – Ages 3 Months to 17 Years | NCQA |
| 1516 | <i>Child and Adolescent Well-Care Visits (WCV)</i> | NCQA |
| 0038 | <i>Childhood Immunization Status (Combination 10) (CIS)</i> | NCQA |
| 0033 | <i>Chlamydia Screening in Women (CHL) – Ages 16 to 20</i> | NCQA |
| 0576 | Follow-Up After Hospitalization for Mental Illness (FUH) – Ages 6 to 17 | NCQA |
| 0108 | Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD) | NCQA |
| 1407 | <i>Immunizations for Adolescents (Combination 2) (IMA)</i> | NCQA |
| 2800 | Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) | NCQA |
| 0418/0418e | <i>Screening for Depression and Follow-Up Plan (CDF) – Ages 12 to 17</i> | CMS |
| 2801 | Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) | NCQA |
| 1392 | <i>Well-Child Visits in the First 30 Months of Life (W30)</i> | NCQA |
| Adult Measures (Age 18 or Older Unless Otherwise Noted) | | |
| N/A ⁴⁰ | Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) | NCQA |
| 0105 | Antidepressant Medication Management (AMM) | NCQA |
| 1800 | Asthma Medication Ratio (AMR) – Ages 19 to 64 | NCQA |
| 0058 | Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) | NCQA |
| 0032 | <i>Cervical Cancer Screening (CCS) – Ages 21 to 64</i> | NCQA |
| 0033 | <i>Chlamydia Screening in Women (CHL) – Ages 21 to 24</i> | NCQA |
| 0034 | Colorectal Cancer Screening (COL) | NCQA |

³⁹ Includes Adult measures with pediatric strata, where indicated.

⁴⁰ The Adult Core Set includes the NCQA version of the measure, which is adapted from the CMS measure (NQF #1879).

| NQF# | Measure Name | Steward |
|----------------------------|--|-----------------|
| 3389 | Concurrent Use of Prescription Opioids and Benzodiazepines (COB) | PQA |
| 3175 | Continuity of Pharmacotherapy for Opioid Use Disorder | USC |
| 0018 | <i>Controlling High Blood Pressure (CBP)</i> | NCQA |
| 1932 | Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) | NCQA |
| 0039 | Flu Vaccinations for Adults (FVA)* | NCQA |
| 0576 | Follow-Up After Hospitalization for Mental Illness (FUH) | NCQA |
| 0059/ 0575 | <i>Hemoglobin A1c Control for Patients with Diabetes (HBD)</i> | NCQA |
| N/A | Long-Term Services and Supports Comprehensive Care Plan and Update (CPU) | NCQA |
| 0027 | Medical Assistance with Smoking and Tobacco Use Cessation (MSC)* ⁴¹ | NCQA |
| 1768 | <i>Plan All-Cause Readmissions (PCR) [Observed versus expected ratio]*</i> | NCQA |
| N/A | Rate of Screening for Health-Related Resource Needs (HRRN)* ⁴² | DHHS |
| 0418 / 0418e ⁴³ | <i>Screening for Depression and Follow-Up Plan (CDF)</i> ⁴⁴ | CMS |
| N/A | <i>Total Cost of Care*</i> | Health Partners |
| Maternal Measures | | |
| N/A | Low Birth Weight* ⁴⁵ | DHHS |
| 1517 | <i>Prenatal and Postpartum Care (PPC)</i> <ul style="list-style-type: none"> • Timeliness of Prenatal Care • Postpartum Care | NCQA |
| N/A | Rate of Screening for Pregnancy Risk* | DHHS |

Table 6. Tailored Plan State-funded Measure Set

The following measures assess quality in state-funded services and are reported by Tailored Plans, unless otherwise specified. An asterisk (*) indicates the measure is calculated by the Department. Measures with associated liquidated damages are indicated with italics.

| Measure | Steward | Frequency |
|--|---------|-----------|
| Alcohol and Drug Abuse Treatment Center (ADATC) Readmissions within 30 Days and 180 Days | DHHS | Quarterly |

⁴¹ Note: this measure may not be stratified by all sub-strata listed Table 2 in Section IV (B).

⁴² The Department is exploring potential adoption of HEDIS' new Social Needs Screening and Intervention (SNS-E) [measure](#).

⁴³ Plans must report to the Department whether they are using the standard or electronic measure.

⁴⁴ Pending additional feedback regarding the collection of clinical data. This measure will be accompanied by future guidance to limit screening in members where it's not appropriate.

⁴⁵ The Department will work jointly with plans to calculate and report this measure.

| Measure | Steward | Frequency |
|---|---------|-----------|
| Average Length of Stay in Community Hospitals (mental health treatment & substance use disorder treatment) | DHHS | Quarterly |
| Community Mental Health Inpatient Readmissions within 30 Days | DHHS | Quarterly |
| Community Substance Use Disorder Inpatient Readmission within 30 Days | DHHS | Quarterly |
| Initiation of Services (alcohol or other drug abuse or dependence treatment, and one for persons receiving MH treatment) | DHHS | Quarterly |
| Engagement in Services (alcohol or other drug abuse or dependence treatment, and one for persons receiving MH treatment) | DHHS | Quarterly |
| State Psychiatric Hospital Readmissions within 30 Days and 180 Days | DHHS | Quarterly |
| <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 | Quarterly |
| <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 | Quarterly |

Table 7. Department-calculated Measure Set for Both Standard Plans and Tailored Plans

The Department will calculate and monitor the following quality measures in the Medicaid program and reserves the right to report these measures at the plan-level. This list is subject to change.

| NQF# | Measure Name | Steward |
|--|---|---|
| Pediatric Measures⁴⁶ | | |
| N/A | Ambulatory Care: Emergency Department (ED) Visits (AMB) – Ages 1 to 19 | NCQA |
| N/A | Antibiotic Utilization for Respiratory Conditions (AXR) – Ages 3 Months to 17 Years | NCQA |
| 0727/0728/NA/NA | Avoidable Pediatric Utilization <ul style="list-style-type: none"> • 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 | Agency for Healthcare Research and Quality (AHRQ) |

⁴⁶ Includes Adult measures with pediatric strata, where indicated.

