Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child 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

LICENSE AGREEMENTS AND ACKNOWLEDGMENTS

Use of the Technical Specifications and Resource Manual for the Child Core Set indicates acceptance of the following license agreements.

The American Medical Association (AMA), the American Dental Association (ADA), and the American Hospital Association (AHA) permit the use of Current Procedural Terminology (CPT), Current Dental Terminology (CDT), and National Uniform Billing Committee (NUBC) UB-04 codes solely for the purpose of reporting state data on Medicaid and CHIP Core Set measures to the Centers for Medicare & Medicaid Services (CMS).

The National Committee for Quality Assurance (NCQA) permits the use of their technical specifications solely for the purpose of reporting state data on Medicaid and CHIP Core Set measures to the Centers for Medicare & Medicaid Services (CMS).

For Proprietary Codes in the Child Core Set:

CPT® codes, descriptions and other data only are copyright 2024 American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association (AMA). Applicable FARS/HHSARS restrictions apply to government use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

The Uniform Billing Codes (UB) are Copyright © 2024, the American Hospital Association (AHA), Chicago, Illinois. The UB Codes are included with the permission of the AHA. All uses of the UB Codes may require a license from the AHA. Specifically, anyone desiring to use the UB Codes in a commercial manner must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@aha.org.

Some measure specifications contain coding from LOINC® (http://loinc.org). The LOINC table, LOINC codes, LOINC panels and form file, LOINC linguistic variants file, LOINC/RSNA Radiology Playbook, and LOINC/IEEE Medical Device Code Mapping Table are copyright © 1995–2024, Regenstrief Institute, Inc. and the Logical Observation Identifiers Names and Codes (LOINC) Committee and available at no cost under the license at https://loinc.org/kb/license/.

“SNOMED” and “SNOMED CT” are registered trademarks of the International Health Terminology Standards Development Organisation (IHTSDO).

“HL7” is the registered trademark of Health Level Seven International.

For NCQA measures in the Child Core Set:

HEDIS® is a registered trademark of the National Committee for Quality Assurance (“NCQA”). The HEDIS measures and specifications are owned by NCQA. NCQA holds a copyright in these materials and may rescind or alter these materials at any time. Users of the HEDIS measures and specifications shall not have the right to alter, enhance or otherwise modify the HEDIS measures and specifications, and shall not disassemble, recompile, or reverse engineer the HEDIS measures and specifications. Anyone desiring to use or reproduce the materials without modification for the sole purpose of Core Set reporting may do so without obtaining any approval from NCQA. All other uses, including a commercial use (including but not limited to vendors using the measures and specifications with a product or service to calculate measure results), must be approved by NCQA and are subject to a license at the discretion of NCQA.

HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided “as is” without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA also makes no representations, warranties or endorsements about the quality of any organization or clinician who

uses or reports performance measures. NCQA has no liability to anyone who relies on HEDIS measures and specifications or data reflective of performance under such measures and specifications.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

CPT® codes copyright 2024 American Medical Association. All rights reserved. CPT is a trademark of the American Medical Association. Applicable FARS/HHSARS restrictions apply to government use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

The American Hospital Association holds a copyright to the Uniform Billing Codes (UB) contained in the HEDIS Value Set Directory (VSD). The UB Codes are included with the permission of the AHA. All uses of the UB Codes may require a license from the AHA. Specifically, anyone desiring to use the UB Codes in a commercial manner to generate measure results or for any other commercial use, must obtain a commercial use license directly from the AHA. To inquire about licensing, contact ub04@aha.org.

NCQA Measure Certification Notice:

A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on unadjusted HEDIS specifications, may not be called a "Health Plan HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as **"Uncertified, Unaudited Health Plan HEDIS Rates."**

For the CMS Screening for Depression and Follow-up Plan measure in the Child Core Set:

These performance measures are not clinical guidelines and do not establish a standard of medical care and have not been tested for all potential applications.

THE MEASURE AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets.

CPT® contained in the Measure specifications is copyright 2004–2023 American Medical Association. LOINC® is copyright 2004–2023 Regenstrief Institute, Inc. This material contains SNOMED Clinical Terms® (SNOMED CT®) copyright 2004–2023 International Health Terminology Standards Development Organisation. ICD-10 is copyright 2023 World Health Organization. All Rights Reserved.

For the Developmental Screening measure in the Child Core Set:

Copyright established November 7, 2013 to the Oregon Pediatric Improvement Partnership at Oregon Health and Science University. The copyright is 2010 - Oregon Pediatric Improvement Partnership at Oregon Health and Science University.

For the Dental Quality Alliance measures in the Child Core Set:

2025 American Dental Association on behalf of the Dental Quality Alliance (DQA) ©. All rights reserved. Use by individuals or other entities for purposes consistent with the DQA's mission and that is not for commercial or other direct revenue generating purposes is permitted without charge.

Dental Quality Alliance Measures (Measures) and related data specifications, developed by the Dental Quality Alliance (DQA), are intended to facilitate quality improvement activities.

These Measures are intended to assist stakeholders in enhancing quality of care. These performance Measures are not clinical guidelines and do not establish a standard of care. The DQA has not tested its Measures for all potential applications.

Measures are subject to review and may be revised or rescinded at any time by the DQA. The Measures may not be altered without the prior written approval of the DQA. The DQA shall be acknowledged as the measure steward in any and all references to the Measures. Measures developed by the DQA, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and DQA. Neither the DQA nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the Measure specifications for convenience.

For Proprietary Codes: These materials contain Current Dental Terminology (CDT). The Code on Dental Procedures and Nomenclature have been obtained from CDT (including procedure codes, nomenclatures, descriptors, and other data contained therein). Current Dental Terminology (CDT), Copyright © 2024 American Dental Association (ADA). All rights reserved. CDT is a trademark of the ADA. Applicable FAR/HHSAR apply.

This material contains National Uniform Claim Committee (NUCC) Health Care Provider Taxonomy codes (http://www.nucc.org/index.php?option=com_content&view=article&id=14&Itemid=125). Copyright © 2024 American Medical Association. All rights reserved.

Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The DQA, American Dental Association (ADA), and its members disclaim all liability for use or accuracy of any terminologies or other coding contained in the specifications.

THE SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

For Codes in the Public Domain used in the Child Core Set measures:

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the World Health Organization (WHO). ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 9th Revision, Procedure Coding System (ICD-9-PCS) is published by the World Health Organization (WHO). ICD-9-PCS is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) is published by the World Health Organization (WHO). ICD-10-CM is an official Health Insurance Portability and Accountability Act standard.

The International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) is published by the World Health Organization (WHO). ICD-10-PCS is an official Health Insurance Portability and Accountability Act standard.

The National Drug Code (NDC) Directory is published by the U.S. Food and Drug Administration and is made available under the Open Database License at http://opendatacommons.org/licenses/odbl/1.0/. Any rights on individual contents of the database are licensed under the Database Contents License at http://opendatacommons.org/licenses/dbcl/1.0/.

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

Date	Location of change	Update
March 2025	Section III, AMR-CH, 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, TFL-CH, Eligible Population	Updated the first age stratification. It now reads: Report 4 age stratifications (optional for 2025) and a total rate (required for 2025): • Ages 1 to 2. • Ages 3 to 5. • Ages 6 to 14. • Ages 15 to 20. Total ages 1 through 20.
March 2025	Section III, PPC2-CH, Numerator	Clarified that the Postpartum Care numerator should refer to the "Postpartum Care Value Set" rather than the "Postpartum Visits Value Set."
March 2025	Section III, FUM-CH, Numerator	Clarified the numerator bullets related to Electroconvulsive therapy (Numerator bullets 6 and 15)

CONTENTS

I. THE CORE SET OF CHILDREN'S HEALTH CARE QUALITY MEASURES (CHILD CORE SET)

Background

Section 1139A of the Social Security Act (the Act) includes broad mandates to strengthen the quality of care for and health outcomes of children in Medicaid and the Children's Health Insurance Program (CHIP). The Act calls for the Secretary of the U.S. Department of Health and Human Services (HHS) to identify and publish a core set of children's health care quality measures (Child Core Set) for voluntary use by state programs administered under Titles XIX and XXI, health insurance issuers, managed care entities, and providers of items and services under Medicaid and CHIP.

More specifically, the Act requires the Secretary of Health and Human Services (HHS) to identify measures applicable to the duration of enrollment and health care coverage, preventive and health promotion services, and the treatment and management of acute and chronic conditions in children. The Act also calls for measures that could be used to assess families' experiences with health care, the availability of services, and care in the most integrated health settings. Ultimately, the goals of the Child Core Set are to provide a national estimate of the quality of health care for children served by Medicaid or CHIP and support states to drive improvements in health care quality and health outcomes using Core Set data; facilitate comparative analyses across various dimensions of pediatric health care quality; and help identify racial, ethnic, and socioeconomic disparities.

Implementation of a standardized Child 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 children receive through Medicaid and CHIP programs. 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 children under Medicaid and CHIP.

Section 50102(b) of the Bipartisan Budget Act of 2018 made state reporting of the Child Core Set measures mandatory starting with the 2024 Core Set. Mandatory reporting of the Child 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 Child Core Set

The initial core set was published in February 2011. The Act required the Secretary to publish annual changes to the Child Core Set beginning in January 2013. The Compilation of Annual Updates to the Child and Adult Core Health Care Quality Measurement Sets web page on

[1] Legislation making reporting of the Child Core Set measures mandatory: Bipartisan Budget Act of 2018 available at https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.xml.

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

Medicaid.gov provides historical policy documentation.[3] In addition, the Core Set History table provides a history of the measures included in the Child Core Set.[4]

Table 1 lists each measure in the 2025 Child Core Set, the CMS Measures Inventory Tool (CMIT) number, and the measure steward. The data collection methods include administrative (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 Child Core Set is available on Medicaid.gov at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

Table 1. 2025 Child Core Set

2025 Mandatory Child Core Set Measures

CMIT #[a]	Measure Steward[b]	Measure Name	Data Collection Method(s)	Data Submission Location[c]
Behavioral Health Care				
271	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	ECDS or EHR	QMR System
672	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	Administrative or EHR	QMR System
268	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	Administrative	QMR System
448	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	ECDS	QMR System
743	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Administrative	QMR System

[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.

CMIT #[a]	Measure Steward[b]	Measure Name	Data Collection Method(s)	Data Submission Location[c]
264	NCQA	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)	Administrative	QMR System
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	Administrative	QMR System
Primary Care Access and Preventive Care				
760	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	Administrative, hybrid, or EHR	QMR System
128	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	Administrative or EHR	QMR System
124	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, ECDS or EHR	QMR System
761	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)	Administrative	QMR System
363	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative, hybrid, or ECDS	QMR System
1003	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid	QMR System
24	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)	Administrative	QMR System
1775	NCQA	Lead Screening in Children (LSC-CH)	Administrative or hybrid	QMR System
Maternal and Perinatal Health				
413	CDC/NCHS	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records	CDC WONDER
581	NCQA	Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)	Administrative or hybrid	QMR System
166	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative	QMR System

CMIT #[a]	Measure Steward[b]	Measure Name	Data Collection Method(s)	Data Submission Location[c]
1002	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative	QMR System
508	CDC/NCHS	Low-Risk Cesarean Delivery: Under Age 20 (LRCD-CH)[d]	State vital records	CDC WONDER
Care of Acute and Chronic Conditions				
84	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)	Administrative	QMR System
80	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	Administrative	QMR System
Dental and Oral Health Services				
897	DQA (ADA)	Oral Evaluation, Dental Services (OEV-CH)	Administrative	QMR System
1672	DQA (ADA)	Topical Fluoride for Children (TFL-CH)	Administrative	QMR System
830	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)	Administrative	QMR System
Experience of Care				
151[e]	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)[f]	Survey	AHRQ CAHPS Database[g]

2025 Provisional Child 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: Under Age 21 (PDS-CH)	ECDS	QMR System
1782	NCQA	Prenatal Immunization Status: Under Age 21 (PRS-CH)	ECDS	QMR System

CMIT #[a]	Measure Steward[b]	Measure Name	Data Collection Method(s)	Data Submission Location[c]
1783	DQA (ADA)	Oral Evaluation During Pregnancy: Ages 15 to 20 (OEVP-CH)	Administrative	QMR System

AHRQ = Agency for Healthcare Research & Quality; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); ECDS = Electronic Clinical Data Systems; EHR = Electronic Health Record; NCHS = National Center for Health Statistics; NCQA = National Committee for Quality Assurance; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs; QMR = Quality Measure Reporting; WONDER = Wide-ranging Online Data for Epidemiologic Research.

[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] 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.

[e] AHRQ is the measure steward for the survey instrument in the Child Core Set (CMIT #151) and NCQA is the developer of the survey administration protocol.

[f] CAHPS® is a registered trademark of the AHRQ.

[g] States can also indicate in the QMR system that they conducted the CAHPS survey.

II. DATA COLLECTION AND REPORTING OF THE CHILD CORE SET

Mandatory reporting of the 2025 Child 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 Child 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 Child 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 Child 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 Child 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 Child Core Set value sets and Value Set Directory User Manual are available at https://store.ncqa.org/hedis-2025-child-core-set-hedis-value-set-directory-my-2024.html. HEDIS value set references are underlined in the specifications (e.g., BMI Percentile Value Set).
    - Value sets for the CCP-CH, CCW-CH, CDF-CH, and OEVP-CH measures are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-child-non-hedis-value-set-directory.zip.
    - 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 Child Core Set measures, use the version of the value sets associated with the May 2023 release. This applies to the following Child Core Set

[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 Child Core Set measures with NCQA as the measure steward are HEDIS measures.

measures that have electronic specifications: ADD-CH, CDF-CH, CHL-CH, CIS-CH, and WCC-CH.

- **Medication lists.** Several HEDIS measures in the Child 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 Child Core Set measures: AAB-CH, ADD-CH, AMR-CH, APM-CH, APP-CH, CHL-CH, and FUA-CH.
- **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 child's birthday or diagnosis. 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 Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-child-core-set-measurement-periods.pdf.
- **Continuous enrollment.** Continuous enrollment specifies the minimum amount of time that a beneficiary must be enrolled in Medicaid or CHIP 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 WCV-CH 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. For example, in the CIS-CH measure, beneficiaries must receive three hepatitis B vaccines. Assume a beneficiary was born on February 5, 2022. Documentation in the medical record that the first hepatitis B vaccine was given "at birth" is specific enough to determine that it was given prior to the deadline for this measure (the child's second birthday), but if the medical record states that the third hepatitis B vaccine was given in February 2024, the immunization cannot be counted because the date is not specific enough to confirm that it occurred prior to the beneficiary's second birthday. 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 CIS-CH measure, undated documentation on an immunization chart stating "chicken pox at age 1" is specific enough to determine that it occurred prior to the child's second birthday.
- **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]). 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 separate CHIP) 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 eligibility 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 (such as state-covered children that are above the Medicaid and CHIP eligibility levels). 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 Child Core Set measures following 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 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 Child Core Set reporting, states with a separate CHIP must report on Child Core Set rates separately for separate CHIP (Title XXI) and Medicaid inclusive of CHIP-funded Medicaid expansion (Titles XIX and XXI).

[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.

[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.

- **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 all remaining measures.[5] . For 2025 reporting, the Child Core Set measures subject to stratified reporting requirements include:
  - Well-Child Visits in the First 30 Months of Life (W30-CH)
  - Child and Adolescent Well-Care Visits (WCV-CH)
  - Oral Evaluation, Dental Services (OEV-CH)
  - Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)
  - Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)
  - Live Births Weighing Less Than 2,500 Grams (LBW-CH) (CMS calculates on behalf of states)
  - Low-Risk Cesarean Delivery: Under Age 20 (LRCD-CH) (CMS calculates on behalf of states)

  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 toward 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.

[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 that combines the Medicaid and separate 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 that combines the Medicaid and separate 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 beneficiaries. Examples of supplemental data include immunization registries or case management program data.
- **Hospice exclusion.** Selected HEDIS measures in the Child Core Set include a required hospice exclusion: AAB-CH, ADD-CH, AMR-CH, APM-CH, APP-CH, CHL-CH, CIS-CH, FUA-CH, FUH-CH, FUM-CH, IMA-CH, LSC-CH, PDS-CH, PPC2-CH, PRS-CH, W30-CH, WCC-CH, and WCV-CH. 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., AAB-CH).

- **Deceased beneficiaries exclusion.** Selected HEDIS measures in the Child Core Set include a deceased beneficiary exclusion: AAB-CH, ADD-CH, AMR-CH, APM-CH, APP-CH, CHL-CH, CIS-CH, CPC-CH, FUA-CH, FUH-CH, FUM-CH, IMA-CH, LSC-CH, PDS-CH, PPC2-CH, PRS-CH, W30-CH, WCC-CH, and WCV-CH. 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-CH).

  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 and CHIP programs (including dual Medicare-Medicaid eligibles, where applicable). This includes beneficiaries enrolled in all Medicaid and CHIP 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 Child Core Set have five possible data collection methods: administrative, hybrid, survey, 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 electronic health record (EHR) 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.
  - The survey method uses data collected through a survey to calculate the measure. This data collection method applies to the CPC-CH measure in the Child 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: ADD-CH, CDF-CH, CHL-CH, CIS-CH, and WCC-CH. 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 Child Core Set: ADD-CH, APM-CH, CIS-CH, IMA-CH, PDS-CH and PRS-CH.

- **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 information on using a reduced sample size, refer to Appendix A, Guidance for Selecting Sample Sizes for Hybrid Measures.
  - For the DEV-CH measure, the sample is 411 divided across three age strata, or 137 in each age group.
  - For the CAHPS survey, refer to Appendix D 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 CPC-CH measure) or a denominator less than 100 (for CPC-CH) and the state chooses not to report the measure due to small numbers, please note this in the question that asks, "Why are you not reporting on this measure?" and specify the denominator size.
- **Risk adjustment.** No Child Core Set measure requires risk adjustment.
- **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-CH, ADD-CH, AMR-CH, APM-CH, APP-CH, CCP-CH, CCW-CH, CHL-CH, CIS-CH, CDF-CH, DEV-CH, FUA-CH, FUH-CH, FUM-CH, IMA-CH, LSC-CH, OEV-CH, OEVP-CH, PDS-CH, PPC2-CH, PRS-CH, SFM-CH, TFL-CH, W30-CH, WCC-CH, and WCV-CH.
- **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-CH, ADD-CH, AMR-CH, CIS-CH, and CPC-CH.

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

- **Visits that result in an inpatient stay.** Some HEDIS measures in the Child 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 Child Core Set measures: AAB-CH, FUA-CH, and FUM-CH.

