

Special Report: Results for Measures Leveraging Electronic Clinical Data for HEDIS®

October 2026

This special report describes results for nineteen HEDIS® measures that use the **Electronic Clinical Data Systems reporting standard**.

Key Findings

- Overall, reportable submissions were higher in MY 2025 than in prior years for most measures across product lines.
- There was an increase in the contributions of non-claims data sources (i.e., EHR, HIE/registry and case management data) for numerator reporting.
- Generally, plans that used electronic, non-claims data sources had better performance than plans that used claims data alone.

Background

About HEDIS

The Healthcare Effectiveness Data and Information Set® (HEDIS®¹) is a national measurement set that assesses how well Medicare, Medicaid, and commercial health insurance plans manage the quality of care for their enrolled populations. HEDIS assesses performance using a set of metrics that range from preventive services to behavioral health care and chronic disease management.

HEDIS ECDS Reporting Standard

In 2015, the National Committee for Quality Assurance (NCQA) introduced the HEDIS **Electronic Clinical Data Systems** (ECDS) reporting standard, which permits use of structured data for HEDIS reporting from a variety of sources, including but not limited to electronic health records (EHRs), health information exchanges (HIE) and clinical registries, case management systems and administrative files. The use and sharing of electronic clinical data have the potential to enrich the information available to health care providers for clinical care, and to decrease the burden associated with measures that require manual record abstraction.

NCQA initially introduced ECDS reporting for three depression measures that rely on clinical information not typically available in claims data, including depression screening results, symptom monitoring and patient-reported outcomes. Since then, NCQA has added sixteen additional measures evaluating immunizations, behavioral health, cancer screening, maternal health, chronic condition management and health equity. This report summarizes aggregate reporting results for the nineteen measures specified using the ECDS reporting method. Reportable submission results are presented for all measures, while performance and data source analyses focus on selected measures that illustrate broader ECDS reporting trends.

Traditional HEDIS Reporting Methods

Most measures in HEDIS have been reported using a plan's administrative data, such as claims for health care services and enrollment files (referred to as the Administrative Method). Some measure concepts cannot be evaluated using administrative data alone; in these cases, plans pull a systematic sample of medical records

¹ HEDIS is a registered trademark of the National Committee for Quality Assurance.

and review information manually to ascertain whether health care services were provided (referred to as the Hybrid Method). For both the Administrative and Hybrid methods, results are often enhanced by “supplemental data,” or information coming from a variety of data sources plans collect and to more completely capture services provided.

As electronic clinical data has become more available and accessible, NCQA has expanded the ECDS reporting method across HEDIS and continues to transition measures from traditional reporting methods to ECDS reporting over time. Most recently, *Cervical Cancer Screening (CCS-E)*, *Childhood Immunization Status (CIS-E)* and *Immunizations for Adolescents (IMA-E)* transitioned to ECDS-only reporting for MY 2025. This ongoing expansion supports the move to digital quality measurement, reduces reliance on manual medical record review and promotes the use of interoperable clinical data for quality reporting.

Data Source and Methods

This report is based on data submitted to NCQA by health plans for the 19 measures that were reported using the HEDIS ECDS reporting method (Box 1) for measurement year 2025. Reporting and performance rates are calculated for the 2023, 2024 and 2025 measurement years. Key data elements (e.g., numerator) are reported by the data source category in which they were found. When a data element is found in more than one source, a hierarchy is applied to assign the data source category that should be used for reporting. The hierarchy prioritizes data from EHRs first, followed by HIE/registries, then case management registries and lastly administrative claims.²

We assessed the number of plans with a reportable rate, defined as rates meeting the minimum denominator criterion of 30 members (or deliveries in the case of the perinatal measures). These results were validated by an NCQA-certified auditor. We also completed an analysis of the reporting results by type of data source used. To understand variation in the use of data sources and its contribution to differences in performance, we assessed the proportion of each data source contributing to the measure numerator over time across reportable submissions, as well as the performance among submissions that used only claims data compared to those that used any non-claims data.

Box 1. HEDIS Measures for ECDS Reporting

- Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)
- Adult Immunization Status (AIS-E)
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)
- Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)
- Breast Cancer Screening (BCS-E)
- Blood Pressure Control for Patients with Hypertension (BPC-E)
- Cervical Cancer Screening (CCS-E)
- Childhood Immunization Status (CIS-E)
- Colorectal Cancer Screening (COL-E)
- Documented Assessment After Mammogram (DBM-E)
- Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)
- Depression Remission or Response for Adolescents and Adults (DRR-E)
- Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)
- Follow-Up After Abnormal Mammogram Assessment (FMA-E)
- Immunizations for Adolescents (IMA-E)
- Postpartum Depression Screening and Follow-Up (PDS-E)
- Prenatal Depression Screening and Follow-Up (PND-E)
- Prenatal Immunization Status (PRS-E)
- Social Need Screening and Intervention (SNS-E)

Findings

Reporting trends over the last three years across all nineteen measures are shown below, followed by performance and data source use results for immunization, behavioral health and cancer screening measures. The measures highlighted in this report, unless otherwise indicated, illustrate the trends observed across measures. Additional measure-specific reporting results are provided in the Appendix.

² Refer to the ECDS reporting guidelines in the [HEDIS Volume 2](#) publication for more information.

Reporting Trends

- There was an increase in reportable submissions for ECDS-reported measures for most measures across all product lines compared to previous years (Tables 1 & 2).
- In MY 2025, 100 percent of commercial, 97.5 percent of Medicaid and 97.2 percent of Medicare plans submitted reportable results based on the ECDS reporting method. In comparison, 100 percent of commercial, 96.8 percent of Medicaid and 95.1 percent of Medicare plans submitted ECDS-based results in MY 2023.
- In MY 2025, 95.5 percent of commercial and 85.6 percent of Medicaid plans reported *Prenatal Immunization Status (PRS-E)*, which was the first ECDS-reported measure to be publicly reported (MY 2020) and incorporated into NCQA's Health Plan Ratings program (MY 2021). See Table 1 for more detail on submissions for measures originally specified for ECDS by product line and measurement year.
- In MY 2025, 99.5 percent of commercial, 89.6 percent of Medicaid, and 84.7 percent of Medicare plans reported *Breast Cancer Screening (BCS-E)*, which was the first traditional measure specified for ECDS to have the traditional specification retired. See Table 2 for measures originally specified for traditional reporting by product line and measurement year.

