

# **DRAFT OF PROPOSED QUALITY MEASURES**

February 2019



Measures	Measure Description	Measure Steward	Aim
Adult Access to Preventive/Ambulatory Services	<p>The percentage of members age 20 years and older who had an ambulatory or preventive care visit during the measurement year. Three age stratifications and a total rate are reported:</p> <ul style="list-style-type: none"> <li>• 20-44 years</li> <li>• 45-64 years</li> <li>• 65 years and older</li> <li>• Total</li> </ul>	NCCQA	Better Care
Flu Vaccinations for Adults Ages 18 to 64	<p>The percentage of adults 18 years of age and older who self-report receiving an influenza vaccine within the measurement period.</p>	NCCQA	Healthier People, Healthier Communities
Adult Body Mass Index Assessment	<p>The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement or the year prior to the measurement year.</p>	NCCQA	Healthier People, Healthier Communities
Chlamydia Screening in Women	<p>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.</p>	NCCQA	Healthier People, Healthier Communities
Cervical Cancer Screening	<p>Percentage of women 21-64 years of age who were screened for cervical cancer:</p> <ul style="list-style-type: none"> <li>• Women 21-64 who had cervical cytology performed every 3 years.</li> <li>• Women 30-64 who had cervical cytology/HPV co-testing performed every 5 years.</li> </ul>	NCCQA	Healthier People, Healthier Communities
Breast Cancer Screening	<p>Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer.</p>	NCCQA	Healthier People, Healthier Communities

Measures	Measure Description	Measure Steward	Aim
Colorectal Cancer Screening	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	NCQA	Healthier People, Healthier Communities
HIV Screening *	The percentage of eligible members who had appropriate screening for HIV infection.	State	Healthier People, Healthier Communities
HCV Screening *	The percentage of eligible members who had appropriate screening for HCV infection.	State	Healthier People, Healthier Communities
Medical Assistance With Smoking and Tobacco Use Cessation	Assesses different facets of providing medical assistance with smoking and tobacco use cessation.  MCOs will report three components (questions): <ul style="list-style-type: none"> <li>• Advising Smokers and Tobacco Users to Quit</li> <li>• Discussing Cessation Medications</li> <li>• Discussing Cessation Strategies</li> </ul> The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year	NCQA	Healthier People, Healthier Communities
Controlling High Blood Pressure	Number of discharges for diabetes short term complications per 100,000 member months per Medicaid enrollees age 18 and older.	NCCQA	Healthier People, Healthier Communities
Diabetes Short-Term Complications Admission Rate		AHRQ	Healthier People, Healthier Communities

*Note: A lower rate indicates better performance.*

Measures	Measure Description	Measure Steward	Aim
Diabetes Short-Term Complications Admission Rate	Number of discharges for diabetes short term complications per 100,000 member months per Medicaid enrollees age 18 and older.	AHRQ	Healthier People, Healthier Communities
Statin Therapy for Patients with Cardiovascular Disease	<p><i>Note: A lower rate indicates better performance.</i></p> <ul style="list-style-type: none"> <li>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 clinical atherosclerotic cardiovascular disease (ASCVD) and who received statin therapy (were dispensed at least one high or moderate-intensity statin medication during the measurement year.)</li> <li>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 clinical atherosclerotic cardiovascular disease (ASCVD) and who had statin adherence of at least 80% (who remained on a high or moderate-intensity statin medication for at least 80% of the treatment period.)</li> </ul>	NCCQA	Healthier People, Healthier Communities
Heart Failure Admission Rate	Percent of population with an admissions for heart failure (reported by Recipient Parish). The number of discharges for heart failure per 100,000 member months for Medicaid enrollees age 18 and older (reported by Recipient Parish).	AHRQ	Healthier People, Healthier Communities

