NCQA Data Resource Guide

The tables below share guidelines for ensuring accurate, high-quality data submissions. If your practice data does not align with the guidance in the tables, enter a note in Q-PASS describing your circumstances to provide context for your evaluator and the Review Oversight Committee (ROC).

eCQM Average Percentage Guidance

This table displays the measurement year (MY) 2025 (submission year 2026) eCQM standardized measures and a threshold percentage that is an average of one standard deviation below the averages of data submitted by PCMH practices from (MY) 2023 and 2024 (submission years 2024 and 2025, respectively).

If your submitted percentage is less than the percentage listed, enter a descriptive note in Q-PASS to provide context to your evaluator and the ROC. Note that for inverse measures (i.e., CMS 122), a lower denominator is better than a high percentage.

Some measures have updated definitions for MY 2025 (submission year 2026) that could impact performance. These are notated below with the definition change as well as MY 2023 and MY 2024's averages, for your reference. Currently, there are no threshold percentages listed for these eCQMs due to the new definitions not being an "apples-to-apples" comparison. Please enter the data you have for your practice(s) and a note of context if you feel clarifying information would be useful for your evaluator and the ROC.

Measure Name	Threshold Percentage
Immunization Category	
CMS 117: Childhood Immunization Status (Pediatric practices)	20%
Custom immunization measure (Adult practices)	
Preventive Category	
CMS 124: Cervical Cancer Screening	43%
CMS 130: Colorectal Cancer Screening	45%
CMS 125: Breast Cancer Screening	51%
CMS 69: Body Mass Index Screening and Follow-Up Plan	64%
CMS 138: Tobacco Use: Screening and Cessation Intervention (Rate 1)	70%
CMS 138: Tobacco Use: Screening and Cessation Intervention (Rate 2)	39%
CMS 138: Tobacco Use: Screening and Cessation Intervention (Rate 3)	40%
CMS 22: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	47%
CMS 349: HIV Screening	46%
CMS 155: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (Rate 1)	80%
CMS 155: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (Rate 2)	60%
CMS 155: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Rate 3)	56%

CMS 153: Chlamydia Screening in Women	40%
CMS 139: Fall: Screening for Future Fall Risk	67%
CMS 1188: Sexually Transmitted Infection Testing for People with HIV	73%
Behavioral Health Category	
CMS 136: Follow-Up Care for Children Prescribed ADHD Medication (ADD) (Rate 1)	32%
CMS 136: Follow-Up Care for Children Prescribed ADHD Medication (ADD) (Rate 2)	44%
CMS 2: Screening for Depression and Follow-Up Plan	59%
CMS 137: Initiation and Engagement of Substance Use Disorder Treatment (Rate 1)	33%
CMS 137: Initiation and Engagement of Substance Use Disorder Treatment (Rate 2)	15%
CMS 159: Depression Remission at Twelve Months	4%
CMS 128: Anti-depressant Medication Management (Rate 1) ***Note:*** *MY 2025's denominator definition has changed from, "Patients 18 years of age and older as of April 30 of the measurement period…" to "Patients 18 years of age and older as of the IPSD…" (MY 2023 average = 20%; MY 2024 average = 60%)*	
CMS 128: Anti-depressant Medication Management (Rate 2) ***Note:*** *MY 2025's denominator definition has changed from, "Patients 18 years of age and older as of April 30 of the measurement period…" to "Patients 18 years of age and older as of the IPSD…" (MY 2023 average = 29%; MY 2024 average = 39%)*	
CMS 177: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	35%
Chronic or Acute Care Category	
CMS 165: Controlling High Blood Pressure	61%
CMS 122: Diabetes HbA1C Poor Control (>9%) *(Inverse Measure)* ***Note:*** *MY 2025 includes glucose management indicator in addition to A1c measurement. (MY 2023 average = >42%; MY 2024 average = >41%)*	
CMS 131: Diabetes Eye Exam	37%
CMS 347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Rate 1)	69%
CMS 347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Rate 2)	64%
CMS 347: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Rate 3)	68%
CMS 149: Dementia: Cognitive Assessment	68%
CMS 314: HIV Viral Suppression	84%
Custom chronic or acute care measure for pediatric practices	
Care Coordination Category	
CMS 50: Closing the Referral Loop	43%
CMS 68: Documentation of Current Medications in the Medical Record ***Note:*** *MY 2025 has removed the age requirement of 18 years and older.* ***The measure is now looking at all patients.*** *(MY 2023 average = 79%; MY 2024 average = 78%)*	
Health Care Costs Category	
CMS 146: Appropriate Testing for Pharyngitis	56%
CMS 154: Appropriate Treatment for Upper Respiratory Infection (URI)	61%

