AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

Improving or Maintaining Mental Health

Quick Reference Guide

2026

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MEASURE SNAPSHOT

CMS Part C Star Measure: C05 – Improving or Maintaining Mental Health

CMS Definition: The percentage of sampled Medicare enrollees 65 and older whose mental health, measured by the VR-12 Mental Component Summary (MCS) score, was the **same or better than expected two years later**.[1] No pre-existing mental health diagnosis is required for inclusion in the sample.[1]

FIELD	ENTRY
CMS measure name	Improving or Maintaining Mental Health, MCS
Domain	Staying Healthy: Screenings, Tests and Vaccines
CMS weighting category	Outcome Measure
Weight	**1 for SY2026** (returning-measure rule); returns to **3 beginning SY2027**[1]
Primary data source	HOS survey; patient-reported, two-year cohort; HOS functional health
Unit of measurement	CMS contract-level measure; individual clinicians and practices do not receive a C05 Star Rating
Trend direction	Higher is better
Case-mix adjusted	Yes[1]
Measurement period	HOS follow-up data collection, 07/17/2024 – 11/01/2024, against 2022 baselines[1]
Recall window	The **VR-12 mental health items** ask about the **past four weeks**, at baseline, and again two years later[1]
Star measure credit	The sampled patient's two-year MCS change, compared against a case-mix-adjusted expected change. No screening completed, code billed, or referral documented independently creates credit; **the measure watches whether the patient's reported mental health actually held or improved**[1]
Weight trajectory	Weight 1 for SY2026 under the new-measure rule, because the measure returned from display status this cycle. **The weight returns to 3 beginning with the 2027 Star Ratings**[1]
Statistical method	Clustering, on case-mix-adjusted contract results. Not included in the Part C Improvement Measure and not included in the Categorical Adjustment Index[1]
Measure history	CMS substantively revised the case-mix specification beginning with 2022 data; the measure sat on display through the 2025 Star Ratings and returns to scoring for 2026. Pre-2022 results are not comparable[1]

FIELD	ENTRY
Not reported for	I-SNP-only contracts and Prescription Drug Plans[1]

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services; HOS = Health Outcomes Survey; I-SNP = Institutional Special Needs Plan; MCS = Mental Component Summary; VR-12 = Veterans RAND 12-Item Health Survey

How The Years Line Up

Baseline
Cohort 25 (the 25th annual HOS cohort, sequentially numbered since the survey began in 1998; baseline year 2022) sampled and surveyed in 2022; Baseline = each patient's starting MCS score

↓

Two Years of Care
Everything between the surveys: screening, treatment, follow-through, physical function, and life events across 2022–2024

↓

Follow-Up Survey
The same patients resurveyed July 17 – November 1, 2024; the two-year MCS change computed against the case-mix-adjusted expectation

↓

Published Rating
Reported in the 2026 Star Ratings, published October 2025, contributing at weight **1 this cycle, weight 3 from SY2027**
The 2026 Star Rating closes a loop that opened in 2022. The cohort answering baseline surveys this year will report back two years from now, into ratings two further years out, at **triple weight**[1]

In One Sentence

Among the Medicare patients 65 and older in a health plan's HOS cohort, surveyed twice, two years apart, this measure counts the share whose reported mental health held steady or improved relative to what would be expected for patients like them.

CMS Cut Points

These are the CMS base-group cut-point ranges used for the 2026 Star Ratings. Final measure-level Star assignment also incorporates CMS statistical significance testing; the cut points from the 2024

measurement year can be used as a directional benchmark but should not be interpreted as guaranteed prospective thresholds.

PLAN TYPE	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
MA/MA-PD	<81%	≥81% to <83%	≥83% to <85%	≥85% to <88%	≥88%

ABBREVIATIONS: MA = Medicare Advantage; MA-PD = Medicare Advantage Prescription Drug; PDP = Prescription Drug Plan

2026 Industry Performance

National Numeric Average: The Improving or Maintaining Mental Health **(C05)** measure has a national average rate of **84%**, an average measure rating of **3.2 Stars**. The measure returned from display status this cycle under a **revised specification**, so 2026 is the new baseline; no prior-year trend applies.[1]

Band Structure: The full range from 1 Star to 5 Stars spans only **seven points, 81 to 88**. At this range, **small shifts in reported mental health outcomes** can move a health plan multiple tiers, and the measure's weight increases further next cycle, raising significance of this range.[1]

Broader MA market context: roughly **64%** of MA-PD enrollees are in contracts rated **four or more Stars** for 2026, and **18 MA-PD contracts** earned an overall **5-Star rating**.[2]

WHAT THE MEASURE IS ASKING

AAVBC PERSPECTIVE — HOW THIS MEASURE WORKS

This measure is assessed entirely through patient-reported HOS survey responses, not through claims or medical-record abstraction. Documentation still matters for safe care, continuity, outreach, and record accuracy, but it doesn't itself determine Star measure credit.