Table 1. Reportable submissions for measures developed for ECDS Method, MY 2023-2025

Measure	Product Line	Number of Reportable Submissions ¹		
		MY 2023 (%)	MY 2024 (%)	MY 2025 (%)
Utilization of PHQ-9 (DMS-E), Total Indicator, All Ages	Commercial	366 (87.1)	347 (87.2)	356 (89.9)
	Medicaid	164 (59.0)	198 (71.7)	211 (75.9)
	Medicare	498 (65.5)	539 (77.0)	452 (67.8)
	Total	1,028	1,084	1,019
Depression Remission or Response (DRR-E), Remission Indicator, All Ages	Commercial	77 (18.3)	107 (26.9)	188 (47.5)
	Medicaid	71 (25.5)	105 (38.0)	144 (51.8)
	Medicare	113 (14.9)	159 (22.7)	170 (25.5)
	Total	261	371	502
Depression Screening and Follow-up (DSF-E), Screening Indicator, All Ages	Commercial	386 (91.9)	371 (93.2)	371 (93.7)
	Medicaid	200 (71.9)	231 (83.7)	239 (86.0)
	Medicare	718 (94.5)	677 (96.7)	646 (96.9)
	Total	1,304	1,279	1,256
Alcohol Screening and Follow-up (ASF-E), Unhealthy Alcohol Use Screening Indicator, All Ages	Commercial	364 (86.7)	342 (85.9)	355 (89.6)
	Medicaid	162 (58.3)	193 (69.9)	208 (74.8)
	Medicare	522 (68.7)	557 (79.6)	455 (68.2)
	Total	1,048	1,092	1,018
Adult Immunization Status (AIS-E), Td/Tdap, All Ages	Commercial	414 (98.6)	390 (98.0)	393 (99.2)
	Medicaid	239 (86.0)	251 (90.9)	255 (91.7)
	Medicare	723 (95.1)	679 (97.0)	648 (97.2)
	Total	1,376	1,320	1,296
Prenatal Immunization Status (PRS-E), Tdap Indicator	Commercial	395 (94.0)	375 (94.2)	378 (95.5)
	Medicaid	236 (84.9)	237 (85.9)	238 (85.6)
	Total	631	612	616
Prenatal Depression Screening and Follow-Up (PND-E), Depression Screening Indicator	Commercial	358 (85.2)	343 (86.2)	347 (87.6)
	Medicaid	172 (61.9)	194 (70.3)	208 (74.8)
	Total	530	537	555
Postpartum Depression Screening and Follow-Up (PDS-E), Depression Screening Indicator	Commercial	360 (85.7)	345 (86.7)	349 (88.1)
	Medicaid	171 (61.5)	200 (72.4)	208 (74.8)
	Total	531	545	557
Social Needs Screening and Intervention (SNS-E), Food Screening Indicator, All Ages	Commercial	317 (75.5)	317 (79.6)	315 (79.5)
	Medicaid	184 (66.2)	222 (80.4)	230 (82.7)
	Medicare	712 (93.7)	671 (95.9)	467 (70.0)
	Total	1,213	1,210	1,012
Documented Assessment After Mammogram (DBM-E)	Commercial			306 (77.3)
	Medicaid			214 (77.0)
	Medicare			424 (63.6)
	Total			944
Follow-Up After Abnormal Mammogram Assessment (FMA-E)	Commercial			55 (13.9)
	Medicaid			18 (6.47)
	Medicare			29 (4.35)
	Total			102
Blood Pressure Control for Patients with Hypertension (BPC-E)	Commercial			326 (82.3)
	Medicaid			216 (77.7)
	Medicare			452 (67.8)
	Total			994

¹ Submissions that had a denominator ≥ 30 and were validated by an NCQA-certified auditor.

²Percentage calculated out of the total number of plans that submitted HEDIS (**MY 2023:** Com. = 420, Medicaid = 278, Medicare = 760; **MY 2024:** Com. = 398, Medicaid = 276, Medicare = 700; **MY 2025:** Com. = 396, Medicaid = 278, Medicare = 667).

**Prenatal Immunization Status (PRS-E), Prenatal Depression Screening (PND-E), and Postpartum Depression Screening (PDS-E)* are reported by commercial and Medicaid plans only.

Table 2. Reportable submissions for traditional measures specified for ECDS, MY 2023-2025

Measure	Product Line	Number of Reportable ECDS Submissions ¹		
		MY 2023 (%) ²	MY 2024 (%) ²	MY 2025 (%) ²
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E), Initiation Phase Indicator	Commercial	289 (68.8)	310 (77.9)	317 (80.1)
	Medicaid	161 (57.9)	232 (84.1)	233 (83.8)
	Total	450	542	550
Breast Cancer Screening (BCS-E) ³ , Total Ages	Commercial			394 (99.5)
	Medicaid			249 (89.6)
	Medicare			565 (84.7)
	Total			1,208
Colorectal Cancer Screening (COL-E)	Commercial	404 (96.2)	397 (100.0)	395 (99.7)
	Medicaid	185 (66.5)	253 (91.7)	252 (90.6)
	Medicare	526 (69.2)	630 (90.0)	605 (90.7)
	Total	1,115	1,280	1,252
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), Blood Glucose and Cholesterol Testing Indicator, All Ages	Commercial	243 (57.9)	260 (65.3)	251 (63.4)
	Medicaid	149 (53.6)	225 (81.5)	230 (82.7)
	Total	392	485	481
Childhood Immunization Status (CIS-E), Influenza Indicator	Commercial	362 (86.2)	346 (86.9)	366 (92.4)
	Medicaid	176 (63.3)	202 (73.2)	242 (87.1)
	Total	538	548	608
Immunizations for Adolescents (IMA-E), Tdap Indicator	Commercial	372 (88.6)	349 (87.7)	363 (91.7)
	Medicaid	177 (63.7)	212 (76.8)	247 (88.8)
	Total	549	561	610
Cervical Cancer Screening (CCS-E)	Commercial	388 (92.4)	368 (92.5)	392 (99.0)
	Medicaid	177 (63.7)	216 (78.2)	257 (92.4)
	Total	565	584	649

¹ Submissions that had a denominator ≥ 30 and were validated by an NCQA-certified auditor.

