Core Set of Health Care Quality Measures for 1945 Medicaid Health Home Programs (1945 Health Home Core Set)

Technical Specifications and Resource Manual for
2026 Core Set Reporting

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Center for Medicaid and CHIP Services
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I. THE CORE SET OF HEALTH CARE QUALITY MEASURES FOR 1945 MEDICAID HEALTH HOME PROGRAMS

Background

Section 1945 of the Social Security Act allows states to elect a health homes service option to provide comprehensive care coordination for individuals with chronic conditions under the Medicaid state plan and to receive additional federal support for the first eight quarters of implementation to support the roll out of this new care model. States are responsible for designating qualified health home providers to coordinate primary, acute, behavioral health (mental health and substance use services), and long-term services and supports for Medicaid-eligible individuals with chronic illness. Overall, it provides an opportunity for states to build a person-centered care delivery model that focuses on improving outcomes and disease management for enrollees with chronic conditions and obtaining better value for state Medicaid programs.

For more information, refer to the following links:

Health Home Information Resource Center

https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html

Health Home Quality Reporting

https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html

Frequently Asked Questions about Health Homes

https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/health-homes-faq-12-18-17.pdf

Identifying the 1945 Health Home Core Set

To support ongoing assessment and monitoring of the health home model, the Centers for Medicare & Medicaid Services (CMS) established a Core Set of health care quality measures. These recommended health home quality measures are an integral part of a larger payment and care delivery reform effort that focuses on quality outcomes for Medicaid beneficiaries. This effort is aligned closely with the Department of Health and Human Services' (HHS) National Strategy for Quality Improvement in Health Care, as well as other quality initiatives.

CMS consulted with states considering health home programs and conducted technical assistance calls, presentations, and webinars in order to identify the Core Set of Health Home quality measures for Medicaid-eligible children and adults. CMS also worked with federal partners, including the Office of the Assistant Secretary for Planning and Evaluation and the Substance Abuse and Mental Health Services Administration. The recommended Core Set of Health Home measures were chosen because they reflect key priority areas such as behavioral health and preventive care, and they align with the Core Set of health care quality measures for adults enrolled in Medicaid and the National Quality Strategy.

The 2026 1945 Health Home Core Set includes 9 Core Measures and 2 Utilization Measures. No measures were added to the 2026 1945 Health Home Core Set.

How the 1945 Health Home Core Set Is Used

The 2026 1945 Health Home Core Set is used to evaluate the health homes model. The 1945 Health Home Core Set is used to assess quality outcomes and performance, as well as to inform ongoing quality monitoring of the health home program. Health home providers are expected to report to the state Medicaid program, which reports the data in aggregate to CMS at the health home program level. States are expected to report the 1945 Health Home Core Set measures when their state plan amendment (SPA) has been in effect for six or more months of the measurement period. For SPA amendments, states are expected to include data affected by the amendment combined with data from the original SPA when the amendment is in effect for six or more months of the measurement period. More information on the states expected to report for 2026 is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/1945-health-home-reporting-table.pdf.

As part of Section 50102 of the Bipartisan Budget Act of 2018, mandatory reporting of the Health Home Core Set measures began with 2024 Core Set reporting. Mandatory reporting of the 1945 Health Home Core Set further advances CMS's efforts to ensure a standardized system for quality measurement with the goal of improving the quality of care for health home enrollees.[1]

1945 Health Home Core Set Measures

Table 1 lists the 2026 1945 Health Home Core Set measures, 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), electronic health record (EHR, also referred to as the electronic specification method) and Electronic Clinical Data Systems (ECDS). The technical specifications in Chapters III, IV, and V of this manual provide additional details for each measure.

More information on the 1945 Health Home Core Set is available on Medicaid.gov at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html.

Table 1. 2026 1945 Health Home Core Set

CMIT#*	Measure Steward[a]	Measure Name	Data Collection Method(s)
Core Measures			
394	NCQA	Initiation and Engagement of Substance Use Disorder Treatment (IET-HH)	Administrative or EHR
167	NCQA	Controlling High Blood Pressure (CBP-HH)	Administrative, hybrid, or EHR
139	NCQA	Colorectal Cancer Screening (COL-HH)	ECDS or EHR
672	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	Administrative or EHR

[1] Legislation making reporting of the 1945 Health Home Core Set measures mandatory: Bipartisan Budget Act of 2018 available at https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.xml.

CMIT#*	Measure Steward[a]	Measure Name	Data Collection Method(s)
268	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Administrative
561	NCQA	Plan All-Cause Readmissions (PCR-HH)	Administrative
750	SAMHSA	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)	Administrative
264	NCQA	Follow-Up After Emergency Department Visit for Substance Use (FUA-HH)	Administrative
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Age 6 and Older (FUM-HH)	Administrative
Utilization Measures			
20	CMS	Admission to a Facility from the Community (AIF-HH)	Administrative
397	CMS	Inpatient Utilization (IU-HH)	Administrative

CMIT = CMS Measure Inventory Tool; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; NCQA = National Committee for Quality Assurance; SAMHSA = Substance Abuse and Mental Health Services Administration

* 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.

[a] 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.

II. DATA COLLECTION AND REPORTING OF THE 1945 HEALTH HOME CORE SET

Mandatory reporting of the 2026 1945 Health Home Core Set requires that states adhere to reporting guidance issued by CMS.[1] Adherence to the reporting guidance is essential to provide effective comparisons across programs on standardized quality measure performance and to derive national performance rates for the care provided to Medicaid health home enrollees.

To support consistency in reporting the 1945 Health Home Core Set measures, this chapter provides general guidelines for data collection, preparation, and reporting. The technical specifications are presented in Chapters III, IV, and V 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 I for a list of 2026 1945 Health Home 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 2025. The 2026 1945 Health Home Core Set generally covers services provided during calendar year 2025. For Healthcare Effectiveness Data and Information Set (HEDIS)[2] measures, this manual follows HEDIS measurement year (MY) 2025 specifications. For non-HEDIS measures, the manual includes the most applicable version of the specifications available from the measure steward for reporting 2025 data.
- **Value sets.** Many of the 1945 Health Home 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 Health Home value sets and Value Set Directory User Manual are available free of charge at https://store.ncqa.org/hedis-2026-health-home-core-set-hedis-value-set-directory-my-2025.html. HEDIS value set references are underlined in the specifications (e.g., Acute Inpatient Value Set).
  - The value set for CDF-HH measure is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip.
  - The value set for the AIF-HH measure is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip.
  - The value set for the IU-HH measure is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip.

[1] Mandatory Medicaid 1945 Health Home Core Sets Reporting final rule: https://www.medicaid.gov/sites/default/files/2024-03/smd24002.pdf. Updates to the 2026 Medicaid Health Home Core Set and mandatory reporting guidance is available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd25002.pdf.

[2] For 2026, all 1945 Health Home Core Set measures with NCQA as the measure steward are HEDIS measures.

  - 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. Access to 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 2026 1945 Health Home Core Set measures, use the version of the value sets associated with the March 2024 release. This applies to the following 1945 Health Home Core Set measures that have electronic specifications: CBP-HH, CDF-HH, COL-HH, and IET-HH.

- **Medication lists.** Several HEDIS measures in the 1945 Health Home 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-2025-medication-list-directory.html/). Once ordered, the Medication List Directory can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). This applies to the following 1945 Health Home Core Set measures: CBP-HH, COL-HH, FUA-HH, and IET-HH.

- **Data collection time frames for measures.** States must adhere to the measurement periods identified in the technical specifications for each measure. Some measures are collected on a calendar year basis, whereas others are indexed to a specific date or event, such as a hospital discharge for a mental health condition. When the option is not specified, data collection time frames should align with the calendar year prior to the reporting year; for example, calendar year 2025 data should be reported for the 2026 Core Set. For many measures, the denominator measurement period for the 2026 Core Set corresponds to calendar year 2025 (January 1, 2025–December 31, 2025).

  Some measures also require states to review utilization or enrollment prior to this period. Further information about measurement periods for the 2026 1945 Health Home Core Set is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/1945-hh-core-set-measurement-period-table-2026.pdf.

- **Continuous enrollment.** Continuous enrollment specifies the minimum amount of time that an enrollee must be eligible for Medicaid benefits and enrolled in a health home 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, an individual 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). The dates used to determine continuous enrollment may be defined by the policies of each health home program and do not need to match the health home program effective date. For the purpose of Core Set reporting, states should combine data across health home providers, delivery systems (e.g., managed care and fee-for-service), and managed care plans when analyzing continuous enrollment for an enrollee. For example, an enrollee might switch between health home providers or between managed care plans, and should be included in the numerator and denominator for the measure as long as the enrollee is continuously enrolled in both a health home program and Medicaid for the period specified in the measure.

- **Allowable gap.** Some measures specify an allowable gap that can occur any time during continuous enrollment. For example, the CBP-HH measure requires continuous enrollment throughout the measurement year (January 1–December 31) and allows one gap in health

home enrollment of up to 45 days. Thus, an enrollee 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 enrollee has one 38-day gap (January 1–February 7). An enrollee who switches between health home providers, delivery systems, or managed care plans should be included in a measure as long as there is no gap in health home enrollment that exceeds the allowable gap specified in the measure.