| NQF# | Measure Name | Steward |
|--|--|--------------------|
| 1448 | Developmental Screening in The First Three Years of Life (DEV) | OHSU |
| N/A | EPSDT Screening Ratio | CMS |
| 3488 | Follow-Up After Emergency Department Visit for Substance Use (FUA) – Ages 13 to 17 | NCQA |
| 3489 | Follow-Up After Emergency Department Visit for Mental Illness (FUM) – Ages 6 to 17 | NCQA |
| N/A | Lead Screening in Children (LSC) | NCQA |
| 2517 | Oral Evaluation, Dental Services (OEV) | DQA (ADA) |
| N/A | Sealant Receipt on Permanent First Molars (SFM) | DQA (ADA) |
| 2528/ 3700/ 3701 | Topical Fluoride for Children (TFL) – Ages 1 to 20 | DQA (ADA) |
| 0024 | Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) | NCQA |
| Adult Measures (Age 18 or Older Unless Otherwise Noted) | | |
| N/A | Admission to an Institution from the Community (AIF) | CMS |
| N/A | Antibiotic Utilization for Respiratory Conditions (AXR) | NCQA |
| 0272/027 5/0277/ 0283 | Avoidable Adult Utilization: <ul style="list-style-type: none"> • PQI 01: Diabetes Short-term Complication Admission Rate • PQI 05: COPD or Asthma in Older Adults Admission Rate • PQI 08: Heart Failure Admission Rate • PQI 15: Asthma in Younger Adults Admission Rate | AHRQ |
| N/A | Blood Pressure Control for Patients with Diabetes (BPD) | NCQA |
| 2372 | Breast Cancer Screening (BCS) – Ages 50-74 | NCQA ⁴⁷ |
| 0547 | Diabetes and Medication Possession Ratio for Statin Therapy | CMS |
| 2607 | Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI) | NCQA |
| 3489 | Follow-Up After Emergency Department Visit for Mental Illness (FUM) | NCQA |
| 3488 | Follow-Up After Emergency Department Visit for Substance Use (FUA) | NCQA |
| 2082/ 3210e | HIV Viral Load Suppression (HVL) | HRSA |
| 0004 | Initiation and Engagement of Substance Use Disorder Treatment (IET) | NCQA |
| N/A | Inpatient Utilization (IPU) | NCQA |
| 2856 | Pharmacotherapy Management of COPD Exacerbation (PCE) | NCQA |
| N/A | Statin Therapy for Patients With Cardiovascular Disease (SPC) | NCQA |

⁴⁷ The administrative reporting method for this measure was retired by the measure steward in HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans. The Department will run this measure internally using the administrative specifications set forth in HEDIS® Measurement Year 2022 Volume 2.

| NQF# | Measure Name | Steward |
|--|---|---------------------------------|
| 2940 | Use of Opioids at High Dosage in Persons Without Cancer (OHD) | PQA |
| 2950 | Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) | PQA |
| 3400 | Use of Pharmacotherapy for Opioid Use Disorder (OUD) | CMS |
| Maternal Measures⁴⁸ | | |
| 2903/ 2904 | Contraceptive Care: All Women (CCW) <ul style="list-style-type: none"> Ages 15-20 Ages 21-44 | US Office of Population Affairs |
| 2902 | Contraceptive Care: Postpartum (CCP) <ul style="list-style-type: none"> Ages 15-20 Ages 21-44 | US Office of Population Affairs |
| 1382 | Live Births Weighing Less Than 2,500 Grams ⁴⁹ | CDC |
| N/A | Prenatal Depression Screening and Follow-Up (PND) | NCQA |
| Select Public Health Measures | | |
| N/A | Diet/Exercise <ul style="list-style-type: none"> Increase fruit and vegetable consumption among adults Increase percentage of adults who get recommended amount of physical activity Opioid Use <ul style="list-style-type: none"> Reduce the unintentional poisoning mortality rate Tobacco Use <ul style="list-style-type: none"> Decrease the percentage of adults who are current smokers Decrease the percentage of high school students using tobacco Decrease the percentage of women who smoke during pregnancy Decrease exposure to secondhand smoke in the workplace | N/A |
| Patient Satisfaction⁵⁰ | | |
| 0006 | CAHPS Survey | AHRQ |
| Provider Satisfaction | | |
| NA | Provider Survey | DHHS |

⁴⁸ CMS to calculate the Low-Risk Cesarean Delivery (LRCDD) measure (Centers for Disease Control).

⁴⁹ Calculated at the state level.

⁵⁰ The Department is conducting other surveys and will assess survey results in addition to CAHPS to evaluate patient satisfaction, including the DMH/DD/SAS Perceptions of Care Survey. See Section III (E) for more information.

Table 8. Additional Measure Set Specifications

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

| Measure Set | Specifications Location |
|---|---|
| InCK | https://medicaid.ncdhhs.gov/nc-inck-tools-resources |
| Measure Set | Specifications Location |
| Transitions to Community Living (TCL) | https://www.ncdhhs.gov/about/department-initiatives/transitions-community-living |
| Innovations 1915(c) Medicaid Home and Community-Based Services Waiver (HCBS) Waiver | https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/nc-innovations-waiver |
| TBI 1915(c) Medicaid HCBS Waiver | https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/traumatic-brain-injury |

