Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

Technical Specifications and Resource Manual for
2025 Core Set Reporting

January 2025 (Updated March 2025)

Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

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Updates to the 2025 Adult Core Set Resource Manual since the Initial January 2025 Release

Date	Location of change	Update
March 2025	Section III, AMR-AD, Administrative Specification	Removed three asthma controller medication lists from Table AMR-A (Fluticasone Furoate Umeclidinium Vilanterol Medications, Salmeterol Medications, Tiotropium Medications), as a result of January 15, 2025 measure specification update.
March 2025	Section III, FUM-AD, Numerator	Clarified the numerator bullets related to Electroconvulsive therapy (Numerator bullets 6 and 15)

CONTENTS

I. THE CORE SET OF ADULT HEALTH CARE QUALITY MEASURES (ADULT CORE SET)

Background

Section 1139B of the Social Security Act (the Act) requires the Secretary of Health and Human Services (HHS) to identify and publish a core set of health care quality measures for Medicaid-enrolled adults (Adult Core Set). This legislation parallels the requirement under Section 1139A of the Act to identify and publish a core set of quality measures for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

Implementation of a standardized Adult Core Set is helping the Centers for Medicare & Medicaid Services (CMS) and states move toward a national system for quality measurement, reporting, and improvement. The data collected from these measures help CMS to better understand the quality of health care that adults enrolled in Medicaid receive. The Act requires the Secretary of HHS to make publicly available the information states report to CMS on the quality of health care furnished to adults covered by Medicaid.

Section 5001 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) of 2018 made state reporting of the Behavioral Health measures in the Adult Core Set mandatory starting with the 2024 Core Set. Mandatory reporting of the Behavioral Health measures in the Adult Core Set further advances CMS's efforts to develop a national, data-driven system for measuring and improving the quality of care for beneficiaries in Medicaid and CHIP.[1] CMS released a final rule in August 2023 that outlines the reporting requirements that will lead to standardized quality measures for all States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, and Guam.[2] While American Samoa and the Mariana Islands are not required to report Child and Adult Core Sets measures, they are encouraged to consider reporting.

Description of the Adult Core Set

In January 2012, the Secretary selected and published an initial core set of 26 adult health care quality measures for voluntary use by states. The Act required the Secretary to issue updates to the Adult Core Set beginning in January 2014 and annually thereafter. The Compilation of Annual Updates to the Child and Adult Core Health Care Quality Measurement Sets web page on Medicaid.gov provides historical policy documentation.[3] In addition, the Core Set History table provides a history of the measures included in the Adult Core Set.[4]

Table 1 lists each measure in the 2025 Adult Core Set, the CMS Measures Inventory Tool (CMIT) number, and the measure steward. The data collection methods include administrative

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[1] Legislation making reporting of the behavioral health measures in the Adult Core Set mandatory: Section 5001 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT) for Patients and Communities Act of 2018 available at https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf.

[2] Core Set Final Rule 88 FR 60278: https://www.federalregister.gov/d/2023-18669.

[3] Historical Policy Guidance is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/compilation-of-annual-updates-child-and-adult-core-health-care-quality-measurement-sets/index.html.

[4] The Core Set History table is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

(such as claims, encounters, vital records, and registries), hybrid (a combination of administrative data and medical records), survey, electronic health record (EHR, also referred to as the electronic specification method), and Electronic Clinical Data Systems (ECDS). The technical specifications in Chapters III and IV of this manual provide additional details for each measure.

More information on the Adult Core Set is available on Medicaid.gov at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html.

Table 1. 2025 Adult Core Set

2025 Mandatory Adult Core Set Measures

CMIT #[a]	Measure Steward[b]	Measure Name	Data Collection Method(s)	Data Submission Location[c]
Behavioral Health Care				
394	NCQA	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	Administrative or EHR	QMR System
432	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Survey	AHRQ CAHPS Database[d]
63	NCQA	Antidepressant Medication Management (AMM-AD)	Administrative or EHR	QMR System
672	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Administrative or EHR	QMR System
268	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Administrative	QMR System
202	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Administrative	QMR System
196	NCQA	Diabetes Care for People with Serious Mental Illness: Glycemic Status > 9.0% (HPCMI-AD)[e]	Administrative or hybrid	QMR System
750	SAMHSA	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	Administrative	QMR System
264	NCQA	Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)	Administrative	QMR System

CMIT #[a]	Measure Steward[b]	Measure Name	Data Collection Method(s)	Data Submission Location[c]
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Administrative	QMR System
18[f]	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	Administrative	QMR System

2025 Voluntary Adult Core Set Measures

CMIT #[a]	Measure Steward	Measure Name	Data Collection Method(s)	Data Submission Location[b]
Preventive Care Access and Preventive Care				
118	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, ECDS, or EHR	QMR System
128	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR	QMR System
139	NCQA	Colorectal Cancer Screening (COL-AD)	ECDS or EHR	QMR System
93	NCQA	Breast Cancer Screening (BCS-AD)	ECDS or EHR	QMR System
26	NCQA	Adult Immunization Status (AIS-AD)[g]	ECDS	QMR System
Maternal and Perinatal Health				
581	NCQA	Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD)	Administrative or hybrid	QMR System
166	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative	QMR System
1002	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)	Administrative	QMR System
508	CDC / NCHS	Low-Risk Cesarean Delivery: Age 20 and Older (LCRD-AD)[h]	State vital records	CDC WONDER
1782	NCQA	Prenatal Immunization Status: Age 21 and Older (PRS-AD)[g]	ECDS	QMR System
Care of Acute and Chronic Conditions				
167	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR	QMR System

84	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older (AAB-AD)	Administrative	QMR System
1820	NCQA	Glycemic Status Assessment for Patients with Diabetes (GSD-AD)[i]	Administrative or hybrid	QMR System
577	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative	QMR System
578	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative	QMR System
579	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative	QMR System
580	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative	QMR System
561	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative	QMR System
80	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative	QMR System
325	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR	QMR System
748	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Administrative	QMR System
150	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Administrative	QMR System
Dental and Oral Health Services				
1783	DQA (ADA)	Oral Evaluation During Pregnancy: Ages 21 to 44 (OEVP-AD)[g]	Administrative	QMR System
1784	DQA (ADA)	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-AD)[g]	Administrative	QMR System
Experience of Care				
152[j]	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)[k]	Survey	AHRQ CAHPS Database[d]

Long-Term Services and Supports				
961	NCQA	Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD)	Case management record review	QMR System
457	NASDDDS / HSRI	National Core Indicators Survey (NCIIDD-AD)	Survey	Calculated by CMS using data submitted by states to NASDDDS/ HSRI

2025 Provisional Adult Core Set Measures (Voluntary for 2025 Reporting)

CMIT #[a]	Measure Steward[b]	Measure Name	Data Collection Method(s)	Data Submission Location[c]
1781	NCQA	Postpartum Depression Screening and Follow-Up: Age 21 and Older (PDS-AD)	ECDS	QMR System

AHRQ = Agency for Healthcare Research & Quality; CMIT = CMS Measure Inventory Tool; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; ECDS = Electronic Clinical Data Systems; HRSA = Health Resources and Services Administration; HSRI = Human Services Research Institute; NASDDDS = National Association of State Directors of Developmental Disabilities Services; NCQA = National Committee for Quality Assurance; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance; QMR = Quality Measure Reporting; WONDER = Wide-ranging Online Data for Epidemiologic Research; SAMHSA = Substance Abuse and Mental Health Services Administration.

[a] The CMS Measures Inventory Tool (CMIT) is the repository of record for information about the measures that CMS uses to promote health care quality and quality improvement. More information is available at https://cmit.cms.gov/cmit/. A public access quick start guide for CMIT is available at https://cmit.cms.gov/cmit/assets/CMIT-QuickStartPublicAccess.pdf.

[b] The measure steward is the organization responsible for maintaining a particular measure or measure set. Responsibilities of the measure steward include updating the codes that are tied to technical specifications and adjusting measures as the clinical evidence changes.

[c] The QMR system is available at https://mdctqmr.cms.gov/. CDC WONDER is available at https://wonder.cdc.gov/. The AHRQ CAHPS Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/index.html.

[d] States can also indicate in the QMR system that they conducted the CAHPS survey for the CPA-AD measure. For the MSC-AD measure, states can indicate that they conducted the survey and enter performance rates in the QMR system.

[e] The Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) measure was modified by the measure steward and is now the Diabetes Care for People with Serious Mental Illness: Glycemic Status > 9.0% (HPCMI-AD) measure.

[f] The Adult Core Set includes the NCQA version of this measure, which is adapted from the CMS measure.

[g] This measure was added to the 2025 Adult Core Set.

[h] This measure is calculated by CMS on behalf of states. Starting with the 2025 Core Set, the Low-Risk Cesarean Delivery measure is included in both the Child and Adult Core Sets. For the Child Core Set, the measure is reported for beneficiaries under age 20. For the Adult Core Set, the measure is reported for beneficiaries age 20 and older.

[i] The Hemoglobin A1c Control for Patients With Diabetes (HBD-AD) measure was modified by the measure steward and is now the Glycemic Status Assessment for Patients with Diabetes (GSD-AD) measure.

[j] AHRQ is the measure steward for the survey instrument in the Adult Core Set (CMIT #152) and NCQA is the developer of the survey administration protocol.

[k] CAHPS® is a registered trademark of AHRQ.

II. DATA COLLECTION AND REPORTING OF THE ADULT CORE SET

Mandatory reporting of the behavioral health measures in the 2025 Adult Core Set requires that states adhere to reporting guidance issued by CMS which includes reporting according to the specified age groups.[1] Adherence to the reporting guidance is essential to provide effective comparisons across states on standardized quality measure performance and to derive national performance rates for the care provided to Medicaid and CHIP beneficiaries.

To support consistency in reporting the Adult Core Set measures, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapters III and IV and provide detailed information on how to calculate each measure. For technical assistance with calculating and reporting these measures, contact the TA mailbox at MACQualityTA@cms.hhs.gov.

Refer to Table 1 in Chapter 1 for a list of 2025 Adult Core Set measures, measure acronyms, measure stewards, and data collection methods.

Data Collection and Preparation for Reporting

- **Version of specifications.** This manual includes the most applicable version of the measure specifications provided by the measure stewards to CMS as of December 2024. The 2025 Adult Core Set generally covers services provided during calendar year 2024. For Healthcare Effectiveness Data and Information Set (HEDIS)[2] measures, this manual follows HEDIS measurement year (MY) 2024 specifications. For non-HEDIS measures, the manual includes the most applicable version of the specifications available from the measure steward for reporting 2024 data.
- **Value sets.** Many of the Adult Core Set measure specifications reference value sets that must be used for calculating the measures. A value set is the complete set of codes used to identify a service or condition included in a measure.
  - The HEDIS Adult Core Set value sets and Value Set Directory User Manual are available at https://store.ncqa.org/hedis-2025-adult-core-set-value-set-directory-my-2024.html. HEDIS value set references are underlined in the specifications (e.g., Major Depression Value Set).
  - Value sets for the CCP-AD, CCW-AD, CDF-AD, EDV-AD, HVL-AD, OEVP-AD, OUD-AD, PQI01-AD, PQI05-AD, PQI08-AD, and PQI15-AD measures are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.
  - The value set for the COB-AD and OHD-AD measures, as well as the National Drug Codes (NDCs) for opioid medications, is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.

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[1] Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting final rule: https://www.federalregister.gov/d/2023-18669. 2025 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24001.pdf.

[2] For 2025, all Adult Core Set measures with NCQA as the measure steward are HEDIS measures, with the exception of HPCMI-AD, which is NCQA-owned and copyrighted but not currently contained in HEDIS.

  - Value sets for electronic specifications are available from the U.S. National Library of Medicine Value Set Authority Center (VSAC), located at https://vsac.nlm.nih.gov. To download value sets the VSAC requires a Unified Medical Language System (UMLS) license; states may apply for a free UMLS license at https://www.nlm.nih.gov/databases/umls.html. When searching for value sets for a measure, states should use the measure's associated electronic specification number. To report on the 2025 Adult Core Set measures, use the version of the value sets associated with the May 2023 release. This applies to the following Adult Core Set measures that have electronic specifications: AMM-AD, BCS-AD, CBP-AD, CCS-AD, CDF-AD, CHL-AD, COL-AD, HVL-AD, and IET-AD.

- **Medication lists.** Several HEDIS measures in the Adult Core Set reference medication lists, which are a list of codes and medications used to identify dispensed medications. The Medication List Directory is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html/). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). This applies to the following Adult Core Set measures: AAB-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CHL-AD, COL-AD, FUA-AD, GSD-AD, HPCMI-AD, IET-AD, SAA-AD, and SSD-AD.
- **Data collection time frames for measures.** States must adhere to the measurement periods identified in the technical specifications for each measure. Some measures are collected on a calendar year basis, whereas others are indexed to a specific date or event, such as a hospital discharge for a mental health condition. When the option is not specified, data collection time frames should align with the calendar year prior to the reporting year; for example, calendar year 2024 data should be reported for the 2025 Core Set. For many measures, the denominator measurement period for the 2025 Core Set corresponds to calendar year 2024 (January 1, 2024–December 31, 2024).

  Some measures also require states to review utilization or enrollment prior to this period. Further information about measurement periods for the 2025 Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-core-set-measurement-periods.pdf.
- **Continuous enrollment.** Continuous enrollment specifies the minimum amount of time that a beneficiary must be enrolled before becoming eligible for a measure. It ensures that the state has enough time to render services during the measurement period. The continuous enrollment period and allowable gaps are specified in each measure. To be considered continuously enrolled, a beneficiary must also be continuously enrolled with the benefit specified for each measure (e.g., pharmacy or mental health), accounting for any allowable gap (see next bullet). For the purpose of Core Set reporting, states should combine data across programs (e.g., Medicaid and CHIP), delivery systems (e.g., managed care and fee-for-service), and managed care plans when analyzing continuous enrollment for a beneficiary. A beneficiary who switches between Medicaid and CHIP programs, delivery systems, or managed care plans should be included in a measure as long as they meet the continuous enrollment criteria at the state-level. For example, a beneficiary might switch between managed care plans; these beneficiaries should be included in the numerator and denominator for the measure as long as the beneficiary is continuously enrolled in Medicaid or CHIP for the period specified in the measure (even if they are not continuously enrolled in a single plan).

- **Allowable gap.** Some measures specify an allowable gap that can occur any time during continuous enrollment. For example, the CBP-AD measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in Medicaid and CHIP enrollment of up to 45 days. Thus, a beneficiary who enrolls for the first time on February 8 of the measurement year is considered continuously enrolled as long as there are no other gaps in enrollment throughout the remainder of the measurement year, because this beneficiary has one 38-day gap (January 1–February 7). A beneficiary who switches between Medicaid and CHIP programs, delivery systems, or managed care plans should be included in a measure as long as there is no gap in Medicaid or CHIP coverage that exceeds the allowable gap specified in the measure.
- **Retroactive eligibility.** This refers to the elapsed time between the actual date when Medicaid or CHIP became financially responsible for a beneficiary and the date when it received notification of the new beneficiary's eligibility. For measures with a continuous enrollment requirement, beneficiaries may be excluded if the retroactive eligibility exceeds the allowable gap requirement. This guideline must be used consistently across all measures.
- **Anchor date.** Some measures include an anchor date, which is the date that an individual must be enrolled in Medicaid or CHIP and have the required benefit to be eligible for the measure. For example, if an enrollment gap includes the anchor date, the individual is not eligible for the measure. For several measures, the anchor date is the last day of the measure's 2025 Core Set measurement period (December 31, 2024). For other measures, the anchor date is based on a specific event, such as a birthdate or a delivery date. States should use the specified anchor dates along with the continuous enrollment requirements and allowable gaps for each measure to determine the measure-eligible population.

  Anchor dates can also be used to attribute Medicaid and separate CHIP beneficiaries to a program. More information about using the anchor date for each measure to attribute beneficiaries for separate Medicaid and separate CHIP reporting is available in a TA resource: https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-medicaid-chip-attribution.pdf.
- **Date specificity.** A date must be specific enough to determine that an event occurred during the time frame specified in the measure. There are instances when documentation of the year alone is adequate; for example, most exclusions and measures that look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent," or "at a prior visit" are not acceptable. For documented history of an event (e.g., documented history of a disease), undated documentation may be used if it is specific enough to determine that the event occurred during the time frame specified in the measure. For example, for the BCS-AD measure, undated documentation on a problem list stating "bilateral mastectomy in 1999" is specific enough to determine that this exclusion occurred prior to December 31 of the measurement year.
- **Reporting unit.** CMS defines the reporting unit for each measure as each state's Medicaid and CHIP program. This means that states should collect data across all of the health care delivery systems used in their state Medicaid and CHIP programs (for example, fee-for-service [FFS], primary care case management [PCCM], and managed care [MC]). States are asked to include CHIP beneficiaries in their calculations; see bullet directly below. If data are collected separately across a state's delivery systems or across a state's managed care plans, states should aggregate data from all these sources into a state-level Medicaid rate and a state-level separate CHIP rate (for states with a separate CHIP that

report the CHIP population for the Adult Core Set) before reporting the data to CMS. As part of this process, the state should also assess the continuous eligibility of individuals that do not meet continuous eligibility for a single program, delivery system, or managed care plan, but meet continuous eligibility requirements for Medicaid or CHIP at the state-level. For more guidance about developing state-level rates, see the bullet on "aggregating information for state-level reporting" below.

- **Eligible population for measurement.** For all measures, denominators must include all Medicaid and CHIP beneficiaries who satisfy all specified criteria (including age, continuous enrollment, benefit, event, and anchor date enrollment requirements). The eligible Medicaid and CHIP population should include Title XIX and Title XXI populations, but not populations funded only by states. States should include any special populations (e.g., waiver enrollees) covered by Medicaid or CHIP in the state. In addition, states should include beneficiaries who moved in or out of a program (Medicaid or CHIP), who were enrolled in more than one managed care plan, or who changed delivery systems (fee-for-service, managed care, primary care case management) during the measurement period. For each reporting year, CMS will issue sub-regulatory guidance with any exceptions to reporting all populations. States may request a 1-year exemption from reporting a specific population for one or more Adult Core Set measures following the guidance included in the 2025 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance State Health Official (SHO) Letter.[3] States interested in requesting an exemption from 2025 Core Set reporting must submit a request letter to CMS by September 1, 2025.
- **Beneficiaries with partial benefits.** For each measure, states should include only the beneficiaries who are eligible to receive the services assessed in the numerator. If a beneficiary is not eligible to receive the services assessed in the measure, the beneficiary should not be included in the denominator for the measure. For example, some states may only cover pregnancy-related services for beneficiaries enrolled in the "from conception to end of pregnancy" population in separate CHIP. These states will need to determine if the individuals in this program are eligible to receive the services assessed in the measure to determine whether the individuals are eligible for each measure. The technical specifications for some measures have guidance regarding which benefits an individual must be eligible for to be included, but each state should assess the specific benefit packages of the beneficiaries in their state.
- **Aggregating information for state-level reporting.** To obtain state-level Medicaid and CHIP rates for a measure that is developed from the rates of multiple reporting units (such as multiple managed care plans, across managed care and FFS delivery systems, or for individuals who switch between plans or delivery systems), the state should calculate a weighted average of the individual rates. How much any one entity (for example, individual plans) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that reporting units with larger eligible populations will contribute more toward the rate than those with smaller eligible populations. Hybrid and administrative data from different sources can be combined to develop a state/program-level rate as long as the specifications allow the use of both data sources to construct the

[3] 2025 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24001.pdf.

measure. For additional guidance on developing state- or program-level rates, refer to the TA Brief titled "Calculating State-Level Rates Using Data from Multiple Reporting Units."[4]

- For 2025 Adult Core Set reporting, reporting CHIP populations is encouraged but not mandatory. States reporting separate CHIP must report rates separately for separate CHIP (Title XXI) and Medicaid inclusive of CHIP-funded Medicaid expansion (Titles XIX and XXI).

- **Reporting stratified data.** Reporting stratified results for Core Set measures is a priority for CMS as it supports CMS's goal of advancing health equity. Starting with 2025 Core Set reporting, states are required to report stratified data for a subset of measures identified by CMS and encouraged to report stratified data for the remaining measures.[5] For 2025 reporting, the Adult Core Set measures subject to stratified reporting requirements include:

  - Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)
  - Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)
  - Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)

  States are required to stratify measures by the following categories.

  - Race and ethnicity. For 2025 Core Set Reporting, states can stratify race and ethnicity using one of two federal standards:
    - 2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15 (Directive No. 15): Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity[6], OR
    - The disaggregation of the 1997 Office of Management and Budget (OMB) minimum race and ethnicity categories[7], as specified in the 2011 HHS standards[8]
  - Sex, defined as biologic sex, using the 2011 HHS standards;
  - Geography, using a minimum standard of core-based statistical area (CBSA)[9] with recommendation to move towards Rural-Urban Commuting Area Codes.[10]

  More information about the stratification categories and guidance on reporting them to CMS is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/QMR-stratification-resource.pdf.

[4] The TA Brief, "Calculating State-Level Rates Using Data from Multiple Reporting Units," is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf.

[5] Requirements for stratified reporting can be found in the 2025 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance: https://www.medicaid.gov/federal-policy-guidance/downloads/sho24001.pdf.

[6] https://www.govinfo.gov/content/pkg/FR-2024-03-29/pdf/2024-06469.pdf.

[7] https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf.

[8] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/43681/index.pdf.

[9] https://www.census.gov/geographies/reference-maps/2020/geo/cbsa.html.

[10] https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/.

- **Reporting a weighted rate.** When a state develops a weighted rate combining data across multiple reporting units, the information entered in the numerator and denominator fields will vary depending on the method used to calculate a state-level rate:
  - If a state-level rate is calculated using only administrative method data, EHR data, or ECDS data, states should enter the numerator and denominator totals in the Numerator and Denominator fields.
  - If a state-level rate is calculated using only hybrid method data, states should enter the total size of the sample used to calculate the measure across reporting units in the Denominator field and sum the numerators for each reporting unit in the Numerator field. The state should also report the total measure-eligible population represented in the data because this information will be used by CMS to create a state-level rate for states that report separate Medicaid and CHIP rates.
  - If the state-level rate is calculated using a combination of administrative and hybrid method data, states should enter the total measure-eligible population in the Denominator field to denote that denominators are a mix of sample sizes and measure-eligible populations and enter 0 in the Numerator field. In the "Data Sources" section, the state should identify the number of reporting units that used each method (administrative and hybrid). The state should also report the total measure-eligible population represented in the data because this information will be used by CMS to create a state-level rate for states that report separate Medicaid and CHIP rates.
- **Age criteria.** The age criteria vary by measure. If a denominator for a measure specifies an age range beyond that eligible for a state's Medicaid and CHIP programs, the state should include only the ages eligible for the program in the denominator.
- **Exclusions.** Some measure specifications contain required exclusions. A beneficiary who meets required exclusion criteria should be removed from the measure denominator.
- **Supplemental data.** Supplemental data are data other than claims and encounters and medical record data abstracted for hybrid reporting used by organizations to collect information about delivery of health services to their beneficiaries. Examples of supplemental data include immunization registries or case management program data.
- **Hospice exclusion.** Selected HEDIS measures in the Adult Core Set include a required hospice exclusion: AAB-AD, AIS-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CCS-AD, CHL-AD, COL-AD, FUA-AD, FUH-AD, FUM-AD, GSD-AD, HPCMI-AD, IET-AD, PCR-AD, PDS-AD, PPC2-AD, PRS-AD, SAA-AD, and SSD-AD. For these measures, states should exclude beneficiaries who use hospice services or elect to use a hospice benefit any time during the measurement period, regardless of when the services began. These beneficiaries may be identified using various methods, which may include but are not limited to, enrollment data, medical record, or claims/encounter data (Hospice Encounter Value Set; Hospice Intervention Value Set), or supplemental data for this required exclusion.

  States should remove these beneficiaries as they determine the measure's eligible population. For hybrid measures, states should remove beneficiaries prior to drawing the sample. If a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed as a valid data error from the sample and replaced by a beneficiary from the oversample. Documentation that a beneficiary is near the end of life (e.g., comfort care, Do Not Resuscitate [DNR], Do Not Intubate [DNI]), or is in palliative care does not meet criteria for the hospice exclusion.)

Supplemental data (see definition above) can be used for the hospice exclusion for all applicable measures, including measures that say “supplemental data may not be used for the measure” (e.g., PCR-AD).

In addition, two PQA measures (COB-AD and OHD-AD) include a hospice exclusion, as defined within the technical specifications for those measures.

- **Deceased beneficiaries exclusion.** Selected HEDIS measures in the Adult Core Set include a deceased beneficiary exclusion: AAB-AD, AIS-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CCS-AD, CHL-AD, COL-AD, CPA-AD, FUA-AD, FUH-AD, FUM-AD, GSD-AD, HPCMI-AD, IET-AD, MSC-AD, PDS-AD, PPC2-AD, PRS-AD, SAA-AD, and SSD-AD. For these measures, beneficiaries who die any time during the measurement period should be excluded consistently from the HEDIS measures listed above. These beneficiaries may be identified using various methods that include, but are not limited to, enrollment data, medical record review, claims/encounter data or supplemental data for this required exclusion.

  States should attempt to remove these beneficiaries prior to determining a measure’s eligible population and drawing the sample for hybrid measures. A deceased beneficiary found during medical record review is removed as a valid data error from the sample and replaced by a beneficiary from the oversample.

  Supplemental data (see definition above) can be used for excluding deceased beneficiaries for all applicable measures, including measures that say “supplemental data may not be used for the measure” (e.g., AAB-AD, PCR-AD).

  This is a beneficiary-level exclusion. For episode-based measures, remove all beneficiary events/episodes from the measure.

- **Telehealth.** HEDIS measures consider synchronous telehealth visits, telephone visits, and asynchronous telehealth (e-visits, virtual check-ins) as separate modalities.
  - Synchronous telehealth requires real-time interactive audio and video telecommunications. A HEDIS measure specification that is silent about telehealth includes synchronous telehealth. This is because telehealth is billed using standard CPT and HCPCS codes for professional services in conjunction with a telehealth modifier and/or a telehealth POS code. Therefore, the CPT or HCPCS code in the value set will meet criteria (regardless of whether a telehealth modifier or POS code is present). A HEDIS measure specification will indicate when synchronous telehealth is not eligible for use and should be excluded.
  - A HEDIS measure specification will indicate when telephone visits are eligible for use by referencing the Telephone Visits Value Set.
  - Asynchronous telehealth, sometimes referred to as an e-visit or virtual check-in, is not "real-time" but still requires two-way interaction between the beneficiary and the provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging, or email. A HEDIS measure specification will indicate when asynchronous telehealth visits are eligible for use by referencing the Online Assessments Value Set.
  - Non-HEDIS measures will specify whether telehealth is allowed and what type of telehealth is included, if applicable.

- **Representativeness of data.** States should use the most complete data available and ensure that the rates reported are representative of the entire population enrolled in their Medicaid program (including individuals simultaneously enrolled in Medicare and Medicaid,

also known as dually eligible beneficiaries, where applicable) and, for maternity measures, CHIP-enrolled beneficiaries who satisfy the measure-specific eligibility criteria. This includes Medicaid and CHIP beneficiaries enrolled in all delivery systems as well as services received in all applicable health care settings (such as hospitals, outpatient settings, federally qualified health centers, rural health centers, and Indian Health Services or Tribal or Urban Indian Health Program facility). For a measure based on administrative data, all beneficiaries who meet the eligible population requirements for the measure should be included in the denominator. For a measure based on a sampling methodology, states should ensure that the sample used to calculate the measure is representative of the entire eligible population for the measure.

- **Data collection methods.** The measures in the Adult Core Set have six possible data collection methods: administrative, hybrid, survey, case management record review, electronic health record (EHR, also referred to as the electronic specification method), and Electronic Clinical Data Systems (ECDS). Each measure specifies the data collection method(s) that can be used. If a measure includes a choice of methods, any of the listed methods may be used.
  - The administrative method uses transaction data (such as claims and encounters) or other administrative data sources (such as vital records and registries) to calculate the measure. These data can be used in cases in which the data are known to be complete, valid, and reliable. When only administrative data are used, the entire eligible population is included in the denominator.
  - The hybrid method uses both administrative data sources and medical record data to determine numerator compliance. Administrative data are reviewed to determine if beneficiaries in the systematic sample received the service, and medical record data are reviewed for beneficiaries who do not meet the numerator criteria through administrative data. The denominator consists of a systematic sample of beneficiaries drawn from the measure's eligible population. The hybrid method, when available, should be used when administrative data and EHR data are incomplete or may be of poor quality, or the data elements for the measure are not captured in administrative data (e.g., the CBP-AD measure).
  - The survey method uses data collected through a survey to calculate the measure. This data collection method applies to the following measures in the Adult Core Set: CPA-AD, MSC-AD, and NCIIDD-AD.
  - The case management record review method is based on a review of case management records from a systematic sample drawn from the eligible population of beneficiaries receiving long-term services and supports. This data collection method applies to the CPU-AD measure in the Adult Core Set.
  - The electronic specification method uses EHR data to calculate the measure. A link to the electronic specifications is included in the following measure specifications: AMM-AD, BCS-AD, CBP-AD, CCS-AD, CDF-AD, CHL-AD, COL-AD, GSD-AD, HVL-AD, and IET-AD. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system.
  - The Electronic Clinical Data Systems (ECDS) method uses multiple data sources to provide complete information about the quality of health services delivered. Data systems that are eligible for HEDIS ECDS reporting include, but are not limited to, beneficiary eligibility files, electronic health records (EHRs), personal health records (PHRs), clinical registries, health information exchanges (HIEs), administrative claims

systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries. Further information on the ECDS method can be found in the Guidelines for Measures Reported Using ECDS (Chapter IV). This data collection method applies to the following measures in the Adult Core Set: AIS-AD, BCS-AD, CCS-AD, COL-AD, PDS-AD, and PRS-AD.

- **Sampling.** For measures that use the hybrid method, sampling guidance is included in the technical specification if available from the measure steward. Sampling should be systematic to ensure that all eligible individuals have an equal chance of inclusion.
  - For HEDIS measures that use the hybrid method, the sample size should be 411 for each reported program (e.g., Medicaid and CHIP), unless special circumstances apply. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix A, Guidance for Selecting Sample Sizes for Hybrid Measures.
  - For the CAHPS survey, refer to Appendix C for information on sampling.
  - For the NCI-IDD survey, refer to Appendix E for information on sampling.
- **Small numbers.** CMS encourages states to report data in the QMR system for measures and rates with small cell sizes. These data will be suppressed for state-level public reporting in accordance with the CMS cell-size suppression policy, which prohibits the direct reporting of beneficiary and record counts of 1 to 10 and values from which users can derive values of 1 to 10.[11] Furthermore, CMS will suppress rates with a denominator less than 30 due to reliability concerns. If a measure has a denominator that is less than 30 (for all measures except the CPA-AD, MSC-AD, and PCR-AD measures), or a denominator less than 100 (for CPA-AD and MSC-AD), or a Count of Index Hospital Stays less than 150 (for PCR-AD) and the state chooses not to report the measure due to the small numbers criterion, please note this in the question that asks "Why are you not reporting on this measure?" and specify the denominator size. The denominator for the Plan All-Cause Readmissions measure is the Count of Index Hospital Stays among non-outlier members. Outliers should not be considered.
- **Risk adjustment.** One measure in the Adult Core Set, PCR-AD, requires risk adjustment. Risk adjustment guidelines are included in the specification for the measure.
- **Inclusion of paid, suspended, pending, and denied claims.** A key aspect in the assessment of quality for some measures is to capture whether or not a service was provided. For some measures, the Guidance for Reporting within each measure's technical specification indicates which claims (paid, suspended, pending, and/or denied) should be included. This applies to the following measures: AAB-AD, AIS-AD, AMM-AD, AMR-AD, BCS-AD, CBP-AD, CCP-AD, CCS-AD, CCW-AD, CDF-AD, CHL-AD, COB-AD, COL-AD, EDV-AD, FUA-AD, FUH-AD, FUM-AD, GSD-AD, HPCMI-AD, HVL-AD, IET-AD, OEVP-AD, OHD-AD, PDS-AD, PCR-AD, PPC2-AD, PRS-AD, PQI01-AD, PQI05-AD, PQI08-AD, PQI15-AD, SAA-AD, and SSD-AD.

[11] CMS Cell Suppression Policy: https://www.hhs.gov/guidance/document/cms-cell-suppression-policy.

- **ICD-9/ICD-10 conversion.** In compliance with the CMS mandate to use ICD-10 codes for services provided on or after October 1, 2015, measures should be calculated using ICD-10 codes for claims with a date of service or date of discharge on or after October 1, 2015. ICD-10 codes are available in the specification or in the corresponding Value Set Directory (see above). ICD-9-CM and ICD-9-PCS codes are still included in measures where the lookback period plus one year prior includes services before October 1, 2015. ICD-9 codes are still relevant to the following measures: AAB-AD, AMR-AD, BCS-AD, CBP-AD, CCS-AD, COL-AD, PCR-AD, and SAA-AD.

Visits that result in an inpatient stay. Some HEDIS measures in the Adult Core Set require exclusion of visits that result in an inpatient stay or observation stay. A visit results in a stay when the visit date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). This applies to the following Adult Core Set measures: AAB-AD, FUA-AD, FUM-AD, and IET-AD.

Reporting and Submission

Procedures for reporting the Adult Core Set measures are provided below.

- **Submission deadline.** The deadline for submitting final data on the 2025 Adult Core Set measures is December 31, 2025. States can update data submitted after the submission deadline; however, updates made after the deadline are not guaranteed to be used in the development of reports by CMS and performance rates on https://data.medicaid.gov, on the Medicaid & CHIP Scorecard, or in the Medicaid & CHIP State Profiles. States should submit data that are as complete as possible by the submission deadline. In addition, states will submit CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Health Plan Survey Database during the 2025 Database submission period in June 2025 for all measures that use the CAHPS survey. Data that are submitted after the submission deadline will not be included in Core Set public reporting for 2025.[12]
- **Completing fields.** Specific fields are applicable to each measure. States should complete each applicable field for each measure submitted to ensure consistent and accurate reporting and comparability across states. States are encouraged to document the methods used to calculate the measures in order to improve CMS's understanding of variations across states.
- **Reasons for not reporting a measure.** Reporting all of the behavioral health measures in the Adult Core Set is mandatory for states beginning with the 2024 Core Set. CMS recognizes that there may be unique circumstances where a state is unable to report a measure. If a state is unable to report a measure, the state should note that in the QMR system in addition to sending an email to the TA mailbox (MACQualityTA@cms.hhs.gov) explaining why the state cannot report the measure. This information will help CMS to understand why a state may not be reporting on a specific measure and to design technical assistance to help them with reporting.
- **Noting variations from measure technical specifications.** As per the Core Set final rule, CMS expects states to report measures adhering to the methods provided in the specifications. However, there may be unique circumstances where this is not possible. In those circumstances, states should provide additional information and context about the rates reported. Examples of variations include eligible population definitions that differ from

[12] More information about the AHRQ CAHPS Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/index.html.

the specifications (age ranges, codes for identifying the population, or missing population segments); differences in data sources used; differences in codes used (added, excluded, or substituted codes); differences in the version used; issues encountered in calculating the measure; and caveats not specified elsewhere. States that have questions about the technical specifications (such as data sources, code sets, or methodologies for identifying numerators and denominators) should contact CMS through the TA mailbox at MACQualityTA@cms.hhs.gov.