- **Anchor date.** Some measures include an anchor date, which is the date that an individual must be enrolled in a health home 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 2026 Core Set measurement period (December 31, 2025). For other measures, the anchor date is based on a specific event, such as a birthdate. 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.
- **Date specificity.** A date must be specific enough to determine that an event occurred during the time frame specified in the measure. There are instances when documentation of the year alone is adequate; for example, most exclusions and measures that look for events in the "measurement year or the year prior to the measurement year." Terms such as "recent," "most recent," or "at a prior visit" are not acceptable. For documented history of an event (e.g., documented history of a disease), undated documentation may be used if it is specific enough to determine that the event occurred during the time frame specified in the measure.
- **Reporting unit.** CMS defines the reporting unit for each measure as each state's health home program. This means that states should collect data across all health home providers[3] within a specific health home program, as defined by the approved SPA applicable to the program. States should aggregate data from all health home providers into one health home program-level rate before reporting data to CMS. States with more than one approved health home program should report separately for each health home program, as defined in their SPA. SPA amendments should be included with the original SPA and not as a separate report. For more guidance about developing a health home program-level rate, see the bullet on "aggregating information for health home program-level reporting" below.
- **Eligible population for measurement.** Health home enrollees are Medicaid beneficiaries (adults and children) who are enrolled in a state health home program and assigned a health home provider. For all measures, the denominator must include all health home enrollees who satisfy all specified criteria (including age, continuous enrollment, benefit, event, and anchor date enrollment requirements). Some measures require a period of continuous enrollment for inclusion in the measure.
- **Enrollees with partial benefits.** For each measure, states should include only the health home enrollees who are eligible to receive the services assessed in the numerator. If an enrollee is not eligible to receive the services assessed in the measure, the enrollee should not be included in the denominator for the measure. The technical specifications for some measures have guidance regarding which benefits an individual must be eligible for to

[3] Section 1945(g) of the Social Security Act requires designated providers of health home services to report to the state, in accordance with such requirements as the Secretary shall specify, on all applicable quality measures as a condition for receiving payment. When appropriate and feasible, quality measure reporting is to be done through the use of health information technology.

be included, but each state should assess the specific benefit packages of the enrollees in their state.

- **Aggregating information for health home program-level reporting.** To obtain a health home program-level rate for a measure that is developed from the rates of multiple reporting units (such as across health home providers), the state should calculate a weighted average of the individual rates. How much any one entity (e.g., each health home provider) will contribute to the weighted average is based on the size of its eligible population for the measure. This means that health home providers serving 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 health home program-level rate as long as the specifications allow the use of these data collection methods or sources to construct the measure. For additional guidance on developing a program-level rate, refer to the TA Brief titled, "Calculating State-Level Rates Using Data from Multiple Reporting Units."[4] Although CMS encourages health home providers and states to use the methods and data sources listed in the specification for each measure, states and providers may use alternative methods and data sources, when necessary. When reporting an aggregated rate that uses alternative data sources or combines data from multiple sources and methods, states should report the data sources and methods used, and the combined rate.

- **Reporting stratified data.** Starting with 2025 Core Set reporting, states are required to report stratified data for a subset of measures identified by CMS and encouraged to report stratified data for the remaining measures.[5]

  For 2026 reporting, the 1945 Health Home Core Set measures subject to stratified reporting requirements include:

  Already Subject to Stratification for 2025 Core Set

  - Colorectal Cancer Screening (COL-HH)
  - Follow-Up After Hospitalization for Mental Illness (FUH-HH)
  - Controlling High Blood Pressure (CBP-HH)

  Additional Measures Subject to Stratification in 2026 Core Set

  - Follow-Up After Emergency Department Visit for Substance Use (FUA-HH)
  - Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)
  - Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)

  States are required to stratify measures by the following standards.

  - Race and ethnicity. For 2026 Core Set reporting, states can stratify race and ethnicity using one of two federal guidelines:

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

[5] 2026 Updates to the Medicaid 1945 Health Home Core Sets of Quality Measures and Mandatory reporting guidance: https://www.medicaid.gov/federal-policy-guidance/downloads/smd25002.pdf.

  - 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) with recommendation to move towards Rural-Urban Commuting Area Codes.[9]

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.

- **Reporting a weighted rate.** When a state develops a weighted rate combining data across multiple reporting units (health home providers), the information entered in the numerator and denominator fields will vary depending on the method used to calculate a health home program-level rate:
  - If a program-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 program-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.
  - If the program-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 Collection Methods” section, the state should identify the number of reporting units that used each method (administrative and hybrid).
- **Age criteria.** The age criteria vary by measure. Some measures have an upper age limit, while others include an age range above age 64 and/or under age 18. For the purpose of 1945 Health Home Core Set reporting, states should calculate and report such measures for three age groups where applicable: enrollees under age 18, enrollees between the ages of 18 and 64, and those age 65 and older. States should also report for the total population. States should note any variation from the specifications in the “Variations from Measure Specifications” field.
- **Exclusions.** Some measure specifications contain required exclusions. An enrollee who meets required exclusion criteria should be removed from the measure denominator.

[6] https://spd15revision.gov/content/spd15revision/en/2024-spd15.html.

[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.ers.usda.gov/data-products/rural-urban-commuting-area-codes/.

- **Supplemental data.** Supplemental data are data other than claims and encounters and medical record data abstracted for hybrid reporting used by organizations to collect information about delivery of health services to their enrollees. Examples of supplemental data include immunization registries or case management program data.
- **Telehealth.** HEDIS measures consider synchronous telehealth visits, telephone visits, and asynchronous telehealth (e-visits, virtual check-ins).
  - Synchronous telehealth requires real-time interactive audio and video telecommunications.
  - 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 enrollee and the provider. For example, asynchronous telehealth can occur using a patient portal, secure text messaging, or email.
  - 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 health home program(s) (including individuals simultaneously enrolled in Medicare and Medicaid, also known as dually eligible beneficiaries, where applicable). This includes enrollees enrolled in all Medicaid 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 enrollees 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 health home eligible population for the measure.
- **Data collection methods.** The measures in the 1945 Health Home Core Set have four possible data collection methods: administrative, hybrid, 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 administrative data are used, the entire eligible population is included in the denominator.
  - The hybrid method uses both administrative data sources and medical record data to determine numerator compliance. Administrative data are reviewed to determine if enrollees in the systematic sample received the service, and medical record data are reviewed for enrollees who do not meet the numerator criteria through administrative data. The denominator consists of a systematic sample of enrollees 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.
  - The electronic specification method uses EHR data to calculate the measure. A link to the electronic specifications is included in the following measure specifications: CBP-HH, CDF-HH, COL-HH, and IET-HH. 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, enrollee 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 located in the Guidelines for Measures Reported Using ECDS in Chapter V. This data collection method applies to the following measure in the 1945 Health Home Core Set: COL-HH

- **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, unless special circumstances apply. If a health home program has fewer than 411 enrollees, all enrollees should be included in the sample. States may reduce the sample size using information from the current year's administrative rate or the prior year's audited hybrid rate. Regardless of the selected sample size, NCQA recommends an oversample to allow for substitution in the event that cases in the original sample turn out to be ineligible for the measure. For additional information on using a reduced sample size, refer to Appendix A, Guidance for Selecting Sample Sizes for Hybrid Measures.
- **Alternative data collection methods and data sources.** States may choose to report on any of these measures using the methods listed in the specifications, or using an alternative method (e.g., medical record review without systematic sample) or data source (e.g., patient registry) if the administrative, hybrid, and medical record/electronic specification methods are not feasible. The data collection method and data source should be explained in the “Variations from Measure Specification” field.
- **Small numbers.** If a measure has a denominator less than 30 (for all measures except the PCR-HH measure) or a Count of Index Hospital Stays less than 150 (for PCR-HH) and the state chooses not to report the measure due to the small numbers criterion, please note this in the question that asks “Why are you not reporting on this measure?” and specify the denominator size. CMS recognizes that some states prohibit the reporting of small cell sizes due to privacy concerns. The denominator for the Plan All-Cause Readmissions measure is the Count of Index Hospital Stays among non-outlier enrollees. Outliers should not be considered.
- **Risk adjustment.** One measure in the 1945 Health Home Core Set, the PCR-HH measure, requires risk adjustment. Risk adjustment guidelines are included in the specification for the measure.
- **Inclusion of paid, suspended, pending, and denied claims.** A key aspect in the assessment of quality for some measures is to capture whether or not a service was provided. For all 1945 Health Home Core Set 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: AIF-HH, CBP-HH, CDF-HH, COL-HH, FUA-HH, FUH-HH, FUM-HH, IET-HH, IU-HH, and PCR-HH.

- **Visits that result in an inpatient stay.** Some measures in the 1945 Health Home Core Set require exclusion of visits that result in an inpatient 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 1945 Health Home Core Set measures: FUA-HH, FUM-HH, and IET-HH.

Definitions

- **1945 Health Home Program.** A state Medicaid program defined in an approved SPA that authorizes the provision of comprehensive care management; care coordination and health promotion; comprehensive transitional care/follow-up; patient and family support; referral to community and social support services; and use of health information technology (HIT) to link services. A health home program may be made up of multiple qualified health home providers.
- **1945 Health home provider.** An individual provider, team of health care professionals, or health team that provides the health home services and meets established standards. States can adopt a mix of these three types of providers identified in the legislation:
  - Designated provider: May be physician, clinical/group practice, rural health clinic, community health center, community mental health center, home health agency, pediatrician, OB/GYN, or other.
  - Team of health professionals: May include physician, nurse care coordinator, nutritionist, social worker, behavioral health professional, and can be free standing, virtual, hospital-based, community mental health centers, or other.
  - Health team: Must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral healthcare providers, chiropractors, licensed complementary and alternative medical practitioners, and physician assistants.
- **1945 Health home enrollee (Enrollee).** Medicaid beneficiary (adult or child) enrolled in a state health home program. Medicaid beneficiaries eligible for health home services:
  - Have two or more chronic conditions, or
  - Have one chronic condition and are at risk for a second, or
  - Have a serious and persistent mental health condition.
  - Health home enrollees may include beneficiaries dually eligible for both Medicare and Medicaid.