Reporting and Submission

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

- **Submission deadline.** The deadline for submitting final data on the 2025 Child 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, in the Medicaid & CHIP Scorecard, or in the State Medicaid & CHIP 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 measures on the Child 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 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.

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

- **Inclusion of all measure-eligible beneficiaries in state reporting.** In the Core Set final rule, CMS specified that mandatory reporting requirements for the Child Core Set require states to ensure that all measure-eligible Medicaid and CHIP beneficiaries are included in state reporting. 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.** For each Child Core Set measure reported to CMS, 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).[13] 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 Child 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] Title XXI programs are required by CHIPRA to collect and separately sample CAHPS survey data beginning in December 2013. A fact sheet with additional information on the CHIPRA CAHPS requirement is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsfactsheet.pdf.

[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 Child Core Set measures, CMS offers technical assistance. Please submit technical assistance requests about the Child 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.

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

III. TECHNICAL SPECIFICATIONS

This chapter presents the technical specifications for each measure in the Child 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.

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

For 2025 Child Core Set reporting, the CIS-CH and IMA-CH measures include ECDS specifications as well as administrative and hybrid specifications. The administrative and hybrid specifications for these measures 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-CH: AVOIDANCE OF ANTIBIOTIC TREATMENT FOR ACUTE BRONCHITIS/BRONCHIOLITIS: AGES 3 MONTHS TO 17 YEARS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of episodes for beneficiaries ages 3 months to 17 years 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.
- 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 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, 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 lookback 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	Ages 3 months to 17 years 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 Child 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 Child 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 AMR-CH: ASTHMA MEDICATION RATIO: AGES 5 TO 18

National Committee for Quality Assurance

A. DESCRIPTION

The percentage of children and adolescents ages 5 to 18 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 Child Core Set reporting, states should calculate and report this measure for two age groups and a total rate: ages 5 to 11, ages 12 to 18, and total (ages 5 to 18).
- 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 identify 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 systems 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 the 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 table 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 5 to 18 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 of 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. • At least four asthma medication dispensing events for any controller or reliever medication. Use all the medication lists in the tables (see Medication List tables below and link to the Medication List Directory in Guidance for Reporting above) to identify asthma controller and reliever medications.

Event/diagnosis (continued)	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 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 Child 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 Child 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

Description	Prescriptions	Medication Lists	Route
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 APP-CH: USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of children and adolescents ages 1 to 17 who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries ages 1 to 17. For the purpose of Child Core Set reporting, states should calculate and report this measure for two age groups and a total rate: ages 1 to 11, ages 12 to 17, and total (ages 1 to 17).
- This measure intends to assess use of psychosocial care as a first-line treatment for conditions for which antipsychotic medications are not indicated. This measure's value set contains typical forms of psychological services, such as behavioral interventions, psychological therapies, and crisis intervention.
- 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, HCPCS, ICD-10-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	January 1 through December 1 of the measurement year.
IPSD	Index Prescription Start Date (IPSD). The earliest prescription dispensing date for an antipsychotic medication where the date is in the intake period and there is a negative medication history.
Negative medication history	A period of 120 days prior to the IPSD when the beneficiary had no antipsychotic medications dispensed for either new or refill prescriptions.

[1] Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and CMS under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18HS020503, from a measure developed by MedNet Medical Solutions.

C. ELIGIBLE POPULATION

Age	Ages 1 to 17 as of December 31 of the measurement year.
Continuous enrollment	120 days prior to the IPSD through 30 days after the IPSD.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	IPSD.
Benefit	Medical, mental health, and pharmacy.
Event/diagnosis	Follow the steps below to identify the eligible population. Step 1 Identify all beneficiaries in the specified age range who were dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List, see link to the Medication List Directory in Guidance for Reporting above) during the Intake Period. Step 2 Test for negative medication history. For each beneficiary identified in step 1, test each antipsychotic prescription for a negative medication history. The IPSD is the dispensing date of the earliest antipsychotic prescription in the intake period with a negative medication history. Step 3 Calculate continuous enrollment. Beneficiaries must be continuously enrolled for 120 days prior to the IPSD through 30 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 for whom first-line antipsychotic medications may be clinically appropriate: beneficiaries with a diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, other psychotic disorder, autism or other developmental disorder (Schizophrenia Value Set; Bipolar Disorder Value Set; Other Psychotic and Developmental Disorders Value Set) on at least two different dates of service during 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 Child 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 Child Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

Psychosocial care (Psychosocial Care Value Set) or residential behavioral health treatment (Residential Behavioral Health Treatment Value Set) in the 121-day period from 90 days prior to the IPSD through 30 days after the IPSD.

MEASURE CCP-CH: CONTRACEPTIVE CARE – POSTPARTUM WOMEN AGES 15 TO 20

HHS Office of Population Affairs

A. DESCRIPTION

Among women ages 15 to 20 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 Child Core Set measure:
  - Ages 15 to 20: Most or moderately effective contraception – within 3 days of delivery.
  - Ages 15 to 20: Most or moderately effective contraception – within 90 days of delivery.
  - Ages 15 to 20: LARC – within 3 days of delivery.
  - Ages 15 to 20: 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-child-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 15 to 20 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 15 to 20 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-child-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-child-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-child-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-child-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,

[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.

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 percent 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.

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.

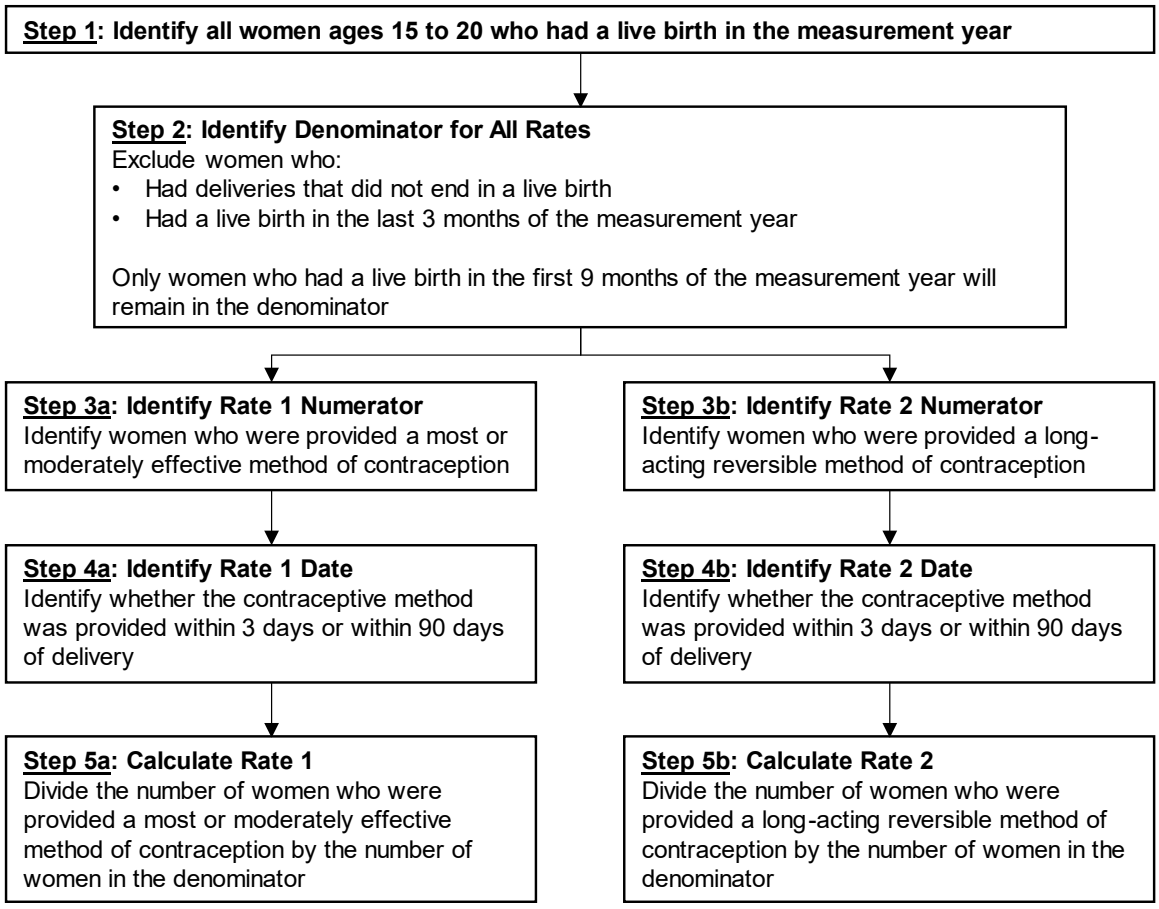
[6] Ross, L.J. "Understanding Reproductive Justice: Sister Song Women of Color Reproductive Health Collective." Feminist Press, 2017.

[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." 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.

Figure CCP-A. Measure Flowchart



MEASURE CCW-CH: CONTRACEPTIVE CARE – ALL WOMEN AGES 15 TO 20

HHS Office of Population Affairs

A. DESCRIPTION

Among women ages 15 to 20 at risk of unintended pregnancy, the percentage that:

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

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-child-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."

The following coding systems are used in this measure: 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 15 to 20 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 15 to 20.

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 comprehensive 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-child-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-child-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-child-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 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

[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.

[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.

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 better understand the limitations of claims data.

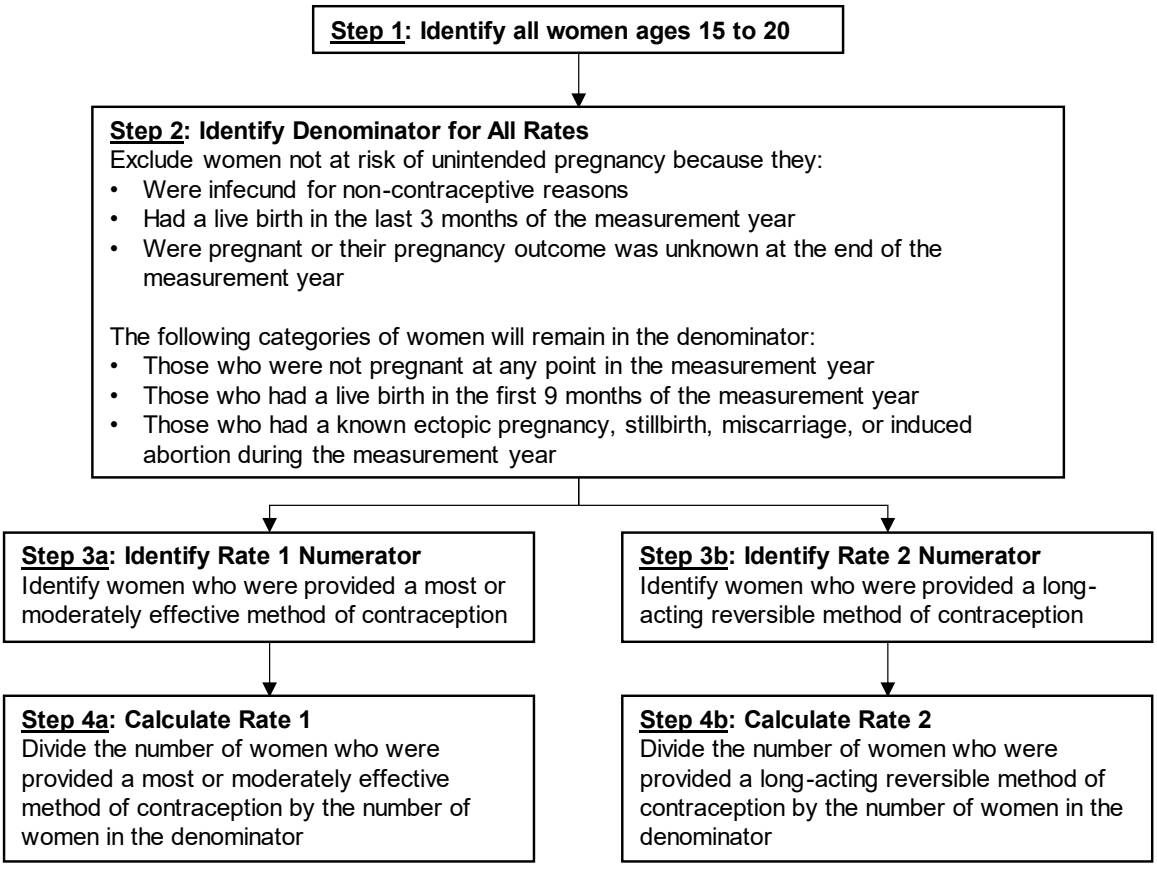
NSFG is a national survey that gathers information on family life, marriage and divorce, pregnancy, infertility, use of contraception, and men's and women's health. It is conducted by CDC's National Center for Health Statistics and generates a nationally representative sample of women and men ages 15 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 that data about health-related risk factors, chronic health conditions, and use of preventive 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.

[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-CH: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN: AGES 12 TO 17

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of beneficiaries ages 12 to 17 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 age 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.
- 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 ages 12 to 17 with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  1. Those beneficiaries with a positive screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool with a follow-up plan documented.
  2. Those beneficiaries with a negative screen for depression on the date of an outpatient visit or up to 14 days prior to the encounter using a standardized tool.
- For the purpose of Child 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. 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-child-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: • Adolescent Screening Tools (12–17 years) Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ2. • 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 psychologist, 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	Ages 12 to 17 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 available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-child-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-child-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-child-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-child-non-hedis-value-set-directory.zip) to identify exceptions.

MEASURE CHL-CH: CHLAMYDIA SCREENING IN WOMEN AGES 16 TO 20

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of women ages 16 to 20 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 16 to 20 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 claim/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 the 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 Child 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 Child 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 CIS-CH: CHILDHOOD IMMUNIZATION STATUS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.

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

Guidance for Reporting:

- States should report a separate rate for each vaccine, as well as three separate combination rates.
- When no sampling methods are involved, claims or registry data may be used together or alone to obtain immunization records for the entire eligible population (all children who turned age 2 during the reporting year).
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, any immunizations missing from claims or registry data must be sought from medical records.
- If immunization registry data are used to calculate this measure, select “Immunization Registry” as an Administrative data source in the Data Source section of the web-based reporting system. States can select “Immunization Registry” in addition to other data sources used to calculate the measure. If use of immunization registry data varies by reporting unit, describe the data source used by each reporting unit in the “Additional Notes/Comments on Measures” section.
- The 14-Day Rule specifies that the vaccinations (with the exception of MMR) must be given 14 days apart to avoid double counting events when either the administrative or hybrid method is used to calculate the numerator. This rule does not apply to the MMR vaccine. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- 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/cms117v12. 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, CVX, 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. ELIGIBLE POPULATION

Age	Children who turn age 2 during the measurement year.
Continuous enrollment	365 days prior to the child's second birthday through the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the beneficiary's second birthday. 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 continuously enrolled).
Anchor date	Enrolled on the child's second birthday.
Benefit	Medical.
Event/diagnosis	None.
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 Child 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 Child Core Set. • Beneficiaries who had a contraindication to a childhood vaccine (Contraindications to Childhood Vaccines Value Set) on or before their second birthday. Do not include laboratory claims (claims with POS code 81).

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

DTaP

Any of the following on or before the child's second birthday meet criteria:

- At least four DTaP vaccinations (DTAP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- 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).

IPV

Either of the following on or before the child's second birthday meets criteria:

- At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the IPV vaccine (SNOMED CT code 471321000124106).

MMR

Any of the following meet criteria:

- At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays.
- All of the following any time on or before the child's second birthday (on the same or different date of service). Do not include laboratory claims (claims with POS code 81):
  - History of measles illness (Measles Value Set).
  - History of mumps illness (Mumps Value Set).
  - History of rubella illness (Rubella Value Set).
- Anaphylaxis due to the MMR vaccine (SNOMED CT code 471331000124109) on or before the child's second birthday.

HiB

Either of the following on or before the child's second birthday meets criteria:

- At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the HiB vaccine (SNOMED CT code 433621000124101).

Hepatitis B

Any of the following on or before the child's second birthday meet criteria:

- At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service.
  - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the 8-day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the child's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8.
- History of hepatitis illness (Hepatitis B Value Set). Do not include laboratory claims (claims with POS code 81).
- Anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101).

VZV

Any of the following meet criteria:

- At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday. Do not include laboratory claims (claims with POS code 81).
- Anaphylaxis due to the VZV vaccine (SNOMED CT code 471341000124104) on or before the child's second birthday.

Pneumococcal Conjugate

Either of the following on or before the child's second birthday meets criteria:

- At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth.
- Anaphylaxis due to the pneumococcal conjugate vaccine (SNOMED CT code 471141000124102).

Hepatitis A

Any of the following meet criteria:

- At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; Hepatitis A Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays.
- History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday. Do not include laboratory claims (claims with POS code 81).
- Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the child's second birthday.

Rotavirus

Any of the following on or before the child's second birthday meet criteria. Do not count a vaccination administered prior to 42 days after birth:

- At least two doses of the two-dose rotavirus vaccine (CVX code 119; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) on different dates of service.
- At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set) on different dates of service.
- At least one dose of the two-dose rotavirus vaccine (CVX code 119; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set), all on different dates of service.
- Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103).

Influenza

Either of the following meets criteria:

- At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set), with different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 6 months (180 days) after birth.
  - An influenza vaccination recommended for children 2 years and older (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) administered on the child's second birthday meets criteria for one of the two required vaccinations.
- Anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100) on or before the child's second birthday.

Combination rates

Calculate the following rates for Combinations 3, 7, and 10.

Combination Vaccinations for Childhood Immunization Status

Combination	DTaP	IPV	MMR	HiB	Hep B	VZV	PCV	Hep A	RV	Influenza
Combination 3	x	x	x	x	x	x	x			
Combination 7	x	x	x	x	x	x	x	x	x	
Combination 10	x	x	x	x	x	x	x	x	x	x

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 Child Core Set for additional information.

Numerators

For DTaP, count any of the following:

- Evidence of the antigen or combination vaccine
- Anaphylaxis due to the vaccine
- Encephalitis due to the vaccine

For MMR, VZV, hepatitis A, and hepatitis B, count any of the following:

- Evidence of the antigen or combination vaccine
- Documented history of the illness
- Anaphylaxis due to the vaccine

For IPV, pneumococcal conjugate, influenza, HiB, and rotavirus, count either of the following:

- Evidence of the antigen or combination vaccine
- Anaphylaxis due to the vaccine

For combination vaccinations that require more than one antigen (DTaP and MMR), the state must find evidence of all the antigens.