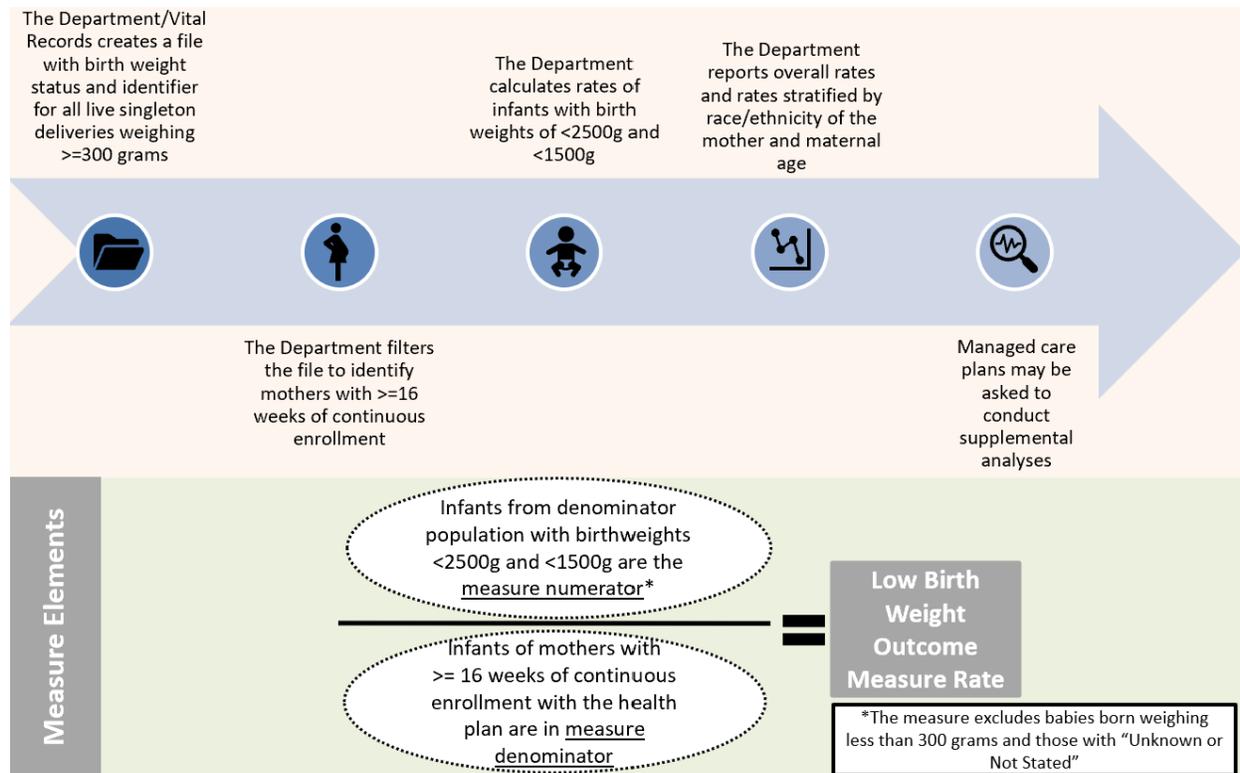
Appendix B: Measure Modifications: Low Birth Weight

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 and 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.”
2. 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.
3. 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.
4. 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 3 for a representation of the process for reporting the low birth weight outcome measure.

Figure 3: Approach to Calculating Low Birth Weight Outcome 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 period⁵¹; 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.

⁵¹ 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.

NQF Number and Measure Steward

National Quality Forum 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 Standard Plan and Tailored Plan-Reported Measures

Pediatric Measures

Child and Adolescent Well-Care Visits (WCV)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1516, 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 (Well-Care Value Set) 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 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Childhood Immunization Status (CIS)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0038, 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 influenza 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 three combination rates.

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 (Severe Combined Immunodeficiency Value Set).
- Immunodeficiency (Disorders of the Immune System Value Set).
- HIV (HIV Value Set; HIV Type 2 Value Set).
- Lymphoreticular cancer, multiple myeloma or leukemia (Malignant Neoplasm of Lymphatic Tissue Value Set).
- *Intussusception* (*Intussusception Value Set*).

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

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

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0108, 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 (9 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 (9 months) after IPSD.

Denominator Statement

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

Denominator Exclusions

Members who had an acute inpatient encounter for mental health or chemical dependency following the IPSD.

Members with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year.

Members using hospice services during the measurement year.

Members who died during the measurement year.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Immunizations for Adolescents (IMA)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1407, 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).

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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Measure Type

Process

NQF Number and Measure Steward

NQF# 2800, 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 glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set) during the measurement year.

Cholesterol: Members 1–17 years of age who received at least one test for LDL-C (LDL-C Lab Test Value Set, LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set, Cholesterol Test Result or Finding Value Set) 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 (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
- At least one test for LDL-C (LDL-C Lab Test Value Set, LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set, Cholesterol Test Result or Finding Value Set).

Denominator Statement

Children and adolescents 1–17 years of age who had ongoing use of antipsychotic medications (at least two prescriptions).

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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2801, 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 (Psychosocial Care Value Set) 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 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Well-Child Visits in the First 30 Months of Life (W30)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1392, 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 (Well-Care Value Set) 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 (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Adult Measures

Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) (Tailored Plan Only)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, 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 (Dementia Value Set).

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 (Long-Acting Injections 14 Days' Supply Value Set; Long-Acting Injections 28 Days' Supply Value Set; Long-Acting Injections 30 Days' Supply Value Set).
- Pharmacy data. Dispensed an antipsychotic medication. Use all the medication lists in the Oral Antipsychotic Medications and Long-Acting Injections tables below to identify antipsychotic medication dispensing events.

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

Members who died anytime during the measurement year.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Antidepressant Medication Management (AMM) (Tailored Plan Only)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0105, Measure Steward: NCQA

Brief Description of Measure

The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and remained on an antidepressant medication treatment. Two rates are reported:

1. Effective Acute Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. Effective Continuation Phase Treatment. The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Numerator Statement

Effective Acute Phase Treatment: At least 84 days (12 weeks) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the index prescription start date

(IPSD) through 114 days after the IPSD (115 total days). This allows gaps in medication treatment up to a total of 31 days during the 115-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Effective Continuation Phase Treatment: At least 180 days (6 months) of treatment with antidepressant medication (Antidepressant Medications List), beginning on the IPSD through 231 days after the IPSD (232 total days). This allows gaps in medication treatment up to a total of 52 days during the 232-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Denominator Statement

Members 18 years of age and older with a diagnosis of major depression who were newly treated with antidepressant medication.

Denominator Exclusions

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

Members who did not have a diagnosis of major depression in an inpatient, outpatient, ED, observation, telehealth/telephone/e-visit or virtual check-in, intensive outpatient, community mental health center visit, or partial hospitalization setting or who received electroconvulsive therapy or had a transcranial magnetic stimulation visit during the 121-day period from 60 days prior to the IPSD through the IPSD and the 60 days after the IPSD.