In Plain Language

CMS draws a **randomized sample** of each health plan's Medicare enrollees **age 65 and older, regardless of mental health diagnosis**. At **baseline**, sampled patients complete the **VR-12**, a 12-item questionnaire covering functioning over the past four weeks, with items asking how often they felt calm, had energy, felt downhearted, and how much emotional problems interfered with work or social activities.[2] CMS uses the answers to calculate a starting **Mental Component Summary (MCS) score**. **Two years later**, the same patients complete the VR-12 again, and CMS calculates a **new MCS score**. CMS then compares that follow-up score to the score **expected** for a patient of similar age, health conditions, and starting function, and asks: did this patient's mental health hold up compared with that expectation?[1]

Why it Exists

The U.S. population is aging rapidly, and with that shift comes a growing number of older adults living with **mental health needs**. Chronic illness becomes more common with age, and managing multiple conditions **raises the risk of depression**. Loneliness and social isolation also become more common as people age, and depression in older adults can be easy **to overlook**. Symptoms can be mistaken for normal aging or masked by physical illness, and when left untreated, it can worsen the course of other chronic conditions; severe mental illness can shorten life by a decade or more through diagnostic overshadowing.[3,4] The measure exists to hold health plans accountable for a patient's mental health outcome over a two-year period.[1]

CLINICAL PEARL — MAINTENANCE IS SUFFICIENT

The measure specification includes **improvement or maintenance of mental health status**. For a patient with heart failure and recent bereavement, two years of stable mood and preserved social functioning satisfies the measure; improvement is not required. Practices that focus primarily on acute crisis management overlook where most of this measure's performance is determined: **sustained function over the two-year period**.[1]

QUALITY OUTCOME — WHAT THIS MEASURE PROTECTS

Measurement-based care, in which **tracked scores driving timely treatment changes**, raised depression remission rates by roughly **ten points** compared with unmonitored usual care in meta-analysis.[5] Also, a **written safety plan with structured follow-up** nearly halved repeat suicidal behavior after crisis encounters.[6] The measure's two-year period reflects this: **care delivered well is expected to produced sustained, measurable effects over time**.

What A Care Team Actually Controls

Star Ratings are calculated at the CMS contract level, not for individual clinicians or practices. Care teams nevertheless influence the clinical experiences and workflows that contribute to measure performance and overall Star rating.

DIRECTLY WITHIN THE PRACTICE	INFLUENCED, SHARED WITH OTHERS	OUTSIDE THE PRACTICE
• Mental health surveillance-ask about **mood, sleep, energy and loneliness** at **every encounter** • **Access to validated screening tools**with a documented record • **Same-visit treatment** initiation and follow-up at **3–5 days** and **30 days** • **Adjusting a psychiatric medication** that **isn't working,** rather than refilling it automatically at each visit • **Treating the physical decline** that directly affects mood	• **Behavioral health network workflows -** information coordination challenges • **Pharmacy barriers** and prior authorization speed • **Caregiver involvement** • **Community** and social-connection resources	• Who **HOS samples** and the **cohort design** • The **VR-12 instrument** and the expected-change model • **Life events** (bereavement, loss of independence) the model only partly documents • **Cut points and clustering**

ABBREVIATIONS: HOS = Health Outcomes Survey; VR-12 = Veterans RAND 12-Item Health Survey

The VR-12 Instrument

The VR-12 (Veterans RAND 12-Item Health Survey) is a **self-administered questionnaire** CMS sends directly to sampled enrollees as part of the **Health Outcomes Survey (HOS)**. Care teams do not administer, score, or submit it.[1] Patients complete the same 12 items at **baseline** and again **two years later**. CMS scores each patient's answers into two composite scores, a **Physical Component Summary (PCS)** and a **Mental Component Summary (MCS)**, using weighted algorithms in which all 12 items contribute to both scores; items reflecting emotional and social functioning weigh more heavily toward the **MCS**.[1] **C05 uses only the MCS side**: it measures whether a patient's case-mix-adjusted MCS score at follow-up **matched or exceeded what was expected** for someone of their age, conditions, and baseline function.

A care team has **no direct role in the survey**. What it controls is the **clinical care delivered between the two surveys**: screening, treatment, and follow-up for mood and energy, which shapes how a patient's mental health, and therefore their VR-12 answers, trend.

The VR-12 Instrument includes the following 12 components:

1. **General health rating** — single item; 5-point scale (Excellent → Poor)
2. **Physical functioning** — "Does your health now limit you in these activities?"; each rated on a 3-point scale (limited a lot/limited a little/not limited at all):
   a. Moderate activities (e.g., moving a table, pushing a vacuum cleaner, bowling, playing golf)
   b. Climbing several flights of stairs

3. **Role limitations due to physical health** — problems with work or regular activities during the past 4 weeks; each rated on a 5-point frequency scale (none of the time → all of the time):

   a. Accomplished less than desired

   b. Limited in the kind of work or other activities

4. **Role limitations due to emotional problems** — problems with work or regular activities during the past 4 weeks as a result of emotional problems; each rated on the same 5-point frequency scale:

   a. Accomplished less than desired

   b. Did work or activities less carefully than usual

5. **Bodily pain** — extent pain interfered with normal work during the past 4 weeks; single item, 5-point scale (Not at all → Extremely)

6. **Feelings and energy during the past 4 weeks** — each rated on a 6-point frequency scale (all of the time → none of the time):

   a. Felt calm and peaceful (mental health)

   b. Had a lot of energy (vitality)

   c. Felt downhearted and blue (mental health)

