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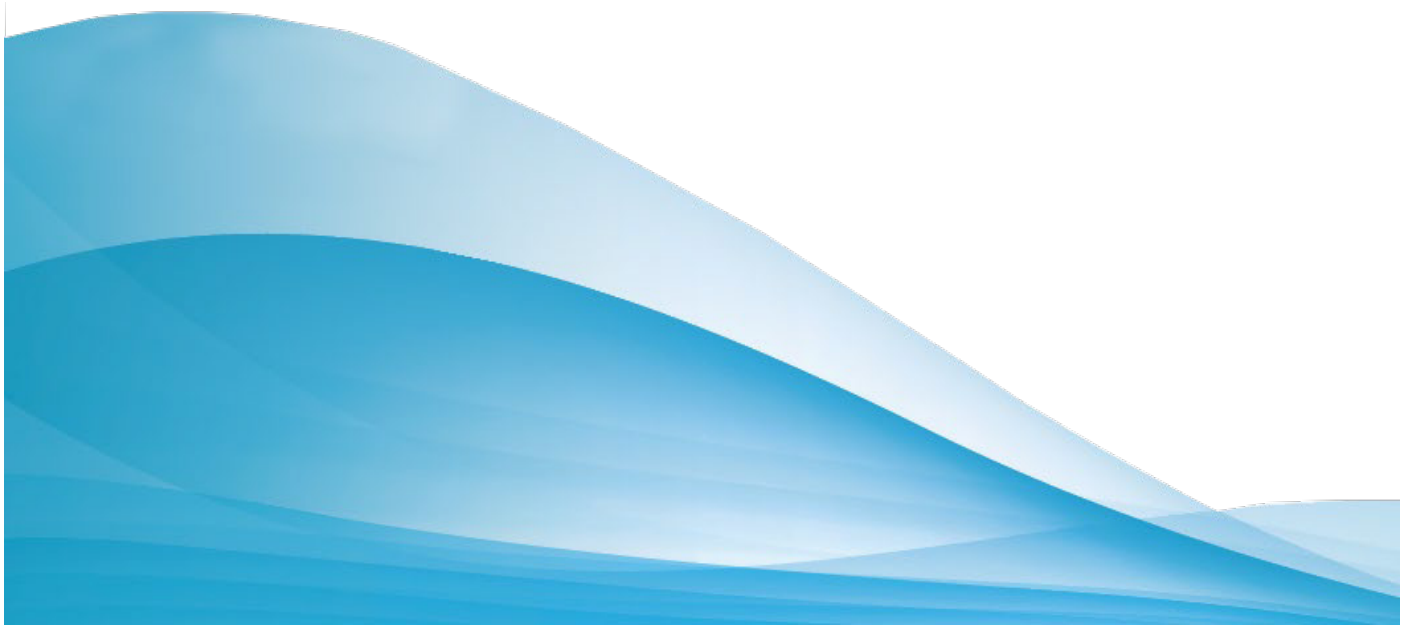
Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP

Summary of a Workgroup Review of the 2026 Child and Adult Core Sets

Final Report

May 2024



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Acknowledgments

This report was developed by Mathematica as part of the Technical Assistance and Analytic Support for the Medicaid and CHIP Quality Measurement and Improvement Program, sponsored by the Center for Medicaid and CHIP Services. The 2026 Child and Adult Core Sets Annual Review Workgroup process and the subsequent development of this report benefitted from the contributions of the entire team:

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Mathematica also acknowledges the contributions of the Child and Adult Core Sets Workgroup members. Each member brought an invaluable perspective that informed the recommendations for the 2026 Child and Adult Core Sets. In particular, we thank the Workgroup co-chairs, Kim Elliott and Rachel La Croix, for their insightful leadership. We also appreciate the participation of the federal liaisons, who provided cross-agency insight during the meetings.

In addition, we express our gratitude to the measure stewards who made themselves available throughout the review process. We appreciate the information they provided on the measures under consideration and thank them for responding to questions from the Workgroup during the meeting.

Mathematica also appreciates the comments provided by members of the public during the Workgroup meetings. The diversity of perspectives enriched the discussion about strengthening the Child and Adult Core Sets.

Finally, we thank the staff in the Division of Quality and Health Outcomes at the Center for Medicaid and CHIP Services for their input and guidance.

Contents

Exhibits

Acronyms

ACOG	American College of Obstetricians and Gynecologists
CAHPS®	Consumer Assessment of Healthcare Providers & Systems
CDC	Centers for Disease Control and Prevention
CDF	Screening for Depression and Follow-Up Plan
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
ECDS	Electronic Clinical Data Systems
ED	Emergency department
EHR	Electronic health record
FFY	Federal fiscal year
HEDIS®	Healthcare Effectiveness Data and Information Set
HCBS	Home and community-based services
HHS	United States Department of Health and Human Services
HRSNs	Health-related social needs
IET-AD	Initiation and Engagement of Substance Use Disorder Treatment
LTSS	Long-term services and supports
MME	Morphine milligram equivalent
NCQA	National Committee for Quality Assurance
NPAC	National Pain Advocacy Center
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer
PQA	Pharmacy Quality Alliance
SUD	Substance use disorder
TA	Technical assistance
TA/AS	Technical Assistance and Analytic Support
T-MSIS	Transformed Medicaid Statistical Information System
WONDER	Wide-ranging Online Data for Epidemiologic Research

Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to more than 85 million people, including eligible children, pregnant individuals, low-income adults, the elderly, and individuals with disabilities.[1] The Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various strategies to help ensure that individuals enrolled in state Medicaid and CHIP programs receive coverage that promotes access to and receipt of high-quality and equitable care. The Medicaid and CHIP Child and Adult Core Sets of health care quality measures are key tools in this effort to measure the quality of care and drive improvement in Medicaid and CHIP.

The purpose of the Child and Adult Core Sets is to estimate the overall national quality of care for Medicaid and CHIP beneficiaries based on a uniform set of health care quality measures. CMCS and states use the Child and Adult Core Set measures to monitor access to and quality of health care for beneficiaries, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives. Federal fiscal year (FFY) 2024 marks the first year that states are mandated to report the Child Core Set measures and behavioral health measures on the Adult Core Set.[2]

The Secretary of the U.S. Department of Health and Human Services is required to review and update the Child and Adult Core Sets each year.[3] The Core Sets Annual Review process is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The annual review includes input from a variety of interested parties, including but not limited to states, managed care plans, health care providers, and quality experts.

CMCS contracted with Mathematica to convene the 2026 Child and Adult Core Sets Annual Review Workgroup. The Workgroup included 34 members representing a diverse array of affiliations, subject matter expertise, and quality measurement and improvement experience (see inside front cover for a list of Workgroup members).

The Workgroup was charged with assessing the 2024 Child and Adult Core Sets and recommending measures for removal or addition, with the goal of strengthening and improving

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[1] The December 2023 Medicaid and CHIP Enrollment Trend Snapshot is available at https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html. Numbers reflect preliminary Medicaid and CHIP enrollment data for December 2023, as of February 8, 2024, as reported by 50 states and the District of Columbia.

[2] Bipartisan Budget Act of 2018, P.L. 115-123 and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, P.L. 115-271. On August 31, 2023, CMS released the Mandatory Medicaid and CHIP Core Set Reporting Final Rule (88 FR 60278), which outlines reporting requirements. More information is available at https://www.federalregister.gov/documents/2023/08/31/2023-18669/medicaid-program-and-chip-mandatory-medicaid-and-childrens-health-insurance-program-chip-core-set.

[3] Annual updates to the Child Core Set are required under the Children's Health Insurance Program Reauthorization Act of 2009. Annual updates to the Adult Core Set are required under the Affordable Care Act. The Child Core Set has undergone these annual reviews since January 2013 and the Adult Core Set since January 2014.

the 2026 Core Sets. Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Child and Adult Core Sets based on several criteria. These criteria support the adoption of measures that are feasible and viable for state-level reporting, are actionable by state Medicaid and CHIP programs, and represent strategic priorities for improving care delivery and health outcomes for Medicaid and CHIP beneficiaries. See Exhibit ES.1 for the criteria Workgroup members considered during the 2026 Child and Adult Core Sets Annual Review.

Exhibit ES.1. Criteria Considered for Removal of Existing Measures and Addition of New Measures to the 2026 Child and Adult Core Sets

Criteria Considered for Removal of Existing Measures
Technical Feasibility
1. The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
2. States report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3. The specifications and data source do not allow for consistent calculations across states (e.g., there is variation in coding or data completeness across states).
4. The measure is being retired by the measure steward and will no longer be updated or maintained.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid and CHIP.
2. The measure is not suitable for comparative analyses of disparities among Medicaid and CHIP beneficiaries by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.[4]
3. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid and CHIP beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
4. The measure cannot be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure is topped out, trending is not possible, or improvement is outside the direct influence of Medicaid and CHIP programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All states may not be able to produce the measure for Core Set reporting within two years of the reporting cycle under review or may not be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

[4] The statute establishing the Child Core Set specifies that measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities in health and health care. More information is available at https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

Exhibit ES.1 *(continued)*

Criteria Considered for Addition of New Measures
Minimum Technical Feasibility Requirements (all requirements must be met)
1. The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets).
2. The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid and/or CHIP programs.
3. An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
4. The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness).
5. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid and CHIP.
2. The measure should be suitable for comparative analyses of disparities among Medicaid and CHIP beneficiaries by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.[5]
3. The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
4. The measure can be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid and CHIP programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3. All states should be able to produce the measure for Core Set reporting within two years of the measure being added to the Core Sets and be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services.

Workgroup members convened virtually on February 6 and 7, 2024, to review two measures suggested for removal and two measures suggested for addition. The four measures were presented, discussed, and voted on beginning with the two measures suggested for removal, and then the two measures suggested for addition. For a measure to be recommended for removal from or addition to the Child and Adult Core Sets, at least two-thirds of the Workgroup members eligible to vote had to vote in favor of removal or addition.

[5] The statute establishing the Child Core Set specifies that measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities in health and health care. More information is available at https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

In summary, the Workgroup recommended removing one measure from the Adult Core Set: *Use of Opioids at High Dosage in Persons Without Cancer* (OHD-AD) and adding one measure to the 2026 Child and Adult Core Sets: *Prenatal Depression Screening and Follow-Up* (Exhibit ES.2). The report summarizes the Workgroup's discussion and rationale for these recommendations.

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2026 Child and Adult Core Sets

Measure Name	Measure Steward
Measure Recommended for Removal	
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Pharmacy Quality Alliance (PQA)
Measure Recommended for Addition[a]	
Prenatal Depression Screening and Follow-Up	National Committee for Quality Assurance (NCQA)

[a] CMCS assigns new measures to a Core Set and domain as part of its annual update.
CMCS = Center for Medicaid and CHIP Services.

Beginning with the 2027 Child and Adult Core Sets Annual Review cycle, Mathematica will conduct a Public Call for Measures. To help inform the 2027 Public Call for Measures, the Workgroup discussed priority gap areas in the current Child and Adult Core Sets. The Workgroup also discussed the criteria for measure submission during the Public Call for Measures.

The Workgroup emphasized the importance of considering measures that advance health equity, including measures related to social drivers of health and maternal health, but acknowledged challenges around the feasibility of state reporting of these measures. Workgroup members also underscored the importance of stratifying Core Set measures to understand disparities. Other gap areas related to patient-reported outcomes and experience of care, behavioral health care, and long-term services and supports. The Workgroup discussion about the criteria for measure submission during the Public Call for Measures concentrated on three themes: (1) stratification and health equity; (2) measure alignment, harmonization, and parsimony; and (3) data collection and reporting burden.

This report summarizes the Workgroup's review process, discussion, and recommendations and presents the public comments submitted on the draft report. CMCS will use the Workgroup's recommendations, public comments, and additional input from CMCS's Quality Technical Advisory Group and federal liaisons to inform decisions about updates to the 2026 Child and Adult Core Sets. CMCS has indicated a goal to release the 2026 updates as soon as the end of 2024.

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to more than 85 million people, including eligible children, pregnant individuals, low-income adults, the elderly, and individuals with disabilities.[6] This represents over one in four individuals in the United States.[7] In 2022, Medicaid and CHIP represented the second-largest source of health insurance coverage in the U.S. behind employer-sponsored coverage, covering more individuals than Medicare.[8] Managed care capitation payments are the largest category of Medicaid and CHIP program expenditures, followed by fee-for-service payments for long-term care (Exhibit 1, next page).

The Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various strategies to help ensure that individuals enrolled in state Medicaid and CHIP programs receive coverage that promotes access to and receipt of high-quality and equitable care. The Medicaid and CHIP Child and Adult Core Sets of health care quality measures are key tools in this effort to measure the quality of care and drive improvement in Medicaid and CHIP.

The purpose of the Child and Adult Core Sets is to estimate the overall national quality of care for Medicaid and CHIP beneficiaries based on a uniform set of health care quality measures. The Core Set measures are intended to cover the continuum of preventive, diagnostic, and treatment services for acute and chronic physical, behavioral, dental, and developmental conditions as well as long-term services and supports (LTSS) and experience of care. CMCS and states use the Child and Adult Core Set measures to monitor access to and quality of health care for beneficiaries, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives.