- **Inclusion of all measure-eligible beneficiaries in state reporting.** In the Core Set final rule, CMS specified that mandatory reporting requirements for the Adult Core Set require states to ensure that all measure-eligible Medicaid beneficiaries are included in state reporting.[13] This includes beneficiaries who moved in or out of a program (Medicaid or CHIP), who were enrolled in more than one managed care plan, or who changed delivery systems (fee-for-service, managed care, primary care case management) during the measurement period. States must ensure that each eligible beneficiary is included in the measure calculation and there is no duplication or double-counting. For each measure, states should assess enrollment and claims data (or other data sources) to determine measure eligibility for the denominator, and calculate numerator compliance. CMS will provide additional technical assistance to states on ensuring that all measure-eligible beneficiaries are included in state reporting. States can also contact the TA mailbox at MACQualityTA@cms.hhs.gov.
- **Reporting separate rates for Medicaid and CHIP populations.** Reporting of the Adult Core Set measures is voluntary but encouraged for CHIP programs. For each Adult Core Set measure reported to CMS that includes the CHIP population, states should calculate and report separate rates for the Medicaid population (inclusive of CHIP-funded Medicaid expansion) and the separate CHIP population (for states with a separate CHIP). States must ensure that each measure-eligible Medicaid and CHIP beneficiary is included in the measure calculation, and attributed to the appropriate program based on the measure eligibility criteria, and that there is no duplication or double-counting. These rates will be reported separately in the reporting system and used to create a combined state-level rate.[14] Any populations excluded from the denominator should be noted in the "Definition of Population Included in Measure" section of the online reporting system. Additional guidance to states on applying attribution guidance for calculation of separate rates for Medicaid and CHIP populations is available in a technical assistance resource.[15] States can also contact the TA mailbox at MACQualityTA@cms.hhs.gov.
- **Data auditing.** For 2025, CMS will not require certification or auditing of HEDIS or other measures. However, states are encouraged to do so when possible. For example, if there are state mechanisms for accreditation, certification, and managed care external quality review, or if the state validates its Adult Core Set rates through another process, states should describe these processes in the applicable fields in the state-level Core Set Questions in the online reporting system.

[13] Reporting of the Adult Core Set measures is voluntary but encouraged for CHIP programs.

[14] A technical assistance resource on reporting Medicaid and Separate CHIP data in the QMR system is available at https://www.medicaid.gov/quality-of-care/downloads/QMRCoreSetCombinedRates.pdf.

[15] A technical assistance resource with measure-specific attribution guidance is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-medicaid-chip-attribution.pdf.

Technical Assistance

To help states collect, report, and use the Adult Core Set measures, CMS offers technical assistance. Please submit technical assistance requests about the Adult Core Set measures to MACQualityTA@cms.hhs.gov.[16]

For access instructions or technical questions regarding use of the Quality Measures Reporting (QMR) application, please reach out to MDCT_Help@cms.hhs.gov.

For states needing further resources for integrating Medicare and Medicaid data for Medicare-Medicaid Dual-Eligible beneficiaries, please go to https://www.cms.gov/data-research/research/statistical-resources-dually-eligible-beneficiaries/state-access-medicare-data. States can obtain forms to request data as well as gather information on webinars and other helpful resources for integrating Medicare and Medicaid data.

[16] States with technical questions about the Child Core Set or the Health Homes Core Set should also contact MACQualityTA@cms.hhs.gov.

III. TECHNICAL SPECIFICATIONS

This chapter presents the technical specifications for each measure in the Adult Core Set with specifications for the administrative, hybrid, EHR, or survey methodology. Each specification includes a description of the measure and information about the eligible population, key definitions, data collection method(s), instructions for calculating the measure, and any other relevant measure information.

Adult Core Set measures with specifications for the Electronic Clinical Data Systems (ECDS) methodology are included in Chapter IV.

For 2025 Adult Core Set reporting, the CCS-AD measure includes ECDS specifications as well as administrative and hybrid specifications. The administrative and hybrid specifications for this measure are included in Chapter III and the ECDS specifications are included in Chapter IV.

These specifications represent the most applicable version available from the measure steward as of December 2024.

MEASURE AAB-AD: AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS/BRONCHIOLITIS: AGE 18 AND OLDER

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of episodes for beneficiaries age 18 and older with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event.

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: ages 3 months to 17 years, ages 18 to 64, age 65 and older, and total (ages 3 months and older). The Child Core Set measure applies to beneficiaries ages 3 months to 17 years and the Adult Core Set measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, and denied claims. Denied claims should be used to identify the eligible population, but cannot be used to identify numerator events.
- Supplemental data may not be used for this measure, except for required exclusions.
- The measure is reported as an inverted rate (see Section E. Calculation below).
- NCQA's Medication List Directory (MLD) is available free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-9-CM, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	July 1 of the year prior to the measurement year to June 30 of the measurement year. The intake period captures eligible episodes of treatment.
Episode date	The date of service for any outpatient, telephone, observation or ED visit, e-visit, or virtual check-in during the intake period with a diagnosis of acute bronchitis/bronchiolitis.

Negative medication history	To qualify for negative medication history, the following criteria must be met: • A period of 30 days prior to the episode date, when the beneficiary had no pharmacy claims for either new or refill prescriptions for a listed antibiotic drug. • No prescriptions were dispensed more than 30 days prior to the episode date and are active on the episode date. A prescription is considered active if the "days supply" indicated on the date when the beneficiary was dispensed the prescription is the number of days or more between the date and the relevant service date. The 30-day look-back period for pharmacy data includes the 30 days prior to the intake period.
Negative comorbid condition history	A period of 365 days prior to and including the episode date, when the beneficiary had no claims/encounters with any diagnosis for a comorbid condition (366 days total).
Negative competing diagnosis	The episode date and 3 days following the episode date when the beneficiary had no claims/encounters with any competing diagnosis.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of the episode date.
Continuous enrollment	30 days prior to the episode date through three days after the episode date (34 total days).
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	None.
Benefits	Medical and pharmacy.
Event/ diagnosis	Follow the steps below to identify the eligible population: Step 1: Identify beneficiaries with a visit with a diagnosis of acute bronchitis/bronchiolitis. Identify all beneficiaries who had an outpatient visit, ED visit, observation visit, telephone visit, e-visit, or virtual check-in (Outpatient, ED and Telehealth Value Set) during the intake period, with a diagnosis of acute bronchitis/bronchiolitis (Acute Bronchitis Value Set). Step 2: Determine all acute bronchitis/bronchiolitis episode dates. For each beneficiary identified in step 1, determine all outpatient, telephone, observation or ED visits, e-visits and virtual check-ins with a diagnosis of acute bronchitis/bronchiolitis. Exclude visits that result in an inpatient stay (Inpatient Stay Value Set).

Event/ diagnosis (continued)	Step 3: Test for negative comorbid condition history. Remove episode dates when the beneficiary had a claim/encounter with any diagnosis for a comorbid condition (Comorbid Conditions Value Set) during the 365 days prior to or on the episode date. Do not include laboratory claims (claims with POS code 81). Step 4: Test for negative medication history. Remove episode dates where a new or refill prescription for an antibiotic medication (AAB Antibiotic Medications List, see link to the Medication List Directory in Guidance for Reporting above) was dispensed 30 days prior to the episode date or was active on the episode date. Step 5: Test for negative competing diagnosis. Remove episode dates where the beneficiary had a claim/encounter with a competing diagnosis on or 3 days after the episode date. Either of the following meets criteria for a competing diagnosis. Do not include laboratory claims (claims with POS code 81). • Pharyngitis Value Set. • Competing Diagnosis Value Set. Step 6: Calculate continuous enrollment. The beneficiary must be continuously enrolled without a gap in coverage from 30 days prior to the episode date through 3 days after the episode date (34 total days). Step 7: Deduplicate eligible episodes. If a beneficiary has more than one eligible episode in a 31-day period, include only the first eligible episode. For example, if a beneficiary has an eligible episode on January 1, include the January 1 visits and do not include eligible episodes that occur on or between January 2 and January 31; then, if applicable, include the next eligible episode that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: The denominator for this measure is based on episodes, not on beneficiaries. All eligible episodes that were not removed or deduplicated remain in the denominator.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Dispensed prescription for an antibiotic medication (AAB Antibiotic Medications List, see link to the Medication List Directory in Guidance for Reporting above) on or three days after the episode date.

E. CALCULATION

The measure is reported as an inverted rate [1 – (numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (e.g., the proportion for episodes that did not result in an antibiotic dispensing event).

MEASURE AMM-AD: ANTIDEPRESSANT MEDICATION MANAGEMENT

National Committee for Quality Assurance

A. DESCRIPTION

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

- **Effective Acute Phase Treatment.** Percentage of beneficiaries who remained on an antidepressant medication for at least 84 days (12 weeks).
- **Effective Continuation Phase Treatment.** Percentage of beneficiaries who remained on an antidepressant medication for at least 180 days (6 months).

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- For HEDIS, this measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report the two rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) is available free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic clinical quality measure (eCQM) specification for the 2025 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2024/cms128v12. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative specification. States should use caution comparing measures calculated using different data collection methods.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	May 1 of the year prior to the measurement year to April 30 of the measurement year.

Index Prescription Start Date (IPSD)	The earliest prescription dispensing date for an antidepressant medication where the date is in the intake period and there is a negative medication history.
Negative medication history	A period of 105 days prior to the IPSD when the beneficiary had no pharmacy claims for either new or refill prescriptions for an antidepressant medication.
Treatment days	The actual number of calendar days covered with prescriptions within the specified measurement interval. For Effective Continuation Phase Treatment, a prescription of 90 days (3 months) supply dispensed on the 151st day will have 82 days counted in the 232-day interval.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of the IPSD.
Continuous enrollment	105 days prior to the IPSD through 231 days after the IPSD.
Allowable gap	One gap in enrollment of up to 45 days. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	IPSD.
Benefits	Medical and pharmacy.

Event/ diagnosis	Follow the steps below to identify the eligible population, which is used for both rates. Step 1: Determine the IPSD. Identify the date of the earliest dispensing event for an antidepressant medication (Antidepressant Medications List, see link to the Medication List Directory in Guidance for Reporting above) during the Intake Period. Step 2: Required exclusions. Exclude beneficiaries who did not have an encounter with a diagnosis of major depression during the 121-day period from 60 days prior to the IPSD, through the IPSD and the 60 days after the IPSD. Beneficiaries who meet any of the following criteria remain in the eligible population: • An acute or nonacute inpatient stay with any diagnosis of major depression (Major Depression Value Set) on the discharge claim. To identify acute and nonacute inpatient stays: - Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). - Identify the admission and discharge dates for the stay. Either an admission or discharge during the required time frame meets criteria. • An acute inpatient encounter with any diagnosis of major depression: Acute Inpatient Value Set with Major Depression Value Set. • A nonacute inpatient encounter with any diagnosis of major depression: Nonacute Inpatient Value Set with Major Depression Value Set. • An outpatient visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Outpatient POS Value Set with Major Depression Value Set. • An outpatient visit with any diagnosis of major depression: BH Outpatient Value Set with Major Depression Value Set. • An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Visit Setting Unspecified Value Set with POS code 52 with Major Depression Value Set. • An intensive outpatient encounter or partial hospitalization with any diagnosis of major depression: Partial Hospitalization or Intensive Outpatient Value Set with Major Depression Value Set. • A community mental health center visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with POS code 53 with Major Depression Value Set. • Electroconvulsive therapy with any diagnosis of major depression: Electroconvulsive Therapy Value Set with Major Depression Value Set.

Event/ diagnosis (continued)	• A transcranial magnetic stimulation visit with any diagnosis of major depression: Transcranial Magnetic Stimulation Value Set with Major Depression Value Set. • A telehealth visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with Telehealth POS Value Set with Major Depression Value Set. • An ED visit (ED Value Set) with any diagnosis of major depression (Major Depression Value Set). • An ED visit with any diagnosis of major depression: Visit Setting Unspecified Value Set with POS code 23 with Major Depression Value Set. • A telephone visit (Telephone Visits Value Set) with any diagnosis of major depression (Major Depression Value Set). • An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of major depression (Major Depression Value Set). Step 3: Test for negative medication history. Remove beneficiaries who filled a prescription for an antidepressant medication 105 days prior to the IPSD. Step 4: Calculate continuous enrollment. Beneficiaries must be continuously enrolled for 105 days prior to the IPSD to 231 days after the IPSD.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet any of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Effective Acute Phase Treatment

At least 84 days of treatment with antidepressant medication (Antidepressant Medications List, see link to the Medication List Directory in Guidance for Reporting above) beginning on the 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 of treatment with antidepressant medication (Antidepressant Medications List, see link to the Medication List Directory in Guidance for Reporting above), 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.

E. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the period specified.

MEASURE AMR-AD: ASTHMA MEDICATION RATIO: AGES 19 TO 64

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of beneficiaries ages 19 to 64 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.

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has four reportable age groups and a total rate: ages 5 to 11, ages 12 to 18, ages 19 to 50, ages 51 to 64, and total (ages 5 to 64). The Child Core Set measure applies to beneficiaries ages 5 to 18 and the Adult Core Set measure applies to beneficiaries ages 19 to 64. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups and a total rate: ages 19 to 50, ages 51 to 64, and a total rate (ages 19 to 64).
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- RxNorm codes cannot be used to assess the numerator.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-10-CM, SNOMED, and UB. The Medication List Directory includes the following coding for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Oral medication dispensing event	One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events (100/30 = 3.33, rounded down to 3). Allocate the dispensing events to the appropriate year based on the date when the prescription is dispensed. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, sum the days supply and divide by 30. Use the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.
Inhaler dispensing event	When identifying the eligible population, use the definition below to count inhaler dispensing events. All inhalers (e.g., canisters) of the same medication dispensed on the same day count as one dispensing event. Different inhaler medications dispensed on the same day are counted as different dispensing events. For example, if a beneficiary received three canisters of Medication A and two canisters of Medication B on the same date, it would count as two dispensing events. Allocate the dispensing events to the appropriate year based on the date when the prescription was dispensed. Use the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs.
Injection dispensing event	Each injection counts as one dispensing event. Multiple dispensed injections of the same or different medications count as separate dispensing events. For example, if a beneficiary received two injections of Medication A and one injection of Medication B on the same date, it would count as three dispensing events. Use the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine if drugs are the same or different. Drugs in different medication lists are considered different drugs. Allocate the dispensing events to the appropriate year based on the date when the prescription was dispensed.

Units of medication	When identifying medication units for the numerator, count each individual medication, defined as an amount lasting 30 days or less, as one medication unit. One medication unit equals one inhaler canister, one injection, one infusion or a 30-day or less supply of an oral medication. For example, two inhaler canisters of the same medication dispensed on the same day count as two medication units and only one dispensing event. Use the package size and units columns in the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to determine the number of canisters or injections. Divide the dispensed amount by the package size to determine the number of canisters or injections dispensed. For example, if the package size for an inhaled medication is 10 g and pharmacy data indicate the dispensed amount is 30 g, three inhaler canisters were dispensed.

C. ELIGIBLE POPULATION

Age	Ages 19 to 64 as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not consider continuously enrolled) during each year of continuous enrollment.
Anchor date	December 31 of the measurement year.
Benefits	Medical during the measurement year and in the year prior to the measurement year. Pharmacy during the measurement year.

Event/ diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify beneficiaries as having persistent asthma who met at least one of the following criteria during both the measurement year and the year prior to the measurement year. Criteria need not be the same across both years. • At least one ED visit or acute inpatient encounter (ED and Acute Inpatient Value Set), with a principal diagnosis of asthma (Asthma Value Set). • At least one acute inpatient discharge with a principal diagnosis of asthma (Asthma Value Set) on the discharge claim. To identify an acute inpatient discharge: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. • At least four outpatient visits, telephone visits or e-visits or virtual check-ins (Outpatient and Telehealth Value Set), on different dates of service, with any diagnosis of asthma (Asthma Value Set) 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. Use all the medication lists (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to identify asthma controller and reliever medications. • At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables below (see Medication List tables below and link to the Medication List Directory in Guidance for reporting above) to identify asthma controller and reliever medications. Step 2 A beneficiary identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers or antibody inhibitors were the sole asthma medication dispensed in that year, must also have at least one diagnosis of asthma (Asthma Value Set), in any setting, in the same year as the leukotriene modifier or antibody inhibitor (e.g., the measurement year or the year prior to the measurement year). Do not include laboratory claims (claims with POS code 81).

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who met any of the following criteria: • Beneficiaries who had a diagnosis that requires a different treatment approach than beneficiaries with asthma (Respiratory Diseases With Different Treatment Approaches Than Asthma Value Set) any time during the beneficiary's history through December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81) • Beneficiaries who had no asthma controller medications or reliever medications (Asthma Controller and Reliever Medications List) dispensed during the measurement year. Use all the medication lists (see Medication List tables below and link to the Medication List Directory in Guidance for reporting above) to identify asthma controller and reliever medications. • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries who have a medication ratio of ≥0.50 during the measurement year. Follow the steps below to calculate the ratio.

Use all the medication lists in Table AMR-A. Asthma Controller Medications table below to identify asthma controller medications. Use all the medication lists in Table AMR-B. Asthma Reliever Medications table below to identify asthma reliever medications.

Step 1

For each beneficiary, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of Units of medications.

Step 2

For each beneficiary, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of Units of medications.

Step 3

For each beneficiary, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4

For each beneficiary, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the 0.5 rule) to the nearest whole number.

Units of Controller Medications (step 1) / Units of Total Asthma Medications (step 3).

Step 5

Sum the total number of beneficiaries who have a ratio of ≥0.50 in step 4.

Table AMR-A. Asthma Controller Medications

Description	Prescriptions	Medication Lists	Route
Antibody inhibitors	Omalizumab	Omalizumab Medications List	Injection
Anti-interleukin-4	Dupilumab	Dupilumab Medications List	Injection
Anti-interleukin-5	Benralizumab	Benralizumab Medications List	Injection
Anti-interleukin-5	Mepolizumab	Mepolizumab Medications List	Injection
Anti-interleukin-5	Reslizumab	Reslizumab Medications List	Injection
Inhaled steroid combinations	Budesonide-formoterol	Budesonide Formoterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-salmeterol	Fluticasone Salmeterol Medications List	Inhalation
Inhaled steroid combinations	Fluticasone-vilanterol	Fluticasone Vilanterol Medications List	Inhalation
Inhaled steroid combinations	Formoterol-mometasone	Formoterol Mometasone Medications List	Inhalation
Inhaled corticosteroids	Beclomethasone	Beclomethasone Medications List	Inhalation
Inhaled corticosteroids	Budesonide	Budesonide Medications List	Inhalation
Inhaled corticosteroids	Ciclesonide	Ciclesonide Medications List	Inhalation
Inhaled corticosteroids	Flunisolide	Flunisolide Medications List	Inhalation
Inhaled corticosteroids	Fluticasone	Fluticasone Medications List	Inhalation
Inhaled corticosteroids	Mometasone	Mometasone Medications List	Inhalation
Leukotriene modifiers	Montelukast	Montelukast Medications List	Oral
Leukotriene modifiers	Zafirlukast	Zafirlukast Medications List	Oral
Leukotriene modifiers	Zileuton	Zileuton Medications List	Oral
Methylxanthines	Theophylline	Theophylline Medications List	Oral

Table AMR-B. Asthma Reliever Medications

Description	Prescriptions	Medication Lists	Route
Short-acting, inhaled beta-2 agonists	Albuterol	Albuterol Medications List	Inhalation
Short-acting, inhaled beta-2 agonists	Levalbuterol	Levalbuterol Medications List	Inhalation

Note

- Do not use RxNorm codes when assessing the numerator.
- When mapping NDC codes, medications described as “injection,” “prefilled syringe,” “subcutaneous,” “intramuscular” or “auto-injector” are considered “injections” (route).
- When mapping NDC codes, medications described as “metered dose inhaler,” “dry powder inhaler,” or “inhalation powder” are considered “inhalation” (route) medications.
- Do not map medications described as “nasal spray” to “inhalation” medications.

MEASURE CBP-AD: CONTROLLING HIGH BLOOD PRESSURE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- For HEDIS, this measure applies to beneficiaries ages 18 to 85. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 85.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic clinical measure (eCQM) specification for the 2025 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2024/cms165v12. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative and hybrid specifications. States should use caution comparing measures calculated using different data collection methods.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, CPT CAT II, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, LOINC, POS, SNOMED, and UB. The Medication List Directory include the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Adequate control	Both a representative systolic BP <140 mm Hg and a representative diastolic BP of <90 mm Hg.
Representative BP	The most recent BP reading during the measurement year on or after the second diagnosis of hypertension. If multiple BP measurements occur on the same date, or are noted in the chart on the same date, use the lowest systolic and lowest diastolic BP reading. If no BP is recorded during the measurement year, assume that the beneficiary is "not controlled."

C. ELIGIBLE POPULATION

Age	Ages 18 to 85 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/ diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify beneficiaries who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Step 2 Remove beneficiaries who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet any of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

Required exclusions (continued) (Supplemental and medical record data may be used for these exclusions)	• Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year. • Beneficiaries who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81). • Beneficiaries with evidence of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Kidney Transplant Value Set), any time during the beneficiary's history on or prior to December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81). • Beneficiaries with a procedure that indicates ESRD: 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) any time during the beneficiary's history on or prior to December 31 of the measurement year. • Beneficiaries with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. Do not include laboratory claims (claims with POS code 81). • Beneficiaries ages 66 to 80 as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both of the following frailty and advanced illness criteria to be excluded: 1. Frailty: At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81). 2. Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year – Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). – Dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above). • Beneficiaries age 81 and older as of December 31 of the measurement year with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Identify the most recent BP reading (Systolic Blood Pressure Value Set; Diastolic Blood Pressure Value Set) taken during the measurement year. Do not include CPT Category II codes (Systolic and Diastolic Result Value Set) with a modifier (CPT CAT II Modifier Value Set). Do not include BPs taken in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set) or during an ED visit (ED Value Set; POS code 23).

The BP reading must occur on or after the date of the second diagnosis of hypertension (identified using the event/diagnosis criteria).

The beneficiary is numerator compliant if the BP is <140/90 mm Hg. The beneficiary is not compliant if the BP is ≥ 140/90 mm Hg, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.

If the most recent blood pressure was identified based on a CPT Category II code (Systolic and Diastolic Result Value Set) use the following to determine numerator compliance:

- Systolic Compliant: Systolic Less Than 140 Value Set.
- Systolic Not Compliant: CPT-CAT-II code 3077F.
- Diastolic Compliant: Diastolic Less Than 90 Value Set.
- Diastolic Not Compliant: CPT-CAT-II code 3080F.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

Identifying the Medical Record

All eligible BP measurements recorded in the record must be considered. If a beneficiary's medical record cannot be found, the beneficiary remains in this measure denominator and is considered noncompliant for the numerator.

Use the following guidance to find the appropriate medical record to review.

- Identify the beneficiary's PCP.
- If the beneficiary had more than one PCP for the time-period, identify the PCP who most recently provided care to the beneficiary.
- If the beneficiary did not visit a PCP for the time-period or does not have a PCP, identify the practitioner who most recently provided care to the beneficiary.

- If a practitioner other than the beneficiary's PCP manages the hypertension, the state may use the medical record of that practitioner.

Numerator

The number of beneficiaries in the denominator whose most recent BP (both systolic and diastolic) is adequately controlled during the measurement year. For a beneficiary's BP to be controlled the systolic and diastolic BP must be <140/90 mm Hg (adequate control). To determine if a beneficiary's BP is adequately controlled, the representative BP must be identified.

Administrative Data

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical Record Review

Identify the most recent BP reading noted during the measurement year.

The BP reading must occur on or after the date when the second diagnosis of hypertension (identified using the event/diagnosis criteria) occurred.

Do not include BP readings:

- Taken during an acute inpatient stay or ED visit
- Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests
- Taken by the beneficiary using a non-digital device such as with a manual blood pressure cuff and a stethoscope

Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If multiple readings were recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading.

BP readings taken by the beneficiary and documented in the beneficiary's medical record are eligible for use in reporting (provided the BP does not meet any exclusion criteria). There is no requirement that there be evidence the BP was collected by a PCP or specialist.

The beneficiary is not numerator compliant if the BP reading is ≥ 140/90 mm Hg or is missing, if there is no BP reading during the measurement year, or if the reading is incomplete (e.g., the systolic or diastolic level is missing).

Ranges and thresholds do not meet criteria for this measure. A distinct numeric result for both the systolic and diastolic BP reading is required for numerator compliance. A BP documented as an "average BP" (e.g., "average BP: 139/70") is eligible for use.

F. ADDITIONAL NOTES

- When identifying the most recent BP reading, all eligible BP readings in the appropriate medical record should be considered, regardless of practitioner type and setting (excluding acute inpatient and ED visit settings).

- An electronic medical record (EMR) can be used to identify the most recent BP reading if it meets the criteria for appropriate medical record.
- When excluding BP readings from the numerator, the intent is to identify diagnostic or therapeutic procedures that require a medication regimen, a change in diet, or a change in medication. Examples of such procedures include colonoscopies; dialysis, infusions, and chemotherapy; and nebulizer treatments with albuterol. A beneficiary forgetting to take regular medications on the day of the procedure is not considered a required change in medication, and therefore the BP reading is eligible.
- BP readings taken on the same day that the patient receives a common low-intensity or preventive procedure are eligible for use. These include procedures such as vaccinations; injections (e.g., allergy, vitamin B-12, insulin, steroid, toradol, Depo-Provera, testosterone, lidocaine); tuberculosis tests; intrauterine device (IUD) insertions; eye exams; or wart or mole removal.

MEASURE CCP-AD: CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 21 TO 44

HHS Office of Population Affairs

A. DESCRIPTION

Among women ages 21 to 44 who had a live birth, the percentage that:

1. Were provided a most effective or moderately effective method of contraception within 3 days of delivery and within 90 days of delivery.
2. Were provided a long-acting reversible method of contraception (LARC) within 3 days of delivery and within 90 days of delivery.

The first rate is an intermediate outcome measure, and it is desirable to have a high percentage of women who are provided the most effective or moderately effective contraceptive methods during the postpartum period to support maternal health outcomes regarding birth spacing. The second rate is an access measure, and the focus is on making sure that women have access to LARC methods during the postpartum period.

These rates are reported at two points in time: contraceptive provision within 3 days of delivery is used to monitor the provision of contraception in the immediate postpartum period, while contraceptive provision within 90 days of delivery is used to monitor the provision of contraception throughout the postpartum period. A 90-day period is used because the 2018 American College of Obstetricians and Gynecologists [ACOG] Committee Opinion No. 736 recommended a postpartum visit within the first 3 weeks postpartum, which should then be followed up with ongoing care as needed, concluding with a comprehensive postpartum visit no later than 12 weeks after birth, and six additional days are allowed for women whose postpartum care visit is delayed.[1]

This measure is episode-based and uses live birth delivery as the start of the episode.

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – Postpartum Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44. The Child Core Set measure applies to beneficiaries ages 15 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 44.
- In total, four rates will be reported for the Adult Core Set measure:
  - Ages 21 to 44: Most or moderately effective contraception – within 3 days of delivery.
  - Ages 21 to 44: Most or moderately effective contraception – within 90 days of delivery.
  - Ages 21 to 44: LARC – within 3 days of delivery.
  - Ages 21 to 44: LARC – within 90 days of delivery.

[1] ACOG. "Optimizing Postpartum Care: Committee Opinion Number 736". *Obstetrics & Gynecology*, vol. 131, no.5, 2018, pp.e140–e150. https://doi.org/10.1097/AOG.0000000000002633.

- The measurement year is calendar year 2024. There is no lookback period for this measure.
- Include all paid, suspended, pending, and denied claims.
- Some women may have more than one delivery in the measurement year; this measure is designed to identify unique live births (defined as those that occur ≥ 180 days apart) rather than women who had a live birth. Each live birth delivery is evaluated separately to assess if most or moderately effective contraception is provided during the postpartum period.
- Women with a live birth occurring after September 30 are excluded from the denominator because there may not have been an opportunity to provide the woman with contraception in the postpartum period (defined as within 90 days of delivery).
- When calculating the number of days postpartum for the numerator, consider the date of delivery to be day 0. For instance, if a live birth occurred on September 27, 2024, review all claims through September 30, 2024 for the 3-day postpartum rates and review all claims through December 26, 2024 for the 90-day postpartum rates.
- The codes used to calculate this measure are available in Tables CCP-A through CCP-D at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.
- The code sets and SAS programs needed to calculate this measure are available at https://opa.hhs.gov/claims-data-sas-program-instructions.
- Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system. However, contraceptive surveillance codes cannot be used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision because this measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.
- For more information on interpreting performance results on this measure, see Section E, “Additional Notes.”

This measure includes the following coding systems: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, or ring.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants, intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2024.

C. ELIGIBLE POPULATION

Age	Women ages 21 to 44 as of December 31 of the measurement year who had a live birth.
Continuous enrollment	Within the measurement year, women enrolled from the date of delivery to 90 days postpartum.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical or Family Planning Only Services.
Event/ diagnosis	Delivery of a live birth.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population includes women ages 21 to 44 who had a live birth in the measurement year.

Women with a live birth occurring after September 30 will be excluded from the denominator because they may not have an opportunity to receive contraception in the postpartum period (defined as within 90 days of delivery). Follow the steps below to identify the eligible population:

Step 1

Identify live births by using codes in Table CCP-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Step 2

Exclude deliveries that did not end in a live birth (e.g., miscarriage, ectopic, stillbirth, or pregnancy termination) by using the codes in Table CCP-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Exclude live births that occurred during the last 3 months of the measurement year. These deliveries should be excluded from the denominator because there may not have been an

opportunity to provide contraception during the postpartum period. ACOG recommends having a comprehensive postpartum visit no later than 12 weeks after birth.

Figure CCP-A below provides a flowchart for implementing these exclusion and inclusion categories.

Numerator for Rate 1

The eligible population that was provided a most or moderately effective method of contraception.

Step 3a: Identify Rate 1 Numerator

Define the numerator by identifying women in the denominator who were provided a most (sterilization, IUD/IUS, implant) or moderately (injectables, oral pills, patch, or ring) effective method of contraception in the measurement year. To do this, use the codes in Table CCP-C, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Step 4a: Identify Rate 1 Date

Determine the date that the contraceptive method was provided to identify: (a) women that were provided contraception in the immediate postpartum period of 3 days after delivery; and (b) women that were provided contraception within 90 days of delivery. The second category will also include women who were provided contraception in the first 3 days postpartum.

Step 5a: Calculate Rate 1

Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception by the number of women in the denominator.

Numerator for Rate 2

The eligible population that was provided a LARC method.

Step 3b: Identify Rate 2 Numerator

Define the numerator by identifying women in the denominator who were provided a LARC in the measurement year. To do this, use the codes in Table CCP-D, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Step 4b: Identify Rate 2 Date

Determine the date that the LARC method was provided to identify: (a) women that were provided LARC in the immediate postpartum period of 3 days after delivery; and (b) women that were provided LARC within 90 days of delivery. The second category will also include women who were provided LARC in the first 3 days postpartum.

Step 5b: Calculate Rate 2

Calculate the rates by dividing the number of women who were provided a LARC method of contraception by the number of women in the denominator.

Figure CCP-A below provides a flowchart to calculate Rate 1 and Rate 2.

E. ADDITIONAL NOTES

Racial and socioeconomic disparities in contraceptive access and use are substantial. Studies suggest that these disparities are driven by structural barriers such as the cost of contraceptives, health insurance access, racial bias, distrust in the medical system, and pharmacy-level barriers.[2] In particular, Black and Latina women are less likely to use any contraceptive methods compared to white women.[3,4] However, women of color are more frequently offered LARC methods.[5] Given the history of coercive and involuntary female sterilizations in the United States, which disproportionately impacted women of color, ACOG recommends that contraceptive counseling should focus on patient-centered shared decision making. Specifically, ACOG recommends that "obstetrician-gynecologists should intentionally incorporate the reproductive justice framework[6] by (1) acknowledging historical and ongoing reproductive mistreatment of people of color and other marginalized individuals, (2) recognizing that counselor bias, unconscious or otherwise, may affect care and working to minimize the effect, and (3) prioritizing patients' values, preferences, and lived experiences in the selection or discontinuation of a contraceptive method."[7] Against this background, stratifying measure results by race and ethnicity can help illuminate disparities in contraceptive provision and help identify program improvement opportunities to reduce/close this gap.

Healthy People 2030[8] and the World Health Organization recommend an inter-pregnancy interval of at least 18 months; therefore, all postpartum women can be considered at risk of unintended pregnancy for that period of time.

The Lactational Amenorrhea Method (LAM) is a highly effective, temporary method of contraception that can be used in the postpartum period. If the infant is being fed only its mother's breast milk, and the woman has not experienced her first postpartum menses, then LAM provides 98% protection from pregnancy in the first 6 months postpartum.[9]

Despite the protection from LAM, many health care providers will want to provide contraceptive services to women at the postpartum visit because the effectiveness of breastfeeding for pregnancy prevention drops quickly when women stop exclusive breastfeeding. It may be difficult for many clients to receive contraceptive services at that time.

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[2] Sutton, Madeline Y., Ngozi F. Anachebe, Regina Lee, and Heather Skanes. "Racial and Ethnic Disparities in Reproductive Health Services and Outcomes." *Obstetrics & Gynecology,* vol. 137, issue 2, February 2021, pp. 225–233. https://doi.org/10.1097/AOG.0000000000004224.

[3] Dehlendorf, C.,, Seo Young Park, Chetachi A. Emeremni, Diane Comer, Kathryn Vincett, and Sonya Borrero. "Racial/Ethnic Disparities in Contraceptive Use: Variation By Age and Women's Reproductive Experiences." *American Journal of Obstetrics and Gynecology*, vol. 210, issue 6, 2014, article 526.e1-526.e9.

[4] Sutton et al. (2021), Op. Cit.

[5] Kathawa, C.A., and K.S. Arora. "Implicit Bias in Counseling for Permanent Contraception: Historical Context and Recommendations for Counseling." *Health Equity*, vol. 4, 2020, pp. 326–329. https://doi.org/10.1089/heq.2020.0025.

[6] Ross, L.J. "Understanding Reproductive Justice: Sister Song Women of Color Reproductive Health Collective." Feminist Press, 2017.

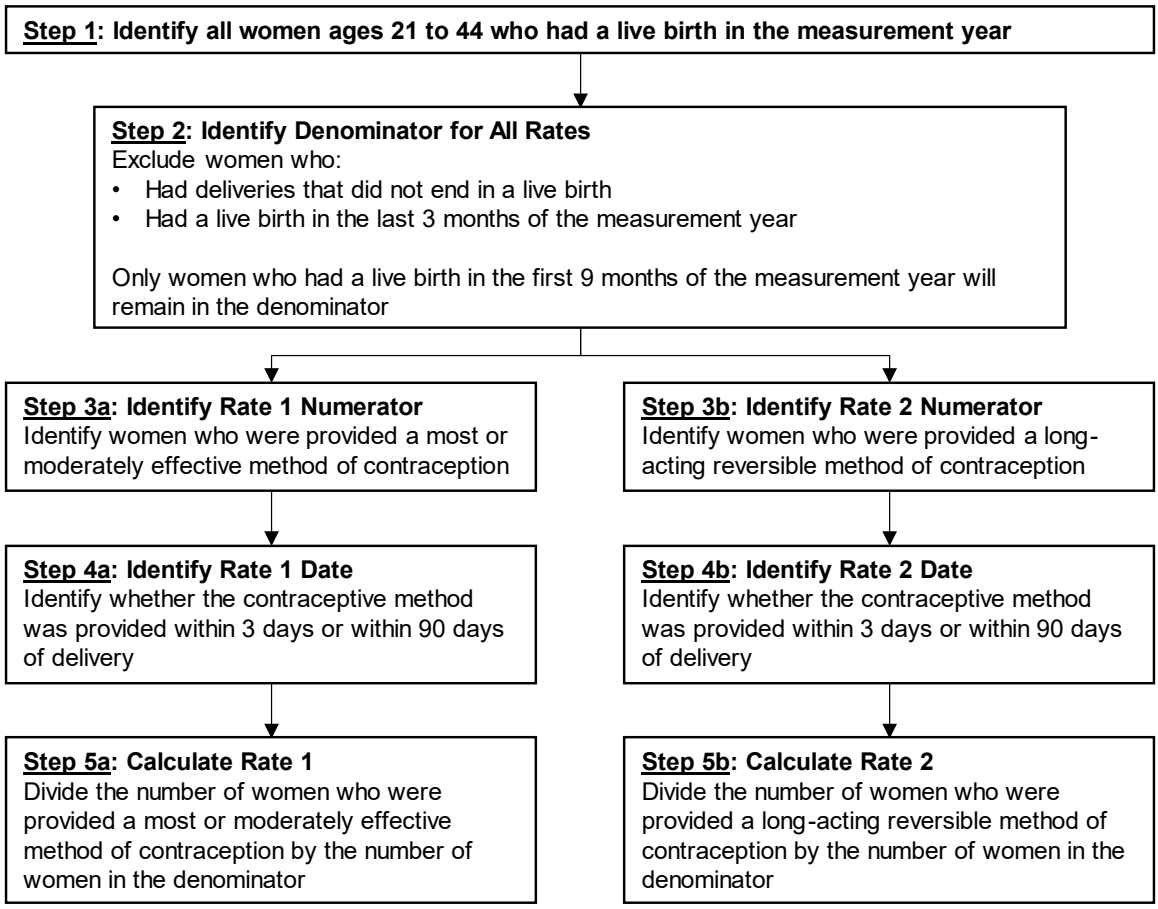
[7] ACOG. "Patient-Centered Contraceptive Counseling: Committee Statement Number 1." *Obstetrics & Gynecology*, vol. 139, no. 2, 2022, pp. 350–353. https://doi.org/10.1097/AOG.0000000000004659.

