BHT IMPACT

Primer Guide

Quality Measures Decoded:

Building a Better Understanding of Youth Mental Health Quality Measures in Medicaid

BHT Impact is a fiscally sponsored project of Moore Impact, a 501(c)3 public charity.

Why Quality Measures in Youth Mental Health Medicaid Matter

Around 50% of youth in the United States are covered by Medicaid or CHIP, making these public programs the predominant financial source for youth behavioral health. In our prior work, we've covered the federal, state, and local programs and systems for coverage and we're now going to step into a key frontier of understanding: quality measures. For any innovators working in youth mental health, quality measures are more than a reporting exercise, they are one method used to hold health plans, providers, and programs accountable. By understanding it and how your solution could impact it, it can create quality impact for youth and financial stability for your solution.

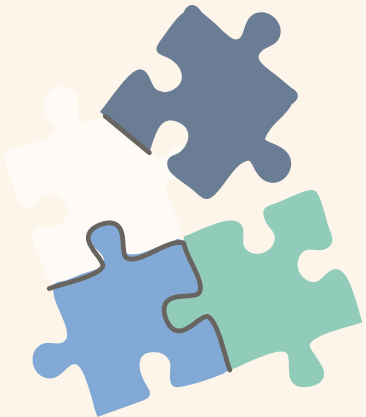
The purpose of this guide is to summarize the measures that matter most to Medicaid for youth mental health, which are mandatory versus optional, and how all of this is connected to payment or fees.

Quality Measures Landscape

Youth mental health quality measures in Medicaid is not a single list. The measures fall into five overlapping layers, each with its own owner and its own mandatory-versus-optional rules. Knowing which is which prevents the common mistake of just saying “HEDIS” as a synonym for all quality measurement.

Below is a quick overview of these measures and towards the second half of this guide are tables organized by each of the layers numbered below. To keep this streamlined, we’ve also linked the technical specs of each of the measures to their owner in the references section at the end.

MEASURE SET	DESCRIPTION	OWNER
1. Child Core Set: BH domain	The federal mandatory floor; behavioral health measures every state must report.	CMS
2. Child Core Set: Adjacent	Mandatory non-BH measures (primary care, perinatal, well-care, developmental, weight) where youth BH is captured indirectly.	CMS
3. Broader HEDIS BH	NCQA BH measures beyond the Core Set; reported by plans for accreditation, state contracts, payments, and enrollment benefits	NCQA
4. CCBHC Measure Set	A separate clinic- and state-collected slate for Certified Community Behavioral Health Clinics; some tied to payment.	SAMHSA / CMS
5. State / MCO / 1115	State-specific measures layered onto managed care and waiver contracts	States / Plans



Mandatory vs. Optional Reporting

Reporting is becoming increasingly mandatory and evolves each year

For most of its history, state reporting on the Child Core Set was voluntary. That changed under the 2023 Mandatory Medicaid and CHIP Core Set Reporting final rule. Beginning with federal fiscal year 2024, states are required to report all measures on the Child Core Set, as well as the behavioral health measures on the Adult Core Set.

- **Mandatory since FFY 2024:** State reporting of the full Child Core Set and the Adult Core Set behavioral health measures is required, not optional.
- **All beneficiaries:** States report mandatory measures for the full Medicaid and CHIP child population.
- **Stratified reporting is phasing in:** To surface disparities, states began reporting stratified data on a subset of Child Core Set measures, with the goal of disaggregating all eligible mandatory measures by FFY 2028.
- **Annual refresh:** CMS, NCQA, and SAMHSA each update their sets each year; measures are added, retired, or moved between sets, so the slate is not static. Be sure to look each year to ensure you have the most up to date information.

Keep in Mind

Level or System Specific

A measure can be mandatory in one layer and optional in another (e.g., suicide risk assessment is optional in CCBHC clinic-collected but may be state-required).