Members who filled a prescription for an antidepressant 105 days prior to the IPSD.

Members who died during the measurement year.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Asthma Medication Ratio (AMR)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1800, 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.

Adult measure with pediatric strata

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 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 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

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

Measure Type

Process

NQF Number and Measure Steward

NQF# 0058, Measure Steward: NCQA

Brief Description of Measure

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

Adult measure with pediatric strata

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 age 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Cervical Cancer Screening (CCS)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0032, Measure Steward: NCQA

Brief Description of Measure

The percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Numerator Statement

The number of women who were screened for cervical cancer.

Denominator Statement

Women 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 (Absence of Cervix Diagnosis Value Set; Hysterectomy With No Residual Cervix Value Set) anytime during the member's history through December 31 of the measurement year.

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

Members who died anytime during the measurement year.

Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) anytime during the measurement year.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Chlamydia Screening in Women (CHL) Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0033, Measure Steward: NCQA

Brief Description of Measure

The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Adult measure with pediatric strata

Numerator Statement

At least one chlamydia test (Chlamydia Tests Value Set) during the measurement year.

Denominator Statement

Females 16–24 years who had a claim or encounter indicating sexual activity.

Denominator Exclusions

Members who received a pregnancy test (Pregnancy Test Value Set) to determine contraindications for medication (isotretinoin, Retinoid Medications List) or X-ray (Diagnostic Radiology Value Set) during the measurement year.

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

Members who died during the measurement year.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Colorectal Cancer Screening (COL)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0034, 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 5 years, colonoscopy every 10 years, computed tomography colonography every 5 years, stool DNA test every 3 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 in hospice or using hospice services during the measurement year. Members who died during the measurement year.

Members who died anytime during the measurement year.

Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) anytime during the measurement year.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Concurrent Use of Prescription Opioids and Benzodiazepines (COB)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 3389, 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](#).

Continuity of Pharmacotherapy for Opioid Use Disorder (Tailored Plan Only)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 3175, Measure Steward: 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 7 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.

More information on calculating this measure is available [here](#).

Controlling High Blood Pressure (CBP)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 0018, 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.

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 6 months of the measurement year.

Denominator Exclusions

Members with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set), dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set; History of Kidney Transplant Value Set) anytime during the member's history on or prior to December 31 of the measurement year.

Members with a diagnosis of pregnancy during the measurement year.

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

Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

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

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1932, 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) 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Flu Vaccinations for Adults (FVA)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0039, Measure Steward: NCQA (retired)

Brief Description of Measure

The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period. This measure is collected via the CAHPS 5.0H adults survey.

Numerator Statement

Respondents to the CAHPS survey who report having received an influenza vaccination since July of the previous year.

Denominator Statement

CAHPS respondents 18–64 years of age.

Denominator Exclusions

None.

For full measure specifications, please refer to the HEDIS® Measurement Year 2022 Volume 2 Technical Specifications for Health Plans. This measure was retired by the measure steward for Measurement Year 2023; however, it will still be included as part of the CAHPS survey that is fielded for 2023.

Follow-Up After Hospitalization for Mental Illness (FUH)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0576, Measure Steward: NCQA

Brief Description of Measure

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge.
- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

Adult measure with pediatric strata

Numerator Statement

30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge.

Denominator Statement

Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) 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 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 (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Hemoglobin A1c Control for Patients with Diabetes (HBD) Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 0059, Measure Steward: NCQA

Brief Description of Measure

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

1. HbA1c Control (<8.0%).
2. HbA1c Poor Control (>9.0%).

Numerator Statement

HbA1c Control <8%: Use codes (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is <8.0%. The member is not numerator compliant if the result for the most recent HbA1c test is ≥8.0% or if a result is missing, or if an HbA1c test was not done during the measurement year.

HbA1c Poor Control >9%: Use codes (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set) to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent HbA1c level is >9.0% or if a result is missing, or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the result for the most recent HbA1c test during the measurement year is ≤9.0%.

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 (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) anytime during the measurement year.

Members who did not have a diagnosis of diabetes (Diabetes Value Set), in any setting, during the measurement year or the year prior to the measurement year and who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Long-term Services and Supports Comprehensive Care Plan and Update (CPU) Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: NCQA

Brief Description of Measure

The percentage of Medicaid Managed Long Term Services and Supports (MLTSS) participants age 18 and older who have documentation of a long-term services and supports comprehensive care plan in a specified timeframe that includes documentation of core elements.

Two performance rates are reported for this measure:

1. Care Plan with Core Elements. Medicaid MLTSS participants who had a long-term services and supports comprehensive care plan with nine core elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants).
2. Care Plan with Supplemental Elements. Medicaid MLTSS participants who had a long-term services and supports comprehensive care plan with nine core elements and at least four supplemental elements documented within 120 days of enrollment (for new participants) or during the measurement year (for established participants).

Numerator Statement

Rate 1:

The number of Medicaid MLTSS participants who had either of the following:

- New participants: A long-term services and supports comprehensive care plan completed within 120 days of enrollment with all nine core elements documented.
- Established participants: A long-term services and supports comprehensive care plan completed at least once during the measurement year with all nine elements documented.

Rate 2:

The number of Medicaid MLTSS participants who had either of the following:

- New participants: A long-term services and supports comprehensive care plan completed within 120 days of enrollment with nine core elements and at least four supplemental elements documented.
- Established participants: A long-term services and supports comprehensive care plan created during the measurement year with nine core elements and at least four supplemental elements documented.

Denominator Statement

Medicaid MLTSS participants age 18 and older as of the first day of the measurement year.

Denominator Exclusions

Participant Could Not Be Contacted: Medicaid MLTSS plan participants who could not be contacted to create a long-term services and supports comprehensive care plan within 120 days of enrollment (for new participants) or during the measurement year (for established participants).

Participant Refused Care Planning: Medicaid MLTSS plan participants who refused a comprehensive care plan.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Technical Specifications for Long-Term Services and Support Measures.

Measure Type

Process

NQF Number and Measure Steward

NQF# 0027, 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Plan All-Cause Readmissions (PCR)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1768, Measure Steward: NCQA

Brief Description of Measure

For members 18 years of age and older, the number of acute inpatient 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* (denominator).
- Count of 30-Day Readmissions (numerator).
- Average Adjusted Probability of Readmission.

