2018 HPA Standards and Guidelines

Quality Management and Improvement (QI)

QI 1: Program Structure

- Does the organization have a written description of its QI program that is reviewed and updated annually?
- Does the QI program specifically address behavioral health?
- Does a QI Committee oversee the QI program?
- Is there a physician and behavioral health practitioner involved in the QI program?
- Are the roles, structures and functions of the QI Committee and other committees described in the QI program description?
- Is there an annual QI work plan?
- Does the QI program include objectives for culturally and linguistically diverse memberships?
- Does the QI program include objectives for serving members with complex needs?

QI 2: Program Operations

- Does the QI committee meet regularly and take action on QI activities?
- Is there documentation of QI committee meetings?
- Are practitioners involved in the planning, design, implementation and review of the QI program?
- Is the QI program information available to members?

QI 3: Health Services Contracting

- Do participating practitioners and providers cooperate with QI activities, maintain the confidentiality of member information and allow the plan to use practitioner performance data?
- Do contracts with practitioners and providers ensure their free communication with patients about treatment?

QI 4: Member Experience

- Does the organization have standards to ensure access to Member Services and Behavioral Healthcare by telephone?
- Does the organization annually assess member complaints and appeals?
- Does the organization analyze results of member experience surveys and identify opportunities for improvement?
- Does the organization report separate complaint and appeal results concerning behavioral healthcare?
- Does the organization take steps to improve performance in these areas?
- Does the organization evaluate member and practitioner experiences with its UM process, and does it act to improve areas of dissatisfaction?

QI 5: Continuity and Coordination of Medical Care

- Does the organization identify improvement opportunities?
- Does the organization monitor the continuity and coordination of care between practitioners; for example, between a primary care physician and a specialist?
- Does the organization measure its performance and make improvements when needed?
- Does the organization annually act to improve coordination of medical care?

QI 6: Continuity and Coordination Between Medical Care and Behavioral Healthcare

- Does the organization annually collect data about opportunities for coordination between general medical care and behavioral health care?
- Does the organization collaborate with behavioral health specialists to collect and analyze data and implement improvement of coordination of behavioral health and general medical care?

QI 7: Delegation of QI

- If the organization delegates QI activity, has it worked with the delegate to develop a mutually agreed-upon document that outlines responsibilities, delegated activities, and evaluation processes?
- Does the organization provide member experience and clinical performance data to the delegate when requested?
- Has the organization evaluated whether the delegate can perform the activities?
- Does the organization review the delegate's QI program and review its performance annually?

Population Health Management (PHM)

PHM 1: PHM Strategy

- Does the organization have a comprehensive strategy for meeting care needs of its members?
- Does the organization's strategy include four areas of focus?
- Does the strategy describe how member programs are coordinated and how members are informed about the available PHM programs?

PHM 2: Population Identification

- Does the organization assess its population and uses the findings for appropriate interventions?
- Does the organization integrate data from multiple sources to support its PHM functions?
- Does the organization annually assess the characteristics and needs of its population?
- Does the organization identify and assess the characteristics and needs of subpopulation?
- Does the organization use its annual population assessment to review and update its PHM structure, activities and resources?
- Does the organization annual review its community resources available to members and connect members to the appropriate resources?
- Does the organization annually segment or stratifies its population into subgroups for targeted intervention?

PHM 3: Delivery System Supports

- Does the organization provide support to practitioner and providers in its network?
- Does the organization have a value-based payment (VBP) arrangement?

PHM 4: Wellness and Prevention

- Does the organization provide a health appraisal that allows members to assess their risks of morbidity and mortality and identify how they can reduce risk?
- Does the organization disclose how information from the HA will be used, to whom it may be provided and for what purpose, and does the plan offer an opportunity for the member to consent or decline to have their information used or disclosed?
- Does the HA assess at least the 13 personal health characteristics and behaviors that are listed in the Standards and Guidelines?
- Does the organization provide HA results to the member such that the results are easy for the member to understand?
- Is the health appraisal available on the plan's website, as well as in an alternative format (in print or be telephone)?
- Does the organization have the capability to administer the health appraisal annually?
- Is the health appraisal reviewed and updated at least every two years?
- Does the organization offer self-management tools in at least the following health areas: healthy weight (BMI) maintenance; smoking and tobacco use cessation; encouraging physical activity; healthy eating; managing stress; avoiding at-risk drinking; and identifying depressive symptoms?
- Are the self-management tools tested for their usefulness to members with consideration of language that is easy to understand and members' special needs, including vision and hearing?
- Are the self-management tools reviewed and updated?
- Does the organization offer self-management tools online for each of the seven health areas?