Administrative Data

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

Medical Record Review

For immunization evidence obtained from the medical record, count children where there is evidence that the antigen was rendered from one of the following:

- A note indicating the name of the specific antigen and the date of the immunization
- A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered

For documented history of illness or anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the child's second birthday.

Notes in the medical record indicating that the child received the immunization "at delivery" or "in the hospital" may be counted toward the numerator only for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth). A note that the "child is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.

Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP. The burden on states to substantiate the DTaP antigen is excessive compared to a risk associated with data integrity.

Immunizations documented using a generic header (e.g., polio vaccine) or "IPV/OPV" can be counted as evidence of IPV. The burden on states to substantiate the IPV antigen is excessive compared to a risk associated with data integrity.

For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

MEASURE CPC-CH: CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS (CAHPS®) HEALTH PLAN SURVEY 5.1H – CHILD VERSION INCLUDING MEDICAID AND CHILDREN WITH CHRONIC CONDITIONS SUPPLEMENTAL ITEMS

Agency for Healthcare Research and Quality (survey instrument)

National Committee for Quality Assurance (survey administration protocol)

A. DESCRIPTION

A.1 – CAHPS Health Plan Survey 5.1H, Child Version

This measure provides information on parents' experiences with their child's health care. Results summarize children's experiences through ratings, composites, and individual 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.

A.2 – Children with Chronic Conditions (CCC)

This measure provides information on parents' experience with their child's health care for the population of children with chronic conditions. Three composites summarize satisfaction with basic components of care essential for successful treatment, management, and support of children with chronic conditions:

- Access to Specialized Services
- Family-Centered Care: Personal Doctor Who Knows the Child
- Coordination of Care for Children with Chronic Conditions

Item-specific question summary rates are reported for each composite question. Question summary rates are also reported individually for two items summarizing the following concepts:

- Access to Prescription Medicines
- Family-Centered Care: Getting Needed Information

Data Collection Method: Survey

Guidance for Reporting:

- This measure applies to beneficiaries age 17 and younger as of December 31 of the measurement year.
- The version included in the Child Core Set is CAHPS 5.1H − Child Version Including Medicaid and Children with Chronic Conditions (CCC) Supplemental Items. Appendix C contains the CAHPS 5.1H instrument with CCC Supplemental Items.
- The survey should be conducted by a third-party vendor according to CAHPS Health Plan Survey guidelines or the HEDIS protocol. Appendix D contains additional guidance on conducting the CAHPS 5.1H Child 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 to the AHRQ CAHPS Health Plan Survey Database. Alternatively, states can report that they conducted a CAHPS survey for the Child Medicaid and CHIP populations for 2025 in the online Core Set reporting system.
- More information about the CAHPS Health Plan Survey Database is available at https://www.ahrq.gov/cahps/cahps-database/hp-database/participate.html.
- CHIP requirements for CAHPS: The Core Set mandatory reporting final rule updated the requirements for CHIP reporting by amending 42 CFR 457 to align reporting requirements with those required for the Medicaid and CHIP Child Core Set. Therefore, CHIP programs are required to report on the version 5.1H- Child Version Including Medicaid and Children with Chronic Conditions (CCC) Supplemental Items of the CAHPS measure included in the Medicaid and CHIP Child Core Set. The new requirements instruct states to sample Title XXI-funded Medicaid expansion CHIPs with Title XIX-funded Medicaid, and separate CHIPs are required to be sampled separately. Additionally, states are required to report CAHPS survey results for CHIP in the AHRQ CAHPS Health Plan Survey Database. Summary CAHPS survey results for CHIP are no longer collected in the CHIP annual report as of 2024, except for verification.

B. ELIGIBLE POPULATION

Age	Age 17 and younger 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 D 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 for both the GC and CCC populations 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 beneficiary 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**				
Children With CCC	Q3	Q25	Q40	Q44	Q49

Note: See Appendix C for the Children with CCC questionnaire.

Note: 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 DEV-CH: DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE

Oregon Health and Sciences University

A. DESCRIPTION

Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.

Data Collection Method: Administrative or Hybrid

Guidance for Reporting:

- This measure includes three age-specific indicators assessing whether children are screened before or on their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.
- The code 96110 has been shown to have questionable validity in states that do not have policies clarifying the standardized tools meeting the criterion stated in the specification (see Section C).
  - The measure steward recommends that such policies be in place if a state uses the administrative data component of the specifications. It is recommended (although not required) that states assess the accuracy of their claims/encounter data compared to medical charts.
  - For example, a state may conduct a chart review on a sample of records where the CPT code was used to determine whether the developmental screening occurred and whether the tools used met the criteria for a standardized developmental screening.
- When calculating the numerator, modified claims can be included depending on the intent of the modifier:
  - States should include claims with a modifier that indicates a global developmental screening occurred. For example, Z13.42 can be used to indicate an “Encounter for screening for global developmental delays.”
  - If states have policies that clarify if modifiers are used with 96110 for other types of screening (e.g. Autism), then they should exclude claims with a modifier indicating that only a domain-specific screening occurred. Otherwise, all 96110 claims may be used.
  - Modifiers that indicate that a screening was performed at a certain type of visit can be included.
- To facilitate CMS’s understanding of the data reported for this measure, states should use the “Additional Notes/Comments on Measure” section to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.
- States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).
- Include all submitted claims (e.g., paid, suspended, pending, or denied) as the claims reflect services that were rendered.

- The Bright Futures/American Academy of Pediatrics periodicity schedule includes more information about the recommendations for developmental screening and is available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.[1]
  - As noted in the periodicity schedule, screening should occur per "Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening" and is accessible at https://pediatrics.aappublications.org/content/145/1/e20193449.[2]
  - The article also includes more information about the developmental screening tools that meet the measure criteria and is available at https://aap2.silverchair-cdn.com/aap2/content_public/journal/pediatrics/145/1/10.1542_peds.2019-3449/7/peds_20193449supplementarydata.pdf.[2]
- During the development of this measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (social emotional development or autism, respectively), rather than a full, general assessment of developmental delays.
- States should use the "Variations from Measure Specifications" field to document any variations from the specifications for this measure.

This measure includes the following coding system: CPT. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children age 1, 2, or 3 between January 1 and December 31 of the measurement year.
Continuous enrollment	Children who are enrolled continuously for 12 months prior to the child's 1st, 2nd, or 3rd birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 12 months prior to the child's first, second, or third birthday. 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 or 60 days is not considered continuously enrolled).
Anchor date	Enrolled on the child's first, second, or third birthday.
Benefit	Medical.
Event/diagnosis	None.

[1] Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.* 4th ed. American Academy of Pediatrics; 2017. https://www.aap.org/periodicityschedule.

[2] Lipkin, Paul H., and Michelle M. Macias. "Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening." *Pediatrics*, vol. 145, no. 1, January 1, 2020. https://pediatrics.aappublications.org/content/145/1/e20193449.

C. GUIDANCE ON DEVELOPMENTAL SCREENING TOOLS

Criteria for developmental screening tools used in the measure, as well as example tools that do and do not meet criteria, are included below in Section E.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Denominator 1

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

Denominator 2

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

Denominator 3

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

Denominator 4

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

Numerators

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

Numerator 1

Children in Denominator 1 who had a claim with CPT code 96110 before or on their first birthday.

Numerator 2

Children in Denominator 2 who had a claim with CPT code 96110 after their first and before or on their second birthdays.

Numerator 3

Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays.

Numerator 4

Children in the entire eligible population who had claim with CPT code 96110 in the 12 months preceding or on their 1st, 2nd, or 3rd birthday (the sum of numerators 1, 2 and 3).

Claims data

CPT code 96110 (Developmental testing, with interpretation and report)

Important note about appropriate use of claims data

This measure is anchored to standardized tools that meet four criteria specified below in the paragraph beginning with “Tools must meet the following criteria.” States that have policies clarifying that standardized tools meeting this criterion must be used to bill for 96110 should be able to report using claims data.

States should include claims with a modifier that indicates that a global developmental screening occurred. For example, Z13.42 can be used to indicate an “Encounter for screening for global developmental delays.”

Claims NOT included in this measure

It is important to note that modified 96110 claims should not be included IF the modifier is used to indicate that the screening is for a specific domain of development (for example, social emotional screening via the ASQ-SE or autism screening). This measure is anchored to recommendations focused on global developmental screening using tools that focus on identifying risk for developmental, behavioral, and social delays.

Exclusions

None.

E. MEDICAL RECORD SPECIFICATION

Denominator

A systematic sample of 411 drawn from the eligible population stratified by age.

Denominator 1

137 children from the sample who turned 1 during the measurement year.

Denominator 2

137 children from the sample who turned 2 during the measurement year.

Denominator 3

137 children from the sample who turned 3 during the measurement year.

Denominator 4

The entire sample of 411 children.

Numerators

Numerator 1

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

Numerator 2

Children in Denominator 2 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their first and before or on their second birthday.

Numerator 3

Children in Denominator 3 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented after their second and before or on their third birthday.

Numerator 4

Children in Denominator 4 who had screening for risk of developmental, behavioral, and social delays using a standardized screening tool that was documented in the 12 months preceding or on their first, second or third birthday (the sum of numerators 1, 2 and 3).

Documentation in the medical record must include all of the following:

- A note indicating the date on which the test was performed, and
- The standardized tool used (see below), and
- Evidence of a screening result or screening score

Tools must meet the following criteria:

1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional.
2. Established Reliability: Reliability scores of approximately 0.70 or above.
3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s).
4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

Example developmental screening tools that meet criteria for the measure

The following tools meet the above criteria and are included in the Bright Futures Recommendations for Preventive Care (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf)[3], which reference the updated January 2020 American Academy of Pediatrics (AAP) Statement:[4]

- Ages and Stages Questionnaire - 3rd Edition (ASQ-3)
- Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8
- Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM)
- Survey of Well-Being in Young Children (SWYC)

Note: The 2020 AAP Statement describes the screening tool properties that may be useful for states to consider in designing their policies.

[3] Hagan JF, Shaw JS, Duncan PM, eds. *Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents.* 4th ed. American Academy of Pediatrics; 2017. https://www.aap.org/periodicityschedule.

[4] Lipkin, Paul H., and Michelle M. Macias. "Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening." *Pediatrics*, vol. 145, no. 1, January 1, 2020. https://pediatrics.aappublications.org/content/145/1/e20193449.

Tools included in the 2006 Statement that meet the above criteria but were not listed in the 2020 Statement (as they often are not used by primary care providers in the context of routine well-child care) include the following:[5]

- Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months
- Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2
- Brigance Screens-II - Birth to 90 months
- Child Development Inventory (CDI) - 18 months to age 6
- Infant Development Inventory - Birth to 18 months

The tools listed above are not specific recommendations but are examples of tools cited in Bright Futures that meet the above criteria.

Tools that do NOT meet the criteria

It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.

Exclusions

None.

F. CALCULATION ALGORITHM

Step 1

Determine the denominators.

From the total denominator, sort into three age cohorts: children who turned age one, two or three between January 1 and December 31 of the measurement year.

Step 2

Determine the numerators.

For each age cohort, and for the total, identify children who had a screening for developmental, behavioral, and social delays performed before or on their birthday as found through claims data or documented in the medical chart.

Administrative Data: Children for whom a claim of 96110 was submitted for services in the 12 months preceding or on their birthday.

Medical Record Review: Children who had documentation in the medical record of developmental screening using a standardized, validated tool in the 12 months preceding or on their birthday. Documentation must include a note indicating the standardized tool that was used, the date of screening, and evidence that the tool was completed and scored.

[5] Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening." *Pediatrics,* vol. 118, no.1, July 2006, pp. 405-420. https://pediatrics.aappublications.org/content/118/1/405.

Step 3

Calculate the age-specific indicators (ages 1 to 3) by dividing the age-specific numerator by the age-specific denominator and multiplying by 100 to get a percentage.

Step 4

Create the overall measure of screening based on the age-specific numerators and denominators.

Total Numerator: Numerator 1 + Numerator 2 + Numerator 3

Total Denominator: Denominator 1 + Denominator 2 + Denominator 3

Sampling Methodology

If administrative data are used, the entire eligible population is used for the denominator. If using the hybrid method (administrative plus medical record data sources), a systematic sample can be drawn of 411, with 137 in each age group.

G. OPTIONAL AGE-SPECIFIC OVERSAMPLING FOR THE DENOMINATOR

A sample of 411 will provide sufficient statistical power for states reporting a statewide developmental screening rate for children ages 1 to 3. With the smaller age-specific samples, the confidence intervals around the age-specific rates will be larger. Some states may wish to augment the sample in order to monitor screening rates for a particular age group; compare screening rates for a particular age group with that in other states; or look within an age group at subgroups, defined by race/ethnicity, geographic region, or language. For these applications, the age-specific sample of 137 may be insufficient, and the state may need a larger sample to obtain statistically meaningful results. The size of the sample required depends on the use of the data, so consultation with a statistician is recommended. The following instructions guide the development of an oversample.

The eligible population, from which the original sample was drawn, should be stratified by age, and the age-specific sample drawn from within each stratum. To oversample for any age group, the state should return to the original listing of eligible children in that age group, and continue adding children to the sample until the larger sample is complete. However, to maintain consistency of reporting and avoid having to weight the age groups to calculate the total, the state should only include the first 137 children sampled in the age-specific and total rates reported to CMS.

MEASURE FUA-CH: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE: AGES 13 TO 17

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries ages 13 to 17 years 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.
- 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).
- Include all paid, suspended, pending and denied claims.
- Refer to Appendix B 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).

[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. HSP23320100019WI/HHSP23337001T, in which NCQA was a subcontractor to Mathematica. Additional financial support was provided by the Substance Abuse and Mental Health Services Administration (SAMHSA).

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	Ages 13 to 17 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 between ages 13 and 17 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 Child 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 Child 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-CH: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS: AGES 6 TO 17

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for beneficiaries ages 6 to 17 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.
- 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.
- 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 B 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	Ages 6 to 17 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. 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.

Acute readmission or direct transfer (continued)	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 Child 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 Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30 Day Follow-up

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-CH: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS: AGES 6 TO 17

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for beneficiaries ages 6 to 17 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.
- 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	Ages 6 to 17 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 between ages 6 and 17 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 Child 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 Child 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 IMA-CH: IMMUNIZATIONS FOR ADOLESCENTS

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.

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

Guidance for Reporting:

- When no sampling is involved, states may use claims or registry data together or alone to obtain immunization records for the entire eligible population (all adolescents who turned age 13 during the reporting year) and report using the administrative specification.
- If the state uses the hybrid method in which immunization data are obtained for a sample of the eligible population, seek any immunizations missing from claims or registry data from medical records.
- If immunization registry data are used to calculate this measure, select “Immunization Registry” as an Administrative data source in the Data Source section of the web-based reporting system. States can select “Immunization Registry” in addition to other data sources used to calculate the measure. If use of immunization registry data varies by reporting unit, describe the data source used by each reporting unit in the “Additional Notes/Comments on Measure” section.
- This measure adheres to the HEDIS 14-Day Rule. The 14-Day Rule specifies that vaccinations must be given 14 days apart to avoid double counting events when either the administrative or hybrid method is used to calculate the numerator. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- 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, CVX, HCPCS, SNOMED, and UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

[1] Adapted with financial support from the Centers for Disease Control & Prevention (CDC).

B. ELIGIBLE POPULATION

Age	Adolescents who turn age 13 during the measurement year.
Continuous enrollment	365 days prior to the beneficiary's 13th birthday through the beneficiary's 13th birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the 13th birthday. 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 continuously enrolled).
Anchor date	Enrolled on the beneficiary's 13th birthday.
Benefit	Medical.
Event/diagnosis	None.
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 Child 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 Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Meningococcal Serogroups A, C, W, Y

Either of the following meets criteria:

- At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set; Meningococcal Vaccine Procedure Value Set), with a date of service on or between the adolescent's 11th and 13th birthdays.
- Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the child's 13th birthday

Tdap

Any of the following meet criteria:

- At least one tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine (CVX code 115; Tdap Vaccine Procedure Value Set), with a date of service on or between the adolescent's 10th and 13th birthdays.
- Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the child's 13th birthday
- Encephalitis due to the tetanus, diphtheria or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) on or before the child's 13th birthday

HPV

Any of the following meet criteria:

- At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), on or between the child's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be after July 25.
- At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set), with different dates of service on or between the adolescent's 9th and 13th birthdays
- Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the child's 13th birthday

Combination 1 (Meningococcal, Tdap)

Adolescents who are numerator compliant for both the meningococcal and Tdap indicators.

Combination 2 (Meningococcal, Tdap, HPV)

Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).

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 Child Core Set for additional information.

Numerators

For meningococcal and HPV, count either of the following:

- Evidence of the antigen or combination vaccine
- Anaphylaxis due to the vaccine

For Tdap, count any of the following:

- Evidence of the antigen or combination vaccine
- Anaphylaxis due to the vaccine
- Encephalitis due to the vaccine

Administrative Data

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

Medical Record Review

For immunization information obtained from the medical record, count adolescents where there is evidence that the antigen was rendered from either of the following:

- A note indicating the name of the specific antigen and the date of the immunization
- A certificate of immunization prepared by an authorized health care provider or agency, including the specific dates and types of immunizations administered

For documented history of anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the child's 13th birthday.

For the two-dose HPV vaccination series, there must be at least 146 days between the first and second dose of the HPV vaccine.

For meningococcal, do not count meningococcal recombinant (serogroup B) (MenB) vaccines. However, immunizations documented under a generic header of "meningococcal" and generic documentation that the "meningococcal vaccine", "meningococcal conjugate vaccine" or "meningococcal polysaccharide vaccine" were administered meet criteria.

Immunizations documented using a generic header or "Tdap/Td" can be counted as evidence of Tdap. The burden on states to substantiate the Tdap antigen is excessive compared to a risk associated with data integrity.

E. ADDITIONAL NOTES

To align with Advisory Committee on Immunization Practices (ACIP) recommendations, only the quadrivalent meningococcal vaccine (serogroups A, C, W and Y) is included in the measure.

To align with ACIP recommendations, the minimum interval for the two-dose HPV vaccination schedule is 150 days, with a 4-day grace period (146 days).

MEASURE LBW-CH: LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS

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

A. DESCRIPTION

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

Note: A lower rate indicates better performance.

Data Collection Method: State Vital Records submitted to the National Center for Health Statistics (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.**
- 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 Child Core Set reporting year. For example, calendar year 2024 data should be used for the 2025 reporting year.
- Eligibility for this measure is based on deliveries that have Medicaid as principal source of payment for 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. 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.