*An acute inpatient stay with a discharge during the first 11 months of the measurement year (i.e., from January 1 until December 1).

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

Members age 18 years and older with a discharge from an acute inpatient stay (Index Hospital Stay) between January 1 (or on that day) and December 1 of the measurement year.

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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

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

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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.

Three rates are reported:

1. *Screening attempts within 90 days of health plan enrollment*: Percent of enrollees who received the minimum three screening attempts⁵² within 90 days of enrollment or re-enrollment.⁵³
2. *Successful screening within 90 days of health plan enrollment or re-enrollment*: Percent of enrollees who completed a screening within 90 days of enrollment or re-enrollment.
3. *Successful screening within the calendar year*: Percent of enrollees who completed a screening within the calendar year (January 1st- December 31st).

Numerator Statement

1. *Screening attempts within 90 days of health plan enrollment*: All NC Medicaid Managed Care enrollees that received an initial SDOH Screening and, if the first attempt is

⁵² Per the contract, PHPs are responsible for undertaking best efforts to conduct a Care Needs Screening, which includes an SDOH screening, of every member within ninety (90) calendar days of the effective date of enrollment. The Department defines “best efforts” as including at least two documented follow up attempts to contact the Member if the first attempt is unsuccessful.

⁵³ Re-enrollment (also known as recertification, renewal, or eligibility redetermination) is the way beneficiaries review their information to make sure they are still eligible for Medicaid health coverage. Re-enrollment takes place every 6 or 12 months based on the specific Medicaid program.

unsuccessful, at least two follow up screening attempts through approved methods (phone, mail, text, mail, other) within 90 days of enrollment or re-enrollment.⁵⁴ A completed screening must be administered by the PHP or their affiliated care manager.

2. *Successful screening within 90 days of health plan enrollment:* All NC Medicaid Managed Care enrollees that completed* a SDOH screening. within the first 90 days of enrollment or re-enrollment.⁵³ A completed screening must be administered by the PHP or their affiliated care manager.
3. *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 PHP or their affiliated care manager.

*Completed screenings are defined as:

- Beneficiaries who received a screening and answered at least one question or
- Beneficiaries who received a screening and actively declined to respond.

Note: An N/A response 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 continuously enrolled with the respective plan for at least 90 consecutive days during the measurement year. A beneficiary may be part of the eligible population for multiple plans in the same calendar year.

For members who were not enrolled at least 90 days before the end of the measurement year (October 1st), the PHP would not have sufficient opportunity to provide the screening within 90 days. To account for this, the measure will track screenings completed between Jan 1st and December 31st of the measurement year. The eligible population will be those members enrolled from October 1st of the previous measurement year through September 30th of the current measurement year.

Denominator Exclusions

None.

Continuous Enrollment Criteria:

Members must be continuously enrolled in a health plan for 90 consecutive days during the measurement year. A member may meet continuous enrollment criteria for more than one health plan during the measurement year.

⁵⁴ If the re-enrollment occurs with less than a 90-day gap in coverage/eligibility the PHP is not required to re-screen their members within the 90-days post re-enrollment. However, if it has been more than ninety days from the member's previous eligibility, the PHP shall conduct the NC DHHS standardized SDOH Screening again within ninety days of re-enrollment.

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 PHPs 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)⁵⁵
*Descriptive Information***Measure Type**

Process

NQF Number and Measure Steward

NQF# 0418/0418e, 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.

Adult measure with pediatric strata

⁵⁵ Plans must report to the Department whether they are using the standard or electronic measure.

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.

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.

Maternal Measures

Prenatal and Postpartum Care (PPC)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1517, Measure Steward: NCQA

Brief Description of Measure

The percentage of 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. For these members, the measure assesses the following facets of prenatal and postpartum care:

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 7 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 7 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.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Rate of Screening for Pregnancy Risk Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: DHHS

Brief Description of Measure

The proportion of pregnant enrollees who received a pregnancy risk screening.

Numerator Statement

Number of pregnant enrollees with a pregnancy risk screening performed.

Denominator Statement

Women with a claim/encounter for prenatal services.

Denominator Exclusions

Exclude if any of the following were documented during the first prenatal visit:

- Spontaneous abortion (ICD-10 codes O03.0–O03.9).
- Ectopic pregnancies (O00.0, O00.1, O00.2, O00.8, O00.9).
- Molar pregnancy (O01.0, O01.1, O01.9).
- Other abnormal products of conception (O02.0, O02.1, O02.8, O02.9).
- Complications following induced termination of pregnancy (O04.5–O04.8).
- Complications following ectopic and molar pregnancy (O08.0–O08.9).

Health plans should refer to the Care Management for High Risk Pregnancy Daily Member Report file for the numerator and to the Pregnancy Risk Screening Denominator Codes file for the denominator.

Appendix E: Specifications for Behavioral Health I/DD Tailored Plan State-funded Services Measures

For full measure specifications, please refer to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services Quality Strategy

ADATC Readmissions within 30 Days and 180 Days *Descriptive Information*

Measure Type

Process

NQF Number and Measure Steward

NQF# 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 a 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, as recorded in HEARTS, 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).

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.

Average Length of Stay in Community Hospitals for Mental Health Treatment

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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.

Community Mental Health Inpatient Readmissions within 30 Days

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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 or facility-based crisis service 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 or facility-based crisis service 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.

Community Substance Use Disorder Inpatient Readmissions within 30 Days

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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 or detox/facility-based crisis service 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 or detox/facility-based crisis service with a principal SUD diagnosis during the measurement period.

Denominator Exclusions

None.

Measurement

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

Initiation of Mental Health Services

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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.

Engagement in Mental Health Services

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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 as described above 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).

Initiation of Substance Use Disorder Services

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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.

Engagement in Substance Use Disorder Services

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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.

State Hospital Readmissions within 30 Days and 180 Days *Descriptive Information*

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 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 a state psychiatric hospital within 30 days and 180 days of discharge.

Numerator Statement

The number of discharges in the denominator readmitted to any state psychiatric hospital within 30 days and 180 days (inclusive) of the discharge date.