PHM 5: Complex Case Management

- Does the organization systematically identify members with complex conditions and refer them for case management?
- Are the organization's case management systems based on sound evidence?

- Does the organization have automated systems to support the case management staff?
- Do the organization's case management systems ensure appropriate documentation and follow-up?
- Do the organization's case management systems have processes for initial assessment and ongoing management of members?
- Does the organization measure its performance and member satisfaction, and take steps to improve performance when necessary?

PHM 6: Population Health Management Impact

- Does the organization annually measure the effectiveness of its PHM strategy and make improvements when necessary?
- Does the organization annually act improve its PHM program and acts on opportunities for improvement?

PHM 7: Delegation of PHM

- If the organization delegates PHM activity, has it worked with the delegate to develop a mutually agreed-upon document that outlines responsibilities, delegated activities, and evaluation processes?
- Does the organization provide member experience and clinical performance data to the delegate when requested?
- Has the organization evaluated whether the delegate can perform the activities?
- Does the organization review the delegate's PHM program and review its performance annually?

Network Management (NET)

NET 1: Availability of Practitioners

- Are practitioners located throughout the plan's service area?
- Did the organization consider the cultural needs of its members when it created its practitioner network? For example, are there multilingual practitioners?
- Does the organization take steps to ensure that there are sufficient numbers of primary care and specialty practitioners available to its members?
- Does the organization measure its performance and make improvements when needed?

NET 2: Accessibility of Services

- Does the organization have standards to ensure access to medical care, including routine primary care, emergency care and after-hours care?
- Can members get behavioral health care when they need it?
- Does the organization measure its performance and make improvements when needed?

NET 3: Assessment of Network Adequacy

- Does the organization analyze data from complaints and appeals to determine if there are issues concerning geographic distribution or types of practitioners in its network?
- Does the organization make improvements in its network from information it receives from its analysis of access and availability?

NET 4: Marketplace Network Transparency and Experience

- Does the organization explain the criteria it uses to select practitioners for its Marketplace Silver-tier plans?
- Does the organization explain the criteria it uses to select hospitals for its Marketplace plans?
- Does the organization assess Marketplace plan member experience through analysis of complaints, appeals and requests for out-of-network services?

NET 5: Continued Access to Care

- Does the organization or practitioner notify members affected by the termination of a primary care practitioner's contract?
- Are there circumstances where members may continue to see a practitioner whose contract has been terminated?

NET 6: Physician and Hospital Directories

- Does the organization provide a searchable Web-based directory of its physicians and hospitals?
- Does the physician and hospital directory contain the most current information?
- Does the plan test the directory for understanding and member ease of use?
- Is the directory available in other formats (e.g., printed, by telephone)?

NET 7: Delegation of NET

- If the organization delegates NET activity, has it worked with the delegate to develop a mutually agreed-upon document that outlines responsibilities, delegated activities, and evaluation processes?
- Does the organization provide member experience and clinical performance data to the delegate when requested?
- Has the organization evaluated whether the delegate can perform the activities?
- Does the organization review the delegate's NET program and review its performance annually?

Utilization Management (UM)

UM 1: Utilization Program Structure

- Does the organization have a written description of its program for managing care?
- Is a senior physician involved in the program's operation?
- Is a behavioral health practitioner involved in the behavioral health aspects of the program?
- Is the program evaluated, updated and approved annually?

UM 2: Clinical Criteria for UM Decisions

- Are evidence-based clinical criteria and procedures for approving and denying care objective and based on clinical evidence?
- Do practitioners help develop criteria?
- Does the organization review and revise criteria annually?
- Can practitioners get a copy of the criteria if they ask for it?
- Does the organization evaluate how consistently criteria are applied?

UM 3: Communication Services

- Is appropriate staff available to discuss UM issues with members and practitioners?
- Are there resources available for UM staff to communicate to members with special needs?

UM 4: Appropriate Professionals

- Do qualified licensed health professionals oversee all medical necessity decisions?
- Does a licensed physician or other appropriate health care professional review denials of care based on medical necessity?
- Does the organization use board-certified consultants to assist in making medical necessity determinations?
- Does the organization ensure that no one involved in the decision-making process benefits from denying treatment to members?
- Does the organization notify members, health care professionals and staff that UM decisions are based on appropriateness of care and benefit coverage?
- Does the organization classify denials of treatment appropriately?