CM 04: Person-Centered Care Plan Guidance

An NCQA patient-centered care plan has five requirements:

Problem List	A full problem list gives the patient and their providers a global view of the patient's health.	
Medication List and Management	A list of all medications the patient is currently taking (not only medication adjustments made during a visit with a provider).	
Expected outcomes/prognosis	Often a clinical goal. Think about it as if the patient follows their care plan, this should be the result.	***Example #1**: Achieve a BMI of <25.* ***Example #2**: Improve attention at school and increase social interactions with peers.*
Treatment goals	The patient's goals to reach the expected outcome/prognosis.	***Example #1**: Eat fried fast food only once a week and walk on the treadmill for 30 minutes three times a week.* ***Example #2**: Continue to take ADHD medication, create a calendar and follow structured routines, increase sleep to 8 hours a night. Join a school club for increased in-person socialization outside of the classroom.*
Schedule to review and revise	A specific date or schedule, such as "every 2 months." A schedule is important for both the patient and care team; it lets them check in, celebrate successes, talk about barriers and update the plan if necessary.	

A robust care plan includes the five requirements above plus any (or all) of these components:

Patient preferences and goals (CM 06)	Goals that are personal to the patient. If goals are meaningful, a patient may be more likely to adhere to the care plan.	***Example #1:** "I want to walk in a 5K next summer."* ***Example #2**: "I want to be comfortable around people and have a birthday party."*
Patient barriers to goals (CM 07)	Addressing barriers early helps the patient from deviating from the plan and supports their success. This is another reason to schedule follow-up visits.	
Self-management plans (CM 08)	Self-management instructions help patients through day-to-day challenges. They may also reduce ED visits, as the patient can manage changes in their condition on their own with a self-management tool.	
Person-centered outcomes approach (CM 10)	This component of the care plan quantifies a patient's progress in meeting their personal goal, using a patient-reporting outcome measure (PROM) or a goal attainment scale.	***Example #1:** Goal Attainment Scale for time on the treadmill.* ***Example #2:** PROMIS tool: Social Isolation.*
Person-centered outcomes approach (CM 11)	This involves monitoring and follow-up with the patient, revisiting the PROM or goal attainment scale and comparing the initial score with a new score. Is the patient getting closer to meeting their personal goals, or does the care plan need to be revised?	

A care plan should be created collaboratively by patient and provider and should be easily understood by the patient/family/caregivers. This gives the patient ownership of their health and confidence in meeting their goals.

Data Consistency

This table provides guidance to assist practices with data consistency. The examples below are Transform criteria but align and are relevant to Annual Reporting criteria.

Verify Size of Patient Population		
Step 1—Collect the following information	Patient population (number of unique patients seen in the last calendar year): KM 09: Diversity denominator..... KM 10: Language denominator.....	
Step 2—Review the data	Are the numbers consistent? For example, if a practice sees 10,000 patients in 1 year, but the denominator for KM 09 (with 6 months of data) is 1,000, the data are not consistent. The practice's KM 09 denominator should be aligned with 5,000 patients. NCQA would ask the practice to rerun the data and work with its vendor if there is a reporting issue. ***Note:*** *A full year is recommended for KM 09 and KM 10 to fully represent the patient population, but it is not required.*	
Criteria	**Data Consistency Questions**	**Recommended Guidelines & Logic**
CM 01–CM 03: Care Management	Is the percentage of care managed patients reasonable for your practice size? **Numerator:** Total number of patients enrolled in care management. **Denominator:** Total number of patients in the practice.	**Review CM 01 and rework data.** Ensure that only patients enrolled in care management are counted. Care management targets a subset of higher-need or at-risk patients, not only "average" patients. Care plans *are not* for acute conditions or for patients who are not enrolled in care management. *This guidance applies to CM 02 as well.*
	Is the number of care-managed patients <30?	**Review CM 01 and rework data.** Ensure the practice addresses a minimum of three categories identified in CM 01. Expand the categories if necessary to meet the minimum requirement. CM 01: Establish a systematic process and criteria for identifying patients who may benefit from care management (must include at least three): A. Behavioral health conditions. B. High cost/high utilization. C. Poorly controlled or complex conditions. D. Social determinants of health. E. Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver.