7. **Social functioning** — how much of the time physical health or emotional problems interfered with social activities during the past 4 weeks; single item, 5-point frequency scale

Two additional unscored "health change" items (compared with one year ago; 5-point scale, much better → much worse):

   a. Physical health now vs. one year ago

   b. Emotional problems now vs. one year ago

AAVBC PERSPECTIVE — THE SCREENING IS THE BEGINNING OF THE MEASURE

Completing a validated screen, such as a **PHQ-9**, is **not sufficient by itself** to satisfy this measure. The follow-up survey two years from now will not ask whether the patient was screened, it will ask whether the patient still has the **energy and function to engage in daily life**, including social activity. What actually drives that outcome is the **clinical management delivered between the two surveys**: a medication adjusted when it wasn't working, a safety plan reinforced, a referral made and followed through. **C05 measures sustained function over time**.[3]

MEASURE SPECIFICATION

HOS Two-Year Cohort Measure

The denominator follows a cohort longitudinally, with the same sampled patients, surveyed twice, two years apart.

ELEMENT	SPECIFICATION
Who enters the analysis	Sampled Medicare patients 65 or older at baseline who completed the HOS with a calculable MCS score, were **alive at follow-up**, still enrolled in the same health plan when the follow-up sample was drawn, and completed the follow-up survey with a calculable score[1]
Numerator	Number of patients from cohort whose two-year MCS change was the same as or better than expected, where "expected" is computed per patient from a case-mix model[1]
The instrument	The MCS is derived from the **VR-12.** For the 2026 result, the two-year change draws on questions **4a–b** (accomplishing less, and working less carefully, due to emotional problems), **6a–c** (feeling calm and peaceful, having energy, feeling downhearted and blue, each over the past four weeks), and **7** (how much physical or emotional problems interfered with normal social activities)[1]
Cohort design	The 2026 result uses **Cohort 25** (baseline 2022, follow-up 2024) with follow-up fielded July 17 to November 1, 2024.[1] A new cohort baselines while the prior one follows up, so fielding happens **every year**
Death handling	Patients who died are excluded from the mental health analysis. Death is folded into the companion physical health measure **(C04)**[1]
Case-mix adjustment	**Applied**. Expected outcomes come from a logistic model using baseline sociodemographics, chronic conditions and functional status, with contract-mean imputation for missing covariates[1]
Exclusions and suppression	Contracts with fewer than 100 usable baseline-plus-follow-up responses are suppressed. There are **no clinical exclusions;** depression, dementia and frailty leave a patient in the cohort if they can complete the survey[1]
Measurement period	Follow-up data collection July 17 – November 1, 2024, reflecting two years of care since the 2022 baseline[1]

ABBREVIATIONS: HOS = Health Outcomes Survey; MCS = Mental Component Summary; VR-12 = Veterans RAND 12-Item Health Survey

⚠ RED FLAG — THE TWO-YEAR GAP

A patient may be screened, diagnosed, and started on treatment during a single visit, but the follow-up survey reflects the outcome of everything that occurs (or fails to occur) in the interval that follows. Common contributing factors include medication discontinued without follow-up, a specialty referral delayed for months, or a depressive episode that goes unmonitored following bereavement. **Treatment initiation must not be equated with treatment completion.**[5]

Commonly Misunderstood

- Teams assume screening completion is the metric → **the metric is the patient's reported trajectory.** A perfect screening rate with untreated results scores as decline[1]
- Teams assume a psychiatric diagnosis is required **→ every sampled patient counts.** The measure includes **all Medicare Advantage enrollees age 65 and older** who are **randomly sampled for the HOS panel**, regardless of psychiatric diagnosis[1]
- Case-mix adjustment might be assumed to take into account unforeseen or life hardships → **it adjusts for baseline health and demographics.** For example, a patient starting with **severe physical limitations and multiple chronic conditions** is expected to have a **lower two-year MCS score** than a patient starting in excellent health; each patient is judged against their **own baseline-adjusted benchmark**, not a single fixed target [1]
- The measure is assumed to be triple weighted → **it is 1 for SY2026** under the returning-measure rule, and 3 from SY2027

HOW PERFORMANCE IS MEASURED

From Two Surveys to a Score

Each sampled patient completes the **VR-12 survey twice**: once at **baseline**, and again **two years later**. CMS calculates a **Mental Component Summary (MCS) score** from each survey and compares the two to determine whether the patient's mental health was **the same, better, or worse than expected**. The term "expected" is not a fixed number, it is calculated individually for each patient based on their **starting health, chronic conditions, and demographics**. Therefore, a patient who begins in poor health is held to a different benchmark than one who begins in excellent health. A contract's reported score is simply the **percentage of its sampled patients whose actual outcome matched or exceeded their own individual expected outcome**.[1]

Because each patient is judged against **their own expected trajectory**, not a single universal target, the measure already accounts for the fact that **function typically declines with age**. Holding steady counts as a favorable outcome, and a contract is **not penalized for serving an**

older or sicker population, it is only penalized when its patients do worse than similar patients elsewhere.[1]

Internal Performance is not the Official Star Result

Internal dashboards can support care improvement, but they should be distinguished from the official CMS result because the populations, denominators and data pathways differ.