Overlap is Real

The same measure (FUH-CH, ADD-CH) appears across the Core Set, HEDIS, and CCBHC layers but the reporting entity differs in each and often requires different reports (i.e., provider can't easily copy and paste □ admin burden)

Screening and Documentation Gap

Measures like CDF-CH, APP-CH, and DEP-REM-6 reward documented workflows. Strong clinical care with weak documentation scores poorly.

Crisis-to-Care Transitions

FUH and FUM are where youth systems most often fail and where the most measurable improvement and savings tend to live.

Confirm Each Year

Provisional measures graduate to mandatory and specifications change annually; Be sure to check each year for what changes exist (and what opportunities as well!).

Equity Stratification

As stratified reporting expands toward FFY 2028, performance gaps by race, ethnicity, and language will become visible and contractually relevant.

How to Read a Measure

Nearly every measure across these layers shares the same anatomy. Understanding it once lets you read any of them.

Denominator

The eligible population (e.g., children 6–17 discharged after a mental health hospitalization).

Numerator

Those who met the care standard (e.g., had an outpatient follow-up within 7 or 30 days).

Exclusions

Cases removed for valid clinical or data reasons (e.g., death during the measurement year, or readmission within the follow-up window).

Data Collection Method

Administrative (claims), hybrid (claims plus chart review), survey, or electronic (ECDS/EHR). The method drives data burden and what counts*

*One of the most frustrating experiences for providers is often that their data of who is in the numerator or denominator varies from their data vs. what shows up on the measure owner or health plans side. This is due to the variances in data collection methods and requires “true ups” or a tedious back and forth data reconciliation process.

From Measures to Money

Quality measures matter financially because states increasingly tie managed care payment to performance on them and the ability for innovators to impact these measures can lead to alternative payment models, bonus payments, and general financial opportunity.

To dig in more here, we’ll be releasing a follow-up article shortly that digs into how innovators can understand how quality measure money flows and how to structure their data and impact capture to create opportunities for these contracts and alternative payment models.

1. Child Core Set: BH Domain

Since federal fiscal year 2024, states are mandated to report the entire Child Core Set. These are nationally standardized and demonstrate what is most prioritized at the federal level.

MEASURE ID	MEASURE NAME	STATUS	YOUTH RELEVANCE
FUH-CH	Follow-Up After Hospitalization for Mental Illness (Ages 6–17)	Mandatory	Core care-transition measure; 7- and 30-day follow-up.
FUM-CH	Follow-Up After ED Visit for Mental Illness (Ages 6–17)	Mandatory	Crisis-to-care transition; 7- and 30-day follow-up.
FUA-CH	Follow-Up After ED Visit for Substance Use (Ages 13–17)	Mandatory	Adolescent SUD ED follow-up.
ADD-CH	Follow-Up Care for Children Prescribed ADHD Medication	Mandatory	Initiation and continuation-phase visits.
APM-CH	Metabolic Monitoring for Children & Adolescents on Antipsychotics	Mandatory	Glucose and cholesterol testing.
APP-CH	Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics	Mandatory	Psychosocial care before medication.
CDF-CH	Screening for Depression and Follow-Up Plan (Ages 12–17)	Mandatory	Documentation-dependent; PHQ-based.

FUH-CH and FUM-CH are the workhorse accountability measures and are the most heavily used in value-based contracts because they capture gaps in care or care transition failures that drive avoidable readmissions and cost.

2. Child Core Set: Adjacent

These Child Core Set measures sit outside the behavioral health domain but are where youth mental health is often detected, documented, or financially affected. They are mandatory in the same way as Layer 1. Below we have only pulled the ones that are adjacent to behavioral health but note that there are additional measures that pertain to primary care or other domains which can be found here.