UM 5: Timeliness of UM Decisions

- Does the organization use time frames specific to the clinical urgency of a situation when it makes coverage decisions? Specifically, does it make urgent concurrent decisions within 24 hours; urgent preservice decisions within 72 hours; nonurgent preservice decisions within 15 calendar days; and postservice decisions within 30 calendar days?
- Does the organization notify members and practitioners about coverage decisions within required time frames?
- Does the organization monitor and report on timeliness of its decisions?

UM 6: Clinical Information

- Does the organization gather relevant clinical information when determining whether to approve or deny coverage based on medical necessity?

UM 7: Denial Notices

- Does the organization clearly document and communicate its reason(s) for denying a service?
- May practitioners discuss a medical necessity denial with the plan's physician or a designated reviewer?
- Does the organization notify members and practitioners of the reason(s) for a denial in writing?
- Are appeal processes and rights outlined clearly in all denial notifications?

UM 8: Policies for Appeals

- Does the organization have written policies and procedures for resolving member appeals?
- Does the organization have a process for responding to preservice, expedited, postservice, and external appeals?
- Do members have at least 180 days to appeal initial denial decisions?
- Does the organization give members access to all documents relevant to their appeal?
- May members submit comments, documents or other information relating to their appeal?
- Are appeal reviewers disinterested parties (i.e., not involved in the initial denial decision)?
- Are same-or-similar-specialty reviewers (i.e., practitioners in the same or a similar specialty who treat the condition under appeal) involved in appeals?
- Does the organization allow members' authorized representatives to act on their behalf?
- Are members notified of additional appeal rights?

UM 9: Appropriate Handling of Appeals

- Does the organization have a full and fair process for resolving member appeals, and does it follow its policies regarding appeals?
- Does the organization document and investigate the substance of all appeals?
- Does the organization resolve appeals in a timely manner?
- Does the organization notify members in writing of appeal decisions, the reason(s) for the decision and their additional appeal rights?
- Does the organization ensure that overturned decisions are handled appropriately?

UM 10: Evaluation of New Technology

- Does the organization have a written description of the process it uses to evaluate new technology for inclusion in its benefits plan?

UM 11: Procedures for Pharmaceutical Management

- Does the organization have clearly documented policies and procedures for drug coverage?
- If the organization restricts pharmacy benefits, does it have an exceptions policy?
- Do procedures cover patient safety issues?
- Are pharmaceutical management procedures reviewed and updated annually?
- Are pharmacists and appropriate practitioners involved in developing and updating procedures?
- Is there a clear process in place for applying procedures and ensuring that practitioners are aware of them?

UM 12: Triage and Referral for Behavioral Healthcare

- Does the organization assess and connect members to appropriate behavioral healthcare services in a timely manner based on the level of clinical urgency?
- Do licensed behavioral healthcare practitioners make all clinical triage and referral decisions?
- Is there appropriate clinical supervision and oversight of behavioral healthcare triage and referral decisions?

UM 13: Delegation of UM

- If the organization delegates UM activities, does a delegation agreement outline responsibilities of the delegate and the organization, the delegated activities and the evaluation process?
- Does the organization provide member experience and clinical performance data to the delegate when requested?
- Has the organization evaluated whether the delegate can perform the activities?
- Does the organization annually review the delegate's UM program, receive reports, evaluate delegate performance, and identify opportunities for improvement?

Credentialing and Recredentialing (CR)

CR 1: Credentialing Policies

- Does the organization have clearly defined and documented procedures for assessing practitioner qualifications and practice history?
- Does the organization identify practitioner types that must be credentialed?
- Does the organization have policies and procedures that define a practitioner's right to review and correct credentialing information?

CR 2: Credentialing Committee

- Does the organization have a designated Credentialing Committee that reviews practitioner credentials and makes recommendations?

CR 3: Credentialing Verification

- Does the organization verify practitioner credentials, including a valid license to practice medicine, education and training, board certification (if applicable), malpractice history and work history?
- Do practitioner applications include an attestation about limitations that would affect a practitioner's performance; a history of loss of medical license and felony convictions; a history of limitation of privileges or disciplinary actions; and current malpractice insurance coverage?
- Before making a decision on a practitioner's qualifications, does the plan review information (e.g., about disciplinary actions) from third parties?