[8] Office of Disease Prevention and Health Promotion. Healthy People 2030. "Family Planning." at https://health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning.

[9] Trussell J., A.R.A. Aiken, E. Micks, and K.A. Guthrie. "Efficacy, Safety, and Personal Considerations." In *Contraceptive Technology,* 21st edition, edited by R.A. Hatcher, A.L. Nelson, J. Trussell, C. Cwiak, P. Cason, M.S. Policar, A. Edelman, A.R.A. Aiken, J. Marrazzo, and D. Kowal. Ayer Company Publishers, Inc., 2018.

More information on how to interpret performance results on this measure is available at https://opa.hhs.gov/sites/default/files/2020-07/interpreting-rates-for-contraceptive-care-measures.pdf.

Figure CCP-A. Measure Flowchart



MEASURE CCS-AD: CERVICAL CANCER SCREENING

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 21 to 64 who were recommended for routine cervical cancer screening and were screened using any of the following criteria:

- Beneficiaries ages 21 to 64 who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years.
- Beneficiaries ages 30 to 64 who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Beneficiaries ages 30 to 64 who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

Data Collection Method: Administrative, Hybrid, or EHR; the measure is also specified for ECDS, see ECDS specifications in Chapter IV.

Guidance for Reporting:

- This measure should include (1) all beneficiaries ages 24 to 64 who were recommended for routine cervical cancer screening and have had cervical cytology during the measurement year or the two years prior to the measurement year, and (2) beneficiaries ages 30 to 64 who were recommended for routine cervical cancer screening and have had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year. Both criteria must be evaluated for numerator compliance; however, beneficiaries only need to meet one criterion to be included in the numerator for this measure. Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.
- The eligible population (denominator) includes beneficiaries who are ages 24 to 64 who were recommended for routine cervical cancer screening as of the end of the measurement year to account for the 3-year look-back period for assessing numerator criterion (e.g., the measure is looking back three years from age 24 for evidence of cervical cytology).
- Include all paid, suspended, pending, and denied claims.
- The electronic clinical quality measure (eCQM) specification for the 2025 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2024/cms124v12. States that use electronic specifications should indicate this by selecting “Electronic Health Records” in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative, hybrid, and ECDS specifications. States should use caution comparing measures calculated using different data collection methods.

This measure’s Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, LOINC, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Beneficiaries ages 24 to 64 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/ diagnosis	None.
Beneficiaries recommended for routine cervical cancer screening	Include beneficiaries recommended for routine cervical cancer screening with Administrative Gender of Female (AdministrativeGender code Female) any time in the beneficiary's history. Note: Administrative gender is the gender the beneficiary is considered to have for administrative and record-keeping purposes. It is typically provided in enrollment data.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet any of the following criteria: • Hysterectomy with no residual cervix (Hysterectomy With No Residual Cervix Value Set) any time during the beneficiary's history through December 31 of the measurement year. • Cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set) any time during the beneficiary's history through December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81). • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year.

	• Beneficiaries who had an encounter for palliative care (ICD-10-CM doe Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81). • Beneficiaries with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time in the beneficiary's history.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries recommended for routine cervical cancer screening who were screened for cervical cancer. Either of the following meets criteria:

- Beneficiaries ages 24 to 64 as of December 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement year or the two years prior to the measurement year.
- Beneficiaries ages 30 to 64 as of December 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set;, SNOMEDCT code 718591004) during the measurement year or the four years prior to the measurement year and who were 30 years or older on the test date.

  Note: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

Numerator

The number of beneficiaries who were recommended for routine cervical cancer screening and were appropriately screened for cervical cancer as documented through either administrative data or medical record review.

Administrative Data

Refer to the Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Appropriate screenings are defined by any of the following:

- Beneficiaries ages 24 to 64 as of December 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical cytology during the measurement year or the two years prior to the measurement year
  - Documentation in the medical record must include both of the following:
    - A note indicating the date when the cervical cytology was performed
    - The result or finding "Unknown" is not considered a result/finding.
  - Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.
  - Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Note: Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

- Beneficiaries ages 30 to 64 as of December 31 of the measurement year who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing during the measurement year or the four years prior to the measurement year and who were 30 years or older as of the date of testing
  - Documentation in the medical record must include both of the following:
    - A note indicating the date when the hrHPV test was performed. Generic documentation of "HPV test" can be counted as evidence of hrHPV test
    - The results or findings "Unknown" is not considered a result/finding.
  - Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

Note: Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting.

MEASURE CCW-AD: CONTRACEPTIVE CARE – ALL WOMEN AGES 21 TO 44

HHS Office of Population Affairs

A. DESCRIPTION

Among women ages 21 to 44 at risk of unintended pregnancy, the percentage that:

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

The first rate is an intermediate outcome measure. A state should exercise caution in using this measure for payment purposes, because performance on this measure is an indicator of a woman's preferences for the contraceptive care that best fits her needs. The goal is to provide an indicator for states to assess the provision of most or moderately effective contraceptive methods within the state and identify where there is room for improvement. The second rate is an access measure, which focuses on establishing that women have access to LARC methods.

This measure is person-based and calculated so that every person in the measure is counted only once.

Data Collection Method: Administrative

Guidance for Reporting:

- The Contraceptive Care – All Women measure is stratified into two age groups: ages 15 to 20 and ages 21 to 44. The Child Core Set measure applies to beneficiaries ages 15 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 44.
- The measurement year is calendar year 2024. There is no lookback period for this measure to determine if there was a previous sterilization, LARC insertion, or other contraceptive method provided prior to the measurement year.
- Include all paid, suspended, pending, and denied claims.
- A secondary data source, such as the National Survey of Family Growth (NSFG) can be used to interpret the results of this measure. For more information, see Section E, "Additional Notes."
- The codes used to calculate this measure are available in Tables CCW-A through CCW-F at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.
- The code sets and SAS programs needed to calculate this measure are available at https://opa.hhs.gov/claims-data-sas-program-instructions.

- Contraceptive surveillance codes can be used to document repeat prescriptions of contraceptives, contraceptive maintenance, or routine checking of a contraceptive device or system. However, contraceptive surveillance codes cannot be used for the initial prescription or provision of a contraceptive method. Contraceptive surveillance codes are included in the first rate for most or moderately effective contraceptive provision because this measure is intended to capture both new and existing contraceptive users. The second rate for LARC provision is designed to capture new LARC insertions, so contraceptive surveillance codes are not included in the second rate.
- For more information on interpreting performance results on this measure, see Section E, "Additional Notes."

This measure includes the following coding systems: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Provision of a most effective method of contraception	Provision of female sterilization, contraceptive implants, or intrauterine devices or systems (IUD/IUS).
Provision of a moderately effective method of contraception	Provision of injectables, oral pills, patch, or ring.
Provision of a long-acting reversible method of contraception (LARC)	Provision of contraceptive implants, intrauterine devices or systems (IUD/IUS).
Measurement year	Calendar year 2024.

C. ELIGIBLE POPULATION

Age	Women ages 21 to 44 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical or Family Planning Only Services.
Event/diagnosis	At risk of unintended pregnancy.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Follow the steps below to define the denominator:

Step 1

Identify all women ages 21 to 44.

Step 2

Define the denominator by excluding women not at risk of unintended pregnancy because they:

- Were infecund due to non-contraceptive reasons such as natural menopause or oophorectomy. To do this, use the codes listed in Table CCW-A.
- Had a live birth in the last 3 months of the measurement year because there may not have been an opportunity to provide them with contraception. A three-month period was selected because the American College of Obstetricians and Gynecologists (ACOG) recommends having a postpartum visit by 12 weeks, and an additional 6 days was added to allow for reasonable delays in attending the postpartum visit. To identify live births, use the codes listed in Table CCW-D.
- Were still pregnant at the end of the measurement year, as indicated by a pregnancy code (Table CCW-B) and an absence of a pregnancy outcome code indicating a non-live birth (Table CCW-C) or a live birth (Table CCW-D).

Once the exclusions are applied, the denominator includes women who were:

- Not pregnant at any point in the measurement year.
- Pregnant during the measurement year but whose pregnancy ended in the first 9 months of the measurement year, since there was adequate time to provide contraception in the postpartum period.
- Pregnant during the measurement year but whose pregnancy ended in an ectopic pregnancy, stillbirth, miscarriage, or induced abortion.

All code tables used in the calculation of the denominator are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Figure CCW-A below provides a flowchart for implementing these exclusion and inclusion categories.

Numerator

Follow the steps below to define the numerator rates:

Step 3a: Identify Rate 1 Numerator

The eligible population that was provided a most or moderately effective method of contraception.

Define the numerator by identifying women in the denominator who were provided a most (sterilization, IUD/IUS, or implant) or moderately (injectables, oral pills, patch, or ring) effective method of contraception in the measurement year. To do this, use the codes in Table CCW-E.

All code tables used in the calculation of the numerator are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Step 3b: Identify Rate 2 Numerator

The eligible population that was provided a LARC method.

Define the numerator by identifying women in the denominator who were provided a LARC in the measurement year. To do this, use the codes in Table CCW-F.

All code tables used in the calculation of the numerator are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Measure calculation

Follow the steps below to calculate the measure performance rates:

Step 4a: Calculate Rate 1

Calculate the rates by dividing the number of women who were provided a most or moderately effective method of contraception by the number of women in the denominator.

Step 4b: Calculate Rate 2

Calculate the rates by dividing the number of women who were provided a LARC by the number of women in the denominator.

Figure CCW-A below provides a flowchart to calculate Rate 1 and Rate 2.

E. ADDITIONAL NOTES

Racial and socioeconomic disparities in contraceptive access and use are substantial. Studies suggest that these disparities are driven by structural barriers such as the cost of contraceptives, health insurance access, racial bias, distrust in the medical system, and pharmacy-level barriers.[1] In particular, Black and Latina women are less likely to use any contraceptive methods compared to white women.[2,3] However, women of color are more frequently offered LARC methods.[4] Given the history of coercive and involuntary female sterilizations in the United States, which disproportionately impacted women of color, ACOG recommends that contraceptive counseling should focus on patient-centered shared decision making. Specifically, ACOG recommends that "obstetrician-gynecologists should intentionally incorporate the reproductive justice framework[5] by (1) acknowledging historical and ongoing reproductive mistreatment of people of color and other marginalized individuals, (2) recognizing that counselor bias, unconscious or otherwise, may affect care

[1] Sutton, Madeline Y., Ngozi F. Anachebe, Regina Lee, and Heather Skanes. "Racial and Ethnic Disparities in Reproductive Health Services and Outcomes." *Obstetrics & Gynecology*, vol. 137, issue 2, February 2021, pp. 225–233. https://doi.org/10.1097/AOG.0000000000004224.

[2] Dehlendorf, C.,, Seo Young Park, Chetachi A. Emeremni, Diane Comer, Kathryn Vincett, and Sonya Borrero. "Racial/Ethnic Disparities in Contraceptive Use: Variation By Age and Women's Reproductive Experiences." *American Journal of Obstetrics and Gynecology*, vol. 210, issue 6, 2014, article 526.e1-526.e9.

[3] Sutton et al. (2021), Op. Cit.

[4] Kathawa, C.A., and K.S. Arora. "Implicit Bias in Counseling for Permanent Contraception: Historical Context and Recommendations for Counseling." *Health Equity,* vol. 4, 2020, pp. 326–329. https://doi.org/10.1089/heq.2020.0025.

[5] Ross, L.J. "Understanding Reproductive Justice: Sister Song Women of Color Reproductive Health Collective." Feminist Press, 2017.

and working to minimize the effect, and (3) prioritizing patients' values, preferences, and lived experiences in the selection or discontinuation of a contraceptive method."[6] Against this background, stratifying measure results by race and ethnicity can help illuminate disparities in contraceptive provision and help identify program improvement opportunities to reduce/close this gap.

In addition, stratification of measure results by category of Medicaid eligibility (e.g., family planning waiver vs. other Medicaid eligibility) is also recommended for interpretation. A secondary data source, such as the National Survey of Family Growth[7] (NSFG) or the Behavioral Risk Factor Surveillance System[8] (BRFSS) could be used to interpret provision of most and moderately effective contraceptive methods. Secondary data sources may be used to interpret the results for the general Medicaid population. However, the results for the family planning waiver recipients do not need to be adjusted with secondary data as the vast majority of clients who receive services from these programs are seeking contraceptive services and should therefore be considered at risk of unintended pregnancy.

The ideal denominator for a clinical performance measure of contraceptive services is all women at risk of unintended pregnancy (e.g., who are fecund, are not pregnant or seeking pregnancy, and have ever had sex). However, it is not possible to identify this population with existing claims data because there are no codes for a woman's pregnancy intention or history of sexual activity. Further, both sterilization and LARC are long-lasting but there is no systematic record of receipt of sterilization or LARC in the year(s) preceding the measurement year. These limitations can be offset by using estimates from secondary survey data to help interpret this measure's results and to set better understand the limitations of claims data.

NSFG is a national survey that gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. It is conducted by CDC's National Center for Health Statistics and generates a nationally representative sample of women and men ages 15 to 49. Approximately 5,000 individuals are interviewed each year, and updated data files are released every two years. This survey can be used to identify the portion of beneficiaries that are not at risk of unintended pregnancy because they never had sex, are infecund, or are trying to get pregnant. This information can then help determine the population at risk for unintended pregnancy to provide context for measure performance.

BRFSS is a national telephone survey that collects data about health-related risk factors, chronic health conditions, and use of preventive health services.

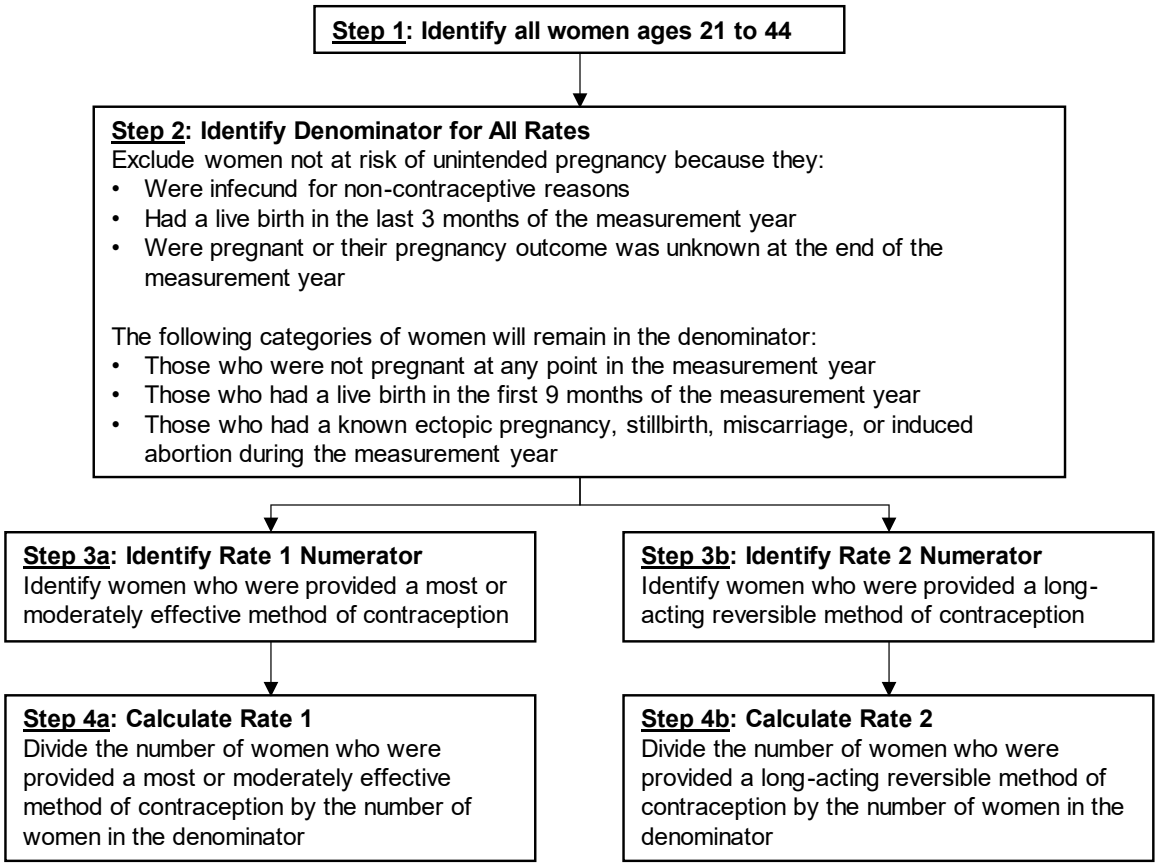
More information on how to interpret performance results on this measure is available at https://opa.hhs.gov/sites/default/files/2020-07/interpreting-rates-for-contraceptive-care-measures.pdf.

[6] ACOG. "Patient-Centered Contraceptive Counseling: Committee Statement Number 1." *Obstetrics & Gynecology*, vol. 139, no. 2, 2022, pp. 350–353. https://doi.org/10.1097/AOG.0000000000004659.

[7] Centers for Disease Control and Prevention. "National Survey of Family Growth." November 2020. https://www.cdc.gov/nchs/nsfg/index.htm.

[8] Centers for Disease Control and Prevention. "Behavioral Risk Factor Surveillance System." August 2020. https://www.cdc.gov/brfss/.

Figure CCW-A. Measure Flowchart



MEASURE CDF-AD: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGE 18 AND OLDER

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of beneficiaries age 18 and older 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, a follow-up plan is documented on the date of the qualifying encounter.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The Screening for Depression and Follow-Up Plan measure includes beneficiaries ages 12 and older. The Child Core Set measure applies to beneficiaries ages 12 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- The intent of the measure is to screen for depression in beneficiaries who have never had a diagnosis of bipolar disorder prior to the qualifying encounter used to evaluate the numerator. Beneficiaries who have been diagnosed with bipolar disorder will be excluded from the measure.
- The denominator for this measure includes beneficiaries age 18 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  - 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.
  - 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.
- For the purpose of Adult Core Set reporting, there are two G codes included in the numerator to capture whether depression screening using an age-appropriate standardized tool was done on the date of the eligible encounter or up to 14 days prior to the date of the encounter and if the screen was positive, whether a follow-up plan was documented on the date of the eligible encounter.
- An age-appropriate, standardized, and validated depression screening tool must be used and results documented as positive or negative for numerator compliance. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record. This measure does not require documentation of a specific score, just whether results of the normalized and validated depression screening tool used are considered positive or negative. Each standardized screening tool provides guidance on whether a particular score is considered positive for depression. The screening should occur on the date of a qualifying encounter or up to 14 calendar days prior to the date of the qualifying encounter. The depression screening must be reviewed and addressed by the provider on the date of the

encounter. Positive pre-screening results indicating a beneficiary is at high risk for self-harm should receive more urgent intervention as determined by the provider practice.

- The measure assesses the most recent depression screening completed either during the qualifying encounter or within the 14 calendar days prior to that encounter. Therefore, a clinician would not be able to complete another screening at the time of the encounter to count toward a follow-up, because that would serve as the most recent screening. In order to satisfy the follow-up requirement for a beneficiary screening positively, the eligible clinician would need to provide one of the specified follow-up actions, which includes one or more of the following:
  - Referral to a provider for additional evaluation.
  - Pharmacological interventions.
  - Other interventions for the treatment of depression.
- For beneficiaries with multiple qualifying encounters, the beneficiary does not need to be screened at every encounter, only once during the performance year.
- A follow-up plan must be documented on the date of the qualifying encounter for a positive depression screen.
- Should a beneficiary screen positive for depression:
  - A clinician should only order pharmacological intervention when appropriate and after sufficient diagnostic evaluation. However, for the purposes of this measure, additional screening and assessment during the qualifying encounter will not qualify as a follow-up plan.
  - A clinician could opt to complete a suicide risk assessment when appropriate and based on individual beneficiary characteristics. However, for the purposes of this measure, a suicide risk assessment will not qualify as a follow-up plan.
- The screening tools listed in the measure specifications are examples of standardized tools. However, states may use any assessment tool that has been appropriately normalized and validated for the population in which it is being utilized. The name of the age-appropriate standardized depression screening tool utilized must be documented in the medical record.
- This measure contains both exclusions and exceptions:
  - Denominator exclusion criteria are evaluated before checking if a beneficiary meets the numerator criteria; a beneficiary who qualifies for the denominator exclusion should be removed from the denominator.
  - Denominator exception criteria are only evaluated if the beneficiary does not meet the numerator criteria; beneficiaries who do not meet numerator criteria and also meet denominator exception criteria (e.g., medical reason for not performing a screening) should be removed from the denominator.
- This measure can be calculated using administrative data only. Medical record review may be used to validate the state's administrative data (for example, documentation of the name of the standardized depression screening tool utilized). However, validation is not required to calculate and report this measure.
- Include all paid, suspended, pending, and denied claims.
- Tables CDF-A through CDF-E are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

- The electronic clinical quality measure (eCQM) specification for the 2025 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v13.html. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative specification. States should use caution comparing measures calculated using different data collection methods.

This measure includes the following coding systems: CPT, HCPCS, ICD-9-CM, and ICD-10-CM. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized depression screening tool	A normalized and validated depression screening tool developed for the population in which it is being utilized. Examples of depression screening tools include but are not limited to: • Adult Screening Tools (age 18 and older) Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety- Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD). • Perinatal Screening Tools Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale.
Follow-up plan	Documented follow-up for a positive depression screening *must* include one or more of the following: • Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen. • Pharmacological interventions. • Other interventions or follow-up for the diagnosis or treatment of depression. Examples of a follow-up plan include but are not limited to:

	• Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychiatric nurse practitioner, psychologist, clinical social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. • Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options. • The documented follow-up plan must be related to positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."

C. ELIGIBLE POPULATION

Age	Age 18 or older on date of encounter.
Event/ diagnosis	Outpatient visit (Table CDF-A) during the measurement year.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population with an outpatient visit during the measurement year (Table CDF-A). (Table CDF-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip).

Numerator

Beneficiaries 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, a follow-up plan is documented on the date of the qualifying encounter using one of the codes in Table CDF-B available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Exclusions

A beneficiary is not eligible if one or more of the following conditions are documented in the beneficiary medical record:

- Beneficiaries who have been diagnosed with bipolar disorder

Use the codes in Table CDF-C and CDF-D (available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip) to identify exclusions.

Exceptions

A beneficiary that does not meet the numerator criteria and meets the following exception criteria should be removed from the measure denominator. However, if the beneficiary meets the numerator criteria, the beneficiary would be included in the measure denominator.

- Beneficiary reason:
  - Beneficiary refuses to participate.
- Medical reason:
  - Beneficiary is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the beneficiary's health status.
  - Situations where the beneficiary's cognitive, functional, or motivational limitations may impact the accuracy of results.

Use the code in Table CDF-E (available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip) to identify exceptions.

MEASURE CHL-AD: CHLAMYDIA SCREENING IN WOMEN AGES 21 TO 24

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of women ages 21 to 24 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- For HEDIS, this measure has two reportable age groups and a total rate: ages 16 to 20, ages 21 to 24, and total (ages 16 to 24). The Child Core Set measure applies to beneficiaries ages 16 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 24.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic clinical quality measure (eCQM) specification for the 2025 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2024/cms153v12. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative specification. States should use caution comparing measures calculated using different data collection methods.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, LOINC, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Women ages 21 to 24 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/ diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify beneficiaries who are sexually active. Two methods identify sexually active women: pharmacy data and claims/encounter data. The state must use both methods to identify the eligible population; however, a beneficiary only needs to be identified in one method to be eligible for this measure. Claim/encounter data. Beneficiaries who had a claim or encounter indicating sexual activity during the measurement year. Any of the following meets criteria: • Diagnoses Indicating Sexual Activity Value Set. Do not include laboratory claims (claims with POS code 81). • Procedures Indicating Sexual Activity Value Set. • Pregnancy Tests Value Set. Pharmacy data. Beneficiaries who were dispensed prescription contraceptives during the measurement year (Contraceptive Medications List, see link to the Medication List Directory in Guidance for Reporting above). Step 2 For the beneficiaries identified in step 1 based on a pregnancy test alone, remove beneficiaries who meet either of the following: • A pregnancy test (Pregnancy Tests Value Set) during the measurement year and a prescription for isotretinoin (Retinoid Medications List, see link to the Medication List Directory in Guidance for Reporting above) on the date of the pregnancy test or 6 days after the pregnancy test. • A pregnancy test (Pregnancy Tests Value Set) during the measurement year and an x-ray (Diagnostic Radiology Value Set) on the date of the pregnancy test or 6 days after the pregnancy test.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

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

MEASURE COB-AD: CONCURRENT USE OF OPIOIDS AND BENZODIAZEPINES

Pharmacy Quality Alliance

A. DESCRIPTION

Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older. Age groups should be based on age as of January 1 of the measurement year.
- The opioid medications used to calculate this measure are in the "Value Sets – Medications" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip. The only opioids that should be included when calculating this measure are those in the "Value Sets – Medications" tab.
- Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or in hospice or palliative care at any point during the measurement year are excluded from this measure. Individuals with a cancer diagnosis or sickle cell disease diagnosis may be identified using the ICD-10-CM codes in the Cancer Value Set and Sickle Cell Disease Value Set and beneficiaries in hospice or palliative care may be identified using the codes in the Hospice Encounter Value Set, Hospice Intervention Value Set, and Palliative Care Value Set available in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.
- The exclusion criteria are for beneficiaries with a diagnosis code for cancer or sickle cell disease during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
- When determining the eligible population, under Step 1 of the Event/Diagnosis, the process for counting the total days' supply when there are multiple prescriptions with overlapping days of supply depends on whether the prescriptions are filled on the same day or on different days.
  - If prescriptions are filled on the **same day**, states should count only the days' supply for the prescription filled with the longest supply toward the total. For example, if an individual had two prescriptions filled, one with a 7-day supply and the other with a 30-day supply, on October 15 during the measurement year, of the two claims filled, the state should count only the 30 days' supply claim toward the cumulative days' supply.

- If prescriptions are dispensed on **different days** with overlapping days' supply, states should not account for overlapping days' supply. Each day of overlap should be counted separately towards the total days' supply. For example, if a beneficiary has two claims that were dispensed during the measurement year, the first on January 15, 2023 for a 30-day supply, and the second, on January 20, 2023 for a 7-day supply, then the beneficiary's cumulative days' supply is 37 days.

- Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.
Opioid	See medications listed in Table COB-A.
Benzodiazepine	See medications listed in Table COB-B.
Concurrent use	Overlapping supply for an opioid and a benzodiazepine for 30 or more cumulative days during the measurement year. Concurrent use is identified using the dates of service and days' supply of a beneficiary's prescription claims. The days of concurrent use is the count of days with overlapping days' supply for an opioid and a benzodiazepine.
Prescription claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for an opioid prescription during the measurement year. The IPSD must occur at least 30 days before the end of the measurement year. (i.e., January 1–December 2).
Hospice	Any beneficiary in hospice care at any time during the measurement year. Beneficiaries in hospice are identified by the presence of specific hospice codes in the Hospice Encounter Value Set and Hospice Intervention Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.
Cancer diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for cancer, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Cancer Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.

Sickle cell disease diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for sickle cell disease, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Sickle Cell Disease Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.
Palliative care	Any beneficiary with an ICD-10-CM diagnosis code for palliative care, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Palliative Care Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year with one allowable gap, as defined, below.
Allowable gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).
Anchor date	None.
Benefit	Medical and pharmacy.
Event/ diagnosis	Use the steps below to determine the eligible population. Step 1 • Identify beneficiaries with 2 or more prescription claims for opioid medications (Table COB-A) on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year. • Exclude days' supply that occur after the end of the measurement year. Note: • The prescriptions can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply.

Event/ diagnosis (continued)	Step 2 Identify beneficiaries with an IPSD on January 1 through December 2 of the measurement year. Step 3 Exclude beneficiaries with at least one of the following during the measurement year: • Hospice. • Cancer diagnosis. • Sickle cell disease diagnosis. • Palliative care.

Table COB-A. Opioid Medications[a,b]

Benzhydrocodone	Hydrocodone	Morphine	Oxymorphone
Buprenorphine	Hydromorphone	Opium	Pentazocine
Butorphanol	Levorphanol	Oxycodone	Tapentadol
Codeine	Meperidine		Tramadol
Dihydrocodeine	Methadone		
Fentanyl			

[a] Includes combination products and prescription opioid cough medications.

[b] Excludes the following: injectable formulations; sublingual sufentanil (used in a supervised setting); and single-agent and combination buprenorphine products used to treat opioid use disorder (e.g., buprenorphine sublingual tablets, Probuphine® Implant kit subcutaneous implant, and all buprenorphine/naloxone combination products).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries from the denominator with:

- Two or more prescription claims for any benzodiazepine (Table COB-B) with different dates of service, AND
- Concurrent use of opioids and benzodiazepines for 30 or more cumulative days

Follow the steps below to identify beneficiaries for the numerator.

Step 1

From the denominator population, identify beneficiaries with two or more prescription claims with different dates of service for any benzodiazepine (Table COB-B) during the measurement year.

Step 2

Of the population identified in Step 1, determine the total days of overlap (concurrent use) between the opioids and benzodiazepine prescriptions during the measurement year. Concurrent use is identified using the dates of service and days' supply of an individual's opioid and benzodiazepine prescription drug claims. The days of concurrent use is the sum of the number of days (cumulative) during the measurement year with overlapping days' supply for an opioid and a benzodiazepine. Exclude days of supply and overlap that occur after the end of the measurement year.

Note:

- If multiple prescriptions for opioids (or benzodiazepines) are dispensed on the same day, calculate the number of days covered by an opioid (or benzodiazepine) using the prescriptions with the longest days' supply.
- If multiple prescription claims of opioids (or benzodiazepines) are dispensed on different days with overlapping days' supply, count each day in the measurement year only once toward the numerator. There is no adjustment for early fills or overlapping days' supply for opioids (or benzodiazepines).

Step 3

Count the number of beneficiaries with concurrent use for 30 or more cumulative days. This is the numerator.

Table COB-B. Benzodiazepine Medications[a,b]

Alprazolam	Clorazepate	Lorazepam	Temazepam
Chlordiazepoxide	Diazepam	Midazolam	Triazolam
Clobazam	Estazolam	Oxazepam	
Clonazepam	Flurazepam	Quazepam	

[a] Excludes injectable formulations.

[b] Includes combination products.

Rate

Divide the numerator by the denominator and multiply by 100.

E. ADDITIONAL NOTES

This measure is not intended for clinical-decision-making. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Centers for Disease Control and Prevention (CDC) 2022 Clinical Practice Guideline for Prescribing Opioids for Pain available at https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w.

MEASURE CPA-AD: CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) HEALTH PLAN SURVEY 5.1H, ADULT VERSION (MEDICAID)

Agency for Healthcare Research and Quality (survey instrument)

National Committee for Quality Assurance (survey administration protocol)

A. DESCRIPTION

This measure provides information on the experiences of beneficiaries' with their health care and gives a general indication of how well the health care meets the beneficiaries' expectations. Results summarize beneficiaries' experiences through ratings, composites, and question summary rates.

Four global rating questions reflect overall satisfaction:

- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often
- Rating of Health Plan

Four composite scores summarize responses in key areas:

- Getting Care Quickly
- Getting Needed Care
- How Well Doctors Communicate
- Customer Service

A single question reflects experience of care in the following key area:

- Coordination of Care

In addition, item-specific results ("question summary rates") are reported for select questions.

Data Collection Method: Survey

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older as of December 31 of the measurement year.
- The version included in the Adult Core Set is CAHPS 5.1H, Adult Version (Medicaid). See Appendix B for the CAHPS 5.1H Adult Questionnaire.
- The survey should be conducted by a third-party vendor according to CAHPS Health Plan Survey guidelines or the HEDIS protocol. Appendix C contains additional guidance on conducting the CAHPS 5.1H Adult Survey, including the sampling protocol.

- To reduce state burden and streamline reporting, CMS will calculate state-level performance results for this measure using data submitted for the state to the AHRQ CAHPS Health Plan Survey Database. Alternatively, states can report that they conducted a CAHPS survey for the Adult Medicaid population for 2025 in the online Core Set reporting system.
- More information about participating in the CAHPS Health Plan Survey Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/participate.html.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.
Required exclusion (Supplemental and medical record data may be used for this exclusion)	Beneficiaries who die any time during the measurement year.

C. IMPLEMENTING THE CAHPS SURVEY

Administration	Survey should be conducted by a third-party vendor according to CAHPS Health Plan Survey guidelines or the HEDIS protocol. See Appendix C for more information.
Collection mode	Survey data collection methodologies include Mail-Only and Mixed (mail and telephone) mode protocols. In addition, Internet enhancements are permitted.
Sample size	The sample needs to be large enough to achieve a goal of 411 completed surveys per reporting unit (e.g., health plan, PCCM program, or state) and at least 100 valid responses on each question, a cost-effective method shown to produce statistically valid survey comparisons.

D. COMPLETION CRITERIA

The survey vendor assigns a disposition code of Complete and Eligible when the following conditions are met:

- Responses indicate that the beneficiary meets the eligible population criteria
- Three of the five questions listed in the table below are answered appropriately

Survey Type	Questions for Complete and Eligible Survey				
Adult Medicaid	Q3	Q10	Q19	Q23	Q28

Notes:

- See Appendix B for the Adult Medicaid questionnaire.
- The questions for the Complete and Eligible Survey represent the first question in each section of the CAHPS survey (except for the “About You” section) and the Rating of Health Plan question.

MEASURE CPU-AD: LONG-TERM SERVICES AND SUPPORTS COMPREHENSIVE CARE PLAN AND UPDATE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries receiving long-term services and supports (LTSS) services ages 18 and older who have documentation of a comprehensive long-term services and supports (LTSS) care plan in a specified time frame that includes core elements. The following rates are reported:

1. Care Plan with Core Elements Documented. Beneficiaries who had a comprehensive LTSS care plan with 9 core elements documented within 120 days of enrollment (for new beneficiaries) or during the measurement year (for established beneficiaries).
2. Care Plan with Supplemental Elements Documented. Beneficiaries who had a comprehensive LTSS care plan with 9 core elements and at least 4 supplemental elements documented within 120 days of enrollment (for new beneficiaries) or during the measurement year (for established beneficiaries).

In addition, states should report the number of exclusions by type: “Could Not Be Reached for Care Planning” and “Refusal to Participate in Care Planning.”

Data Collection Method: Case management record review

Guidance for Reporting:

- LTSS are a spectrum of health and social services that support older adults or people with disabilities who need help with daily tasks. They can be provided in the home and community or in a facility. LTSS organizations eligible to report the measure are organizations that provide, coordinate, or pay for comprehensive LTSS (e.g., managed LTSS plans and community-based organizations [CBOs] engaged in coordinating LTSS).
- The measure intends to include those beneficiaries receiving LTSS services. States may define the LTSS benefit differently and may include home- and community-based services and/or institutional care services. For health plans, the initial population is the LTSS plan benefit-package level in the MCO. Include beneficiaries if the plan has received authorization or notification from the state that they are in a rate class that covers LTSS. Do not include beneficiaries who do not require the use of LTSS services. For example, if aged, blind, and disabled beneficiaries are automatically enrolled in the LTSS benefit, but they do not require LTSS services, do not include them in the initial population.
- Because the measure evaluates nonmedical services, it is not necessary to review medical records. States may choose administrative data or review beneficiary medical records if they are available, but this is not required.