Reporting and Submission

Procedures for reporting the 1945 Health Home Core Set measures are provided below.

- **Reporting eligibility.** States are expected to report the 1945 Health Home Core Set measures when their SPA has been in effect for six months or more of the measurement period. A health home program that had an effective date before July 1, 2025, or during a previous year should report for 2026. While some measures may have a continuous enrollment requirement that exceeds the time that enrollees were in a health home, states should report as many measures as possible for which their enrollees meet the continuous enrollment requirements. The continuous enrollment requirements are specified in the eligible population section for each measure.

- **Submission deadline.** The deadline for submitting final data on the 2026 1945 Health Home Core Set measures is December 31, 2026. 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. States are encouraged to submit data that are as complete as possible by the submission deadline.
- **Completing fields.** Specific fields apply 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 to improve CMS's understanding of variations across states.
- **Reasons for not reporting a measure.** If a state is unable to report a measure, the state should explain its reason for not reporting the measure. We recognize 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 and in addition send an email to the TA mailbox (MACQualityTA@cms.hhs.gov) explaining why the state cannot report the measure. This information will assist CMS in understanding why each state or why all states as a group may not be reporting on specific measures and design technical assistance to help all states with reporting.
- **Noting variations from the 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.
- **Reporting by population.** For each 1945 Health Home Core Set measure reported to CMS, states should specify the population included in the measure: Medicaid, Dually eligible beneficiaries, and Other as appropriate. Any populations excluded from the denominator should be noted in the "Definition of Population Included in Measure" section of the online reporting system.
- **Data auditing.** For 2026, CMS will not require certification or auditing of HEDIS or other measures. However, states are encouraged to do so when possible. If there are current state mechanisms for accreditation, certification, and managed care external quality review, or if the state validates its 1945 Health Home Core Set rates through another process, states should describe these processes in the applicable fields in the program-level Core Set Question in the online reporting system.

Technical Assistance

To help states collect, report, and use the 1945 Health Home Core Set measures, CMS offers technical assistance. Please submit technical assistance requests about the 1945 Health Home Core Set measures to MACQualityTA@cms.hhs.gov.[10]

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

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

[10] States with technical questions about the 1945A Health Home Core Set measures should also contact MACQualityTA@cms.hhs.gov.

III. TECHNICAL SPECIFICATIONS FOR THE 1945 HEALTH HOME CORE SET MEASURES

This chapter presents the technical specifications for each measure in the 1945 Health Home Core Set with specifications for the administrative or hybrid 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 other relevant measure information.

These specifications have been modified from their original version for use in the Medicaid 1945 Health Home Core Set. They also may differ slightly from the specifications used in the Medicaid Child or Adult Core Sets. Where applicable, substantive differences between the 1945 Health Home Core Set specifications and the original specifications provided by the measure steward are listed in the Guidance for Reporting section for each measure.

1945 Health Home Core Set measures with Electronic Clinical Data Systems (ECDS) specifications are included in Chapter V.

These specifications represent the most applicable version available from the measure steward as of December 2025.

MEASURE CBP-HH: CONTROLLING HIGH BLOOD PRESSURE

National Committee for Quality Assurance

A. DESCRIPTION

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

Data Collection Method: Administrative, Hybrid, or EHR

Guidance for Reporting:

- For the purpose of 1945 Health Home Core Set reporting, states should calculate and report this measure for two age groups (as applicable) and a total rate: ages 18 to 64, ages 65 to 85, and total (ages 18 to 85).
- Include all paid, suspended, pending, and denied claims.
- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2025-medication-list-directory.html/). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads).
- The electronic specification for 2026 is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2025/cms0165v13.States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the "Data Collection Method" section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative and hybrid specifications. States should use caution comparing measures calculated using different data collection methods.

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

B. DEFINITIONS

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

C. ELIGIBLE POPULATION

Age	Ages 18 to 85 as of December 31 of the measurement year.

Continuous enrollment	Enrolled in a Medicaid health home program for 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 health home enrollee for whom enrollment is verified monthly, the enrollee may not have more than a 1-month gap in coverage (e.g., an enrollee 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 enrollees who had at least two outpatient visits, telephone visits, e-visits or virtual check-ins (Outpatient and Telehealth Without UBREV Value Set) on different dates of service with a diagnosis of hypertension (Essential Hypertension Value Set) on or between January 1 of the year prior to the measurement year and June 30 of the measurement year. Step 2 Remove enrollees who had a nonacute inpatient admission during the measurement year. To identify nonacute inpatient admissions: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude enrollees who meet any of the following criteria: • Enrollees 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 an enrollee is found to be in hospice or using hospice services during medical record review, the enrollee is removed from the sample and replaced by an enrollee from the oversample. • Enrollees who die any time during the measurement year. • Enrollees receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement year. • Enrollees who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS code 81).

Required exclusions (Supplemental and medical record data may be used for these exclusions) (continued)	• Enrollees with a diagnosis of end-stage renal disease (ESRD) (ESRD Diagnosis Value Set; History of Nephrectomy or Kidney Transplant Value Set), any time during the enrollee's history on or prior to December 31 of the measurement year. Do not include laboratory claims (claims with POS code 81). • Enrollees with a procedure that indicates ESRD: dialysis (Dialysis Procedure Value Set), nephrectomy (Total Nephrectomy Value Set; Partial Nephrectomy Value Set) or kidney transplant (Kidney Transplant Value Set) any time during the enrollee's history on or prior to December 31 of the measurement year. • Enrollees with a diagnosis of pregnancy (Pregnancy Value Set) any time during the measurement year. Do not include laboratory claims (claims with POS code 81). • Enrollees ages 66 to 80 as of December 31 of the measurement year with frailty and advanced illness. Enrollees must meet both frailty and advanced illness criteria to be excluded: 1. Frailty: At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81). 2. Advanced Illness: Either of the following during the measurement year or the year prior to the measurement year – Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS code 81). – Dispensed dementia medication (Dementia Medications List, see link to the Medication List Directory in Guidance for Reporting above). • Enrollees age 81 and older as of December 31 of the measurement year with at least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement year. Do not include laboratory claims (claims with POS code 81).

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerator

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

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

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

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

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

E. HYBRID SPECIFICATION

Denominator

A systematic sample drawn from the eligible population. Refer to the sampling guidance under Section II. Data Collection and Reporting of the 1945 Health Home Core Set for additional information.

Identifying the Medical Record

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

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

- Identify the enrollee’s PCP.
- If the enrollee had more than one PCP for the time period, identify the PCP who most recently provided care to the enrollee.
- If the enrollee did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the enrollee.
- If a practitioner other than the enrollee’s PCP manages the hypertension, the state may use the medical record of that practitioner.

Numerator

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

Administrative Data

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

Medical Record Review

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

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

Do not include BP readings:

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

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

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

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

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

F. ADDITIONAL NOTES

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

MEASURE CDF-HH: SCREENING FOR DEPRESSION AND FOLLOW-UP PLAN

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Percentage of enrollees age 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the qualifying encounter.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- The Screening for Depression and Follow-Up Plan measure includes enrollees age 12 and older. For the purpose of 1945 Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 12 to 17, ages 18 to 64, age 65 and older, and total (age 12 and older).
- The intent of the measure is to screen for depression in enrollees who have never had a diagnosis of bipolar disorder prior to the qualifying encounter used to evaluate the numerator. Enrollees who have been diagnosed with bipolar disorder will be excluded from the measure.
- The denominator for this measure includes enrollees age 12 and older with an outpatient visit during the measurement year. The numerator for this measure includes the following two groups:
  1. Those enrollees 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 enrollees 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 1945 Health Home 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 an enrollee 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 an enrollee 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 an enrollee 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 enrollee 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 an enrollee meets the numerator criteria; an enrollee who qualifies for the denominator exclusion should be removed from the denominator.
  - Denominator exception criteria are only evaluated if the enrollee does not meet the numerator criteria; enrollees 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/2026-1945-HH-non-hedis-value-set-directory.zip.

- The electronic clinical quality measure (eCQM) specification for the 2026 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/sites/default/files/ecqm/measures/CMS2v14.html. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the "Data Collection Method" 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, 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 (ages 12 to 17) 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. • Adult Screening Tools (age 18 and older) Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale for Depression in Dementia (CSDD), PRIME MD-PHQ2, Hamilton Rating Scale for Depression (HAM-D), and Quick Inventory of Depressive Symptomatology Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD). • Perinatal Screening Tools Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale.

Follow-up plan	Documented follow-up for a positive depression screening *must* include one or more of the following: • Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression Examples of a follow-up plan include but are not limited to: • Referral to a provider or program for further evaluation for depression, for example, referral to a psychiatrist, psychiatric nurse practitioner, psychologist, clinical social worker, mental health counselor, or other mental health service such as family or group therapy, support group, depression management program, or other service for treatment of depression. • Other interventions designed to treat depression such as behavioral health evaluation, psychotherapy, pharmacological interventions, or additional treatment options. The documented follow-up plan must be related to positive depression screening, for example: "Patient referred for psychiatric evaluation due to positive depression screening."

C. ELIGIBLE POPULATION

Age	Age 12 or older on date of encounter.
Event/ diagnosis	Outpatient visit (Table CDF-A) during the measurement year.
Continuous enrollment	None

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population with an outpatient visit during the measurement year (Table CDF-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip).

Numerator

Enrollees 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/2026-1945-HH-non-hedis-value-set-directory.zip.