CALL IT THIS	WHICH MEANS
Official result	The contract-level result calculated and published by CMS using **its own data and methodology**
Internal proxy	An **organization's internal estimate** based on its own patient population and available records. Useful for improvement work, but not equivalent to the official result
Documentation completeness	How consistently the care delivered is documented in structured fields
Patient understanding	Whether patients leave encounters with a **clear understanding** of what care they received, supported by an accessible record

ABBREVIATIONS: CMS = Centers for Medicare & Medicaid Services
Internal estimates should be labeled clearly and interpreted separately from the official CMS contract-level result because the populations, denominators, and measurement pathways differ

Adjustment and Comparability

This measure is case-mix adjusted.[1] The adjustment accounts for each patient's baseline health, demographics, and functional status, so **patients with different starting points are compared against different expected outcomes**. It does **not** account for what happens **between baseline and follow-up**. A medication discontinued without follow-up, a referral that is never completed, or loneliness that goes unaddressed can all occur during that two-year period, and outcomes worse than expected often reflect gaps like these.

HIGH-YIELD INTERVENTIONS

Interventions align with four points on the measure's timeline: **identification of declining patients through effective screening, initiation of treatment with barriers to access addressed, continuity of treatment through structured follow-up, and management of physical health conditions that affect mental health**. These effects are not observed within the current measurement cycle; they accumulate and are reflected in the **two-year follow-up survey.**

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Screen systematically at routine and wellness visits: administer PHQ-2/PHQ-9 and GAD-7 at rooming, record scores in structured fields, and flag elevated results promptly	**Every eligible visit** MA administers; PCP acts	Late-life depression more often presents as fatigue, pain, and withdrawal than sadness. Waiting for patients to raise the topic identifies only a minority of cases[3]
Treat to target with measurement-based care: recheck the score at 4–6 weeks, and adjust treatment if the score has not improved	**Every treatment start** PCP with care manager recall	Measurement-based care raised remission rates from roughly **43% to 53%** compared with usual care. Early non-response predicts eventual non-remission if the regimen is left unchanged.[5] The recheck should be set as an **automatic recall in the EHR**
Complete a structured handoff at treatment initiation: the pharmacist counsels the patient on side effects and the expected two-to-six-week lag before mood improves, and resolves prior authorization before the patient leaves	**Same visit** Clinical pharmacist	Most **early discontinuation** happens in the **first weeks** of treatment. Pharmacist-led counseling roughly doubled the odds of continuing antidepressant therapy at six months,[7] and most physicians report that authorization delays lead to treatment abandonment. **Resolve them the sameday**[8]
Complete a written safety plan for every high-risk encounter, followed by a 72-hour follow-up call	**Every crisis or high-risk contact** Clinician plans; care manager calls	The structured safety planning intervention with follow-up contact roughly doubled outpatient engagement and produced **45% fewer** suicidal behaviors over six months versus usual care.[6] A verbal conversation alone does **not** suffice
Establish a collaborative care program for patients primary care would otherwise manage without specialty support	**Ongoing** Behavioral care manager + consulting psychiatrist	The **collaborative care model** (a registry, a behavioral care manager, and psychiatric caseload consultation inside primary care) carries significant trial evidence for late-life depression. It reduces reliance on the three-to-six-month specialty waitlist by resolving most cases within primary care[9]

ACTION	WHEN/WHO	WHY IT MATTERS FOR THIS MEASURE
Address mobility, pain, sleep, and sensory loss as part of mental health management	**Ongoing** PCP with PT and care team	In older adults, **mental and physical scores are closely linked**. Lost mobility and untreated pain register as emotional interference with daily life on the items this measure scores.[1] A physical therapy referral, a pain management plan, and a hearing aid are examples of mental health interventions
Address loneliness as a clinical problem by connecting patients to social and community resources	**Every touchpoint for isolated patients** Care coordinator/CHW	Bereavement, loss of driving privileges, and shrinking social networks are significant **mental health risk factors in late life**. Senior centers, peer support programs, and transportation services address this risk directly

ABBREVIATIONS: CHW = community health worker; EHR = electronic health record; MA = medical assistant; PCP = primary care provider; PHQ = Patient Health Questionnaire; PT = physical therapy

Risk Stratification — Who to Reach First

TIER	CRITERIA	RESPONSE
STAT- Ongoing mental health crisis	Any endorsement of suicidal or homicidal ideation; Concerned family or caregivers for uncontrolled mental health episode	**Consider Baker Act, ER and Law enforcement intervention**
Urgent: within 48 hours	Recent psychiatric hospitalization or behavioral health ED visit; **PHQ-9 above 15**	**Conduct a safety check by phone or video and complete a written safety plan.** Reconcile and fill medications. Clear prior authorizations within 24 hours. Schedule the 3-to-5-day follow-up call before the encounter ends[6]
Priority: within 7 days	New antidepressant or anxiolytic start; **PHQ-9 (10–14)**; missed behavioral health follow-up	**Conduct a tolerability call at day 3 to 5.** Verify adherence and prescription fill status. Have the **care team rebook** any missed appointment. Flag the 30-day score recheck[5]
Routine: at 30 days	**PHQ-9 (5–9)**, or post-acute treatment without remission	**Re-administer the score** at the next visit or by scheduled recall. Reinforce adherence. Escalate care if the score rises or a refill is missed[5]