B. DEFINITIONS

New beneficiary	A beneficiary who was newly enrolled in the LTSS services between August 1 of the year prior to the measurement year and July 31 of the measurement year.
Established beneficiary	A beneficiary who was enrolled prior to August 1 of the year prior to the measurement year.
Care manager	The LTSS employee or contracted employee responsible for conducting an assessment and developing a care plan with the LTSS beneficiary. The care manager is not required to have a specific type of professional license.
LTSS care plan	Also referred to as a "service plan," a document or electronic tool that identifies beneficiary needs, preferences, and risks, and contains a list of services and supports planned to meet needs and reduce risks. The care plan must include nine core elements and may also include supplemental elements. It must include evidence that a beneficiary agreed to the care plan.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	Enrollment in LTSS services for at least 150 days between August 1 of the year prior to the measurement year and December 31 of the measurement year. For beneficiaries with multiple distinct continuous enrollment periods during the measurement year, look at the care plan completed in the last continuous enrollment period of 150 days or more during the measurement year.
Allowable gap	None.
Anchor date	December 31 of the measurement year.
Benefits	Coverage or coordination of home and community- or institution-based LTSS. This includes beneficiaries who are enrolled in the LTSS benefit and require LTSS.
Event/ diagnosis	None.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Required exclusions are reported with the measure rates. • Could not be reached for care planning. – New beneficiaries who could not be contacted to create an LTSS comprehensive care plan within 120 days of enrollment. – Established beneficiaries who could not be contacted to create an LTSS comprehensive care plan during the measurement year. – LTSS services organizations use their own process for identifying beneficiaries who cannot be contacted for care planning. There must be documentation in the case management record that at least three attempts were made to contact the beneficiary, the date and mode of each contact (e.g., telephone call, letter), and that the beneficiary could not be reached. Beneficiaries with partial care plans may not be classified as "could not be contacted for care plan." • Refusal to participate in care planning. – Beneficiaries who refused a LTSS comprehensive care plan. There must be documentation in the case management record that the beneficiary was contacted and refused the care plan, and the date of the refusal. Beneficiaries with partial care plans may not be classified as "refused care plan."

D. SPECIFICATION

Denominator

This measure is based on review of LTSS case management records drawn from a sample of the eligible population. The minimum required sample size for this measure is 96.

Numerators

The measure reports two numerators:

Care Plan with Core Elements Documented

New beneficiaries who had: A comprehensive LTSS care plan completed within 120 days of enrollment, with 9 core elements documented. If the comprehensive care plan is developed as part of the process to determine eligibility for the LTSS benefit and occurs within 30 days prior to the enrollment start date, it may be counted toward the measure if the care plan meets the rest of the numerator criteria.

OR

Established beneficiaries who had: A comprehensive LTSS care plan completed during the measurement year, with 9 core elements documented.

The care plan must be discussed during a face-to-face, telephone, or video conference encounter between the care manager and the beneficiary. The care plan is not required to be created in the beneficiary's home. Assessment of the beneficiary and development of the care plan may be done during the same encounter or during different encounters.

Note: Beneficiaries without a care plan, or with an incomplete care plan, may not be excluded.

Core elements of the care plan

1. At least one individualized beneficiary goal (medical or nonmedical outcome important to the beneficiary, such as losing weight, reducing specific symptoms, staying out of the hospital, engaging in a hobby, pursuing an interest, seeking out social contact, taking a special trip, living to see a relative's life milestone). Documenting that beneficiary is too cognitively impaired to provide a goal and has no family members meets the element.
    a. Note: Goals that are determined solely by the provider without beneficiary input, or automatically generated based on patient conditions or risk factors, do not count as a beneficiary goal.
2. A plan of care to meet the beneficiary's medical needs; for example, support for managing or treating chronic or acute conditions. Document either that the plan addresses the beneficiary's needs or that the beneficiary does not have medical needs.
3. A plan of care to meet the beneficiary's functional needs; for example, support for activities of daily living limitations (bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking) or instrumental activity of daily living limitations (shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances). Document either that the plan addresses the beneficiary's needs or that the beneficiary does not have functional needs.
4. A plan of care to meet the beneficiary's needs due to cognitive impairment; for example, support for behavioral difficulties, caregiver support or education to address cognitive impairment, support for engaging the beneficiary in activities. Document either that the plan addresses the beneficiary's needs or that the beneficiary does not have needs resulting from cognitive impairment.
5. A list of all LTSS services and supports the beneficiary receives, or is expected to receive in the next month, in the home (paid or unpaid) or in other settings (e.g., adult day health center, nursing facility), including the number (e.g., hours, days) and frequency (e.g., every day, once a week). Documenting that the beneficiary does not receive LTSS meets numerator criteria.
6. A plan for the care manager to follow up and communicate with the beneficiary (e.g., a follow-up and communication schedule).
7. A plan to ensure that the beneficiary's needs are met in an emergency (e.g., the care assistant or home health aide cannot get to the beneficiary's home, natural disaster). At a minimum, include the name of the LTSS staff member or a contracted provider to contact in an emergency.
8. Family/friend caregivers who were involved in development of the care plan, and their contact information. Documenting either that there is no family/friend caregiver involvement or that family/friend caregivers were invited to participate in care planning, but declined, meets the element.
9. Beneficiary or beneficiary representative agreement to or appeal of the completed care plan. Documentation includes beneficiary/ representative verbal agreement by telephone or in person, or written agreement (e.g., a signature) sent by mail to the case manager.
    a. A "beneficiary representative" is anyone who has been authorized to make decisions on behalf of the beneficiary, including, but not limited to, power of attorney, spouse, parent, or other family beneficiary.

b. Documenting that a care plan was discussed or reviewed does not meet the measure. Agreement or appeal by the beneficiary/representative must be documented.

Care Plan with Supplemental Elements Documented

New beneficiaries who had: A comprehensive LTSS care plan completed within 120 days of enrollment, with 9 core elements and at least 4 supplemental elements documented. If the comprehensive care plan is developed as part of the process to determine eligibility for the LTSS benefit and occurs within 30 days prior to the enrollment start date, it may be counted toward the measure if the care plan meets the rest of the numerator criteria.

OR

Established beneficiaries who had: A comprehensive LTSS care plan created during the measurement year, with 9 core elements and at least 4 supplemental elements documented.

The care plan must be discussed during a face-to-face, telephone, or video conference encounter between the care manager and the beneficiary. The care plan is not required to be created in the beneficiary's home.

Assessment and development of the care plan may be done during the same encounter or during different encounters.

Supplemental elements of the care plan:

1. A plan of care to meet the beneficiary's mental health needs (e.g., depression, anxiety). Document either that the plan addresses the beneficiary's needs or that the beneficiary does not have mental health needs.
2. A plan of care to meet the beneficiary's social or community integration needs; for example, through planned social activities with friends and family, participation in community-based activities, participation in work or volunteer activities. Documenting that the beneficiary does not have social or community integration needs meets the numerator criteria.
3. The duration (how long services will be provided or when need for services will be assessed) of all LTSS the beneficiary receives or is expected to receive in the next month, in the home (paid or unpaid) or in other settings (e.g., adult day health center, nursing facility), or the date when services will be reassessed. Documenting that the beneficiary does not receive LTSS meets the numerator criteria.
4. Contact information for the beneficiary's LTSS providers. Documenting that the beneficiary does not receive LTSS meets the numerator criteria.
5. A plan to assess the beneficiary's progress toward meeting established goals, including a time frame for reassessment and follow-up.
6. Barriers to meeting defined goals (e.g., life, community, or health factors that may make it difficult for the beneficiary to meet goals).
7. The beneficiary's first point of contact. Providing the care manager's contact information to the beneficiary meets the element.
8. Contact information for beneficiary's primary care practitioner (PCP), or a plan for connecting the beneficiary to a PCP if the beneficiary does not currently have one.

MEASURE EDV-AD: AMBULATORY CARE SENSITIVE EMERGENCY DEPARTMENT VISITS FOR NON-TRAUMATIC DENTAL CONDITIONS IN ADULTS

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Number of emergency department (ED) visits for ambulatory care sensitive non-traumatic dental conditions per 100,000 beneficiary months for adults age 18 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups: ages 18 to 64 and age 65 and older.
- The measurement period for this measure is the calendar year.
- States should report this measure as a rate per 100,000 beneficiary months.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 18 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator. Assignment of beneficiary months to the age stratifications (18 to 64 or 65 and older) for the denominator is based on the beneficiary's age during the eligible beneficiary month (as of the consistent date referenced above). For beneficiaries turning 65 during the reporting year, it is possible to contribute beneficiary months to both age stratifications during the year.
  - For each ED visit representing a qualifying numerator event, assess the beneficiary's age on the date of the visit. Assignment of ED visits to the age stratifications (18 to 64 or 65 and older) for the numerator is based on the beneficiary's age on the date of the ED visit. Only visits for beneficiaries age 18 or older should be included in the numerator. In addition, the visit must occur during a month in which the beneficiary is enrolled and included in the denominator to count for the numerator.
- Include only paid claims.
- The codes used to calculate this measure are included below and in Tables EDV-A and EDV-B at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-

adult-non-hedis-value-set-directory.zip. Both the specifications and the tables must be referenced to identify all needed codes.

This measure includes the following coding systems: CPT, Revenue, UB, and ICD-10-CM. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 18 and older as of the 15th or 30th day of the month. Date for counting beneficiaries must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	Not applicable (no continuous enrollment requirement).
Anchor date	None.
Benefit	Medical.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of Medicaid enrollment for beneficiaries age 18 and older during the measurement year.

Numerator

ED visits with an ambulatory care sensitive non-traumatic dental condition diagnosis code among beneficiaries age 18 and older during eligible beneficiary months within the measurement year.

Step1

Identify a health care encounter as an ED visit if any of the following codes are present:

- [CPT CODE] = 99281-99285 (ED visit for patient evaluation/management), OR
- [REVENUE CODE] = 0450-0459 (Emergency Room) or 0981 (professional fees for ER services), OR
- [CMS place of service code for professional claims] = 23 (Emergency Room)

If any these criteria are met, include in the numerator and continue to the next step.

Step 2

Confirm that the beneficiary is age 18 or older on the date of ED visit.

Step 3

Identify an ED visit as being for an ambulatory care sensitive non-traumatic dental condition if:

- Any of the ICD-10-CM diagnosis codes in Table EDV-A is listed as a FIRST-LISTED diagnosis code associated with the visit, OR
- If both of the following criteria are met:
  - Any of the ICD-10-CM diagnosis codes in Table EDV-B is listed as a FIRST-LISTED diagnosis, AND
  - Any of the ICD-10-CM diagnosis codes in Table EDV-A is listed as an ADDITIONAL LISTED diagnosis.

  Note: Codes from Table EDV-B must be accompanied by a code from Table EDV-A to qualify as a non-traumatic dental condition ED visit.

  Note: Tables EDV-A and EDV-B are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Step 4

Exclude visits that result in inpatient admissions, where inpatient admissions are identified as:

- The patient has an inpatient admission defined by UB Type of Bill = 11x OR 12x OR 41x, AND
- That admission occurred within 48 hours of the ED visit:
  [inpatient admit date] – [ED admit date] >= 0 days AND <= 2 days.

Note: If there are 2 or more dental ED visits that occurred within 2 days of the same inpatient admission, only one of those ED visits should be counted as resulting in an inpatient admission.

Example: If there is one dental-related ED visit on May 1 and a second dental-related ED visit on May 2 with an inpatient admission also occurring on May 2, then this would be counted as two ED visits with one being excluded as “resulting in an inpatient admission” and one retained in the denominator as “did not result in an inpatient admission.”

Step 5

Count only one ED visit per beneficiary per day.

Step 6

Sum the number of ED visits for ambulatory care sensitive non-traumatic dental conditions.

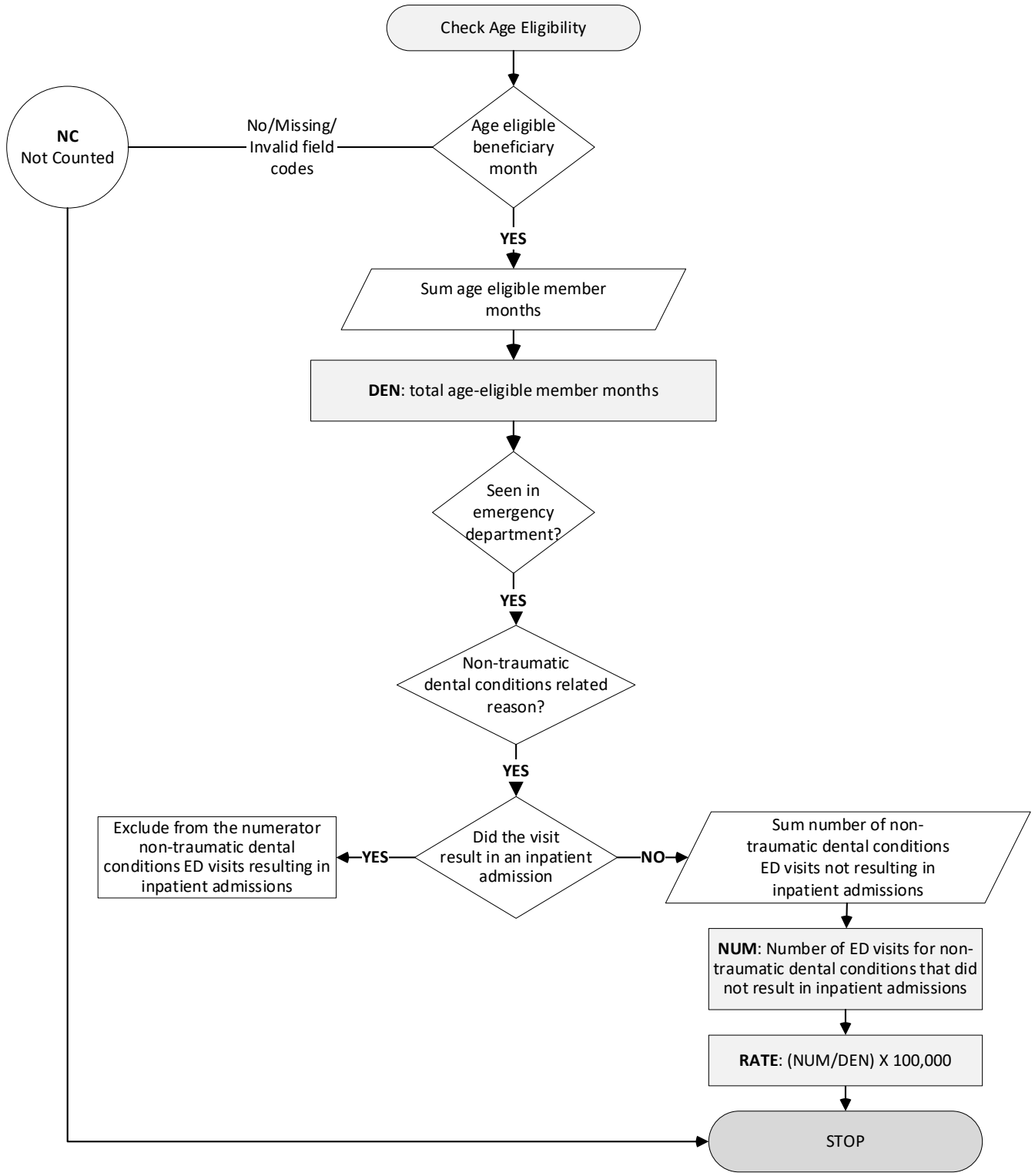
Reporting note for age stratifications: Numerator cases are stratified based on age on date of ED visit.

Exclusions

None.

Figure EDV-A provides a flowchart for implementing these exclusion and inclusion criteria.

Figure EDV-A. Measure Flowchart



D. ADDITIONAL NOTES

More information on the rationale for and implementation of this measure is provided in the DQA Measures User Guide, available at http://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2025/2025_dqa_adult_measures_user_guide_final.pdf.

Data quality considerations:

Reliability of the measure score depends on the quality of the data elements that are used to calculate the measure. The percentages of missing and invalid data for each data element used to calculate the measure must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the accuracy and reliability of the measure rate.

MEASURE FUA-AD: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE: AGE 18 AND OLDER

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

- Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).
- Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: Ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older). The Child Core Set measure applies to beneficiaries ages 13 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- The denominator should be the same for the 30-day rate and the 7-day rate within each age group.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then use only facility claims to identify services and diagnoses (the codes must be on the same claim).

[1] Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix D for the definition of a mental health provider. States must develop their own methods to identify mental health providers.
- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of the ED visit.
Continuous enrollment	The date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical, chemical dependency, and pharmacy. Note: Beneficiaries with withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.
Event/ diagnosis	An ED visit (ED Value Set) with a principal diagnosis of SUD (AOD Abuse and Dependence Value Set) or any diagnosis of drug overdose (Unintentional Drug Overdose Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period, as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

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. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay.
ED visits followed by residential treatment	Exclude ED visits followed by residential treatment on the date of the ED visit or within the 30 days after the ED visit. Any of the following meets criteria for residential treatment: • Residential Behavioral Health Treatment Value Set. • Psychiatric Residential Treatment Center (POS code 56). • Residential Substance Abuse Treatment Facility (POS code 55). • Residential Program Detoxification Value Set. These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up visit or pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider
- An outpatient visit (BH Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An outpatient visit (BH Outpatient Value Set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with POS code 52 with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with POS code 52 with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a mental health provider
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with a mental health provider
- A community mental health center visit (Visit Setting Unspecified Value Set) with POS code 53 with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set) with POS code 53 with a mental health provider
- A peer support service (Peer Support Services Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)

- An opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider
- A telephone visit (Telephone Visits Value Set), with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- A telephone visit (Telephone Visits Value Set) with a mental health provider
- An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of SUD (AOD Abuse and Dependence Value Set), substance use (Substance Induced Disorders Value Set) or drug overdose (Unintentional Drug Overdose Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a mental health provider
- A substance use disorder service (Substance Use Disorder Services Value Set; Substance Abuse Counseling and Surveillance Value Set)
- A behavioral health screening or assessment for SUD or mental health disorders (Behavioral Health Assessment Value Set)
- A substance use service (Substance Use Services Value Set)
- A pharmacotherapy dispensing event (Alcohol Use Disorder Treatment Medications List, Opioid Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or medication treatment event (AOD Medication Treatment Value Set; OUD Weekly Drug Treatment Service Value Set)

D. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after the ED visit or within 7 days after the ED visit).

MEASURE FUH-AD: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: AGE 18 AND OLDER

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for beneficiaries age 18 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 provider. Two rates are reported:

- Percentage of discharges for which the beneficiary received follow-up within 30 days after discharge.
- Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge.

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The Child Core Set measure applies to beneficiaries ages 6 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Follow the detailed specifications to (1) include the appropriate discharge when the beneficiary was transferred directly or readmitted to an acute or non-acute care facility for a mental health diagnosis, and (2) exclude discharges in which the beneficiary was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.
- The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate within each age group.
- This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or from the same visit.
  - This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).

- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix D for the definition of a mental health provider. States must develop their own methods to identify mental health providers.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of date of discharge.
Continuous enrollment	Date of discharge through 30 days after discharge.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health (inpatient and outpatient).
Event/ diagnosis	An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness and Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on beneficiaries. If beneficiaries have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.
Acute readmission or direct transfer	Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay (the admission date must occur during the 30-day follow-up period). 4. Identify the discharge date for the stay. Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

Acute readmission or direct transfer (continued)	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.
Nonacute readmission or direct transfer	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of the principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. These discharges are excluded from this measure because rehospitalization or direct transfer may prevent an outpatient follow-up visit from taking place.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up

A follow-up visit with a mental health provider within 30 days after discharge. Do not include visits that occur on the date of discharge.

7-Day Follow-Up

A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider
- An outpatient visit (BH Outpatient Value Set) with a mental health provider
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with POS code 52)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Transitional Care Management Services Value Set) with POS code 53
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set) with a mental health provider
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set)
- A telephone visit (Telephone Visits Value Set) with a mental health provider
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set)

D. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required period for the rate (e.g., within 30 days after discharge or within 7 days after discharge).

MEASURE FUM-AD: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS: AGE 18 AND OLDER

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported:

- Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).
- Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older). The Child Core Set measure applies to beneficiaries ages 6 to 17 and the Adult Core Set measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- The denominator should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate within each age group.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending and denied claims.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

[1] Adapted from an NCQA measure with financial support from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under Prime Contract No. HHSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

B. ELIGIBLE POPULATION

Age	Age 18 and older as of the date of the ED visit.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health.
Event/ diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness and Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the beneficiary was age 18 or older on the date of the visit. The denominator for this measure is based on ED visits, not on beneficiaries. If a beneficiary has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.
Multiple visits in a 31-day period	If a beneficiary has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a beneficiary has an ED visit on January 1, include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically, including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.
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. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. These events are excluded from this measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up

A follow-up visit with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of mental health disorder 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 a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with POS code 52 with a principal diagnosis of mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set with POS code 53 with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with POS code 52 with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A community mental health center visit (Visit Setting Unspecified Value Set) with POS code 53 with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Outpatient POS Value Set; POS code 24; POS code 52; POS code 53) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An e-visit or virtual check-in (Online Assessments Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)

D. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient visits and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are

comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required period specified for the rate (within 30 days after the ED visit or within 7 days after the ED visit).

MEASURE GSD-AD: GLYCEMIC STATUS ASSESSMENT FOR PATIENTS WITH DIABETES

National Committee for Quality Assurance

A. DESCRIPTION

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

- Glycemic Status <8.0%.
- Glycemic Status >9.0%.

Note: States must use the same data collection method (Administrative or Hybrid) to report these indicators.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- For HEDIS, this measure applies to beneficiaries ages 18 to 75. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, CPT CAT II, HCPCS, ICD-10-CM, LOINC, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 18 to 75 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.

Benefit	Medical.
Event/ diagnosis	There are two ways to identify beneficiaries with diabetes: by claim/encounter data and by pharmacy data. The state must use both methods to identify the eligible population, but a beneficiary only needs to be identified by one method to be included in this measure. Beneficiaries may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data. Beneficiaries who had at least two encounters with diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). Pharmacy data. Beneficiaries who were dispensed insulin or hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List, see link to the Medication List Guidance for Reporting above) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet any of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. If a state reports this measure using the Hybrid method, and a beneficiary is found to be using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year. • Beneficiaries who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81). • Beneficiaries age 66 and older as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both frailty and advanced illness criteria to be excluded: 1. Frailty. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set;

Required exclusions (Supplemental and medical record data may be used for these exclusions) (continued)	Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81). 2. Advanced Illness: Either of the following during the measurement year or the year prior to the measurement year: - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). - Dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above).

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Glycemic Status <8%

Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HBA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set) or from laboratory claims (claims with POS code 81). The beneficiary is numerator compliant if the most recent glycemic status assessment has a result of <8.0%. The beneficiary is not numerator compliant if the result of the most recent glycemic status assessment is ≥ 8.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. If there are multiple glycemic status assessments on the same date of service, use the lowest result.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- Compliant: HbA1c Level Less than 8.0 Value Set
- Not compliant: HbA1c Level Greater Than or Equal To 8.0 Value Set.

Glycemic Status >9%

Identify the most recent glycemic status assessment (HbA1c or GMI) (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HBA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set) or from laboratory claims (claims with POS code 81). The beneficiary is numerator compliant if the most recent glycemic status assessment has a result of >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. The beneficiary is not numerator compliant if the result for the most recent glycemic status assessment during the measurement year is ≤ 9.0%. If there are multiple glycemic status assessments on the same date, use the lowest result.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- Compliant: CPT Category II code 3046F.
- Not compliant: HbA1c Level Less Than or Equal To 9.0 Value Set.

Note: A lower rate indicates better performance for this indicator (e.g., low rates of Glycemic Status >9% indicate better care).

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

Numerators

Glycemic Status <8%

The result of the most recent glycemic status assessment (HbA1c or GMI) (performed during the measurement year) is <8.0% as documented through laboratory data or medical record review.

Administrative Data

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical Record Review

At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed, and the result. The beneficiary is numerator compliant if the result of the most recent glycemic status assessment during the measurement year is <8.0%.

When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date.

If multiple glycemic status assessments were recorded for a single date, use the lowest result.

GMI results collected by the beneficiary and documented in the beneficiary's medical record are eligible for use in reporting (provided the GMI does not meet any exclusion criteria). There is no requirement that there be evidence the GMI was collected by a PCP or specialist.

The beneficiary is not numerator compliant if the result of the most recent glycemic status assessment during the measurement year is ≥ 8.0% or is missing, or if a glycemic status assessment was not performed during the measurement year. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. "Unknown" is not considered a result/finding.

Glycemic Status >9%

The result of the most recent glycemic status assessment (HbA1c or GMI) (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through laboratory data or medical record review.

Note: A lower rate indicates better performance (e.g., low rates of Glycemic Status >9% indicate better care).

Administrative Data

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical Record Review

At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment was performed and the result. The beneficiary is numerator compliant if the result of the most recent glycemic status assessment during the measurement year is >9.0% or is missing, or if a glycemic status assessment was not done during the measurement year.

When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value. The terminal date in the range should be used to assign assessment date.

If multiple glycemic status assessments were recorded for a single date, use the lowest result.

GMI results collected by the beneficiary and documented in the beneficiary's medical record are eligible for use in reporting (provided the GMI does not meet any exclusion criteria). There is no requirement that there be evidence the GMI was collected by a PCP or specialist.

The beneficiary is not numerator compliant if the most recent glycemic status during the measurement year is ≤ 9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. "Unknown" is not considered a result/finding.

E. ADDITIONAL NOTES

If a combination of administrative, supplemental, or hybrid data are used, the most recent glycemic status assessment must be used, regardless of data source.

MEASURE HPCMI-AD: DIABETES CARE FOR PEOPLE WITH SERIOUS MENTAL ILLNESS: GLYCEMIC STATUS > 9.0%

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 18 to 75 with a serious mental illness and diabetes (type 1 and type 2) who had a glycemic status assessment result of >9.0%.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This is a NCQA-owned and copyrighted measure that is not currently contained in HEDIS®.
- This measure applies to beneficiaries ages 18 to 75. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and ages 65 to 75.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding for services, procedures, and diagnoses: CPT, CPT CAT II, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Ages 18 to 75 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.

Event/ diagnosis	Follow the steps below to identify beneficiaries with diabetes and serious mental illness. Step 1 Identify beneficiaries ages 18 to 75 as of the end of the measurement year. Step 2 Identify beneficiaries from step 1 with a diagnosis of serious mental illness. Beneficiaries are identified as having serious mental illness if they met at least one of the following criteria during the measurement year: • At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder. Either of the following code combinations meet criteria: – BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set). – Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set; Bipolar Disorder Value Set; Other Bipolar Disorder Value Set. • At least two of the following, on different dates of service where both encounters have any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) or both encounters have any diagnosis of bipolar disorder (Bipolar Disorder Value Set; Other Bipolar Disorder Value Set). – An outpatient visit (Visit Setting Unspecified Value Set) with Outpatient POS Value Set. – An outpatient visit (BH Outpatient Value Set). – An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with POS code 52). – An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). – A community mental health center visit (Visit Setting Unspecified Value Set with POS code 53). – Electroconvulsive therapy (Electroconvulsive Therapy Value Set). – An ED visit (ED Value Set). – An ED visit (Visit Setting Unspecified Value Set with POS code 23). – A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set). – A nonacute inpatient encounter (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set). – A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set).

Event/ diagnosis (continued)	– A telephone visit (Telephone Visits Value Set). – An e-visit or virtual check-in (Online Assessments Value Set). Step 3 Identify beneficiaries from step 2 with diabetes. There are two ways to identify beneficiaries with diabetes: by claim/encounter data and by pharmacy data. The state must use both methods to identify the eligible population, but a beneficiary only needs to be identified by one method to be included in this measure. Beneficiaries may be identified as having diabetes during the measurement year or the year prior to the measurement year. Claim/encounter data. Beneficiaries who had at least two encounters with diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). Pharmacy data. Beneficiaries who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List, see link to the Medication List Directory in Guidance for Reporting above) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet any of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year. • Beneficiaries age 66 and older as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both frailty and advanced illness criteria to be excluded:

Required exclusions (Supplemental and medical record data may be used for these exclusions) (continued)	1. Frailty. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81). 2. Advanced Illness: Either of the following during the measurement year or the year prior to the measurement year): - Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). - Dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above).

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Identify the most recent glycemic status assessment (HbA1c or GMI) (see HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set; LOINC code 97506-0) during the measurement year. Do not include CPT Category II codes (HbA1c Test Result or Finding Value Set) with a modifier (CPT CAT II Modifier Value Set) or from laboratory claims (claims with POS code 81). The beneficiary is numerator compliant if the most recent glycemic status assessment is >9.0% or is missing a result, or if a glycemic status assessment was not done during the measurement year. The beneficiary is not numerator compliant if the result for the most recent glycemic status assessment during the measurement year is ≤ 9.0%. If there are multiple glycemic status assessments on the same date, use the lowest result.

If the most recent glycemic status assessment was an HbA1c test identified based on a CPT Category II code (HbA1c Test Result or Finding Value Set), use the following to determine compliance:

- Compliant: CPT Category II code 3046F.
- Not compliant: HbA1c Level Less Than or Equal To 9.0 Value Set.

Note: A lower rate indicates better performance for this indicator (e.g., low rates of Glycemic Status >9% indicate better care).

D. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

Numerator

The result of the most recent glycemic status assessment (HbA1c or GMI) (performed during the measurement year) is >9.0% or is missing, or was not done during the measurement year, as documented through laboratory data or medical record review.

Note: A lower rate indicates better performance (e.g., low rates of Glycemic Status >9% indicate better care).

Administrative Data

Refer to the Administrative Specification to identify positive numerator hits from administrative data.

Medical Record Review

At a minimum, documentation in the medical record must include a note indicating the date when the glycemic status assessment was performed and the result. The beneficiary is numerator compliant if the result of the most recent glycemic status assessment during the measurement year is >9.0% or is missing, or if a glycemic status assessment was not done during the measurement year.

When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glycose monitoring data date range to derive the value. The terminal date in the range should be used to assign assessment date.

If multiple glycemic status assessments were recorded for a single date, use the lowest result.

GMI results collected by the beneficiary and documented in the beneficiary's medical record are eligible for use in reporting (provided the GMI does not meet any exclusion criteria). There is no requirement that there be evidence the GMI was collected by a PCP or specialist.

The beneficiary is not numerator compliant if the most recent glycemic status assessment during the measurement year is ≤ 9.0%.

Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance. "Unknown" is not considered a result/finding.

E. ADDITIONAL NOTES

If a combination of administrative, supplemental or hybrid data are used, the most recent glycemic status assessment result must be used, regardless of data source.

MEASURE HVL-AD: HIV VIRAL LOAD SUPPRESSION

Health Resources and Services Administration

A. DESCRIPTION

Percentage of beneficiaries age 18 and older with a diagnosis of Human Immunodeficiency Virus (HIV) who had a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- There are no patient exclusions for this measure.
- States may use a combination of administrative data (Medicaid claims data and HIV surveillance data) or EHR data to calculate the measure.
- The electronic clinical quality measure (eCQM) specifications for the 2025 Core Set are located at https://ecqi.healthit.gov/ecqm/ec/2024/cms0314v1?qt-tabs_measure=specifications-and-data-elements. Please note, the eCQM specifications are the same as those under consideration for adoption into the Centers for Medicare & Medicaid Services Merit Based Incentive Payment System Program (MIPS). States that use electronic specifications should indicate this by selecting “Electronic Health Records” in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative specification. States should use caution comparing measures calculated using different data collection methods.
- States can find technical assistance resources to assist in calculating the measure at https://targethiv.org/spns/medicaid_data_set.
- The eligible population and the denominator population are the same.
- The eligible population includes beneficiaries who have received a medical visit, but not necessarily an HIV viral load test, during the measurement year.
- The eligible/denominator population should be limited to people who have a laboratory test confirming HIV diagnosis that occurred prior to the measurement year or within the first 90 days of the measurement year AND have a medical visit during the first 240 days of the measurement year. States may use HIV surveillance data or match HIV surveillance and Medicaid data to identify the eligible/denominator population and numerator population.
- States that are interested in using HIV surveillance data to calculate this measure may request additional information by emailing MACQualityTA@cms.hhs.gov.
- Include all paid, suspended, pending, and denied claims.

- Medical visits should be conducted by a provider with prescribing privileges (e.g., physician, nurse practitioner, and/or physician's assistant) within a primary care or infectious disease specialty care setting.
- Users should convert the test results reported in logs copies/mL to copies/mL. For example, if the HIV viral load result is 10^3 or 3 on a logarithmic scale, it would be equal to 10 x 10 x 10 copies, or 10^3 or 1,000 copies/mL.
- The tables contain value sets that use an object identifier (OID). The OIDs are available at the National Library of Medicine's Value Set Authority Center (VSAC) - https://vsac.nlm.nih.gov/.

This measure includes the following coding systems: CPT, ICD-10-CM, LOINC, and SNOMED. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

HIV viral load	The HIV viral load is the number of copies of the human immunodeficiency virus in the blood.
HIV viral load test	The HIV viral load test measures the number of HIV copies in a milliliter of blood.
Measurement year	Calendar year 2024.

C. ELIGIBLE POPULATION

The eligible population is the same as the denominator.

Age	Age 18 and older as of December 31 of the measurement year.
HIV diagnosis	Beneficiaries who had a diagnosis of HIV (Table HVL-A) prior to the start of the measurement year or within the first 90 days of the measurement year.
Event	At least one medical visit in the first 240 days of the measurement year (Tables HVL-B – HVL-I).

D. ADMINISTRATIVE SPECIFICATION

Eligible Population/Denominator

The beneficiary must meet all three criteria to be included in the eligible population/denominator.

1. Age 18 and older
2. Diagnosis of HIV (Table HVL-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip or HIV surveillance data) prior to the start of the measurement year or within the first 90 days of the measurement year

3. At least one medical visit (Tables HVL-B – HVL-I available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip or HIV surveillance data) must occur in the first 240 days of the measurement year

Numerator

The number of beneficiaries in the eligible population/denominator with a HIV viral load less than 200 copies/mL (Table HVL-J available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip or HIV surveillance data. Table HVL-J lists the HIV viral load tests. Users should convert the test results reported in logs copies/mL to copies/mL. Users need to determine which test results were less than 200 copies/mL at last HIV viral load test during the measurement year.

MEASURE IET-AD: INITIATION AND ENGAGEMENT OF SUBSTANCE USE DISORDER TREATMENT

National Committee for Quality Assurance

A. DESCRIPTION

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

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

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- For HEDIS, this measure has three reportable age groups and a total rate: ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older). For the purpose of Adult Core Set reporting, this measure should be calculated for beneficiaries age 18 and older. States should calculate and report each of the rates for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- Two rates are reported: initiation of SUD treatment and engagement of SUD treatment. For each rate, report the following SUD diagnosis cohorts for each age group:
  - Alcohol use disorder.
  - Opioid use disorder.
  - Other substance use disorder.
  - Total (the total is the sum of the SUD diagnosis cohort stratifications).
- Exclude beneficiaries from the denominator for both rates (initiation of SUD treatment and engagement of SUD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.
- Include all paid, suspended, pending, and denied claims.
- This measure requires that medication assisted treatment (MAT) services match the diagnosis category of the index episode identified in the denominator in order to count towards the numerator of the engagement rate. Depending on the diagnosis used in the denominator (e.g., opioid abuse or dependence and alcohol abuse and dependence), a corresponding MAT medication should be used to satisfy the numerator.
- The SUD diagnosis in the Negative SUD Diagnosis History does not need to match the diagnosis on the claim for the given SUD episode.

- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic clinical quality measure (eCQM) specification for the 2025 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2024/cms137v12. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative specification. States should use caution comparing measures calculated using different data collection methods.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Intake period	November 15 of the year prior to the measurement year to November 14 of the measurement year. The intake period is used to capture new SUD episodes.
SUD episode	An encounter during the Intake Period with a diagnosis of SUD. For visits that result in an inpatient stay, the inpatient discharge is the SUD episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).
SUD episode date	The date of service for an encounter during the intake period with a diagnosis of SUD. For a visit (not resulting in an inpatient stay), the SUD episode date is the date of service. For an inpatient stay or for withdrawal management (i.e., detoxification) that occurred during an inpatient stay, the SUD episode date is the date of discharge. For withdrawal management (i.e., detoxification), other than those that occurred during an inpatient stay, the SUD episode date is the date of service. For direct transfers, the SUD episode date is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

Dates of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the SUD episode date, negative diagnosis history and numerator events).
Direct transfer	A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of the SUD episode date.
SUD diagnosis cohort stratification	Report the following SUD diagnosis cohort stratifications and a total: • Alcohol use disorder. • Opioid use disorder. • Other substance use disorder. • Total (the total is the sum of the SUD diagnosis cohort stratifications).
Continuous enrollment	194 days prior to the SUD episode date through 47 days after the SUD episode date (242 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefits	Medical, pharmacy, and chemical dependency (inpatient and outpatient). Note: Beneficiaries with withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.
Event/ diagnosis	New episode of SUD during the intake period. Follow the steps below to identify the denominator for both rates. Step 1 Identify all SUD episodes. Any of the following meet criteria:

Event/ diagnosis (continued)	• An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An outpatient visit (BH Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with POS code 52 with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • A community mental health center visit (Visit Setting Unspecified Value Set) with POS code 53 with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • A substance use disorder service (Substance Use Disorder Services Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • A withdrawal management event (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

Event/ diagnosis (continued)	• An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the discharge date for the stay. • A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An opioid treatment service (OUD Weekly Non Drug Service Value Set, OUD Monthly Office Based Treatment Value Set, OUD Weekly Drug Treatment Service Value Set) with a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set). Step 2 Test for negative SUD diagnosis history. Remove SUD episodes if the beneficiary had an SUD diagnosis (Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set) during the 194 days prior to the SUD episode date. Do not include ED visits (ED Value Set), withdrawal management events (Detoxification Value Set) or lab claims (claims with POS code 81). If the SUD episode was an inpatient stay, use the admission date to determine negative SUD history. For visits with an SUD diagnosis that resulted in an inpatient stay (where the inpatient stay becomes the SUD episode), use the earliest date of service to determine the negative SUD diagnosis history (so that the visit that resulted in the inpatient stay is not considered a positive diagnosis history). For direct transfers, use the first admission date to determine the negative SUD diagnosis history. Step 3 Test for negative SUD medication history. Remove SUD episodes if any of the following occurred during the 194 days prior to the SUD episode date: • An SUD medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, Naltrexone Injection Medications List, Buprenorphine Oral Medications List, Buprenorphine Injection Medications List, Buprenorphine Implant Medications List, Buprenorphine Naloxone Medications List,

Event/ diagnosis (continued)	see link to the Medication List Directory in Guidance for Reporting above). • An SUD medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Naloxone Value Set, Buprenorphine Implant Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set). Step 4 Remove SUD episodes that do not meet continuous enrollment criteria. Beneficiaries must be continuously enrolled from 194 days before the SUD episode date through 47 days after the SUD episode date (242 total days), with no gaps. Note: The denominator for this measure is based on episodes, not on beneficiaries. All eligible episodes that were not removed remain in the denominator. Step 5 Deduplicate eligible episodes. If a beneficiary has more than one eligible episode on the same day, include only one eligible episode. For example, if a beneficiary has two eligible episodes on January 1, only one eligible episode would be included; then, if applicable, include the next eligible episode that occurs after January 1. Note: The denominator for this measure is based on episodes, not on beneficiaries. All eligible episodes that were not removed or deduplicated remain in the denominator. Step 6 Identify the SUD diagnosis cohort for each SUD episode. • If the SUD episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the alcohol use disorder cohort. • If the SUD episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the opioid use disorder cohort. • If the SUD episode has a diagnosis of SUD that is neither for opioid nor alcohol (Other Drug Abuse and Dependence Value Set), place the beneficiary in the other substance use disorder cohort. Include SUD episodes in all SUD diagnosis cohorts for which they meet criteria. • For example, if the SUD episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Initiation of SUD Treatment

Initiation of SUD treatment within 14 days of the SUD episode date.

Follow the steps below to identify numerator compliance.

Step 1

If the SUD episode was an inpatient discharge, the inpatient stay is considered initiation of treatment and the SUD episode is compliant.

Step 2

If the SUD episode was an opioid treatment service that bills monthly (OUD Monthly Office Based Treatment Value Set), the opioid treatment service is considered initiation of treatment and the SUD episode is compliant.

Step 3

For remaining SUD episodes (those not compliant after steps 1–2), identify episodes with at least one of the following on the SUD episode date or during the 13 days after the SUD episode date (14 total days).

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An outpatient visit (BH Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with POS code 52 with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A community mental health center visit (Visit Setting Unspecified Value Set) with POS code 53 with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A substance use disorder service (Substance Use Disorder Services Value Set; Substance Abuse Counseling and Surveillance Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set, OUD Monthly Office Based Treatment Value Set, OUD Weekly Drug Treatment Service Value Set)
- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set)
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List, Naltrexone Injection Medications List, Buprenorphine Oral Medications List, Buprenorphine Injection Medications List, Buprenorphine Implant Medications List, Buprenorphine Naloxone Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set)

For all initiation events except medication treatment dispensing events and medication administration events, initiation on the same day as the SUD episode date must be with different providers in order to count.

Remove the beneficiary from the denominator for both indicators (Initiation of SUD Treatment and Engagement of SUD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

Engagement of SUD Treatment

Follow the steps below to identify numerator compliance.

If Initiation of SUD Treatment was an inpatient admission, the 34-day period for engagement begins the day after discharge.

Step 1

Identify all SUD episodes compliant for the Initiation of SUD Treatment numerator. SUD episodes that are not compliant for Initiation of SUD Treatment are not compliant for Engagement of SUD Treatment.

Step 2

Identify SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration (OUD Monthly Office Based Treatment Value Set, OUD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD episode is compliant.

Step 3

Identify SUD episodes with long-acting SUD medication administration events on the day after the initiation encounter through 34 days after the initiation event. The long-acting SUD medication administration event is considered engagement of treatment and the SUD episode is compliant. Any of the following meet criteria:

- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Naltrexone Injection Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set)
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Injection Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set)

Step 4

For remaining SUD episodes identify episodes with at least two of the following (any combination) on the day after the initiation encounter through 34 days after the initiation event:

- Engagement visit
- Engagement medication treatment event

Two engagement visits may be on the same date of service, but they must be with different providers to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Refer to the descriptions below to identify engagement visits and engagement medication treatment events.

Engagement Visits

Any of the following meet criteria for an engagement visit:

- An acute or nonacute inpatient admission with a diagnosis (on the discharge claim) of one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Identify the admission date for the stay.
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An outpatient visit (BH Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with POS code 52 with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A non-residential substance abuse treatment Facility visit (Visit Setting Unspecified Value Set) with (Non-residential Substance Abuse Treatment Facility POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A community mental health center visit (Visit Setting Unspecified Value Set) with POS code 53 with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A substance use disorder service (Substance Use Disorder Services Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An opioid treatment service (OUD Weekly Non Drug Service Value Set)

Engagement Medication Treatment Events

Either of the following meets criteria for a medication treatment event:

- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above)

  For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List, Buprenorphine Oral Medications List, Buprenorphine Naloxone Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set).

Alcohol Use Disorder Treatment Medications

Description	Prescription
Aldehyde dehydrogenase inhibitor	Disulfiram (oral)
Antagonist	Naltrexone (oral and injectable)
Other	Acamprosate (oral; delayed- release tablet)

Opioid Use Disorder Treatment Medications

Description	Prescription	Medication Lists
Antagonist	Naltrexone (oral)	Naltrexone Oral Medications List
Antagonist	Naltrexone (injectable)	Naltrexone Injection Medications List
Partial agonist	Buprenorphine (sublingual tablet)	Buprenorphine Oral Medications List
Partial agonist	Buprenorphine (injection)	Buprenorphine Injection Medications List
Partial agonist	Buprenorphine (implant)	Buprenorphine Implant Medications List
Partial agonist	Buprenorphine/naloxone (sublingual tablet, buccal film, sublingual film)	Buprenorphine Naloxone Medications List

E. ADDITIONAL NOTES

There may be different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date, and units of service. Where billing methods are comparable to inpatient billing, each unit of service may be counted as an individual visit. The unit of service must have occurred during the required time frame for the rate.

Methadone is not included on the medication lists for this measure. Methadone for opioid use disorder (OUD) administered or dispensed by federally certified opioid treatment programs (OTP) is billed on a medical claim. A pharmacy claim for methadone would be indicative of treatment for pain rather than OUD.

MEASURE LRCD-AD: LOW-RISK CESAREAN DELIVERY: AGE 20 AND OLDER

Centers for Disease Control and Prevention /National Center for Health Statistics

A. DESCRIPTION

Percentage of nulliparous (first birth), term (37 or more completed weeks based on the obstetric estimate), singleton (one fetus), in a cephalic presentation (head-first) births to mothers age 20 and older delivered by cesarean during the measurement year.

Note: A lower rate indicates better performance.

Data Collection Method: State Vital Records submitted to the NCHS National Vital Statistics System, Natality.

Guidance for Reporting:

- To reduce state burden and streamline reporting, CMS will calculate this measure for states using state natality data obtained through the Centers for Disease Control and Prevention Wide-ranging Online Data for Epidemiologic Research (CDC WONDER). **States are not asked to report data for this measure for 2025 Core Set reporting.**
- This measure is included in the Child Core Set for births to mothers under age 20 at the time of birth. This measure is included in the Adult Core Set for births to mothers age 20 and older at the time of birth.
- The most recent NCHS natality data for each state are available at: http://wonder.cdc.gov/natality-expanded-current.html.
- The measurement period for this measure is the calendar year before the Adult Core Set reporting year. For example, calendar year 2024 data will be used for the 2025 reporting year.
- Eligibility for this measure is based on deliveries that have Medicaid as the principal source of payment for the delivery as indicated on the birth certificate. For more information on the principal source of payment field see "21. Principal source of payment" in NCHS's Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.

B. DEFINITIONS

Cephalic	Presenting part of the fetus listed as vertex, occiput anterior (OA), or occiput posterior (OP).
Cesarean delivery	Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.
Nulliparous	The birth is a first live birth (Live Birth Order is "1").
Principal source of payment for the delivery	The following four principal sources of payment are available in all states' birth certificates: (1) Private insurance, (2) Medicaid (or a comparable state program), (3) Self-pay, or (4) Other. More detailed information for the "other" category is available for 34 states and the District of Columbia. In some states, deliveries covered by CHIP may be included in the "Medicaid" category. For more information on the principal source of payment field see "21. Principal source of

	payment“ in NCHS’s Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.
Singleton	Plurality is “Single.”
Term	Term is 37 or more completed weeks based on the obstetric estimate.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The number of resident live births in the state in the reporting period with Medicaid as the principal source of payment for the delivery. All of the following additional criteria must be met:

- The birth is a first live birth (Live Birth Order is “1”)
- Age of Mother is greater than or equal to 20 years
- Fetal Presentation is “Cephalic”
- The obstetric estimate of gestational age (OE Gestational Age Recode) is greater than or equal to 37 weeks
- Plurality is “Single”

The following four principal sources of payment for the delivery are available in all states’ birth certificates: (1) Private insurance, (2) Medicaid (or a comparable state program), (3) Self-pay, or (4) Other. More detailed information for the “other” category is available for 34 states and the District of Columbia. In some states, deliveries covered by CHIP may be included in the “Medicaid” category. For more information on the principal source of payment field see “21. Principal source of payment“ in NCHS’s Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death.

Numerator

The number of resident live births in the state in the reporting period with Medicaid as the principal source of payment for the delivery. All of the following additional criteria must be met:

- The birth is a first live birth (Live Birth Order is “1”)
- Age of Mother is greater than or equal to 20 years
- Fetal Presentation is “Cephalic”
- The obstetric estimate of gestational age (OE Gestational Age Recode) is greater than or equal to 37 weeks
- Plurality is “Single”
- Delivery Method of “Cesarean” on the birth certificate

Units

Report as a percentage.

D. EXCLUSIONS

Exclude resident live births from both the denominator and numerator that meet any of the following criteria:

- Births to women with previous live births or unknown parity (live birth order >1 or "Unknown or Not Stated")
- Delivery method is "Unknown or Not Stated"
- Multiple gestations (plurality equal to "Twin," "Triplet," "Quadruplet," or "Quintuplet or higher")
- Other or unknown presentations (fetal presentation equal to "Breech," "Other," "Unknown or Not Stated," or "Not Reported")
- Gestational age <37 weeks or "Unknown or Not Stated"

MEASURE MSC-AD: MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION

National Committee for Quality Assurance

A. DESCRIPTION

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

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

Data Collection Method: Survey

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report the three separate rates listed above for each of the two age groups (as applicable): ages 18 to 64 and age 65 and older.
- To reduce state burden and streamline reporting, CMS will calculate state-level performance results for this measure using data submitted for the state to the AHRQ CAHPS Health Plan Survey Database. Alternatively, states can report this measure for 2025 in the online Core Set reporting system.
- This measure requires a denominator of at least 100 beneficiaries. If a single year of data collection does not yield enough responses to be reportable, the state can use a rolling two-year average to achieve a sufficient number of respondents for reporting. First-year data collection will generally not yield enough responses to be reportable. If the denominator is less than 100, this measure is not reported. States should note the reason for not reporting as “denominator too small.”
- Results may vary by reporting source due to differences in state-level result calculation methodologies. For example, results for this measure calculated from the AHRQ CAHPS Health Plan Survey Database are based on one year of data whereas states may choose to report two-year rolling averages in the online Core Set reporting system to achieve sufficient denominator sizes.
- More information about participating in the CAHPS Health Plan Survey Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/participate.html.

B. ELIGIBLE POPULATION

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.
Required exclusion (Supplemental and medical record data may be used for this exclusion)	Beneficiaries who die any time during the measurement year.

C. PROTOCOL AND SURVEY INSTRUMENT

Collected annually as part of the CAHPS Health Plan Survey 5.1H, Adult Version using a rolling average methodology.

D. QUESTIONS INCLUDED IN THIS MEASURE

Questions		Response Choices
Q31	Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Every day Some days Not at all → If Not at all, Go to Question 35 Don't know → If Don't know, Go to Question 35
Q32	In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	Never Sometimes Usually Always

Q33	In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	Never Sometimes Usually Always
Q34	In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.	Never Sometimes Usually Always

E. CALCULATION OF MEASURE

Rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator) / (Year 1 Denominator + Year 2 Denominator)

- If the denominator is less than 100, this measure is not reported.
- If the denominator is 100 or more, a rate is calculated.

If the state did not report results for the current year (Year 2), this measure is not reported.

If the state did not report results in the prior year (Year 1), but reports results for the current year and achieves a denominator of 100 or more, a rate is calculated; if the denominator is less than 100, this measure is not reported.

Advising Smokers and Tobacco Users to Quit

Denominator

The number of beneficiaries who responded to the survey and indicated that they were current smokers or tobacco users. Beneficiary response choices must be as follows to be included in the denominator:

Q31 = “Every day” or “Some days.”

Q32 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of beneficiaries in the denominator who indicated that they received advice to quit from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to Q32.

Discussing Cessation Medications

Denominator

The number of beneficiaries who responded to the survey and indicated that they were current smokers or tobacco users. Beneficiary response choices must be as follows to be included in the denominator:

Q31 = “Every day” or “Some days.”

Q33= “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of beneficiaries in the denominator who indicated that their doctor or health provider recommended or discussed cessation medications by answering “Sometimes” or “Usually” or “Always” to Q33.

Discussing Cessation Strategies

Denominator

The number of beneficiaries who responded to the survey and indicated that they were current smokers or tobacco users. Beneficiary response choices must be as follows to be included in the denominator:

Q31 = “Every day” or “Some days.”

Q34 = “Never” or “Sometimes” or “Usually” or “Always.”

Numerator

The number of beneficiaries in the denominator who indicated that their doctor or health provider discussed or provided cessation methods and strategies by answering “Sometimes” or “Usually” or “Always” to Q34.

Percentage of Current Smokers and Tobacco Users - Supplemental Calculation

This calculation is provided to support analysis of Medical Assistance with Smoking and Tobacco Use Cessation rates and provides additional context for unreportable results (that is, where the denominator is less than 100). A state with a small number of smokers or tobacco users may not be able to obtain a large enough denominator to achieve reportable rates.

The percentage of current smokers and tobacco users is calculated using data collected during the current reporting year only (not calculated as a rolling average).

Denominator

The number of beneficiaries who responded “Every day,” “Some days,” “Not at all,” or “Don’t know” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Numerator

The number of beneficiaries in the denominator who responded “Every day” or “Some days” to the question “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

MEASURE NCIIDD-AD: NATIONAL CORE INDICATORS SURVEY

National Association of State Directors of Developmental Disabilities Services (NASDDDS)

Human Services Research Institute (HSRI)

A. DESCRIPTION

The National Core Indicators® – Intellectual and Developmental Disabilities (NCI-IDD®)[1] provide information on beneficiaries' experience and self-reported outcomes of long-term services and supports for individuals with intellectual and/or developmental disabilities (I/DD) and their families. NCI-IDD includes an in-person survey, family surveys for parents and guardians of adults and children who receive I/DD supports, and a State of the Workforce Survey. For the purpose of the Adult Core Set, only data from the NCI-IDD In-Person Survey will be reported. Therefore, the technical specifications for the NCI-IDD measure in the Adult Core Set include only the In-Person Survey.

Data Collection Method: Survey

Guidance for Reporting:

- To reduce state burden, CMS will calculate state-level performance results for this measure using data submitted to NASDDDS/HSRI. **States are not asked to report data for this measure for 2025 in the online Core Set reporting system.**
- This measure applies to Medicaid beneficiaries age 18 and older with intellectual and/or developmental disabilities, receiving at least one service from the state-administered Developmental Disabilities system in addition to case management.
- To begin collecting NCI-IDD In-Person Survey data each year, states must complete an annual planning call and work plan with NASDDDS and HSRI (NCI-IDD National Team). The work plan identifies the methods for conducting the survey, including any populations being oversampled or excluded from the sample.
- See Appendix E for additional guidance on conducting the NCI-IDD In-Person Survey, including sampling and administration protocols. The In-Person Survey can be conducted by either state staff or a contracted survey vendor. States are responsible for assuring all surveyors have received training consistent with NCI-IDD requirements and protocols for demonstration of adequate knowledge and skill in carrying out the interview procedures. Portions of the survey may be completed via specific videoconference protocols as specified in Appendix E.
- See https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-national-core-indicators-questionnaire.pdf for the NCI-IDD In-Person Survey Questionnaire.

[1] National Core Indicators® is a registered trademark of the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI).

B. ELIGIBLE POPULATION

Age	Age 18 and older as of June 30 of the measurement year.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	June 30 of the measurement year.
Current enrollment	Currently enrolled in Medicaid at the time the survey is completed.
Event/ diagnosis	Beneficiaries with intellectual and/or developmental disabilities receiving at least one service through the state-administered Developmental Disabilities system in addition to case management.

C. IMPLEMENTING THE NCI IN-PERSON SURVEY

Administration	Survey must be conducted by the state or a state-contracted third-party vendor according to NCI-IDD requirements and protocols.
Collection mode	The Background Information Section of the survey requires states to collect demographic, service, and health care data from administrative records and submit them along with responses from the in-person questionnaire. Sub-section I of the direct-contact section of the NCI-IDD In-Person Survey requires in-person or videoconference-based data collection. Sub-section II of the direct-contact section of the NCI-IDD In-Person Survey also requires in-person or videoconference-based data collection and permits proxy respondents. Surveys must follow protocols established in NCI-IDD trainings and training materials. The NCI-IDD In-Person Survey Questionnaire is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-national-core-indicators-questionnaire.pdf.
Sample size	The NCI-IDD National Team will work with the state to determine the number of beneficiaries to be surveyed in order to yield at least a 95 percent confidence level and a 5 percent margin of error. The recommended minimum sample size is typically 400 completed surveys but will depend on the size of the eligible population in each state and any additional stratification. See Appendix E for additional guidance on determining the sample size for the NCI-IDD In-Person Survey.

D. ADDITIONAL NOTES

The NCI-IDD National Team works with new and continuing states on implementation and provides general oversight of NCI-IDD activities; states are responsible for the operational administration of the NCI-IDD surveys in accordance with NCI-IDD requirements and protocols. See https://idd.nationalcoreindicators.org/how-it-works/participating-states/ for a list of states participating in NCI-IDD.

States submit NCI-IDD data to the NCI-IDD National Team using the Online Data Entry System (ODESA). The NCI-IDD National Team obtains approval from the state Developmental Disabilities director to transmit these data to CMS for the purpose of Adult Core Set reporting.

For more information on how to get started with NCI or the use of NCI-IDD data for Core Set reporting, please contact MACQualityTA@cms.hhs.gov.

MEASURE OEVP-AD: ORAL EVALUATION DURING PREGNANCY: AGES 21 TO 44

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Percentage of enrolled persons ages 21 to 44 with live-birth deliveries in the measurement year who received a comprehensive or periodic oral evaluation during pregnancy.

Data Collection Method: Administrative

Guidance for Reporting:

- The Oral Evaluation During Pregnancy measure includes beneficiaries ages 15 to 44. The Child Core Set measure applies to beneficiaries ages 15 to 20 and the Adult Core Set measure applies to beneficiaries ages 21 to 44.
- The measurement period for this measure is the calendar year.
- Adults enrolled in Medicaid and CHIP (both Medicaid expansion and separate CHIP programs) are eligible for this measure.
- Include all paid, suspended, pending, and denied claims.
- The codes used to calculate this measure are included below and in Tables OEVP-A through OEVP-D at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip. Both the specifications and the tables must be referenced to identify all needed codes.

This measure includes the following coding systems: CPT, CDT, NUCC, ICD-10-PCS, and ICD-10-CM. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	People who are >=21 and <45 as of December 31st of the measurement year.
Continuous enrollment	Continuously enrolled for 180 days prior to delivery through the delivery date. Note: For programs/plans that verify enrollment on a monthly basis, the continuous enrollment criteria should include the month in which the delivery occurred AND 6 months prior to the month in which the delivery occurred.
Allowable gap	No allowable gaps.
Anchor date	Date of live-birth delivery.
Benefit	Medical and dental.
Event/diagnosis	Live-birth delivery from January 1 of the measurement year through December 31 of the measurement year.

Event/diagnosis (continued)	Check for unduplicated persons with live-birth deliveries during the measurement year through one of the following: • Check for procedure codes signifying delivery AND diagnosis codes signifying live birth - If [ICD-10-PCS CODE] = any code in Table OEVP-A OR if [CPT CODE] = any code in Table OEVP-B, AND - If [ICD-10-CM CODE] = any code in Table OEVP-C, then proceed to next step. Both a procedure code from Table OEVP-A or Table OEVP-B AND a diagnosis code from Table OEVP-C must be present to count as a live-birth delivery. These tables are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip. Note: Check all procedure code fields. Check all diagnosis code fields, including admitting diagnosis, principal diagnosis, and additional-listed diagnoses. OR • Check for diagnosis codes that signify both delivery and live birth: - If [ICD-10-CM CODE] = O80 or O82, then proceed to next step. Note 1: Check all diagnosis code fields, including admitting diagnosis, principal diagnosis, and additional-listed diagnoses. Note 2: If a person has more than one live-birth delivery between January 1 of the measurement year and December 31 of the measurement year, use the first delivery date as the anchor date. Do not count the second live-birth delivery. Note 3: Delivery dates should be identified using the procedure code dates where possible. If procedure code dates are unavailable, then the admission date may be used.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The unduplicated number of enrolled beneficiaries who received a comprehensive or periodic oral evaluation as a dental service during the 270 days prior to the delivery date.

Check if beneficiary received an oral evaluation as a dental service.

- [CDT CODE] = (D0120 or D0150 or D0180), AND

- [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table OEVP-D[1], AND
- [DELIVERY DATE – ORAL EVAL DATE] <= 270 days

If all of these criteria are met, include in the numerator.

Note: In this step, all claims with missing or invalid CDT code, missing or invalid NUCC maintained Provider Taxonomy Codes, or NUCC maintained Provider Taxonomy Codes that do not appear in Table OEVP-D will not be counted in the numerator.

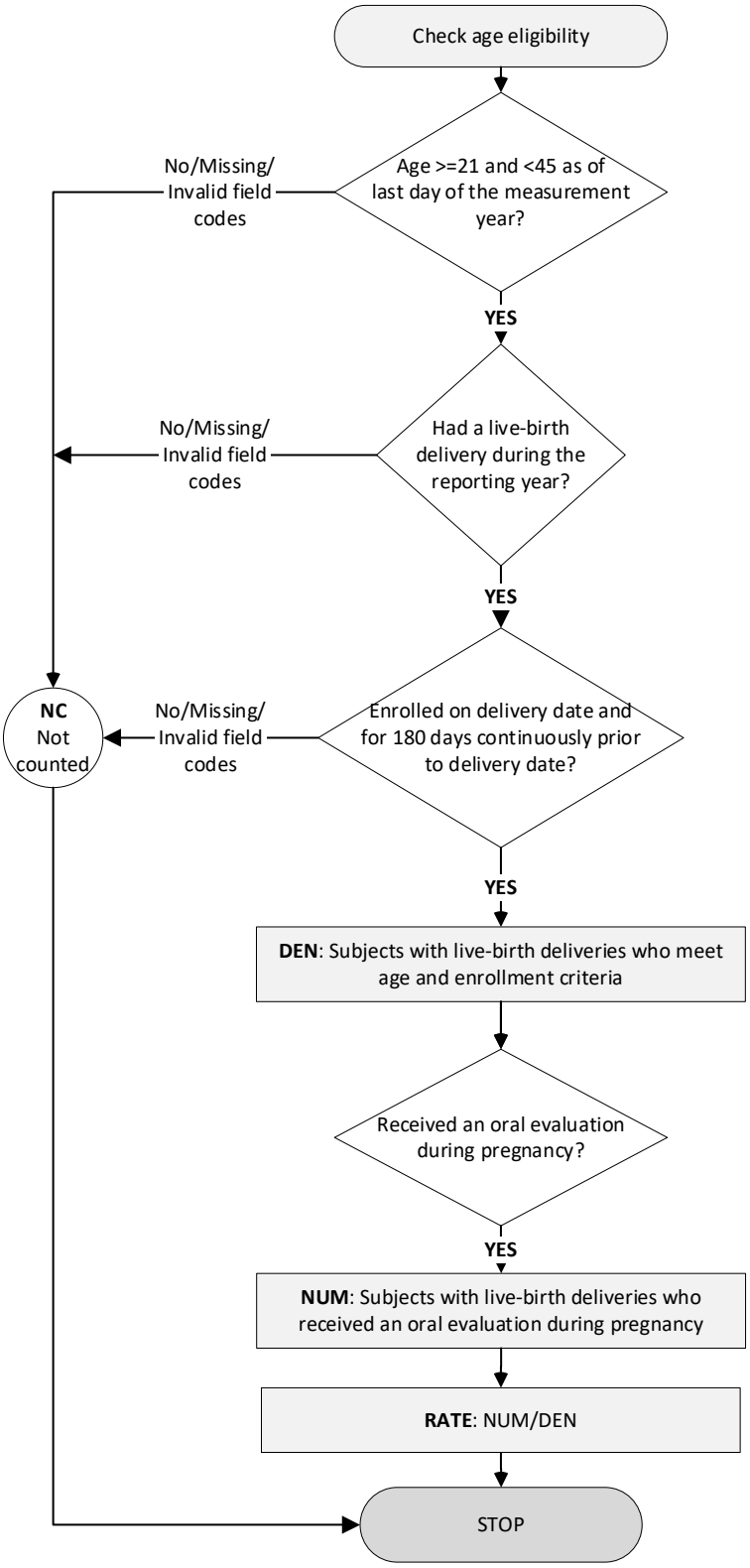
Exclusions

None.

Figure OEVP-A provides a flowchart for implementing these exclusion and inclusion criteria.

[1] Identifying “dental” services: Programs and plans that do not use standard NUCC maintained provider taxonomy codes should use valid mapping to identify providers whose services will be categorized as “dental” services. In the case of stand-alone dental plans that reimburse ONLY for services rendered by or under the supervision of the dentist, states should consider all claims as “dental” services.

Figure OEVP-A. Measure Flowchart



D. ADDITIONAL NOTES

More information on the rationale for and implementation of this measure is provided in the DQA Measures User Guide, available at http://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2025/2025_dqa_adult_measures_user_guide_final.pdf.

Data quality considerations:

Reliability of the measure score depends on the quality of the data elements that are used to calculate the measure. The percentages of missing and invalid data for each data element used to calculate the measure must be investigated prior to measurement. Data elements with high rates of missing or invalid data will adversely affect the subsequent counts that are recorded. For example, beneficiaries who have records with missing or invalid CDT code may be counted in the denominator but not in the numerator. These records are assumed to not have had a qualifying service. In this case, a low-quality data set will result in a measure score that will not be reliable.

MEASURE OHD-AD: USE OF OPIOIDS AT HIGH DOSAGE IN PERSONS WITHOUT CANCER

Pharmacy Quality Alliance

A. DESCRIPTION

The percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older. Age groups should be based on age as of January 1 of the measurement year.
- The opioid medications used to calculate this measure are available in the "Value Sets – Medications" tab of the value set directory available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip. The only opioids that should be included when calculating this measure are those in the "Value Sets – Medications" tab. This file also contains additional guidance on MME conversion factors.
- Beneficiaries with a cancer diagnosis, a sickle cell disease diagnosis, or in hospice or palliative care at any point during the measurement year are excluded from this measure. Individuals with a cancer diagnosis or sickle cell disease diagnosis may be identified using the ICD-10-CM codes in the Cancer Value Set and Sickle Cell Disease Value Set and beneficiaries in hospice or palliative care may be identified using the codes in the Hospice Encounter Value Set, Hospice Intervention Value Set, and Palliative Care Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.
- The exclusion criteria are for beneficiaries with a diagnosis code for cancer or sickle cell disease during the measurement year. Their initial diagnosis may have occurred previously; however, the diagnosis code for cancer or sickle cell disease must be present during the measurement year for the beneficiary to be excluded.
- Commercial claims for beneficiaries with primary commercial insurance and secondary Medicaid coverage should be included if the beneficiaries have pharmacy benefits through Medicaid.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and NDC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.
Opioid	See medications listed in Table OHD-A.
Morphine milligram equivalent (MME)	Oral morphine milligram equivalent. The MME conversion factor used to retrospectively calculate daily MME to inform analyses of risks associated with opioid prescribing. MME conversion factors are available in the "Value Sets – Medications" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.
Prescription claims	Only paid, non-reversed prescription claims are included in the data set to calculate the measure.
Index Prescription Start Date (IPSD)	The earliest date of service for an opioid prescription during the measurement year. The IPSD must occur at least 90 days before the end of the measurement year (i.e., January 1–October 3).
Opioid episode	The period of time beginning on the date of the first fill (i.e., IPSD) of an opioid medication during the measurement year and ending on the date of the last fill of any opioid medication plus the days' supply of the last fill during the measurement year, minus 1. If the days' supply extends past the measurement year, the opioid episode length is truncated to the last day of the measurement year (i.e., December 31).
Hospice	Any beneficiary in hospice care at any time during the measurement year. Beneficiaries in hospice are identified by the presence of specific hospice codes in the Hospice Encounter Value Set and Hospice Intervention Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.
Cancer diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for cancer, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Cancer Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.
Sickle Cell Disease diagnosis	Any beneficiary with an ICD-10-CM diagnosis code for sickle cell disease, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Sickle Cell Disease Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.

Palliative care	Any beneficiary with an ICD-10-CM diagnosis code for palliative care, including primary diagnosis or any other diagnosis fields, any time during the measurement year in the Palliative Care Value Set in the "Value Sets – Other" tab of the value set directory, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-COB-OHD-value-set-NDC-directory.zip.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year with one allowable gap, as defined, below.
Allowable gap	No more than one gap in continuous enrollment of up to 31 days during the measurement year. When enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).
Anchor date	None.
Benefit	Medical and pharmacy.
Event/ diagnosis	Use the steps below to determine the eligible population. Step 1 • Identify beneficiaries with 2 or more prescription claims for opioids medications (Table OHD-A) on different dates of service and with a cumulative days' supply of 15 or more days during the measurement year. • Exclude days' supply that occur after the end of the measurement year. NOTE: • The prescriptions can be for the same or different opioids. • If multiple prescriptions for opioids are dispensed on the same day, calculate the number of days covered by an opioid using the prescriptions with the longest days' supply. • If multiple prescriptions for opioids are dispensed on different days, sum the days' supply for all the prescription claims, regardless of overlapping days' supply. Step 2 • Identify beneficiaries with an IPSD on January 1 through October 3 of the measurement year. Step 3 • Identify beneficiaries with an opioid episode of 90 or more days during the measurement year. NOTE: Exclude days of supply that occur after the end of the measurement year.

Event/ diagnosis (continued)	Step 4 Exclude beneficiaries who met at least one of the following during the measurement year: • Hospice. • Cancer Diagnosis. • Sickle Cell Disease Diagnosis. • Palliative Care.

Table OHD-A. Opioid Medications[a,b]

Benzhydrocodone	Hydrocodone	Morphine	Oxymorphone
Butorphanol	Hydromorphone	Opium	Pentazocine
Codeine	Levorphanol	Oxycodone	Tapentadol
Dihydrocodeine	Meperidine		Tramadol
Fentanyl	Methadone		

[a] Includes combination products.

[b] Excludes the following: injectable formulations; opioid cough and cold products; sublingual sufentanil (used in a supervised setting); and all buprenorphine products (as a partial opioid agonist is not expected to be associated with overdose risk in the same dose-dependent manner as doses for full agonist opioids).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Any beneficiary in the denominator with an average daily dosage ≥ 90 morphine milligram equivalent (MME) during the opioid episode.

Follow the steps below to identify beneficiaries for the numerator:

Step 1

For each beneficiary in the denominator population, identify all opioid prescription claims during the opioid episode.

Step 2

Calculate the daily MME for each opioid prescription claim during the opioid episode, using the following equation:

[Strength * (Quantity Dispensed / Days' Supply)] * MME conversion factor = MME / day

The "Quantity Dispensed" and "Days' Supply" comes from the prescription claim. Strength and MME conversion factor is determined by the NDC code and provided in the "Value Sets – Medications" tab of the value set directory.

Example: 10 mg oxycodone tablets * (120 tablets / 30 days) * 1.5 = 60 MME/day

Step 3

Apply the MME for each opioid prescription claim to the days from the date of service to the date of the last dose (date of service + days' supply - 1).

Note:

- If multiple prescriptions for opioids are dispensed on the same day or on different days with overlapping days' supply, do not adjust for overlap, and calculate the daily MME using the days' supply for each prescription claim.
- Apply the MME through to the last day of the opioid episode, e.g., do not include days that extend beyond the end of the opioid episode.

Step 4

For each beneficiary, sum the daily MMEs across all days during the opioid episode.

Step 5

Calculate the average MME across all days during the opioid episode. The average daily MME = total MME / days in opioid episode. Calculate the average daily MME rounded to the nearest hundredth (e.g., 89.97597 is rounded to 89.98).

Step 6

Count the beneficiaries with an average daily dosage ≥ 90.00 MME during the opioid episode.

Rate

Divide the numerator by the denominator and multiply by 100.

E. ADDITIONAL NOTES

This measure is not intended for clinical-decision-making. This measure is intended for retrospective evaluation of populations of patients and should not be used to guide clinical decisions for individual patients. For clinical guidance on opioid prescribing, see the Centers for Disease Control and Prevention (CDC) 2022 Clinical Practice Guideline for Prescribing Opioids for Pain available at https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w.

MEASURE OUD-AD: USE OF PHARMACOTHERAPY FOR OPIOID USE DISORDER

Substance Abuse and Mental Health Services Administration

A. DESCRIPTION

Percentage of Medicaid beneficiaries age 18 and older with an opioid use disorder (OUD) who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measurement year. Five rates are reported:

- A total (overall) rate capturing any medications used in medication assisted treatment of opioid dependence and addiction (Rate 1).
- Four separate rates representing the following types of FDA-approved drug products:
  - Buprenorphine (Rate 2)
  - Oral naltrexone (Rate 3)
  - Long-acting, injectable naltrexone (Rate 4)
  - Methadone (Rate 5)

Data Collection Method: Administrative

Guidance for Reporting:

- The measure includes a total rate (Rate 1) and four separate rates for the following four types of FDA-approved drug products:
  - Buprenorphine (Rate 2).
  - Oral naltrexone (Rate 3).
  - Long-acting, injectable naltrexone (Rate 4).
  - Methadone (Rate 5).
- Tables OUD-A and OUD-B are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip. Table OUD-B designates which medications are assigned to the separate rates. Filter on the "Numerator" column to identify which HCPCS codes and NDCs are assigned to each rate.
- OUD includes diagnoses of opioid abuse, dependence, and/or remission. ICD-10 codes for OUD and related conditions may be the primary diagnosis or appear in other positions on the claim. The diagnosis may be recorded by any medical professional whom the beneficiary sees at any point during the measurement year.
- The measure uses inpatient, outpatient, residential, long-term care, and pharmacy claims and encounters.
- The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count beneficiaries in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report beneficiaries with multiple drug products only once for the numerator for the total rate.
- Only formulations with an OUD indication (not pain management) are included in value sets for measure calculation.

This measure includes the following coding systems: HCPCS, NDC, and ICD-10-CM. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Measurement year	January 1 to December 31 of the measurement year.