The readmission does not have to be to the same facility from which the person was originally discharged.

Denominator Statement

The number of discharges, as defined below, from a state psychiatric hospital during the measurement quarter, as recorded in HEARTS, that fall within the responsibility of an LME/MCO to coordinate services.

Denominator Inclusions/Exclusions

Discharges include only those coded as “direct” discharges 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).

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 a state psychiatric hospital during the measurement quarter, count all discharges.

Department-reported Measures

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

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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 1 to 7 and 1 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 7 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 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 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).

Measure Type

Process

NQF Number and Measure Steward

NQF# 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 1 to 7 days and 1 to 30 days after discharge.

Numerator Statement

For discharges included in the denominator, a follow-up visit with a behavioral health practitioner within 1 to 7 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 7 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).

Appendix F: Specifications for Department-Calculated Measures

Pediatric Measures

Ambulatory Care: Emergency Department (ED) Visits (AMB)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: NCQA

Brief Description of Measure

Rate of emergency department (ED) visits per 1,000 beneficiary months among members.

Numerator Statement

Number of ED visits: Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit.

Identify ED visits using either of the following:

- An ED visit (ED Value Set).
- A procedure code (ED Procedure Code Value Set) with an ED place of service code (ED POS Value Set)

Do not include ED visits that result in an inpatient stay (Inpatient Stay Value Set). When an ED visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the admission date for the inpatient stay occurs on the ED date of service or 1 calendar day after. An ED visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

Age of Beneficiary: Report age as of the date of service.

Matching Enrollment with Utilization: Run enrollment reports used for beneficiary month calculations to determine utilization rates (such as ED visits/1,000 beneficiary months) within

30 days of the claims reports and for the same time period. Include retroactive additions and terminations in these reports.

Counting Multiple Services: For combinations of multiple ambulatory services falling in different categories on the same day, report each service that meets the criteria in the appropriate category.

Count multiple codes with the same practitioner on the same date of service as a single visit. Count visits with different practitioners separately (count visits with different providers on the same date of service as different visits).

Report services without regard to practitioner type, training or licensing.

Denominator Statement

Number of beneficiary months. Beneficiary months are a beneficiary's contribution to the total yearly enrollment. Beneficiary months are calculated by summing the total number of months each beneficiary is enrolled in the program during the measurement year.

Denominator Exclusions

Mental health or chemical dependency services.

Claims and encounters that indicate the encounter was for mental health or chemical dependency.

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

Any of the following:

- A principal diagnosis of mental health or chemical dependency (Mental and Behavioral Disorders Value Set.)
- Psychiatry (Psychiatry Value Set.)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set.)

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Avoidable Pediatric Utilization – Pediatric Quality Indicators (PDI)

Descriptive Information

Measure Type

Rate/proportion

NQF Number and Measure Steward

NQF# 0728/0727/NA/NA, Measure Steward: AHRQ

Brief Description of Measure

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

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

Numerator Statement

Discharges for members ages 6–17 years that meet the inclusion and exclusion rules for 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

Population ages 6–17 years in metropolitan area or county. Discharges in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.

Denominator Exclusions

See each component measure for exclusions.

More information and full specifications are available [here](#).

Development Screening in the First Three Years of Life (DEV)
Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 1448, Measure Steward: OHSU

Brief Description of Measure

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.

Numerator Statement

The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. National recommendations call for children to be screened three times in the first three years of life. The measure is based on three, age specific indicators.

Numerator 1: Children in Denominator 1 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first birthday.

Numerator 2: Children in Denominator 2 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their second birthday.

Numerator 3: Children in Denominator 3 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their third birthday.

Numerator 4: Children in Denominator 4 who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by their first, second or third birthday.

Denominator Statement

Denominator 1: The children in the eligible population who turned 1 during the measurement year.

Denominator 2: The children in the eligible population who turned 2 during the measurement year.

Denominator 3: The children in the eligible population who turned 3 during the measurement year.

Denominator 4: All children in the eligible population who turned 1, 2, or 3 during the measurement year, i.e., the sum of denominators 1, 2, and 3.

Denominator Exclusions

None.

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

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# NA, 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](#).

Lead Screening in Children (LSC)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, 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 (Lead Tests Value Set) 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Oral Evaluation, Dental Services (OEV)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2517, 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](#).

Sealant Receipt on Permanent First Molars (SFM)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, Measure Steward: ADA

Brief Description of Measure

Percentage of enrolled members who have ever received sealants on permanent first molar teeth. Two rates are reported: (1) at least one sealant and (2) all four molars sealed by the 10th birthday.

Numerator Statement

The unduplicated number of enrolled members who ever received a sealant on:

- At least one permanent first molar tooth.
- All four permanent first molars.

Denominator Statement

Members who turn 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 10th birthday.

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

Topical Fluoride for Children (TFL)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2528/3700/3701, 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 ages 1 through 20 as of December 31 of the measurement year.

Denominator Exclusions

None.

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

Measure Type

Process

NQF Number and Measure Steward

NQF# 0024, 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.

Numerator Statement

Members who had evidence of the following during the measurement year of a body mass index (BMI) percentile documentation; counseling for nutrition; and/or counseling for physical activity.

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 (Pregnancy Value Set) 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Adult Measures

Admission to an Institution from the Community (AIF)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# N/A, Measure Steward: CMS

Brief Description of Measure

The number of MLTSS enrollee admissions to an institution (nursing facility or intermediate care facility for individuals with intellectual disabilities [ICF/IID]) from the community that result in a short-term (1 to 20 days), medium-term (21 to 100 days), or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months. The following three rates are reported: Institution (nursing facility or ICF/IID) stay 1 20 days (short-term stay) Institution (nursing facility or ICF/IID) stay 21 to 100 days (medium-term stay) Institution (nursing facility or ICF/IID) stay 101 days(long-term stay) Each rate should be reported for four age groups: Ages 18 to 64A Ages 65 to 74A Ages 75 to 84A Age 85 and older.