Measures	Measure Description	Measure Steward	Aim
Comprehensive Diabetes Care	The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the following:	NCQA	Healthier People, Healthier Communities
\$ testing	<ul style="list-style-type: none"> <li>• Hemoglobin A1c (HbA1c) testing</li> </ul>		
\$ retinal exam	<ul style="list-style-type: none"> <li>• HbA1c poor control (&gt;9.0%)</li> </ul>		
\$ nephropathy	<ul style="list-style-type: none"> <li>• HbA1c control (&lt;8.0%)</li> <li>• HbA1c control (&lt;7.0%) for a selected population*</li> <li>• Eye exam (retinal) performed</li> <li>• Medical attention for nephropathy.</li> <li>• BP control (&lt;140/90 mm Hg)</li> </ul>		
Asthma in Younger Adults Admission Rate	Admissions for a principal diagnosis of asthma per 100,000 population, ages 18 to 39 years. Excludes admissions with an indication of cystic fibrosis or anomalies of the respiratory system, obstetric admissions, and transfers from other institutions. Number of discharges for asthma per 100,000 member months for Medicaid enrollees ages 18 to 39.	AHRQ	Healthier People, Healthier Communities
Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate	This measure is used to assess the number of admissions for chronic obstructive pulmonary disease (COPD) per 100,000 population. The number of discharges for chronic obstructive pulmonary disease (COPD) or asthma per 100,000 member months for Medicaid enrollees age 40 and older.	AHRQ	Healthier People, Healthier Communities
HIV Viral Load Suppression	Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200.	HRSA	Healthier People, Healthier Communities

Measures	Measure Description	Measure Steward	Aim
Measures for stratified data: Adult: Colorectal Cancer Screening, HIV Viral Load Suppression, Controlling High Blood Pressure	Refer to individual measures, will be stratified by race/ethnicity and urban/rural status.	Various	Healthier People, Healthier Communities
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis *	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	NCQA	Smarter Spending
Use of Imaging Studies for Low Back Pain *	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	NCQA	Smarter Spending

Measures	Measure Description	Measure Steward	Aim
\$ Well-Child Visits in the First 15 Months of Life	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.	NCCQA	Better Care
\$ Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life Adolescent Well-Care Visits	The percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	NCCQA	Better Care
\$ Developmental Screening in the First Three Years of Life * Lead Screening in Children *	The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.	OHSU	Healthier People, Healthier Communities
\$ Percentage of Eligibles Who Received Preventive Dental Services *	The percentage of individuals ages 1 to 20 who are enrolled for at least 90 continuous days, are eligible EPSDT services, and who received at least one preventive dental service during the reporting period.	CMS	Communities Healthier People, Healthier Communities


Measures	Measure Description	Measure Steward	Aim
Childhood Immunization Status	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 nine separate combination rates.	NCQA	Healthier People, Healthier Communities
Immunizations for Adolescents	Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday. Report all individual vaccine numerators and combinations.	NCQA	Healthier People, Healthier Communities
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents	Percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner and whose weight is classified based on body mass index percentile for age and gender. The percentage of children ages 3 to 17 that had an outpatient visit with a primary care practitioner (PCP) or obstetrical/gynecological (OB/GYN) practitioner, with evidence of : <ul style="list-style-type: none"> <li>• BMI percentile documentation</li> <li>• Counseling for nutrition</li> <li>• Counseling for physical activity</li> </ul>	NCQA	Healthier People, Healthier Communities



Measures	Measure Description	Measure Steward	Aim
<p>Measures for stratified data: Child: Developmental Screening in the First Three Years of Life, Percentage of Eligibles Who Received Preventive Dental Services, Immunizations for Adolescents</p>	<p>Refer to individual measures, will be stratified by race/ethnicity and urban/rural status</p>	<p>Steward Various</p>	<p>Healthier People, Healthier Communities</p>
<p>Appropriate Treatment for Children With Upper Respiratory Infection *</p>	<p>The percentage of children 3 months–18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.</p>	<p>NCCQA</p>	<p>Smarter Spending</p>

Measures	Measure Description	Measure Steward	Aim
<p>Syphilis Screening During Pregnancy – 3<sup>rd</sup> Trimester *</p>	<p>The percentage of pregnant members who received appropriate syphilis screening</p>	<p>Measure Steward State</p>	<p>Healthier People, Healthier Communities</p>
<p>Prenatal and Postpartum Care: Timeliness of Prenatal Care</p>	<p>The percentage of deliveries of live births on or between November 6 of the year prior to the measurement year and November 5 of the measurement year that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.</p>	<p>NCCQA</p>	<p>Healthier People, Healthier Communities</p>
<p>Elective Delivery or Early Induction Without Medical Indication</p>	<p>This measure assesses patients with elective vaginal deliveries or elective cesarean sections at <math>\geq 37</math> and <math>&lt; 39</math> weeks of gestation completed</p>	<p>TJC</p>	<p>Healthier People, Healthier Communities</p>
<p>Cesarean Rate for Low-Risk First Birth Women</p>	<p>The percentage of cesareans in live births at or beyond 37.0 weeks gestation to women that are having their first delivery and are singleton (no twins or beyond) and are vertex presentation (no breech or transverse positions).</p>	<p>TJC</p>	<p>Healthier People, Healthier Communities</p>
<p>Prenatal and Postpartum Care: Postpartum Care</p>	<p><i>Note: A lower rate indicates better performance.</i> The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</p>	<p>NCCQA</p>	<p>Healthier People, Healthier Communities</p>
<p>Unexpected Complications in Term Newborns *</p>	<p>The percentage of infants with unexpected newborn complications among full term newborns with no preexisting conditions.</p>	<p>TJC</p>	<p>Healthier People, Healthier Communities</p>