C. ELIGIBLE POPULATION

Age	Age 18 and older. Age is calculated as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency (inpatient, residential, and outpatient).
Event/ diagnosis	Beneficiaries who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-10 codes for OUD are provided in Table OUD-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.
Care settings	Inpatient/hospital, outpatient, emergency department.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

For each beneficiary in the denominator population, follow the steps below to identify beneficiaries for the total numerator and the numerator for each rate.

Total

Identify beneficiaries with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Note: The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count beneficiaries in the numerator for the total rate if they had at least one of the

four FDA-approved drug products for OUD during the measurement year. Report beneficiaries with multiple drug products only once for the numerator for the total rate.

Buprenorphine

Identify beneficiaries with evidence of at least one prescription for buprenorphine at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip. Include HCPCS codes and NDCs assigned to Numerator 2 in the Numerator column in Table OUD-B.

Oral Naltrexone

Identify beneficiaries with evidence of at least one prescription for oral naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip. Include HCPCS codes and NDCs assigned to Numerator 3 in the Numerator column in Table OUD-B.

Long-Acting, Injectable Naltrexone

Identify beneficiaries with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip. Include HCPCS codes and NDCs assigned to Numerator 4 in the Numerator column in Table OUD-B.

Methadone

Identify beneficiaries with evidence of at least one dose of methadone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip. This rate includes HCPCS codes only. There are no NDC codes assigned to this rate.

Rates

The total rate is calculated by dividing the number of beneficiaries with evidence of at least one prescription (Numerator 1) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

To calculate the separate rates for each of the four FDA-approved medications for OUD, divide the Numerator for the medication by the Denominator. For example, to calculate the buprenorphine rate, divide the number of beneficiaries with evidence of at least one prescription for buprenorphine during the measurement year (Numerator 2) by the number of beneficiaries with at least one encounter associated with a diagnosis of opioid abuse, dependence, or remission (i.e., the Denominator).

E. ADDITIONAL NOTES

None.

MEASURE PCR-AD: PLAN ALL-CAUSE READMISSIONS

National Committee for Quality Assurance

A. DESCRIPTION

For beneficiaries ages 18 to 64, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

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

Data Collection Method: Administrative

Guidance for Reporting:

- For HEDIS, this measure applies to beneficiaries ages 18 to 64. Although the HEDIS measure includes stratified reporting by age, for the Adult Core Set, states should calculate and report only the Total rate.
- This measure requires risk adjustment. Risk adjustment guidelines are provided in the administrative specification. Please note that in the risk adjustment tables, clinical conditions (CCs) and hierarchical clinical conditions (HCCs) not listed receive a weight of ZERO (e.g., 0.0000).
- Report the Count of Expected 30-Day Readmissions for this measure to four decimal places.
- As shown in Table PCR-A, the data elements in columns 1, 2, 4, 7, and 8 are reported by the state. The data elements in columns 3, 5, 6, and 9 will be derived from the reported data.
- Supplemental data may not be used for this measure, except for required exclusions.
- When applying risk adjustment, include all services, whether or not the state paid for them or expects to pay for them (e.g., include denied claims). When identifying all other events, do not include denied services (e.g., only include paid services and services expected to be paid).
- If this measure has a Count of Index Hospital Stays less than 150 and the state chooses not to report this measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.
- For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Index Hospital Stay (IHS)	An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The Index Discharge Date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described under step 3, Count of Observed 30-Day Readmissions.
Direct transfer	A direct transfer is when the discharge date from the initial stay precedes the admission date to a subsequent stay by one calendar day or less. For example: • A discharge on June 1, followed by a subsequent admission on June 1, is a direct transfer. • A discharge on June 1, followed by a subsequent admission on June 2, is a direct transfer. • A discharge on June 1, followed by a subsequent admission on June 3, is not a direct transfer; these are two distinct inpatient stays. • A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, is a direct transfer. Direct transfers may occur from and between different facilities and/or different service levels.
Count of Beneficiaries in the Medicaid Population	Beneficiaries in the eligible population prior to exclusion of outliers (denominator steps 1-5). The Count of Beneficiaries in the Medicaid Population is only used as a denominator for the Outlier rate. Beneficiaries must be ages 18 to 64 as of the earliest Index Discharge Date. The Count of Beneficiaries in the Medicaid Population is based on beneficiaries, not discharges - count beneficiaries only once.
Outlier	Beneficiaries in the eligible population with four or more index hospital stays (IHS) between January 1 and December 1 of the measurement year.

Nonoutlier	Beneficiaries in the eligible population who are not considered outliers.
Classification period	365 days prior to and including Index Discharge Date.

Risk Adjustment Tables

The PCR measure leverages the Risk Adjustment Tables, which define condition-based risk-adjustment variables. The table helps users determine a beneficiary's condition-based risk-adjustment variables and select the proper risk weights.

Table	Table Description
Table CC-Mapping	Discharge Clinical Condition category codes for Risk Adjustment Determination. Comorbid Clinical Condition category codes for Risk Adjustment Determination step 2.
Table HCC–Rank	HCC rankings for Risk Adjustment Determination step 3.
Table HCC-Comb	Combination HCCs for Risk Adjustment Determination step 5.
PCR Risk Adjustment Table, Medicaid	Medicaid primary discharge weights for Risk Adjustment Weighting step 3. Medicaid comorbidity weights for Risk Adjustment Weighting step 4. Medicaid observation stay, surgery, age and gender weights for Risk Adjustment Weighting steps 1, 2, 5.

Source: Please refer to the HEDIS® MY2024 Volume 2 Risk Adjustment Utilization Tables User Manual for technical detail on table format and content.

Note: The risk adjustment tables and Risk Adjustment Utilization Tables User Manual are available to order free of charge in the NCQA store at https://store.ncqa.org/hedis-my-2024-risk-adjustment-tables.html. Once ordered, the risk adjustment tables can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). The tables needed to calculate this measure are found in both the PCR Risk Adjustment Tables and the RAU Table - PCR Medicaid MY2024 (which includes the CC-Mapping, HCC-Rank, and HCC-Comb tables).

C. ELIGIBLE POPULATION

Age	Ages 18 to 64 as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.

Event/ diagnosis	An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not beneficiaries. Include all acute inpatient or observation stay discharges for nonoutlier beneficiaries who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.
Required exclusion (Supplemental and medical record data may be used for these exclusions)	Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

D. ADMINISTRATIVE SPECIFICATION

Count of Index Hospital Stays (IHS)

The eligible population as defined above.

Step 1

Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year.

To identify acute inpatient and observation stay discharges:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Identify the discharge date for the stay.

Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.

This measure includes acute discharges from any type of facility (including behavioral healthcare facilities).

Step 2

Direct transfers: For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition of “direct transfer” above.

Exclude the hospital stay if the direct transfer’s discharge date occurs after December 1 of the measurement year.

Step 3

Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 4

Exclude hospital stays for the following reasons:

- The beneficiary died during the stay.
- Beneficiaries with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
- A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 5

Calculate continuous enrollment.

Step 6

Remove hospital stays for outlier beneficiaries and report these beneficiaries as outliers.

Note: Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier beneficiaries.

Risk Adjustment Determination

For each IHS among nonoutlier beneficiaries, use the following steps to identify risk adjustment categories based on presence of observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and gender.

Observation Stay	Determine if the IHS at discharge was an observation stay (Observation Stay Value Set). For direct transfers, determine the hospitalization status using the last discharge.
Surgeries	Determine if the beneficiary underwent surgery during the stay (Surgery Procedure Value Set). Consider an IHS to include a surgery if at least one procedure code is present from any provider between the admission and discharge dates.
Discharge Condition	Assign a discharge Clinical Condition (CC) category code or codes to the IHS based on its principal discharge diagnosis, using Table CC-Mapping. For direct transfers, use the principal discharge diagnosis from the last discharge. Exclude diagnoses that cannot be mapped to Table CC-Mapping.
Comorbidities	Assign Risk Adjustment Comorbidity Category Determination based on all the encounters during the classification period, as described in the Steps for Risk Adjustment Comorbidity Category Determination.

Steps for Risk Adjustment Comorbidity Category Determination

Follow the steps below for Risk Adjustment Comorbidity Category Determination.

Step 1

Identify all diagnoses for encounters during the classification period for each index hospital stay (IHS). Include the following when identifying encounters:

- Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient visits (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set)

Use the date of service for outpatient, observation, and ED visits. Use the discharge date for inpatient events.

Exclude the principal discharge diagnosis on the index hospital stay (IHS).

Step 2

Assign each diagnosis to a comorbid Clinical Condition (CC) category using Table CC—Mapping, available at https://store.ncqa.org/hedis-my-2024-risk-adjustment-tables.html. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC category. For beneficiaries with no qualifying diagnoses from face-to-face encounters, skip to the Risk Adjustment Weighting section.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3

Determine Hierarchical Condition Categories (HCCs) for each comorbid CC identified. Refer to Table HCC—Rank, available at https://store.ncqa.org/hedis-my-2024-risk-adjustment-tables.html.

For each denominator unit's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group
- The rank
- The HCC

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1.

Note: One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

Step 4

Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the “Rank” column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

Example:

Assume a denominator unit with the following comorbid CCs: CC-85, CC-17, and CC-19 (assume no other CCs).

- CC-85 does not have a map to the ranking table and becomes HCC-85.
- HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.
- The final comorbidities for this denominator unit are HCC-17 and HCC-85.

Example: Table HCC—Rank

Ranking Group	CC	Description	Rank	HCC
Not Applicable (NA)	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes without Complication	3	HCC-19

Step 5

Identify combination HCCs listed in Table HCC—Comb, available at https://store.ncqa.org/hedis-my-2024-risk-adjustment-tables.html.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes and congestive heart failure are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each denominator unit's list of unique HCCs to those in the Comorbid HCC columns in Table HCC—Comb and assign any additional HCC conditions.

If there are fully nested combinations, use only the more comprehensive pattern. For example, if the diabetes/CHF combination is nested in the diabetes/CHF/renal combination, count only the diabetes/CHF/renal combination.

If there are overlapping combinations, use both sets of combinations. Based on the combinations, a denominator unit can have none, one, or more than one of these added HCCs.

Example:

For a denominator unit with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This does not replace HCC-17 and HCC-85.

Example: Table HCC—Comb

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

Risk Adjustment Weighting

For each index hospital stay (IHS) among nonoutlier beneficiaries, use the following steps to identify risk adjustment weights based on observation stay status at discharge, surgeries,

discharge condition, comorbidity, age, and gender. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

Step 1	For each IHS discharge that is an observation stay, link the observation stay IHS weight.
Step 2	For each IHS with a surgery, link the surgery weight.
Step 3	For each IHS with a discharge CC Category, link the primary discharge weights.
Step 4	For each IHS with a comorbidity HCC Category, link the comorbidity weights.
Step 5	Link the age and gender weights for each IHS.
Step 6	Sum all weights associated with the IHS (i.e., observation stay, presence of surgery, principal discharge diagnosis, comorbidities, age and gender) and use the formula below to calculate the Estimated Readmission Risk for each IHS. $$\text{Estimated Readmission Risk} = \frac{e^{(\sum WeightsforIHS)}}{1 + e^{(\sum WeightsforIHS)}}$$ ***OR*** Estimated Readmission Risk = [exp (sum of weights for IHS)] / [1 + exp (sum of weights for IHS)] Note: “Exp” refers to the exponential or antilog function. Truncate the estimated readmission risk for each IHS to 10 decimal places. Do not truncate or round in previous steps.
Step 7	Calculate the Count of Expected Readmissions. The Count of Expected Readmissions is the sum of the Estimated Readmissions Risk calculated in step 6 for each IHS. *Count of Expected Readmissions* = $\sum$ *(Estimated Readmission Risk)*
Step 8	Use the formula below and the Estimated Readmission Risk calculated in step 6 to calculate the variance for each IHS. Variance = Estimated Readmission Risk x (1 – Estimated Readmission Risk) Truncate the variance *for each IHS* to 10 decimal places. For example: If the Estimated Readmission Risk is 0.1518450741 for an IHS, then the variance for this IHS is 0.1518450741 x 0.8481549259 = 0.1287881475.

Count of Observed 30-Day Readmissions

At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1

Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient and observation admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Step 2

Direct transfers: For discharges with one or more direct transfers, use the last discharge.

Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition of "direct transfer" above.

Step 3

Exclude acute hospitalizations meeting any of the following criteria on the discharge claim:

- Beneficiaries with a principal diagnosis of pregnancy (Pregnancy Value Set)
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set)
- A planned hospital stay using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set)
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set)
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set)
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Conditions Value Set)

Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.

Step 4

For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.

Note: Count each acute hospitalization only once toward the numerator for the last denominator event.

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

- Acute Inpatient Stay 1: May 1–10
- Acute Inpatient Stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy)
- Acute Inpatient Stay 3: May 30–June 5.

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only toward the last denominator event (Stay 2, May 15–25).

Reporting: Count of Index Hospital Stays (IHS)

Count the number of IHS among nonoutlier beneficiaries and enter this value into the reporting table under Count of Index Stays (Table PCR-A, column 1).

Reporting: Count of 30-Day Readmissions

Count the number of observed IHS among nonoutlier beneficiaries with a readmission within 30 days of discharge and enter this value into the reporting table under Count of Observed 30-Day Readmissions (Table PCR-A, column 2).

Reporting: Count of Expected 30-Day Readmissions

Step 1

Sum the Expected Readmission Risk for each IHS among nonoutlier beneficiaries to calculate the Count of Expected Readmissions.

Step 2

Round to four decimal places using the .5 rule and enter the Count of Expected Readmissions into the reporting table (Table PCR-A, column 4).

Reporting: Count of Beneficiaries in Medicaid Population

Step 1

Determine the beneficiary's age as of the earliest Index Discharge Date.

Step 2

Report the count of beneficiaries in the Medicaid population and enter this value into the reporting table under Count of Beneficiaries in Medicaid Population (Table PCR-A, column 7).

Reporting: Number of Outliers

Step 1

Determine the beneficiary's age as of the earliest Index Discharge Date.

Step 2

Report the count of outlier beneficiaries and enter this value into the reporting table under Number of Outliers (Table PCR-A, column 8).

E. ADDITIONAL NOTES

The following data elements will be calculated based on the five reported data elements:

- Observed Readmission Rate: Count of Observed 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 3).
- Expected Readmission Rate: Count of Expected 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 5).
- Observed-to-Expected Ratio (O/E): Count of Observed 30-Day Readmissions divided by Count of Expected 30-Day Readmissions (Table PCR-A, column 6).

- Outlier Rate: Number of Outlier beneficiaries divided by Count of Beneficiaries in Medicaid Population (Table PCR-A, column 9), displayed as a permillage (multiplied by 1,000).
- Note: The O/E ratio is interpreted as “lower-is-better”:
  - O/E ratio < 1.0 means the state had fewer readmissions than expected given the case mix.
  - O/E ratio = 1.0 means that the number of readmissions was the same as expected given the case mix.
  - O/E ratio > 1.0 means that the state had more readmissions than expected given the case mix.

Table PCR-A. Plan All-Cause Readmissions Rates

	Count of Index Hospital Stays (1)	Count of Observed 30-Day Readmissions (2)	Observed Readmission Rate (3)	Count of Expected 30-Day Readmissions (4)	Expected Readmission Rate (5)	O/E Ratio (Count of Observed 30-Day Readmissions/ Count of Expected 30-Day Readmissions) (6)	Count of Beneficiaries in Medicaid Population (7)	Number of Outliers (8)	Outlier Rate (9)
Total			Calculated		Calculated	Calculated			Calculated

MEASURE PPC2-AD: PRENATAL AND POSTPARTUM CARE: AGE 21 AND OLDER

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these beneficiaries, the measure assesses the following facets of prenatal and postpartum care.

- Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment state date or within 42 days of enrollment.
- Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- For the purpose of Adult Core Set reporting, both the Timeliness of Prenatal Care and the Postpartum Care rates are reported for beneficiaries age 21 and older as of the delivery date. The Child Core Set measure is reported for beneficiaries under age 21 as of the delivery date.
- States that use the hybrid methodology will need to draw separate samples by age, in order to submit results for the Adult Core Set (age 21 and over) and Child Core Set (under age 21).
- States may use vital records as an alternative data source for the timeliness of prenatal care rate if they have confidence in the completeness and accuracy of these data. States can use Medicaid/CHIP administrative data to determine the measure-eligible population (including the requirement of continuous eligibility from 43 days before delivery through 56 days after delivery) and then link the Medicaid/CHIP records to vital records data to identify the information needed to calculate the numerator, including gestational age at delivery and the timing of these visits in relation to the gestational age. States using vital records should document this data source in the “Additional Notes/Comments on Measure” section. States should also provide information about the proportion of measure-eligible beneficiaries who were identified in Medicaid/CHIP administrative data but for whom a birth certificate could not be found in vital records data.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix D for definitions of a PCP, OB/GYN, and other prenatal care practitioners.

This measure’s Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, CPT CAT II, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, POS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITION

First trimester	280–176 days prior to delivery (or estimated delivery date [EDD]).

C. ELIGIBLE POPULATION

Age	Age 21 and older as of date of delivery.
Continuous enrollment	43 days prior to delivery through 60 days after delivery.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/ diagnosis	Live birth deliveries on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Include deliveries that occur in any setting. Follow the steps below to identify the eligible population, which is the denominator for both rates. Step 1 Identify deliveries. Identify all beneficiaries with a delivery (Deliveries Value Set) on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Note: The intent is to identify the date of delivery (the date of the "procedure"). If the date of delivery cannot be interpreted on the claim, use the date of service or, for inpatient claims, the date of discharge. Step 2 Remove non-live births (Non-live Births Value Set). Step 3 Identify continuous enrollment. Determine if enrollment was continuous 43 days prior to delivery and 60 days after delivery, with no gaps. Step 4 Remove multiple deliveries in a 180-day period. If a beneficiary has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable, include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period. Note: The denominator for this measure is based on deliveries, not on beneficiaries. All eligible deliveries that were not removed in steps 1-4 remain in the denominator.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. If a state reports this measure using the Hybrid method, and a beneficiary is found to be in hospice or using hospice services during medical record review, the beneficiary is removed from the sample and replaced by a beneficiary from the oversample. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Timeliness of Prenatal Care

A prenatal visit during the required time frame. Follow the steps below to identify numerator compliance.

Step 1

Identify beneficiaries who were continuously enrolled (with no gaps) from at least 219 days before delivery (or EDD) through 60 days after delivery.

These beneficiaries must have a prenatal visit during the first trimester.

Step 2

Identify beneficiaries who were not continuously enrolled from at least 219 days before delivery (or EDD) through 60 days after delivery.

These beneficiaries must have a prenatal visit any time during the period that begins 280 days prior to delivery and ends 42 days after their enrollment start date.

Do not count visits that occur on or after the date of delivery. Visits that occur prior to the beneficiary's enrollment start date during the pregnancy meet criteria.

Step 3

Identify prenatal visits that occurred during the required timeframe (the time frame identified in step 1 or 2). Any of the following, where the practitioner type is an OB/GYN or other prenatal care practitioner or PCP, meet criteria for a prenatal visit:

- A bundled service (Prenatal Bundled Services Value Set) where the state can identify the date when prenatal care was initiated (because bundled service codes are used on the date of delivery, these codes may be used only if the claim form indicates when prenatal care was initiated).

- A visit for prenatal care (Stand Alone Prenatal Visits Value Set). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- A prenatal visit (Prenatal Visits Value Set) with a pregnancy-related diagnosis code (Pregnancy Diagnosis Value Set).

Postpartum Care

A postpartum visit on or between 7 and 84 days after delivery. Any of the following meet criteria:

- A postpartum visit (Postpartum Care Value Set). Do not include codes with a modifier (CPT CAT II Modifier Value Set).
- An encounter for postpartum care (Encounter for Postpartum Care Value Set). Do not include laboratory claims (claims with POS code 81).
- Cervical cytology (Cervical Cytology Lab Test Value Set, Cervical Cytology Result or Finding Value Set).
- A bundled service (Postpartum Bundled Services Value Set) where the state can identify the date when postpartum care was rendered (because bundled service codes are used on the date of delivery, not on the date of the postpartum visit, these codes may be used only if the claim form indicates when postpartum care was rendered).

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

Note: The practitioner requirement only applies to the Hybrid Specification. The state is not required to identify practitioner type in administrative data.

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Adult Core Set for additional information.

Numerators

Timeliness of Prenatal Care

A prenatal visit during the required time frame. Refer to Administrative Specification to identify the required time frame for each beneficiary based on the date of enrollment and the gaps in enrollment during the pregnancy.

Administrative Data

Refer to the Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Prenatal care visit to an OB/GYN or other prenatal care practitioner, or PCP. For visits to a PCP, a diagnosis of pregnancy must be present. Documentation in the medical record must include a note indicating the date when the prenatal care visit occurred and evidence of one of the following.

- Documentation indicating the beneficiary is pregnancy or references to the pregnancy; for example:
  - Documentation in a standardized prenatal flow sheet, or
  - Documentation of last menstrual period (LMP), EDD or gestational age, or
  - A positive pregnancy test result, or
  - Documentation of gravidity and parity, or
  - Documentation of complete obstetrical history, or
  - Documentation of prenatal risk assessment and counseling/education.
- A basic physical obstetrical examination that includes auscultation for fetal heart tone, or pelvic exam with obstetric observations, or measurement of fundus height (a standardized prenatal flow sheet may be used).
- Evidence that a prenatal care procedure was performed, such as:
  - Screening test in the form of an obstetric panel (must include all of the following: hematocrit, differential WBC count, platelet count, hepatitis B surface antigen, rubella antibody, syphilis test, RBC antibody screen, Rh and ABO blood typing, or
  - TORCH antibody panel alone, or
  - A rubella antibody test/titer with an Rh incompatibility (ABO/Rh) blood typing, or
  - Ultrasound of a pregnant uterus.

Postpartum Care

A postpartum visit on or between 7 and 84 days after delivery, as documented through either administrative data or medical record review.

Administrative Data

Refer to the Administrative Specification to identify positive numerator hits from the administrative data.

Medical Record Review

Postpartum visit to an OB/GYN practitioner or other prenatal care practitioner, or PCP on or between 7 and 84 days after delivery. Do not include postpartum care provided in an acute inpatient setting.

Documentation in the medical record must include a note indicating the date when a postpartum visit occurred and one of the following.

- Pelvic exam
- Evaluation of weight, BP, breasts, and abdomen
  - Notation of “breastfeeding” is acceptable for the “evaluation of breasts” component.
- Notation of postpartum care, including, but not limited to:
  - Notation of “postpartum care,” “PP care,” “PP check,” “6-week check.”
  - A preprinted “Postpartum Care” form in which information was documented during the visit.
- Perineal or cesarean incision/wound check
- Screening for depression, anxiety, tobacco use, substance use disorder, or preexisting mental health disorders

- Glucose screening for beneficiaries with gestational diabetes
- Documentation of any of the following topics:
  - Infant care or breastfeeding
  - Resumption of intercourse, birth spacing, or family planning
  - Sleep/fatigue
  - Resumption of physical activity
  - Attainment of healthy weight

F. ADDITIONAL NOTES

- Criteria for identifying prenatal care for beneficiaries who were not enrolled during the first trimester allow more flexibility than criteria for beneficiaries who were enrolled.
  - For beneficiaries who were enrolled at least 219 days before delivery, the state has sufficient opportunity to provide prenatal care by the end of the first trimester.
  - For beneficiaries who were not enrolled at least 219 days before delivery, the state has sufficient opportunity to provide prenatal care within 42 days after enrollment.
- Services that occur over multiple visits count toward the measure if all services are within the time frame established in this measure. Ultrasound and lab results alone are not considered a visit; they must be combined with an office visit with an appropriate practitioner in order to count for the measure.
- For each beneficiary, the state must use one date (date of delivery or EDD) to define the start and end of the first trimester. If multiple EDDs are documented, the state must define a method to determine which EDD to use, and use that date consistently. If the state elects to use EDD, and the EDD is not on or between October 8 of the year prior to the measurement year and October 7 of the measurement year, the beneficiary is excluded as a valid data error and replaced by the next beneficiary of the oversample. The LMP may not be used to determine the first trimester.
- The state may use EDD to identify the first trimester for the Timeliness of Prenatal Care rate and use the date of delivery for the Postpartum Care rate.
- A Pap test does not count as a prenatal care visit for the administrative and hybrid specification of the Timeliness of Prenatal Care rate, but is acceptable for the Postpartum Care rate as evidence of a pelvic exam. A colposcopy alone is not numerator compliant for either rate.
- The intent is that a prenatal visit is with a PCP or OB/GYN or other prenatal care practitioner. Ancillary services (lab, ultrasound) may be delivered by an ancillary provider. Nonancillary services (e.g., fetal heart tone, prenatal risk assessment) must be delivered by the required provider type.
- The intent is to assess whether prenatal and preventive care was rendered on a routine, outpatient basis rather than assessing treatment for emergent events.
- For both rates and for both Administrative and Hybrid data collection methods, services provided during a telephone visit, e-visit, or virtual check-in are eligible for use in reporting.

MEASURE PQI01-AD: PQI 01: DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE

Agency for Healthcare Research and Quality

A. DESCRIPTION

Hospitalizations for a principal diagnosis of diabetes with short-term complications (ketoacidosis, hyperosmolarity, or coma) per 100,000 beneficiary months for beneficiaries age 18 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- States should report this measure as a rate per 100,000 beneficiary months as opposed to per 100,000 beneficiaries.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 18 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital discharge representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only discharges for beneficiaries age 18 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI01-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure at https://www.qualityindicators.ahrq.gov/Software/Default.aspx. Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a variation from specifications in the "Variations from Measurement Specifications" field.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 18 and older as of the 15th or the 30th day of the month. Date for counting beneficiary months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of Medicaid enrollment for beneficiaries age 18 and older during the measurement period.

Numerator

All inpatient hospital discharges for beneficiaries age 18 and older with ICD-10-CM principal diagnosis code for short-term complications of diabetes (ketoacidosis, hyperosmolarity, or coma) (Table PQI01-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI01-B below for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)

Table PQI01-B. Admission Codes for Transfers

SID ASOURCE codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or other Nursing Facility (NF)
	6 – Transfer from another health care facility
	F – Transfer from a hospice facility

MEASURE PQI05-AD: PQI 05: CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) OR ASTHMA IN OLDER ADULTS ADMISSION RATE

Agency for Healthcare Research and Quality

A. DESCRIPTION

Hospitalizations with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 beneficiary months for beneficiaries age 40 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries age 40 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 40 to 64 and age 65 and older.
- States should report this measure as a rate per 100,000 beneficiary months as opposed to per 100,000 beneficiaries.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 40 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 40 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital discharge representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only discharges for beneficiaries age 40 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI05-C, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure at https://www.qualityindicators.ahrq.gov/Software/Default.aspx. Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a deviation from specifications in the "Deviations from Measurement Specifications" field.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 40 and older as of the 15th or the 30th day of the month. Date for counting beneficiary months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of Medicaid enrollment for beneficiaries age 40 and older during the measurement period.

Numerator

All inpatient hospital discharges for beneficiaries age 40 and older with an ICD-10-CM principal diagnosis code for:

- COPD (excluding acute bronchitis) (Table PQI05-A), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip or
- Asthma (Table PQI05-B), available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip.

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI05-C below for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Cases with any listed ICD-10-CM diagnosis codes for cystic fibrosis and anomalies of the respiratory system (Table PQI05-D, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip)

Table PQI05-C. Admission Codes for Transfers

SID ASOURCE codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or other Nursing Facility (NF)
	6 – Transfer from another health care facility
	F – Transfer from a hospice facility

MEASURE PQI08-AD: PQI 08: HEART FAILURE ADMISSION RATE

Agency for Healthcare Research and Quality

A. DESCRIPTION

Hospitalizations with a principal diagnosis of heart failure per 100,000 beneficiary months for beneficiaries age 18 and older.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries age 18 and older. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 18 to 64 and age 65 and older.
- States should report this measure as a rate per 100,000 beneficiary months as opposed to per 100,000 beneficiaries.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was age 18 or older by that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital discharge representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only discharges for beneficiaries age 18 or older should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI08-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure at https://www.qualityindicators.ahrq.gov/Software/Default.aspx. Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a variation from specifications in the "Variations from Measurement Specifications" field.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM, ICD-10-PCS, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries age 18 and older as of the 15th or the 30th day of the month. Date for counting beneficiary months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of Medicaid enrollment for beneficiaries age 18 and older during the measurement period.

Numerator

All inpatient hospital discharges for beneficiaries age 18 and older with ICD-10-CM principal diagnosis code for heart failure (Table PQI08-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI08-B below for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Cases with any listed ICD-10-PCS procedure codes for cardiac procedure (Table PQI08-C, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip)

Table PQI08-B. Admission Codes for Transfers

SID ASOURCE codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or other Nursing Facility (NF)
	6 – Transfer from another health care facility
	F – Transfer from a hospice facility

MEASURE PQI15-AD: PQI 15: ASTHMA IN YOUNGER ADULTS ADMISSION RATE

Agency for Healthcare Research and Quality

A. DESCRIPTION

Hospitalizations with a principal diagnosis of asthma per 100,000 beneficiary months for beneficiaries ages 18 to 39.

Note: A lower rate indicates better performance.

Data Collection Method: Administrative

Guidance for Reporting:

- States should report this measure as a rate per 100,000 beneficiary months as opposed to per 100,000 beneficiaries.
- A two-step process should be used to determine whether beneficiaries should be counted in this measure:
  - For each beneficiary month considered for the denominator, assess the beneficiary's age at either the 15th or 30th of the month (or the 28th of the month in February). If the beneficiary was ages 18 to 39 on that date, the beneficiary month should be counted in the denominator. A consistent date should be used to assess age across all months. For example, if a state counts enrollment as of the 30th of the month and a beneficiary is over age 18 on the 30th but only has eligibility through the 27th, that month would not count toward the denominator. However, if a state counts enrollment as of the 15th, that month would count toward the denominator.
  - For each hospital discharge representing a qualifying numerator event, assess the beneficiary's age on the date of admission. Only discharges for beneficiaries ages 18 to 39 should be included in the numerator.
- This measure is designed to exclude transfers from other institutions from the numerator. However, the variables contained in the software to identify transfers, shown in Table PQI15-B, may not exist in all data sources. If that is the case, states should describe how transfers are identified and excluded in their calculations.
- Free software is available from the AHRQ Web site for calculation of this measure at https://www.qualityindicators.ahrq.gov/Software/Default.aspx. Use of the AHRQ software is optional for calculating the PQI measures. Because the software is optional, states that do not use it should not document this as a variation from specifications in the "Variations from Measurement Specifications" field.
- Include paid claims only.

This measure includes the following coding systems: ICD-10-CM and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Beneficiary months	All beneficiary months for beneficiaries ages 18 to 39 as of the 15th or the 30th day of the month. Date for counting beneficiary months must be consistent across the reporting period.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

Total number of months of Medicaid enrollment for beneficiaries ages 18 to 39 during the measurement period.

Numerator

All inpatient hospital discharges for beneficiaries ages 18 to 39 with an ICD-10-CM principal diagnosis code of asthma (Table PQI15-A, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip).

Exclusions

- Transfer from a hospital (different facility), a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF), hospice facility, or another health care facility (see Table PQI15-B below for admission codes for transfers)
- Discharges with an ungroupable DRG (DRG = 999)
- Discharges with missing age (AGE = missing), year (YEAR = missing), or principal diagnosis (DX1 = missing)
- Cases with any listed ICD-10-CM diagnosis code for cystic fibrosis and anomalies of the respiratory system (Table PQI15-C, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-adult-non-hedis-value-set-directory.zip)

Table PQI15-B. Admission Codes for Transfers

SID ASOURCE codes	2 – Another hospital
	3 – Another facility, including long-term care
Point of Origin UB-04 codes	4 – Transfer from a hospital
	5 – Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Assisted Living Facility (ALF), or other Nursing Facility
	6 – Transfer from another health care facility
	F – Transfer from a hospice facility

MEASURE SAA-AD: ADHERENCE TO ANTIPSYCHOTIC MEDICATIONS FOR INDIVIDUALS WITH SCHIZOPHRENIA

National Committee for Quality Assurance[1]

A. DESCRIPTION

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

Data Collection Method: Administrative

Guidance for Reporting:

- If an oral medication and a long-acting injection are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.
- If an oral medication and long-acting injection are dispensed on different days, with some overlapping days of supply, count each day within the treatment period only once toward the numerator.
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) f is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-10-CM, ICD-10-PCS, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Index Prescription Start Date (IPSD)	The earliest prescription dispensing date for any antipsychotic medication during the measurement year.
Treatment period	The period of time beginning on the IPSD through the last day of the measurement year.
PDC	Proportion of days covered. The number of days a beneficiary is covered by at least one antipsychotic medication prescription, divided by the number of days in the treatment period.

[1] Adapted by NCQA with permission of the measure developer, CMS.

Oral medication dispensing event	One prescription of an amount lasting 30 days or less. To calculate dispensing events for prescriptions longer than 30 days, divide the days supply by 30 and round down to convert. For example, a 100-day prescription is equal to three dispensing events. Multiple prescriptions for different medications dispensed on the same day are counted as separate dispensing events. If multiple prescriptions for the same medication are dispensed on the same day, use the prescription with the longest days supply. Use the medication lists (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to determine if the drugs are the same or different. Drugs in different lists are considered different drugs.
Long-acting injections dispensing event	Injections count as one dispensing event. Multiple codes (from the value sets and medication lists) for the same or different medication on the same day are counted as a single dispensing event.
Calculating number of days covered for oral medications	If multiple prescriptions for the same or different oral medications are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply. If multiple prescriptions for different oral medications are dispensed on different days, count each day within the treatment period only once toward the numerator. If multiple prescriptions for the same oral medication are dispensed on different days, sum the days supply and use the total to calculate the number of days covered by an antipsychotic medication (for the numerator). For example, if three antipsychotic prescriptions for the same oral medication are dispensed on different days, each with a 30-day supply; sum the days supply for a total of 90 days covered by an oral antipsychotic (even if there is overlap). Use the medication lists (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to determine if the drugs are the same or different. Drugs in different lists are considered different drugs.
Calculating number of days covered for long-acting injections	Calculate number of days covered (for the numerator) for long-acting injections using the days supply specified for the medication in the medication list or in the value set name. For direct reference codes: • Count HCPCS code J2794 as a 14 days supply. • Count HCPCS code J2798 as a 30 days supply. For multiple codes (from the value sets and medication lists) for the same or different medications on the same day, use the medication with the longest days supply. For multiple codes (from the value sets and medication lists) for the same or different medications on different days with overlapping days supply, count each day within the treatment period only once toward the numerator.

Note: If an oral medication and a long-acting injection are dispensed on the same day, calculate number of days covered by an antipsychotic medication (for the numerator) using the prescription with the longest days supply.

If an oral medication and long-acting injection are dispensed on different days, with some overlapping days of supply, count each day within the treatment period only once toward the numerator.

C. ELIGIBLE POPULATION

Age	Ages 18 and older as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefits	Medical and pharmacy.
Event/ diagnosis	Identify beneficiaries with schizophrenia or schizoaffective disorder as those who met at least one of the following criteria during the measurement year: • At least one acute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder. Either of the following code combinations meets criteria: – BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set. – Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set. • At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED, or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or schizoaffective disorder. Two of any of the following meets criteria: – An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Outpatient POS Value Set with Schizophrenia Value Set). – An outpatient visit with any diagnosis of schizophrenia or schizoaffective disorder (BH Outpatient Value Set with Schizophrenia Value Set). – An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 52 with Schizophrenia Value Set).

Event/ diagnosis (continued)	– An intensive outpatient encounter or partial hospitalization with any diagnosis of schizophrenia or schizoaffective disorder (Partial Hospitalization or Intensive Outpatient Value Set with Schizophrenia Value Set). – A community mental health center visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 53 with Schizophrenia Value Set). – Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set). – An ED visit (ED Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set). – An ED visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with POS code 23 with Schizophrenia Value Set). – A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set). – A nonacute inpatient encounter with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set with Schizophrenia Value Set). – A telehealth visit with any diagnosis of schizophrenia or schizoaffective disorder (Visit Setting Unspecified Value Set with Telehealth POS Value Set with Schizophrenia Value Set). – A telephone visit (Telephone Visits Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set). – An e-visit or virtual check-in (Online Assessments Value Set) with any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set).