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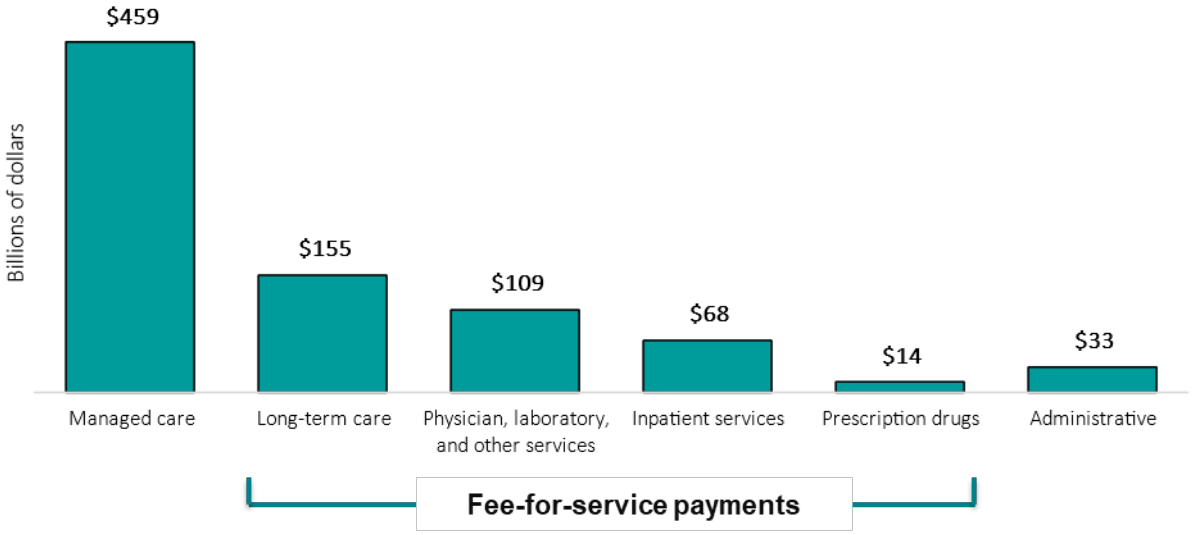
[6] The December 2023 Medicaid and CHIP Enrollment Trend Snapshot is available at https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html. Numbers reflect preliminary Medicaid and CHIP enrollment data for December 2023, as of February 8, 2024, as reported by 50 states and the District of Columbia.

[7] Based on "Monthly Medicaid & CHIP Application Eligibility Determination, and Enrollment Reports & Data." Updated July 2023 data; and U.S. Census Bureau. "National Population by Characteristics: 2020–2023." Estimates of the Resident Population for July 1, 2023. Table SCPRC-EST2023-18+POP. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html; and https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html, respectively.

[8] Katherine Keisler-Starkey, Lisa N. Bunch, and Rachel A. Lindstrom, U.S. Census Bureau, Current Population Reports, P60-281, *Health Insurance Coverage in the United States: 2022*. Table 1. U.S. Government Publishing Office, Washington, DC, September 2023. Available at https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf.

Exhibit 1. Annual Medicaid and CHIP Expenditures by Service Category, FFY 2022



Source: CMS. 2023 Medicaid and CHIP Scorecard. Analysis of CMS-64 reports for FFY 2022 from the Medicaid Budget and Expenditures System/State Children's Health Insurance Program Budget and Expenditures System (MBES/CBES). Available at https://www.medicaid.gov/state-overviews/scorecard/main?pillar=4.

Notes: Expenditures by service category do not sum to the total expenditures. Total expenditures also include Medicare payments for some beneficiaries and adjustments to prior year payments. Managed care expenditures cover the same services that are delivered via fee-for-service. Data do not permit allocation of managed care expenditures to the different service categories. Data are for FFY 2022.

CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services; FFY = Federal Fiscal Year.

The Secretary of the U.S. Department of Health and Human Services (HHS) is required to review and update the Child and Adult Core Sets each year.[9] The Core Sets Annual Review process is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The annual review includes input from a variety of interested parties, including but not limited to states, managed care plans, health care providers, and quality experts. The Child Core Set has undergone these annual reviews since January 2013 and the Adult Core Set since January 2014.

CMCS contracted with Mathematica to convene the 2026 Child and Adult Core Sets Annual Review Workgroup. The Workgroup included 34 members who represent a diverse array of affiliations, subject matter expertise, and quality measurement and improvement experience (see inside front cover for a list of Workgroup members).

[9] Annual updates to the Child Core Set are required under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Annual updates to the Adult Core Set are required under the Patient Protection and Affordable Care Act (Affordable Care Act).

The Workgroup was charged with assessing the 2024 Child and Adult Core Sets[10] and recommending measures for removal or addition, with the goal of strengthening and improving the 2026 Core Sets. Workgroup members were asked to suggest, discuss, and vote on measures for removal from or addition to the Child and Adult Core Sets based on several criteria. These criteria support the adoption of measures that are feasible and viable for state-level reporting, are actionable by state Medicaid and CHIP programs, and represent strategic priorities for improving care delivery and health outcomes for Medicaid and CHIP beneficiaries.

This report provides an overview of the Child and Adult Core Sets, describes the 2026 Core Sets Annual Review process, summarizes the Workgroup's recommendations for improving the Core Sets, and includes public comments on the Workgroup recommendations.

Overview of the Child and Adult Core Sets

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included several provisions aimed at improving the quality of health care for children enrolled in Medicaid and CHIP. CHIPRA required the Secretary of the Department of Health and Human Services to identify and publish a core set of children's health care quality measures for voluntary use by state Medicaid and CHIP programs (referred to as the Child Core Set), and to review and update the list annually. The initial Child Core Set, which was released for public comment in December 2009, included 24 measures that covered both physical and behavioral health. The core set of health care quality measures for adults covered by Medicaid (Adult Core Set) was established in 2010 under the Patient Protection and Affordable Care Act (Affordable Care Act) in the same manner as the Child Core Set. The initial Adult Core Set, which was released in January 2012, included 26 measures.

FFY 2024 marks the first year that states are required to report the Child Core Set measures and behavioral health measures on the Adult Core Set (other measures on the Adult Core Set remain voluntary for state reporting).[11] Beginning with FFY 2025 reporting, states will be expected to report stratified data for 25 percent of eligible mandatory measures by three separate categories: Race and ethnicity, sex, and geography. For FFY 2026 Core Set reporting, states will be expected to report stratified data for 50 percent of mandatory measures.[12]

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[10] More information about the annual review of the Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview. More information about the 2023 and 2024 updates to the Child and Adult Core Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib111522.pdf.

[11] Bipartisan Budget Act of 2018, P.L. 115-123 and Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, P.L. 115-271. On August 31, 2023, CMS released the Mandatory Medicaid and CHIP Core Set Reporting Final Rule (88 FR 60278), which outlines reporting requirements. More information is available at https://www.federalregister.gov/documents/2023/08/31/2023-18669/medicaid-program-and-chip-mandatory-medicaid-and-childrens-health-insurance-program-chip-core-set.

[12] On December 1, 2023, CMS issued a State Health Official (SHO) letter (SHO #23-005), which provides further guidance and outlines expectations for submission of quality measure data. More information is available at https://www.medicaid.gov/sites/default/files/2023-12/sho23005_0.pdf.

The 2024 Child Core Set

The 2024 Child Core Set includes 27 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Dental and Oral Health Services, and (6) Experience of Care.[13] Nearly 75 percent of the measures in the 2024 Child Core Set fall into the Primary Care Access and Preventive Care, Maternal and Perinatal Health, and Behavioral Health Care domains (Exhibit 2). Eighty-nine percent (24 measures) can be calculated using an administrative data collection methodology. Appendix A lists the 2024 Child Core Set measures.

Highlights of FFY 2022 Child Core Set reporting,[14] the most recent year for which data are publicly available, include the following:

- All states[15] voluntarily reported at least one Child Core Set measure.
- Fifty states reported on at least half (12) of the 25 measures in the 2022 Child Core Set.
- Forty states reported on more measures for FFY 2022 than for FFY 2021.
- Fifty states reported data on both the Medicaid and CHIP populations for at least one measure, consistent with FFYs 2020 and 2021.
- The median number of measures reported by states was 21.5, up from a median of 20 measures reported for FFY 2021 and 19 measures reported for FFY 2020.
- Twenty-four of the 25 measures in the 2022 Child Core Set (96 percent) met CMCS's threshold for public reporting of state-specific results, including four measures that were publicly reported for the first time for FFY 2022.[16]
- The most frequently reported Child Core Set measures for FFY 2022 focus on primary care access and preventive care, maternal and perinatal health, asthma management, emergency department (ED) use, and behavioral health care.
- CMS calculated and publicly reported two Child Core Set measures for all states using CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) data: *Live Births Weighing Less Than 2,500 Grams* and *Low-Risk Cesarean Delivery*.

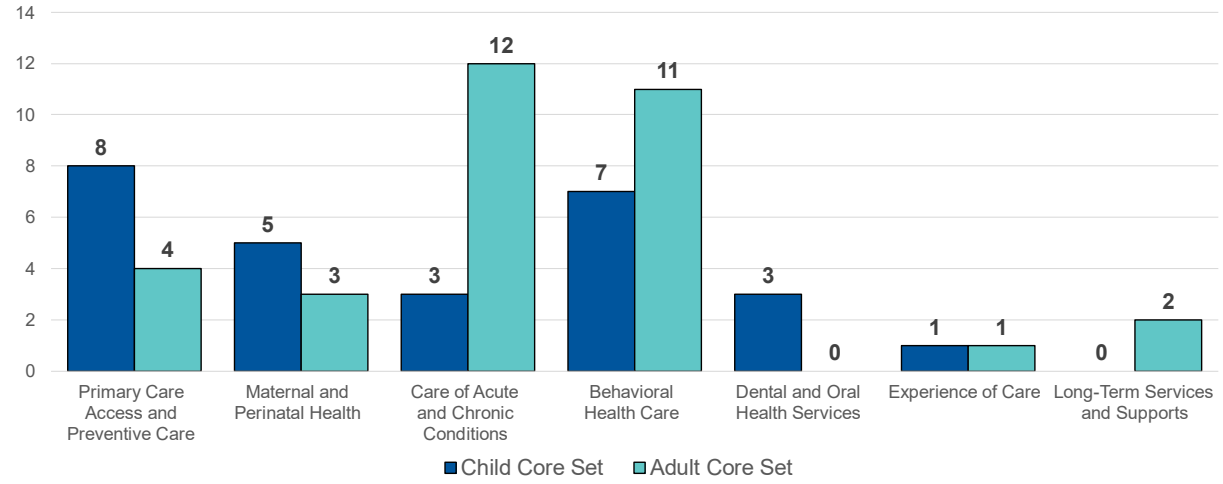
[13] More information about the Child Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html.

[14] More information about FFY 2022 Core Set reporting is available at https://www.medicaid.gov/media/163326. A chart pack summarizing FFY 2022 Child Core Set results is available at https://www.medicaid.gov/media/170596.

[15] The term "states" includes the 50 states and the District of Columbia.

[16] CMCS publicly reports Child and Adult Core Set measures that were reported by at least 25 states and met CMCS standards for data quality.

Exhibit 2. Distribution of 2024 Child and Adult Core Set Measures, by Domain



The 2024 Adult Core Set

The 2024 Adult Core Set includes 33 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Experience of Care, and (6) Long-Term Services and Supports.[17] Almost 70 percent of the 2024 Adult Core Set measures fall into the Care of Acute and Chronic Conditions and Behavioral Health Care domains (Exhibit 2). Eighty-eight percent (29 measures) can be calculated using an administrative data collection methodology. Appendix A lists the 2024 Adult Core Set measures.

Highlights of FFY 2022 Adult Core Set reporting,[18] the most recent year for which data are publicly available, include the following:

- Fifty states voluntarily reported at least one Adult Core Set measure, consistent with FFY 2021.
- Forty-seven states reported on at least half (16) of the 33 measures in the 2022 Adult Core Set.
- Forty states reported more measures for FFY 2022 than for FFY 2021.
- States reported a median of 26 measures, an increase from 23.5 measures for FFY 2021 and 22 measures for FFY 2020.

[17] More information about the Adult Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html.

[18] More information about FFY 2022 Core Set reporting is available at https://www.medicaid.gov/media/163326. A chart pack summarizing FFY 2022 Adult Core Set results is available at https://www.medicaid.gov/media/170606.

- Twenty-nine of the 33 measures in the 2022 Adult Core Set (88 percent) met CMCS's threshold for public reporting of state-specific results, including one measure that was publicly reported for the first time for FFY 2022.
- The most frequently reported Adult Core Set measures for FFY 2022 focus on access to primary and preventive care, postpartum care visits, asthma management, and behavioral health care.