² Percentage calculated out of the total number of plans that submitted HEDIS (**MY 2023:** Com. = 420, Medicaid = 278, Medicare = 760; **MY 2024:** Com.=398, Medicaid = 276, Medicare = 700; **MY 2025:** Com. = 396, Medicaid = 278, Medicare = 667).

³ *Breast Cancer Screening (BCS-E)* changed its age ranges in MY2025, so previous years' data are not shown.

**Follow-Up Care for Children Prescribed ADHD Medication (ADD-E), Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E), Childhood Immunization Status (CIS-E), Immunization for Adults (IMA-E), and Cervical Cancer Screening (CCS-E)* are reported by commercial and Medicaid plans only.

Immunization Measures

The *Adult Immunization Status (AIS-E)*, *Childhood Immunization Status (CIS-E)*, *Immunization for Adolescents (IMA-E)*, and *Prenatal Immunization Status (PRS-E)* measures assess whether adults, children, adolescents, and pregnant people, respectively, receive recommended vaccines (based on the Advisory Committee on Immunization Practices).

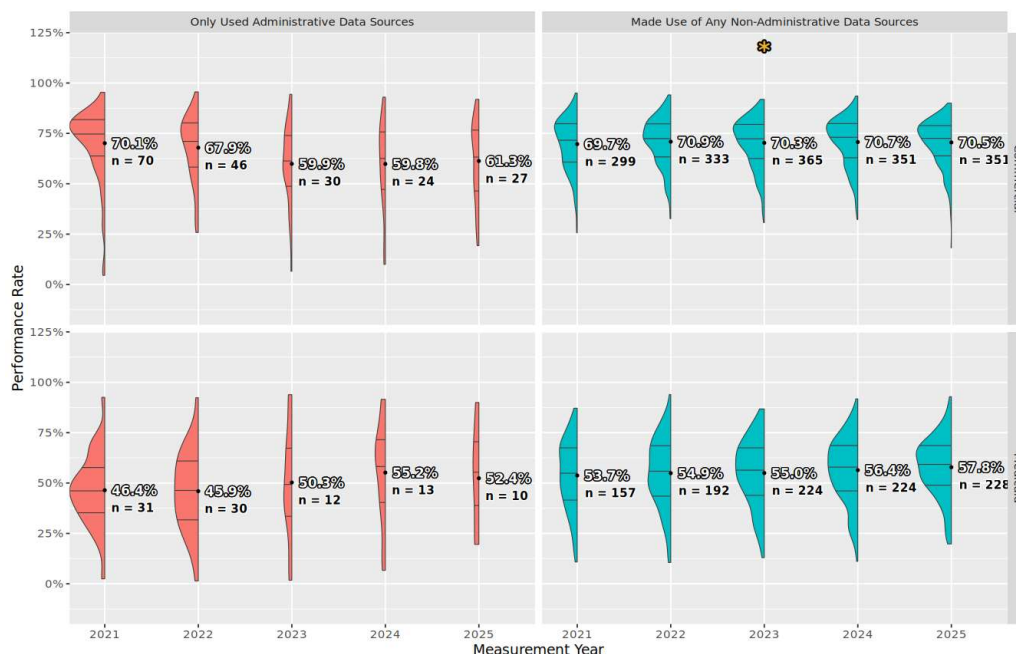
Overall Performance

- *PRS-E* performance decreased slightly across the Combination, Influenza, and Tdap indicators for the Commercial product line from MY 2024 to MY 2025, while increasing across all three indicators for the Medicaid product line. These performance rates are lower than prenatal vaccination rates reported in the Center for Disease Control & Prevention's (CDC) annual survey, except for the Tdap indicator in the commercial line.³
- *AIS-E* performance rates cannot be compared to previous years as its age ranges across indicators were changed between MY2024 and MY2025.
- *CIS-E* and *IMA-E* were transitioned to ECDS-only for MY 2025. Performance rates were similar between ECDS-only reporting in MY2025 and traditional reporting in MY2024.

Performance Rates by Data Sources Used

- Performance rates for the immunization measures varied by the data sources used for reporting.
 - Average performance rates across indicators and product lines were higher among plans that used any non-claims data for numerator calculations when compared with the average performance among plans that used only claims data (Table A1 in Appendix). For example, for MY 2025, the average performance among Medicaid plans that used only claims data for the *PRS-E*, Tdap indicator, was 52.4 percent, compared to 57.8 percent among plans that used any non-claims data (Figure 1).

Figure 1. Average Tdap performance rates for PRS-E by data source used, MY 2021-2025