Exclusions

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

- Enrollees 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/2026-1945-HH-non-hedis-value-set-directory.zip) to identify exclusions.

Exceptions

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

- Enrollee reason:
  - Enrollee refuses to participate.
- Medical reason:
  - Enrollee is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the enrollee's health status.
  - Situations where the enrollee'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/2026-1945-HH-non-hedis-value-set-directory.zip) to identify exceptions.

MEASURE FUA-HH: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR SUBSTANCE USE

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for enrollees age 13 and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

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

Data Collection Method: Administrative

Guidance for Reporting:

- For the purpose of 1945 Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 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-2025-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	Age 13 and older as of the ED visit.
Continuous enrollment	The date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical, chemical dependency and pharmacy. Note: Enrollees 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 enrollee was age13 or older on the date of the visit. The denominator for this measure is based on ED visits, not on enrollees. If an enrollee 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 an enrollee has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if an enrollee 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 enrollees who meet either of the following criteria: • Enrollees 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. • Enrollees who die any time during the measurement year.

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 (Nonresidential 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 (Nonresidential 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 use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set). Do not include laboratory claims (claims with POS code 81).
- 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)

MEASURE FUH-HH: FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS

National Committee for Quality Assurance

A. DESCRIPTION

Percentage of discharges for enrollees age 6 and older who were hospitalized for a principal diagnosis of mental illness, or any diagnosis intentional self-harm, and had a mental health follow-up service. Two rates are reported:

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

Data Collection Method: Administrative

Guidance for Reporting:

- For the purpose of 1945 Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (ages 6 and older).
- Follow the detailed specifications to (1) include the appropriate discharge when the enrollee 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 enrollee was transferred directly or readmitted to an acute or non-acute care facility for a non-mental health diagnosis.
- The denominator for this measure should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow up rate should be greater than or equal to the 7-day follow-up rate within each age group.
- This measure specifies that when a visit code or procedure code must be used in conjunction with a diagnosis code, both the visit/procedure code and the diagnosis code must be on the same claim or from the same visit.
  - This measure references value sets that include codes used on professional claims (e.g., CPT, HCPCS) and codes used on facility claims (e.g., UB). Diagnosis and procedure codes from both facility and professional claims should be used to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - For value sets that include codes used only on facility claims (e.g., UB), use facility claims only to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.
- Refer to Appendix B for the definition of mental health provider. States must develop their own methods to identify mental health providers.

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

B. ELIGIBLE POPULATION

Age	Age 6 and older as of the date of discharge.
Continuous enrollment	Enrolled in a Medicaid health home program from the 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 (Mental Illness Value Set) or any diagnosis of intentional self-harm (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 enrollees. If enrollees 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 of mental health disorder, or any diagnosis of intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self Harm Value Set), count only the last discharge (use only the discharge claim).

Acute readmission or direct transfer (continued)	If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis, and intentional self-harm was not on the claim in any diagnosis position, exclude both the original and the readmission/direct transfer discharge (use only the discharge claim).
Nonacute readmission or direct transfer	Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting (except for psychiatric residential treatment) within the 30-day follow-up period, regardless of the diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays except for residential psychiatric treatment (Inpatient Stay Except Psychiatric Residential 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 enrollees who meet either of the following criteria: • Enrollees 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. • Enrollees who die any time during the measurement year.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up

A follow-up service for mental health within 30 days after discharge. Do not include services that occur on the date of discharge.

7-Day Follow-Up

A follow-up service for mental health within 7 days after discharge. Do not include services that occur on the date of discharge.

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

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider
- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with any diagnosis of mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient Value Set) with a mental health provider

- An outpatient visit (BH Outpatient Value Set) with any diagnosis of mental health disorder (Mental Health Diagnosis 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; 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
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with any diagnosis of mental health disorder (Mental Health Diagnosis Value Set)
- Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider
- Transitional care management services (Transitional Care Management Services Value Set) with any diagnosis of mental health disorder (Mental Health Diagnosis Value Set)
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set)
- A telephone visit (Telephone Visits Value Set) with a mental health provider
- A telephone visit (Telephone Visits Value Set) with any diagnosis of mental health disorder (Mental Health Diagnosis Value Set)
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set)
- Peer support services (Peer Support Services Value Set) with any diagnosis of mental health disorder (Mental Health Diagnosis Value Set)
- Psychiatric residential treatment (Residential Behavioral Health Treatment Value Set)
- Psychiatric residential treatment (Visit Setting Unspecified Value Set with POS code 56)

MEASURE FUM-HH: FOLLOW-UP AFTER EMERGENCY DEPARTMENT VISIT FOR MENTAL ILLNESS: AGE 6 AND OLDER

National Committee for Quality Assurance[1]

A. DESCRIPTION

Percentage of emergency department (ED) visits for enrollees ages 6 and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. Two rates are reported:

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

Data Collection Method: Administrative

Guidance for Reporting:

- For the purpose of 1945 Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 6 to 17, ages 18 to 64, age 65 and older, and total (age 6 and older).
- The denominator should be the same for the 30-day rate and the 7-day rate.
- The 30-day follow-up rate should be greater than or equal to the 7-day follow-up rate within each age group.
- When a visit code or procedure code must be used in conjunction with a diagnosis code, the codes must be on the same claim or from the same visit.
  - If a value set includes codes used on professional claims (e.g., CPT, HCPCS) and includes codes used on facility claims (e.g., UB), use diagnosis and procedure codes from both facility and professional claims to identify services and diagnoses (the codes can be on the same claim or from the same visit).
  - If a value set includes codes used only on facility claims (e.g., UB) then only use facility claims to identify services and diagnoses (the codes must be on the same claim).
- Include all paid, suspended, pending, and denied claims.

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

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

B. ELIGIBLE POPULATION

Age	Age 6 and older as of the date of the ED visit.
Continuous enrollment	Date of the ED visit through 30 days after the ED visit (31 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefit	Medical and mental health.
Event/diagnosis	An ED visit (ED Value Set) with a principal diagnosis of mental illness (Mental Illness Value Set), or any diagnosis of intentional self-harm (Intentional Self Harm Value Set) on or between January 1 and December 1 of the measurement year where the enrollee was age 6 or older on the date of the visit. The denominator for this measure is based on ED visits, not on enrollees. If an enrollee 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 an enrollee has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if an enrollee 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 except for residential psychiatric treatment (Inpatient Stay Except Psychiatric Residential 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 enrollees who meet either of the following criteria: • Enrollees 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. • Enrollees who die any time during the measurement year.

C. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

30-Day Follow-Up

A follow-up service for mental health within 30 days after the ED visit (31 total days). Include services that occur on the date of the ED visit.

7-Day Follow-Up

A follow-up service for mental health within 7 days after the ED visit (8 total days). Include services that occur on the date of the ED visit.

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

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- An outpatient visit (BH Outpatient 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
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient 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
- 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 any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- A telephone visit (Telephone Visits 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 any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set)
- Psychiatric collaborative care management (Psychiatric Collaborative Care Management Value Set)
- Peer support services (Peer Support Services Value Set) with any diagnosis of mental health disorder (Mental Health Diagnosis Value Set)

- Psychiatric residential treatment (Residential Behavioral Health Treatment Value Set)
- Psychiatric residential treatment (Visit Setting Unspecified Value Set with POS code 56)
- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set)

Note: An event that meets both eligible population and numerator criteria should not be included in the numerator.

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

National Committee for Quality Assurance

A. DESCRIPTION

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

- **Initiation of SUD Treatment.** The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
- **Engagement of SUD Treatment**. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

Data Collection Method: Administrative or EHR

Guidance for Reporting:

- For the purpose of 1945 Health Home Core Set reporting, states should calculate and report each of the rates listed above for three age groups (as applicable) and a total rate: ages 13 to 17, ages 18 to 64, age 65 and older, and total (age 13 and older).
- Two rates are reported: initiation of SUD treatment and engagement of SUD treatment. For each rate, report the following SUD diagnosis cohorts for each age group:
  - Alcohol use disorder.
  - Opioid use disorder.
  - Other substance use disorder.
  - Total (The total is the sum of the SUD diagnosis cohort stratifications).
- Exclude enrollees from the denominator for both rates (initiation of SUD treatment and engagement of SUD treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.
- Include all paid, suspended, pending, and denied claims.
- This measure requires that medication assisted treatment (MAT) services match the diagnosis category of the index episode identified in the denominator in order to count towards the numerator of the engagement rate. Depending on the diagnosis used in the denominator (e.g., opioid abuse or dependence and alcohol abuse and dependence), a corresponding MAT medication should be used to satisfy the numerator.
- The SUD diagnosis in the Negative SUD Diagnosis History does not need to match the diagnosis on the claim for the given SUD episode.
- NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2025-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 2026 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2025/cms0137v13. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the "Data Collection Method" section of the online reporting system. Please note that there may be variations between the electronic specification and the administrative specification. States should use caution comparing measures calculated using different data collection methods.

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

B. DEFINITIONS

Intake period	November 15 of the year prior to the measurement year to November 14 of the measurement year. The intake period is used to capture new SUD episodes.
SUD episode	An encounter during the Intake Period with a diagnosis of SUD. For visits that result in an inpatient stay, the inpatient discharge is the SUD episode (an SUD diagnosis is not required for the inpatient stay; use the diagnosis from the visit that resulted in the inpatient stay to determine the diagnosis cohort).
SUD episode date	The date of service for an encounter during the intake period with a diagnosis of SUD. For a visit (not resulting in an inpatient stay), the SUD episode date is the date of service. For an inpatient stay or for withdrawal management (i.e., detoxification) that occurred during an inpatient stay, the SUD episode date is the date of discharge. For withdrawal management (i.e., detoxification), other than those that occurred during an inpatient stay, the SUD episode date is the date of service. For direct transfers, the SUD episode date is the discharge date from the last admission (an SUD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).
Dates of service for services billed weekly or monthly	For an opioid treatment service that bills monthly or weekly (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set), if the service includes a range of dates, then use the earliest date as the date of service. Use this date for all relevant events (the SUD episode date, negative diagnosis history and numerator events).