CR 4: Recredentialing Cycle Length

- Does the plan evaluate practitioner qualifications every 36 months?

CR 5: Ongoing Monitoring and Interventions

- Does the organization monitor practitioner sanctions, complaints and quality issues between the recredentialing cycles?
- Does the organization take appropriate action when issues are identified?

CR 6: Notification to Authorities and Practitioner Appeal Rights

- Does the organization have a process for terminating the contracts of practitioners who demonstrate poor performance?
- Does the organization have a process for practitioners to appeal a terminated contract?
- Does the organization report to appropriate authorities when it suspends or terminates a practitioner's contract?

CR 7: Assessment of Organizational Providers

- Does the organization confirm that hospitals, home health care agencies, skilled nursing facilities, nursing homes and behavioral health facilities are in good standing with state and federal agencies and accrediting organizations?
- Does the organization review the standings above at least every three years?

CR 8: Delegation of CR

- If the organization delegates CR activities, does a delegation agreement outline responsibilities of the delegate and the organization, the delegated activities and the evaluation process?
- Has the organization evaluated whether the delegate can perform the activities?
- Does the organization evaluate the delegate on a regular basis?
- Does the organization review the delegate's CR process annually?

Members' Rights and Responsibilities (RR)

RR 1: Statement of Members' Rights and Responsibilities

- Does the organization have a written members' rights and responsibilities policy?
- Does the policy state the plan's expectations of members' responsibilities?
- Does the organization distribute its rights and responsibilities policy to members and participating practitioners?

RR 2: Policies and Procedures for Complaints and Appeals

- Does the organization have written policies and procedures for the timely resolution of member complaints and appeals?
- Does the organization have written policies and procedures that include provisions for language services?

RR 3: Subscriber Information

- Does the organization provide written information about benefits and charges for which members are responsible, including co-payments?
- Does the organization provide written information to members about how they can obtain care?
- Does the organization provide written information to members about how they can obtain language assistance?
- Does the organization provide written information to members about how they can file a complaint or appeal a decision about care?
- Does the organization provide interpreter or bilingual services for telephone functions based on the needs of its members?

RR 4: Marketing Information

- Do the organization's marketing materials describe its procedures for approving or denying coverage; covered benefits, including pharmacy benefits; services that are not covered; practitioner and provider availability; and any applicable restrictions?
- Does the organization monitor new-member understanding of its procedures and update its marketing materials accordingly?
- Does the organization take steps to protect the privacy of member information and records?
- Does the organization tell practitioners and current and potential members about these policies?

RR 5: Delegation of RR

- If the organization delegates RR activities, does a delegation agreement outline responsibilities of the delegate and the organization, the delegated activities and the evaluation process?
- Does the organization provide member experience and clinical performance data to the delegate when requested?
- Has the organization evaluated whether the delegate can perform the activities?
- Does the organization evaluate the delegate's performance annually?

Member Connections (MEM)

MEM 1: Functionality of Claims Processing

- Does the organization have a website and telephone services where members can obtain information about claims?
- Does the organization measure whether claims are handled in a timely and accurate way?

MEM 2: Pharmacy Benefit Information

- Can members get information about their pharmacy benefits, their financial responsibility for medications and pharmacy operations on the Web and by telephone?
- Does the organization have a process to ensure that pharmacy information is accurate and current?

MEM 3: Personalized Information on Health Plan Services

- Can members request or reorder an ID card or change a primary care practitioner on the plan's website?
- Can members get information about referrals and services on the plan's website or by telephone?
- Does the organization ensure the accuracy of the benefit information it communicates?
- Does the organization assess member satisfaction with its member materials and Customer Services telephone assistance?

MEM 4: Member Support

- Does the organization encourage the use of technology to improve services, convenience and appropriate use of health benefits?

MEM 5: Delegation of MEM

- If the organization delegates member connections activities, does a delegation agreement outline responsibilities of the delegate and the organization, the delegated activities and the evaluation process?
- Does the organization provide member experience and clinical performance data to the delegate when requested?
- Has the organization evaluated whether the delegate can perform the activities?
- Does the organization annually evaluate the delegate's performance?