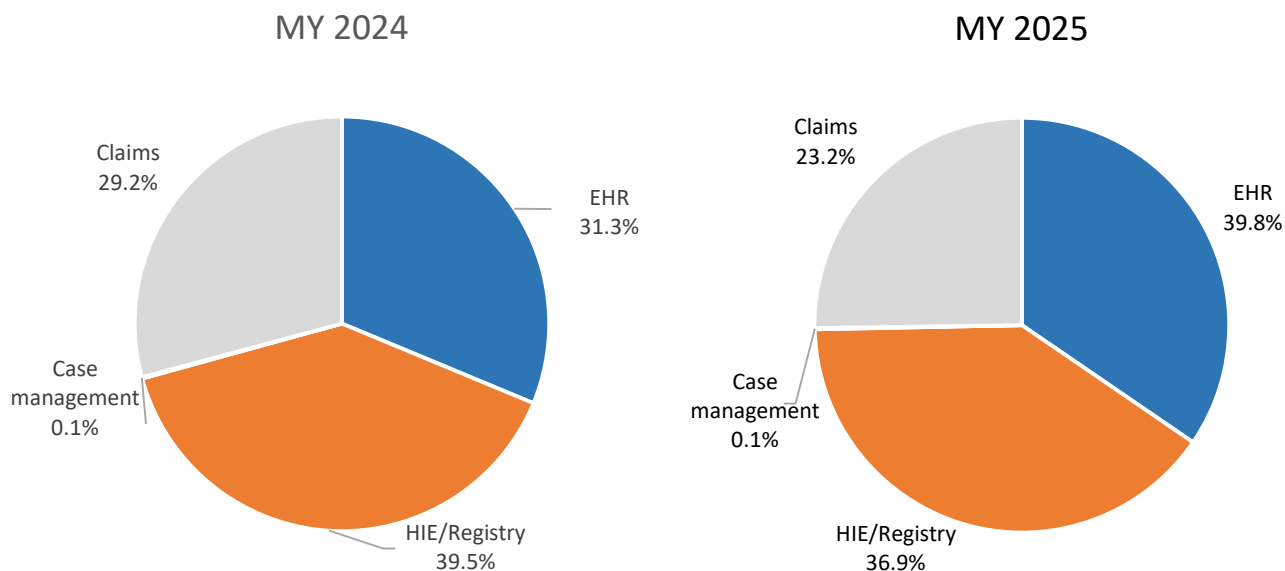


³ <https://www.cdc.gov/fluview/coverage-by-season/pregnant-april-2024.html>

Contribution to the Numerator by Data Source

- Health plans' use of non-claims data sources to report immunizations has generally increased over time across indicators and product lines for all four immunization measures.
- Figure 2** shows the average data source contribution to the numerator of the Combination indicator for the PRS-E measure across Medicaid health plans in measurement years 2024 and 2025. An increase in EHR use can be observed between the two years, as well as a reduced dependence on claims data.

Figure 2. Average data source contribution to the PRS-E numerator, Combination Indicator, Medicaid, MY 2024-2025



Behavioral Health Measures

For MY 2025, there were eight behavioral health measures specified for ECDS reporting. For *ADD-E* and *APM-E*, plans use primarily claims data whereas for the other six behavioral health measures use patient-reported outcomes to link to clinical actions for follow-up care. These measures require clinical data that is not found in claims (e.g., results of a standardized tool to assess and monitor depression).

Overall Performance

- The number of plans who reported performance rates for the behavioral health measures that assess screening, follow-up, and routine symptom monitoring that were greater than zero percent has increased between MY 2022 and MY 2025 (**Figure 3**).
- In MY 2025, there were increases from the previous year's proportion of non-zero rates among all product lines across the five measures shown, which may reflect greater familiarity with measure requirements and improved access to the clinical data needed for reporting (**Figure 3**).

Figure 3. Percentage of submissions with rates greater than zero, MY 2022-2025



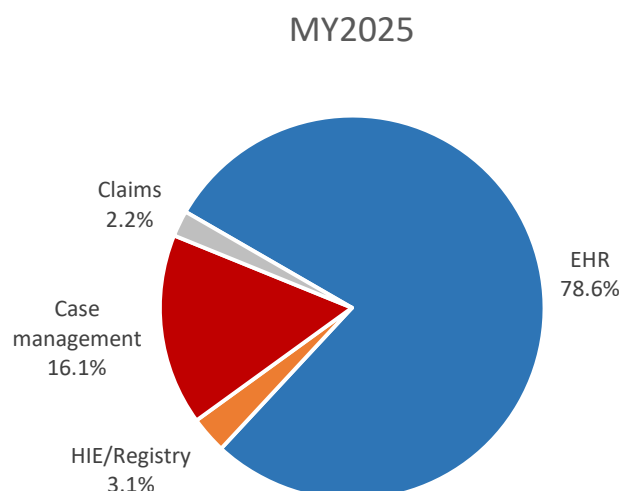
Performance Rates by Data Sources Used

- The average performance rate for the screening indicator for the *Prenatal Depression Screening and Follow-Up* measure was 15.4 and 26.5 percent, among commercial and Medicaid plans, respectively, that used any non-claims data source (Table A2 in Appendix). This difference in performance was consistent across the other behavioral health measures that rely on screening assessments which often are not documented in claims.

Contribution to the Numerator by Data Source

- Among plans with rates greater than zero, most screening information was reported using EHR or case management data (**Figure 4**). This was consistent with results from previous years.
- Across the behavioral health screening and follow-up measures, follow-up information was mostly reported using non-claims data.

Figure 4. Average data source contribution to the DSF-E numerator, Screening Indicator, All Ages, Commercial, MY 2025



Cancer Screening Measures

There are three cancer screening measures available for ECDS reporting: *Breast Cancer Screening (BCS-E)*, *Colorectal Cancer Screening (COL-E)*, and *Cervical Cancer Screening (CCS-E)*. CCS-E transitioned to ECDS-only reporting in MY 2025, completing the transition of all cancer screening measures to ECDS reporting.

Overall Performance (ECDS vs. traditional reporting methods)

- For *Cervical Cancer Screening*, performance rates are slightly higher when comparing the MY2025 ECDS performance rates to the MY2024 traditional method performance rates.

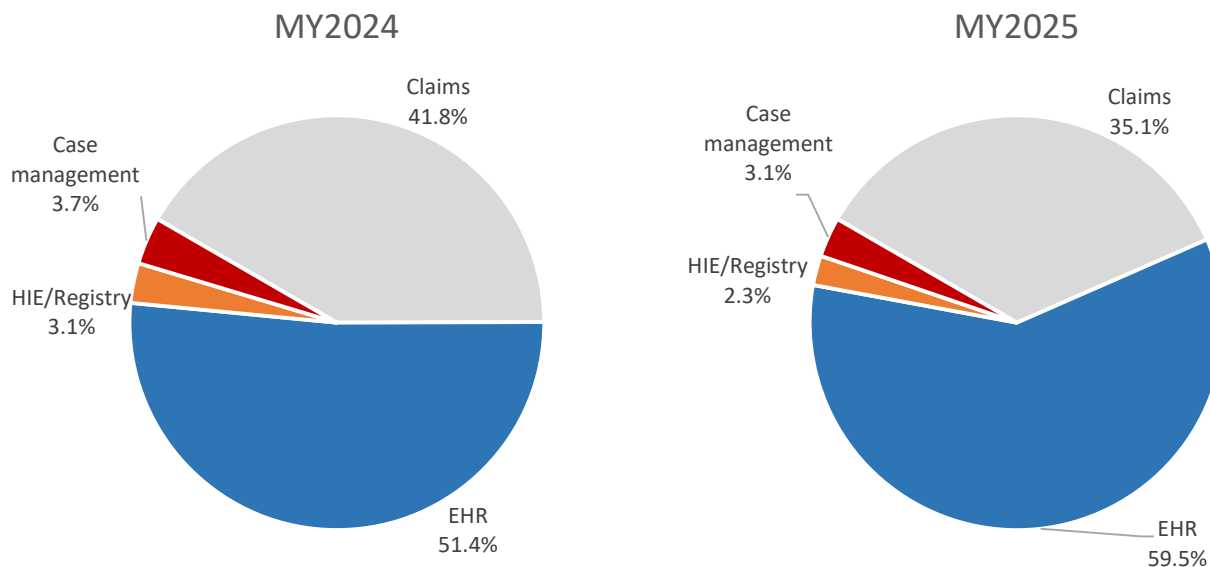
Performance Rates by Data Sources Used (ECDS reporting)

- For *BCS-E*, *COL-E*, and *CCS-E*, average performance among all plans that used only claims data was consistently lower when compared to the average performance that used any non-claims data across all product lines (Table A3 in Appendix).