Numerator Statement

Number of admissions to an institution (nursing facility or ICF/IID) during the measurement year per 1,000 enrollee months for MLTSS beneficiaries 18 and older. Three rates will be reported for this measure: Admissions that result in a short-term stay (1 to 20 days) Admissions that result in a medium-term stay (21 to 100 days) Admissions that result in a long-term stay (greater than or equal to 101 days).

Denominator Statement

Number of enrollee months for MLTSS beneficiaries age 18 and older.

Denominator Exclusions

Months in which the enrollee resided in an institution or was hospital for the full month.

Members who died during the measurement year.

Antibiotic Utilization for Respiratory Conditions (AXR)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 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 3 days after the episode date.

Denominator Statement

Members 3 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 3 days after the episode date.

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

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Avoidable Adult Utilization – Prevention Quality Indicators (PQI)

Descriptive Information

Measure Type

Rate/Proportion

NQF Number and Measure Steward

NQF# 0272/0275/0277/0283, 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.

Numerator Statement

Discharges, for members age 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 and full specifications are available [here](#).

Blood Pressure Control for Patients with Diabetes (BPD)

Descriptive Information

Measure Type

Outcome: Intermediate Clinical Outcome

NQF Number and Measure Steward

NQF# 0061, Measure Steward: NCQA

Brief Description of Measure

The percentage of members 18–75 years of age with diabetes (type 1 or 2) whose most recent blood pressure level taken during the measurement year was <140/90 mm Hg.

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 in hospice or with advanced illness and frailty, as well as Medicare adults 65 years of age and older enrolled in an Institutional Special Needs Plan (I-SNP) or living long term in institutional settings.

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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Breast Cancer Screening (BCS)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2372, Measure Steward: NCQA (retired)

Brief Description of Measure

Percentage of women 50–74 years of age who 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 50–74 years of age.

Denominator Exclusions

Members with a history of bilateral mastectomy.

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.

The administrative reporting method for this measure was retired by the measure steward in HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans. The Department will run this measure internally using the administrative specifications set forth in HEDIS® Measurement Year 2022 Volume 2.

Diabetes and Medication Possession Ratio for Statin Therapy *Descriptive Information*

Measure Type

Process

NQF Number and Measure Steward

NQF# 0547, Measure Steward: CMS

Brief Description of Measure

Medication Possession Ratio (MPR) for statin therapy in individuals with diabetes over 18 years of age.

Numerator Statement

The sum of the days' supply that falls within the measurement window for a statin fill for each patient in the denominator. Time window is anytime during the measurement period (12 consecutive months).

MPR Numerator

Members with no prescriptions in the 180 days prior to the measurement period, the sum of all days' supply of all medications from the first prescription until the end of the measurement period.

Continuous users or members with one or more prescriptions in the 180 days prior to the measurement period, the sum of all days' supply of all medications in the measurement period.

Denominator Statement

Members 18–85 years of age with diabetes mellitus and at least one Part D claim for a statin.

MPR Denominator

- New users – the number of days from the first prescription to the end of measurement period.
- Continuous users – the number of days from the beginning to the end of the measurement period.

Denominator Exclusions

Members who died during the measurement period.

Members who are actively enrolled in multiple plans concurrently as of the end of the measurement period.

Members with a diagnosis of polycystic ovaries who did not have a face-to-face visit with a diagnosis of diabetes in any setting during the measurement period (if medical claims (Part A/B data) are available).

Members with a diagnosis of gestational diabetes or steroid-induced diabetes who did not have a face-to-face visit with a diagnosis of diabetes in any setting during the measurement period (if medical claims (Part A/B data) are available).

Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 2607, 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%.

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 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.

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.

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

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 3489, Measure Steward: NCQA

Brief Description of Measure

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are submitted:

1. The percentage of discharges for which the patient received follow-up within 30 days after discharge.
2. The percentage of discharges for which the patient received follow-up within 7 days after discharge.

Adult measure with pediatric strata

Numerator Statement

The numerator consists of two rates:

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).

7-day Follow-Up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 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 and December 1 of the measurement year.

Denominator Exclusions

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

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

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

Members who died anytime during the measurement year.

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

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

Measure Type

Process

NQF Number and Measure Steward

NQF# 3488, 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 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Adult measure with pediatric strata

Numerator Statement

The numerator consists of two rates:

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.

7-day Follow-Up: A follow-up visit with any practitioner, with a principal diagnosis of SUD, within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

These rates are stratified by age (13–17, 18 and older, total).

Denominator Statement

ED visits with a primary diagnosis of AOD abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

HIV Viral Load Suppression (HVL)

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 2082/3210e, Measure Steward: HRSA

Brief Description of Measure

Percentage of members, regardless of age, with a diagnosis of HIV with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Numerator Statement

Number of members in the denominator with an HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Denominator Statement

Number of members, regardless of age, with a diagnosis of HIV with at least one medical visit in the measurement year.

Denominator Exclusions

None.

For more information, please see the full specifications [here](#).

Initiation and Engagement of Substance Use Disorder Treatment (IET)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 0004, 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 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–November 15).

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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Inpatient Utilization – General Hospital/Acute Care (IPU)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, 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 and December 31 of the measurement year.

Denominator Statement

Eligible population.

Denominator Exclusions

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

For full measure specifications, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Measure Type

Process

NQF Number and Measure Steward

NQF# 2856, Measure Steward: NCQA

Brief Description of Measure

The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED visit on or between January 1 and November 30 of the measurement year and who were dispensed appropriate medications. Two rates are reported:

1. Dispensed a systemic corticosteroid (or there was evidence of an active prescription) within 14 days of the event.
2. Dispensed a bronchodilator (or there was evidence of an active prescription) within 30 days of the event.

Note: The eligible population for this measure is based on acute inpatient discharges and ED visits, not on members. It is possible for the denominator to include multiple events for the same individual.

Numerator Statement

Systemic Corticosteroids: The number of members dispensed a prescription for a systemic corticosteroid (Systemic Corticosteroid Medications List) on or 14 days after the Episode Date. Count systemic corticosteroids that are active on the relevant date.

Bronchodilators: The number of members dispensed a prescription for a bronchodilator (Bronchodilator Medications List) on or 30 days after the Episode Date. Count bronchodilators that are active on the relevant date.