TIER	CRITERIA	RESPONSE
Maintenance	Stable, **PHQ-9 (<5),** regimen unchanged	**Re-screen annually at the wellness visit.** Maintain light-touch check-ins. Discuss any medication taper deliberately, as a planned decision

ABBREVIATIONS: ED = emergency department; PHQ-9 = Patient Health Questionnaire-9

QUALITY OUTCOME — COUNSELING AT INITIATION REDUCES EARLY DISCONTINUATION

The following points delivered to patients at treatment initiation have a significant **effect on outcomes**:

1. Physical symptoms may improve within the first week, but **mood improvement typically takes four to six weeks**
2. Mild nausea and headaches are usually resolved within days
3. Treatment should **continue even after the patient feels better**

Patients who do not receive this counseling commonly **discontinue treatment by week three**, whether they perceive no improvement or believe they have fully recovered. Both patterns are reflected two years later as a **worse-than-expected outcome.**[7]

COMMON PITFALLS AND PRACTICAL FIXES

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Screening treated as the endpoint	The PHQ-9 is completed and documented, but **no action follows**	A positive screen requires a **same-visit diagnosis and treatment initiation**, or a scheduled alternative plan. Track the rate of **positive screens with a documented plan**[5]
Initiation without structured follow-up	Medication is started, side effects appear before benefit, and **no follow-up contact occurs**; discontinuation is not identified until the follow-up survey years later	A **fixed follow-up sequence** for every new prescription: pharmacist handoff, a call at **day 3 to 5**, a **30-day symptom score recheck**, and a medication change when the score has not improved[5,7]

FAILURE MODE	WHY IT HAPPENS	WHAT PREVENTS IT
Referral to an inaccessible specialist network	The directory lists many psychiatrists, but the actual wait time is **three to six months**, and the patient does not follow up during that interval[2]	A **collaborative care model** that resolves most cases within primary care, **validated rapid-access telepsychiatry** for remaining cases, and an **interim primary-care treatment plan** established the day the referral is placed. A referral alone should not constitute the treatment plan[9]
"Stable" used as a clinical finding	Documentation states "mood normal, patient stable, continue current medications" without a **score, comparison, or actionable detail**	Every relevant note should include the **screening tool, current score, date, and change from the prior score**. For example, "PHQ-9 score 4, down from 12" is a documented finding; "stable" alone is not
Physical and mental health managed independently	A chronic condition such as heart failure is actively managed while a **decline in the patient's activity and engagement** goes unaddressed	Manage **mobility, pain, hearing, and vision alongside mood** as a single set of functional targets, since the VR-12 instrument scores them together[1]
Unmonitored grief progressing to depression	A bereaved patient is appropriately given space to grieve, but **no follow-up is scheduled**, and grief that progresses to depression goes undetected	Schedule a **follow-up contact for every major loss** (spouse, home, driving privileges), with **screening at the next two visits**

ABBREVIATIONS: PHQ-9 = Patient Health Questionnaire-9

HOS Survey Integrity — What CMS Prohibits

CMS **prohibits** health plans and anyone acting on their behalf from:

- Attempting to **influence how a patient answers HOS questions**, or encourage a particular response;
- Administering HOS or HOS-Modified survey questions to Medicare beneficiaries in the **eight weeks before or during** the HOS administration window;
- **Offering incentives** of any kind to prompt, influence or increase participation;
- Showing or providing the survey instrument to patients **before administration**, or rehearsing its items in clinical or outreach contact

These prohibitions are from CMS, set out in the Medicare HOS Quality Assurance Guidelines and Technical Specifications. CMS also discourages fielding other patient surveys that use the same or similar questions around the HOS administration window.

AAVBC PERSPECTIVE — PATIENT EXPERIENCE

Screening, education, and a clearly explained intervention are part of **standard clinical care**. They should **not** be used to rehearse HOS survey questions, suggest preferred answers, or influence how a patient responds. The test for any reinforcement contact: does it change what the patient experiences and understands, **or only what they report**?

BARRIERS AND EVIDENCE-BASED SOLUTIONS

Patient-side

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Stigma toward mental illness	Many older patients, and some communities, view mental illness as a **personal or moral failing** rather than a medical condition	Present mood and energy screening as a **routine part of every visit**. Framing it as standard protocol reduces the sense that a patient is being singled out
Somatic presentation of depression	Late-life depression commonly presents as **fatigue, pain, insomnia, or weight change**, and is frequently evaluated as a physical condition without a mental health screen	Include a **mood screen as part of the standard workup** for fatigue and pain[3]
Cost and coverage friction	**Copays, step-therapy requirements, and prior authorization delays** disproportionately affect patients with the fewest resources; most physicians report that **these delays lead to treatment abandonment**[8]	Prescribe **formulary-preferred agents at initiation**, have the pharmacist **resolve coverage barriers before the visit ends**, and use **expedited authorization pathways** for behavioral health medications[8]