Direct transfer	A direct transfer is when the discharge date from the first inpatient setting precedes the admission date to a second inpatient setting by one calendar day or less. For example: • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 1, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to an inpatient setting on June 2, is a direct transfer. • An inpatient discharge on June 1, followed by an admission to another inpatient setting on June 3, is not a direct transfer; these are two distinct inpatient stays. Use the following method to identify admissions to and discharges from inpatient settings. 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission and discharge dates for the stay.

C. ELIGIBLE POPULATION

Age	Age 13 and older as of the SUD episode date.
SUD diagnosis cohort stratification	Report the following SUD diagnosis cohort stratifications and a total: • Alcohol use disorder • Opioid use disorder • Other substance use disorder • Total (The total is the sum of the SUD diagnosis cohort stratifications)
Continuous enrollment	Enrolled in a Medicaid health home program for at least 194 days prior to the SUD episode date through 47 days after the SUD episode date (242 total days).
Allowable gap	No allowable gaps in the continuous enrollment period.
Anchor date	None.
Benefits	Medical, pharmacy, and chemical dependency (inpatient and outpatient). Note: Enrollees with withdrawal management/detoxification-only chemical dependency benefits do not meet these criteria.
Event/ diagnosis	New episode of SUD during the intake period. Follow the steps below to identify the denominator for both rates. Step 1 Identify all SUD episodes. Any of the following meet criteria: • An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set

Event/ diagnosis (continued)	• An outpatient visit (BH Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with POS code 52 and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Nonresidential Substance Abuse Treatment Facility POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • A community mental health center visit (Visit Setting Unspecified Value Set) with POS code 53 and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • A substance use disorder service (Substance Use Disorder Services Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set • Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. Do not include laboratory claims (claims with POS code 81). • A withdrawal management event (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An acute or nonacute inpatient discharge with one of the following on the discharge claim: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:

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

Event/ diagnosis (continued)	Step 4 Remove SUD episodes that do not meet continuous enrollment criteria. Enrollees must be continuously enrolled from 194 days before the SUD episode date through 47 days after the SUD episode date (242 total days), with no gaps. Step 5 Deduplicate eligible episodes. If an enrollee has more than one eligible episode on the same day, include only one eligible episode. For example, if an enrollee has two eligible episodes on January 1, only one eligible episode would be included; then, if applicable, include the next eligible episode that occurs after January 1. Note: The denominator for this measure is based on episodes, not on enrollees. All eligible episodes that were not removed or deduplicated remain in the denominator. Step 6 Identify the SUD diagnosis cohort for each SUD episode. • If the SUD episode has a diagnosis of alcohol use disorder (Alcohol Abuse and Dependence Value Set), include the episode in the alcohol use disorder cohort. • If the SUD episode has a diagnosis of opioid use disorder (Opioid Abuse and Dependence Value Set), include the episode in the opioid use disorder cohort. • If the SUD episode has a diagnosis of SUD that is neither for opioid nor alcohol (Other Drug Abuse and Dependence Value Set), place the enrollees in the other substance use disorder cohort. Include SUD episodes in all SUD diagnosis cohorts for which they meet criteria. For example, if the SUD episode has a diagnosis of alcohol use disorder and opioid use disorder, include the episode in the alcohol use disorder and opioid use disorder cohorts.
Required exclusions (Supplemental and medical record data may be used for these exclusions)	Exclude enrollees who meet either of the following criteria: • Enrollees 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. • Enrollees who die any time during the measurement year.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

Initiation of SUD Treatment

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

Follow the steps below to identify numerator compliance.

Step 1

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

Step 2

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

Step 3

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

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

- Substance use disorder counseling and surveillance (Substance Abuse and Surveillance Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set). Do not include laboratory claims (claims with POS code 81).
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A weekly or monthly opioid treatment service (OUD Weekly Non Drug Service Value Set; OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set)
- For SUD episodes in the alcohol use disorder cohort, an alcohol use disorder medication treatment dispensing event (Alcohol Use Disorder Treatment Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set)
- For SUD episodes in the opioid use disorder cohort, an opioid use disorder medication treatment dispensing event (Naltrexone Oral Medications List; Naltrexone Injection Medications List; Buprenorphine Oral Medications List; Buprenorphine Injection Medications List; Buprenorphine Implant Medications List; Buprenorphine Naloxone Medications List, see link to the Medication List Directory in Guidance for Reporting above) or a medication administration event (Naltrexone Injection Value Set, Buprenorphine Oral Value Set, Buprenorphine Oral Weekly Value Set, Buprenorphine Injection Value Set, Buprenorphine Implant Value Set, Buprenorphine Naloxone Value Set, Methadone Oral Value Set, Methadone Oral Weekly Value Set)

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

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

Engagement of SUD Treatment

Follow the steps below to identify numerator compliance.

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

Step 1

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

Step 2

Identify SUD episodes that had at least one weekly or monthly opioid treatment service with medication administration (OUD Monthly Office Based Treatment Value Set; OUD Weekly Drug Treatment Service Value Set) on the day after the initiation encounter through 34 days

after the initiation event. The opioid treatment service is considered engagement of treatment and the SUD episode is compliant.

Step 3

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

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

Step 4

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

- Engagement visit
- Engagement medication treatment event

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

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

Engagement Visits

Any of the following meet criteria for an engagement visit:

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

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with POS code 52 with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A non-residential substance abuse treatment facility visit (Visit Setting Unspecified Value Set) with (Nonresidential Substance Abuse Treatment Facility POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A community mental health center visit (Visit Setting Unspecified Value Set) with POS code 53 with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A telehealth visit (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- A substance use disorder service (Substance Use Disorder Services Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- Substance use disorder counseling and surveillance (Substance Abuse Counseling and Surveillance Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set). Do not include laboratory claims (claims with POS code 81).
- A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An e-visit or virtual check-in (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set
- An opioid treatment service (OUD Weekly Non Drug Service Value Set)

Engagement Medication Treatment Events

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

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

Alcohol Use Disorder Treatment Medications

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

Opioid Use Disorder Treatment Medications

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

E. ADDITIONAL NOTES

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

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

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

Substance Abuse and Mental Health Services Administration

A. DESCRIPTION

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

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

Data Collection Method: Administrative

Guidance for Reporting:

- The measure includes a total rate (Rate 1) and four separate rates for the following four types of FDA-approved drug products:
  - Buprenorphine (Rate 2)
  - Oral naltrexone (Rate 3)
  - Long-acting, injectable naltrexone (Rate 4)
  - Methadone (Rate 5)
- Tables OUD-A and OUD-B are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip. Table OUD-B designates which medications are assigned to the separate rates. Filter on the 'Numerator' column to identify which HCPCS codes and NDCs are assigned to each rate.
- OUD includes diagnoses of opioid abuse, dependence, and/or remission. ICD-10 codes for OUD and related conditions may be the primary diagnosis or appear in other positions on the claim. The diagnosis may be recorded by any medical professional who sees the beneficiary at any pointduring the measurement year.
- The measure uses inpatient, outpatient, residential, long-term care, and pharmacy claims and encounters.
- The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count enrollees in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report enrollees with multiple drug products only once for the numerator for the total rate.
- Only formulations with an OUD indication (not pain management) are included in value sets for measure calculation.

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

B. DEFINITIONS

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

C. ELIGIBLE POPULATION

Age	Age 18 and older. Age is calculated as of January 1 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	None.
Benefit	Medical and chemical dependency (inpatient, residential, and outpatient).
Event/ diagnosis	Enrollees who had at least one encounter with a diagnosis of opioid abuse, dependence, or remission (primary or other) at any time during the measurement year. ICD-10 codes for OUD are provided in Table OUD-A available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip.
Care settings	No restrictions.

D. ADMINISTRATIVE SPECIFICATION

Denominator

The eligible population as defined above.

Numerators

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

Total

Identify enrollees with evidence of at least one prescription filled, or who were administered or dispensed an FDA-approved medication for OUD during the measurement year through use of pharmacy claims (relevant NDC code) or through relevant HCPCS coding of medical service. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip.

Note: The numerator for the total rate is not a sum of the numerators for the four medication cohorts. Count enrollees in the numerator for the total rate if they had at least one of the four FDA-approved drug products for OUD during the measurement year. Report enrollees with multiple drug products only once for the numerator for the total rate.

Buprenorphine

Identify enrollees with evidence of at least one prescription for buprenorphine at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip. Include HCPCS codes and NDCs assigned to Numerator 2 in the Numerator column in Table OUD-B.

Oral Naltrexone

Identify enrollees with evidence of at least one prescription for oral naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip. Include HCPCS codes and NDCs assigned to Numerator 3 in the Numerator column in Table OUD-B.

Long-Acting, Injectable Naltrexone

Identify enrollees with evidence of at least one prescription for long-acting, injectable naltrexone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip. Include HCPCS codes and NDCs assigned to Numerator 4 in the Numerator column in Table OUD-B.

Methadone

Identify enrollees with evidence of at least one dose of methadone at any point during the measurement year. See Table OUD-B, available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-HH-non-hedis-value-set-directory.zip. This rate includes HCPCS codes only. There are no NDC codes assigned to this rate.