Measures	Measure Description	Measure Steward	Aim
\$	Initiation of Injectable Progesterone for Preterm Birth Prevention	State	Healthier People, Healthier Communities
	Appropriate Use of Antenatal Steroids *	JCAHO	Healthier People, Healthier Communities
	Percentage of Low Birthweight Births	AHRQ	Healthier People, Healthier Communities
	Contraceptive Care – All Women Ages 21–44 *	OPA	Healthier People, Healthier Communities
	Contraceptive Care – Postpartum Women Ages 21–44	OPA	Healthier People, Healthier Communities

Measures	Measure Description	Measure Steward	Aim
Measures for stratified data: Pregnancy: Percentage of Low Birthweight Births, Contraceptive Care – Postpartum Women Ages 21–44, Initiation of Injectable Progesterone for Preterm Birth Prevention Non-recommended Cervical Cancer Screening in Adolescent Females *	Refer to individual measures, will be stratified by race/ethnicity and urban/rural status	Various	Healthier People, Healthier Communities
The percentage of adolescent females 16–20 years of age who were screened unnecessarily for cervical cancer.	NCCQA	Smarter Spending	
Note: A lower rate indicates better performance.			

Measures	Measure Description	Measure	Aim
§ Follow-Up After Hospitalization for Mental Illness	<p>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 reported:</p> <ul style="list-style-type: none"> <li>• The percentage of discharges for which the member received follow-up within 30 days after discharge.</li> <li>• The percentage of discharges for which the member received follow-up within 7 days after discharge.</li> </ul> <p>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.</p>	Steward NCCQA	Better Care
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications  Concurrent Use of Opioids and Benzodiazepines *	<p>Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded.</p>	PQA	Healthier People, Healthier Communities

Measures	Measure Description	Measure Steward	Aim
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment *	<p>The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following.</p> <ul style="list-style-type: none"> <li>Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.</li> <li>Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional AOD services or medication treatment within 34 days of the initiation visit.</li> </ul>	NCCQA	Healthier People, Healthier Communities
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	<p>The measure calculates the percentage of individuals 19 years of age or greater as of the beginning of the measurement year with schizophrenia or schizoaffective disorder who are prescribed an antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement year (12 consecutive months).</p>	NCCQA	Healthier People, Healthier Communities
Antidepressant Medication Management	<p>The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.</p>	NCCQA	Healthier People, Healthier Communities

Measures	Measure Description	Measure Steward	Aim
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics *	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.	NCCQA	Healthier People, Healthier Communities
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication	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. <ul style="list-style-type: none"> <li>• Initiation Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.</li> <li>• Continuation and Maintenance (C&amp;M) Phase. The percentage of members 6–12 years of age as of the IPSD with an ambulatory 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.</li> </ul>	NCCQA	Healthier People, Healthier Communities
\$ initiation			
\$ continuation			

Measures	Measure Description	Measure Steward	Aim
Depression Screening and Follow-Up for Adolescents and Adults *	<p>The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.</p> <ul style="list-style-type: none"> <li>• <i>Depression Screening.</i> The percentage of members who were screened for clinical depression using a standardized instrument.</li> </ul>	NCCQA Steward	Better Care
Depression Remission or Response for Adolescents and Adults *	<ul style="list-style-type: none"> <li>• <i>Follow-Up on Positive Screen.</i> The percentage of members who received follow-up care within 30 days of screening positive for depression.</li> </ul> <p>The percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score.</p> <ul style="list-style-type: none"> <li>• <i>Follow-Up PHQ-9.</i> The percentage of members who have a follow-up PHQ-9 score documented within the 4–8 months after the initial elevated PHQ-9 score.</li> <li>• <i>Depression Remission.</i> The percentage of members who achieved remission within 4–8 months after the initial elevated PHQ-9 score.</li> <li>• <i>Depression Response.</i> The percentage of members who showed response within 4–8 months after the initial elevated PHQ-9 score.</li> </ul>	NCCQA	Better Care