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who met any of the following criteria: • A diagnosis of dementia (Dementia Value Set). Do not include laboratory claims (claims with POS code 81). • 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 state must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. – Claims/encounter data. An antipsychotic medication (HCPCS code J2794, HCPCS code J2798, Long-Acting Injections 28 Days Supply Value Set). – Pharmacy data. Dispensed an antipsychotic medication. Use all the medication lists in the Oral Antipsychotic Medications and Long-Acting Injections (see Medication List table below and link to the Medication List Directory in Guidance for Reporting above) to identify antipsychotic medication dispensing events. • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries ages 66 to 80 as of December 31 of the measurement year with frailty and advanced illness. Beneficiaries must meet both frailty and advanced illness criteria to be excluded: – Frailty. At least two indications of frailty (Frailty Device Value Set, Frailty Diagnosis Value Set, Frailty Encounter Value Set, Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81). – Advanced Illness. Either of the following during the measurement year or the year prior to the measurement year: 1. Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). 2. Dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above). • Beneficiaries ages 81 and older as of December 31 of the measurement year with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set), with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).

Oral Antipsychotic Medications

Description	Prescription	Medication Lists
Miscellaneous antipsychotic agents (oral)	Aripiprazole	Aripiprazole Oral Medications List
	Asenapine	Asenapine Oral Medications List
	Brexpiprazole	Brexpiprazole Oral Medications List
	Cariprazine	Cariprazine Oral Medications List
	Clozapine	Clozapine Oral Medications List
	Haloperidol	Haloperidol Oral Medications List
	Iloperidone	Iloperidone Oral Medications List
	Loxapine	Loxapine Oral Medications List
	Lumateperone	Lumateperone Oral Medications List
	Lurasidone	Lurasidone Oral Medications List
	Molindone	Molindone Oral Medications List
	Olanzapine	Olanzapine Oral Medications List
	Paliperidone	Paliperidone Oral Medications List
	Quetiapine	Quetiapine Oral Medications List
	Risperidone	Risperidone Oral Medications List
	Ziprasidone	Ziprasidone Oral Medications List
Phenothiazine antipsychotics (oral)	Chlorpromazine	Chlorpromazine Oral Medications List
	Fluphenazine	Fluphenazine Oral Medications List
	Perphenazine	Perphenazine Oral Medications List
	Prochlorperazine	Prochlorperazine Oral Medications List
	Thioridazine	Thioridazine Oral Medications List
	Trifluoperazine	Trifluoperazine Oral Medications List
Psychotherapeutic combinations (oral)	Amitriptyline-perphenazine	Amitriptyline Perphenazine Oral Medications List
Thioxanthenes (oral)	Thiothixene	Thiothixene Oral Medications List

Long-Acting Injections

Description	Prescription	Medication Lists
Long-acting injections 14 days supply	Risperidone (excluding Perseris®)	Long Acting Injections 14 Days Supply Medications List

Description	Prescription	Medication Lists
Long-acting injections 28 days supply	Aripiprazole Aripiprazole lauroxil Fluphenazine decanoate Haloperidol decanoate Olanzapine	Long Acting Injections 28 Days Supply Medications List
Long-acting injections 30 days supply	Risperidone (Perseris®)	Long Acting Injections 30 Days Supply Medications List
Long-acting injections 35 days supply	Paliperidone palmitate (Invega Sustenna)	Long Acting Injections 35 Days Supply Medications List
Long-acting injections 104 days supply	Paliperidone palmitate (Invega Trinza)	Long Acting Injections 104 Days Supply Medications List
Long-acting injections 201 days supply	Paliperidone palmitate (Invega Hafyera)	Long Acting Injections 201 Days Supply Medications List

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The number of beneficiaries who achieved a PDC of at least 80 percent for their antipsychotic medications during the measurement year.

Follow the steps below to identify numerator compliance. Use the HCPCS code J2794, HCPCS code J2798, Long Acting Injections 28 Days Supply Value Set and all the medication lists in the Oral Antipsychotic Medications and Long-Acting Injections (see Medication List table above and link to the Medication List Directory in Guidance for Reporting above) to identify antipsychotic medication dispensing events.

Step 1

Identify the IPSD. The IPSD is the earliest dispensing event for any antipsychotic medication during the measurement year.

Step 2

To determine the treatment period, calculate the number of days beginning on the IPSD through the end of the measurement year.

Step 3

Count the days covered by at least one antipsychotic medication during the treatment period. To ensure that days supply that extend beyond the measurement year are not counted, subtract any days supply that extends beyond December 31 of the measurement year.

Step 4

Calculate the beneficiary's PDC using the following equation. Multiply the equation by 100 and round (using the .5 rule) to the nearest whole number. For example, if a beneficiary has 291 total days covered by a medication during a 365-day treatment period, this calculates to 0.7972. Multiply this number by 100, convert it to 79.72% and round it to 80%, the nearest whole number.

$$\frac{\textit{Total days covered by antipsychotic medication in the treatment period (Step 3)}}{\textit{Total days in treatment period (Step2)}}$$

Step 5

Sum the number of beneficiaries whose PDC is ≥ 80% for their treatment period.

MEASURE SSD-AD: DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTIC MEDICATIONS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of beneficiaries ages 18 to 64 with schizophrenia, schizoaffective disorder, or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).

This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, CPT CAT II, HCPCS, ICD-10-CM, ICD-10-PCS, LOINC, POS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Age 18 to 64 as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical and pharmacy.

Event/ diagnosis	Identify beneficiaries with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year: • At least one acute inpatient encounter with any diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. Either of the following code combinations meet criteria: – BH Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set). – Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set. • At least two of the following, on different dates of service, where both encounters have any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) or both encounters have any diagnosis of bipolar disorder (Bipolar Disorder Value Set, Other Bipolar Disorder Value Set). – An outpatient visit (Visit Setting Unspecified Value Set) with Outpatient POS Value Set. – An outpatient visit (BH Outpatient Value Set). – An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with POS code 52). – An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). – A community mental health center visit (Visit Setting Unspecified Value Set with POS code 53). – Electroconvulsive therapy (Electroconvulsive Therapy Value Set). – An ED visit (ED Value Set). – An ED visit (Visit Setting Unspecified Value Set with POS code 23). – A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set). – A nonacute inpatient encounter (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set). – A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set). – A telephone visit (Telephone Visits Value Set). – An e-visit or virtual check-in (Online Assessments Value Set).

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who met any of the following criteria: • Beneficiaries with diabetes. There are two ways to identify beneficiaries with diabetes: By claims/encounter data and by pharmacy data. The state must use both methods to identify beneficiaries with diabetes, but a beneficiary need only be identified by one method to be excluded from the measure. Beneficiaries may be identified as having diabetes during the measurement year or the year prior to the measurement year. – Claim/encounter data. Beneficiaries who had at least two encounters with diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81) – Pharmacy data. Beneficiaries who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List, see link to the Medication List Directory in Guidance for Reporting above) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). • Beneficiaries who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The state 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 Value Set). – Pharmacy data. Dispensed an antipsychotic medication (SSD Antipsychotic Medications List, see link to the Medication List Directory in Guidance for Reporting above). • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set. • Beneficiaries who die any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Adult Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Diabetes Screening

A glucose test or an HbA1c test performed during the measurement year.

- Glucose Lab Test Value Set
- Glucose Test Result or Finding Value Set
- HbA1c Lab Test Value Set
- HbA1c Test Result or Finding Value Set. Do not include codes with a modifier (CPT CAT II Modifier Value Set) or from laboratory claims (claims with POS code 81).

IV. CORE SET MEASURES REPORTED USING ELECTRONIC CLINICAL DATA SYSTEMS

This chapter presents the technical specifications for each measure in the Adult Core Set with Electronic Clinical Data Systems (ECDS) specifications. Each specification includes a description of the measure and information about the eligible population, key definitions, data collection method(s), instructions for calculating the measure, and any other relevant measure information. In addition, Chapter IV includes guidelines for reporting measures using ECDS specifications.

For 2025 Adult Core Set reporting, the CCS-AD measure includes ECDS specifications as well as administrative and hybrid specifications. The administrative and hybrid specifications for this measure are included in Chapter III and the ECDS specifications are included in Chapter IV.

These specifications represent the most applicable version available from the measure steward as of December 2024.

Guidelines For Measures Reported Using Electronic Clinical Data Systems (ECDS)

A. Description

HEDIS measures reported using ECDS draw on electronic clinical data. ECDS are the network of data containing a beneficiary's personal health information and records of their experiences within the health care system. Data in these systems follow standard layouts and are structured such that automated queries can be consistently and reliably executed.

Visit www.ncqa.org/ecds for more information and FAQs about ECDS reporting.

B. Guidelines

HEDIS measures in the Adult Core Set reported using ECDS follow the guidelines in *Section II Data Collection and Reporting* of this Manual, unless there is an ECDS-specific guideline listed below that overrides those rules.

- **HEDIS Definitions for ECDS**
  - **Initial Population.** Describes the criteria for the population eligible to be included in the measure.

    Includes: whether the measure is based on persons or events, beneficiary attribution criteria including required benefits, continuous enrollment, and allowable gap as well as any additional criteria.
  - **Measure Item Count.** Describes whether the measure is counting persons or events.
  - **Attribution.** Describes the basis for inclusion in the measure. For the Core Set ECDS measures, attribution refers to enrollment in the state Medicaid or CHIP program.
  - **Exclusions.** Describes required exclusions for the measure. The category includes both exclusions that apply to multiple measures and measure-specific exclusions.
  - **Denominator.** The initial population, minus exclusions.
  - **Scoring.** Describes how the measure is scored. For the 2025 Core Sets, all ECDS measures use proportion scoring.
- **Types of ECDS Data.** States may use several data sources to provide complete information about the quality of health services delivered. Data systems that are eligible for ECDS reporting include, but are not limited to, beneficiary eligibility files, Electronic Health Records (EHRs), Personal Health Records (PHRs), clinical registries, Health Information Exchanges (HIEs), administrative claims systems, electronic laboratory reports (ELR), electronic pharmacy systems, immunization information systems (IIS) and disease/case management registries.

  The data within these systems come in a variety of formats. Beneficiary-reported services are acceptable if the information is recorded, dated, and maintained in the beneficiary's legal health record.

  Data sources are categorized using the following criteria.

  For the purposes of Core Set reporting, states will report overall results rather than by data source. See Section II for additional guidance on reporting:

- **EHR/PHR.** EHRs and PHRs are transactional systems that store clinically relevant information collected directly from or managed by a patient. An EHR contains the medical and treatment histories of patients; a PHR includes both the standard clinical data collected in a provider's office or another care setting, in addition to information curated directly in the PHR by the patient though an application programming interface (API).

  This data category includes biometric information and clinical samples obtained directly from a patient as well as clinical findings resulting from samples collected from a patient (e.g., pathology, laboratory and pharmacy records generated from entities not directly connected to the patient's EHR).

- **HIE/clinical registry.** HIEs and clinical registries eligible for this reporting category include state HIEs, IIS, public health agency systems, regional HIEs (Regional Health Information Organizations), Patient-Centered Data Homes™ or other registries developed for research or to support quality improvement and patient safety initiatives.

  Doctors, nurses, pharmacists, other health care providers and patients can use HIEs to access and share vital medical information, with the goal of creating a complete patient record.[1] HIEs used for ECDS reporting must use standard protocols to ensure security, privacy, data integrity, sender and receiver authentication and confirmation of delivery.

  Clinical registries collect information about people with a specific disease or condition, or patients who may be willing to participate in research about a disease. Registries can be sponsored by a government agency, nonprofit organization, health care facility, or private company, and decisions regarding use of the data in the registry are the responsibility of the registry's governing committee.[2]

- **Case management system.** A shared database of information collected through a collaborative process of individual assessment, care planning, care coordination or monitoring of an individual's functional status and care experience.

  Case management systems eligible for this category of ECDS reporting include any system developed to support the organization's case/disease management activities, including activities performed by delegates.

- **Administrative.** Includes data from administrative claims processing systems for all services incurred (paid, suspended, pending, and denied) during the period defined by each measure as well as beneficiary management files, beneficiary eligibility and enrollment files, electronic rosters, and internal audit files.

[1] https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie

[2] https://www.nih.gov/health-information/nih-clinical-research-trials-you/list-registries

MEASURE AIS-AD: ADULT IMMUNIZATION STATUS[1]

National Committee for Quality Assurance

Description	The percentage of beneficiaries age 19 and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster and pneumococcal.
Core Set data collection method	Electronic Clinical Data Systems (ECDS)
Guidance for Core Set reporting	• All measure rates are specified based on clinical guideline recommendations for the age group included in the rate. • Include all paid, suspended, pending, and denied claims. • Please refer to Section II. Data Collection and Reporting and Section IV. Guidelines for Measures Reported Using ECDS for additional guidance.
Coding systems referenced	This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, CVX, HCPCS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.
Measure characteristics	**Scoring** Proportion. **Type** Process. **Stratification** • Influenza. – Age (as of the start of the measurement period): – Ages 19 to 65. – Age 66 and older. • Td/Tdap. – Age (as of the start of the measurement period): – Ages 19 to 65. – Age 66 and older. • Zoster. – Age (as of the start of the measurement period): – Ages 50 to 65. – Age 66 and older. • Pneumococcal. – Age (as of the start of the measurement period): – Age 66 and older.

[1] Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO).

Measure characteristics (continued)	**Risk adjustment** None. **Improvement notation** A higher rate indicates better performance.
Initial population	*Measure Item Count*: Person *Attribution*: Enrollment *Benefit*: Medical *Continuous enrollment:* The measurement period. *Allowable gap:* No more than one gap in enrollment of up to 45 days during the measurement period. The beneficiary must be enrolled on the last day of the measurement period. *Ages:* 19 years and older at the start of the measurement period. **Initial populations 1 and 2 – Immunization Status: Influenza and Td/Tdap** Beneficiaries age 19 and older at the start of the measurement period **Initial population 3 – Immunization Status: Zoster** Beneficiaries age 50 and older at the start of the measurement period **Initial population 4 – Immunization Status: Pneumococcal** Beneficiaries age 66 and older at the start of the measurement period
Required exclusions (Supplemental and medical record data may be used for these exclusions)	**Exclusions (apply to initial populations 1-4)** • Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. • Beneficiaries who die any time during the measurement period.
Denominator	**Denominators 1 and 2 – Immunization Status: Influenza and Td/Tdap** The initial populations 1 and 2, minus exclusions. **Denominator 3 – Immunization Status: Zoster** The initial population 3, minus exclusions. **Denominator 4 – Immunization Status: Pneumococcal** The initial population 4, minus exclusions.
Numerator	**Numerator 1 – Immunization Status: Influenza** • Beneficiaries who received an influenza vaccine (Adult Influenza Immunization Value Set; Adult Influenza Vaccine Procedure Value Set; Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) on or between July 1 of the year prior to the measurement period and June 30 of the measurement period, ***or*** • Beneficiaries with anaphylaxis due to the influenza vaccine (SNOMEDCT code 471361000124100) any time before or during the measurement period.

Numerator (continued)	**Numerator 2 – Immunization Status: Td/Tdap** • Beneficiaries who received at least one Td vaccine (Td Immunization Value Set; Td Vaccine Procedure Value Set) or one Tdap vaccine (CVX code 115; Tdap Vaccine Procedure Value Set) between 9 years prior to the start of the measurement period and the end of the measurement period, ***or*** • Beneficiaries with a history of at least one of the following contraindications any time before or during the measurement period: – Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set). – Encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set). **Numerator 3 – Immunization Status: Zoster** • Beneficiaries who received at least one dose of the herpes zoster live vaccine (CVX code 121; Herpes Zoster Live Vaccine Procedure Value Set) or two doses of the herpes zoster recombinant vaccine (CVX code 187; Herpes Zoster Recombinant Vaccine Procedure Value Set) at least 28 days apart, any time on or after the beneficiary's 50th birthday and before or during the measurement period, ***or*** • Beneficiaries with anaphylaxis due to the herpes zoster vaccine (Anaphylaxis Due to Herpes Zoster Vaccine Value Set) any time before or during the measurement period. **Numerator 4 – Immunization Status: Pneumococcal** • Beneficiaries who were administered at least one dose of an adult pneumococcal vaccine (Adult Pneumococcal Immunization Value Set; Adult Pneumococcal Vaccine Procedure Value Set) on or after their 19th birthday and before or during the measurement period, ***or*** • Beneficiaries with anaphylaxis due to the pneumococcal vaccine (SNOMEDCT code 471141000124102) any time before or during the measurement period.
Clinical recommendation statement	The Advisory Committee on Immunization Practices recommends annual influenza vaccination. They recommend tetanus, diphtheria and acellular pertussis (Tdap) and/or tetanus and diphtheria (Td) vaccine; herpes zoster vaccine; and pneumococcal vaccination for adults at various ages.
Citations	Murthy, N., Wodi, A.P., McNally, V., Cineas, S., Ault, K. 2023. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years and Older—United States, 2023." MMWR Morb Mortal Wkly Rep 2023; 72:141–133. DOI: http://dx.doi.org/10.15585/mmwr.mm7206a2

MEASURE BCS-AD: BREAST CANCER SCREENING

National Committee for Quality Assurance

Description	The percentage of beneficiaries ages 50 to 74 who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
Core Set data collection method	Electronic Clinical Data Systems (ECDS)
Guidance for Core Set reporting	• This measure applies to beneficiaries ages 52 to 74 to account for the 2-year, 3-month look-back period. For the purpose of Adult Core Set reporting, states should calculate and report this measure for two age groups (as applicable): ages 50 to 64 and ages 65 to 74. • This measure should include all beneficiaries ages 52 to 74 who had a mammogram to screen for breast cancer any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year. • This measure requires a continuous enrollment period of 2 years and 3 months. Allowable gaps in enrollment may be one month or up to 45 days per full calendar year. No gap in enrollment is allowed during the first 3 months of the continuous enrollment period. • Include all paid, suspended, pending, and denied claims. • NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). • The electronic clinical quality measure (eCQM) specification for the Core Set 2025 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2024/cms125v12. States that use electronic specifications should indicate this by selecting “Electronic Health Records” in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the ECDS specification. States should use caution comparing measures calculated using different data collection methods. • Please refer to Section II. Data Collection and Reporting and Section IV. Guidelines for Measures Reported Using ECDS for additional guidance.
Coding systems referenced	• This measure’s Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, LOINC, Modifier, SNOMED, and UB. • The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

<table>
<tr><td>Measure characteristics</td><td>Scoring</td><td>Proportion.</td></tr>
<tr><td></td><td>Type</td><td>Process.</td></tr>
<tr><td></td><td>Stratification</td><td>Core Set age stratifications:
Ages 50 to 64
Ages 65 to 74</td></tr>
<tr><td></td><td>Risk adjustment</td><td>None.</td></tr>
<tr><td></td><td>Improvement notation</td><td>A higher rate indicates better performance.</td></tr>
<tr><td>Initial population</td><td colspan="2">Measure Item Count: Person
Attribution: Enrollment
Benefit: Medical

Continuous enrollment: October 1 two years prior to the measurement period through the end of the measurement period.

Allowable gap: No more than one gap in enrollment of up to 45 days for each full calendar year (i.e., the measurement period and the year prior to the measurement period). To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled) during each year of continuous enrollment.

No gaps in enrollment are allowed from October 1 two years prior to the measurement period through December 31 two years prior to the measurement period. The beneficiary must be enrolled on the last day of the measurement period.

Beneficiaries ages 52 to 74 by the end of the measurement period who were recommended for routine breast cancer screening.

Include beneficiaries recommended for routine breast cancer screening with any of the following criteria:
Administrative Gender of Female (AdministrativeGender code Female) at any time in the beneficiary’s history.
Note: Administrative gender is the gender the beneficiary is considered to have for administrative and record-keeping purposes. It is typically provided in enrollment data.
Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) at any time in the beneficiary’s history.
Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period.</td></tr>
</table>

<table>
<tr><td>Initial population (continued)</td><td colspan="2">Note: A Sex Parameter for Clinical Use is a parameter that provides guidance on how a recipient should apply settings or reference ranges that are derived from observable information such as an organ inventory, recent hormone lab tests, genetic testing, menstrual status, obstetric history, etc. This property is intended for use in clinical decision making, and indicates that treatment or diagnostic tests should consider best practices associated with the relevant reference population. More information is available at Model - HL7 Cross Paradigm Implementation Guide: Gender Harmony - Sex and Gender Representation, Edition 1 v1.0.0.</td></tr>
<tr><td rowspan="5">Required exclusions
(Supplemental and medical record data may be used for these exclusions)</td><td colspan="2">• Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period.
• Beneficiaries who die any time during the measurement period.
• Beneficiaries who had a bilateral mastectomy or both right and left unilateral mastectomies any time during the beneficiary's history through the end of the measurement period. Any of the following meet the criteria for bilateral mastectomy:
– Bilateral mastectomy (Bilateral Mastectomy Value Set).
– Unilateral mastectomy (Unilateral Mastectomy Value Set) with a bilateral modifier (CPT Modifier code 50) (same procedure).
– Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a bilateral qualifier value (SNOMED CT Modifier code 51440002) (same procedure).
– History of bilateral mastectomy (History of Bilateral Mastectomy Value Set).
– Any combination of codes from the table below that indicate a mastectomy on both the left and right side on the same date of service or on different dates of service.</td></tr>
<tr><td>Left Mastectomy
(any of the following)</td><td>Right Mastectomy
(any of the following)</td></tr>
<tr><td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a left-side modifier (CPT Modifier code LT) (same procedure)</td><td>Unilateral mastectomy (Unilateral Mastectomy Value Set) with a right- side modifier (CPT Modifier code RT) (same procedure)</td></tr>
<tr><td>Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a left-side qualifier value (SNOMED CT Modifier code 24028007) (same procedure)</td><td>Unilateral mastectomy found in clinical data (Clinical Unilateral Mastectomy Value Set) with a right-side qualifier value (SNOMED CT Modifier code 7771000) (same procedure)</td></tr>
<tr><td>Absence of the left breast (Absence of Left Breast Value Set)</td><td>Absence of the right breast (Absence of Right Breast Value Set)</td></tr>
</table>

<table>
<tr><td rowspan="2">Required exclusions
(Supplemental and medical record data may be used for these exclusions) (continued)</td><td>Left unilateral mastectomy (Unilateral Mastectomy Left Value Set)</td><td>Right unilateral mastectomy (Unilateral Mastectomy Right Value Set)</td></tr>
<tr><td colspan="2">Note: The “clinical” mastectomy value sets identify mastectomy; the word “clinical” refers to the data source, not to the type of mastectomy.
Beneficiaries who had gender-affirming chest surgery (CPT code 19318) with a diagnosis of gender dysphoria (Gender Dysphoria Value Set) any time during the beneficiary’s history through the end of the measurement period.
Beneficiaries 66 years of age and older by the end of the measurement period, with frailty and advanced illness. Beneficiaries must meet BOTH frailty and advanced illness criteria to be excluded:
Frailty. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS 81).
Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period:
Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS 81).
Dispensed dementia medication (Dementia Medications List).
Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period.
Beneficiaries who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS 81).</td></tr>
<tr><td>Denominator</td><td colspan="2">The initial population, minus exclusions.</td></tr>
<tr><td>Numerator</td><td colspan="2">One or more mammograms (Mammography Value Set) any time on or between October 1 two years prior to the measurement period and the end of the measurement period.</td></tr>
<tr><td>Clinical recommendation statement</td><td colspan="2">The U.S. Preventive Services Task Force recommends screening women 50–74 years of age for breast cancer every 2 years. (B recommendation)

The Fenway Institute recommends that for patients assigned female at birth who have not undergone chest reconstruction (including those who have had breast reduction), breast/chest screening recommendations are the same as for cisgender women of a similar age and medical history.

The University of California San Francisco Center of Excellence for Transgender Health recommends that transgender men who have not undergone bilateral mastectomy, or who have only undergone breast reduction, undergo screening according to current guidelines for non-transgender women.</td></tr>
</table>

Clinical recommendation statement (continued)	The World Professional Association for Transgender Health recommends health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people with breasts from natal puberty who have not had gender-affirming chest surgery.
Citations	Fenway Health. 2021. *Medical Care of Trans and Gender Diverse Adults*. https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and-Gender-Diverse-Adults-Spring-2021-1.pdf University of California San Francisco Center of Excellence for Transgender Health. 2016. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*. https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6-17-16.pdf U.S. Preventive Services Task Force. 2016. “Screening for Breast Cancer: U.S. Preventive Services Task Force Recommendation Statement." *Ann Intern Med* 164(4):279–96. World Professional Association for Transgender Health. 2022. *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8.* https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644

Measure CCS-AD: Cervical Cancer Screening

National Committee for Quality Assurance

Description	The percentage of beneficiaries ages 21 to 64 who were recommended for routine cervical cancer screening and were screened for cervical cancer using any of the following criteria: • Beneficiaries ages 21 to 64 who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. • Beneficiaries ages 30 to 64 who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. • Beneficiaries ages 30 to 64 who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
Core Set data collection method	Electronic Clinical Data Systems (ECDS) This measure is also specified for Administrative, Hybrid, or EHR, see Chapter III.
Guidance for Core Set reporting	• This measure should include (1) all beneficiaries ages 24 to 64 who have had cervical cytology during the measurement period or the two years prior to the measurement period, and (2) beneficiaries ages 30 to 64 who have had cervical high-risk human papillomavirus (hrHPV) testing during the measurement period or the four years prior to the measurement period. Both criteria must be evaluated for numerator compliance; however, beneficiaries only need to meet one criterion to be included in the numerator for this measure. Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary. • The eligible population (denominator) includes beneficiaries who are ages 24 to 64 as of the end of the measurement period to account for the 3-year look-back period for assessing numerator criterion (e.g., the measure is looking back three years from age 24 for evidence of cervical cytology). • Include all paid, suspended, pending, and denied claims. • The electronic clinical quality measure (eCQM) specification for the 2025 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2024/cms124v12. States that use electronic specifications should indicate this by selecting “Electronic Health Records” in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative, hybrid, and ECDS specifications. States should use caution comparing measures calculated using different data collection methods. • Please refer to Section II. Data Collection and Reporting and Section IV. Guidelines for Measures Reported Using ECDS for additional guidance.

Coding systems referenced	This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-9-CM, ICD-9-PCS, ICD-10-CM, ICD-10-PCS, LOINC, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.
Measure characteristics	**Scoring** Proportion. **Type** Process. **Stratification** None. **Risk adjustment** None. **Improvement notation** A higher rate indicates better performance.
Initial population	*Measure Item Count*: Person *Allocation*: Enrollment *Benefit*: Medical *Continuous enrollment*: The measurement period. *Allowable gap*: No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). The beneficiary must be enrolled on the last day of the measurement period. *Age*: Beneficiaries ages 24 to 64 as of the last day of the measurement period. Include beneficiaries recommended for routine cervical cancer screening with any of the following criteria: • Administrative Gender of Female (AdministrativeGender code Female) any time in the beneficiary's history. Note: Administrative gender is the gender the beneficiary is considered to have for administrative and record-keeping purposes. It is typically provided in enrollment data. • Sex Assigned at Birth (LOINC code 76689-9) of Female (LOINC code LA3-6) any time in the beneficiary's history. • Sex Parameter for Clinical Use of Female (SexParameterForClinicalUse code female-typical) during the measurement period. Note: A Sex Parameter for Clinical Use is a parameter that provides guidance on how a recipient should apply settings or reference ranges that are derived from observable information such as an organ inventory, recent hormone lab tests, genetic testing, menstrual status, obstetric history, etc.

Initial population (continued)	This property is intended for use in clinical decision making, and indicates that treatment or diagnostic tests should consider best practices associated with the relevant reference population. More information is available at Model - HL7 Cross Paradigm Implementation Guide: Gender Harmony - Sex and Gender Representation, Edition 1 v1.0.0.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	• Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. • Beneficiaries who die any time during the measurement period. • Hysterectomy with no residual cervix (Hysterectomy With No Residual Cervix Value Set) any time during the beneficiary's history through December 31 of the measurement period. • Cervical agenesis or acquired absence of cervix (Absence of Cervix Diagnosis Value Set) any time during the beneficiary's history through the end of the measurement period. Do not include laboratory claims (claims with POS 81). • Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Beneficiaries who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement period. Do not include laboratory claims (claims with POS 81). • Beneficiaries with Sex Assigned at Birth (LOINC code 76689-9) of Male (LOINC code LA2-8) at any time during the beneficiary's history.
Denominator	The initial population, minus exclusions.
Numerator	The number of beneficiaries recommended for routine cervical cancer screening who were screened for cervical cancer. Either of the following meets criteria: • Beneficiaries ages 24 to 64 by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical cytology (Cervical Cytology Lab Test Value Set; Cervical Cytology Result or Finding Value Set) during the measurement period or the 2 years prior to the measurement period. • Beneficiaries ages 30 to 64 by the end of the measurement period who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing (High Risk HPV Lab Test Value Set; SNOMED CT code 718591004) during the measurement period or the 4 years prior to the measurement period, and who were ages 30 or older on the test date. **Note:** Evidence of hrHPV testing within the last 5 years also captures patients who had cotesting; therefore, additional methods to identify cotesting are not necessary.

Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21–29 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (A recommendation) The USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with hrHPV testing alone or every 5 years with hrHPV testing in combination with cytology (cotesting) in women aged 30–65 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (A recommendation) The USPSTF recommends against screening for cervical cancer in women younger than 21 years. This recommendation statement applies to all asymptomatic individuals with a cervix. (D recommendation) The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. This recommendation statement applies to all asymptomatic individuals with a cervix. (D recommendation) The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix, and do not have a history of a high-grade precancerous lesion or cervical cancer. (D recommendation) The American Cancer Society recommends that individuals with a cervix initiate cervical cancer screening at age 25 years, and undergo primary HPV testing every 5 years through age 65 years (preferred). If primary HPV testing is not available, individuals aged 25–65 years should be screened with cotesting (HPV testing in combination with cytology) every 5 years, or cytology alone every 3 years (acceptable). The recommendations apply to all asymptomatic individuals with a cervix, regardless of their sexual history or HPV vaccination status, including those who have undergone supracervical hysterectomy and transgender men who retain their cervix. (Strong Recommendation) The Fenway Institute recommends that transgender and gender diverse patients who have a cervix have regular cervical pap tests, as per the published guidelines for cisgender women. The University of California San Francisco Center of Excellence for Transgender Health recommends that cervical cancer screening for transgender men, including intervals of screening and age to begin and end screening, follows recommendations for non-transgender women as endorsed by the American Cancer Society, the American Society of Colposcopy and Cervical Pathology, the American Society of Clinical Pathologists, the U.S. Preventive Services Task Force and the World Health Organization. The World Professional Association for Transgender Health recommends that health care professionals offer cervical cancer screening to transgender and gender diverse people who currently have or previously had a cervix, following local guidelines for cisgender women.

Citations	American Cancer Society. 2020. Cervical cancer screening for individuals at average risk: 2020 guideline update from the American Cancer Society. https://acsjournals.onlinelibrary.wiley.com/doi/full/10.3322/caac.21628 Fenway Health. 2021. Medical Care of Trans and Gender Diverse Adults. https://fenwayhealth.org/wp-content/uploads/Medical-Care-of-Trans-and- Gender-Diverse-Adults-Spring-2021-1.pdf University of California San Francisco Center of Excellence for Transgender Health. 2016. Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People.https://transcare.ucsf.edu/sites/transcare.ucsf.edu/files/Transgender-PGACG-6- 17-16.pdf U.S. Preventive Services Task Force. 2018. “Screening for Cervical Cancer: U.S. Preventive Services Task Force Recommendation Statement.” JAMA 320(7): 674–86. World Professional Association for Transgender Health. 2022. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. https://www.tandfonline.com/doi/pdf/10.1080/26895269.2022.2100644

MEASURE COL-AD: COLORECTAL CANCER SCREENING

National Committee for Quality Assurance

Description	The percentage of beneficiaries ages 45 to 75 years who had appropriate screening for colorectal cancer.
Core Set data collection method	Electronic Clinical Data Systems (ECDS)
Guidance for Core Set reporting	• This measure applies to beneficiaries ages 46 to 75 to account for the lookback period (to ensure that the beneficiary was at least age 45 for the entire measurement year). For HEDIS, this measure has two reportable age groups and a total rate: ages 46 to 50, ages 51 to 75, and total (ages 46 to 75). For the purpose of Adult Core Set reporting, states should calculate and report this measure for three age groups (as applicable): ages 46 to 50, ages 51 to 65, and ages 66 to 75. • NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). • Include all paid, suspended, pending, and denied claims. • Please refer to Section II. Data Collection and Reporting and Section IV. Guidelines for Measures Reported Using ECDS for additional guidance. • The electronic clinical quality measure (eCQM) specification for the 2025 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2024/cms130v12. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the Data Source section of the online reporting system. Please note that there may be variations between the electronic specification and the ECDS specifications. States should use caution comparing measures calculated using different data collection methods.
Coding systems referenced	• This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, ICD-9-CM, ICD-9-PCS, LOINC, SNOMED, and UB. • The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.
Measure characteristics	**Scoring** Proportion. **Type** Process. **Stratification** Core Set age stratifications: • Ages 46 to 50. • Ages 51 to 65. Ages 66 to 75. **Risk adjustment** None.

Measure characteristics (continued)	**Improvement notation**	A higher rate indicates better performance.
Initial population	*Measure Item Count*: Person *Attribution*: Enrollment *Benefit*: Medical *Continuous enrollment:* The measurement period and year prior to the measurement period. *Allowable gap:* No more than one gap in enrollment of up to 45 days during each calendar year (i.e., the measurement period and the year prior to the measurement period). The beneficiary must be enrolled on the last day of the measurement period. *Age:* 46 to 75 as of the end of the measurement period.	
Required exclusions (Supplemental and medical record data may be used for these exclusions)	• Beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. • Beneficiaries who die any time during the measurement period. • Beneficiaries who had colorectal cancer (Colorectal Cancer Value Set) any time during the beneficiary's history through December 31 of the measurement year. Do not include laboratory claims (claims with POS 81). • Beneficiaries who had a total colectomy (Total Colectomy Value Set; SNOMEDCT code 119771000119101) any time during the beneficiary's history through December 31 of the measurement period. • Beneficiaries ages 66 and older by the end of the measurement period, with frailty and advanced illness. Beneficiaries must meet BOTH frailty and advanced illness criteria to be excluded: – **Frailty.** At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS 81). – **Advanced Illness.** Either of the following during the measurement period or the year prior to the measurement period: – Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS 81). – Dispensed dementia medication (Dementia Medications List). • Beneficiaries receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Beneficiaries who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS 81).	
Denominator	The initial population, minus exclusions.	

Numerator	Beneficiaries with one or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type. • Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; SNOMEDCT code 708699002) during the measurement period or the 2 years prior to the measurement period. • Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; SNOMEDCT code 841000119107) during the measurement period or the 4 years prior to the measurement period. • CT colonography (CT Colonography Value Set) during the measurement period or the 4 years prior to the measurement period. • Colonoscopy (Colonoscopy Value Set; SNOMEDCT code 851000119109) during the measurement period or the 9 years prior to the measurement period.
Clinical recommendation statement	The U.S. Preventive Services Task Force "recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation) and all adults aged 45 to 49 years (B recommendation)." Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA with FIT test (sDNA FIT) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year.
Citations	U.S. Preventive Services Task Force. 2021. "Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 325(19):1965–1977. doi:10.1001/jama.2021.6238

MEASURE PDS-AD: POSTPARTUM DEPRESSION SCREENING AND FOLLOW-UP: AGE 21 AND OLDER[1]

National Committee for Quality Assurance

Description	The percentage of deliveries in which beneficiaries were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care. • *Depression Screening.* The percentage of deliveries in which beneficiaries were screened for clinical depression using a standardized instrument during the postpartum period. • *Follow-Up on Positive Screen.* The percentage of deliveries in which beneficiaries received follow-up care within 30 days of a positive depression screen finding.
Core Set data collection method	Electronical Clinical Data Systems (ECDS)
Guidance for Core Set reporting	• For the purpose of Adult Core Set reporting, states should calculate and report this measure for beneficiaries age 21 and older as of the delivery date. The Child Core Set measure is reported for beneficiaries under age 21 as of the delivery date. • The denominator for this measure is based on deliveries, not on beneficiaries. • The following guidelines apply when identifying the initial population: – Include deliveries that occur in any setting. – Determine the delivery date using the date as of the end of the delivery. – If a beneficiary has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period. – Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and continuous enrollment before removing multiple deliveries in a 180-day period. • This measure requires the use of an age-appropriate screening instrument. The beneficiary's age is used to select the appropriate depression screening instrument.

[1] Developed with support from the California HealthCare Foundation (CHCF). CHCF works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit https://www.chcf.org/ to learn more. Also supported by the Zoma Foundation.