The 2025 Child and Adult Core Sets

The 2025 Child and Adult Core Sets Annual Review Workgroup met in April 2023 to recommend measures for removal from or addition to the 2025 Core Sets. The Workgroup recommended adding two measures to the Child and Adult Core Sets: *Oral Evaluation During Pregnancy* and *Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults*. The Workgroup did not recommend removing any measures from the Child and Adult Core Sets for 2025.[19]

The 2025 Workgroup also reconsidered three measures that use the Healthcare Effectiveness Data and Information Set® (HEDIS®) Electronic Clinical Data Systems (ECDS) reporting method. Prior Workgroups had recommended these measures for addition to the Core Sets but CMCS deferred a decision pending further assessment of how the proprietary nature of the ECDS reporting method could impact the feasibility and viability of the measures for state-level reporting in the Core Sets. The Workgroup affirmed its support for adding these three measures to the Child and Adult Core Sets: *Postpartum Depression Screening and Follow-Up*, *Prenatal Immunization Status*, and *Adult Immunization Status*.

CMCS is finalizing updates to the 2025 Child and Adult Core Sets. Updated measure lists will be available at https://www.medicaid.gov/medicaid/quality-of-care/index.html.

Use of the Child and Adult Core Sets for Quality Measurement and Improvement

CMCS and states use the Child and Adult Core Sets to monitor and improve the quality of care provided to Medicaid and CHIP beneficiaries at the national and state levels, and to measure progress over time. CMCS publicly reports information on state performance on the Child and Adult Core Sets through annual reporting products.[20] Pillar I of the Medicaid and CHIP

[19] More information about the 2025 Workgroup recommendations is available at https://mathematica.org/-/media/internet/features/2023/child-and-adult-core-set/2025coresetreview-finalreport.pdf.

[20] Chart packs, measure performance tables, fact sheets, and other annual reporting resources are available for the Child and Adult Core Sets at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html.

Scorecard, State Health System Performance, also includes data for a subset of Child and Adult Core Set measures.[21]

Through its Technical Assistance and Analytic Support (TA/AS) Program, CMCS supports states and their partners in collecting, reporting, and using the Core Set measures to drive improvement in Medicaid and CHIP.[22] CMCS strives to achieve several goals for state reporting: maintaining or increasing the number of states that report the Core Set measures, maintaining or increasing the number of measures reported by each state, improving the quality and completeness of the data reported, and increasing state reporting of stratified data. CMCS also continuously explores opportunities to increase the efficiency of reporting and reduce state reporting burden, streamline Core Set reporting for states, and improve the transparency and comparability of the data reported across states. The TA/AS Program offers states various opportunities to address technical issues related to collecting and reporting the Core Set measures, including a technical assistance (TA) mailbox, one-on-one individualized consultations, fact sheets, toolkits, analytic reports, and virtual learning opportunities. The CMS Quality Conference also provides states with learning opportunities to support their quality measurement and improvement efforts.

CMCS has developed initiatives to drive improvement in health care quality and outcomes using Core Set measures—for example, through the Maternal and Infant Health Initiative and the Oral Health Initiative.[23] The TA/AS Program supports CMCS and states in designing and implementing quality improvement initiatives focused on the Core Set measures through affinity groups, online training opportunities, one-on-one and group coaching, and other approaches.

Description of the 2026 Child and Adult Core Sets Annual Review Process

This section describes the 2026 Child and Adult Core Sets Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2026 Child and Adult Core Sets Annual Review included 34 voting members from state Medicaid and CHIP programs, managed care plans, professional associations, universities, hospitals, consumer advocacy groups, and other organizations across the country. The Workgroup members for the 2026 Child and Adult Core Sets Annual Review are listed on the inside front cover of this report.

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[21] More information about the Medicaid and CHIP Scorecard is available at https://www.medicaid.gov/state-overviews/scorecard/index.html.

[22] More information about the TA/AS program is available at https://www.medicaid.gov/media/4691.

[23] More information about Medicaid and CHIP quality improvement initiatives is available at https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/index.html.

The 2026 Child and Adult Core Sets Annual Review Workgroup members offered expertise in behavioral health and substance use, dental and oral health, care of acute and chronic conditions, LTSS, maternal and perinatal health, primary care access and preventive care, and health equity. Although Workgroup members had individual subject matter expertise, and some were nominated by an organization, they were asked to participate as stewards of the Medicaid and CHIP program as a whole and not represent their individual organizational points of view. They were asked to consider what measures would best drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

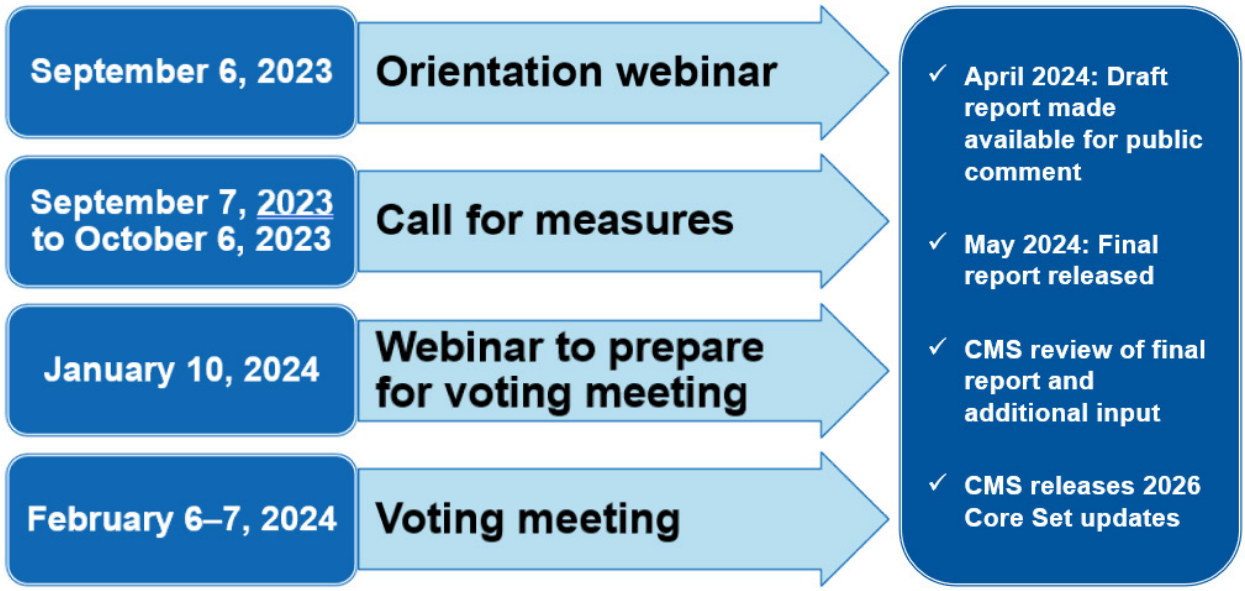
Workgroup members were required to submit a disclosure of interest form to report any interests, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest or the appearance of a conflict of interest related to the current Child and Adult Core Set measures, or other measures reviewed during the Workgroup process. Workgroup members deemed to have an interest in a measure recommended for consideration were required to recuse themselves from voting on that measure.

The Workgroup also included nonvoting federal liaisons representing nine agencies (see page iii of this report). The inclusion of federal liaisons reflects CMCS's commitment to promoting quality measurement alignment and working in partnership with other federal agencies to collect, report, and use the Core Set measures to drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

Workgroup Timeline and Meetings

As shown in Exhibit 3, Mathematica held virtual meetings via webinar in September 2023 and January 2024 to orient Workgroup members to the 2026 Child and Adult Core Sets Annual Review process and to prepare them for the voting meeting, which took place in February 2024. All meetings were open to the public, with public comment invited during each meeting.

Exhibit 3. 2026 Child and Adult Core Sets Annual Review Workgroup Timeline



CMS = Centers for Medicare & Medicaid Services.

Orientation Webinar

During the orientation webinar on September 6, 2023, Mathematica introduced the Workgroup members, discussed the disclosure of interest process, outlined the Workgroup charge, and described the timeline and process for the 2026 Child and Adult Core Sets Annual Review. Next, Mathematica provided background on the Child and Adult Core Sets and summarized the recommendations of the 2025 Annual Review. Mathematica then presented gaps identified during previous annual review meetings.

Mathematica also explained the Call for Measures process, through which Workgroup members suggested measures for removal from or addition to the Child and Adult Core Sets. Mathematica asked Workgroup members to balance three interdependent components when considering measures for removal or addition: (1) the technical feasibility of measures, (2) the desirability of measures, and (3) the financial and operational viability for states (Exhibit 4, next page).

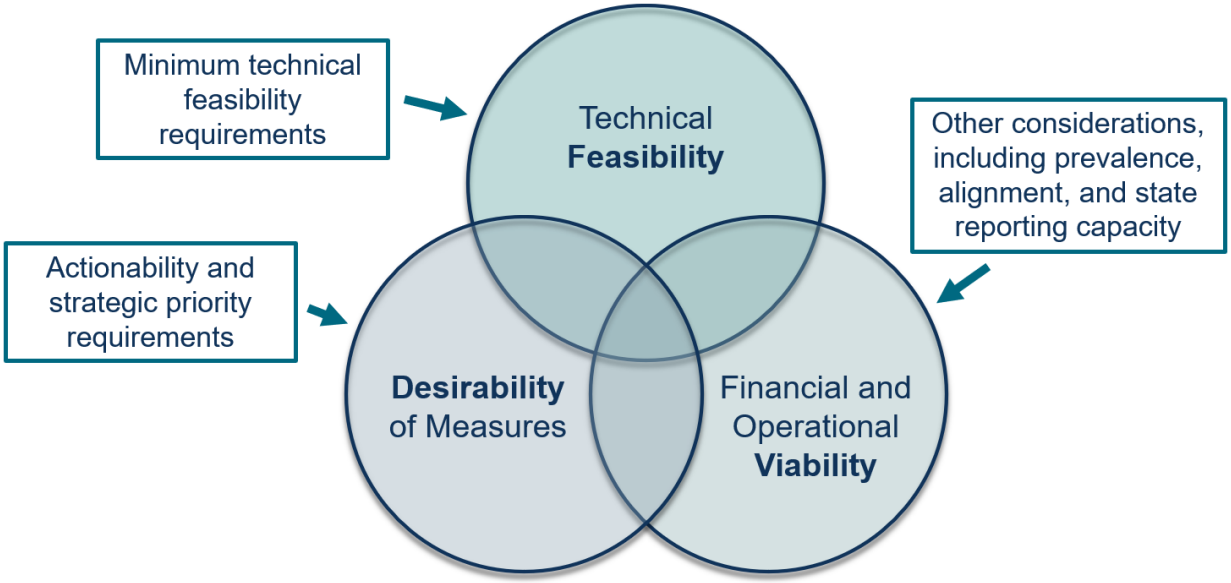
Workgroup Charge

The Child and Adult Core Sets Workgroup for the 2026 Annual Review is charged with assessing the 2024 Core Sets and recommending measures for removal or addition in order to strengthen and improve the Core Sets for Medicaid and CHIP.

The Workgroup should focus on recommending measures that are actionable, aligned, and appropriate for state-level reporting, to ensure that the measures can meaningfully drive improvement in health care delivery and outcomes in Medicaid and CHIP.

Given the mandatory reporting requirements, the Workgroup should consider the feasibility of state reporting by all states for all Medicaid and CHIP populations as well as opportunities for advancing health equity through stratification of Core Set measures.

Exhibit 4. Framework for Assessing Measures for the 2026 Child and Adult Core Sets



Mathematica then presented the criteria used to assess measures during all phases of the Workgroup process:

- **Minimum technical feasibility requirements.** Availability of detailed technical specifications that enable production of the measure at the state level; evidence of field testing or use in a state Medicaid or CHIP program; availability of a data source with all the data elements needed to produce consistent calculations across states; and technical specifications provided at no charge for state use. As discussed below, all measures considered by the Workgroup were required to meet the minimum technical feasibility requirements.
- **Actionability and strategic priority requirements.** Contributes to estimating the overall national quality of health care in Medicaid and CHIP together with other Core Set measures; allows for comparative analyses of disparities by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language; provides useful and actionable results to drive improvement in care delivery and health outcomes; and addresses a strategic performance measurement priority.
- **Other considerations.** Sufficient prevalence of the condition or outcome being measured to produce meaningful and reliable results across states; alignment with measures used in other CMS programs; capacity for all states to report the measure within two years of it being added to the Core Sets; and ability to include all Medicaid and CHIP populations.

CMCS provided introductory remarks regarding the Workgroup's charge, underscoring the importance of considering updates to the Core Sets to improve health outcomes and delivery of high-quality care and to advance health equity among Medicaid and CHIP beneficiaries. CMCS noted that individuals enrolled in Medicaid and CHIP experience disparities in health care

access, quality, experience of care, and outcomes. Advancing health equity in these programs depends on the ability to measure disparities to support innovation and adoption of equity-focused interventions and initiatives, and to orient payment and delivery system reforms to close equity gaps.

CMCS also affirmed its commitment to support states in the transition to mandatory reporting of Child Core Set measures and behavioral health measures on the Adult Core Set beginning in FFY 2024. CMCS shared its appreciation for state reporting progress continuing to move in a positive direction and the commitment across states to use Core Set measures as part of their quality improvement efforts.