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 weighing less than 2,500 grams at birth with Medicaid as the principal source of payment for the delivery.

Units

Report as a percentage.

C. EXCLUSIONS

Exclude resident live births from both the denominator and numerator with a birth weight that is “Unknown or Not Stated.”

MEASURE LRCD-CH: LOW-RISK CESAREAN DELIVERY: UNDER AGE 20

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 under age 20 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 Child 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 less than 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 less than 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 LSC-CH: LEAD SCREENING IN CHILDREN

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday.

Data Collection Method: Administrative, Hybrid

Guidance for Reporting:
• 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, LOINC, SNOMED, and UB.

B. ELIGIBLE POPULATION

Age	Children who turn 2 years old during the measurement year.
Continuous enrollment	365 days prior to the child's second birthday through the child's second birthday.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the child's second birthday. 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	Enrolled on the child's second birthday.
Benefits	Medical.
Event/diagnosis	None.
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 Child 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 Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

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 Child Core Set for additional information.

States that use the Hybrid Method to report the Childhood Immunization Status (CIS-CH) and Lead Screening and Children (LSC-CH) measures may use the same sample for both measures. Because required exclusions are applied to the CIS-CH measure, if the state uses the CIS-CH systematic sample, the same children will be excluded from the LSC-CH measure. Excluding these children will not create a statistically significant difference in the LSC-CH eligible population.

States may reduce the sample size based on the current year's administrative rate or prior year's rate for the lowest rate of all CIS-CH antigen, CIS-CH combinations, and LSC-CH rate.

If a separate sample from the CIS-CH measure is used for LSC-CH, states may reduce the sample based on the current measurement year's administrative rate or the prior year's rate for LSC-CH.

Numerator

At least one lead capillary or venous blood test on or before the child's second birthday as documented through either administrative data or medical record review.

Administrative Data

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

Medical Record Review

Documentation in the medical record must include both of the following:

- A note indicating the date the test was performed.
- The result or finding. "Unknown" is not considered a result/finding.

MEASURE OEV-CH: ORAL EVALUATION, DENTAL SERVICES

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- The measurement period for this measure is the calendar year.
- Children enrolled in Medicaid and CHIP (both Medicaid expansion and separate CHIP programs) are eligible for this measure.
- For 2025 Child Core Set reporting, the following rate is required: Total (<Age 21).
- Include all paid, suspended, pending, and denied claims.

This measure includes the following coding systems: CDT and NUCC. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children who are under age 21 as of December 31 of the measurement year. Report 4 age stratifications (optional for 2025) and a total rate (required for 2025): • Age < 3. • Ages 3 to 5. • Ages 6 to 14. • Ages 15 to 20. • Total (< Age 21).
Continuous enrollment	180 days during measurement year.
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

The unduplicated number of enrolled children who received a comprehensive or periodic oral evaluation as a dental service during the measurement year.

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

- [CDT CODE] = D0120 or D0150 or D0145, AND
- [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table OEV-A below[1]

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

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 OEV-A will not be counted in the numerator.

Exclusions

None.

Table OEV-A. NUCC maintained Provider Taxonomy Codes classified as "Dental Service" *

122300000X	1223P0106X	1223X0008X	125Q00000X	126800000X
1223D0001X	1223P0221X	1223X0400X	261QF0400X	261QD0000X
1223D0004X	1223P0300X	124Q00000X+	261QR1300X	204E00000X
1223E0200X	1223P0700X	125J00000X	1223X2210X	261QS0112X
1223G0001X	1223S0112X	125K00000X	122400000X	

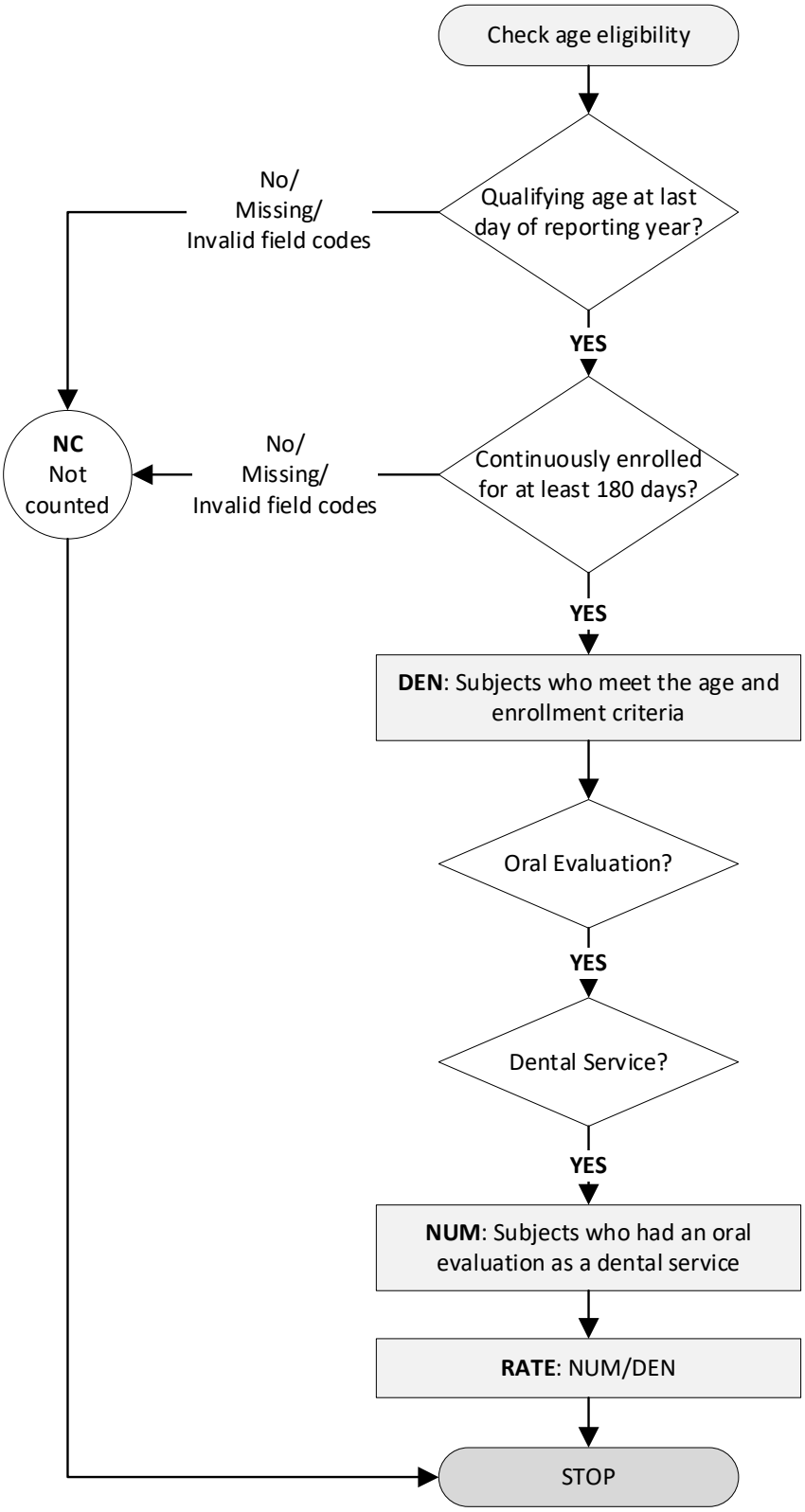
* Services provided by County Health Department dental clinics may also be included as "dental" services.

+ Only dental hygienists who provide services under the supervision of a dentist should be classified as "dental" services. Services provided by independently practicing dental hygienists should be classified as "oral health" services and are not applicable for this measure.

[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 OEV-A provides a flowchart for implementing these exclusion and inclusion criteria.

Figure OEV-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_pediatric_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 OEVP-CH: ORAL EVALUATION DURING PREGNANCY: AGES 15 TO 20

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Percentage of enrolled persons ages 15 to 20 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.
- Children 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-child-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 >=15 and <21 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. 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 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-child-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.

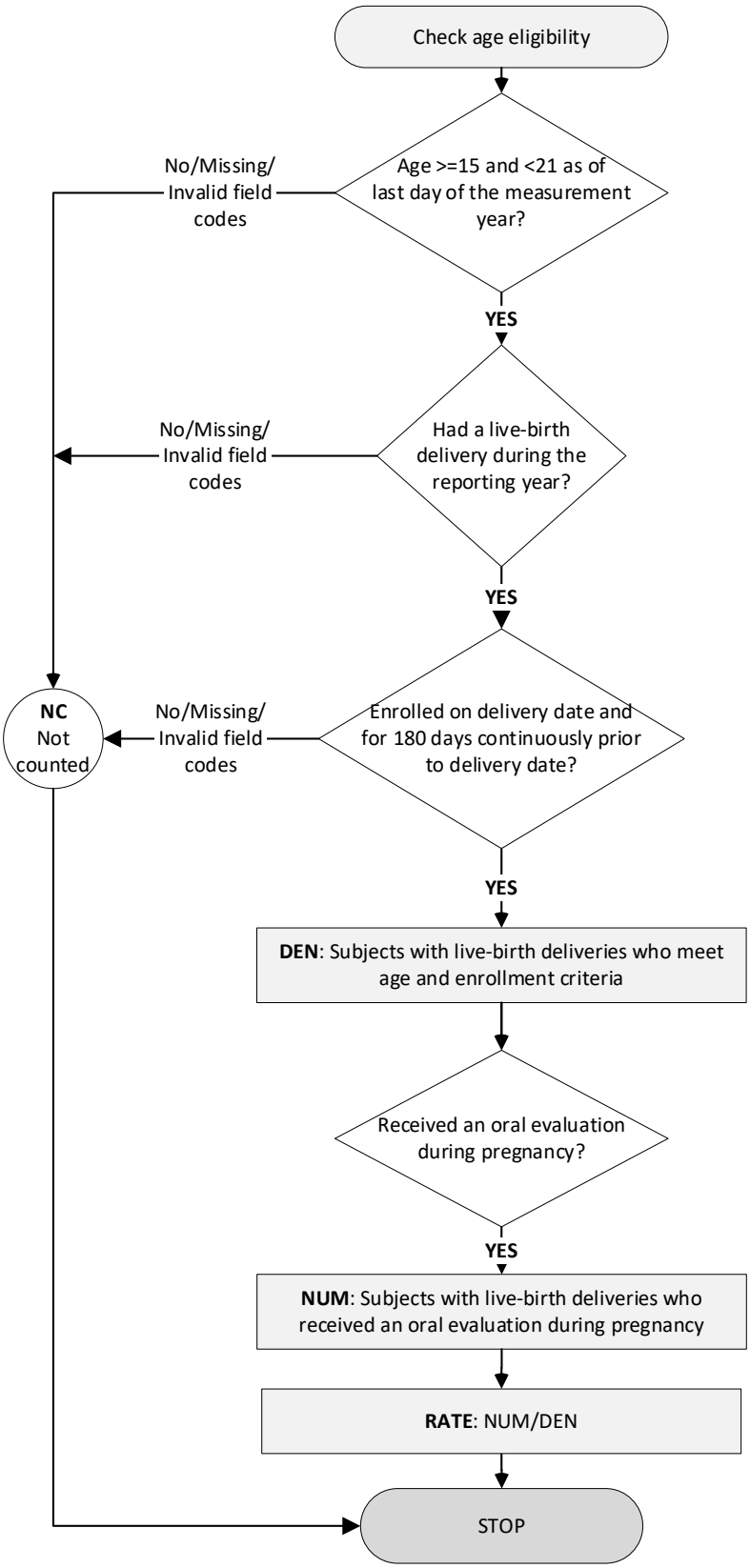
Exclusions

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 PPC2-CH: PRENATAL AND POSTPARTUM CARE: UNDER AGE 21

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 start 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 Child Core Set reporting, both the Timeliness of Prenatal Care and the Postpartum Care rates are reported for beneficiaries under age 21 as of the delivery date. The Adult Core Set measure is reported for beneficiaries age 21 and older 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 Child Core Set (under age 21) and Adult Core Set (age 21 and over).
- States may use vital records as an alternative data source for the prenatal care rate if they have confidence in the completeness and accuracy of these data. States can use Medicaid and 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 and 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 and 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 B 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	Under age 21 as of the 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 through 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 Child 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 Child 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 Child Core Set for additional information.

Numerators

Timeliness of Prenatal Care

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

Administrative Data

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

Medical Record Review

Postpartum visit to an OB/GYN 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 this measure if all services are within the time frame established in the 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 removed 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 SFM-CH: SEALANT RECEIPT ON PERMANENT FIRST MOLARS

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

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

Data Collection Method: Administrative

Guidance for Reporting:

- The measurement period for this measure is the calendar year.
- States should use a 48-month look-back period when calculating the numerator. Enrollment in prior years is not required. States that do not have 48 months of look-back data should note this as a data limitation when reporting.
- Sealants received on the 10th birthdate are not included in the numerator.
- Sealants received prior to 48 months before the 10th birthday are not included in the numerator.
- Children 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.

This measure includes the following coding system: CDT. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. ELIGIBLE POPULATION

Age	Children who turn age 10 in the measurement year.
Continuous enrollment	12 months prior to the child's 10th birthdate.
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 child may not have more than a 1-month gap in coverage.
Anchor date	Enrolled on the 10th birthdate.
Benefit	Dental.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Numerator for Rate 1 (At Least One Sealant)

The unduplicated number of enrolled children who ever received a sealant on at least one permanent first molar tooth.

To calculate the number of beneficiaries who have ever received a sealant on at least one permanent first molar in the 48 months prior to the 10th birthdate, check for the following criteria:

- [CDT CODE] = D1351 in the 48 months prior to the 10th birthdate, AND
- [TOOTH-NUMBER] = 3 OR 14 OR 19 OR 30, using the Universal Numbering System.

If these criteria are met, include in numerator 1 and continue to the next step.

Numerator for Rate 2 (All Four Molars Sealed)

The unduplicated number of enrolled children who have received sealants on all four permanent first molars.

To calculate the number of beneficiaries who have received sealants on ALL FOUR permanent first molars in the 48 months prior to the 10th birthdate, check for the following criteria:

- [CDT CODE] = D1351 AND [TOOTH-NUMBER] = 3, using the Universal Numbering System, in the 48 months prior to the 10th birthdate, AND
- [CDT CODE] = D1351 AND [TOOTH-NUMBER] = 14, using the Universal Numbering System, in the 48 months prior to the 10th birthdate, AND
- [CDT CODE] = D1351 AND [TOOTH-NUMBER] = 19, using the Universal Numbering System, in the 48 months prior to the 10th birthdate, AND
- [CDT CODE] = D1351 AND [TOOTH-NUMBER] = 30, using the Universal Numbering System, in the 48 months prior to the 10th birthdate.

If these criteria are met, include in Numerator 2.

Exclusions

Exclude children from the denominator and numerator who have received treatment (restorations, extractions, endodontic, prosthodontic, and other dental treatments) on all four permanent first molars in the 48 months prior to the 10th birthdate.

To determine exclusions, check if the beneficiary meets any of the following criteria for all four permanent molars (tooth numbers 14, 3, 19 and 30):

TOOTH NUMBER 14

On permanent first molar maxillary left [TOOTH NUMBER=14 using the Universal Numbering System]; check if beneficiary meets any of the criteria:

Beneficiary has PREVENTIVE RESIN RESTORATION CODE [D1352]

OR

Beneficiary has any RESTORATIVE CODE [D2140, D2150, D2160, D2161, D2391, D2392, D2393 or D2394] that includes OCCLUSAL TOOTH SURFACE alone [O] or in combination with any other surface codes [examples: MO or DO or MOD or MODL or MODBL or MOL or DOL or MOB or MODB or DOB or BO or LO][1]

OR

Beneficiary has any RESTORATIVE CODE [D2410 – D2999]

OR

Beneficiary has any ENDODONTIC CODE [D3110 – D3999]

OR

Beneficiary has any EXTRACTION CODE [D7111 – D7250]

OR

Beneficiary has any PROSTHODONTIC CODE [D6205 – D6794]

AND

TOOTH NUMBER 3

On permanent first molar maxillary right [TOOTH NUMBER=3 using the Universal Numbering System]; check if beneficiary meets any of the criteria:

Beneficiary has PREVENTIVE RESIN RESTORATION CODE [D1352]

OR

Beneficiary has any RESTORATIVE CODE [D2140, D2150, D2160, D2161, D2391, D2392, D2393 or D2394] that includes OCCLUSAL TOOTH SURFACE alone [O] or in combination with any other surface codes [examples: MO or DO or MOD or MODL or MODBL or MOL or DOL or MOB or MODB or DOB or BO or LO][1]

OR

Beneficiary has any RESTORATIVE CODE [D2410 – D2999]

OR

Beneficiary has any ENDODONTIC CODE [D3110 – D3999]

OR

Beneficiary has any EXTRACTION CODE [D7111 – D7250]

OR

Beneficiary has any PROSTHODONTIC CODE [D6205 – D6794]

AND

TOOTH NUMBER 19

[1] All surface combinations including the occlusal surface “O” should be included irrespective of the position of the “O.”