* The Episode Date is the date of service for any acute inpatient discharge or ED claim/encounter during the 11-month intake period with a principal diagnosis of COPD.

Denominator Statement

All members age 40 years or older as of January 1 of the measurement year with a COPD exacerbation as indicated by an acute inpatient discharge or ED encounter with a principal diagnosis of COPD.

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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Statin Therapy for Patients with Cardiovascular Disease (SPC) Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# N/A, 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 (Pregnancy Value Set) during the measurement year or the year prior to the measurement year.

In vitro fertilization (IVF Value Set) in the measurement year or the year prior to the measurement year.

Dispensed at least one prescription for clomiphene (Estrogen Agonists Medications List) during the measurement year or the year prior to the measurement year.

ESRD (ESRD Diagnosis Value Set) or dialysis (Dialysis Procedure Value Set) during the measurement year or the year prior to the measurement year.

Cirrhosis (Cirrhosis Value Set) during the measurement year or the year prior to the measurement year.

Myalgia, myositis, myopathy or rhabdomyolysis (Muscular Pain and Disease Value Set) 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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

Use of Opioids at High Dose in Persons Without Cancer (OHD) Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 2940, Measure Steward: PQA

Brief Description of Measure

The percentage of individuals ≥ 18 years of age who received prescriptions for opioids with an average daily dosage of ≥ 90 morphine milligram equivalents (MME) over a period of ≥ 90 days.

A lower rate indicates better performance.

Numerator Statement

Individuals from the denominator with an average daily dosage ≥ 90 MME during the opioid episode.

Denominator Statement

Individuals ≥ 18 years of age with ≥ 2 prescription claims for opioid medications on different dates of service and with a cumulative days' supply ≥ 15 during the measurement year.

Denominator Exclusions

Hospice, cancer and sickle cell disease.

More information on the PQA measures can be found [here](#).

Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) *Descriptive Information*

Measure Type

Process

NQF Number and Measure Steward

NQF# 2950, Measure Steward: PQA

Brief Description of Measure

The percentage of individuals ≥ 18 years of age who received prescriptions for opioids from ≥ 4 prescribers and ≥ 4 pharmacies within ≤ 180 days.

A lower rate indicates better performance.

Numerator Statement

Individuals from the denominator with opioid prescription claims from ≥ 4 prescribers **and** ≥ 4 pharmacies within ≤ 180 days during the opioid episode.

Denominator Statement

Individuals ≥ 18 years of age with ≥ 2 prescription claims for opioid medications on different dates of service and with a cumulative days' supply ≥ 15 during the measurement year.

Denominator Exclusions

Members in hospice.

Members who have cancer or sickle cell disease.

Members who died during the measurement year.

More information on the PQA measures can be found [here](#).

Use of Pharmacotherapy for Opioid Use Disorder (OUD)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 3400, Measure Steward: CMS

Brief Description of Measure

The percentage of members ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measurement year. The measure will report any medications used in medication-assisted treatment of opioid dependence and addiction and four separate rates representing the following types of FDA-approved drug products: buprenorphine; oral naltrexone; long-acting, injectable naltrexone; and methadone.

Numerator Statement

Members ages 18 to 64 with an OUD who filled a prescription for or were administered or ordered an FDA-approved medication for the disorder during the measurement year.

Denominator Statement

Number of members with 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.

Maternal Measures

Contraceptive Care: All Women (CCW)

Descriptive Information

Measure Type

Outcome: Intermediate Clinical Outcome

NQF Number and Measure Steward

NQF# 2903/2904, 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 noncontraceptive reasons.
- 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.

Refer to the full specification [here](#).

Contraceptive Care: Postpartum (CCP) Descriptive Information

Measure Type

Outcome: Intermediate Clinical Outcome

NQF Number and Measure Steward

NQF# 2902, 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 3 and 60 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery.

Numerator Statement

Most or moderately effective method of contraception within 3 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 3 days of delivery.

Most or moderately effective method of contraception within 60 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 60 days of delivery.

LARC within 3 days: Women aged 15–44 years who had a live birth and are provided contraceptive implants or intrauterine devices or systems (IUD/IUS) within 3 days of delivery.

LARC within 60 days: Women aged 15–44 years who had a live birth and are provided contraceptive implants or intrauterine devices or systems (IUD/IUS) within 60 days of delivery.

Denominator Statement

Women ages 15–44 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 two months of the measurement year.

Refer to the full specification [here](#).

Live Births Weighing Less Than 2,500 Grams

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 1382, Measure Steward: CDC

Brief Description of Measure

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

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."

Prenatal Depression Screening and Follow-Up (PND)

Descriptive Information

Measure Type

Process

NQF Number and Measure Steward

NQF# 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.

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

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

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

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

- An outpatient, telephone, e-visit or virtual check-in follow-up visit with a diagnosis of depression or other behavioral health condition.
- A depression case management encounter that documents assessment for symptoms of depression or a diagnosis of depression or other behavioral health condition.
- A behavioral health encounter, including assessment, therapy, collaborative care or medication management.
- A dispensed antidepressant medication.

OR

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

Denominator

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, please refer to the HEDIS® Measurement Year 2023 Volume 2 Technical Specifications for Health Plans.

CAHPS® Survey

Descriptive Information

Measure Type

Outcome

NQF Number and Measure Steward

NQF# 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 enrollees to report on their experiences accessing care, experiences with their health plan, and assess the quality of care received by physicians.⁵⁶

The survey's target population includes individuals of all 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 1st through December 31st of previous year) with no more than one 45-day gap in enrollment.

The CAHPS 5.1 Adult Medicaid Health Plan Survey has 39 items, and the CAHPS Child Health Plan Survey has 41 core items. Ten of the adult survey items and 11 of the child survey items are organized into four composite measures. Each survey also has four single-item rating measures. Each measure is used to assess a particular domain of health plan and care quality from the patient's perspective.

The department will include the following CAHPS measures:

⁵⁶ 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>.

| 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 | Flu Vaccination (Adult Population Only) | Discussing Cessation Medications |
| Rating of Personal Doctor | How Well Doctors Communicate | | Discussing Cessation Strategies |
| Rating of Specialist Seen Most Often | Customer Service | | |