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Life events affecting mental health	**Widowhood, loss of driving privileges, and shrinking social networks** are common in late life and directly affect mental health; the VR-12 identifies these effects through its social and role-functioning items[2]	**Ask about major life events directly**, not only about symptoms. Connect patients to **transportation, senior programs, and peer support**, and **schedule follow-up proactively**

CLINICAL PEARL — SCREEN FOR MOOD, ENERGY, AND SOCIAL ENGAGEMENT AS PART OF ROUTINE CARE

Routine use of **validated screening tools**, such as the **PHQ-9 and GAD-7**, identifies the same clinical concepts this measure reflects: **mood, energy, and social functioning**. This screening should be conducted as **standard clinical practice**, independent of the HOS survey and using **standard clinical language and instruments**, not the survey's own wording. Identifying decline early through ordinary clinical care allows **treatment to begin before the two-year follow-up survey.**

System and Workflow

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Primary care managing psychiatric care without support	A large share of psychiatric care is delivered **entirely within primary care**, under significant time pressure, and only a small fraction meets **minimally adequate treatment standards**[3]	The **collaborative care model** addresses this directly: a **behavioral care manager** maintains the registry and follow-up, a **consulting psychiatrist** reviews the caseload, and the **PCP** prescribes **with psychiatric support**[8]
Behavioral health data not returning to primary care	Behavioral health EHRs are **not required to interoperate** with primary care systems, so scores and medication changes made in specialty care are often **absent from the primary record**	Establish **data-sharing agreements** with contracted behavioral health providers, require **structured score reporting** into a shared registry, and use the **care manager to relay** information when electronic data sharing fails

BARRIER	HOW IT SHOWS UP	WHAT HELPS
Psychiatric workforce shortage	Nearly **half the population** lives in a designated mental health professional **shortage** area, and low reimbursement keeps many psychiatrists **outside plan provider networks**[10]	Offer **tele-behavioral health**, including audio-only visits, use the **collaborative care model** to extend limited psychiatric time across more patients, and **audit network directories** for accuracy[9]
Step therapy delays within a fixed measurement window	Fail-first requirements require patients to complete weeks of a treatment expected to be ineffective before an alternative is authorized, even as the **two-year measurement period elapses**	Use **documented clinical-exception pathways**, **expedited authorization** for behavioral health medications, and **escalate any pending authorization beyond 24 hours**[8]

ABBREVIATIONS: EHR = electronic health record; PCP = primary care provider

Disparity Gaps Requiring Targeted Action

The disparities described below occur **between the baseline and follow-up surveys**, and they are addressable through clinical and operational changes. Track **screening, treatment initiation, follow-up completion, and remission rates** by race, income, rurality, and diagnosis.

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Low-income and dual-eligible patients	**Low reimbursement rates reduce provider availability** in the areas where these patients live, and **hourly employment, lack of paid leave, and unreliable transportation** further limit access	Offer **telephone and evening appointment options**, apply **transportation benefits at the time of booking**, use **community health worker outreach**, and account for **medication cost at the time of prescribing**
Rural patients	**Limited local provider availability** combined with **inconsistent broadband access** restricts both in-person and video visits[10]	Establish **audio-only contact as a planned care pathway**, integrate **tele-behavioral health into local primary care**, and use **community-based touchpoints** in addition to clinic visits

POPULATION SEGMENT	PATIENT IMPACT	INTERVENTIONS
Patients with severe mental illness	Physical symptoms are frequently **attributed to the patient's psychiatric history** rather than evaluated independently, and **fragmented care contributes to a reduced life expectancy** of a decade or more[4]	**Provide primary care and psychiatric care in the same setting,** including primary care delivered directly within psychiatric care for patients who engage more consistently there. Require **metabolic and physical health screening** for psychiatric caseloads, and assign **one accountable care manager** across both systems[4]

DOCUMENTATION REMINDER

Chart documentation does not directly affect the HOS result, but it is what **carries a patient's care forward** between visits and providers. This measure depends on a **coordinated transition of care**, from medical assistant to PCP to pharmacist to care manager, sustained over two years. Clear documentation allows each person in that sequence to **continue care where the last person left off**. Each note should include the score and its date, the specific barrier identified, and who is responsible for the next contact.

CLINICAL CONTEXTS AND APPLICATIONS

Clinical Contexts

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
Decline of mobility and mood	**Physical decline directly affects the mental health score**[1]	Prescribe **PT and structured exercise as mood interventions**, and address **pain and sleep with the same priority** given to the PHQ score they influence
Dementia and cognitive impairment	**Apathy, agitation, and withdrawal** are often attributed solely to depression, while **patient self-report becomes less reliable** as cognitive impairment progresses	Incorporate **caregiver input as a standing data source**, evaluate behavioral symptoms **systematically**, and **treat depression when present** rather than attributing it entirely to dementia

CONDITION OR SITUATION	WHY THIS MEASURE MATTERS HERE	WHAT TO WATCH FOR
Diabetes and heart failure	**Depression impairs the self-management** these conditions require, and the conditions in turn **increase the risk of depression**	**Screen mood during chronic-disease visits**, and **prioritize collaborative care** for patients with both conditions[9]
Bereavement and major life transition	The **highest-risk mental health events in late life**, including widowhood, relocation, and loss of driving privileges, **do not carry a diagnosis code** and can be easily overlooked	**Schedule a follow-up contact** after every known major loss, **screen at the next two visits**, and **offer social reconnection resources** as part of treatment