Contribution to the Numerator by Data Source (ECDS reporting)

- In MY 2025, a majority of numerator contributions for BCS-E still comes from claims. However, the percentage of numerator contributions from EHR data has steadily increased in the past 4 years, suggesting that plans are investing resources into collecting electronic clinical data for reporting.
- In MY 2025, the percentage of numerator contributions for *COL-E*, on average, is increasingly coming from structured clinical data sources (**Figure 5**).

Figure 5. Average data source contribution to the COL-E numerator, Medicare, MY 2024-2025



Assessing the Impact of Transitioning from Hybrid to ECDS for HEDIS Reporting

In the interest of supporting fully digital quality measurement and reducing reliance on manual medical record reviews, NCQA is continuing to expand the ECDS reporting method across HEDIS measures. In MY 2025, 8 HEDIS measures (**Box 2**) still allow the hybrid method. NCQA has proposed a multi-year timeline to remove the hybrid reporting option from these measures by MY 2029. Measure-specific timelines and additional information about the hybrid transition are available on the [Digital Quality Hub](#).

ECDS reporting data is not yet available for all 8 of these measures; however, analyses to date provide insight into the potential impact of transitioning from hybrid to ECDS reporting. Each measure poses distinct transition challenges depending on the availability and accuracy of electronic clinical data needed to calculate the measure. We analyzed the hybrid “lift” which is the influence of manual medical review on the performance rates of submissions using the hybrid reporting method. The hybrid method calculates the performance on a sample of 411 records. The “lift”, displayed as the “gap” in the figures below,

expresses the difference in average performance rates with and without the inclusion of manual medical review (full hybrid rate versus rate without including the manual medical review). Below, we highlight results from two hybrid measures: *Lead Screening in Children* (**Figure 6**) and *Controlling High Blood Pressure* (**Figure 7**). *Lead Screening in Children* has had a small “lift” throughout the years (averaging 2.48 to 3.55 percentage points in the Medicaid product line) as plans are primarily using claims data to identify screenings. For *Controlling High Blood Pressure*, the “lift” is larger because plans utilize unstructured clinical information found in medical charts to identify blood pressure readings. However, the “lift” has been decreasing over time. For example, between 2024 and 2025 in the commercial line, the “lift” decreased by 3.64 percentage points. Thus, the calculated hybrid reporting performance rate without the inclusion of manual medical review is gradually closing the gap to the performance rate with the inclusion of manual medical review. The size of the hybrid lift varies across measures, but the overall trend of decreasing “lift” and less reliance on medical record review data was observed across most hybrid measures.

Box 2. Hybrid Measures as of HEDIS MY 2025

- Lead Screening in Children (LSC)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
- Prenatal and Postpartum Care (PPC)
- Blood Pressure Control for Patients with Diabetes (BPD)
- Controlling High Blood Pressure (CBP)
- Glycemic Status Assessment for Patients With Diabetes (GSD)
- Transitions of Care (TRC)
- Care for Older Adults (COA)

Figure 6. Comparing Performance Rates When Including vs. Excluding Manual Medical Record Review – Lead Screening in Children, MY 2021-2025

Mean rates labeled in white. Gap = Percentage point difference (Rate Including MRR minus Rate Not Including MRR).