On permanent first molar mandibular left [TOOTH NUMBER=19 using the Universal Numbering System]; check if beneficiary meets any of the criteria:

Beneficiary has PREVENTIVE RESIN RESTORATION CODE [D1352]

OR

Beneficiary has any RESTORATIVE CODE [D2140, D2150, D2160, D2161, D2391, D2392, D2393 or D2394] that includes OCCLUSAL TOOTH SURFACE alone [O] or in combination with any other surface codes [examples: MO or DO or MOD or MODL or MODBL or MOL or DOL or MOB or MODB or DOB or BO or LO][1]

OR

Beneficiary has any RESTORATIVE CODE [D2410 – D2999]

OR

Beneficiary has any ENDODONTIC CODE [D3110 – D3999]

OR

Beneficiary has any EXTRACTION CODE [D7111 – D7250]

OR

Beneficiary has any PROSTHODONTIC CODE [D6205 – D6794]

AND

TOOTH NUMBER 30

On permanent first molar mandibular right [TOOTH NUMBER=30 using the Universal Numbering System]; check if beneficiary meets any of the criteria:

Beneficiary has PREVENTIVE RESIN RESTORATION CODE [D1352]

OR

Beneficiary has any RESTORATIVE CODE [D2140, D2150, D2160, D2161, D2391, D2392, D2393 or D2394] that includes OCCLUSAL TOOTH SURFACE alone [O] or in combination with any other surface codes [examples: MO or DO or MOD or MODL or MODBL or MOL or DOL or MOB or MODB or DOB or BO or LO][1]

OR

Beneficiary has any ENDODONTIC CODE [D3110 – D3999]

OR

Beneficiary has any RESTORATIVE CODE [D2410 – D2999]

OR

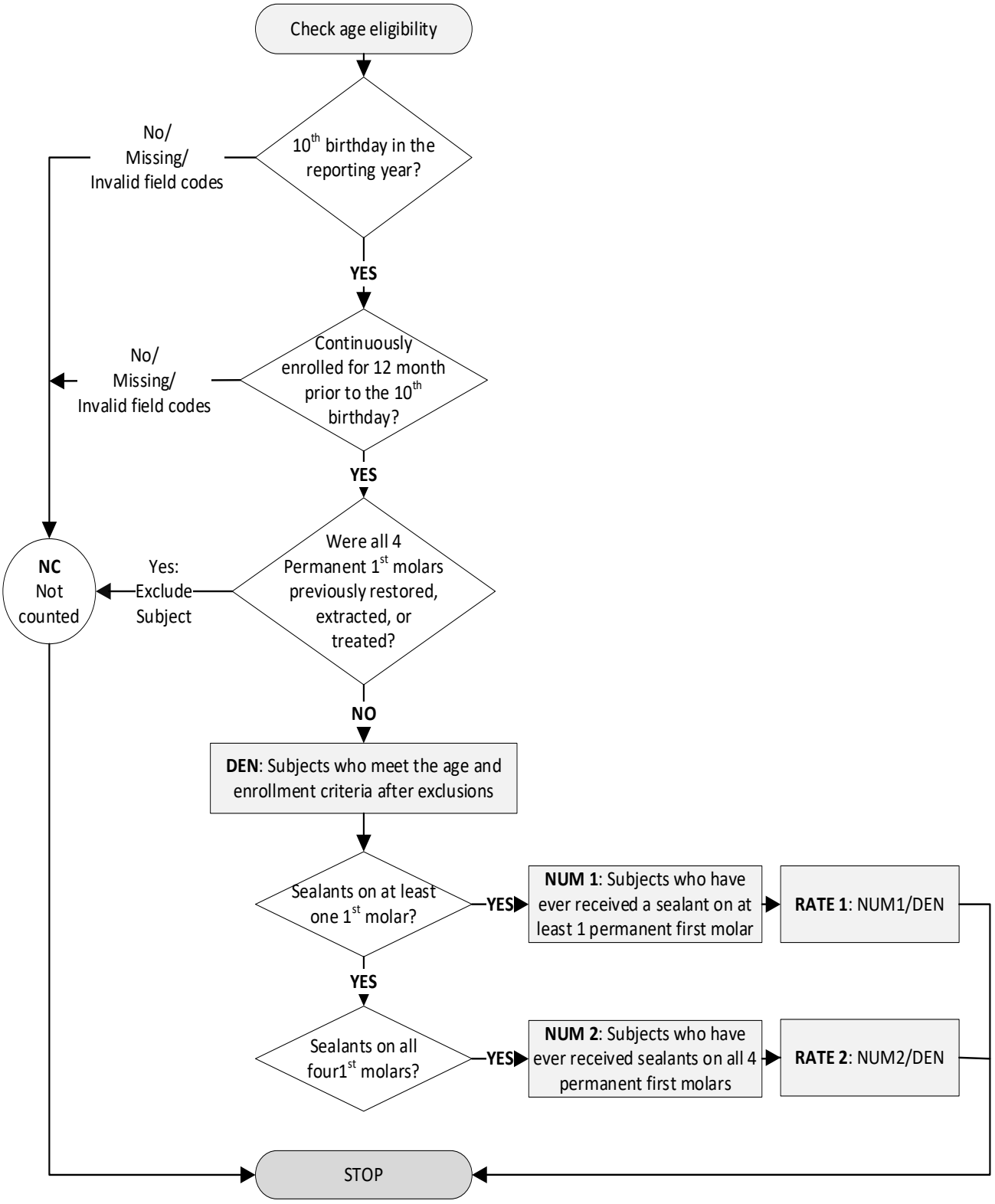
Beneficiary has any EXTRACTION CODE [D7111 – D7250]

OR

Beneficiary has any PROSTHODONTIC CODE [D6205 – D6794]

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

Figure SFM-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_pediatric_measures_user_guide_final.pdf.

Impact of exclusions on the measure rates:

Consideration should be given to evaluation of the impact of exclusions on the measure rates, particularly when using the measure to compare rates between reporting entities. Such consideration may assist in allowing users to understand the impact of access or other factors on the measure rates and the potential for measurement bias.

Stratifying by caries risk:

The dental sealant measure previously included in the Child Core Set (Dental Sealants for 6–9 Year-Old Children at Elevated Caries Risk [SEAL-CH], which was in the 2015-2020 Core Sets) assessed receipt of dental sealants among children at elevated caries risk. If programs are interested in understanding the rate of sealant application by risk status, the measure denominator may be stratified by elevated risk for dental caries:

- Elevated risk
- Not at elevated risk

For details on the elevated risk methodology, please refer to 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_pediatric_measures_user_guide_final.pdf.

Data quality considerations:

Reliability of the measure score depends on the quality of the data elements used to calculate the measure. The percentages of missing and invalid data for each data element 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 TOOTH-NUMBER 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 Limitations Due to Limitations of Administrative Data:

1. Claims data cannot identify (a) teeth with active decay, (b) sealants not billed to the program/plan, or (c) treatment (e.g., restorations/extractions) not billed to the program/plan, thus impacting the precision of both the numerator and denominator.
2. Comparisons would be biased if programs being compared have significant differences in enrollment duration resulting in differences in the availability of complete treatment history for beneficiaries, which reduces the ability to consistently identify children to be included in the numerator or excluded from the denominator. However, this is not unique to dental measures.

3. The 12-month enrollment criterion, with the allowed single gap in coverage, may result in a significantly reduced population that is eligible for inclusion in the denominator in programs with shorter enrollment durations (greater “churn”) and, therefore, may be less representative of the population that is the focus of measurement.

MEASURE TFL-CH: PREVENTION: TOPICAL FLUORIDE FOR CHILDREN

American Dental Association on behalf of the Dental Quality Alliance

A. DESCRIPTION

Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- The measurement period for this measure is the calendar year.
- Children enrolled in Medicaid and CHIP (both Medicaid expansion and separate CHIP programs) are eligible for this measure.
- For 2025 Child Core Set reporting, the following three rates are required: (1) Dental or oral health services: Total ages 1 through 20; (2) Dental services: Total ages 1 through 20; and (3) Oral health services: Total ages 1 through 20.
- Include all paid, suspended, pending, and denied claims.
- Numerator 1 is not the sum of numerators 2 and 3:
  - There could be instances where a child is eligible to be included in numerator 1 but not in numerator 2 or 3 (for example, if the child received two topical fluoride applications, one as a dental service and another as an oral health service).
  - There could also be instances where a child is eligible to be included in both numerators 2 and 3 (for example, if the child received two topical fluoride applications as a dental service and two topical fluoride applications as an oral health service).

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

B. ELIGIBLE POPULATION

Age	Children ages 1 through 20 as of December 31 of the measurement year. Report 4 age stratifications (optional for 2025) and a total rate (required for 2025): • Ages 1 to 2. • Ages 3 to 5. • Ages 6 to 14. • Ages 15 to 20. • Total ages 1 through 20.
Continuous enrollment	The measurement year.

Allowable gap	No more than one gap in enrollment of up to 31 days during the measurement year. To determine continuous enrollment for a beneficiary for whom enrollment is verified monthly the child may not have more than a single 1-month gap in coverage.
Anchor date	None.
Benefit	Dental.
Event/diagnosis	None.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Numerator for Rate 1 (Dental or oral health services)

The unduplicated number of enrolled children who received at least two fluoride applications as dental or oral health services during the measurement year, where there were at least two unique dates of service when topical fluoride was provided. Services provided on each date should satisfy the following criteria:

- [SERVICE CODE] = CDT D1206 or CDT D1208 or CPT 99188

If these criteria are met, include in Numerator 1 and continue to the next step.

Note 1: No more than one fluoride application can be counted for the same beneficiary on the same date of service.

Note 2: In this step, all claims with missing or invalid SERVICE CODE should be excluded.

Numerator for Rate 2 (Dental services)

The unduplicated number of enrolled children who received at least two fluoride applications as dental services during the measurement year, where there were at least two unique dates of service when topical fluoride was provided. Service provided on each date should satisfy the following criteria:

- [SERVICE CODE] = CDT D1206 or D1208 AND
- [RENDERING PROVIDER TAXONOMY] code = any of the NUCC maintained Provider Taxonomy Codes in Table TFL-A below[1]

If these criteria are met, include in Numerator 2 and continue to the next step.

Note 1: No more than one fluoride application can be counted for the same beneficiary on the same date of service.

[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.

Note 2: In this step, all claims with missing or invalid SERVICE CODE or with missing or invalid NUCC maintained Provider Taxonomy Codes should be excluded.

Numerator for Rate 3 (Oral health services)

The unduplicated number of enrolled children who received at least two fluoride applications as oral health services during the measurement year, where there were at least two unique dates of service when topical fluoride was provided. Services provided on each date should satisfy the following criteria:

- [SERVICE CODE] = CDT D1206 or CDT D1208 or CPT 99188 AND
- [RENDERING PROVIDER TAXONOMY] code is a valid NUCC maintained Provider Taxonomy code but NOT included in the NUCC maintained Provider Taxonomy Codes in Table TFL-A below

If these criteria are met, include in Numerator 3.

Note 1: No more than one fluoride application can be counted for the same member on the same date of service.

Note 2: In this step, all claims with missing or invalid SERVICE CODE or with missing or invalid NUCC maintained Provider Taxonomy Codes should be excluded.

Exclusions

None.

Table TFL-A. NUCC maintained Provider Taxonomy Codes classified as "Dental Service" *

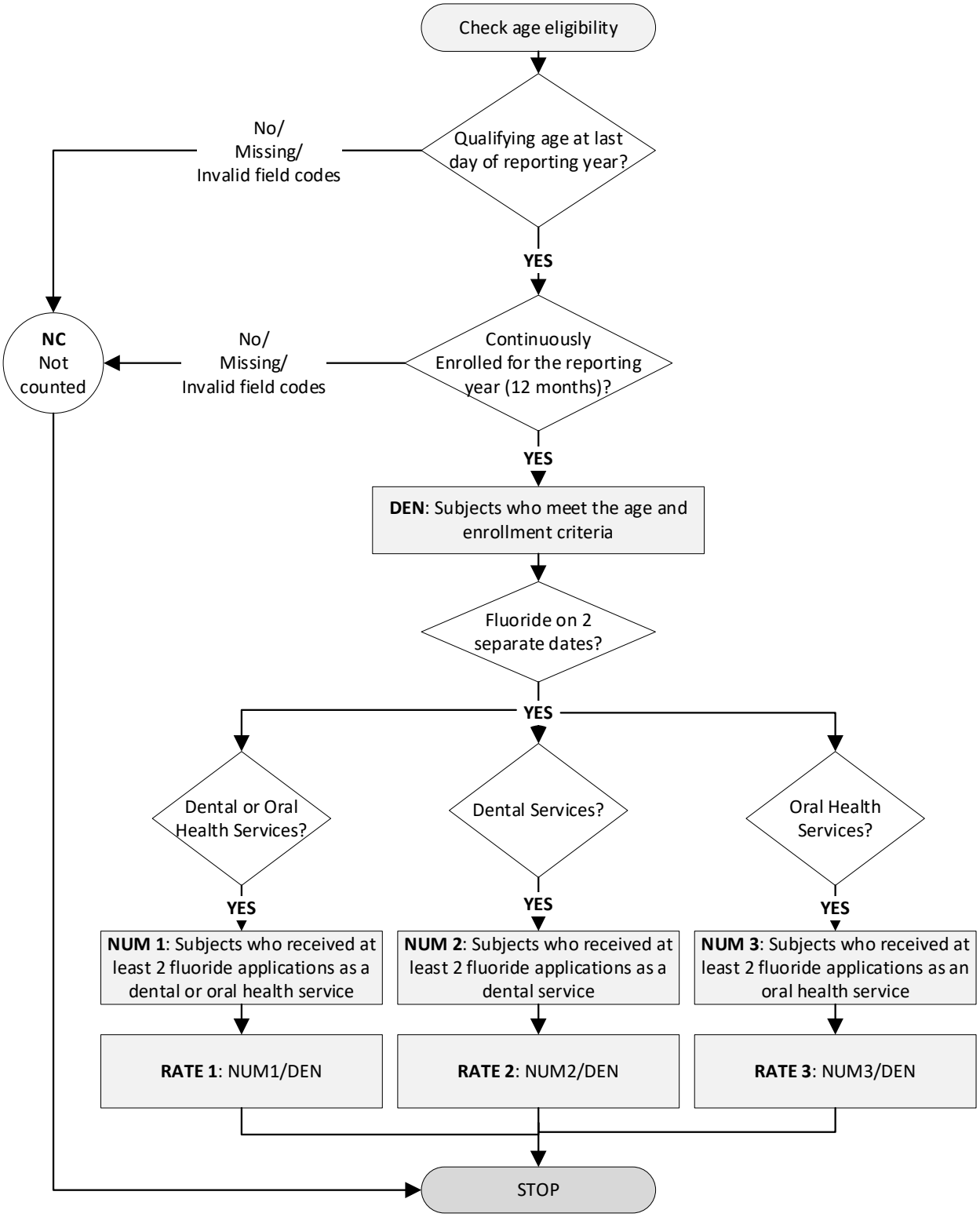
122300000X	1223P0106X	1223X0008X	125Q00000X	126800000X
1223D0001X	1223P0221X	1223X0400X	261QF0400X	261QD0000X
1223D0004X	1223P0300X	124Q00000X+	261QR1300X	204E00000X
1223E0200X	1223P0700X	125J00000X	1223X2210X	261QS0112X
1223G0001X	1223S0112X	125K00000X	122400000X	

* Services provided by County Health Department dental clinics may also be included as "dental" services.

+ Only dental hygienists who provide services under the supervision of a dentist should be classified as "dental" services. Services provided by independently practicing dental hygienists should be classified as "oral health" services and are not applicable for this measure.

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

Figure TFL-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_pediatric_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 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 SERVICE CODE to identify topical fluoride 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 Limitations:

This measure assumes that all modes of topical fluoride application are equally effective. This measure calls for the documentation of at least two instances (on different dates of service) of any combination of two fluoride specific CDT codes, D1206 and D1208 (or equivalent CPT codes when billed by non-dental providers). D1206 refers to professionally applied fluoride varnish and D1208 is any topical application of fluoride including fluoride gels or fluoride foams (excluding fluoride varnish).

This measure does not take into account alternate home-use fluoride products including supplements.

MEASURE W30-CH: WELL-CHILD VISITS IN THE FIRST 30 MONTHS OF LIFE

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children who had the following number of well-child visits with a primary care practitioner (PCP) during the last 15 months. The following rates are reported:

- Well-Child Visits in the First 15 Months. Children who turned age 15 months during the measurement year: Six or more well-child visits.
- Well-Child Visits for Age 15 Months–30 Months. Children who turned age 30 months during the measurement year: Two or more well-child visits.

Data Collection Method: Administrative

Guidance for Reporting:
- Include all paid, suspended, pending, and denied claims.
- This measure adheres to the HEDIS 14-Day Rule. The 14-Day Rule specifies that well-child visits must occur 14 days apart to avoid double counting events when calculating the numerator. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines.
- Refer to Appendix B for the definition of a PCP.

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

B. ELIGIBLE POPULATION

Eligible Population: Rate 1 – Well-Child Visits in the First 15 Months

Ages	Children who turn age 15 months during the measurement year. Calculate the 15-month birthday as the child's first birthday plus 90 days.
Continuous enrollment	31 days – age 15 months. Calculate 31 days of age by adding 31 days to the date of birth.
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	The date when the child turns age 15 months.
Benefit	Medical.
Event/diagnosis	None.

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 Child 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 Child Core Set.

Eligible Population: Rate 2 – Well-Child Visits for Age 15 Months–30 Months

Ages	Children who turn age 30 months during the measurement year. Calculate the 30-month birthday as the second birthday plus 180 days.
Continuous enrollment	15 months plus 1 day–30 months of age. Calculate the 15-month birthday plus 1 day as the first birthday plus 91 days.
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	The date when the child turns age 30 months.
Benefit	Medical.
Event/diagnosis	None.
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 Child 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 Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Rate 1 – Well-Child Visits in the First 15 Months

Denominator

The Rate 1 eligible population.

Numerator

Six or more well-child visits on different dates of service on or before the 15-month birthday. Either of the following meet criteria:

- A well-care visit (Well Care Visit Value Set)
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Rate 2 – Well-Child Visits for Age 15 Months–30 Months

Denominator

The Rate 2 eligible population.

Numerator

Two or more well-child visits (Well-Care Value Set) on different dates of service between the child's 15-month birthday plus 1 day and the 30-month birthday.. Either of the following meet criteria:

- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

D. ADDITIONAL NOTES

This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/).

MEASURE WCC-CH: WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children ages 3 to 17 who had an outpatient visit with a primary care practitioner (PCP) or obstetrician/gynecologist (OB/GYN) and who had evidence of the following during the measurement year:

- Body mass index (BMI) Percentile documentation*
- Counseling for Nutrition
- Counseling for Physical Activity

* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed, rather than an absolute BMI value.

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- This measure applies to beneficiaries ages 3 to 17. For the purpose of Child Core Set reporting, states should calculate and report this measure for two age groups and a total rate for each of the three indicators: ages 3 to 11, ages 12 to 17, and total (ages 3 to 17).
- The eligible population (denominator) for this measure includes children ages 3 to 17 who have an outpatient visit and meet the continuous enrollment criteria.
- A BMI percentile is included in the numerator count if the specified documentation is present, regardless of the primary intent of the visit. A BMI without a percentile is not acceptable for inclusion in the numerator count.
- The height, weight, and BMI must be from the same data source.
- The height and weight measurement should be taken during the measurement year.
- If using hybrid specifications, documentation in the medical record should indicate the weight and BMI value, dated during the measurement year.
- Include all paid, suspended, pending, and denied claims.
- The electronic clinical quality measure specification for the 2025 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2024/cms155v12. 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.
- Refer to Appendix B for definitions of a PCP and OB/GYN and other prenatal care practitioner.

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. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITION

BMI percentile	The percentile ranking based on the CDC's BMI-for-age growth charts, which indicates the relative position of the patient's BMI number among others of the same gender and age.