MEASURE ID	MEASURE NAME	STATUS	YOUTH RELEVANCE
WCV-CH	Child and Adolescent Well-Care Visits	Mandatory	Primary entry point for BH screening.
DEV-CH	Developmental Screening in the First Three Years of Life	Mandatory	Early identification of developmental/BH concerns.
WCC-CH	Weight Assessment & Counseling for Nutrition/Physical Activity	Mandatory	Tracks antipsychotic-related weight effects.
PDS-CH	Postpartum Depression Screening & Follow-Up (Under Age 21)	Optional	
PND-CH	Prenatal Depression Screening & Follow-Up (Under Age 21)	Optional	Maternal mental health for under-21.

WCV and WCC matter to BH indirectly because well-care visits are the screening entry point, and weight assessment is important to appropriately capture antipsychotic side effects.

PDS-CH and PND-CH are optional for 2026 and 2027 but future guidance may turn them into mandatory reports.

3. Broader HEDIS BH Measures

NCQA's full HEDIS behavioral health set is larger than the Core Set subset (and also has many measures beyond behavioral health). Health plans calculate and report these to NCQA for accreditation and after accreditation as well. States also frequently fold them into managed care contracts.

We will dig into this much more during the next guide where we chat about how money flows for these measures.

MEASURE ID	MEASURE NAME	STATUS	YOUTH RELEVANCE
DSF-E	Depression Screening & Follow-Up for Adolescents and Adults (12+)	NCQA / Plan Dependent	Broader than CDF-CH; ECDS.
DRR-E	Depression Remission or Response for Adolescents and Adults (12+)	NCQA / Plan Dependent	Outcome measure (response/remission).
DMS-E	Utilization of PHQ-9 to Monitor Depression for Adolescents and Adults (12+)	NCQA / Plan Dependent	Measurement-based care indicator.
IET	Initiation & Engagement of SUD Treatment (13+)	NCQA / Plan Dependent	Adolescent SUD engagement.
APP / APM	Antipsychotic measures (full HEDIS versions)	NCQA / Plan Dependent	Plans report full versions to NCQA.

4. CCBHC BH Measure Set (1/2)

If an organization is a Certified Community Behavioral Health Clinic (CCBHC), an entirely separate set of measures apply which are defined by SAMHSA and CMS. This is split into measures that the clinic collects (from their own records) and ones the state collects (from Medicaid claims). A subset of these measures must be met to earn a Quality Bonus Payment (QBPs) under a payment method called PPS (Prospective Payment System). For innovators, helping CCBHCs achieve these QBPs can create valuable strategic partnerships and/or vendor-provider relationships.

Clinic Collected Measures

MEASURE ID	MEASURE NAME	STATUS	YOUTH RELEVANCE
I-SERV	Time to Services	Mandatory	All ages incl. youth; access + crisis response time.
DEP-REM-6	Depression Remission at Six Months	Mandatory	Youth 12+ via PHQ-9/PHQ-9M; under 12 excluded.
ASC	Unhealthy Alcohol Use: Screening & Brief Counseling	Mandatory	Adolescent-applicable screening.
SDOH	Screening for Social Drivers of Health	Mandatory	Whole-population incl. youth.
CDF-CH	Screening for Depression & Follow-Up Plan (child version)	Mandatory	Child version explicitly required.
TSC	Tobacco Use: Screening & Cessation Intervention	Federally Optional; State May Mandate	Adolescent-applicable.
SRA (child/adol.)	Suicide Risk Assessment — Child & Adolescent MDD	Federally Optional; State May Mandate	Now optional under 2023 criteria; states may require.

4. CCBHC BH Measure Set (2/2)

State Collected (Claims-Based) Measures

MEASURE ID	MEASURE NAME	STATUS	YOUTH RELEVANCE
FUH-CH	Follow-Up After Hospitalization for Mental Illness (child)	Mandatory	Claims-based; state reports.
FUM-CH	Follow-Up After ED Visit for Mental Illness (child)	Mandatory	Claims-based; state reports.
FUA-CH	Follow-Up After ED Visit for SUD (child)	Mandatory	Claims-based; state reports.
ADD-CH	Follow-Up Care for Children Prescribed ADHD Medication	Mandatory	Also a QBP-relevant measure.
APM-CH	Metabolic Monitoring for Children/Adolescents on Antipsychotics	Mandatory	Claims-based.
YFEC	Youth/Family Experience of Care Survey	Mandatory	Survey; youth-specific experience measure.
PEC	Patient Experience of Care Survey	Mandatory	Survey; adolescent respondents where applicable.