Measures	Measure Description	Measure Steward	Aim
Ambulatory Care: \$ Emergency Department Visits	This measure summarizes utilization of ambulatory care ED Visits per 1,000 member months.  <i>Note: A lower rate indicates better performance.</i>  The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: <ul style="list-style-type: none"> <li>The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).</li> <li>The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).</li> </ul>	NCCQA	Better Care
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence *	The rate of ED visits resulting in diagnoses that indicate that the visit may potentially have been preventable (3M software)	NCCQA	Better Care
Potentially Preventable ED Visits *	The rate of ED visits resulting in diagnoses that indicate that the visit may potentially have been preventable (3M software)	State	Better Care

Measures	Measure Description	Measure Steward	Aim
Plan All-Cause Readmissions	For members 18-64 years of age, the risk-adjusted rate of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	NCCQA	Better Care
Potentially Preventable Readmissions *	The rate of hospital readmissions that may have been preventable (3M software)	State	Better Care
\$ Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H - Child Version (Medicaid)	This measure provides information on parents' experience with their child's Medicaid organization.	NCCQA	Better Care
\$ Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.0H, Adult Version (Medicaid)	This measure provides information on the experiences of Medicaid members with the organization and gives a general indication of how well the organization meets members' expectations.	NCCQA	Better Care
Percentage of members who complete the initial health needs assessment within 90 calendar days of the enrollee's effective date of enrollment *	Refer to measure name	N/A	Healthier People, Healthier Communities
Provider payments tied to incentivized quality measures *	Refer to measure name	N/A	Smarter Spending

**Adult – Past Incentivized Measures**

Diabetes Care – Testing

Diabetes Care – Retinal Exams

Diabetes Care – Nephropathy

Controlling High Blood Pressure



**Adult – Suggested Incentivized Measures**

Diabetes Care – Poor Control (A1c > 9)

Controlling High Blood Pressure

Colorectal Cancer Screening

HIV Viral Load Suppression

**Pediatric – Past Incentivized Measures**

Well-Child Visits in the First 15 Months of Life

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Adolescent Well Care Visit



**Pediatric – Suggested Incentivized Measures**

Childhood Immunization Status

Immunizations for Adolescents

Developmental Screening

**Reproductive and Maternal Health - Past  
Incentivized Measures**

Initiation of Injectable Progesterone for  
Preterm Birth Prevention

Prenatal and Postpartum Care - Timeliness  
of Prenatal Care

Prenatal and Postpartum Care –  
Postpartum Care



**Reproductive and Maternal Health –  
Suggested Incentivized Measures**

Initiation of Injectable Progesterone for  
Preterm Birth Prevention

Contraceptive Care-Postpartum (ages 21-  
44)

Cervical Cancer Screening

Cesarean Rate for Low-Risk First Birth  
Women

**Behavioral Health – Past Incentivized Measures**

Follow-up Care for Children Prescribed ADHD Medication-Initiation Phase  
Follow-up Care for Children Prescribed ADHD Medication-Continuation Phase  
Follow-Up After Hospitalization for Mental Illness - Within 30 days of discharge



**Behavioral Health – Suggested Incentivized Measures**

Follow-up After Emergency Department Visit for Alcohol or Other Drug Abuse  
Follow-up After Emergency Department Visit for Mental Illness  
Initiation and Engagement in Alcohol or Other Drug Abuse Treatment

**EM/Care Process – Past Incentivized Measures**

**Ambulatory Care- ED Visits**

CAHPS Health Plan Survey 5.0H, Child  
(Rating of Health Plan-General  
Population, 8+9+10)

CAHPS Health Plan Survey 5.0H, Adult  
(Rating of Health Plan, 8+9+10)



**EM/Care Process – Suggested Incentivized Measures**

**Ambulatory Care- ED Visits**

(ED-related measures listed in  
Behavioral Health section)