Medicaid Benefits and Services (MED)

MED 1: Medicaid Benefits and Services

- Does the Medicaid plan provide direct access to women's health services?
- Does the Medicaid plan provide for a second opinion from an in-network provider or arranges for the member to obtain a second opinion outside the network?
- Does the Medicaid plan adequately cover services out of network when it cannot provide them within its network in a timely fashion?
- Does the Medicaid plan ensure that the cost to members for out-of-network services when it cannot provide them in its network is the same as the cost of in-network services?
- Does the Medicaid plan require the hours of operation that providers offer to Medicaid members to be no less than those offered to commercial members?

MED 2: Practice Guidelines

- Does the Medicaid plan adopt evidence-based practice guidelines for at least two medical conditions and at least two behavioral conditions with at least one behavioral guideline addressing children/adolescents?
- Is there a clinical basis to the guidelines?
- Are the guidelines reviewed at least every two years?
- Are the guidelines distributed to appropriate practitioners?
- Does the Medicaid plan annually measure its performance against the guidelines?

MED 3: Emergency Services

- Does the Medicaid plan cover emergency services without precertification in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed?

MED 4: Practitioner Office Site Quality

- Does the Medicaid plan set thresholds for office-site criteria and medical/treatment record-keeping practices?
- Does the Medicaid plan visit practice sites that reach its member complaint threshold?
- Does the Medicaid plan take necessary steps when an office does not meet its standards, and does it evaluate those steps regularly until the office improves?

MED 5: Privacy and Confidentiality

- Does the Medicaid plan take steps to protect the privacy of member information and records?
- Does the Medicaid plan tell practitioners and current and potential members about these policies?

MED 6: Delegation of MED

- If the organization delegates Medicaid benefits and services activities, does a delegation agreement outline responsibilities of the delegate and the Medicaid plan, the delegated activities and the evaluation process?
- Does the Medicaid plan provide Medicaid benefits and services and clinical performance data to the delegate when requested?
- Has the organization evaluated whether the delegate can perform the activities?
- Does the Medicaid plan annually evaluate the delegate's performance?

Long-Term Services and Supports (LTSS)

LTSS 1: Core Features

- Does the organization have criteria for identifying members who are eligible for the long-term services and support (LTSS) program?
- Does the organization have a description of the services offered to members?
- Does the organization specify the evidence and professional standards it uses for the program operations?
- Does the organization define the goals of the LTSS program?
- Does the organization describe how it coordinates CM services with the members' other care?
- Does the organization have a process for assessing the health, functioning and communication needs of its members?
- Does the organization have a process for assessing the resources available to its members?
- Does the organization implement its resource assessment plan?
- Does the organization have a process for assessing, creating, and implementing person-centered case management plans?
- Does the organization have a process for managing critical incidents?
- Does the organization have a process for evaluating LTSS provider qualifications and providing assistance to them when needed?

LTSS 2: Measure and Improve Performance

- Does the organization obtain feedback and analyze complaints from members to evaluate member experience?
- Does the organization track and analyze three measures of effectiveness annually?
- Does the organization implement at least one intervention that addresses one or more identified opportunities from the effectiveness measure analysis?
- Does the organization annually measure and analyze participation rates for each program?
- Does the organization identify and implement at least one action to improve participation rates?
- Is the organization transparent about its calculation method for reporting participation rates?

LTSS 3: Care Transitions

- Does the organization have a process to facilitate safe transitions of care?
- Does the organization identify members at high risk of an unplanned transition and take action to mitigate the risk of unplanned transitions?
- Does the organization reduce unplanned transitions by analyzing rates of unplanned admissions, identifying opportunities for improvement and taking action to improve these areas?

LTSS 4: Delegation of LTSS

- If the organization delegates LTSS activities, has it worked with the delegate to develop a mutually agreed-upon document that outlines responsibilities, delegated activities and evaluation processes?
- Does the organization provide member experience and clinical performance data to the delegate when requested?
- Has the organization evaluated whether the delegate can perform the activities?
- Does the organization annually evaluate the delegate's performance?

HEDIS Measures Required for 2018 Accreditation

- What performance measures must plans report?