Rates

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

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

E. ADDITIONAL NOTES

None.

MEASURE PCR-HH: PLAN ALL-CAUSE READMISSIONS

National Committee for Quality Assurance

A. DESCRIPTION

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

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

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to enrollees ages 18 to 64. Although the HEDIS measure includes stratified reporting by age, for the 1945 Health Home Core Set, states should calculate and report only the Total rate.
- This measure requires risk adjustment. Risk adjustment guidelines are provided in the administrative specification. Please note that in the risk adjustment tables, clinical conditions (CCs) and hierarchical clinical conditions (HCCs) not listed receive a weight of ZERO (e.g., 0.0000).
- Report the Count of Expected 30-Day Readmissions for this measure to four decimal places.
- As shown in Table PCR-A, the data elements in columns 1, 2, 4, 7, and 8 are reported by the state. The data elements in columns 3, 5, 6 and 9 will be derived from the reported data.
- Supplemental data may not be used for this measure, except for required exclusions.
- When applying risk adjustment, include all services, whether or not the state paid for them or expects to pay for them (e.g., include denied claims). When identifying all other events, do not include denied services (e.g., only include paid services and services expected to be paid).
- If this measure has a Count of Index Hospital Stays less than 150 and the state chooses not to report this measure due to small numbers, please note this in the "Reason for Not Reporting" field and specify the denominator size.
- For observation stays (Observation Stay Value Set) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim.

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

B. DEFINITIONS

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

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

Risk Adjustment Tables

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

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

Source: Please refer to the HEDIS® MY 2025 Volume 2 Risk Adjustment Utilization Tables User Manual for technical detail on table format and content.

Note: The risk adjustment tables and Risk Adjustment Utilization Tables User Manual are available to order free of charge in the NCQA store at https://store.ncqa.org/hedis-my-2025-risk-adjustment-tables.html. Once ordered, the risk adjustment tables can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). The tables needed to calculate this measure are found in both the PCR Risk Adjustment Tables and the RAU Shared Table - PCR MY 2025 (which includes the CC-Mapping, HCC-Rank, and HCC-Comb tables).

C. ELIGIBLE POPULATION

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

Event/ diagnosis	An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not enrollees. Include all acute inpatient or observation stay discharges for nonoutlier enrollees who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.
Required exclusion (Supplemental and medical record data may be used for this exclusion)	Enrollees 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.

D. ADMINISTRATIVE SPECIFICATION

Count of Index Hospital Stays (IHS)

The eligible population as defined above.

Step 1

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

To identify acute inpatient and observation stay discharges:

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

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

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

Step 2

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

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

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

Step 3

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

Step 4

Exclude hospital stays for the following reasons:

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

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

Step 5

Calculate continuous enrollment.

Step 6

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

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

Risk Adjustment Determination

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

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

Steps for Risk Adjustment Comorbidity Category Determination

Follow the steps below for Risk Adjustment Comorbidity Category Determination.

Step 1

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

- Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute patient encounters(Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service during the classification period.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date during the classification period.

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

Step 2

Assign each diagnosis to a comorbid Clinical Condition (CC) category using Table CC—Mapping, available at https://store.ncqa.org/hedis-my-2025-risk-adjustment-tables.html. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

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

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

Step 3

Determine Hierarchical Condition Categories (HCCs) for each comorbid CC identified. Refer to Table HCC—Rank, available at https://store.ncqa.org/hedis-my-2025-risk-adjustment-tables.html.

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

- The ranking group
- The rank
- The HCC

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

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

Step 4

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

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

Example:

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

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

Example: Table HCC—Rank

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

Step 5

Identify combination HCCs listed in Table HCC—Comb, available at https://store.ncqa.org/hedis-my-2025-risk-adjustment-tables.html.

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

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

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

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

Example:

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

Example: Table HCC—Comb

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

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

Risk Adjustment Weighting

For each index hospital stay (IHS) among nonoutlier enrollees use the following steps to identify risk adjustment weights based on observation stay status at discharge, surgeries, discharge condition, comorbidity, age, and gender. Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately.

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

Count of Observed 30-Day Readmissions

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

Step 1

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

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

Step 2

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

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

Step 3

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

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

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

Step 4

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

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

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

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

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

Reporting: Count of Index Hospital Stays (IHS)

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

Reporting: Count of 30-Day Readmissions

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

Reporting: Count of Expected 30-Day Readmissions

Step 1

Calculate the Count of Expected Readmissions among nonoutlier enrollees for each IHS..

Step 2

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

Reporting: Count of Enrollees in Health Home Population

Step 1

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

Step 2

Report the count of enrollees in the health home population and enter this value into the reporting table under Count of Enrollees in Health Home Population (Table PCR-A, column 7).

Reporting: Number of Outliers

Step 1

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

Step 2

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

E. ADDITIONAL NOTES

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

- Observed Readmission Rate: Count of Observed 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 3).

- Expected Readmission Rate: Count of Expected 30-Day Readmissions divided by the Count of Index Hospital Stays (Table PCR-A, column 5).
- Observed-to-Expected Ratio (O/E): Count of Observed 30-Day Readmissions divided by Count of Expected 30-Day Readmissions (Table PCR-A, column 6).
- Outlier Rate: Number of Outlier enrollees divided by Count of Enrollees in Health Home Population (Table PCR-A, column 9), displayed as a permillage (multiplied by 1,000).
- Note: The O/E ratio is interpreted as “lower-is-better”:
  - O/E ratio <1.0 means the state had fewer readmissions than expected given the case mix
  - O/E ratio = 1.0 means that the number of readmissions was the same as expected given the case mix
  - O/E ratio >1.0 means that the state had more readmissions than expected given the case mix

Table PCR-A. Plan All-Cause Readmissions Rates

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

IV. TECHNICAL SPECIFICATIONS FOR THE HEALTH HOME UTILIZATION MEASURES

This chapter presents the technical specifications for each enrollee utilization measure. 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 other relevant measure information.

These specifications represent the most applicable version available from the measure steward as of December 2025.

MEASURE AIF-HH: ADMISSION TO A FACILITY FROM THE COMMUNITY

Centers for Medicare & Medicaid Services

A. DESCRIPTION

The number of admissions to a facility among enrollees age 18 and older residing in the community for at least one month. The number of short-term, medium-term, or long-term admissions is reported per 1,000 enrollee months. Enrollee months reflect the total number of months each enrollee is enrolled in the program and residing in the community for at least one day of the month.

The following three performance rates are reported across four age groups (ages 18 to 64, ages 65 to 74, ages 75 to 84, and age 85 and older):

- **Short-Term Stay.** The rate of admissions resulting in a short-term stay (1 to 20 days) per 1,000 enrollee months.
- **Medium-Term Stay.** The rate of admissions resulting in a medium-term stay (21 to 100 days) per 1,000 enrollee months.
- **Long-Term Stay.** The rate of admissions resulting in a long-term stay (greater than or equal to 101 days) per 1,000 enrollee months.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to enrollees age 18 and older. For the purpose of 1945 Health Home Core Set reporting, states should calculate and report this measure for four age groups (as applicable) and a total performance rate: ages 18 to 64, ages 65 to 74, ages 75 to 84, age 85 and older, and total (age 18 and older).
- Three rates are reported for each age group: short-term stay, medium-term stay, and long-term stay.
- Include paid claims only.

The measure includes the following coding systems: UB. Refer to the Acknowledgments section at the beginning of the manual for copyright information.

B. DEFINITIONS

Enrollee months	Enrollee months are an enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program and residing in the community for at least one day of the month from August 1 of the year prior to the measurement year through July 31 of the measurement year. Enrollee months do not include the month that an enrollee dies or any subsequent months. See Section D for guidance on calculating enrollee months and the performance rates.

Facility	A Medicaid- or Medicare-certified nursing facility providing skilled nursing or medical care or both; rehabilitation needed because of injury, illness or disability; or long-term care (also referred to as “custodial care”). A Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
Community residence	Any residence that is not a facility (see definition above). Note: Residence might include the enrollee’s home, assisted living, adult foster care, or other care in another setting that is not defined as a facility.
Facility admission (FA)	An admission to a facility from the community or from the hospital (where the hospital admission originated in the community) from August 1 of the year prior to the measurement year through July 31 of the measurement year. Facility admission (FA) is based on paid claims only.
Index admission date	The index admission date is the first date of the facility admission.
Look-back period	The look-back period is the window that precedes the numerator action to add or remove certain conditions from the measurement. The measurement year is January 1 to December 31 of the calendar year being measured. There is a look-back period from August 1 of the year prior to the measurement year to December 31 of the year prior to the measurement year. Data from the look-back period should be collected from the measurement year prior to the reporting year. For example, for the 2026 reporting period, look-back period data should be collected from August 1, 2025 through December 31, 2025.

C. ELIGIBLE POPULATION

Age	Age 18 and older as of the first day of the measurement year.
Continuous enrollment	Enrollee must be continuously enrolled in a health home program for at least 30 days from August 1 of the year prior to the measurement year to July 31 of the measurement year.
Allowable gap	None.
Anchor date	None.
Benefit	Medical.
Event/ diagnosis	None.

Required exclusions	Exclude enrollee-months that meet any of the following criteria: • Enrollees who resided in a facility for an entire month: Enrollees whose residence was identified as within a facility (i.e., did not reside at home or a location identified as their home) do not contribute days in the community for this month. • Enrollees who died: Enrollees who die during the measurement period contribute days in the community to the measure until the month in which they die. The month containing date of death (and any subsequent months for which coverage is extended) do not contribute days in the community.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Number of enrollee months where the enrollee was residing in the community for at least one day of the month.[1]

Step 1

Identify the eligible population as defined above.