Guidance for Core Set reporting (continued)	• Depression screening captured in health risk assessments or other types of health assessments are allowed if the questions align with a specific instrument that is validated for depression screening. For example, if a health risk assessment includes questions from the PHQ-2, it counts as screening if the beneficiary answered the questions and a total score is calculated. • Include all paid, suspended, pending, and denied claims. • Please refer to Section II. Data Collection and Reporting and Section IV. Guidelines for Measures Reported Using ECDS for additional guidance.
Coding systems referenced	This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, SNOMED, and UB. The Medication List Directory includes the following coding systems for medications: NDC and RxNorm. Refer to the Acknowledgments section at the beginning of the manual for copyright information.
Measure characteristics	**Scoring** Proportion. **Type** Process. **Stratification** None. **Risk adjustment** None. **Improvement notation** A higher rate indicates better performance.
Definitions	
Depression screening instrument	A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:

	Instruments for Adults (18+ years)	Total Score LOINC Codes	Positive Finding
	Patient Health Questionnaire (PHQ-9)®	44261-6	Total score ≥10
	Patient Health Questionnaire-2 (PHQ-2)®[1]	55758-7	Total score ≥3
	Beck Depression Inventory-Fast Screen (BDI-FS)®[1,2]	89208-3	Total score ≥8
	Beck Depression Inventory (BDI-II)	89209-1	Total score ≥20
	Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)	89205-9	Total score ≥17
	Duke Anxiety-Depression Scale (DUKE-AD)®[2]	90853-3	Total score ≥30
	Edinburgh Postnatal Depression Scale (EPDS)	99046-5	Total score ≥10

	Instruments for Adults (18+ years)	Total Score LOINC Codes	Positive Finding
	My Mood Monitor (M-3)®	71777-7	Total score ≥5
	PROMIS Depression	71965-8	Total score (T Score) ≥60
	Clinically Useful Depression Outcome Scale (CUDOS)	90221-3	Total score ≥31
	[1]Brief screening instrument. All other instruments are full-length. [2]Proprietary; may be cost or licensing requirement associated with use.		
Initial population	*Measure Item Count*: Event *Attribution*: Enrollment *Benefit*: Medical *Continuous enrollment*: The delivery date through 60 days following the delivery date. *Allowable gap*: No gaps in enrollment from the delivery date through 60 days following the delivery date. *Age:* 21 and older as of the delivery date. **Initial populations 1 and 2** Deliveries (Deliveries Value Set) during September 8 of the year prior to the measurement period through September 7 of the measurement period.		
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclusions (apply to initial populations 1 and 2) • Exclude all episodes for beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. • Beneficiaries who die any time during the measurement period.		
Denominator	**Denominator 1 – Depression Screening** The initial population, minus exclusions. **Denominator 2 – Follow-Up on Positive Screen** All deliveries from numerator 1 with a positive finding for depression during the 7 to 84 days following the date of delivery.		
Numerator	**Numerator 1 – Depression Screening** Deliveries in which beneficiaries had a documented result for depression screening, using an age-appropriate standardized instrument, performed during the 7 to 84 days following the delivery date. **Numerator 2 – Follow-Up on Positive Screen** Deliveries in which beneficiaries 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 that meet Numerator 2 criteria:		

Numerator (continued)	• An outpatient, telephone, e-visit or virtual check-in follow-up visit (Follow Up Visit Value Set) with a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A depression case management encounter (Depression Case Management Encounter Value Set) that documents assessment for symptoms of depression (Symptoms of Depression Value Set) or a diagnosis of depression or other behavioral health condition (Depression or Other Behavioral Health Condition Value Set). • A behavioral health encounter, including assessment, therapy, collaborative care or medication management (Behavioral Health Encounter Value Set; ICD-10-CM code Z71.82). • A dispensed antidepressant medication (Antidepressant Medications List). **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. ***Note:*** *For example, if there is a positive screen resulting from a PHQ-2 score, documentation of a negative finding from a PHQ-9 performed on the same day qualifies as evidence of follow-up.*
Clinical recommendation statement	The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression among adolescents and adults, including pregnant and postpartum women. (B recommendation) The American College of Obstetricians and Gynecologists (ACOG) recommends multiple postpartum visits no later than 12 weeks after birth that include a full assessment of psychological well-being, including screening for postpartum depression and anxiety with a validated instrument. The American Academy of Pediatrics recommends that pediatricians screen mothers for postpartum depression at the infant's 1-, 2-, 4- and 6-month visits. The USPSTF and ACOG also recommend that screening be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up. (B recommendation)

Citations	American Academy of Pediatrics. Earls, M.F. 2010. "Committee on Psychosocial Aspects of Child and Family Health. Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice." *Pediatrics* 126(5):1032–9. American College of Obstetricians and Gynecologists. 2018. "Screening for Perinatal Depression. ACOG Committee Opinion No. 757." *Obstetrics & Gynecology* 132(5):e208-12. U.S. Preventive Services Task Force. 2016. "Screening for Depression in Children and Adolescents: U.S. Preventive Services Task Force Recommendation Statement." *Annals of Internal Medicine* 164:360–6. U.S. Preventive Services Task Force. 2016. "Screening for Major Depressive Disorder in Adults: US Preventive Services Task Force Recommendation Statement." *Journal of the American Medical Association* 315(4):380–7.

MEASURE PRS-AD: PRENATAL IMMUNIZATION STATUS: AGE 21 AND OLDER[1]

National Committee for Quality Assurance

Description	The percentage of deliveries in the measurement period in which beneficiaries had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.	
Core Set data collection method	Electronical Clinical Data Systems (ECDS)	
Guidance for Core Set Reporting	• For the purpose of Adult Core Set reporting, states should calculate and report this measure for beneficiaries age 21 and older as of the delivery date. The Child Core Set measure is reported for beneficiaries under age 21 as of the delivery date. • The denominator for this measure is based on deliveries, not on beneficiaries. • The following guidelines apply when identifying the initial population: – Include deliveries that occur in any setting. – Determine the delivery date using the date as of the end of the delivery. – If a beneficiary has more than one delivery in a 180-day period, include only the first eligible delivery. Then, if applicable include the next delivery that occurs after the 180-day period. Identify deliveries chronologically, including only one per 180-day period. – Removal of multiple deliveries in a 180-day period is based on eligible deliveries. Assess each delivery for exclusions and continuous enrollment before removing multiple deliveries in a 180-day period. • Include all paid, suspended, pending, and denied claims. • Please refer to Section II. Data Collection and Reporting and Section IV. Guidelines for Measures Reported Using ECDS for additional guidance.	
Coding systems referenced	This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, CVX, HCPCS, ICD-10-CM, ICD-10-PCS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.	
Measure characteristics	**Scoring**	Proportion.
	Type	Process.
	Stratification	None.
	Risk adjustment	None.
	Improvement notation	A higher rate indicates better performance.

[1] Developed with support from the Department of Health and Human Services (DHHS), Office of the Assistant Secretary for Health (OASH), National Vaccine Program Office (NVPO).

Definitions	
Pregnancy episode	Pregnancy start date is calculated by subtracting the gestational age (in weeks) at the time of delivery from the delivery date. Use the last gestational age assessment or diagnosis within 1 day of the start or end of the delivery.
Initial population	*Measure Item Count*: Event *Attribution*: Enrollment *Benefit*: Medical *Continuous enrollment*: 28 days prior to delivery through the delivery date. *Allowable gap*: No gaps in enrollment throughout the 28 days prior to the delivery date through the delivery date. *Age*: 21 and older as of the delivery date. **Initial populations 1-3** Deliveries (Deliveries Value Set) during the measurement period that meet the following criteria: • Have a gestational age assessment (SNOMED CT code 412726003; value is not null) or gestational age diagnosis within 1 day of the start or end of the delivery. A code from any of the following value sets meets criteria for gestational age diagnosis: – Weeks of Gestation Less Than 37 Value Set. – 37 Weeks Gestation Value Set. – 38 Weeks Gestation Value Set. – 39 Weeks Gestation Value Set. – 40 Weeks Gestation Value Set. – 41 Weeks Gestation Value Set. – 42 Weeks Gestation Value Set. – 43 weeks gestation (ICD-10-CM code Z3A.49).
Required exclusions (Supplemental and medical record data may be used for these exclusions)	**Exclusions (apply to initial populations 1-3)** • Deliveries that occurred at less than 37 weeks gestation. Length of gestation in weeks is identified by one of two methods: – Gestational age assessment (SNOMED CT code 412726003; value <37 weeks), ***or*** – Gestational age diagnosis (Weeks of Gestation Less Than 37 Value Set). • Exclude all pregnancy episodes for beneficiaries who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. • Beneficiaries who die any time during the measurement period.
Denominator	**Denominators 1-3** The initial population, minus exclusions.

Numerator	**Numerator 1 – Immunization Status: Influenza** • Deliveries where beneficiaries received an adult influenza vaccine (Adult Influenza Immunization Value Set; Adult Influenza Vaccine Procedure Value Set) on or between July 1 of the year prior to the measurement period and the delivery date, ***or*** • Deliveries where beneficiaries had anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100) on or before the delivery date. **Numerator 2 – Immunization Status: Tdap** • Deliveries where beneficiaries received at least one Tdap vaccine (CVX code 115; Tdap Vaccine Procedure Value Set) during the pregnancy (including on the delivery date), ***or*** • Deliveries where beneficiaries had any of the following: – Anaphylaxis due to the diphtheria, tetanus or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) on or before the delivery date. – Encephalitis due to the diphtheria, tetanus or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) on or before the delivery date. **Numerator 3 – Immunization Status: Combination** • Deliveries that met criteria for both numerator 1 *and* numerator 2.
Clinical recommendation statement	Advisory Committee on Immunization Practices (ACIP) clinical guidelines recommend that all women who are pregnant or who might be pregnant in the upcoming influenza season receive inactivated influenza vaccines. ACIP also recommends that pregnant women receive one dose of Tdap during each pregnancy, preferably during the early part of gestational weeks 27–36, regardless of prior history of receiving Tdap.
Citations	Murthy, N., Wodi, A.P., McNally, V., Cineas, S., Ault, K. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Adults Aged 19 Years and Older—United States, 2023." MMWR Morb Mortal Wkly Rep 2023; 72:141–133. DOI: http://dx.doi.org/10.15585/mmwr.mm7206a2

Appendix A: Guidance for Selecting Sample Sizes for HEDIS® Hybrid Measures

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This appendix provides additional information on when it may be feasible to use a sample size of less than 411 when the hybrid method is used. States may use a rate calculated from the current year's administrative rate or the prior year's reported rate to determine the sample size. The guidance in the table below is designed to minimize the burden of medical record review, while providing an adequate sample size for calculating the measure.

Table A-1. Sample Sizes for Hybrid Measures When Data Are Available from the Current Year's Administrative Rate or Prior Year's Reported Rate

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
≤51%	411
52%	410
53%	410
54%	409
55%	407
56%	405
57%	403
58%	401
59%	398
60%	395
61%	392
62%	388
63%	384
64%	380
65%	376
66%	371
67%	366
68%	360
69%	354
70%	348
71%	342
72%	335
73%	328
74%	321
75%	313
76%	305

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
77%	296
78%	288
79%	279
80%	270
81%	260
82%	250
83%	240
84%	229
85%	219
86%	207
87%	196
88%	184
89%	172
90%	159
91%	147
92%	134
93%	120
94%	106
≥ 95%	100

Notes: Table A-1 reflects the minimum required sample size. When reducing, a state's sample size may be between the allowed minimum sample size in Table A-1 and 411.

States that report using socioeconomic status (SES) categories must use the total rate for sample size reduction, not the cohort rates based on SES stratification.

Truncate the decimal portion of the rate to obtain a whole number.

Appendix B:
CAHPS® Health Plan Survey 5.1H
Adult Questionnaire (Medicaid)

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CAHPS® Health Plan Survey 5.1H Adult Questionnaire (Medicaid)

SURVEY INSTRUCTIONS

- Answer each question by marking the box to the left of your answer
- You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

  ☑ Yes ➔ **If Yes, Go to Question 1**

  ☐ No

{This box should be placed on the Cover Page}

Personally identifiable information will not be made public and will only be released in accordance with federal laws and regulations.

You may choose to answer this survey or not. If you choose not to, this will not affect the benefits you get. You may notice a number on the cover of this survey. This number is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

If you want to know more about this study, please call

{SURVEY VENDOR TOLL-FREE TELEPHONE NUMBER}.

1. Our records show that you are now in {INSERT HEALTH PLAN NAME/ STATE MEDICAID PROGRAM NAME}. Is that right?

1☐ Yes → **If Yes, Go to Question 3**

2☐ No

2. What is the name of your health plan? (Please print)

_____

YOUR HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your own health care from a clinic, emergency room, or doctor's office. This includes care you got in person, by phone, or by video. Do <u>not</u> include care you got when you stayed overnight in a hospital. Do <u>not</u> include the times you went for dental care visits.

3. In the last 6 months, did you have an illness, injury, or condition that <u>needed care right away</u>?

1☐ Yes

2☐ No → **If No, Go to Question 5**

4. In the last 6 months, when you <u>needed care right away</u>, how often did you get care as soon as you needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

5. In the last 6 months, did you make any in person, phone, or video appointments for a <u>check-up or routine care</u>?

1☐ Yes

2☐ No → **If No, Go to Question 7**

6. In the last 6 months, how often did you get an appointment for a <u>check-up or routine care</u> as soon as you needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

7. In the last 6 months, <u>not</u> counting the times you went to an emergency room, how many times did you get health care for yourself in person, by phone, or by video?

0☐ None → **If None, Go to Question 10**

1☐ 1 time

2☐ 2

3☐ 3

4☐ 4

5☐ 5 to 9

6☐ 10 or more times

8. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

00☐ 0 Worst health care possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best health care possible

9. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

YOUR PERSONAL DOCTOR

10. A personal doctor is the one you would talk to if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

1☐ Yes

2☐ No → **If No, Go to Question 19**

11. In the last 6 months, how many times did you have an in person, phone, or video visit with your personal doctor about your health?

0☐ None → **If None, Go to Question 18**

1☐ 1 time

2☐ 2

3☐ 3

4☐ 4

5☐ 5 to 9

6☐ 10 or more times

12. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

13. In the last 6 months, how often did your personal doctor listen carefully to you?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

14. In the last 6 months, how often did your personal doctor show respect for what you had to say?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

15. In the last 6 months, how often did your personal doctor spend enough time with you?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

16. In the last 6 months, did you get care from a doctor or other health provider besides your personal doctor?

1☐ Yes
2☐ No → **If No, Go to Question 18**

17. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

18. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

00☐ 0 Worst personal doctor possible
01☐ 1
02☐ 2
03☐ 3
04☐ 4
05☐ 5
06☐ 6
07☐ 7
08☐ 8
09☐ 9
10☐ 10 Best personal doctor possible

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, include the care you got in person, by phone, or by video. Do not include dental visits or care you got when you stayed overnight in a hospital.

19. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments with a specialist?

1☐ Yes

2☐ No → **If No, Go to Question 23**

20. In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

21. How many specialists have you talked to in the last 6 months?

0☐ None → **If None, Go to Question 23**

1☐ 1 specialist

2☐ 2

3☐ 3

4☐ 4

5☐ 5 or more specialists

22. We want to know your rating of the specialist you talked to most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

00☐ 0 Worst specialist possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best specialist possible

YOUR HEALTH PLAN

The next questions ask about your experience with your health plan.

23. In the last 6 months, did you get information or help from your health plan's customer service?

1☐ Yes

2☐ No → **If No, Go to Question 26**

24. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

25. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

26. In the last 6 months, did your health plan give you any forms to fill out?

1☐ Yes

2☐ No → **If No, Go to Question 28**

27. In the last 6 months, how often were the forms from your health plan easy to fill out?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

28. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

00☐ 0 Worst health plan possible

01☐ 1

02☐ 2

03☐ 3

04☐ 4

05☐ 5

06☐ 6

07☐ 7

08☐ 8

09☐ 9

10☐ 10 Best health plan possible

ABOUT YOU

29. In general, how would you rate your overall health?

1☐ Excellent
2☐ Very Good
3☐ Good
4☐ Fair
5☐ Poor

30. In general, how would you rate your overall mental or emotional health?

1☐ Excellent
2☐ Very Good
3☐ Good
4☐ Fair
5☐ Poor

31. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

1☐ Every day
2☐ Some days
3☐ Not at all → **If Not at all, Go to Question 35**
4☐ Don't know → **If Don't know, Go to Question 35**

32. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

33. In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

34. In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

35. What is your age?

1☐ 18 to 24
2☐ 25 to 34
3☐ 35 to 44
4☐ 45 to 54
5☐ 55 to 64
6☐ 65 to 74
7☐ 75 or older

36. Are you male or female?

1☐ Male
2☐ Female

37. What is the highest grade or level of school that you have completed?

1☐ 8th grade or less
2☐ Some high school, but did not graduate
3☐ High school graduate or GED
4☐ Some college or 2-year degree
5☐ 4-year college graduate
6☐ More than 4-year college degree

38. Are you of Hispanic or Latino origin or descent?

1☐ Yes, Hispanic or Latino
2☐ No, Not Hispanic or Latino

39. What is your race? Mark one or more.

a☐ White
b☐ Black or African-American
c☐ Asian
d☐ Native Hawaiian or other Pacific Islander
e☐ American Indian or Alaska Native
f☐ Other

THANK YOU

Please return the completed survey in the postage-paid envelope.

Appendix C: Guidance for Conducting the Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H (Medicaid)

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Assessing patient experiences with health care is an important dimension of the quality of care. The Adult Core Set includes a measure of experiences with health care based on the CAHPS® Survey.[1] This appendix provides additional guidance to states in carrying out CAHPS data collection, including information on the version of CAHPS used for 2025 Adult Core Set reporting, contracting with a survey vendor, generating a sample frame, drawing the sample, and conducting the survey using standard protocols.

A. Version of CAHPS for 2025 Adult Core Set Reporting

CAHPS is a family of surveys designed to assess consumer experiences with care. Different versions of the survey are available for use among various populations, payers, and settings. The version of the CAHPS Survey specified in the 2025 Adult Core Set is the CAHPS Health Plan Survey 5.1H (Medicaid).[2] Appendix B contains the survey instrument.

B. Contracting with a Survey Vendor

To adhere to CAHPS 5.1H measure specifications, states should follow the HEDIS protocol, which includes creating a sample frame and contracting with a survey vendor to administer the survey. The survey vendor draws the actual samples and fields the survey.

NCQA maintains a list of survey vendors that have been trained and certified to administer the CAHPS 5.1H survey. Each survey vendor is assigned a maximum capacity of samples. The capacity reflects the firm's and NCQA's projection of resources available to be dedicated to administer the survey. A current listing of NCQA-certified HEDIS MY 2024 survey vendors is available at https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/cahps-5-1h-survey-certification/vendor-directory/.

C. Generating a Sample Frame

States are responsible for generating a complete, accurate, and valid sample frame data file that is representative of the entire eligible population (Table C-1). If states choose to have their sample frame validated, they should arrange for an auditor to verify the integrity of the sample frame before the survey vendor draws the sample and administers the survey.

[1] CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[2] AHRQ is the measure steward for the survey instrument and NCQA is the developer of the survey administration protocol.

Table C-1. Eligible Population for Adult CAHPS 5.1H (Medicaid)

Age	Age 18 and older as of December 31 of the measurement year.
Continuous enrollment	The last six months of the measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly, the beneficiary may not have more than a 1-month gap in coverage (e.g., a beneficiary whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Current enrollment	Currently enrolled at the time the survey is completed.
Required exclusion (Supplemental and medical record data may be used for this exclusion)	Beneficiaries who die any time during the measurement year.

Source: HEDIS MY 2024 Volume 3: Specifications for Survey Measures (https://store.ncqa.org/hedis-my-2024-volume-3-epub.html).

To enable the survey vendor to generate the systematic sample, states must generate a sample frame data file for each survey to be fielded. States are strongly encouraged to generate sample frames after eliminating disenrolled and deceased beneficiaries and updating eligibility files with address and telephone number corrections. When sampling, keep the following in mind:

- If each managed care plan carries out its own CAHPS survey, a separate sample frame must be generated for each plan.
- If a state has adults enrolled in multiple delivery systems (managed care, primary care case management, and/or fee for service), the sample frame(s) should be representative of all adults covered by the entire program. A state may generate one statewide sample frame that includes adults in all delivery systems or separate sample frames for each delivery system. The sample frame(s) should represent all adults that meet the eligibility criteria specified in Table C-1.

D. Drawing the Sample

The survey vendor is responsible for drawing the survey samples from the sample frame generated by the state. For each survey administered, the survey vendor draws a systematic sample of 1,350 adults.

Deduplication

To reduce respondent burden, the survey vendor should deduplicate samples so that only one adult per household is included in the sample. The survey vendor must use the deduplication method included in HEDIS MY 2024 Volume 3 before pulling the systematic sample.

Oversampling

A state should instruct its survey vendor to oversample if it has a prior history of low survey response rates, if it anticipates that a significant number of addresses or telephone numbers in the enrollment files are inaccurate, if it cannot eliminate disenrolled adults from eligibility files, or if it does not expect to achieve a denominator of 100 for most survey calculations. The required sample size is based on the average number of complete and eligible surveys obtained by health plans during prior years; therefore, using the required sample size for a given survey does not guarantee that a state will achieve the goal of 411 completed surveys or the required denominator of 100 complete responses for each survey result. The state should work with its survey vendor to determine the number of complete and eligible surveys it can expect to obtain without oversampling based on prior experience.

If its prior response rates or the number of completed surveys is expected to fall below the goal of 411 completed surveys, the survey vendor should oversample. For example, if the vendor increases the sample by 5 percent, the final sample size would be 1,418. If the vendor increases the sample by 20 percent, the final sample size would be 1,620. The survey vendor will work with the state to determine an appropriate sampling strategy. For a detailed discussion of oversampling, see “HEDIS MY 2024 Volume 3: Specifications for Survey Measures,” Appendix 7, “General Recommendations for Oversampling Survey Measures.”

E. Survey Administration

The sampling and data collection procedures that the survey vendors have been trained and certified to carry out promote both the standardized administration of the survey instruments by different survey vendors and the comparability of resulting data. For results to comply with CAHPS 5.1H survey specifications, the state’s survey vendor must follow one of the standard CAHPS 5.1H survey protocols. The state will have to work with its survey vendor to select one of two standard options for administering HEDIS CAHPS surveys:

1. The mail-only methodology, a five-wave mail protocol with three questionnaire mailings and two reminder postcards.
2. The mixed methodology, a four-wave mail protocol (two questionnaires and two reminder postcards) with telephone follow-up of a minimum of three and a maximum of six telephone attempts.

The basic tasks and time frames for the two protocol options are detailed in Tables C-2 andC-3. Regardless of the approach selected, the survey vendor is expected to maximize the final survey response rate and to pursue contacts with potential respondents until selected data collection protocol is exhausted. Achieving the targeted number of completed surveys does not justify ceasing the survey protocol.

Neither the state nor the survey vendor may use incentives of any kind for completion of the survey.

The vendor is expected to maintain the confidentiality of sampled adults. The health plan does not have access to the names of adults selected for the survey.

Table C-2. Mail-Only Methodology

Survey Vendor Tasks	Time Frame
Send first questionnaire and cover letter to the surveyed adult	0 days
Send a postcard reminder to non-respondents 4–10 days after mailing the first questionnaire	4–10 days
Send a second questionnaire and second cover letter to non-respondents approximately 35 days after mailing the first questionnaire	35 days
Send a second postcard reminder to non-respondents 4–10 days after mailing the second questionnaire	39–45 days
Send a third questionnaire and third cover letter to non-respondents approximately 25 days after mailing the second questionnaire	60 days
Allow at least 21 days for the third questionnaire to be returned by the respondent	81 days

Source: HEDIS MY 2024 Volume 3: Specifications for Survey Measures.

Table C-3. Mixed Methodology

Survey Vendor Tasks	Time Frame
Send first questionnaire and cover letter to the surveyed adult	0 days
Send a postcard reminder to non-respondents 4–10 days after mailing the first questionnaire	4–10 days
Send a second questionnaire and second cover letter to non-respondents approximately 35 days after mailing the first questionnaire	35 days
Send a second postcard reminder to non-respondents 4–10 days after mailing the second questionnaire	39–45 days
Initiate telephone interviews for non-respondents approximately 21 days after mailing the second questionnaire	56 days
Initiate systematic contact for all non-respondents so that at least 3 telephone calls (and no more than 6 telephone calls) are attempted at different times of the day, on different days of the week, and in different weeks	56–70 days
Complete telephone follow-up sequence (completed interviews obtained or maximum calls reached for all non-respondents) approximately 14 days after initiation	70 days

Source: HEDIS MY 2024 Volume 3: Specifications for Survey Measures.

F. For Further Information

Information about the CAHPS Health Plan Survey is available at https://www.ahrq.gov/cahps/surveys-guidance/hp/index.html.

Information about participating in the CAHPS Health Plan Survey Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/participate.html.

Appendix D: Definitions of Medicaid and CHIP Core Set Practitioner Types

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Practitioner Type	Definition
Mental Health Provider	A provider who delivers mental health services and meets any of the following criteria: • An MD or Doctor of Osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice • A Registered Nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy • An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC) • A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry

Practitioner Type	Definition
Mental Health Provider (continued)	• A certified Community Mental Health Center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC) – Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria: o The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act). o The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or country in which it is located. – Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria: o Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a)(42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC o Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grants or funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC
Obstetrician/Gynecologist (OB/GYN) and Other Prenatal Care Practitioner	Includes: • Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology • Certified nurse midwives, nurse practitioners, and physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)

Practitioner Type	Definition
Primary Care Practitioner (PCP)	A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwife) who offers primary care medical services Licensed practical nurses and registered nurses are not considered PCPs. Only certified Federally Qualified Health Centers (FQHCs) are considered PCPs.
Primary Care Practitioner (PCP) (continued)	• To be certified as an FQHC, an entity must meet any one of the following criteria: – Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements – Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration – Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990 – Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991 • For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above): – Provide comprehensive services and have an ongoing quality assurance program – Meet other health and safety requirements – Not be concurrently approved as a Rural Health Clinic (RHC) o Only certified RHCs are considered PCPs. o To be certified as a RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.
Prescribing Practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications

Appendix E: Guidance for Conducting the National Core Indicators® - INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (NCI®-IDD) In-Person Survey (IPS)

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The National Core Indicators® - Intellectual and Developmental Disabilities (NCI®-IDD)[1] provide information on beneficiaries' experience and self-reported outcomes of long-term services and supports for individuals with intellectual and/or developmental disabilities (I/DD) and their families. This appendix provides additional guidance to states about NCI-IDD, including information on the NCI-IDD In Person Survey (IPS) used for Adult Core Set reporting, state responsibilities and coordination with the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI) (NCI National Team), determining a sample frame, generating a sample, and conducting the survey using standard protocols.

A. NCI Survey for Adult Core Set Reporting

NCI-IDD is a family of surveys designed to assess the experiences and outcomes of individuals with I/DD (and their families) who receive services from their state Developmental Disabilities (DD) system. The NCI-IDD Survey specified in the Adult Core Set is the NCI-IDD In-Person Survey (IPS). The survey instrument includes a Background Information Section and two direct-contact sections, conducted directly with the person receiving DD system supports and a proxy, if applicable. The Background Information Section gathers fact-based data about the individual from existing records or documents (such as case management records, state databases, etc.).

The direct-contact section includes two sub-sections, both of which may be completed via specific video conference protocols. Sub-section I includes perception-based questions that can only be answered by the person receiving DD service system supports from the state. Sub-section II includes objective, fact-based questions that can be answered by the person receiving supports from the state or, if needed, a proxy respondent who knows the person well. The full survey instrument is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-national-core-indicators-questionnaire.pdf.

States have the option to tailor the survey by customizing some language used in the survey (using terms most common in the state such as 'service coordinator' or 'support coordinator') and/or adding up to 10 state-specific questions, complementary. States cannot remove questions from the In-Person Survey. Any requested changes to the survey should be detailed in the state work plan (described below) and approved by the NCI National Team. NCI reserves the right to deny changes if they alter the intent of the question and/or compromise the comparability of a state's data.

B. State Responsibilities and Coordination with the NCI National Team

The NCI National Team works with new and continuing states on implementation of the NCI and provides general oversight of NCI activities. The NCI National Team consults and collaborates with state agency partners with respect to operations, content focus, data and product development, research, and other related activities. Participation dues are determined by the NASDDDS Board of Directors each year.

[1] National Core Indicators® and NCI® are registered trademarks of the National Association of State Directors of Developmental Disabilities Services (NASDDDS) and the Human Services Research Institute (HSRI).

States are responsible for the operational administration of the NCI-IDD surveys. This includes:

- Managing the project at the state level, with technical assistance from NASDDDS and HSRI. A yearly work plan and yearly planning call must be completed with the NCI National Team. This is usually completed in the fall of each data cycle.
  - The annual NCI-IDD Work Plan identifies which surveys will be completed in the year and the sampling method for each, including any populations being oversampled or excluded from the sample.
- Completing the In-Person Survey Background Crosswalk, where state agency partners identify the potential data source for each question in the Background Information section of the survey.
- Assuring awareness of and complying with NCI-IDD policies and procedures including, but not limited to: (1) survey administration, (2) survey methodology (e.g., sampling, surveyor competency requirements), (3) maintaining the confidentiality of the survey respondents, and (4) protocols for conducting remote surveys using videoconference technology.
- Preparing an In-Person Survey sample that will reach the 95% confidence level and 5% margin of error, with consultation from the NCI National Team.
- Collecting specified background information on each individual surveyed.
- Ensuring all surveyors have received training consistent with NCI-IDD requirements for demonstration of adequate knowledge and skill in carrying out the survey procedures.
- Conducting the target number of face-to-face or videoconference surveys using the In-Person Survey tool.
- Entering raw data and submitting complete data files to HSRI in accordance with established timelines.
  - Raw data must be retained until the final data reports are released. States may need to refer to the raw data if the NCI National Team request verification.
  - Each year, all In-Person Survey data must be completed and submitted by June 30 using the Online Data Entry System (ODESA).
- Keeping the NCI National Team informed of changes in state contact information (e.g., state agency partners currently working on NCI and updated email addresses) as well as any revisions that have been made to the state's work plans, timelines, or the data being gathered.
- Reviewing draft reports for accuracy and providing comments and feedback to the NCI National Team within specified timelines.

C. Generating a Sample Frame

States are responsible for generating a complete, accurate, and valid sample frame data file that is representative of the eligible population (Table E-1). States are required to work closely with the NCI National Team as they design their sample.

Table E-1. Eligible Population for In-Person Survey

Age	Age 18 and older as of June 30 of the measurement year.
Continuous enrollment	None.
Allowable gap	None.
Anchor date	June 30 of the measurement year.
Current enrollment	Currently enrolled in Medicaid at the time the survey is completed.
Event/diagnosis	Beneficiaries with intellectual and/or developmental disabilities receiving at least one service through the state-administered Developmental Disabilities system in addition to case management.

States must generate a sample frame data file for fielding the In-Person Survey. States are strongly encouraged to generate the sample frame after eliminating disenrolled and deceased beneficiaries and updating eligibility files with address and telephone number corrections. When sampling, keep the following in mind:

- Any adult age 18 or older who receives at least one service in addition to case management from the state-administered Developmental Disabilities system is eligible to be surveyed. No exclusions should be made before sampling based on, for example, geography or level of disability.
- States may include adults who received only state-funded I/DD services in their sampling frame. However, states must identify surveys completed by adults who are not enrolled in Medicaid at the time of the survey and must ensure that their final sample meets the requirements described below after excluding respondents without Medicaid coverage.
- The sample frame should represent all adults that meet the eligibility criteria specified in Table E-1.

Additional guidance about generating the sample frame is available at: https://www.nationalcoreindicators.org/upload/core-indicators/Quality_Sample_Guide_March_061.pdf.

D. Drawing the Sample

The state (or a survey vendor contracted by the state) is responsible for drawing the survey sample pool from the sampling frame. Each state's final sample of surveys completed in compliance with NCI-IDD protocols and certified valid by the surveyor must reach the 95 percent confidence level and 5 percent margin of error based on the total eligible, Medicaid-enrolled population served by the state. Typically, this is 400 surveys, but may be in lower in states with a small eligible population. Because it is expected that there will be some refusals and/or inaccurate or outdated contact information, the sample pool should be larger than 400 to allow for replacement.

Oversampling

If the state wants to examine sub-populations (for example in a particular waiver program or by region), there may be a need to oversample a population or stratify the sample to assure the sample is statistically valid for comparative purposes.

E. Survey Administration

Data collection strategies are standardized across all states, regardless of the personnel used to carry out the direct-contact sections (independent contractors contracted by the state or state staff). All surveyors are taught the data collection protocols through formal trainings using materials developed by the NCI National Team. The survey data are recorded online using a data entry system called ODESA. These requirements promote both the standardized administration of the survey instrument by different states and survey vendors and the comparability of resulting data. As described above, the survey instrument includes a Background Information Section and two direct-contact sections conducted directly with the person receiving DD system supports (and a proxy, if applicable).

Background Information Section

The completion of this section is critical for the validity of NCI. These data should come from administrative records and are generally collected separately from the direct-contact sections. States may choose to give case managers or agency staff limited access to ODESA to enter background information directly into the system.

Direct-Contact Sections

Data for sub-section I and sub-section II of the In-Person Survey are collected through direct surveys of service participants. On average, it takes between 45 and 60 minutes to conduct the direct-contact sections of the In-Person Survey. States are responsible for identifying surveyors. Surveyors must not have a personal connection with the individual to be surveyed, which precludes service providers, relatives, and case managers from conducting the surveys with individuals they know.

States are responsible for assuring all surveyors and training staff have received training consistent with NCI-IDD requirements for demonstration of adequate knowledge and skill in carrying out the survey procedures. NCI National Team members have created self-paced, online training modules for surveyors, and will consult with new states, states with all-new surveyors, states with new NCI-IDD state coordinators, and any states needing training assistance to be sure that surveyors receive training that will ensure consistent surveying approaches.

In addition, a live, webinar-based training conducted by the state's lead trainer (with NCI National Team assistance, if necessary) is required to go over state-specific training needs.

Data Entry

ODESA is the web-based platform that all states use to enter survey data for the In-Person Survey. Every year ODESA is updated to reflect the current year’s survey tools. Survey data must be entered into ODESA by June 30 of each year. The ODESA application resides on a secure server and requires unique log-in information for each user.

Steps to Prepare for Survey Administration

The NCI National Team is available to provide guidance at all stages of data collection. The following steps should help guide states in preparing for survey administration:

1. Decide whether the state will add questions/customizations to the In-Person Survey. Communicate with the NCI National Team about these customizations to understand timelines for approval and ODESA customizations.
2. Understand state requirements for gathering consent from individuals receiving services and guardians, if necessary.
3. Determine whether the state will conduct surveys using a face-to-face and/or remote (videoconference) protocol.
4. Distribute training materials and schedule a live, webinar training.
5. Decide on a strategy for coordinating survey schedules, including assigning surveys to surveyors (the ODESA platform supports these administrative functions). Set a timeline for scheduling surveys and figure out whether scheduling will be conducted at the same time consent is obtained.
6. Determine a strategy for engaging interpreters and/or using the translations of the NCI surveys if necessary.
7. Set a date when surveys will begin and will be completed.
8. Determine who will enter data from completed surveys into ODESA and when. This includes setting up ODESA accounts, training data enterers, etc.
9. Ensure that refusals, incompletes, inaccurate contacts, etc. will be tracked (this should be tracked in ODESA).
10. Understand how surveyors will contact and gain access to individuals living in settings where they do not have direct access to a phone.
11. Determine how to ensure participation when there is a lack of technology or support and face-to-face surveys are not possible.
12. Understand how the state will address systemic disparities in the populations that have access to, and respond to the survey.
13. Determine whether surveyors will present a badge or show any other kind of official document.
14. Identify or develop state-specific leave-behind documents for surveyors to leave with people or email, such as useful numbers to call to address unmet need, etc.
15. Identify how quality oversight and monitoring of survey administration will be accomplished.
16. Determine the protocol for reporting abuse and/or neglect, if indicated or suspected during the survey.

F. For More Information

More information about the National Core Indicators and the In-Person Survey is available at https://idd.nationalcoreindicators.org/. The website contains state pages with relevant information about the NCI contact in the state, the state history with NCI, and recent state reports. The resources section of the website is where all reports are published online, including data briefs and technical guides. The full survey instrument is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-national-core-indicators-questionnaire.pdf.