Criteria	Data Consistency Questions	Recommended Guidelines & Logic
CC 01: Imaging Test Management	Is the denominator 30, or do <40% of adult patients receive an imaging order? **Numerator:** Number of images ordered for which the practice received a results report. **Denominator:** Number of imaging orders in the reporting period.	**Did the practice use the Record Review Workbook (Transforming practices)?** Enter a note advising the ROC that the workbook was used. **Does the practice have a reliable system in place to capture data?** On average, more than 40% of adult patients will have an imaging study completed during the year. If the denominator is small, enter a note advising the ROC how the practice's system captures the data. ***Note:*** *Pediatric practices typically have considerably lower imaging studies than adult practices.*
QI 01: Clinical Quality Measures	Does the denominator seem appropriate for the patient population size? The denominator should be all patients in the patient population, as defined by CMS eCQM measures, less allowable exceptions. See **the eCQI Resource Center's** website. Select the measure specification identified with the performance year (e.g., for a 2026 submission, select the version with (2025) stated).	**Did the practice use the Record Review Workbook (Transforming practices)?** Enter a note advising the ROC that the workbook was used. **Is the report pulling data correctly?** Contact the EHR vendor to ensure the report is pulling data correctly. *If yes:* Enter a note to the ROC explaining why the data appear large. *If no:* Request a custom measure via PCS, and work with the vendor to correct the report for next year's submission.
General QI	Are the denominators appropriate when the measure applies to "patients" or "visits," as related to the reported population size within the Questionnaire?	Most commonly, CMS 22: Screening for High Blood Pressure and Follow-Up for Ages 18+; CMS 69: BMI Screening and Follow-Up for Ages 18+; CMS 2: Depression Screening and Follow-Up for Ages 12+. Explain inconsistencies in a note to the ROC.
QI 02: Resource Stewardship Measures	Does the denominator seem appropriate for the patient population size?	**Is the report pulling data correctly?** Contact the EHR vendor to ensure the report is pulling data correctly. *If yes:* Enter a note to the ROC explaining why the data appear large. *If no:* Request a custom measure via PCS, and work with the vendor to correct the report for next year's submission.
	Is CMS: 146: Appropriate Testing for Pharyngitis <56% ***and/or***	**Does the practice have a reliable system in place to capture data?** Typically, primary care practices see many URIs per year. If the denominator is small, enter a note

	Is CMS 154: Appropriate Treatment for Upper Respiratory Infection <61%?	advising the ROC how the practice's system captures the data. **What version of the measure is the vendor using?** If the vendor is using an older version of the specifications (age limit 18), provide the vendor with the correct version for future reporting (refer to the link below). Request a custom measure to report for this year. ***Notes:*** *Specifications change yearly. Refer to the* ***eCQI Resource Center*** *yearly to obtain the current version of measures.* *The year posted at the end of the measure title is the measurement year (1 year prior to the submission year). For example, CMS 146: Appropriate Testing for Pharyngitis (2025) is the 2025 measurement year and the 2026 submission year.* **Is the practice documenting appropriately to capture these patients within their EHR?** Review the specifications to ensure the practice is capturing the correct data for further reporting.
	Is CMS 50: Closing the Referral Loop <43%?	**Does the practice have a reliable system in place to capture data?** Closing the referral loop between PCP and specialist ensures patient safety, reduces duplicated tests and improves successful coordination across clinicians. If the denominator is <30, and/or the performance rate is <43%, enter a note to provide their evaluator and the ROC additional context. ***Note:*** *Per CMS measure specifications, "If there are multiple consultant reports received by the referring clinician which pertain to a particular referral, use the first consultant report to satisfy the measure."*

General Data Guidance

If percentages are questionable, confirm with the vendor that reports are pulling data correctly.

If data are being pulled correctly, enter an explanation to give the ROC context for the final decision.

If the report is not pulling data correctly, request a custom measure and work with the vendor to correct the eCQM for next year's reporting.