Step 2

Determine enrollee months between August 1 of the year prior to the measurement year and July 31 of the measurement year using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the state's administrative processes. For example, if the state tallies enrollment on the 15th of the month and an enrollee is enrolled in the health home program on January 15, the enrollee contributes one enrollee month in January. The day selected must be consistent from person to person, month to month, and year to year.

Step 3

Identify the months where the enrollee was residing in a facility for the entire month (e.g., no days in the month were spent residing in the community). Remove these months from the denominator.

Step 4

Remove from the measure denominator the month when an enrollee dies, and any subsequent months.

Step 5

Calculate the continuous enrollment. Remove months for individuals who do not meet the continuous enrollment criteria.

Step 6

Divide the population into age stratification groups. Use the enrollee's age on the specified day of each month to determine to which age group the enrollee months will be attributed. For example, if the state tallies enrollees on the 15th of each month and an enrollee turns

[1] For example, if an enrollee was admitted to a facility on February 12 and discharged on April 15, February and April would count in the denominator, but March would not. States should only count months when there is an opportunity for an admission.

65 on April 3 and is enrolled from August 1 of the year prior to the measurement year through July 31 of the measurement year, then the enrollee contributes eight enrollee months to the 18 to 64 age group category and four enrollee months to the 65 to 74 age category.

Numerator

The number of facility admissions (FA) from a community residence from August 1 of the year prior to the measurement year through July 31 of the measurement year.

FAs are reported in three categories: (1) short-term stay (1 to 20 days), (2) medium-term stay (21 to 100 days), and (3) long-term stay (greater than or equal to 101 days).

Use the steps below to identify numerator events.

Step 1

Identify all FAs between August 1 of the year prior to the measurement year and July 31 of the measurement year (Institutional Facility Value Set (i.e., MLTSS-6-8 Value Sets Facility Uniform Bill Codes)).

Step 2

Remove FAs that are direct transfers from another facility. Keep the original admission date as the date of the new FA. A direct transfer is when the discharge date from the first facility setting precedes the admission date to a second facility setting by one calendar day or less. For example:

- Facility discharge on June 1, followed by an admission to another facility setting on June 1, is a direct transfer.
- Facility discharge on June 1, followed by an admission to another facility setting on June 2, is a direct transfer.
- Facility discharge on June 1, followed by an admission to another facility setting on June 3, is not a direct transfer; these are two distinct new facility stays.

Step 3

Remove admissions from the hospital that originated from a facility. Keep the original FA date (that preceded the admission to the hospital) as a new FA date.

Step 4

Remove admissions that result in death in the facility or death within one day of discharge from the facility.

Step 5

For all FAs, look for location of the first between August 1 of the year prior to the measurement year and July 31 of the measurement year.

- If the enrollee is discharged to the community, calculate length of stay (LOS) as the date of facility discharge minus the index admission date.
- If there is no discharge, calculate LOS as the date of the last day of the measurement year minus the index admission date.
- If the enrollee is discharged to the hospital, look for the hospital discharge and location of discharge. If the enrollee is discharged from the hospital to the community, calculate LOS as the date of hospital discharge minus the FA date.

- If the enrollee is discharged to the hospital and dies in the hospital, exclude the admission from the numerator.
- If the enrollee is discharged to the hospital and remains in the hospital at the end of the measurement year, exclude the admission from the numerator.
- If the enrollee is discharged to the hospital and then admitted back to the facility, repeat Step 5 until there is a discharge to the community or the end of the measurement year. When calculating the LOS, include all hospital days between the FA date and discharge to the community or end of the measurement year.
- If the enrollee is discharged to a different facility (e.g., a transfer), repeat Step 5 until there is a discharge to the community or the end of the measurement year. When calculating the LOS, include all facility days between the FA date and discharge to the community or the end of the measurement year.
- When counting the duration of each stay within a measurement year, include the day of entry (admission) but not the day of discharge, unless the admission and discharge occurred on the same day, in which case the number of days in the stay is equal to one.

Step 6

Classify LOS for each FA as short-term (1 to 20 days), medium-term (21 to 100 days), or long-term (greater than or equal to 101 days).

Step 7

Determine the enrollee's age at the time of admission and assign to an age category: 18 to 64, 65 to 74, 75 to 84, or 85 or older.

Calculating Performance Rate

Calculate the admission rate for each type of stay and age category by dividing the number of admissions by the number of enrollee months and multiplying by 1,000 as follows:

- Short-term admission rate = (Number of short-term admissions / number of enrollee months) x 1,000. Calculate the rate for each of the four age groups: 18 to 64, 65 to 74, 75 to 84, and 85 or older.
- Medium-term admission rate = (Number of medium-term admissions / number of enrollee months) x 1,000. Calculate the rate for each of the four age groups: 18 to 64, 65 to 74, 75 to 84, and 85 or older.
- Long-term admission rate = (Number of long-term admissions / number of enrollee months) x 1,000. Calculate the rate for each of the four age groups: 18 to 64, 65 to 74, 75 to 84, and 85 or older.

Table AIF-A. Table for Reporting Admissions to a Facility from the Community

Age Category	Number of Enrollee Months	Number of Short-term Admissions	Short-term Admissions/ 1,000 Enrollee Months	Number of Medium-term Admissions	Medium-term Admissions/ 1,000 Enrollee Months	Long-Term Admissions	Long-Term Admissions/ 1,000 Enrollee Months
18 to 64							
65 to 74							
75 to 84							
85 and Older							
Total: Age 18 and Older							

MEASURE IU-HH: INPATIENT UTILIZATION

Centers for Medicare & Medicaid Services

A. DESCRIPTION

Rate of acute inpatient care and services (total and mental and behavioral disorders) per 1,000 enrollee months among enrollees.

Data Collection Method: Administrative

Guidance for Reporting:

- This measure applies to enrollees of all ages. For the purpose of 1945 Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable) and a total rate: ages 0 to 17, ages 18 to 64, age 65 and older, and total (all ages).
- Report all services the state paid for or expects to pay for (e.g., claims incurred but not paid). Do not include services and days denied for any reason.
- This measure includes discharges and days for total inpatient use and by type of use (mental and behavioral disorders).
- Supplemental data may not be used for this measure.
- Enrollees in hospice are excluded from the eligible population.

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. DEFINITION

Enrollee months	Enrollee months are an enrollee's "contribution" to the total yearly enrollment. Enrollee months are calculated by summing the total number of months each enrollee is enrolled in the program during the measurement year.

C. ELIGIBLE POPULATION

Age	All health home enrollees.
Continuous enrollment	None.

D. ADMINISTRATIVE SPECIFICATION

Denominator

Number of enrollee months.

Step 1

Determine enrollee months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the state's administrative processes. The

day selected must be consistent from enrollee to enrollee, from month to month, and from year to year. For example, if the state tallies enrollment on the 15th of the month and an enrollee is enrolled in the Medicaid health home program on January 15, the enrollee contributes one enrollee month in January.

Step 2

Use the enrollee's age on the specified day of each month to determine the age group to which the enrollee months will be contributed. For example, if a state tallies enrollees on the 15th of each month and an enrollee turns 65 on April 3 and is enrolled for the entire year, then the enrollee contributes three enrollee months to the ages 18 to 64 category and nine enrollee months to the age 65 and older category.

Numerator

Identify inpatient utilization and report by discharge date, rather than by admission date, and include all discharges that occurred during the measurement year, using the following steps.

Step 1

Identify all acute inpatient discharges on or between January 1 and December 31 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.

Step 2

Exclude newborn care rendered from birth to discharge home from delivery (only include care rendered during subsequent rehospitalizations after the delivery discharge). Identify newborn care by a principal diagnosis of live-born infant (Deliveries Infant Record Value Set). States must develop methods to differentiate between the mother’s claim and the newborn’s claim, if needed.

Step 3

Report total inpatient, using all discharges identified after completing steps 1 and 2.

Step 4

Report mental and behavioral disorders. From total inpatient (identified in step 3), identify mental health and chemical dependency (Mental and Behavioral Disorders Value Set).

Step 5

Use the formulas below to report length of stay (LOS)

- LOS: All approved days from admission to discharge. The last day of the stay is not counted unless the admission and discharge date are the same.
- LOS = Discharge date – admit date – denied days

- Note: When an inpatient revenue code (UB or equivalent code) is associated with a stay, the LOS must equal at least one day. If the discharge date and the admission date are the same, then the discharge date minus the admission date equals one day, not zero days.

Step 6

Report tables IU-A and IU-B using the following instructions:

- Discharge: Total discharges associated with specified diagnosis codes. If the state cannot report by discharge date, report data by admission date and indicate the reason in the "Additional Notes/Comments on Measure" section.
- Discharge / 1,000 enrollee months: (Total discharges / enrollee months) x 1,000
- Total days incurred: The sum of the LOS for all discharges during a measurement year. The total does not include the last day of the stay (unless the last day of stay is also the admit day) or denied days.
  - Total days incurred includes days before January 1 of the measurement year for discharge dates occurring during the measurement year.
  - Total days incurred does not include days during the measurement year that are associated with discharge dates in the year after the measurement year.
- Total days incurred / 1,000 enrollee months: (Total days incurred / enrollee months) x 1,000.
- Average Length of Stay: Total days / total discharges.