Call for Measures

Following the orientation meeting, Workgroup members and federal liaisons were invited to suggest measures for removal from or addition to the Child and Adult Core Sets. Workgroup members used an online form to submit their suggestions for removal or addition, and were asked to provide the following information about the measure(s):

- The rationale for the suggestion
- Information about the technical feasibility, actionability, and strategic priority of measures suggested for removal or addition
- Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language
- Whether the measure was reviewed previously by the Workgroup and, if so, information that justifies discussing the measure again
- Whether removal of the measure would leave a gap in the Core Sets
- Whether another measure was proposed to replace the measure suggested for removal
- Whether a measure suggested for addition was intended to replace a current measure
- Potential barriers states could face in calculating a measure suggested for removal or addition within two years of the reporting cycle under review

The Call for Measures was open from September 7, 2023, to October 6, 2023. Workgroup members and federal liaisons suggested two measures for removal and two measures for addition. Mathematica conducted a preliminary assessment of the two measures suggested for addition and determined that they met the minimum technical feasibility requirements and were therefore eligible to be discussed by the Workgroup during the voting meeting.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on January 10, 2024. To help Workgroup members prepare for the discussion at the 2026 Annual Review voting meeting, Mathematica shared a list of the two measures to be considered for removal and the two measures for addition. Mathematica provided guidance to the Workgroup about how to prepare for the measure discussions, including the criteria that Workgroup members should consider for recommending measures for removal from or addition to the Core Sets and the resources available to facilitate their review. These resources included detailed Measure Information Sheets for each measure, a worksheet to record questions and notes for each measure, the Medicaid and CHIP Beneficiary Profile, the Core Sets Reporting History Table, Core Set Chart Packs and Measure Performance Tables, the Core Set Resource Manuals and Technical Specifications, and a list of measures and measure gaps previously discussed by the Workgroup. Workgroup members were responsible for reviewing all materials related to the measures; completing the measure worksheet; and attending the Annual Review meeting prepared with notes, questions, and preliminary votes on the four measures.

Annual Review Voting Meeting Webinar

The 2026 Child and Adult Core Sets Annual Review voting meeting took place virtually on February 6 and 7, 2024. Workgroup members, federal liaisons, measure stewards, and members of the public participated in the meeting. CMCS staff provided welcome remarks at the outset of the meeting and offered reflections and updates on the Core Sets. They commented on the shift to digital measurement and the importance of the annual review process in adapting to changes in the field. They noted that mandatory reporting goes into effect in 2024 for all measures on the Child Core Set and the behavioral health measures on the Adult Core Set. CMCS reported that states have been preparing for this transition and that the number of states voluntarily reporting the Core Set measures and the number of measures reported by states have increased steadily over the last few years. CMCS concluded by emphasizing the value of the Workgroup's efforts to recommend updates to the 2026 Core Sets, commenting that this process is vital to the Medicaid and CHIP programs and the lives of the millions of people the programs serve.

The discussion began with the two measures suggested for removal, followed by the two measures suggested for addition. For each measure, Mathematica provided an overview of the measure, noted the key technical specifications, and summarized the rationale provided by Workgroup members for removal or addition. Mathematica advised the Workgroup not to focus on domain assignments during the meeting because CMCS makes the final determination of the domain and Core Set most appropriate for a measure recommended for addition.

Mathematica then facilitated a discussion of the measures. Mathematica sought comments and questions from Workgroup members about each measure and asked measure stewards to clarify measure specifications when needed. For each measure, an opportunity for public comment followed the Workgroup discussion.

Voting took place after the Workgroup discussion and public comment period. Mathematica facilitated the voting on the measures suggested for removal or addition. Workgroup members voted electronically through a secure web-based polling application during specified voting periods. Workgroup members who experienced technical difficulties with the voting tool submitted their vote through the webinar platform's Q&A feature (which was visible only to the Mathematica team) or via email.

For each measure suggested for removal, Workgroup members could select either "Yes, I recommend removing this measure from the Core Set" or "No, I do not recommend removing this measure from the Core Set." For each measure suggested for addition, Workgroup members could select either "Yes, I recommend adding this measure to the Core Set" or "No, I do not recommend adding this measure to the Core Set."

For a measure to be recommended for removal or addition, at least two-thirds of the Workgroup members eligible to vote had to vote in favor of removal or addition. The two-thirds voting threshold was adjusted according to the number of eligible Workgroup members present for each measure vote. Mathematica presented the voting results immediately after each vote and reported if the results met the two-thirds threshold for a measure to be recommended for removal or addition.

On the second day of the meeting, after voting on the final measure suggested for addition to the Core Sets, the Workgroup discussed priority gap areas and criteria for the 2027 Public Call for Measures. A summary of the discussions about these priority gap areas and criteria for the Public Call for Measures is presented later in this report.

Workgroup Recommendations for Improving the 2026 Child and Adult Core Sets

Criteria Considered for Removal of Existing Measures and Addition of New Measures

To focus the Workgroup discussion on measures that would be a good fit for the Core Sets, Mathematica specified detailed criteria for removal of existing measures and addition of new measures. These criteria are classified into three areas: (1) technical feasibility, (2) actionability and strategic priority, and (3) other considerations (Exhibit 5).

To be considered by the Workgroup, all measures suggested for addition must meet minimum technical feasibility criteria. As noted earlier, Mathematica conducted a preliminary assessment of suggested measures before the Annual Review meeting to ensure that measures discussed by the Workgroup adhered to the minimum technical feasibility criteria.

Mathematica mentioned additional contextual factors to inform the Workgroup discussion:

- The Workgroup should consider each measure on its own merits according to the criteria. There is no target number of measures—maximum or minimum—for the Child and Adult Core Sets.
- The Workgroup should review, discuss, and vote on all measures as they are currently specified by the measure steward.
- The Workgroup should not focus on assignment of measures to a Core Set or domain because these assignments are determined by CMCS.

Exhibit 5. Criteria Considered for Removal of Existing Measures and Addition of New Measures to the 2026 Child and Adult Core Sets

Criteria Considered for Removal of Existing Measures
Technical Feasibility
1. The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the state level (e.g., numerator, denominator, and value sets).
2. States report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
3. The specifications and data source do not allow for consistent calculations across states (e.g., there is variation in coding or data completeness across states).
4. The measure is being retired by the measure steward and will no longer be updated or maintained.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid and CHIP.
2. The measure is not suitable for comparative analyses of disparities among Medicaid and CHIP beneficiaries by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.[24]
3. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid and CHIP beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
4. The measure cannot be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure is topped out, trending is not possible, or improvement is outside the direct influence of Medicaid and CHIP programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across states, considering Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All states may not be able to produce the measure for Core Set reporting within two years of the reporting cycle under review or may not be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

[24] The statute establishing the Child Core Set specifies that measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities in health and health care. More information is available at https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

Exhibit 5 *(continued)*

Criteria Considered for Addition of New Measures
Minimum Technical Feasibility Requirements (all requirements must be met)
1. The measure must be fully developed and have detailed technical specifications that enable production of the measure at the state level (e.g., numerator, denominator, and value sets).
2. The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid and/or CHIP programs.
3. An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid and CHIP beneficiaries (or the ability to link to an identifier).
4. The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness).
5. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid and CHIP.
2. The measure should be suitable for comparative analyses of disparities among Medicaid and CHIP beneficiaries by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.[25]
3. The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP.
4. The measure can be used to assess state progress in improving health care delivery and outcomes in Medicaid and CHIP (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid and CHIP programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across states, taking into account Medicaid and CHIP population sizes and demographics.
2. The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3. All states should be able to produce the measure for Core Set reporting within two years of the measure being added to the Core Sets and be able to include all Medicaid and CHIP populations (e.g., all age groups, eligibility categories, and delivery systems).

CHIP = Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid Services.

Summary of Workgroup Recommendations

The Workgroup recommended removing one measure from the Adult Core Set: *Use of Opioids at High Dosage in Persons Without Cancer* (OHD-AD) and adding one measure to the 2026 Child and Adult Core Sets: *Prenatal Depression Screening and Follow-Up* (Exhibit 6). This section summarizes the Workgroup's discussion and rationale for these recommendations.

[25] The statute establishing the Child Core Set specifies that measures should allow for comparative analyses of racial, ethnic, and socioeconomic disparities in health and health care. More information is available at https://www.ssa.gov/OP_Home/ssact/title11/1139A.htm.

Measure Information Sheets for each measure the Workgroup considered are available on the Mathematica Core Set Review website.[26]

Exhibit 6. Summary of Workgroup Recommendations for Updates to the 2026 Child and Adult Core Sets

Measure Name	Measure Steward
Measure Recommended for Removal	
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Pharmacy Quality Alliance (PQA)
Measure Recommended for Addition[a]	
Prenatal Depression Screening and Follow-Up	National Committee for Quality Assurance (NCQA)

[a] CMCS assigns new measures to a Core Set and domain as part of its annual update.
CMCS = Center for Medicaid and CHIP Services

Measure Recommended for Removal: Use of Opioids at High Dosage in Persons Without Cancer

The Workgroup recommended the removal of *Use of Opioids at High Dosage in Persons Without Cancer* (OHD-AD), which measures the percentage of beneficiaries ages 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MMEs) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded. The measure steward is the Pharmacy Quality Alliance (PQA), and the data collection method is administrative. This measure was discussed previously by the Workgroup at the 2021, 2023, and 2025 Core Sets Annual Review meetings, but it was not recommended for removal. Most recently, at the 2025 Annual Review meeting, the Workgroup voted to retain the measure due to its strategic importance amidst the ongoing opioid epidemic.

The measure was considered for removal during the 2026 Annual Review meeting due to concerns about lack of alignment with federal policy strategies and goals, particularly those included in the Centers for Disease Control and Prevention's (CDC's) 2022 Clinical Practice Guideline for Prescribing Opioids for Pain.[27] Specifically, the Workgroup member who suggested the measure for removal expressed concerns over the measure's actionability and strategic priority, noting that a broad, population-level measure on prescription opioid dosages does not capture the individualized nuance that evidence-based pain care necessitates. They added that the measure may incentivize rapid dosage reduction and disregards the patient care and safety concerns cited in the 2022 Clinical Practice Guideline.

[26] The Measure Information Sheets are available at https://www.mathematica.org/-/media/internet/features/2024/child-and-adult-core-set/coresetreview-2026-removals-and-additions.pdf.

[27] More information about the CDC's 2022 Clinical Practice Guideline for Prescribing Opioids for Pain is available at https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w.

During the discussion, several Workgroup members echoed concerns about the unintended consequences of the measure on patient safety and patient-centered care. For example, one Workgroup member commented that a measure specifying an exact MME dosage threshold is not person-centered and could disrupt the clinician–patient relationship. Another Workgroup member noted that the measure incentivizes providers to rapidly reduce the dosage, which can be harmful to the patient. A CDC representative noted reports of rapid dosage reductions to achieve the 90 MME threshold that put patients at risk. They also noted reports of people being turned away from care, since reducing dosages in patients requires substantial care to reduce patient harm.

In response to the Workgroup's discussion of safety concerns, a representative from the measure steward, PQA, commented that the measure is not intended to promote inflexible standards of care. They encouraged the Workgroup to discuss the measure in context, noting that the Core Sets are a public reporting and benchmarking program intended to help states understand trends in opioid prescribing and make informed comparisons. They said that while pay-for-performance programs may contribute to rapid tapers, the Core Sets do not result in financial penalties for providers that would incentivize rapid tapers.

A few Workgroup members commented that they were not in favor of removing the measure from the Adult Core Set. They suggested the measure is informative at the population level and did not believe the measure was the driving cause of provider apprehension around managing high-dose opioid use. In addition, they felt that retaining the measure sends a message about the importance of understanding opioid prescribing in an ongoing epidemic and encourages providers to explore other ways of managing pain. A Workgroup member from a state Medicaid agency shared that they work with their managed care plans and providers to prevent patient harm and ensure ongoing access to opioids for individuals even if they are on high doses. At the same time, however, the Workgroup member agreed that there are other tools that could be informative and responsive to the quality-of-care and safety concerns raised by other Workgroup members.

Another Workgroup member shared that prescriber attitudes toward acceptable thresholds of opioids vary and that removal of the OHD-AD measure might weaken the message encouraging practitioners away from prescribing high-dose opiates in favor of exploring other ways of managing pain. The Workgroup member also suggested the measure is both a process and outcome measure; the reason individuals end up on high doses of opioids is that they are on them for prolonged periods of time and are liable to develop opioid-induced hyperalgesia. The Workgroup member explained that opioid-induced hyperalgesia is a condition in which patients who are chronically exposed to opioids gradually develop higher levels of pain such that when opioids are taken away, their baseline pain is higher, requiring higher doses of opioids to control pain. The Workgroup member reasoned that the measure signals a poor outcome, where a patient may have been on gradually escalating doses of opioids for years and did not benefit from other sustainable, safe strategies to manage their pain. The Workgroup member reflected that the measure is an indicator of pain that could have been managed more effectively.

A few Workgroup members acknowledged concerns about the OHD-AD measure but expressed reluctance to remove the measure in the absence of a replacement measure. In response to concerns about leaving a gap on the Adult Core Set around opioid prescribing, a CDC representative expressed that the risk the measure presents to patient care is sufficient to justify removal. Another Workgroup member said that if the measure is not effectively contributing to solving the problem it was intended to address, then it should be removed from the Core Set.