ABBREVIATIONS: PHQ = Patient Health Questionnaire; PT = physical therapy

Patient Journey

BEAT	CONTENT
Presents as	A woman in her **early seventies** with **hypertension** and **type 2 diabetes** arrives for her annual wellness visit. Asked directly (she would not have raised it) she mentions **low energy** and **poor sleep** since her **husband died** eight months ago
What happens	The **PHQ-9 returns 13**. The PCP identifies: **depression following bereavement**, common and treatable, and starts a **low-dose SSRI** chosen off the preferred formulary. The pharmacist counsels on the two-to-six-week lag and early side effects and clears the authorization before she leaves; the care manager books the day-3 tolerability call and the 30-day recheck before checkout
Outcome	At **day 30** her **PHQ-9 is 6**. She has started walking with a neighbor, the care manager connected her to a senior-center walking group when transportation came up on the day-3 call. The score, the date and the delta go into the structured field; the six-month taper conversation is scheduled
Follow-up	**Two years later**, when the HOS follow-up reaches her, she reports her mental health as good — **the same or better than expected**. The measure simply recorded that the system asked, treated, followed through, and kept her connected to her own life

ABBREVIATIONS: PCP = primary care provider; PHQ-9 = Patient Health Questionnaire-9; SSRI = selective serotonin reuptake inhibitor Note: Case is illustrative and is not a reported individual case

Companion Guides – Making Connections

GUIDE	WHEN TO REACH FOR IT
Improving or Maintaining Physical Health (C04)	The **partnermeasure**from the same survey and cohort. In older adults, it is half the mechanism: physical function and mood are closely related
Monitoring Physical Activity QRG (C06)	The HOS process measure whose exercise conversation doubles as one of this measure's **best interventions**
Reducing the Risk of Falling QRG (C15)	The same survey, the same independence framing, and fear of falling is itself a **mood and function** event
Major Depression QRG	**The clinical depth behind this guide:** diagnosis, agent selection, and treatment sequencing beyond the measure view

ABBREVIATIONS: HOS = Health Outcomes Survey; QRG = Quick Reference Guide

DOCUMENTATION THAT SUPPORTS CARE

Documentation that Reflects the Care

- Documentation does not directly affect this score, but it should still be maintained consistently. Each note should include the **screening tool used, the exact score, the date, and the change from the prior score**, since care for this two-year measure is continued by whoever next reviews the chart. This is best practice
- Every positive screen should carry a **documented plan**, including the treatment started or an explicit alternative, a **follow-up contact with an owner and date**, and any identified barrier
- Document the explanation given to the patient for the medication, **in the words used with the patient**, for example, "to help your energy and mood recover after this year." Patients who **understand the reasoning** behind a medication are more likely to continue taking it[7]
- Safety plans should be **written, specific, provided to the patient in writing**, and followed by a **logged contact within 72 hours**. A safety plan documented only as "discussed safety" **does not meet this standard**[6]

What Belongs in the Record

ELEMENT	WHAT TO RECORD
The score, every time	**Instrument used, exact score, date, and comparison to the prior score**[5]
The plan behind a positive screen	**At each positive screen, document the clear plan: treatment initiated, referral with an interim plan, or planned monitoring with a scheduled recheck.** The documented plan may change at a later visit as the patient's condition evolves
The follow-up relay	Day 3–5 contact, 30-day recheck, and the medical professional responsible named for **each**
The barrier	Cost, authorization, transport, stigma, network failure, in the patient's own words where possible
The safety plan, when risk is present	Written, specific, copy given, follow-up call logged at **72 hours**[6]
The life context	Bereavement, relocation, lost independence, caregiver strain. These events **explain the patient's trajectory** to whoever reviews the chart in two years

Clinical Documentation Optimization – SOAP

S — Subjective

Annual wellness visit. On direct inquiry, reports low energy and fragmented sleep since her husband's death eight months ago; has stopped attending her book club. **Denies suicidal ideation** on specific questioning. Wants to feel like herself again.

O — Objective

PHQ-9 administered at rooming: **13** (moderate), first documented score. Alert, engaged, appropriately tearful discussing her husband. Diabetes and blood pressure stable per today's review.

A — Assessment

Moderate major depressive episode following bereavement, beyond expected grief in duration and functional impact. Motivated for treatment; no safety concerns today.