2018 HEDIS Measures Required as Part of the NCQA Accreditation Process for Commercial Health Plans

- Adult BMI Assessment
- Antidepressant Medication Management (Both Rates)
- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection
- Medication Management for People With Asthma (Medication Compliance 75% Rate only)
- Asthma Medication Ratio (Total Rate)
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood Immunization Status (Combination 10)
- Chlamydia Screening in Women (Total Rate)
- Colorectal Cancer Screening
- Comprehensive Diabetes Care (Rate—BP Control [<140/90], Rate—HbA1c Control [<8.0%] Eye Exam,)
- Controlling High Blood Pressure
- Emergency Department Utilization ***New Measure***
- Flu Vaccinations for Adults Ages 18–64
- Follow-Up After Hospitalization for Mental Illness (7-Day Rate only)
- Follow-Up for Children Prescribed ADHD Medication (Both Rates)
- Immunizations for Adolescents (Combination 2) **New Rate**
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates **New Rate**
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation (Both Rates)
- Plan All-Cause Readmissions
- Prenatal and Postpartum Care (Postpartum Care Rate only)
- Statin Therapy for Patients With Cardiovascular Disease (Both Rates) **New Measure**
- Statin Therapy for Patients With Diabetes (Both Rates) **New Measure**
- Use of Imaging Studies for Low Back Pain
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates)

CAHPS Measures

- Getting Care Quickly
- Getting Needed Care
- Claims Processing
- Coordination of Care
- Customer Service
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

2018 HEDIS Measures Required as Part of the NCQA Accreditation Process for Medicare Health Plans

- Antidepressant Medication Management (Both Rates)
- Breast Cancer Screening
- Colorectal Cancer Screening
- Comprehensive Diabetes Care (BP Control [<140/90], Rate—HbA1c Control [<8.0%] Eye Exam,)
- Controlling High Blood Pressure
- Emergency Department Utilization **New Measure**
- Flu Vaccinations for Adults Ages 65 and Older
- Follow-Up After Hospitalization for Mental Illness (7-Day Rate only)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates) **New Rate**
- Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Rate only)
- Non-Recommended PSA-Based Screening in Older Men **New Measure**
- Osteoporosis Management in Women Who Had a Fracture
- Persistence of Beta-Blocker Treatment After a Heart Attack
- Pharmacotherapy Management of COPD Exacerbation (Both Rates)
- Plan All-Cause Readmissions
- Pneumococcal Vaccination Status for Older Adults
- Potentially Harmful Drug-Disease Interactions in the Elderly (Total Rate)
- Statin Therapy for Patients With Cardiovascular Disease (Both Rates) **New Measures**
- Statin Therapy for Patients With Diabetes (Both Rates) **New Measures**
- Use of High-Risk Medications in the Elderly (Rate 1 only)

C AHPS Measures

- Coordination of Care
- Getting Care Quickly
- Getting Needed Care
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

2018 HEDIS Measures Required as Part of the NCQA Accreditation Process for Medicaid Health Plans

- Adherence to Antipsychotic Medications for Individuals With Schizophrenia **New Measure**
- Adult BMI Assessment
- Annual Dental Visits (Total Rate)
- Antidepressant Medication Management (Both Rates)
- Appropriate Testing for Children With Pharyngitis
- Appropriate Treatment for Children With Upper Respiratory Infection
- Medication Management for People With Asthma (Medication Compliance 75% Rate Only)
- Asthma Medication Ratio (Total Rate)
- Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis
- Breast Cancer Screening
- Cervical Cancer Screening

- Childhood Immunization Status (Combination 10)
- Chlamydia Screening in Women (Total Rate)
- Comprehensive Diabetes Care (BP Control <140/90, Rate—HbA1c Control (<8.0%), Eye Exam,)
- Controlling High Blood Pressure
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication
- Flu Vaccination for Adults Ages 18-64
- Follow-Up After Hospitalization for Mental Illness (7-Day Rate only)
- Follow-Up for Children Prescribed ADHD Medication (Both Rates)
- Frequency of Prenatal Care (≥81% of expected visits only)
- Human Papillomavirus Vaccine for Female Adolescents
- Immunizations for Adolescents (Combination 2) **New Rate**
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Both Rates) **New Rate**
- Medical Assistance With Smoking and Tobacco Use Cessation (Advising Smokers and Tobacco Users to Quit Rate only)
- Pharmacotherapy Management of COPD Exacerbation (Both Rates)
- Prenatal and Postpartum Care (Both Rates)
- Statin Therapy for Patients With Cardiovascular Disease (Both Rates) **New Measure**
- Statin Therapy for Patients With Diabetes (Both Rates) **New Measure**
- Use of Imaging Studies for Low Back Pain
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (the total of all ages for each of the 3 rates)

CAHPS Measures

- Getting Care Quickly
- Getting Needed Care
- Coordination of Care
- Customer Service
- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often