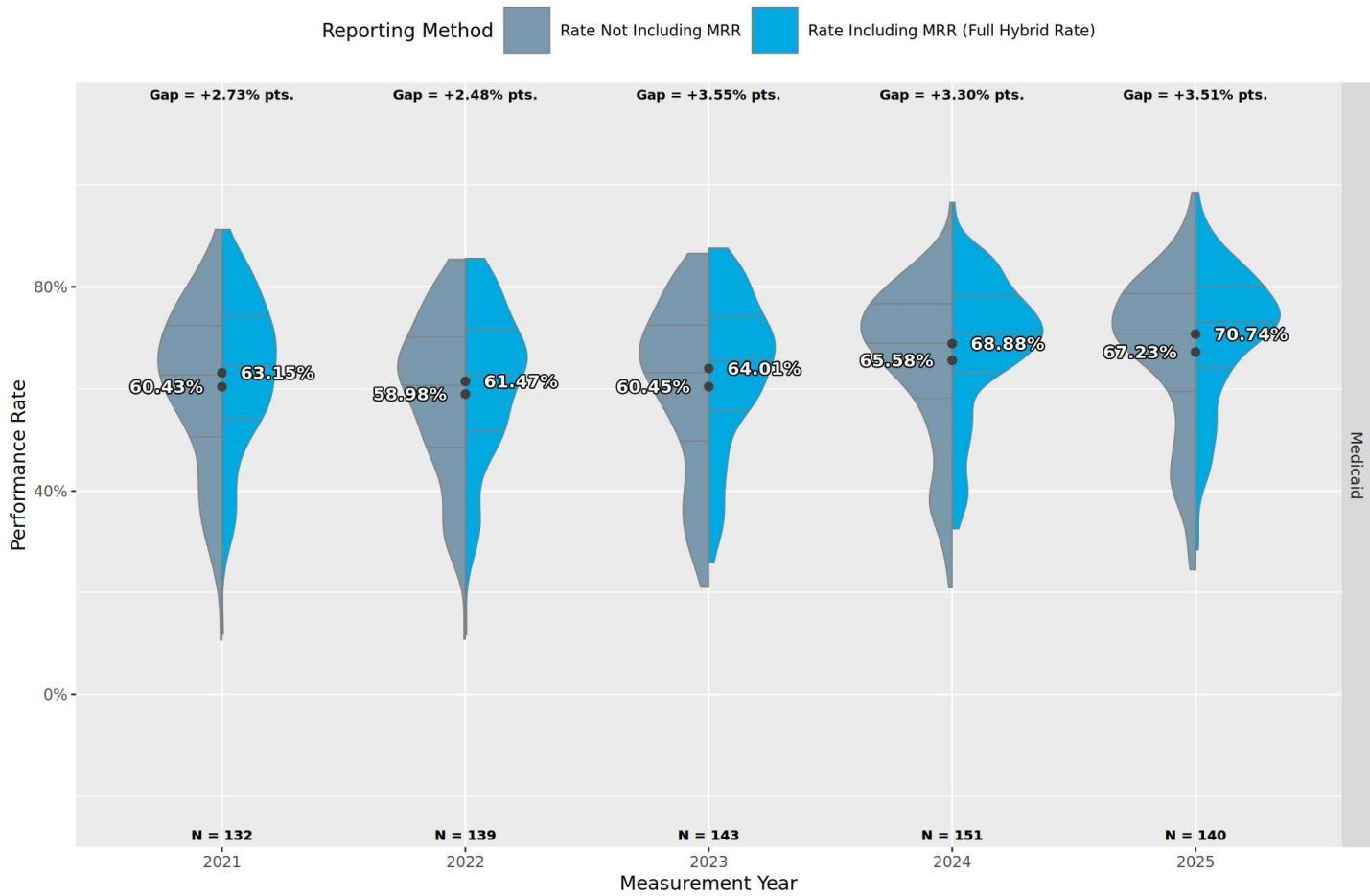
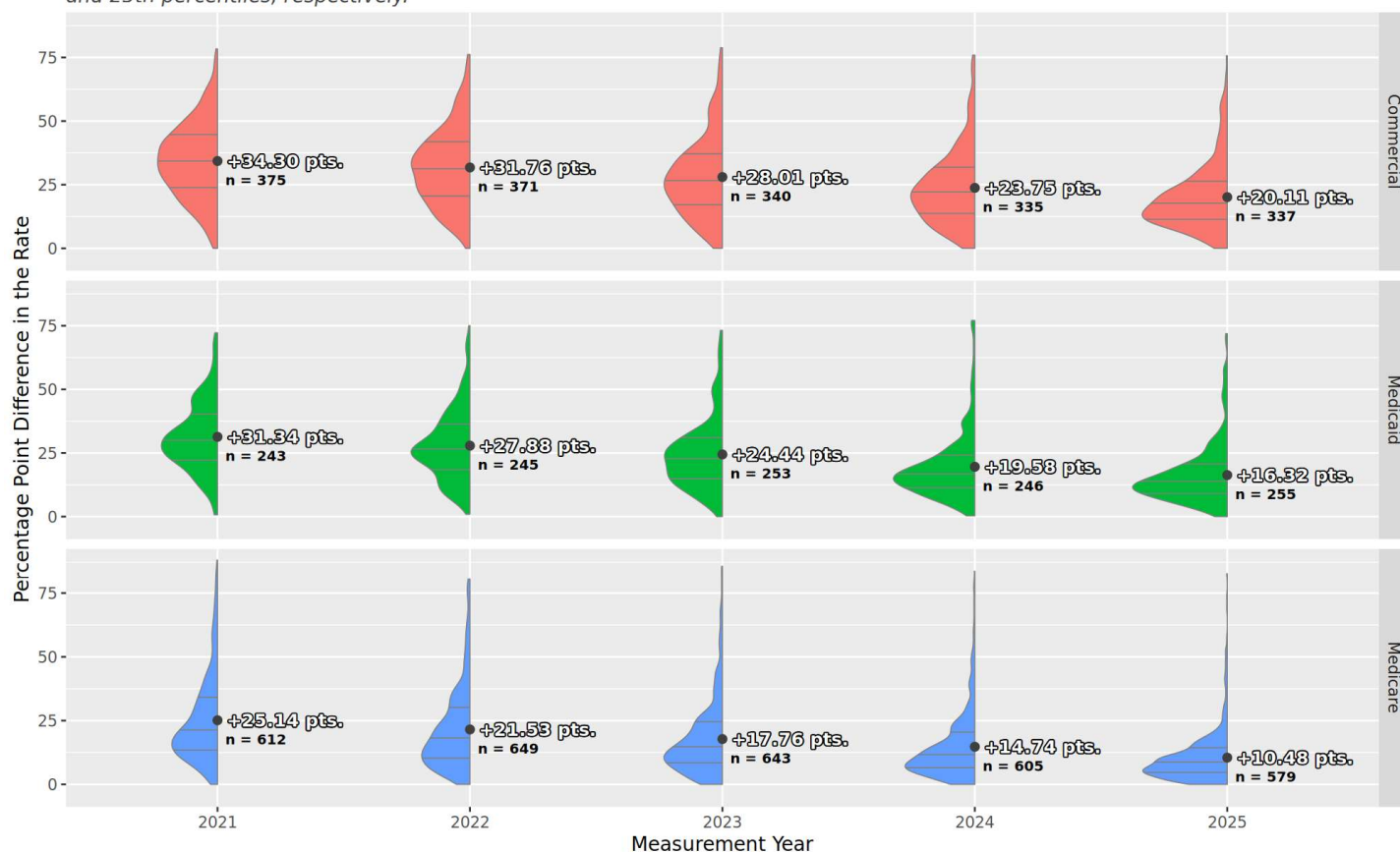


Figure 7. Comparing Performance Rates When Including vs. Excluding Manual Medical Record Review – Controlling High Blood Pressure, MY 2021-2025

Mean percentage point change in rates are labeled in white. The horizontal lines in the violins represent the 75th, 50th (median), and 25th percentiles, respectively.



*Among Hybrid submitters only.

ECDS Data Collection Considerations and Reporting Barriers

Performance on measures that use the ECDS reporting method is highest among measures that already rely primarily on administrative claims data. For those measures, there is little observed difference in performance between the administrative and ECDS reporting methods. The main source of variability between measures using ECDS reporting method and those using the hybrid method arises where health plans have difficulty accessing reliable and interoperable clinical health data. Lack of access to clinical data remains an obstacle for many health plans. Stakeholders have highlighted that regulatory requirements for data interoperability and data exchange between health plans and delivery organizations could enhance access to the clinical data needed for ECDS reporting. Health plans operating in regions with more robust health information exchange infrastructure tend to have improved access to the data required for effective measure reporting.