C. ELIGIBLE POPULATION

Ages	Ages 3 to 17 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	An outpatient visit (Outpatient Value Set) with a PCP or an OB/GYN during the measurement year.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet any of the following criteria: • Beneficiaries who have a diagnosis of pregnancy (Pregnancy Value Set) any time during 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. 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 Child 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 Child Core Set.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

BMI Percentile

BMI percentile (BMI Percentile Value Set) during the measurement year. Do not include laboratory claims (claims with POS code 81).

Counseling for Nutrition

Counseling for nutrition during the measurement year. Either of the following meets criteria:

- Nutrition Counseling Value Set.
- ICD10CM code Z71.3. Do not include laboratory claims (claims with POS code 81).

Counseling for Physical Activity

Counseling for physical activity during the measurement year. Either of the following meets criteria:

- Physical Activity Counseling Value Set
- Encounter for Physical Activity Counseling Value Set. Do not include laboratory claims (claims with POS code 81).

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population for the Total age band (ages 3 to 17). The Total sample is stratified by age to report rates for the ages 3 to 11 and ages 12 to 17 age stratifications. Refer to the sampling guidance under Section II. Data Collection and Reporting of the Child Core Set for additional information.

Numerators

BMI Percentile

BMI percentile during the measurement year as identified by administrative data or medical record review.

Administrative Data

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

Medical Record Review

Documentation must include height, weight, and BMI percentile during the measurement year. The height, weight, and BMI percentile must be from the same data source.

Either of the following meets criteria for BMI percentile:

- BMI percentile documented as a value (e.g., 85th percentile)
- BMI percentile plotted on age-growth chart

Only evidence of the BMI percentile or BMI percentile plotted on an age-growth chart meets criteria.

Beneficiary-reported services and biometric values (height, weight, BMI percentile) are acceptable only if the information is collected by a primary care practitioner (refer to Appendix B for the definition of “PCP”) or specialist, if the specialist is providing a primary

care service related to the condition being assessed, while taking a patient's history. The information must be recorded, dated, and maintained in the beneficiary's legal health record.

Ranges and thresholds do not meet criteria for this indicator. A distinct BMI percentile is required for numerator compliance. Documentation of >99 percent or <1 percent meets criteria because a distinct BMI percentile is evident (e.g., 100 percent or 0 percent).

Counseling for Nutrition

Documentation of counseling for nutrition or referral for nutrition education during the measurement year as identified by administrative data or medical record review.

Administrative Data

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

Medical Record Review

Documentation must include a note indicating the date and at least one of the following:

- Discussion of current nutrition behaviors (e.g., eating habits, dieting behaviors)
- Checklist indicating nutrition was addressed
- Counseling or referral for nutrition education
- Beneficiary received education materials on nutrition during a face-to-face visit
- Anticipatory guidance for nutrition
- Weight or obesity counseling

Counseling for Physical Activity

Documentation of counseling for physical activity or referral for physical activity during the measurement year as identified by administrative data or medical record review.

Administrative Data

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

Medical Record Review

Documentation must include a note indicating the date and at least one of the following:

- Discussion of current physical activity behaviors (e.g., exercise routine, participation in sports activities, exam for sports participation)
- Checklist indicating physical activity was addressed
- Counseling or referral for physical activity
- Beneficiary received educational materials on physical activity during a face-to-face visit
- Anticipatory guidance specific to the child’s physical activity
- Weight or obesity counseling

F. ADDITIONAL NOTES

- The following notations or examples of documentation do not count as numerator compliant:
  - BMI Percentile
    - No BMI percentile documented in medical record or plotted on age-growth chart
    - Notation of BMI value only
    - Notation of height and weight only
  - Nutrition
    - No counseling/education on nutrition and diet
    - Counseling/education before or after the measurement year
    - Notation of “health education” or “anticipatory guidance” without specific mention of nutrition
    - A physical exam finding or observation alone (e.g., well-nourished) is not compliant because it does not indicate counseling for nutrition
    - Documentation related to a beneficiary’s “appetite” does not meet criteria
  - Physical Activity
    - No counseling/education on physical activity
    - Notation of “cleared for gym class” alone without documentation of a discussion
    - Counseling/education before or after the measurement year
    - Notation of “health education” or “anticipatory guidance” without specific mention of physical activity
    - Notation of anticipatory guidance related solely to safety (e.g., wears helmet or water safety) without specific mention of physical activity recommendations
    - Notation solely related to screen time (computer or television) without specific mention of physical activity
- Services may be rendered during a visit other than a well-child visit. These services count if the specified documentation is present, regardless of the primary intent of the visit; however, services specific to the assessment or treatment of an acute or chronic condition do not count toward the Counseling for Nutrition and Counseling for Physical Activity indicators.

  For example, the following documentation is specific to the assessment or treatment of an acute or chronic condition and does not meet criteria:
  - Notation that a beneficiary with chronic knee pain is able to run without limping
  - Notation that a beneficiary has exercise-induced asthma
  - Notation that a beneficiary with diarrhea is following the BRAT diet
  - Notation that a beneficiary has decreased appetite as a result of an acute or chronic condition
- Services rendered for obesity or eating disorders may be used to meet criteria for the Counseling for Nutrition and Counseling for Physical Activity indicators if the specified documentation is present.
- Referral to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) may be used to meet criteria for the Counseling for Nutrition indicator.
- The BMI Percentile, Counseling for Nutrition, and Counseling for Physical Activity indicators do not require a specific setting. Therefore, services rendered during a telephone visit, e-visit, or virtual check-in meet criteria.

MEASURE WCV-CH: CHILD AND ADOLESCENT WELL-CARE VISITS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of children ages 3 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement year.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to beneficiaries ages 3 to 21. For the purpose of Child Core Set reporting, states should calculate and report rates for three age groups and a total rate: ages 3 to 11, 12 to 17, 18 to 21, and total (ages 3 to 21).
- This measure is calculated using administrative data only.
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix B for the definition of a PCP and OB/GYN and other prenatal care practitioner.

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

B. ELIGIBLE POPULATION

Age	Ages 3 to 21 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.
Event/diagnosis	None.

Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude beneficiaries who meet either of the following: • 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 Child 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 Child Core Set.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

One or more well-care visits (Well-Care Value Set) during the measurement year. Either of the following meet criteria:

- A well-care visit (Well Care Visit Value Set).
- An encounter for well-care (Encounter for Well Care Value Set). Do not include laboratory claims (claims with POS code 81).

The well-care visit must occur with a PCP or an OB/GYN, but the practitioner does not have to be the practitioner assigned to the child.

D. ADDITIONAL NOTES

This measure is based on the American Academy of Pediatrics Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents (published by the National Center for Education in Maternal and Child Health). Visit the Bright Futures website for more information about well-child visits (https://www.aap.org/en/practice-management/bright-futures/bright-futures-materials-and-tools/bright-futures-guidelines-and-pocket-guide/).

IV. CORE SET MEASURES REPORTED USING ELECTRONIC CLINICAL DATA SYSTEMS (ECDS)

This chapter presents the technical specifications for each measure in the Child 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 Child Core Set reporting, the CIS-CH and IMA-CH measures include ECDS specifications as well as administrative and hybrid specifications. The administrative and hybrid specifications for these measures 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 Child 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 ADD-CH: FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION

National Committee for Quality Assurance

Description	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. • *Initiation Phase.* The percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. • *Continuation and Maintenance (C&M) Phase.* The percentage of children ages 6 to 12 with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.
Core Set data collection method	Electronic Clinical Data Systems (ECDS)
Guidance for Core Set reporting	• Many of the ADHD medications are also used in the treatment of narcolepsy. In order to have a precise ADHD measure, children with narcolepsy are excluded from both indicators. • Include all paid, suspended, pending, and denied claims. • NCQA's Medication List Directory (MLD) for ADHD Medications 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). • If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, to avoid double counting, if there are both NDC codes and RxNorm codes on the same date of service, use only one data source for that date of service (use only NDC codes or only RxNorm codes) for reporting. • 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/cms136v13. 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.

Guidance for Core Set reporting (continued)	• Refer to Appendix B for the definition of a prescribing practitioner. • 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-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.	
Measure characteristics	**Scoring**	Proportion.
	Type	Process.
	Stratification	None.
	Risk adjustment	None.
	Improvement notation	A higher rate indicates better performance.
Definitions		
Intake period	March 1 of the year prior to the measurement period through the last calendar day of February of the measurement period.	
Negative medication history	A period of 120 days prior to the IPSD when the beneficiary had no ADHD medications dispensed for either new or refill prescriptions.	
IPSD	Index prescription start date. The earliest prescription dispensing date for an ADHD medication where the date is in the intake period and there is a negative medication history.	
Initiation phase	The 30 days following the IPSD.	
C&M phase	The 300 days following the IPSD.	
Continuous medication treatment	There must be ≥210 treatment days during the 301-day period, with allowed gaps in medication of up to a total of 91 days. Gaps may include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may not be more than 91 total gap days. Count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).	

Treatment days (covered days)	The actual number of calendar days covered by prescriptions during the 301-day period. Use the following steps to identify and calculate covered days. **Step 1:** Identify dispensing events where multiple prescriptions for the same medication are dispensed with overlapping days supply (i.e., dispensed on the same day or dispensed on different days with overlapping days supply). Sum the days supply for these dispensing events. Identify the start and end dates: The start date is the date of service of the earliest dispensing event, and the end date is the start date plus the summed days supply minus one. The start date through the end date are considered covered days. For example: • If there are three 7-days supply dispensing events for the same medication on January 1, the start date is January 1 and the end date is January 21. Covered days include January 1–21. • If there are two 7-days supply dispensing events for the same medication on January 1 and January 5, the start date is January 1 and the end date is January 14. Covered days include January 1–14. • If there are three 7-days supply dispensing events for the same medication on January 1, a 7-days supply dispensing event on January 20 and a 7-days supply dispensing event on January 28, the start date is January 1 and the end date is February 4. Covered days include January 1–February 4. **Note:** This step assumes that the beneficiary will take one prescription at a time (and start taking the next prescription after exhausting the previous prescription). **Step 2:** For all other dispensing events (multiple prescriptions for the same medication on different days without overlap; multiple prescriptions for different medications on the same or different days, with or without overlap), identify the start and end dates for each dispensing event individually. The start date through the end date are considered covered days. **Note:** This step assumes the beneficiary will take the different medications concurrently. **Step 3:** Count the covered days. Consider each calendar day covered by 1 or more medications to be 1 covered day.
Identifying same or different drugs	Dispensing events from different medication value sets are considered different drugs; dispensing events from the same medication value set are considered the same drug. Use all of the medication lists below to identify ADHD dispensing events: • Dexmethylphenidate Medications List. • Dextroamphetamine Medications List. • Lisdexamfetamine Medications List. • Methylphenidate Medications List. • Methamphetamine Medications List. • Clonidine Medications List. • Guanfacine Medications List. • Atomoxetine Medications List.

Initial population	*Measure Item Count:* Person **Initial Population 1- Initiation Phase** *Attribution*: Enrollment *Benefits:* Medical and pharmacy. *Continuous Enrollment – Initiation Phase*: 120 days prior to the IPSD through 30 days after the IPSD. *Allowable gap – Initiation Phase:* No gaps in enrollment between 120 days prior to the IPSD through 30 days after the IPSD. There is no requirement for the beneficiary to be enrolled on the last day of the measurement period. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the child 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). *Age:* Age 6 as of March 1 of the year prior to the measurement period to age 12 as of the last calendar day of February of the measurement period. Follow the steps below to identify initial population 1. **Step 1:** Identify all children in the specified age range who were dispensed an ADHD medication (ADHD Medications List) during the 12-month intake period. **Step 2:** For each child identified in step 1, identify the IPSD. **Step 3:** Calculate continuous enrollment. Children must be enrolled with the required benefits throughout Continuous Enrollment – Initiation Phase. **Step 4:** Remove children who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the initiation phase. Either of the following meets criteria: • An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set). • An acute inpatient admission with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set) on the discharge claim. To identify an acute inpatient admission: 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.

Initial population (continued)	**Initial Population 2 – C&M Phase** *Attribution*: Enrollment *Benefits:* Medical and pharmacy. *Continuous Enrollment – C&M Phase:* 120 days prior to the IPSD through 300 days after the IPSD. *Allowable gap – C&M Phase:* No more than one 45-day gap in enrollment is allowed between 31 days after the IPSD through 300 days after the IPSD. There is no requirement for the beneficiary to be enrolled on the last day of the measurement period. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the child 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). *Age – C&M Phase:* Age 6 as of March 1 of the year prior to the measurement period to age 12 as of the last calendar day of February of the measurement period. Follow the steps below to identify initial population 2 – C&M Phase. **Step 1:** Identify all children from initial population 1 – Initiation Phase. **Step 2:** Calculate continuous enrollment. Children must be enrolled with the required benefits throughout Continuous Enrollment – C&M Phase. **Step 3:** Calculate treatment days (covered days) to determine continuous medication treatment. Using the children in step 2, determine if the child was dispensed a sufficient number of prescriptions to provide continuous medication treatment beginning on the IPSD through 300 days after the IPSD. The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 91 days during the 301-day period. **Step 4:** Remove children who had an acute inpatient encounter for a mental, behavioral or neurodevelopmental disorder during the C&M phase. Either of the following meets criteria: • An acute inpatient encounter (Acute Inpatient Value Set) with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set). • An acute inpatient admission with a principal diagnosis of mental, behavioral or neurodevelopmental disorder (Mental, Behavioral and Neurodevelopmental Disorders Value Set) on the discharge claim. To identify an acute inpatient admission: 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.

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 with a diagnosis of narcolepsy (Narcolepsy 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).
Denominator	**Denominator 1 – Initiation Phase** The initial population 1, minus exclusions. **Denominator 2 – C&M Phase** The initial population 2, minus exclusions.
Numerator	**Numerator 1 – Initiation Phase** Children who had a follow-up visit with a practitioner with prescribing authority, within 30 days after the IPSD (do not include visits on the IPSD). Any of the following code combinations meet criteria for a visit; the visit must be with a provider with prescribing authority. • An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set). • An outpatient visit (BH Outpatient Value Set). • A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention 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). • A telehealth visit (Visit Setting Unspecified Value Set ***with*** Telehealth POS Value Set). • A telephone visit (Telephone Visits Value Set). **Numerator 2 – C&M Phase** Children who meet the following criteria: • Numerator compliant for Rate 1—Initiation Phase, ***and*** • At least two follow-up visits on different dates of service with any practitioner, from 31–300 days after the IPSD.

Numerator (continued)	Any of the following code combinations meet criteria for follow-up visits: • An outpatient visit (Visit Setting Unspecified Value Set ***with*** Outpatient POS Value Set). • An outpatient visit (BH Outpatient Value Set). • A health and behavior assessment or intervention (Health and Behavior Assessment or Intervention 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). • 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). Only one of the two visits (during the 31–300 days after the IPSD) may be an e-visit or virtual check-in (Online Assessments Value Set). Note: 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 required for the rate (e.g., within 30 days after or from 31–300 days after the IPSD).
Clinical recommendation statement	American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter for the Assessment and Treatment of Children and Adolescents with ADHD: • Recommendation 6: A Well-Thought-Out and Comprehensive Treatment Plan Should Be Developed for the Patient With ADHD. The treatment plan should be reviewed regularly and modified if the patient's symptoms do not respond. Minimal Standard [MS] • Recommendation 9: During a Psychopharmacological Intervention for ADHD, the Patient Should Be Monitored for Treatment-Emergent Side Effects. Minimal Standard [MS] • Recommendation 12: Patients Should Be Assessed Periodically to Determine Whether There Is Continued Need for Treatment or If Symptoms Have Remitted. Treatment of ADHD Should Continue as Long as Symptoms Remain Present and Cause Impairment. Minimal Standard [MS]

Clinical recommendation statement (continued)	American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation and Treatment of ADHD in Children and Adolescents: • Action Statement 4: The primary care clinician should recognize ADHD as a chronic condition and, therefore, consider children and adolescents with ADHD as children and youth with special health care needs. Management of children and youth with special health care needs should follow the principles of the chronic care model and the medical home (Grade B: Strong Recommendation).
Citations	American Academy of Child and Adolescent Psychiatry (AACAP). 2007. "Practice Parameter for the Assessment and Treatment of Children and Adolescents with ADHD." J. Am. Acad. Child Adolesc. Psychiatry 46(7): 894Y921. American Academy of Pediatrics. November 2011. "ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/ Hyperactivity Disorder in Children and Adolescents." Subcommittee on Attention-Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. Pediatrics 128 (5) 1007–22; DOI: 10.1542/peds.2011-2654

MEASURE APM-CH: METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS[1]

National Committee for Quality Assurance

Description	The percentage of children and adolescents ages 1 to 17 years who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: • The percentage of children and adolescents on antipsychotics who received blood glucose testing. • The percentage of children and adolescents on antipsychotics who received cholesterol testing. • The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.
Core Set data collection method	Electronic Clinical Data Systems (ECDS)
Guidance for Core Set reporting	• This measure applies to beneficiaries ages 1 to 17. For the purpose of Child Core Set reporting, states should calculate and report this measure for two age groups and a total rate: ages 1 to 11, ages 12 to 17, and total (ages 1 to 17). • 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-my2024-medication-list-directory.html). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). • If an organization uses both pharmacy data (NDC codes) and clinical data (RxNorm codes) for reporting, to avoid double counting, if there are both NDC codes and RxNorm codes on the same date of service, use only one data source for that date of service (use only NDC codes or only RxNorm codes) for reporting. • 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, CPT CAT II, HCPCS, 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.

[1] Developed with financial support from the Agency for Healthcare Research and Quality (AHRQ) and the Centers for Medicare & Medicaid Services (CMS) under the CHIPRA Pediatric Quality Measures Program Centers of Excellence grant number U18 HS020503.

Measure characteristics	**Scoring**	Proportion.
	Type	Process.
	Stratification	Core Set age stratifications for each indicator: Ages 1 to 11. Ages 12 to 17. Ages 1 to 17 (Total).
	Risk adjustment	None.
	Improvement notation	A higher rate indicates better performance.
Initial population	*Measure Item Count:* Person *Attribution*: Enrollment *Benefits:* Medical and pharmacy. *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. *Age*: Ages 1 to 17 as of December 31 of the measurement period. Beneficiaries ages 1 to 17 by the end of the measurement period with at least two antipsychotic medication dispensing events (APM Antipsychotic Medications List) of the same or different medications on different dates of service during 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.	
Denominator	The initial population, minus exclusions.	