Several Workgroup members expressed support for finding a replacement measure that could be more effective for safely driving improvement in opioid prescribing practices. One Workgroup member requested that a future replacement measure be able to capture cross-state activities to monitor opioid dispensing and encourage safe prescribing efforts. The CDC representative suggested considering measures that serve as a proactive indicator of high dosage opioid prescribing (rather than after a patient has been on a high dosage over an extended period of time). The CDC representative noted that a measure on general prescribing would be less likely to cause harm, such as a measure on initiation of opioids for headache or fibromyalgia. A representative from CMS's Center for Clinical Standards and Quality shared their experience with new Medicare payment codes that focus on holistic treatment through multiple elements including development of a person-centered care plan, treatment management, diagnosis, medication management, pain and health literacy counseling, crisis care, and connections to other providers, which could inform work to find a replacement measure.

During the public comment period, the executive director of the National Pain Advocacy Center (NPAC) expressed support for removal of the OHD-AD measure from the Adult Core Set. They commented that, regardless of its intended use, in practice the measure has resulted in the strict application of the CDC's 2016 guidelines that have since been rejected due to risks of patient harm. They referenced concerns from national experts that strict metrics incentivizing unilateral dose reduction can lead to increased risks of overdose and suicide. They shared that they continue to hear from people nationwide who are being rapidly tapered and abandoned in care, resulting in adverse health outcomes.

Another public commenter, a professor of medicine from the University of Alabama at Birmingham, encouraged the Workgroup to remove the measure from the Adult Core Set, echoing safety concerns raised about the measure. They noted that metrics that specify an opioid dose level incentivize health plans, state Medicaid agencies, law enforcement, and doctors to taper dosages without tailoring to the patient's unique situation. They commented that the academic literature correlates dose reductions with death or destabilization and that removing the measure could help correct an ongoing harm to patient safety.[28]

[28] Public comments submitted on the *Use of Opioids at High Dosage in Persons Without Cancer* measure can be found in Appendix B.

Measure Recommended for Addition: Prenatal Depression Screening and Follow-Up

The Workgroup recommended the addition of *Prenatal Depression Screening and Follow-Up*, which measures the percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. Two rates are reported for this measure: (1) the percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument; and (2) the percentage of deliveries in which members received follow-up care within 30 days of a positive depression screen finding. The measure steward is the National Committee for Quality Assurance (NCQA), and the data are specified for NCQA's HEDIS ECDS data collection method. The eligible data sources used for ECDS reporting are administrative claims, electronic health records (EHRs), health information exchanges and clinical registries, and case management systems.

This measure was discussed previously by the Workgroup at the 2020 and 2021 Core Sets Annual Review meetings. At the 2020 Annual Review meeting, the Workgroup did not recommend the measure because it was untested at the state level and due to concerns about using a new data collection method. At the 2021 Annual Review meeting, the measure was discussed in conjunction with the *Postpartum Depression Screening and Follow-Up* measure, which the Workgroup prioritized for recommendation to the 2021 Core Sets. The Workgroup member who suggested this measure for addition during the 2026 Core Sets Annual Review cited that pregnant individuals with untreated depression are at risk for developing severe postpartum depression and suicidality, and of delivering premature or low birth weight infants.

The Workgroup broadly acknowledged the feasibility concerns around the *Prenatal Depression Screening and Follow-Up* measure and invited those who had experience reporting the measure to share their perspectives. Three Workgroup members provided their state Medicaid program's experiences with the measure, noting challenges around data capture for the follow-up rate and variation in plan-level reporting. One Workgroup member stated that while their state's managed care plans have been able to report the measure with varying degrees of success, they commented that there may be different feasibility considerations for states that are implementing this measure in a fee-for-service environment. Another Workgroup member said that while their state has been reporting the measure for over a decade, they have found variation in screening and follow-up rates when the measure is collected through chart reviews and when it is collected through ECDS. One Workgroup member shared that prenatal screenings are conducted across various settings and by different providers, such as community health workers and doulas, and expressed concern that adding the measure to the Core Sets might add to providers' burden. Another Workgroup member added that screenings may be underreported due to the way that obstetric care is delivered and billed.

Several Workgroup members requested clarification about the measure's technical specifications. One Workgroup member referenced the measure's exclusion of deliveries that occurred at less than 37 weeks gestation and asked if the American College of Obstetricians and

Gynecologists (ACOG) had a recommendation for when prenatal depression screenings should occur. A Workgroup member responded that ACOG's recommendation is to screen twice during pregnancy and once postpartum, with the first screening to occur during the initial visit. Another Workgroup member asked if there would be potential overlap with the *Screening for Depression and Follow-Up Plan* (CDF) measure and wondered if the inclusion of *Prenatal Depression Screening and Follow-Up* would be duplicative—and if CDF could instead be stratified by prenatal and postpartum populations. Mathematica responded that the specifications for the *Prenatal Depression Screening and Follow-Up* and *Postpartum Depression Screening and Follow-Up* measures are focused on the specific populations, with appropriate screening instruments for prenatal and postpartum individuals.

One Workgroup member asked about experiences stratifying the *Prenatal Depression Screening and Follow-Up* measure. A representative from the measure steward, NCQA, shared that the measure is currently stratified by product line, race, and ethnicity. A Workgroup member replied that their state Medicaid program found equity gaps in both screening and follow-up, adding that stratification allows states to focus on areas to improve maternal health and reduce maternal mortality. Another Workgroup member shared that while their state Medicaid program has not yet applied stratification to the *Prenatal Depression Screening and Follow-Up* measure specifically, they have applied the race and ethnicity stratification to other HEDIS measures and found that some health plans had challenges with data collection.

Woven throughout the Workgroup's discussion about the feasibility of reporting the *Prenatal Depression Screening and Follow-Up* measure was a consistent emphasis on the desirability and strategic priority of addressing the growing maternal mental health crisis. Several Workgroup members contextualized the impact of maternal depression and the importance of early intervention and detection, with some Workgroup members pointing to research on depression as a key contributor to maternal mortality and morbidity. Some Workgroup members and a CDC representative stated that the *Prenatal Depression Screening and Follow-Up* measure would complement the *Postpartum Depression Screening and Follow-Up* measure to allow for a more holistic view of maternal health, with one Workgroup member explaining that many states have implemented a bundled payment approach to maternity care. Another Workgroup member raised that the inclusion of the measure would address concerns about maternal health being a gap in the Core Sets. In response to feasibility concerns, two Workgroup members noted that measures have previously been recommended for addition to the Core Sets despite feasibility concerns due to the measures' strategic importance.[29]

[29] Public comments submitted on the *Prenatal Depression Screening and Follow-Up* measure can be found in Appendix B.

Measure Considered and Not Recommended for Removal: Initiation and Engagement of Substance Use Disorder Treatment

The Workgroup considered and did not recommend the removal of *Initiation and Engagement of Substance Use Disorder Treatment* (IET-AD), which measures the percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported for this measure: (1) the percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days; and (2) the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation. The measure steward is NCQA, and the measure uses administrative or EHR data collection methods.

This measure was previously discussed by the Workgroup at the 2022 Core Sets Annual Review meeting, where the Workgroup discussed concerns that the measure is duplicative of other Adult Core Set measures and that the measure focuses on new substance use events and does not consider an existing substance use event. Other Workgroup members said that removing the measure would leave a gap because IET-AD is broader in scope and settings than similar measures. Ultimately, the Workgroup voted not to recommend the IET-AD measure for removal.

During the 2026 Annual Review, the Workgroup member who suggested the measure for removal noted that IET-AD changed from an individual-based measure to an event-based measure for HEDIS measurement year 2022, which corresponds with the 2023 Adult Core Set. The Workgroup member acknowledged that while the measure has been discussed in the past, it merits discussion again in light of these changes and due to overlap with similar measures on the Adult Core Set, including *Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older* and *Use of Pharmacotherapy for Opioid Use Disorder*.

Another Workgroup member agreed that the IET-AD measure is duplicative and said that, while they appreciate that the measure can be stratified by diagnosis cohort, it is difficult to make the measure actionable because many components of the rates are rolled up into an aggregate rate. Moreover, they noted that with the upcoming mandatory reporting, states' reporting capacities are being stretched and it is important to focus on actionable measures.

Several Workgroup members indicated they were not in support of removing the IET-AD measure, highlighting what makes the measure valuable and unique compared to other measures on the Adult Core Set. For example, one Workgroup member disagreed the measure is redundant and shared that it provides an incentive between their physical and behavioral health plans to assess what is happening across the continuum of care for SUD treatment. They also noted that IET-AD provides a broader perspective on the population than other similar SUD-related measures on the Adult Core Set. Another Workgroup member added that the measure provides managed care plans and states with the opportunity to assess whether a beneficiary engages in treatment and accesses resources.

One Workgroup member asked about the feasibility of reporting the *Initiation and Engagement of Substance Use Disorder* measure. Mathematica shared that the IET-AD measure was reported by 46 states for FFY 2022, and that there is significant room for improvement in timely follow-up, with a state median of 43.4 percent for initiation and 15.8 percent for engagement.[30]

Measure Considered and Not Recommended for Addition: Social Need Screening and Intervention

The Workgroup considered and did not recommend the addition of the *Social Need Screening and Intervention* measure to the Core Sets. This measure assesses the percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported: (1) food screening; (2) food intervention; (3) housing screening; (4) housing intervention; (5) transportation screening; and (6) transportation intervention. The measure steward is NCQA, and the data are specified for NCQA's HEDIS ECDS data collection method.

The Workgroup member who suggested this measure for addition acknowledged challenges around data collection but emphasized the measure's actionability and strategic priority for Medicaid and CHIP. They added that Medicaid and CHIP beneficiaries may be at higher risk for health-related social needs (HRSNs), which are associated with higher chronic disease prevalence and health care utilization. They noted that there would be ample room for improvement in the measure, as it is a new area of measurement.

A Workgroup member from New York's Medicaid program shared their experience with the first year of data collection for the *Social Need Screening and Intervention* measure through their managed care plans. The Workgroup member explained that their program aimed to build out processes whereby the screening and referral data for this measure could be collected at any point at which a provider or health plan has contact with a Medicaid or CHIP beneficiary. They found that the data needed to report the measure are heavily reliant on the provider, adding that many providers have not yet implemented screening as part of their regular operations, with some providers citing the ambiguity around subsequent steps once a beneficiary is found to have a need. Their managed care plans also reported that data included in EHRs are often not standardized or aligned with the measure specifications around appropriate screening instruments and intervention codes. The Workgroup member noted that the sensitive nature of the measure has resulted in low response rates, with some beneficiaries expressing concern around the potential consequence of their responses. They also indicated that this measure only identifies whether a referral has been made and does not assess if the beneficiary's needs have been met through the referral.

[30] Public comments submitted on the *Initiation and Engagement of Substance Use Disorder Treatment* measure can be found in Appendix B.

Despite challenges around data collection and standardization, the Workgroup member emphasized the strategic importance of the measure and expressed excitement about using this information to stratify additional measures. They appreciated that the measure points them toward standardized tools, emphasizing the need to shift toward national standards. In response to a question about the state's ability to implement the measure across all Medicaid and CHIP populations, including fee-for-service, if it were to be included in the 2026 Core Sets, the Workgroup member responded that they are already implementing the measure across all populations, and that they would be able to report within two years. They acknowledged that while the measure performance rates may initially be low due to data collection challenges, states must start somewhere.

Robust discussion of the *Social Need Screening and Intervention* measure among the Workgroup reflected the tension between feasibility and desirability. Despite broad recognition of the importance of addressing social needs as part of care delivery, many Workgroup members raised concerns around feasibility and viability. One Workgroup member, acknowledging the strategic importance of the measure, stated that the question being considered was not about the merits of the measure, but rather, if the measure should be recommended for addition to the 2026 Core Sets. A Workgroup member asked if this measure would be considered part of required reporting in 2026, and Mathematica responded that CMS decides the Core Set and domain assignments for new measures. They asked the Workgroup to consider the criterion of a two-year on-ramp for new measures.

Workgroup members shared several concerns about data collection. A Workgroup member explained that their state Medicaid program started implementing the measure and found difficulties in linking numerator and denominator data, adding that most providers do not use the codes necessary for the measure. Two Workgroup members shared their experiences reviewing and reporting the data and expressed concern about the variation in the results they observed.

Some Workgroup members mentioned the burden of data collection and the responsibility of health plans, providers, or state Medicaid programs. One Workgroup member suggested that providers should play a role in completing the screenings, particularly for young children. Conversely, another Workgroup member noted that pediatricians already have limited time with their patients and raised concerns about provider burnout and shortages. That Workgroup member and another Workgroup member wondered if these data are best captured as part of the Medicaid enrollment process and expressed hesitation about recommending the measure without first addressing the data collection challenges raised by the Workgroup. Another Workgroup member shared concerns around survey burden if the measure were required in both the Child and Adult Core Sets.