***ADD-CH and the experience surveys are among those that carry QBPs payment weight for youth-serving clinics.*

5. State / MCO / 1115 Waivers

This layer cannot be exhaustively listed because it is defined in each state's managed care contracts and Section 1115 demonstration waivers, and it changes year to year. It is also where a large share of youth BH value-based payment is actually anchored. Rather than a closed list, the categories to expect are:

- **Crisis and Step-down Measures:** mobile crisis response time, follow-up after residential or PRTF discharge, 988/crisis-continuum metrics
- **Population-Specific Measures:** foster-care and child-welfare behavioral health, serious emotional disturbance (SED) cohorts, juvenile-justice-involved youth
- **Access and Network Measures:** time-to-first-appointment, provider network adequacy for child psychiatry, telehealth utilization
- **VBP Quality Gates:** a state-chosen subset of Core Set or HEDIS measures used as pass/fail gates in shared-savings and shared-risk arrangements
- **Equity Stratification:** required disaggregation of mandatory Core Set measures by race, ethnicity, and language, expanding toward full coverage by FFY 2028

Where to find this info

To dig into what these measures are, there are various ways to find the information. My recommendation is to start with the finders first to get a high level view and then to always validate the information at the source whether that is the state, the waiver, or in conversations with health plans. As you can imagine, website, reporting, and posting quality varies state by state so using the finders to home in on specifically what you are looking for will help tremendously in your searches at the state level.

- **Two finders:** The KFF 1115 Waiver Tracker (fastest way to orient across states) and Medicaid.gov's demonstration & waiver list (the authoritative filings).
- **State Quality Strategy & EQR reports:** Names the chosen measures, benchmarks, and how plans performed. On the state Medicaid site under "quality."
- **1115 Waiver Special Terms & Conditions (STCs) and Monitoring Reports:** The binding measures and reporting for any waiver-specific program
- **MCO Contract & Procurement (RFPs):** the quality/pay-for-performance exhibit holds the measures, withhold percentages, and percentile thresholds.

Key Resources

Each measure set links to its owner's technical specifications below. Because CMS, NCQA, and SAMHSA refresh their sets annually, always confirm you're viewing the current measurement year — the links point to the landing pages and current-year files as of this writing.

LAYER	OWNER	RESOURCES
1 & 2. Child Core Set (BH domain + adjacent)	CMS	• 2026 Child Core Set: Measure List • 2026 Child Core Set: Resource Manual & Technical Specs • 2026 Core Set: Behavioral Health Measures (look at ages to distinguish youth/adult) • Core Set History Table (added/retired measures)
3. Broader HEDIS BH	NCQA	• HEDIS Measures (index) • HEDIS Behavioral Health measures
4. CCBHC Measure Set	SAMHSA / CMS	• CCBHC Quality Measures Guidance & Webinars • BHC Technical Specifications & Resource Manual
5. State / MCO / 1115 waivers	States / Plans	• KFF Medicaid 1115 Waiver Tracker (orient across states) • Medicaid.gov Demonstrations & Waivers List (authoritative filings)
Policy and Background	N/A	• Mandatory Medicaid & CHIP Core Set Reporting — final rule (2023) • CMS SHO #24-005 — EPSDT best practices (behavioral health for children & youth) • CMS — Compilation of annual updates to the Child & Adult Core Sets

The Child Core Set resource manual contains the full denominator/numerator/exclusion specs for every Layer 1 and Layer 2 measure. HEDIS specifications are NCQA-licensed; some require purchase or an NCQA account to view in full.