Once health plans secure access to the data that support the ECDS reporting method, there will be other barriers to address including varying capabilities of delivery organizations to record data in the structured, standardized digital format essential for ECDS reporting. If data are not in structured fields or linked to standardized coding terminology, they are difficult to use for digital quality measurement. Standardization of provider EHR system workflows could facilitate data quality and enhance the mapping to standard coding terminology thereby promoting the effective use of clinical data for HEDIS measure reporting.

Summary and Conclusions

Despite barriers, reporting results showed that there has been a steady increase in ECDS reporting. The contributions from EHR, HIE/registry and case management data sources continue to increase, demonstrating that more plans are seeking information beyond claims for quality measurement.⁴ However, challenges persist particularly regarding standardized data capture of behavioral health information at the point of care,⁵ and there may not be sharing of relevant information between health care systems.

Improved health plan reporting and measure performance are feasible with strategic multistakeholder approaches that drive better use and sharing of electronic clinical data.⁶ Public reporting of HEDIS measures using ECDS reporting is a critical step in the use of clinical data systems to measure quality. The *Prenatal Immunization Status (PRS-E)* measure was the first publicly reported measure using the ECDS reporting method in MY 2020. Since then, 14 additional measures have been publicly reported, with additional measures being publicly reported every measurement year.

Acknowledgments

This report was written by Nikko Gutierrez, Kaila Boyd, Fern McCree, Evan Jun, and Ryan Acton. The team would also like to thank NCQA staff for their review and input.

⁴ Byron SC, Roth L, Acton RM, Shen A. Harnessing electronic clinical data to report adult and prenatal immunization quality measures. *Journal of the American Medical Informatics Association*. 2021;28(10):2226-2232. doi:[10.1093/jamia/ocab125](https://doi.org/10.1093/jamia/ocab125)

⁵ Morden E, Byron S, Roth L, et al. Health Plans Struggle to Report on Depression Quality Measures that Require Clinical Data. *Academic Pediatrics*. Published online October 11, 2021. doi:[10.1016/j.acap.2021.09.022](https://doi.org/10.1016/j.acap.2021.09.022)

⁶ National Committee for Quality Assurance. "Leveraging Electronic Clinical Data for HEDIS: Insights and Opportunities." NCQA. May 2021. https://www.ncqa.org/wp-content/uploads/2021/05/20210526_Issue_Brief_Leveraging_Electronic_Clinical_Data_for_HEDIS.pdf

Appendix

Immunization Measures

Table A1. Immunization Measures Performance Rates by Data Sources Used, MY 2025

Measure	Indicator	Data Source Use	Commercial		Medicaid		Medicare	
			Submissions (%)	Mean %	Submissions (%)	Mean %	Submissions (%)	Mean %
AIS-E	Influenza, 19-64	Claims Only	17 (4.3)	19.2	7 (2.8)	17.1	89 (14.3)	15.2
		Any Non-claims	376 (95.7)	22.6	246 (97.2)	16.3	533 (85.7)	34.6
	Td/Tdap, Total	Claims Only	16 (4.1)	32.8	8 (3.1)	49.4	95 (14.7)	12.4
		Any Non-claims	377 (95.9)	45.8	247 (96.9)	46.6	553 (85.3)	36.3
	Herpes Zoster, 50-64	Claims Only	22 (5.6)	20.2	17 (6.8)	13.5	154 (25.2)	6.1
		Any Non-claims	371 (94.4)	25.0	233 (93.2)	14.8	458 (74.8)	20.2
	Pneumococcal	Claims Only	20 (5.3)	38.1	3 (1.5)	16.3	73 (11.3)	21.7
		Any Non-claims	361 (94.8)	53.7	192 (98.5)	52.9	572 (88.7)	55.8
	Hepatitis B, Total	Claims Only	19 (4.8)	10.3	9 (3.6)	11.0	102 (17.3)	2.7
		Any Non-claims	374 (95.2)	13.3	240 (96.4)	19.2	486 (82.7)	10.2
PRS-E	Influenza	Claims Only	26 (6.9)	27.7	10 (4.2)	22.2	N/A	N/A
		Any Non-claims	352 (93.1)	36.6	228 (95.8)	25.3	N/A	N/A
	Tdap/Td	Claims Only	27 (7.1)	61.3	10 (4.2)	52.4	N/A	N/A
		Any Non-claims	351 (92.9)	70.5	228 (95.8)	57.8	N/A	N/A
IMA-E	Meningococcal	Claims Only	16 (4.4)	77.6	5 (2.0)	80.1	N/A	N/A
		Any Non-claims	347 (95.6)	81.4	242 (98.0)	80.3	N/A	N/A
	Tdap	Claims Only	15 (4.1)	77.8	5 (2.0)	82.9	N/A	N/A
		Any Non-claims	348 (95.9)	85.4	242 (98.0)	83.5	N/A	N/A
	HPV	Claims Only	21 (5.8)	33.0	7 (2.8)	43.6	N/A	N/A
		Any Non-claims	342 (94.2)	34.1	240 (97.2)	38.4	N/A	N/A
CIS-E	Influenza	Claims Only	22 (6.0)	45.5	7 (2.9)	33.4	N/A	N/A
		Any Non-claims	344 (94.0)	49.5	235 (97.1)	33.7	N/A	N/A
	DTAP/DT	Claims Only	20 (5.5)	65.8	6 (2.5)	61.7	N/A	N/A
		Any Non-claims	346 (94.5)	77.2	236 (97.6)	69.7	N/A	N/A
	Hep B	Claims Only	20 (5.5)	61.2	6 (2.5)	71.8	N/A	N/A
		Any Non-claims	346 (94.5)	77.7	236 (97.5)	82.4	N/A	N/A
	HiB	Claims Only	20 (5.5)	73.6	6 (2.5)	76.4	N/A	N/A
		Any Non-claims	346 (94.5)	83.9	236 (97.5)	82.0	N/A	N/A
	IPV	Claims Only	20 (5.5)	73.9	6 (2.5)	73.3	N/A	N/A
		Any Non-claims	346 (94.5)	83.5	236 (97.5)	83.1	N/A	N/A
	MMR	Claims Only	21 (5.7)	83.5	6 (2.5)	80.6	N/A	N/A
		Any Non-claims	345 (94.3)	87.0	236 (97.5)	83.8	N/A	N/A