Workgroup members questioned whether the measure was ready for "prime time," citing the lack of resources for both states and providers. Two Workgroup members expressed apprehension about the variability of states' capabilities to report the data and urged the Workgroup to be mindful of states that may not have the resources to support implementation of the measure. A

Workgroup member added that some providers may serve communities where there are inadequate resources for referral, reiterating another Workgroup member's point that *Social Need Screening and Intervention* only measures referrals and not whether a beneficiary's needs have been addressed. One Workgroup member and a CDC representative advised a phased approach to implementation of the measure if it were added to the Core Sets to allow time for states to prepare for mandatory reporting.

Several Workgroup members expressed urgency in addressing HRSNs, in spite of the feasibility challenges of the measure, with two Workgroup members noting that inclusion of the measure in the Core Sets will drive continued transformation toward integrated care and health equity. One Workgroup member noted that the measure is focused on the drivers of health and should be prioritized, while another Workgroup member raised the measure's impact on overall population health.

Although the Workgroup ultimately did not recommend the measure for addition to the Core Sets, Workgroup members expressed appreciation for the continued discussions about the impact of housing, food insecurity, transportation, and other HRSNs on overall health outcomes for Medicaid and CHIP beneficiaries.

Discussion of Priority Gap Areas and Criteria for the Public Call for Measures for the 2027 Child and Adult Core Sets

Beginning with the 2027 Child and Adult Core Sets Annual Review cycle, Mathematica will conduct a Public Call for Measures. To help inform the 2027 Public Call for Measures, the Workgroup discussed priority gap areas in the current Child and Adult Core Sets. The Workgroup also discussed the criteria for measure submission during the Public Call for Measures.

Priority Gap Areas in the Child and Adult Core Sets

During the 2026 Child and Adult Core Sets Annual Review, Mathematica asked Workgroup members to discuss priority gap areas in the current Child and Adult Core Sets that could be addressed by the 2027 Public Call for Measures to strengthen and improve the Core Sets. Mathematica reminded the Workgroup that the 2027 Public Call for Measures is expected to broaden the potential measures for the Core Sets and encouraged the Workgroup to focus on the purposes and uses of the Core Sets. That is, the Core Sets are intended to estimate and understand the overall national quality of health care provided in Medicaid and CHIP, assess access to and quality of health care, identify and improve understanding of the disparities experienced by beneficiaries, and inform the development of targeted quality improvement efforts to advance health equity. Mathematica asked each Workgroup member to mention one priority gap area or endorse a gap area mentioned by another Workgroup member. Exhibit 7 synthesizes the gaps mentioned during the discussion, organized by the high-level themes

emerging from the discussion. The exhibit does not assess the feasibility or fit of the suggested gap areas for the Child and Adult Core Sets. [31]

Exhibit 7. Synthesis of Workgroup Discussion About Priority Gap Areas for the Public Call for Measures for the 2027 Child and Adult Core Sets

Themes from Priority Gap Areas Discussion
Health Equity and Social Drivers of Health
• Measurement of screening for social needs or interventions • Assessment of social drivers of health across the lifespan • Stratification of measures by population subgroups including pregnant individuals, individuals with serious mental illness, and individuals with developmental disabilities • Standardized approach to defining disability and stratification of measures by disability status • Measurement of barriers to health care related to lack of accommodation for language and disability • Assessment of adverse childhood experiences, including impacts of relational health, racism, and poverty on children's health
Maternal and Perinatal Health
• Maternal morbidity and mortality • Maternal substance use disorder • Hypertension management for pregnant individuals • Patient-centered contraceptive counseling • Menopause and bleeding disorders • Urinary incontinence
Patient-Reported Outcomes and Experiences of Care
• Patient-reported outcome, patient engagement, and person-centered primary care measures • Consumer experience related to respectful care, beyond what is included in the Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Health Plan Survey 5.1H • Consumer experience related to meeting health-related social needs • Patient-reported outcomes related to oral health; for example, the Oral Impact Health Profile (OHIP-5) • Experience of care measures for the LTSS population and their caregivers
Behavioral Health Care
• Outcome measures, particularly depression treatment outcomes • Screening and referral to treatment for anxiety disorders • Assessment of correlations in social media or internet use with depression and suicide rates among adolescents • Timely use of evidence-based suicide risk strategies after an ED visit for suicidal ideation or attempts • Measurement of opioid utilization through initiation of therapy or more nuanced approaches to pain management • Refinement of existing measures of attention-deficit/hyperactivity disorder treatment
Long-Term Services and Supports
• Quality of care for LTSS and HCBS • Network adequacy for HCBS and specialty providers • Outcomes for people receiving HCBS

[31] Public comments submitted on potential Core Set measurement gaps can be found in Appendix B.

Exhibit 7 *(continued)*

Themes from Priority Gap Areas Discussion
Other Gap Areas Mentioned by the Workgroup
• Adult immunization • Screening and treatment for Hepatitis C • Oral health integration • Ability to assess the impact of health interventions on improvement in patient outcomes

ED = emergency department; HCBS = home and community-based services; LTSS = long-term services and supports.

Throughout the discussion of priority gaps, Workgroup members emphasized the importance of considering measures that advance health equity. Acknowledging the Workgroup's decision not to recommend *Social Need Screening and Intervention*, several Workgroup members noted a gap in the Core Sets around screening for social needs and assessment of social drivers of health across the lifespan and for chronic conditions. Workgroup members also underscored the importance of stratifying Core Set measures to understand disparities. They expressed interest in stratifying Core Set measures not only by race and ethnicity, but also by disability status and population subgroup, including pregnant individuals, individuals with serious mental illness, and individuals with developmental disabilities. One Workgroup member suggested prioritizing the identification of a standardized approach to defining disability to aid in efforts to stratify Core Set measures by disability status. A few Workgroup members also expressed interest in opportunities to incorporate the assessment of adverse childhood experiences into the Core Sets.

Several Workgroup members expressed a desire for measures of maternal mortality and the health disparities that contribute to challenges accessing high-quality maternity care. One Workgroup member acknowledged the importance of addressing maternal mortality, but pointed out that other entities, including the CDC, already measure maternal mortality and that it may not be feasible to include a measure in the Core Sets due to the small number of deaths per state and concerns about the disclosure of protected health information. A CDC representative suggested that the Workgroup should prioritize measurement of maternal morbidities and expressed interest in a measure of hypertension management in pregnant individuals. Other Workgroup members suggested a measure related to maternal substance use disorder.

Workgroup members frequently expressed a desire for measures oriented toward patient experiences and outcomes beyond what is currently available in the Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey. One Workgroup member expressed interest in considering measures that might help assess patient experience with meeting their HRSNs. One Workgroup member mentioned a desire for a patient-reported outcome measure for oral health (specifically the 5-item Oral Health Impact Profile). Another mentioned a gap related to experience-of-care measures targeted to the LTSS population and their caregivers.

The Workgroup also identified gaps in the Core Sets related to behavioral health care. Several Workgroup members suggested identifying measures that assess outcomes for beneficiaries who screen positive for or are diagnosed with depression. Another Workgroup member pointed to a

gap related to screening and referral for anxiety disorders, despite the prevalence of anxiety disorders in the population. Workgroup members also expressed interest in measures of treatment for attention-deficit/hyperactivity disorder and suicidality. Following on the discussion of the OHD-AD measure, a few Workgroup members expressed interest in more nuanced measures of opioid utilization, such as those assessing the initiation of high dosage prescriptions.

The Workgroup also noted that LTSS and home and community-based services (HCBS) measures continue to be a gap area in the Core Sets, and suggested focusing on the quality of care and outcomes for these populations. One Workgroup member also suggested the need for a measure of network adequacy for HCBS and specialty providers.

The Workgroup's reflections about priority gap areas provide a foundation for developing the 2027 Call for Public Measures and further considerations for longer-term planning for the Core Sets, including potential areas for measure development and refinement.

Criteria for the Public Call for Measures for the 2027 Child and Adult Core Sets

Mathematica also engaged the Workgroup in a discussion about the measure criteria for the Public Call for Measures. To start the discussion, Mathematica reviewed the criteria for suggesting measures for addition used during the 2026 Call for Measures (recall Exhibit 5). Mathematica then asked Workgroup members what changes or additional criteria they would suggest incorporating for the 2027 Public Call for Measures. The Workgroup discussion concentrated on three themes: (1) stratification and health equity; (2) measure alignment, harmonization, and parsimony; and (3) data collection and reporting burden.

Stratification and health equity. One Workgroup member suggested stating explicitly that measures submitted as part of the Public Call for Measures must be amenable to stratification by the stratification categories included in the December 2023 State Health Official letter.[32] Two Workgroup members proposed that the Public Call for Measures consider equity more broadly as part of the submission criteria, for example, by considering whether a measure could be used to assess quality of care received by certain population subgroups or whether the measure itself would contribute to more equitable health outcomes.

Measure alignment, harmonization, and parsimony. Workgroup members cautioned against submission of new measures that duplicate existing Core Set measures and that are not aligned or harmonized with measures used in other programs. For example, one Workgroup member warned against duplication in the Core Sets, advising that if an individual suggests a measure (or measure concept) already represented in the Core Sets, that they should also suggest removal of the existing Core Set measure. They noted that new measures could be suggested to replace

[32] The State Health Official letter is available at https://www.medicaid.gov/sites/default/files/2023-12/sho23005_0.pdf.

existing measures if there have been updates in clinical guidance or if an outcome measure can replace a process measure. Another Workgroup member suggested requiring more detail around alignment with quality measurement in other federal and commercial programs to better understand how the measure is implemented. Three Workgroup members emphasized the need for harmonization in the Core Sets, and one suggested that measure submitters research use of the measure by states to identify whether similar measures are used more widely by state Medicaid and CHIP agencies.

Data collection and reporting burden. Two Workgroup members suggested adding criteria around where the burden of data collection may fall (for example, state agencies, managed care plans, providers, health systems, beneficiaries). They acknowledged the role that administrative burden can play in provider burnout. In addition, they alluded to challenges with HRSN screening and referral when data collection is not integrated with existing workflows. A public commenter suggested that as part of the Public Call for Measures, the criteria should consider who would be accountable for improving performance on the suggested measures—providers or some other entity.

Several Workgroup members and one member of the public provided additional comments that were not specific to the criteria for the Public Call for Measures but were broader suggestions related to the 2027 Core Set Annual Review cycle. One Workgroup member suggested inviting the public to comment on Core Set gaps to inform priorities for future measure development. Another Workgroup member suggested using federal funding to push forward measure development, and a public commenter asked whether CMS could accelerate the development of measures for priority gap areas. Another Workgroup member wondered if Workgroup members could suggest revisions to measures, rather than only voting to recommend removal or addition. Another Workgroup member asked if the Workgroup should consider reviewing existing Core Set measures that have undergone changes in their technical specifications.

Suggestions for Technical Assistance to Support State Reporting of the Child and Adult Core Sets

Workgroup members discussed opportunities for TA to support states in collecting, reporting, and using the Child and Adult Core Set measures to improve care delivery and outcomes in Medicaid and CHIP. The Workgroup made the following suggestions for future TA:

- Providing support for reporting digital measures
- Prioritizing TA for the less frequently reported measures and measures with lower performance rates, focusing on the measures that will be mandatory for states to report
- Continuing to explore how using Transformed Medicaid Statistical Information System (T-MSIS) data could reduce the burden on states for claims-based measures

- Organizing TA around areas of the Core Sets where there are inequities, specifically maternity care and physical and behavioral health integration
- Helping states to use supplemental data sources, such as immunization information systems, to yield more complete data for Core Sets reporting
- Engaging community organizations, patients, and families in reviewing Core Set data and making recommendations for quality improvement
- Sharing resources to support quality improvement (such as information about mental health hotlines and federal grant opportunities)

Suggestions for Improving the Child and Adult Core Sets Annual Review Process

Workgroup members also provided feedback on the Child and Adult Core Sets Annual Review process:

- One Workgroup member expressed appreciation for the structure of the meeting whereby the Workgroup discussed each measure one at a time. They also raised consideration of a "pipeline" to bring back measures that the Workgroup determined were not technically feasible for the Core Sets at this point in time but that the Workgroup signaled as a priority to revisit in the future. Another Workgroup member seconded this suggestion.
- One Workgroup member suggested aggregating the unanswered questions from measure discussions along with responses, should the same measure be discussed during a future Workgroup meeting.
- One Workgroup member suggested allowing the Workgroup to make a motion during the Annual Review voting meeting discussion to consider additional measures "in real time." However, the Workgroup member acknowledged that this could be challenging to structure.
- One Workgroup member suggested TA to support the Public Call for Measures. They also suggested allowing adequate time for the Workgroup to review measure suggestions, especially if the Public Call for Measures yields a large number of measures for the Workgroup's consideration.

Next Steps

The 2026 Child and Adult Core Sets Annual Review Workgroup recommended removing one measure from the Adult Core Set and adding one measure to the Child and Adult Core Sets. The Workgroup's recommendations reflected their commitment to using the Core Set measures to drive improvements in care delivery and health outcomes. The Workgroup also suggested priority gap areas and measure criteria to be considered for the 2027 Public Call for Measures.