Numerator	**Numerator 1 – Blood Glucose** Beneficiaries who received at least one test for blood glucose or HbA1c during the measurement period. Any of the following meet criteria: • 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). **Numerator 2 – Cholesterol** Beneficiaries who received at least one test for LDL-C or cholesterol during the measurement period. Any of the following meet criteria: • Cholesterol Lab Test Value Set. • Cholesterol Test Result or Finding Value Set. • LDL-C Lab Test Value Set. • LDL-C 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). **Numerator 3 – Blood Glucose and Cholesterol** Beneficiaries who met criteria for both the blood glucose and cholesterol indicators (numerator 1 and numerator 2).
Clinical recommendation statement	The American Academy of Child & Adolescent Psychiatry (AACAP) practice parameters endorse the American Psychiatric Association and American Diabetes Association recommendations for laboratory monitoring, including a fasting glucose and fasting lipid profile at baseline, 3 and 12 months (Findling, 2011). The Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children calls for more frequent monitoring in youth at baseline, 3, 6 and 12 months, and additional monitoring of fasting insulin (Pringsheim, 2011).
Citations	Findling, R.L., S.S. Drury, P.S. Jensen, J.L. Rapoport, O.G. Bukstein, H.J. Walter, S. Benson, et al. 2011. “Practice Parameter for the Use Of Atypical Antipsychotic Medications in Children and Adolescents.” *J Am Acad Child Adolesc Psychiatry*. Pringsheim, T., C. Panagiotopoulos, J. Davidson, J. Ho, and Canadian Alliance for Monitoring Effectiveness and Safety of Antipsychotics in Children (CAMESA) guideline group. 2011. “Evidence-Based Recommendations for Monitoring Safety of Second-Generation Antipsychotics in Children and Youth.” *Paediatrics & Child Health* 16, no. 9: 581–9.

MEASURE CIS-CH: CHILDHOOD IMMUNIZATION STATUS

National Committee for Quality Assurance

Description	Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
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	• States should report a separate rate for each vaccine, as well as three separate combination rates. • The 14-Day Rule specifies that the vaccinations (with the exception of MMR) must be given 14 days apart to avoid double counting events when calculating the numerator. This rule does not apply to the MMR vaccine. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines. • Claims or registry data may be used together or alone to obtain immunization records for the entire eligible population (all children who turned age 2 during the reporting year). • If immunization registry data are used to calculate this measure, select “Immunization Registry” as an Administrative data source in the Data Source section of the web- based reporting system. • States can select “Immunization Registry” in addition to other data sources used to calculate the measure. If use of immunization registry data varies by reporting unit, describe the data source used by each reporting unit in the “Additional Notes/Comments on Measures” section. • 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/cms117v12. 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, CVX, 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.
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 *Attribution:* Enrollment *Benefit*: Medical *Continuous enrollment:* 365 days prior to the child's second birthday through the child's second birthday. *Allowable gap*: No more than one gap in enrollment of up to 45 days during the 365 days prior to the beneficiary's second birthday. 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 continuously enrolled). The beneficiary must be enrolled on their second birthday. *Age*: Children who turn age 2 during 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 a contraindication to a childhood vaccine (Contraindications to Childhood Vaccines Value Set) on or before their second birthday. Do not include laboratory claims (claims with POS 81).
Denominator	The initial population, minus exclusions.

Numerator	**Numerator 1 – DTaP** Children with any of the following on or before their second birthday meet criteria: • At least four DTaP vaccinations (DTaP Immunization Value Set; DTaP Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • 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 2 – IPV** Children with either of the following on or before their second birthday meet criteria: • At least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Immunization Value Set; Inactivated Polio Vaccine (IPV) Procedure Value Set) with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the IPV vaccine (SNOMED CT code 471321000124106). **Numerator 3 – MMR** Children with any of the following meet criteria: • At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Immunization Value Set; Measles, Mumps and Rubella (MMR) Vaccine Procedure Value Set) on or between the child's first and second birthdays. • All of the following any time on or before the child's second birthday (on the same or different date of service). Do not include laboratory claims (claims with POS 81). - History of measles illness (Measles Value Set). - History of mumps illness (Mumps Value Set). - History of rubella illness (Rubella Value Set). • Anaphylaxis due to the MMR vaccine (SNOMED CT code 471331000124109) on or before the child's second birthday. **Numerator 4 – HiB** Children with either of the following on or before their second birthday meet criteria: • At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Immunization Value Set; Haemophilus Influenzae Type B (HiB) Vaccine Procedure Value Set), with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the HiB vaccine (SNOMED CT code 433621000124101).

Numerator (continued)	**Numerator 5 – Hepatitis B** Children with any of the following on or before their second birthday meet criteria: • At least three hepatitis B vaccinations (Hepatitis B Immunization Value Set; Hepatitis B Vaccine Procedure Value Set), with different dates of service. - One of the three vaccinations can be a newborn hepatitis B vaccination (Newborn Hepatitis B Vaccine Administered Value Set) during the 8 day period that begins on the date of birth and ends 7 days after the date of birth. For example, if the member's date of birth is December 1, the newborn hepatitis B vaccination must be on or between December 1 and December 8. • History of hepatitis B illness (Hepatitis B Value Set). Do not include laboratory claims (claims with POS 81). • Anaphylaxis due to the hepatitis B vaccine (SNOMED CT code 428321000124101). **Numerator 6 – VZV** Children with any of the following meet criteria: • At least one VZV vaccination (Varicella Zoster (VZV) Immunization Value Set; Varicella Zoster (VZV) Vaccine Procedure Value Set) with a date of service on or between the child's first and second birthdays. • History of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set) on or before the child's second birthday. Do not include laboratory claims (claims with POS 81). • Anaphylaxis due to the VZV vaccine (SNOMED CT code 471341000124104) on or before the child's second birthday. **Numerator 7 – Pneumococcal Conjugate** Children with either of the following on or before their second birthday meet criteria: • At least four pneumococcal conjugate vaccinations (Pneumococcal Conjugate Immunization Value Set; Pneumococcal Conjugate Vaccine Procedure Value Set) with different dates of service. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the pneumococcal vaccine (SNOMED CT code 471141000124102). **Numerator 8 – Hepatitis A** Children with any of the following meet criteria: • At least one hepatitis A vaccination (Hepatitis A Immunization Value Set; Hepatitis A Vaccine Procedure Value Set), with a date of service on or between the child's first and second birthdays. • History of hepatitis A illness (Hepatitis A Value Set) on or before the child's second birthday. Do not include laboratory claims (claims with POS 81). • Anaphylaxis due to the hepatitis A vaccine (SNOMED CT code 471311000124103) on or before the child's second birthday.

Numerator (continued)	**Numerator 9 – Rotavirus** Children with any of the following meet criteria: • At least two doses of the two-dose rotavirus vaccine (CVX code 119; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. • At least three doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set) on different dates of service on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. • At least one dose of the two-dose rotavirus vaccine (CVX code 119; Rotavirus Vaccine (2 Dose Schedule) Procedure Value Set) and at least two doses of the three-dose rotavirus vaccine (Rotavirus (3 Dose Schedule) Immunization Value Set; Rotavirus Vaccine (3 Dose Schedule) Procedure Value Set), all on different dates of service, on or before the child's second birthday. Do not count a vaccination administered prior to 42 days after birth. • Anaphylaxis due to the rotavirus vaccine (SNOMED CT code 428331000124103) on or before the child's second birthday. **Numerator 10 – Influenza** Children with any of the following on or before their second birthday meet criteria: • At least two influenza vaccinations (Influenza Immunization Value Set; Influenza Vaccine Procedure Value Set) with different dates of service. Do not count a vaccination administered prior to 180 days after birth. - An influenza vaccination recommended for children 2 years and older (e.g., LAIV) (Influenza Virus LAIV Immunization Value Set; Influenza Virus LAIV Vaccine Procedure Value Set) administered on the child's second birthday meets criteria for one of the two required vaccinations. • Anaphylaxis due to the influenza vaccine (SNOMED CT code 471361000124100). **Numerator 11 – Combination 3** Children who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV and pneumococcal indicators. **Numerator 12 – Combination 7** Children who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A and rotavirus indicators. **Numerator 13 – Combination 10** Children who are numerator compliant for DTaP, IPV, MMR, HiB, hepatitis B, VZV, pneumococcal, hepatitis A, rotavirus and influenza indicators.

Clinical recommendation statement	This measure looks for childhood vaccinations that should be completed by age 2, in accordance with the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) recommended child and adolescent immunization schedule (ACIP 2022).
Citations	Wodi, A.P., N. Murthy, H. Bernstein, V. McNally, S. Cineas, K. Ault. 2022. "Advisory Committee on Immunization Practices Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger—United States, 2022." *MMWR Morb Mortal Wkly Rep* 71:234–237. DOI: http://dx.doi.org/10.15585/mmwr.mm7107a2.

MEASURE IMA-CH: IMMUNIZATIONS FOR ADOLESCENTS[1]

National Committee for Quality Assurance

Description	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates.
Core Set data collection method	Electronic Clinical Data Systems (ECDS) This measure is also specified for Administrative or Hybrid, see Chapter III.
Guidance for Core Set reporting	• States may use claims or registry data together or alone to obtain immunization records for the entire eligible population (all adolescents who turned age 13 during the reporting year) and report using the administrative specification. • If immunization registry data are used to calculate this measure, select "Immunization Registry" as an Administrative data source in the Data Source section of the web-based reporting system. States can select "Immunization Registry" in addition to other data sources used to calculate the measure. If use of immunization registry data varies by reporting unit, describe the data source used by each reporting unit in the "Additional Notes/Comments on Measure" section. • The 14-Day Rule specifies that the vaccinations (with the exception of MMR) must be given 14 days apart to avoid double counting events when calculating the numerator. This rule does not apply to the MMR vaccine. More information on the 14-Day Rule can be found in the HEDIS Volume 2 General Guidelines. • To align with ACIP recommendations, only the quadrivalent meningococcal vaccine (serogroups A, C, W and Y) is included in the measure. • To align with ACIP recommendations, the minimum interval for the two-dose HPV vaccination schedule is 150 days, with a 4-day grace period (146 days). • 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.

[1] Adapted with financial support from the Centers for Disease Control & Prevention (CDC).

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 *Attribution*: Enrollment *Benefit*: Medical *Continuous enrollment*: 365 days prior to their 13th birthday. *Allowable gap*: No more than one gap in enrollment of up to 45 days during the 365 days prior to the beneficiary's 13th birthday. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member 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 continuously enrolled). The beneficiary must be enrolled on their 13th birthday *Age*: Adolescents who turn age 13 during 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.	
Denominator	The initial population, minus exclusions.	
Numerator	**Numerator 1 – Meningococcal Serogroups A, C, W, Y** Adolescents with either of the following meet criteria: • At least one meningococcal serogroups A, C, W, Y vaccine (Meningococcal Immunization Value Set; Meningococcal Vaccine Procedure Value Set) with a date of service on or between the adolescent's 11th and 13th birthdays. • Anaphylaxis due to the meningococcal vaccine (SNOMED CT code 428301000124106) any time on or before the child's 13th birthday.	

Numerator (continued)	**Numerator 2 – Tdap** Adolescents with any of the following meet criteria: • At least one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine (CVX code 115; Tdap Vaccine Procedure Value Set) with a date of service on or between the adolescent's 10th and 13th birthdays. • Anaphylaxis due to the tetanus, diphtheria or pertussis vaccine (Anaphylaxis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the child's 13th birthday. • Encephalitis due to the tetanus, diphtheria or pertussis vaccine (Encephalitis Due to Diphtheria, Tetanus or Pertussis Vaccine Value Set) any time on or before the child's 13th birthday. **Numerator 3 – HPV** Adolescents with any of the following meet criteria: • At least two HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set) on or between the child's 9th and 13th birthdays and with dates of service at least 146 days apart. For example, if the service date for the first vaccine was March 1, then the service date for the second vaccine must be on or after July 25. • At least three HPV vaccines (HPV Immunization Value Set; HPV Vaccine Procedure Value Set) with different dates of service on or between the adolescent's 9th and 13th birthdays. • Anaphylaxis due to the HPV vaccine (SNOMED CT code 428241000124101) any time on or before the child's 13th birthday. **Numerator 4 – Combination 1: Meningococcal, Tdap** Adolescents who are numerator compliant for both the meningococcal and Tdap indicators. **Numerator 5 – Combination 2: Meningococcal, Tdap, HPV** Adolescents who are numerator compliant for all three indicators (meningococcal, Tdap, HPV).
Clinical recommendation statement	*HPV*: The Advisory Committee on Immunization Practices (ACIP) recommends routine HPV vaccination for adolescents at age 11 or 12 years; vaccination may be given starting at age 9 years. In a two-dose schedule of HPV vaccine, the minimum interval between the first and second doses is 5 months. Persons who initiated vaccination with 9vHPV, 4vHPV or 2vHPV before their 15th birthday and received 2 doses of any HPV vaccine at the recommended dosing schedule (0, 6–12 months), or received three doses of any HPV vaccine at the recommended dosing schedule (0, 1–2, 6 months), are considered adequately vaccinated (Meites, Kempe, and Markowitz 2016). *Tdap*: ACIP recommends a single dose of vaccine be administered at age 11 or 12 years (Liang et al. 2018). *Meningococcal*: ACIP recommends routine vaccination with a quadrivalent meningococcal conjugate vaccine (MenACWY) for adolescents aged 11 or 12 years, with a booster dose at age 16 years (Mbaeyi et al. 2020).

Citations	Liang, J.L., T. Tiwari, P. Moro, N.E. Messonnier, A. Reingold, M. Sawyer, T.A. Clark. 2018. "Prevention of Pertussis, Tetanus, and Diphtheria with Vaccines in the United States: Recommendations of the Advisory Committee on Immunization Practices (ACIP)." *MMWR Morb Mortal Wkly Rep* 67(2):1–44. DOI: 10.15585/mmwr.rr6702a1. Mbaeyi, S.A., C.H. Bozio, J. Duffy, et al. 2020. "Meningococcal Vaccination: Recommendations of the Advisory Committee on Immunization Practices, United States, 2020." *MMWR Recomm Rep* 69(No. RR-9):1–41. DOI: http://dx.doi.org/10.15585/mmwr.rr6909a1 Meites, E., A. Kempe, L.E. Markowitz. 2016. "Use of a 2-Dose Schedule for Human Papillomavirus Vaccination—Updated Recommendations of the Advisory Committee on Immunization Practices." *MMWR Morb Mortal Wkly Rep* 65:1405-08. DOI: 10.15585/mmwr.mm6549a5.

MEASURE PDS-CH: POSTPARTUM DEPRESSION SCREENING AND FOLLOW-UP: UNDER AGE 21[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 Child Core Set reporting, states should calculate and report this measure for beneficiaries under age 21 as of the delivery date. The Adult Core Set measure is reported for beneficiaries age 21 and older 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.

[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.

<table>
<tr><td>Guidance for Core Set Reporting (continued)</td><td>

This measure requires the use of an age-appropriate screening instrument. The beneficiary's age is used to select the appropriate depression screening instrument.
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.

</td></tr>
<tr><td>Coding systems referenced</td><td>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.</td></tr>
<tr><td>Measure characteristics</td><td>
Scoring Proportion.
Type Process.
Stratification None.
Risk adjustment None.
Improvement notation A higher rate indicates better performance.
</td></tr>
<tr><td colspan="2">Definitions</td></tr>
<tr><td>Depression screening instrument</td><td>A standard assessment instrument that has been normalized and validated for the appropriate patient population. Eligible screening instruments with thresholds for positive findings include:
<table>
<tr><th>Instruments for Adolescents (≤17 years)</th><th>Total Score LOINC Codes</th><th>Positive Finding</th></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>44261-6</td><td>Total score ≥10</td></tr>
<tr><td>Patient Health Questionnaire Modified for Teens (PHQ-9M)®</td><td>89204-2</td><td>Total score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>55758-7</td><td>Total score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS) ®[1,2]</td><td>89208-3</td><td>Total score ≥8</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td><td>89205-9</td><td>Total score ≥17</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td rowspan="15">Depression screening instrument (continued)</td><td>Instruments for Adolescents (≤17 years)</td><td>Total Score LOINC Codes</td><td>Positive Finding</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>99046-5</td><td>Total score ≥10</td></tr>
<tr><td>PROMIS Depression</td><td>71965-8</td><td>Total score (T Score) ≥60</td></tr>
<tr><td>Instruments for Adults (18+ years)</td><td>Total Score (LOINC Codes)</td><td>Positive Finding</td></tr>
<tr><td>Patient Health Questionnaire (PHQ-9)®</td><td>44261-6</td><td>Total score ≥10</td></tr>
<tr><td>Patient Health Questionnaire-2 (PHQ-2)®[1]</td><td>55758-7</td><td>Total score ≥3</td></tr>
<tr><td>Beck Depression Inventory-Fast Screen (BDI-FS) ®[1,2]</td><td>89208-3</td><td>Total score ≥8</td></tr>
<tr><td>Beck Depression Inventory (BDI-II)</td><td>89209-1</td><td>Total score ≥20</td></tr>
<tr><td>Center for Epidemiologic Studies Depression Scale—Revised (CESD-R)</td><td>89205-9</td><td>Total score ≥17</td></tr>
<tr><td>Duke Anxiety-Depression Scale (DUKE-AD)®[2]</td><td>90853-3</td><td>Total score ≥30</td></tr>
<tr><td>Edinburgh Postnatal Depression Scale (EPDS)</td><td>99046-5</td><td>Total score ≥10</td></tr>
<tr><td>My Mood Monitor (M-3)®</td><td>71777-7</td><td>Total score ≥5</td></tr>
<tr><td>PROMIS Depression</td><td>71965-8</td><td>Total score (T Score) ≥60</td></tr>
<tr><td>Clinically Useful Depression Outcome Scale (CUDOS)</td><td>90221-3</td><td>Total score ≥31</td></tr>
<tr><td colspan="3">[1] Brief screening instrument. All other instruments are full-length.
[2] Proprietary; may be cost or licensing requirement associated with use.</td></tr>
<tr><td>Initial population</td><td colspan="3">Measure Item Count: Event
Attribution: Enrollment
Benefit: Medical
Continuous enrollment: The delivery date through 60 days after delivery.
Allowable gap: No gaps in enrollment from the delivery date through 60 days following the delivery date.
Age: Under age 21 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.</td></tr>
</table>

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 meet Numerator 2 criteria: • 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-CH: PRENATAL IMMUNIZATION STATUS: UNDER AGE 21[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 Child Core Set reporting, states should calculate and report this measure for beneficiaries under age 21 as of the delivery date. The Adult Core Set measure is reported for beneficiaries age 21 and older 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.