P — Plan

Started [**SSRI**, formulary-preferred] at low dose with the timeline explained: energy and sleep may improve first, mood in four to six weeks; early side effects usually pass within days; continue daily even when feeling well. Pharmacist counseling completed and authorization cleared today. Care manager to call **day 3–5** for tolerability, and **PHQ-9** recheck scheduled at 30 days. If improvement is under **20%**, regimen review rather than routine refill. Senior-center walking group information provided; transportation option discussed. Bereavement follow-up flagged for the next two visits[6,8]

Documentation Examples

Complete — The day-30 recheck

"*Day-30 recheck: PHQ-9 11, down from 13 — under 20% improvement at four weeks on [agent/dose]. Adherence confirmed via fill history; tolerating well. Dose increased per plan; next recheck at week 8 booked. Patient understands the timeline and the reason for the change.*"

Complete — Remission, with the trend visible

"*PHQ-9 4, down from 12 at treatment start in [month]. Sleeping through the night, walking regularly, back at her book club. Continue current dose; taper discussion calendared for [date]; annual re-screen thereafter.*"

Not enough — Incomplete

"*Patient stable. Mood normal, appears less anxious today. Up to date on screening from prior visit. Continue current meds, follow up as needed.*" — no score, no date, no trend, no owned next contact. The care may have been excellent; the relay just dropped the baton.[2]

DOCUMENTATION REMINDER

The most clinically important fact for this measure is **the direction of change**. A score moving from **13 to 6 represents improvement**; a score moving from **6 to 13 represents a significant decline**, and either patient may appear stable during a brief visit. Every mood-relevant note should include the **current score, the date, and the prior value** for comparison.

One Status, Clearly Stated

Most records collapse several genuinely different situations into "done" or "not done," and the outreach that follows is wrong for most of them.

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Screened: Negative	**Score and date on file**; re-screen at the next wellness visit, or sooner after any major life event
Positive: Plan initiated	Treatment started with the **day 3–5** and **30-day contacts** booked and identified
Positive: Referred, interim plan running	**Specialty or collaborative care engaged**, with the primary-care plan explicitly holding the gap until the first appointment
Non-response: Regimen under review	Under **20% improvement** at the recheck; change made or consultation obtained. Never document "continue and recheck later" twice in a row[5]
High risk: Safety plan active	**Written plan given**, 72-hour contact logged, escalation pathway named[7]

STATUS	WHAT IT MEANS, AND WHAT FOLLOWS FROM IT
Remission: Maintenance	**PHQ-9 score under 5**; taper conversation scheduled deliberately; annual re-screen
Barrier open	**Cost, authorization, transport or network failure** named, routed, and owned
Life event watch	Bereavement or major transition logged; **screening flagged for the next two contacts**

KEY TAKEAWAYS

1 This measure reflects each patient's own two-year trajectory

The same individuals are surveyed twice, and their mental health is scored against an individualized expectation.

2 Screening rates, diagnosis codes, and chart notes do not directly affect this score[1]

3 Maintaining function qualifies as success

The expected outcome already accounts for age-related decline, thus stable mood and preserved social function in a complex older patient represents a positive outcome.

4 Outcomes are most often affected by the gap between treatment initiation and follow-through

Every treatment start should include a structured follow-up sequence: pharmacist handoff, a call at day 3 to 5, a 30-day score recheck, and a medication change when the score has not improved.[5,7]

5 Screen systematically, including within somatic presentations

Late-life depression commonly presents as fatigue, pain, and withdrawal. Patients frequently will not raise mood symptoms on their own, but they will typically answer honestly when asked directly as part of routine screening.[3]

6 Physical function and mental health are scored together in the VR-12 instrument, since it measures emotional interference with work and social life

A PT referral, a pain management plan, and transportation to a senior center are all interventions that can affect the MCS score.[1]

7 A referral alone, into a three-to-six-month waitlist, does not constitute a treatment plan

In-house collaborative care, an interim primary-care treatment plan established the same day, and a written safety plan for any patient at risk should accompany every referral.[6,9]

8 This measure carries a weight of 1 for the current cycle and will carry a weight of 3 starting with SY2027

Patients completing baseline surveys now will report follow-up results under that higher weight, making these follow-up processes a priority to implement this year.[1]

Changes to Monitor

Current as of 2026-08-20.

KIND OF CHANGE	GOOD PRACTICE
Weight — the headline change	C05 is weight 1 for SY2026 under the returning-measure rule and **returns to weight 3 beginning with the 2027 Star Ratings**. The cohort answering baseline surveys now reports into the triple-weighted era. Revalidate the weight, and the companion physical health measure's identical trajectory, **each cycle**[1]
Measure history and comparability	The case-mix specification changed substantively with 2022 data; the measure sat on display through SY2025 and returned for SY2026. **Treat 2026 as the baseline year**sincepre-2022 rates are not comparable, and the cut-point distribution will keep settling for **several cycles**[1]
Rating-year methodology	Revalidate cut points (clustering), the case-mix model and covariates (TN Attachment A), suppression thresholds, and the measure's exclusion from the Improvement Measure and CAI each cycle[1]
Survey administration	HOS fielding dates, cohort numbering and vendor protocols are set annually; the survey-integrity prohibitions in Section 6 come from the **HOS Quality Assurance Guidelines** and should be rechecked against the current version[12]

KIND OF CHANGE	GOOD PRACTICE
Rating-year policy	The CY2027 final rule did **not** implement the planned health-equity-based reward; the historical reward factor continues. Confirm reward-factor treatment **each Advance Notice cycle**[13]
Clinical guidance and internal tools	**Screening instruments, late-life depression treatment guidance, and collaborative care** billing all carry their own revision cycles; review the registry logic, recall automation and follow-up scripts annually, and label any retained prior-year cut points as prior-year rather than current

ABBREVIATIONS: CAI = Categorical Adjustment Index; HOS = Health Outcomes Survey; TN = Technical Notes

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