The 2026 Child and Adult Core Sets Annual Review took place against the backdrop of mandatory reporting of the Child Core Set and the behavioral health measures on the Adult Core Set, which begins in FFY 2024. This was evident in the measure discussions as the Workgroup sought to strike a balance between the feasibility of reporting measures, with a desire to address strategic priorities in Medicaid and CHIP. The Workgroup emphasized the importance of considering measures that advance health equity, including measures related to social drivers of health and maternal health, but acknowledged challenges around state reporting. Workgroup members also underscored the importance of stratifying measures to understand disparities.

The draft report was available for public comment from April 3, 2024 through May 3, 2024. Seven public comments were submitted. These comments are included in Appendix B. CMCS will review the final report to inform decisions about updates to the 2026 Child and Adult Core Sets. In addition, CMCS will obtain input from federal agencies and from state Medicaid and CHIP quality leaders to ensure that the Core Set measures are evidence-based and promote measure alignment within CMS and across federal agencies.[33] CMCS has indicated a goal to release the 2026 updates as soon as the end of 2024.

[33] More information about the decision making process is available in the CMCS fact sheet, *Medicaid and CHIP Child and Adult Core Sets Annual Review and Selection Process*, at https://www.medicaid.gov/medicaid/quality-of-care/downloads/annual-core-set-review.pdf.

Appendix A.
Child and Adult Core Set Measures

Exhibit A.1. 2024 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)

CMIT #*	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
760	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (WCC-CH)	Administrative, hybrid, or EHR
128	NCQA	Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	Administrative or EHR
124	NCQA	Childhood Immunization Status (CIS-CH)	Administrative, hybrid, or EHR[a]
761	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)	Administrative
363	NCQA	Immunizations for Adolescents (IMA-CH)	Administrative or hybrid[a]
1003	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)	Administrative or hybrid
24	NCQA	Child and Adolescent Well-Care Visits (WCV-CH)	Administrative
1775	NCQA	Lead Screening in Children (LSC-CH)	Administrative or hybrid
Maternal and Perinatal Health			
413	CDC/NCHS	Live Births Weighing Less Than 2,500 Grams (LBW-CH)	State vital records
581	NCQA	Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)**	Administrative or hybrid
166	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative
1002	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative
508	CDC/NCHS	Low-Risk Cesarean Delivery (LRCD-CH)	State vital records
Care of Acute and Chronic Conditions			
84	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)	Administrative
80	NCQA	Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)	Administrative
49	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)	Administrative
Behavioral Health Care			
271	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	Administrative or EHR[a]
672	CMS	Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	Administrative or EHR
268	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)	Administrative
448	NCQA	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	Administrative[a]

Exhibit A.1 *(continued)*

CMIT #*	Measure Steward	Measure Name	Data Collection Method
743	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	Administrative
264	NCQA	Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17 (FUA-CH)	Administrative
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17 (FUM-CH)	Administrative
Dental and Oral Health Services			
897	DQA (ADA)	Oral Evaluation, Dental Services (OEV-CH)	Administrative
1672	DQA (ADA)	Topical Fluoride for Children (TFL-CH)	Administrative
830	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)	Administrative
Experience of Care			
151***	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH)	Survey

More information on Updates to the 2024 Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. A resource that provides a history of the measures included in the Child and Adult Core Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

It is important to note that these measures reflect high quality comprehensive care provided across health care providers and settings. Domains are intended to categorize measure topic areas and are not intended to define the type of providers or the health care settings in which care is provided.

* The CMS Measures Inventory Tool (CMIT) is the repository of record for information about the measures that CMS uses to promote health care quality and quality improvement. More information is available at https://cmit.cms.gov/cmit/. A public access quick start guide for CMIT is available at https://cmit.cms.gov/cmit/assets/CMIT-QuickStartPublicAccess.pdf.

** Starting with the 2024 Core Set, the Prenatal and Postpartum Care measure in the Child and Adult Core Sets includes both the prenatal and postpartum care rates. For the Child Core Set, the rates are reported for beneficiaries under age 21. For the Adult Core Set, the rates are reported for beneficiaries age 21 and older.

*** AHRQ is the measure steward for the survey instrument in the Child Core Set (CMIT #151) and NCQA is the developer of the survey administration protocol.

[a] The Childhood Immunization Status, Immunizations for Adolescents, Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication, and Metabolic Monitoring for Children and Adolescents on Antipsychotics measures are also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Child Core Set reporting.

AHRQ = Agency for Healthcare Research & Quality; CDC = Centers for Disease Control and Prevention; CHIP = Children's Health Insurance Program; CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = Electronic Health Record; NCHS = National Center for Health Statistics; NCQA = National Committee for Quality Assurance; OHSU = Oregon Health and Science University; OPA = U.S. Office of Population Affairs.

Exhibit A.2. 2024 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)

CMIT #*	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
118	NCQA	Cervical Cancer Screening (CCS-AD)	Administrative, hybrid, or EHR
128	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR
139	NCQA	Colorectal Cancer Screening (COL-AD)	Administrative or EHR[a]
93	NCQA	Breast Cancer Screening (BCS-AD)	Administrative or EHR[a]
Maternal and Perinatal Health			
581	NCQA	Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD)**	Administrative or hybrid
166	OPA	Contraceptive Care – Postpartum Women Ages 21 to 44 (CCP-AD)	Administrative
1002	OPA	Contraceptive Care – All Women Ages 21 to 44 (CCW-AD)	Administrative
Care of Acute and Chronic Conditions			
167	NCQA	Controlling High Blood Pressure (CBP-AD)	Administrative, hybrid, or EHR
84	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older (AAB-AD)	Administrative
148	NCQA	Hemoglobin A1c Control for Patients With Diabetes (HBD-AD)	Administrative, hybrid, or EHR
577	AHRQ	PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	Administrative
578	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	Administrative
579	AHRQ	PQI 08: Heart Failure Admission Rate (PQI08-AD)	Administrative
580	AHRQ	PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	Administrative
561	NCQA	Plan All-Cause Readmissions (PCR-AD)	Administrative
80	NCQA	Asthma Medication Ratio: Ages 19 to 64 (AMR-AD)	Administrative
325	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR
748	PQA	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Administrative
150	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Administrative

Exhibit A.2 *(continued)*

CMIT #*	Measure Steward	Measure Name	Data Collection Method
Behavioral Health Care (Mandatory)			
394	NCQA	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	Administrative or EHR
432	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	Survey
63	NCQA	Antidepressant Medication Management (AMM-AD)	Administrative or EHR
672	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	Administrative or EHR
268	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Administrative
202	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Administrative
196	NCQA	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	Administrative or hybrid
750	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)	Administrative
264	NCQA	Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)	Administrative
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Administrative
18***	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	Administrative
Experience of Care			
152****	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)	Survey
Long-Term Services and Supports			
961	NCQA	Long-Term Services and Supports Comprehensive Care Plan and Update (CPU-AD)	Case management record review
457	NASDDDS/ HSRI	National Core Indicators Survey (NCIIDD-AD)	Survey

More information on Updates to the 2024 Child and Adult Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html. A resource that provides a history of the measures included in the Child and Adult Core Sets is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/core-set-history-table.pdf.

It is important to note that these measures reflect high quality comprehensive care provided across health care providers and settings. Domains are intended to categorize measure topic areas and are not intended to define the type of providers or the health care settings in which care is provided.

* The CMS Measures Inventory Tool (CMIT) is the repository of record for information about the measures that CMS uses to promote health care quality and quality improvement. More information is available at https://cmit.cms.gov/cmit/. A public access quick start guide for CMIT is available at https://cmit.cms.gov/cmit/assets/CMIT-QuickStartPublicAccess.pdf.

Exhibit A.2 *(continued)*

** Starting with the 2024 Core Set, the Prenatal and Postpartum Care measure in the Child and Adult Core Sets includes both the prenatal and postpartum care rates. For the Child Core Set, the rates are reported for beneficiaries under age 21. For the Adult Core Set, the rates are reported for beneficiaries age 21 and older.

*** The Adult Core Set includes the NCQA version of the measure, which is adapted from the CMS measure.

**** AHRQ is the measure steward for the survey instrument in the Adult Core Set (CMIT #152) and NCQA is the developer of the survey administration protocol.

[a] The Colorectal Cancer Screening and Breast Cancer Screening measures are also specified for Electronic Clinical Data System (ECDS) reporting for HEDIS. ECDS specifications are not currently available for Adult Core Set reporting.

AHRQ = Agency for Healthcare Research & Quality; CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; HSRI = Human Services Research Institute; NASDDDS = National Association of State Directors of Developmental Disabilities Services; NCQA = National Committee for Quality Assurance; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance.

Appendix B.
Public Comments on the Draft Report

The draft report was available for public review and comment from April 3, 2024 through May 3, 2024 at 8 p.m. Eastern Time, and comments were submitted to Mathematica via email. Mathematica received a total of seven public comments. Commenters included state agencies, professional associations, academic institutions, research firms, and other organizations. Mathematica appreciates the time and effort taken by commenters to prepare and submit their comments on the draft report.

Exhibit B.1 categorizes the public comments received on the draft report by the following topics: measures recommended for removal from or addition to the Core Sets, measures discussed but not recommended for removal, and gap areas. A few comments addressed more than one topic, and commenters are listed under each applicable subject area. The verbatim public comments are included after the exhibit, organized in alphabetical order by commenter name (agency/organization name).

In summary, four of the seven public comments were related to the *Prenatal Depression Screening and Follow-Up* measure, which the Workgroup recommended for addition to the Core Sets. In addition, two comments were received on one measure recommended for removal from the Adult Core Set and one comment was received on another measure considered by the Workgroup but not recommended for removal from the Adult Core Set. Comments also addressed other topics discussed by the Workgroup, including gap areas.

Exhibit B.1. Summary of Public Comments by Topic and Commenter

Topic	Commenter
Measure Recommended for Removal	
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	Association for Community Affiliated Health Plans Pharmacy Quality Alliance
Measure Recommended for Addition	
Prenatal Depression Screening and Follow-Up	Association for Community Affiliated Health Plans Louisiana Department of Health University of Louisiana Monroe Washington State Health Care Authority
Measure Discussed and Not Recommended for Removal	
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	Pew Charitable Trusts
Other Topics	
Gap Areas	Louisiana Department of Health Pew Charitable Trusts Pharmacy Quality Alliance ViiV Healthcare

Public Comments Listed Alphabetically by Agency/Organization Name

Association for Community Affiliated Plans (Margaret A. Murray)

The Association for Community Affiliated Plans (ACAP) is grateful for the opportunity to submit comments on the proposed recommendations for changes to the 2026 Child and Adult Core Sets. ACAP is a national association of 79 not-for profit health plans. Collectively, ACAP health plans provide coverage to over 25 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually eligible individuals, and Qualified Health Plans (QHPs) serving the health insurance Marketplaces. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon Medicaid and CHIP as well as other publicly supported programs. Below are our responses to specific measure recommendations.

Proposed Measures for Removal

Use of Opioids at High Dosage in Persons Without Cancer

Support.

Proposed Measures for Addition

Prenatal Depression Screening and Follow-Up

ACAP plans had varied opinions about the recommendation to add this measure to the Core Measure Set. While this measure aligns with public health priorities, plans did note that there are challenges with the measure.

Screening positive is difficult to ascertain via claims which makes data sharing all the more important. As noted by one Workgroup member, "often prenatal screenings are conducted across various settings and by different providers, such as community health workers and doulas;" if those providers/settings are not part of the health plan's network or the screening results are not entered into the plan's care or claims systems, the rate may be under-reported. Alternatively, the plan may need to require that contracted providers perform that screening leading to duplication of screening and/or additional provider burden.

As noted in the report, a representative from NCQA shared that the HEDIS measure is currently stratified by product line, race, and ethnicity. If the Core Measure is also stratified by race and ethnicity, this presents a challenge especially in those states where plans receive that information from state enrollment files. Often those data are incomplete. As ACAP has noted in public comments to NCQA, race and ethnicity data are difficult to collect, and any requirements for race and ethnicity stratification need to account for self-reporting. More work needs to be done

and more experience gained with the current set of measures – with particular focus on how plans can get more accurate and complete standardized race and ethnicity data.

Finally, one of the biggest challenges facing plans across the country is the lack of behavioral health workforce to conduct the follow-up care required within 30 days of a positive screening. While efforts are being made to address that shortage (e.g., via telehealth, etc.), the lack of sufficient follow-up providers could impact the ability of plans to be successful and they will be held accountable for things that are outside of their control.

Again, we thank you for this opportunity to comment on these important proposed modifications to the Core Set measures. Please feel free to contact me, or Enrique Martinez-Vidal, Vice President for Quality and Operations, if you would like to discuss any of these issues in greater depth.

Louisiana Department of Health (Krystal Ceasor)

On behalf of the Louisiana Department of Health, we support prenatal depression screening; however, is there any interest in a postpartum depression screening measure?[34] This is a big issue in our state.

[34] Note that the *Postpartum Depression Screening and Follow-Up* measure was recommended for addition to the Core Sets by the 2021 Child and Adult Core Sets Annual Review Workgroup. CMCS deferred a decision pending further assessment of how the proprietary nature of the Electronic Clinical Data Systems (ECDS) reporting method could impact the feasibility and viability of the measure for state-level reporting in the Core Sets.

Pew Charitable Funds (Alexandra Duncan and David Hyun)

Thank you for the opportunity to comment on the 2026 Child and Adult Core Sets Annual Review draft report.