[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	**Scoring**	Proportion.
	Type	Process.
	Stratification	None.
	Risk adjustment	None.
	Improvement notation	A higher rate indicates better performance.
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 the delivery date through the delivery date. Allowable gap: No gaps in enrollment throughout the 28 days prior to the delivery date through the delivery date. *Age:* Under age 21 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

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
77%	296

If the Current Year's Administrative Rate or the Prior Year's Reported Rate Is…	…the Minimum Sample Size Is:
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: Definitions of Medicaid and CHIP Core Set Practitioner Types

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 • 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)

Practitioner Type	Definition
Mental Health Provider (continued)	- 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, or physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)
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

Practitioner Type	Definition
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 an 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 C:
CAHPS® Health Plan Survey 5.1H
Child Questionnaire
(with CCC Supplemental Items)

CAHPS® Health Plan Survey 5.1H Child Questionnaire (With CCC Supplemental Items)

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 your child receives. 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}.

Please answer the questions for the child listed on the envelope. Please do not answer for any other children.

1. **Our records show that your child is now in {INSERT STATE MEDICAID PROGRAM NAME}. Is that right?**

   1☐ Yes → **If Yes, Go to Question 3**

   2☐ No

2. **What is the name of your child's health plan? (please print)**

   _____

YOUR CHILD'S HEALTH CARE IN THE LAST 6 MONTHS

These questions ask about your child's health care from a clinic, emergency room, or doctor's office. This includes care your child got in person, by phone, or by video. Do <u>not</u> include care your child got when he or she stayed overnight in a hospital. Do <u>not</u> include the times your child went for dental care visits.

3. **In the last 6 months, did your child 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 your child <u>needed care right away</u>, how often did your child get care as soon as he or she 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> for your child?**

   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 check-up or routine care for your child as soon as your child needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

7. In the last 6 months, not counting the times your child went to an emergency room, how many times did he or she get health care in person, by phone, or by video?

0☐ None → **If None, Go to Question 11**
1☐ 1 time
2☐ 2
3☐ 3
4☐ 4
5☐ 5 to 9
6☐ 10 or more times

8. In the last 6 months, how often did you have your questions answered by your child's doctor or other health providers?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

9. 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 child's 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

10. In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?

1☐ Never
2☐ Sometimes
3☐ Usually
4☐ Always

11. Is your child now enrolled in any kind of school or daycare?

1☐ Yes
2☐ No → **If No, Go to Question 14**

12. In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?

1☐ Yes

2☐ No → **If No, Go to Question 14**

13. In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?

1☐ Yes

2☐ No

SPECIALIZED SERVICES

14. Special medical equipment or devices include a walker, wheelchair, nebulizer, feeding tubes, or oxygen equipment. In the last 6 months, did you get or try to get any special medical equipment or devices for your child?

1☐ Yes

2☐ No → **If No, Go to Question 17**

15. In the last 6 months, how often was it easy to get special medical equipment or devices for your child?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

16. Did anyone from your child's health plan, doctor's office, or clinic help you get special medical equipment or devices for your child?

1☐ Yes

2☐ No

17. In the last 6 months, did you get or try to get special therapy such as physical, occupational, or speech therapy for your child?

1☐ Yes

2☐ No → **If No, Go to Question 20**

18. In the last 6 months, how often was it easy to get this therapy for your child?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

19. Did anyone from your child's health plan, doctor's office, or clinic help you get this therapy for your child?

1☐ Yes

2☐ No

20. In the last 6 months, did you get or try to get treatment or counseling for your child for an emotional, developmental, or behavioral problem?

1☐ Yes

2☐ No → **If No, Go to Question 23**

21. In the last 6 months, how often was it easy to get this treatment or counseling for your child?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

22. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child?

1☐ Yes

2☐ No

23. In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?

1☐ Yes

2☐ No → **If No, Go to Question 25**

24. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?

1☐ Yes

2☐ No

YOUR CHILD'S PERSONAL DOCTOR

25. A personal doctor is the one your child would talk to if he or she needs a checkup, has a health problem or gets sick or hurt. Does your child have a personal doctor?

1☐ Yes

2☐ No → **If No, Go to Question 40**

26. In the last 6 months, how many times did your child have an in person, phone, or video visit with his or her personal doctor?

0☐ None → **If None, Go to Question 36**

1☐ 1 time

2☐ 2

3☐ 3

4☐ 4

5☐ 5 to 9

6☐ 10 or more times

27. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

28. In the last 6 months, how often did your child's personal doctor listen carefully to you?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

29. In the last 6 months, how often did your child's personal doctor show respect for what you had to say?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

30. Is <u>your child</u> able to talk with doctors about his or her health care?

1☐ Yes

2☐ No → **If No, Go to Question 32**

31. In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for <u>your child</u> to understand?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

32. In the last 6 months, how often did your child's personal doctor spend enough time with your child?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

33. In the last 6 months, did your child's personal doctor talk with you about how your child is feeling, growing, or behaving?

1☐ Yes

2☐ No

34. In the last 6 months, did your child get care from a doctor or other health provider besides his or her personal doctor?

1☐ Yes

2☐ No → **If No, Go to Question 36**

35. In the last 6 months, how often did your child's personal doctor seem informed and up-to-date about the care your child got from these doctors or other health providers?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

36. 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 child's 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

37. Does your child have any medical, behavioral, or other health conditions that have lasted for more than <u>3 months</u>?

1☐ Yes

2☐ No → **If No, Go to Question 40**

38. Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?

1☐ Yes

2☐ No

39. Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your <u>family's</u> day-to-day life?

1☐ Yes

2☐ No

GETTING HEALTH CARE FROM SPECIALISTS

When you answer the next questions, include the care your child got in person, by phone, or by video. Do not include dental visits or care your child got when he or she stayed overnight in a hospital.

40. 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 for your child with a specialist?

1☐ Yes

2☐ No → **If No, Go to Question 44**

41. In the last 6 months, how often did you get appointments for your child with a specialist as soon as he or she needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

42. How many specialists has your child talked to in the last 6 months?

0☐ None → **If None, Go to Question 44**

1☐ 1 specialist

2☐ 2

3☐ 3

4☐ 4

5☐ 5 or more specialists

43. We want to know your rating of the specialist your child 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 CHILD'S HEALTH PLAN

The next questions ask about your experience with your child's health plan.

44. In the last 6 months, did you get information or help from customer service at your child's health plan?

1☐ Yes

2☐ No → **If No, Go to Question 47**

45. In the last 6 months, how often did customer service at your child's health plan give you the information or help you needed?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

46. In the last 6 months, how often did customer service staff at your child's health plan treat you with courtesy and respect?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

47. In the last 6 months, did your child's health plan give you any forms to fill out?

1☐ Yes

2☐ No → **If No, Go to Question 49**

48. In the last 6 months, how often were the forms from your child's health plan easy to fill out?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

49. 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 child's 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

PRESCRIPTION MEDICINES

50. In the last 6 months, did you get or refill any prescription medicines for your child?

1☐ Yes

2☐ No → **If No, Go to Question 53**

51. In the last 6 months, how often was it easy to get prescription medicines for your child through his or her health plan?

1☐ Never

2☐ Sometimes

3☐ Usually

4☐ Always

52. Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?

1☐ Yes

2☐ No

ABOUT YOUR CHILD AND YOU

53. In general, how would you rate your child's overall health?

1☐ Excellent

2☐ Very Good

3☐ Good

4☐ Fair

5☐ Poor

54. In general, how would you rate your child's overall <u>mental or emotional</u> health?

1☐ Excellent

2☐ Very Good

3☐ Good

4☐ Fair

5☐ Poor

55. Does your child currently need or use medicine prescribed by a doctor (other than vitamins)?

1☐ Yes

2☐ No → **If No, Go to Question 58**

56. Is this because of any medical, behavioral, or other health condition?

1☐ Yes

2☐ No → **If No, Go to Question 58**

57. Is this a condition that has lasted or is expected to last for at least 12 months?

1☐ Yes

2☐ No

58. Does your child need or use more medical care, more mental health services, or more educational services than is usual for most children of the same age?

1☐ Yes

2☐ No → **If No, Go to Question 61**

59. Is this because of any medical, behavioral, or other health condition?

1☐ Yes

2☐ No → **If No, Go to Question 61**

60. Is this a condition that has lasted or is expected to last for at least 12 months?

1☐ Yes

2☐ No

61. Is your child limited or prevented in any way in his or her ability to do the things most children of the same age can do?

1☐ Yes

2☐ No → **If No, Go to Question 64**

62. Is this because of any medical, behavioral, or other health condition?

1☐ Yes

2☐ No → **If No, Go to Question 64**

63. Is this a condition that has lasted or is expected to last for at least 12 months?

1☐ Yes

2☐ No

64. Does your child need or get special therapy such as physical, occupational, or speech therapy?

1☐ Yes

2☐ No → **If No, Go to Question 67**

65. Is this because of any medical, behavioral, or other health condition?

1☐ Yes

2☐ No → **If No, Go to Question 67**

66. Is this a condition that has lasted or is expected to last for at least 12 months?

1☐ Yes

2☐ No

67. Does your child have any kind of emotional, developmental, or behavioral problem for which he or she needs or gets treatment or counseling?

1☐ Yes

2☐ No → **If No, Go to Question 69**

68. Has this problem lasted or is it expected to last for at least 12 months?

1☐ Yes

2☐ No

69. What is <u>your child's</u> age?

00☐ Less than 1 year old

_____ YEARS OLD *(write in)*

70. Is your child male or female?

1☐ Male

2☐ Female

71. Is your child of Hispanic or Latino origin or descent?

1☐ Yes, Hispanic or Latino

2☐ No, not Hispanic or Latino

72. What is your child's 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

73. What is <u>your</u> age?

0☐ Under 18

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

74. Are you male or female?

1☐ Male

2☐ Female

75. 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

76. How are you related to the child?

1☐ Mother or father

2☐ Grandparent

3☐ Aunt or uncle

4☐ Older brother or sister

5☐ Other relative

6☐ Legal guardian

7☐ Someone else

THANK YOU

Please return the completed survey in the postage-paid envelope.

Appendix D: Guidance for Conducting the Child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H

Assessing patient experiences with health care is an important dimension of the quality of care. The Child 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 Child Core Set reporting, contracting with a survey vendor, generating a sample frame, identifying the supplemental sample of children with chronic conditions, drawing the sample, and conducting the survey using standard protocols.

A. Version of CAHPS for 2025 Child 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 Child Core Set is the CAHPS Health Plan Survey 5.1H, Child Version Including Medicaid and Children With Chronic Conditions (CCC) Supplemental Items.[2] Appendix C contains the survey instrument for the Child Questionnaire with CCC Supplemental Items.

States will produce two separate sets of results: one for the general child population and one for the population of children with chronic conditions. For each population, results include the same ratings, composites, and individual question summary rates included in the core Child Questionnaire. In addition, five CCC-specific results are calculated for the CCC population: (1) Access to Specialized Services, (2) Family-Centered Care: Personal Doctor Who Knows Child, (3) Coordination of Care for Children With Chronic Conditions, (4) Access to Prescription Medicines, and (5) Family-Centered Care: Getting Needed Information.

B. Contracting with a Survey Vendor

To adhere to CAHPS 5.1H measure specifications, states must 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 D-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.

Table D-1. Eligible Population for Child CAHPS 5.1H

Age	Age 17 and younger as of December 31 of the measurement year.

[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.

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 exclusions)	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 a state collects CAHPS data for both its Medicaid and CHIP programs, states must generate a separate sample frame for children in separate CHIP to meet CHIPRA requirements. Children in the Title XXI-funded Medicaid Expansion CHIP may be included in the Medicaid sample.[3]
- 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 children 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 children covered by the entire program. A state may generate one statewide sample frame that includes children in all delivery systems or separate sample frames for each delivery system. The sample frame(s) should represent all children that meet the eligibility criteria specified in Table D-1.

D. Identifying the Supplemental Sample of Children with Chronic Conditions

To identify the supplemental sample of children with chronic conditions, states use transaction data or other administrative databases to assign a prescreen status code to each child

[3] CHIP requirements for CAHPS: Section 2108(e) of the Social Security Act (the Act), as implemented through CHIPRA section 402, requires Title XXI programs to submit to CMS "data regarding access to primary and specialty services, access to networks of care, and care coordination provided under the State child health plan, using quality of care and consumer satisfaction measures included in the CAHPS survey." CHIPRA requires States to submit data that are representative of all children covered by their entire Title XXI program (CHIP Medicaid Expansion, Separate CHIP Program, or Combination CHIP Program). If a state chooses to collect CAHPS data for children in both Medicaid and CHIP, the state must separately sample and submit data for children enrolled in its separate CHIP program to fulfill the CHIPRA requirement. Children in the Title XXI-funded Medicaid Expansion CHIP may be included in the Medicaid sample.

beneficiary in the CAHPS child survey sample frame data file. The prescreen status code identifies children who are more likely to have a chronic condition.

States search claims and encounters for the measurement year and the year prior to the measurement year and assign codes as follows:

1 = No claims or encounters during the measurement year or the year prior to the measurement year that meet the criteria listed for prescreen status code 2.

2 = The child has claims or encounters during the measurement year or the year prior to the measurement year that indicate the child is likely to have a chronic condition. To identify a sample of children with chronic conditions, refer to the CCC-CH value sets in the 2025 Child Core Set HEDIS Value Set Directory. Any of the following meet criteria.

- At least one outpatient visit (Outpatient Value Set), telephone visit (Telephone Visits Value Set), e-visit or virtual check-in (Online Assessments Value Set), nonacute inpatient encounter (Nonacute Inpatient Value Set), acute inpatient encounter (Acute Inpatient Value Set; Newborn/Pediatric Acute Inpatient Value Set) or emergency department visit (ED Value Set) during the measurement year or the year prior to the measurement year ***with*** a diagnosis code from the Chronic Conditions Value Set. The diagnosis does not have to be the principal diagnosis.
- At least one acute or nonacute inpatient discharge during the measurement year or the year prior to the measurement year ***with*** a diagnosis code from the Chronic Conditions Value Set. The diagnosis does not have to be the principal diagnosis. 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.
- At least one psychiatry visit (Psychiatry Value Set) ***with*** a diagnosis code from the Chronic Conditions Value Set ***and*** an acute or nonacute inpatient, ED, outpatient, telehealth, partial hospitalization or community mental health center place of service code (POS Combination 1 Value Set).
- At least two outpatient visits (Outpatient Value Set), telephone visits (Telephone Visits Value Set) or e-visits or virtual check-ins (Online Assessments Value Set) on different dates of service during the measurement year or the year prior to the measurement year ***with*** a diagnosis code from any of the value sets listed below. The two visits must have diagnosis codes from the same value set (for example, one visit with a code from the Conduct Disorder Value Set and another visit with a code from the Asthma Value Set does not qualify). The diagnosis does not have to be the principal diagnosis. The visit codes need not be from the same value set (for example, one visit with a code from the Outpatient Value Set and another visit with a code from the Telephone Visits Value Set qualifies).
  - Conduct Disorder Value Set.
  - Emotional Disturbance Value Set.
  - Hyperkinetic Syndrome Value Set.
  - Asthma Value Set.
  - Failure To Thrive Value Set.
- At least two psychiatry visits (Psychiatry Value Set) on different dates of service during the measurement year or the year prior to the measurement year ***with*** an outpatient, telehealth,

partial hospitalization or community mental health center place of service code (POS Combination 2 Value Set) ***and*** a diagnosis code from any of the value sets listed below. The two visits must have diagnosis codes from the same value set (for example, one visit with a code from the Conduct Disorder Value Set and another visit with a code from the Asthma Value Set does not qualify). The diagnosis does not have to be the principal diagnosis.

- Conduct Disorder Value Set.
- Emotional Disturbance Value Set.
- Hyperkinetic Syndrome Value Set.
- Asthma Value Set.
- Failure To Thrive Value Set.

- At least one acute inpatient encounter (Acute Inpatient Value Set; Newborn/Pediatric Acute Inpatient Value Set), nonacute inpatient encounter (Nonacute Inpatient Value Set) or emergency department visit (ED Value Set) during the measurement year or the year prior to the measurement year with a diagnosis code from any of the value sets listed below. The diagnosis does not have to be the principal diagnosis.
  - Conduct Disorder Value Set.
  - Emotional Disturbance Value Set.
  - Hyperkinetic Syndrome Value Set.
  - Asthma Value Set.
  - Failure To Thrive Value Set.
- At least one acute or nonacute inpatient discharge during the measurement year or the year prior to the measurement year ***with*** a diagnosis code from any of the following value sets: Conduct Disorder Value Set; Emotional Disturbance Value Set; Hyperkinetic Syndrome Value Set; Asthma Value Set; Failure To Thrive Value Set. The diagnosis does not have to be the principal diagnosis. 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.
- At least one psychiatry visit (Psychiatry Value Set) with a diagnosis code (the diagnosis does not have to be the principal diagnosis) and an acute inpatient, nonacute inpatient or ED place of service code from the lists below.

Diagnosis Code Value Sets	Place of Service Code Value Sets
• Conduct Disorder Value Set • Emotional Disturbance Value Set • Hyperkinetic Syndrome Value Set • Asthma Value Set • Failure To Thrive Value Set	• POS Combination 3 Value Set

E. 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 1,650 children from the general child population and then draws the CCC

supplemental sample. The survey vendor selects 1,840 children for the CCC supplemental sample from the set of beneficiaries with a prescreen status code of 2 who were not already selected for the general child population sample. The survey vendor combines the general child population sample (n=1,650) and the CCC supplemental sample (n=1,840) for survey administration and submission of survey results.

Deduplication

To reduce respondent burden, the survey vendor should deduplicate samples so that only one child 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 children from eligibility files, or if it does not expect to achieve a denominator of 100 for most survey calculations. The required sample sizes are 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 general child population sample by 5 percent, the final sample size would be 1,733. If the vendor increases the general child population sample by 20 percent, the final sample size would be 1,980. 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.”

F. 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 D-2 and D-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 the 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. Either a parent or caretaker who is familiar with the child's health care may complete the child survey.

The vendor is expected to maintain the confidentiality of sampled children. The health plan does not have access to the names of children selected for the survey.

Table D-2. Mail-Only Methodology

Survey Vendor Tasks	Time Frame
Send first questionnaire and cover letter to the surveyed child's family.	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 D-3. Mixed Methodology

Survey Vendor Tasks	Time Frame
Send first questionnaire and cover letter to the surveyed child's family.	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.

G. 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.