Table IU-A. Table for Reporting Enrollee Months, by Age

Age	Enrollee Months
0–17	
18–64	
65 and Older	
Unknown	
Total	

Table IU-B. Table for Reporting Inpatient Utilization per 1,000 Enrollee Months, by Age and Type of Inpatient Utilization

Age and Type of Inpatient Utilization	Discharges	Discharges/ 1,000 Enrollee Months	Days	Days/ 1,000 Enrollee Months	Average Length of Stay
Inpatient					
0–17					
18–64					
65 and Older					
Unknown					

Age and Type of Inpatient Utilization	Discharges	Discharges/ 1,000 Enrollee Months	Days	Days/ 1,000 Enrollee Months	Average Length of Stay
Total Inpatient					
Mental and Behavioral Disorders					
0–17					
18–64					
65 and Older					
Unknown					
Total Mental and Behavioral Disorders					

E. ADDITIONAL NOTES

This measure has been adapted from the retired NCQA HEDIS measure Inpatient Utilization—General Hospital/Acute Care. The 1945 Health Home Core Set measure specification includes value sets for mental and behavioral disorders-related inpatient care; excludes stratification for maternity-related stays; includes additional language from the HEDIS section, Guidelines for Utilization Measures; and modifies the age stratifications.

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

This chapter presents the technical specifications for each measure in the 1945 Health Home 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 V includes guidelines for reporting measures using ECDS specifications.

These specifications represent the most applicable version available from the measure steward as of December 2025.

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 an enrollee'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 1945 Health Home 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, enrollee 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 a Health Home 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 2026 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, enrollee 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. Enrollee-reported services are acceptable if the information is recorded, dated, and maintained in the enrollee's legal health record.

  Data sources are categorized using the following criteria.

- **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, enrollee eligibility and enrollment files, electronic rosters, and internal audit files.

- **Reporting ECDS Measure Results**. For the purposes of Core Set reporting, states will report overall results rather than by data source. There is no requirement that states must use all of the allowable ECDS data sources included in the specifications. For example, for measures that transitioned from Administrative to ECDS, states can continue to rely on administrative data where available using the ECDS reporting specifications. When reporting ECDS measures in the online reporting system, states are encouraged to indicate which types of ECDS data sources were used. See Section II for additional guidance on reporting.

[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 COL-HH: COLORECTAL CANCER SCREENING

National Committee for Quality Assurance

Description	The percentage of enrollees ages 45 to 75 years who had appropriate screening for colorectal cancer.
Core Set data collection method	Electronic Clinical Data Systems (ECDS)
Guidance for Core Set reporting	• This measure applies to enrollees ages 46 to 75 to account for the lookback period (to ensure that the enrollee was at least age 45 for the entire measurement period). For HEDIS, this measure has two reportable age groups and a total rate: ages 46 to 50, ages 51 to 75, and total (ages 46 to 75). For the purpose of Health Home Core Set reporting, states should calculate and report this measure for three age groups (as applicable): ages 46 to 50, ages 51 to 65, and ages 66 to 75. • NCQA's Medication List Directory (MLD) is available to order free of charge in the NCQA Store (https://store.ncqa.org/hedis-my-2025-medication-list-directory.html/). Once ordered, it can be accessed through the NCQA Download Center (https://my.ncqa.org/Downloads). • Include all paid, suspended, pending, and denied claims. • Please refer to Section II. Data Collection and Reporting and Section V. Guidelines for Measures Reported Using ECDS for additional guidance. • The electronic clinical quality measure (eCQM) specification for the 2026 Core Set is located on the eCQI resource center at https://ecqi.healthit.gov/ecqm/ec/2025/cms0130v13. States that use electronic specifications should indicate this by selecting "Electronic Health Records" in the "Data Collection Method" section of the online reporting system. Please note that there may be variations between the electronic specification and the ECDS specifications. States should use caution comparing measures calculated using different data collection methods.
Coding systems referenced	• This measure's Value Set Directory includes the following coding systems for services, procedures, and diagnoses: CPT, HCPCS, ICD-10-CM, ICD-10-PCS, 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.

<table>
<tr><td>Measure characteristics</td><td>Scoring Proportion.
Type Process.
Stratification Core Set age stratifications:
Ages 46 to 50.
Ages 51 to 65.
Ages 66 to 75.
Risk adjustment None.
Improvement notation A higher rate indicates better performance.</td></tr>
<tr><td>Initial population</td><td>Measure Item Count: Person
Attribution: Enrollment
Benefit: Medical
Continuous enrollment: The measurement period and the year prior to the measurement period.
Allowable gap: No more than one gap in enrollment of up to 45 days during each calendar year (i.e., the measurement period and the year prior to the measurement period).
The enrollee must be enrolled on the last day of the measurement period.
Age: 46 to 75 as of the end of the measurement period.</td></tr>
<tr><td>Required Exclusions
(Supplemental and medical record data may be used for these exclusions)</td><td>Enrollees 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.
Enrollees who die any time during the measurement period.
Enrollees who had colorectal cancer (Colorectal Cancer Value Set) any time during the enrollee’s history through December 31 of the measurement year. Do not include laboratory claims (claims with POS 81).
Enrollees who had a total colectomy (Total Colectomy Value Set; SNOMEDCT code 119771000119101) any time during the enrollee’s history through December 31 of the measurement period.
Enrollees age 66 years and older by the end of the measurement period, with frailty and advanced illness. Enrollees must meet BOTH frailty and advanced illness criteria to be excluded:
Frailty. At least two indications of frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) with different dates of service during the measurement period. Do not include laboratory claims (claims with POS 81).
Advanced Illness. Either of the following during the measurement period or the year prior to the measurement period:
Advanced illness (Advanced Illness Value Set) on at least two different dates of service. Do not include laboratory claims (claims with POS 81).
Dispensed dementia medication (Dementia Medications List).</td></tr>
</table>

Required Exclusions (Supplemental and medical record data may be used for these exclusions) (continued)	• Enrollees receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) any time during the measurement period. • Enrollees who had an encounter for palliative care (ICD-10-CM code Z51.5) any time during the measurement year. Do not include laboratory claims (claims with POS 81).
Denominator	The initial population, minus exclusions.
Numerator	Enrollees with one or more screenings for colorectal cancer. Any of the following meet criteria: • Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement period. For administrative data, assume the required number of samples were returned, regardless of FOBT type. • Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; SNOMEDCT code 708699002) during the measurement period or the 2 years prior to the measurement period. • Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; SNOMEDCT code 841000119107) during the measurement period or the 4 years prior to the measurement period. • CT colonography (CT Colonography Value Set) during the measurement period or the 4 years prior to the measurement period. • Colonoscopy (Colonoscopy Value Set; SNOMEDCT code 851000119109) during the measurement period or the 9 years prior to the measurement period.
Clinical recommendation statement	The U.S. Preventive Services Task Force "recommends screening for colorectal cancer in all adults aged 50 to 75 years (A recommendation) and all adults aged 45 to 49 years (B recommendation)." Potential screening methods include an annual guaiac-based fecal occult blood test (gFOBT), annual fecal immunochemical test (FIT), multitargeted stool DNA with FIT test (sDNA FIT) every 3 years, colonoscopy every 10 years, CT colonography every 5 years, flexible sigmoidoscopy every 5 years or flexible sigmoidoscopy every 10 years, with FIT every year.
Citations	U.S. Preventive Services Task Force. 2021. "Screening for Colorectal Cancer: U.S. Preventive Services Task Force Recommendation Statement." *JAMA* 325(19):1965–1977. doi:10.1001/jama.2021.6238

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 a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC) • A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry

Practitioner Type	Definition
Mental Health Provider (continued)	• A certified Community Mental Health Center (CMHC), or the comparable term (e.g., behavioral health organization, mental health agency, behavioral agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC) - Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria: o The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act). o The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or country in which it is located. - Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria: o Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a)(42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC o Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grants or funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC
Obstetrician/ Gynecologist (OB/GYN) and Other Prenatal Care Practitioner	Includes: • Physicians certified as obstetricians or gynecologists by the American Medical Specialties Board of Obstetrics or Gynecology or the American Osteopathic Association; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in obstetrics and gynecology • Certified nurse midwives, nurse practitioners, and physician assistants who deliver prenatal care services in a specialty setting (under the direction of an OB/GYN certified or accredited provider)

Practitioner Type	Definition
Primary Care Practitioner (PCP)	A physician or nonphysician (e.g., nurse practitioner, physician assistant, certified nurse midwives) 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. • To be certified as an FQHC, an entity must meet any one of the following criteria: - Is receiving a grant under Section 330 of the Public Health Service (PHS) Act (42 United States Code Section 254a) or is receiving funding from such a grant and meets other requirements - Is not receiving a grant under Section 330 of the PHS Act but is determined by the Secretary of the Department of Health & Human Services (HHS) to meet the requirements for receiving such a grant (qualifies as a "FQHC look-alike") based on the recommendation of the Health Resources and Services Administration - Was treated by the Secretary of HHS for purposes of Medicare Part B as a comprehensive Federally-funded health center as of January 1, 1990 - Is operating as an outpatient health program or facility of a tribe or tribal organization under the Indian Self Determination Act or as an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1991 • For certification as an FQHC, the entity must meet all of the following criteria (in addition to one of the criteria above): - Provide comprehensive services and have an ongoing quality assurance program - Meet other health and safety requirements - Not be concurrently approved as a Rural Health Clinic (RHC) o Only certified RHCs are considered PCPs. o To be certified as a RHC, the entity must meet CMS requirements to qualify for payment via an all-inclusive rate (AIR) for medically-necessary primary health services and qualified preventive health services furnished by an RHC practitioner.
Prescribing Practitioner	A practitioner with prescribing privileges, including nurse practitioners, physician assistants, and other non-MDs who have the authority to prescribe medications