The Pew Charitable Trusts is an independent, nonprofit research and public policy organization with a number of initiatives focused on improving health care quality and population health outcomes in the United States. Through its Substance Use Prevention and Treatment Initiative (SUPTI), Pew works with states and at the federal level to address the nation's overdose crisis by developing solutions that improve access to timely, comprehensive, evidence-based, and sustainable treatment for substance use disorders. Pew's Antibiotic Resistance Project works to spur the creation of new antibiotics by removing the economic obstacles that impede antibiotic discovery and development and encouraging the establishment of stewardship programs to ensure that antibiotics are prescribed appropriately in human health care settings. We offer the following comments on (1) the retention of the initiation and engagement of substance use disorder treatment measure and (2) the inclusion of the antibiotic utilization for respiratory conditions (AXR) measure in both the Child and Adult Core Sets.

Initiation and Engagement of Substance Use Disorder Treatment

Pew supports the recommendation of the Workgroup to retain the measure *Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)* in the Adult Core Set.

In 2021, Pew convened an expert panel comprising state and federal officials, people with lived expertise, advocates, treatment providers, and experts in health measurement and analytics to recommend a small set of measures that state officials could use to assess the quality of their opioid use disorder (OUD) treatment system and guide efforts to improve treatment policy and programming.[i]

IET-AD, stratified for individuals with an OUD, was one of the recommended measures.[ii] Panelists endorsed its use because many people with OUD leave care early – as of FFY 2022, the median state rate for engagement in OUD treatment was just 29.5%, meaning more than 70% of people who started treatment did not return for two or more services after that first visit.[iii] Using this measure to identify people most at risk of leaving treatment in the early stages provides the opportunity to develop strategies to retain them in care. A 2023 study provided additional evidence for the importance of this measure, finding that engagement in care among people with OUD, as measured by IET-AD, strongly predicts retention in care with buprenorphine at 6, 12, and 24 months.[iv]

As noted by the Workgroup, nearly all (46) states reported the measure in FFY 2022, demonstrating its feasibility.[v] Retaining this measure ensures that all states will soon have access to this valuable data, as reporting of the Behavioral Health Core Set becomes mandatory in fall 2024.

Antibiotic Utilization for Respiratory Conditions

We also recommend that the Workgroup consider adding the National Committee Quality Assurance AXR measure to both the Child and Adult Core Sets. The AXR measure was added to the Healthcare Effectiveness Data and Information Set (HEDIS) as of 2022 and remains a valuable tool for monitoring inappropriate outpatient antibiotic prescribing.

Improving antibiotic prescribing practices in outpatient health care settings in the United States is critical to combatting the threat of antibiotic resistance. Antibiotic use is a primary driver in the development of antibiotic-resistant bacteria, which cause more than 2.8 million infections and 35,000 deaths nationwide each year.[vi] It is estimated that 30% of antibiotics prescribed in these settings are unnecessary.[vii] When looking specifically at antibiotics prescribed for acute respiratory conditions – which include a range of diagnoses such as bronchitis, the common cold, and sinus infections – about half of these prescriptions are unnecessary.[viii] These data show clear room for improving outpatient antibiotic prescribing.

Beyond the threat of antibiotic resistance, improving outpatient antibiotic prescribing can significantly enhance the quality of care provided to individual patients. Two recent studies found that inappropriate prescribing in outpatient settings for common respiratory infections increases the risk of some adverse drug events.[ix] For example, inappropriate antibiotic prescribing for pharyngitis resulted in an 8 times increased risk of *Clostridioides difficile* infections in children and a 3 times increased risk in adults.[x] A better understanding of how outpatient antibiotics are prescribed for these conditions can help health care stakeholders better target efforts for improvement.

We applaud the inclusion of the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) measure in both the Adult and Child Core Sets. However, addition of the AXR measure will provide critical insight for states on antibiotic prescribing practices for conditions that most often contribute to inappropriate antibiotic prescribing.

While the AAB measure only includes prescribing for bronchitis and bronchiolitis, the AXR measure assesses overall antibiotic utilization for patients 3 months and older with a diagnosis of a respiratory condition that resulted in an antibiotic prescription in an outpatient setting.[xi] Although understanding prescribing for individual diagnoses, such as bronchitis, is important, such diagnosis-specific measures also have limitations. A previous study showed that providers who prescribe large amounts of antibiotics may be more likely to use an antibiotic-appropriate diagnosis than those who prescribe fewer antibiotics.[xii] This may reflect conscious or unconscious "diagnosis-shifting," where a physician may diagnose a patient with a diagnosis like sinusitis, even if the patient has a viral infection in order to justify the use of an antibiotic.[xiii] Adding the AXR measure would overcome these limitations by evaluating prescribing based on the full range of potential diagnoses for patients with similar respiratory symptoms.

Acute respiratory prescribing measures have already been successfully implemented at both the health system and state levels. Antibiotic stewardship leaders at Intermountain Healthcare incorporated the measure into a transparent prescribing dashboard for individual clinicians, along with other stewardship measures such as patient education efforts and implementation of quality goals to reduce prescribing.[xiv] This work resulted in a 15% absolute reduction in antibiotic prescribing for respiratory conditions after one year. Additionally, the Washington Health Care Authority has added the AXR measure to their state's Common Measure Set, demonstrating the feasibility of obtaining and tracking these data at the state level.[xv]

Thank you for your consideration of our comments on retaining IET-AD in the Adult Core Set and the inclusion of the AXR measure as part of the Child and Adult Core Sets.

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Pharmacy Quality Alliance (Ben Shirley)

PQA, the Pharmacy Quality Alliance, thanks you for the opportunity to provide comments on the draft report of the 2026 Child and Adult Core Sets Annual Review Workgroup. PQA recognizes and appreciates the hard work from the Medicaid Adult Core Set Review Workgroup to produce the report. The Adult Core Set is a critical resource for providers, policymakers, and patients to understand Medicaid quality and draw meaningful comparisons between states.

PQA is a national quality organization dedicated to improving medication safety, adherence and appropriate use. A measure developer, researcher, educator and convener, PQA's quality initiatives support better medication use and high-quality care. PQA was established in 2006 as a public-private partnership with the Centers for Medicare & Medicaid Services. PQA was created because prescription drug programs were a major area of health care where there was no organization or national program focused on quality improvement. Today, PQA is an independent, non-profit organization with more than 220 diverse members across health care.

PQA expresses concern at the recommended removal of the Use of Opioids at High Dosage in Persons Without Opioids (OHD) measure from the Adult Core Set. PQA developed and is the steward of this measure, and we believe the evidence supports its continued inclusion in the set.

Public comments prior to evaluation meeting, and comments during the evaluation meeting, both alluded to an opioid epidemic that has evolved away from prescription opioid as a primary driver. While overdoses involving synthetic opioids have skyrocketed, opioid overdoses stemming from prescription opioids have not abated. Forty-five (45) Americans died every day from a prescription opioid overdose in 2021, per the CDC's most recent available data.

[i] The most recent available Adult Core Set data on the OHD measure suggests substantial differences in performance among states, from a low of under 1% to a high of nearly 20%. Awareness of differences in opioid prescribing patterns and quality among states is critical to continue to battle the opioid epidemic.

To fill the gap in the Adult Core Set related to opioid prescribing, and to respond to Workgroup preferences for a more upstream measure, PQA plans to recommend addition of the Initial Opioid Prescribing for Long Duration measure to the 2027 Adult Core Set. This measure, already used in the Medicare Part D quality program, is CMS' CBE-endorsed (NQF/Battelle) and evaluates the percentage of individuals ≥18 years of age with ≥1 initial opioid prescriptions for >7 cumulative days' supply. The measure encourages care coordination and follow up to avoid high-risk initial opioid prescription durations while ensuring patients retain access to needed pain care. The measure is supported by epidemiologic evidence and aligns with the CDC Clinical Practice Guideline for Prescribing Opioids for Pain, which emphasizes the need to prescribe no greater quantity than needed for acute pain, and the importance of mechanisms allowing for timely re-evaluation.

Citations

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University of Louisiana Monroe (Eddy Myers)

I am submitting the following 2026 Child and Adult Core Set Annual Review public comment (Louisiana):

The new Prenatal Depression Screening and Follow-Up measure would likely result in states reporting very low rates, similar to the rates reported for the existing Screening for Depression and Follow-Up Plan (CDF-CH and CDF-AD) measures. The issue is that the codes for depression screening are not regularly utilized by providers and are not often captured in claims data for reporting by the administrative method.

ViiV Healthcare (Kristen Tjaden)

ViiV Healthcare Company (ViiV) supports Medicaid's commitment to ensuring all individuals receive coverage that promotes access to high quality and equitable care.

ViiV is the only independent, global specialist company devoted exclusively to delivering advancements in human immunodeficiency virus (HIV) treatment and prevention to support the needs of people with HIV and those vulnerable to HIV. From its inception in 2009, ViiV has had a singular focus to improve the health and quality of life of people affected by this disease and has worked to address significant gaps and unmet needs in HIV care. In collaboration with the HIV community, ViiV remains committed to developing meaningful treatment advances, improving access to its HIV medicines, and supporting the HIV community to facilitate enhanced care and treatment.

Medicaid programs have a significant impact on people with HIV, so it is essential that they continue to address quality of care to improve outcomes for this population.

ViiV appreciates that the HIV Viral Load Suppression (HVL) measure remains in the 2026 Adult Core set, and respectfully submits the following related comments:

ViiV urges CMS to support initiatives that enhance state reporting capabilities of the HIV Viral Load Suppression (HVL) measure. Viral load suppression is the gold standard in HIV quality, as it signifies that a patient has reached the clinical goal of HIV treatment. Since Medicaid is the largest source of health care coverage for people with HIV, it is imperative for Medicaid programs to evaluate HIV care and outcomes meaningful to patients and providers by measuring and reporting HVL. In addition to improving patient health, inclusion of this measure aligns with the national Ending the HIV Epidemic (EHE)

[i] Initiative's strategies of rapid treatment and HIV transmission prevention.[ii]

There is an opportunity to increase reporting of the HVL measure within state Medicaid programs. Only 11 states reported on the HVL measure through the Medicaid Adult Core Measure Set in FY2022,[iii] signaling a need to address the challenges that states face in obtaining data needed to calculate the measure. We are encouraged by the work of NASTAD to provide technical assistance to states[iv] as well as by the actions from the Centers for Medicaid and CHIP Services (CMCS) Technical Assistance and Analytic Support (TA/AS) Program to improve state capacity to report high quality data for the Core Set measures by establishing more efficient and streamlined data collection processes.[v] However, ViiV urges CMS and the CMCS to continue to support similar efforts that create partnerships among Medicaid, other federal agencies, and public health entities to help states gain access to laboratory data required to measure viral load suppression. Coordinated, high-quality care for people with HIV requires sophisticated data use and sharing capabilities between Medicaid agencies, surveillance divisions, and state health departments of HIV programs.

States that participate in HIV quality measure reporting recognize that sharing clinical and health care utilization data between Medicaid and state health department HIV programs is an important first step in reporting HIV quality measures.[vi] Data-sharing can support people who are not virally suppressed and help link them to care, enhance HIV quality measurement, and drive providers and health plans to make improvements across the HIV care continuum. Bolstering state reporting will allow for public reporting of state-level HVL measure performance, thus supporting greater transparency and accountability for state Medicaid programs in caring for people with HIV.

ViiV applauds the Workgroup's commitment to HIV treatment as a public health priority and encourages the Workgroup to further consider how to close gaps in HIV prevention measurement. The use of HIV-related quality measures will promote standards of health care coverage that support adherence to current HIV clinical and federal guidelines.[vii] There are several quality measures used in federal reporting programs, such as MIPS, to evaluate quality of care and outcomes across the HIV care continuum (e.g., HIV Screening, HIV Medical Visit Frequency). However, there is a clear gap in measures that support HIV prevention initiatives. Because prevention is a key component of the EHE, there needs to be a greater focus on quality measures that support ongoing HIV prevention.

Regional and demographic disparities exist in preexposure prophylaxis (PrEP) usage and access across the U.S. For example, the Southern U.S. accounted for more than half (52 percent) of all new HIV diagnoses but represented only 39 percent of all PrEP users in 2021.[viii] Additionally, in 2021, only 30% of individuals for which PrEP is recommended received a prescription.[ix] Although the use of PrEP has increased significantly in recent years across all groups, tactics to promote HIV prevention remains critically necessary to reduce disparities in HIV incidence.

ViiV Healthcare appreciates CMS's consideration of these comments and applauds CMS and the Workgroup for its commitment to improving health outcomes for our most vulnerable individuals. We look forward to working with CMS, CMCS, and other stakeholders, to ensure Medicaid recipients have access to quality HIV care and prevention. Please feel free to contact me should you have any questions.

Citations

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Washington State Health Care Authority (Becky Breidenbach)

I am commenting on the proposed addition of the Prenatal Depression Screening measure. We support the addition of this measure. However, we will have the same problems reporting this measure as we do with CDF if HCPCS codes are required to identify screenings instead of CPT codes with or without ICD-10 modifiers. We do not use HCPCS codes for Medicaid billing.

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