	PCV	Claims Only	21 (5.7)	65.5	6 (2.5)	62.9	N/A	N/A
		Any Non-claims	345 (94.3)	77.6	236 (97.5)	69.4	N/A	N/A
	VZV	Claims Only	21 (5.7)	82.5	6 (2.5)	79.9	N/A	N/A
		Any Non-claims	345 (94.3)	86.2	236 (97.5)	83.4	N/A	N/A
	Hep A	Claims Only	21 (5.7)	82.0	6 (2.5)	79.8	N/A	N/A
		Any Non-claims	345 (94.3)	84.3	236 (97.5)	81.2	N/A	N/A
	RV	Claims Only	20 (5.5)	65.5	6 (2.5)	63.5	N/A	N/A
		Any Non-claims	346 (94.5)	76.9	236 (97.5)	67.9	N/A	N/A

Behavioral Health Measures

Table A2. Performance rates by data sources used, MY 2025

Measure	Indicator	Data Source Use	Commercial		Medicaid		Medicare	
			Submissions (%)	Mean %	Submissions (%)	Mean %	Submissions (%)	Mean %
PND-E	Screening	Claims Only	47 (13.5)	2.8	28 (13.5)	4.2	N/A	N/A
		Any Non-claims	300 (86.5)	15.4	180 (86.5)	26.5	N/A	N/A
	Follow-Up	Claims Only	3 (3.8)	68.1	5 (3.8)	38.6	N/A	N/A
		Any Non-claims	76 (96.2)	45.1	110 (95.7)	53.7	N/A	N/A
PDS-E	Screening	Claims Only	43 (12.3)	2.6	25 (12.0)	3.9	N/A	N/A
		Any Non-claims	306 (87.7)	11.8	183 (88.0)	19.1	N/A	N/A
	Follow-Up	Claims Only	1 (1.3)	82.7	6 (5.4)	69.9	N/A	N/A
		Any Non-claims	74 (98.7)	67.6	105 (94.6)	66.6	N/A	N/A
DSF-E	Screening	Claims Only	39 (10.5)	2.9	26 (10.9)	2.9	118 (18.3)	3.8
		Any Non-claims	332 (89.5)	9.6	213 (89.1)	12.0	528 (81.7)	28.3
	Follow-Up	Claims Only	33 (12.4)	48.1	4 (2.1)	54.5	15 (4.7)	59.3
		Any Non-claims	234 (87.6)	73.7	188 (97.9)	68.4	303 (95.3)	66.6
DMS-E	Total	Claims Only	48 (13.5)	1.8	26 (12.3)	2.8	74 (16.4)	1.5
		Any Non-claims	308 (86.5)	8.7	185 (87.7)	12.0	378 (83.6)	17.8
DRR-E	Remission	Claims Only	8(4.3)	3.6	8 (5.6)	2.8	3 (1.8)	7.0
		Any Non-claims	180 (95.7)	9.0	136 (94.4)	9.2	167 (98.2)	11.9
	Response	Claims Only	6 (3.2)	8.4	5 (3.5)	7.1	3 (1.8)	11.4
		Any Non-claims	182 (96.8)	13.3	139 (96.5)	12.9	167 (98.2)	15.8
	PHQ-9	Claims Only	2 (1.1)	58.6	2 (1.4)	36.7	2 (1.2)	38.4
		Any Non-claims	186 (98.9)	29.1	142 (98.6)	31.8	168 (98.8)	32.8
ASF-E	Screening	Claims Only	131 (36.9)	0.6	64 (30.8)	1.1	207 (45.5)	0.4
		Any Non-claims	224 (63.1)	2.2	144 (69.2)	4.1	248 (54.5)	14.3
	Follow-Up	Claims Only	105 (82.0)	1.0	48 (71.6)	3.8	117 (87.3)	0.3
		Any Non-claims	23 (17.97)	1.3	19 (28.4)	2.3	17 (12.7)	0.8
ADD-E	Initiation	Claims Only	120 (37.9)	43.1	45 (19.3)	43.4	N/A	N/A
		Any Non-claims	197 (62.2)	44.6	188 (80.7)	47.6	N/A	N/A
	Continuation	Claims Only	115 (50.0)	48.5	48 (22.4)	53.3	N/A	N/A
		Any Non-claims	115 (50.0)	49.7	166 (77.6)	55.7	N/A	N/A
APM-E	Blood Glucose & Cholesterol	Claims Only	11 (4.4)	37.1	14 (6.1)	45.6	N/A	N/A
		Any Non-claims	240 (95.6)	38.1	216 (93.9)	40.3	N/A	N/A
	Blood Glucose	Claims Only	7 (2.8)	60.5	10 (4.4)	59.1	N/A	N/A
		Any Non-claims	244 (97.2)	57.2	220 (95.7)	59.6	N/A	N/A
	Cholesterol	Claims Only	16 (6.4)	39.9	15 (6.5)	44.6	N/A	N/A
		Any Non-claims	235 (93.6)	39.9	215 (93.5)	41.9	N/A	N/A

Cancer Screening Measures

Table A3. Performance rates by data sources used, MY 2025

Measure	Data Source Use	Commercial		Medicaid		Medicare	
		Submissions (%)	Mean %	Submissions (%)	Mean %	Submissions (%)	Mean %
BCS-E	Claims Only	50 (12.7)	72.6	21 (8.4)	52.2	22 (3.9)	71.6
	Any Non-claims	344 (87.3)	74.1	228 (91.6)	53.2	543 (96.1)	72.8
COL-E	Claims Only	19 (4.8)	59.8	14 (5.6)	38.9	14 (2.3)	59.6
	Any Non-claims	376 (95.2)	61.6	238 (94.4)	46.7	591 (97.7)	72.6
CCS-E	Claims Only	18 (4.6)	64.3	9 (3.5)	43.7	N/A	N/A
	Any Non-claims	374 (95.4)	71.6	248 (96.5)	52.7	N/A	N/A