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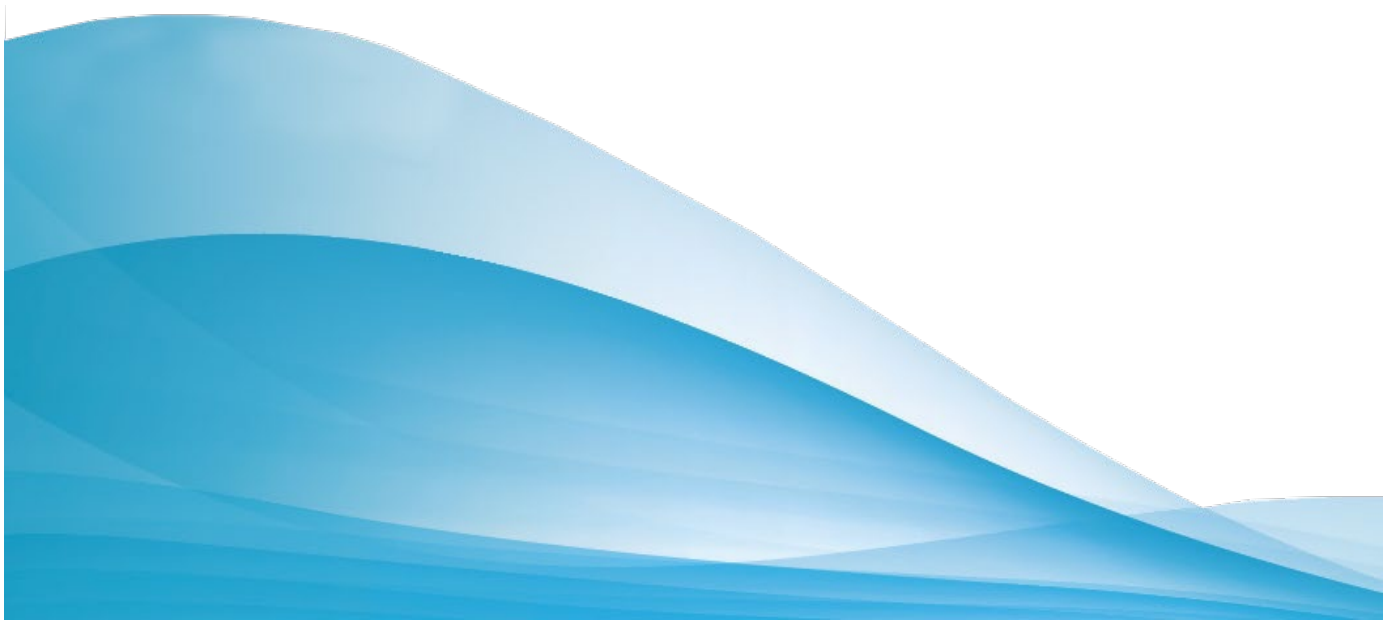
Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP

Summary of a Workgroup Review of the 2027 Child and Adult Core Sets

Draft Report
April 2025



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Acknowledgments

Mathematica developed this report 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. We gratefully acknowledge the contributions of the following team members to the 2027 Child and Adult Core Sets Annual Review Workgroup process and the subsequent development of this report:

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Mathematica also acknowledges the contributions of the Child and Adult Core Sets Workgroup. Each Workgroup member brought an invaluable perspective that informed the recommendations for the 2027 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.

In addition, we express our gratitude to the measure stewards who made themselves available throughout the review. 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

AAB-AD	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Age 18 and Older
AAB-CH	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years
AAP	American Academy of Pediatrics
AAPD	American Academy of Public Dentistry
ADA	American Dental Association
AMR-AD	Asthma Medication Ratio: Ages 19 to 64
CCP-AD	Contraceptive Care—Postpartum Women: Ages 21 to 44
CCP-CH	Contraceptive Care—Postpartum Women: Ages 15 to 20
CCW-AD	Contraceptive Care—All Women: Ages 21 to 44
CCW-CH	Contraceptive Care—All Women: Ages 15 to 20
CDC	Centers for Disease Control and Prevention
CDF-AD	Screening for Depression and Follow-Up Plan: Age 18 and Older
CDF-CH	Screening for Depression and Follow-Up Plan: Ages 12 to 17
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
DQA	Dental Quality Alliance
EHR	Electronic health record
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIV	Human immunodeficiency virus
LARC	Long-acting reversible method of contraception
LOINC	Logical Observation Identifiers Names and Codes
MODRN	Medicaid Outcomes Distributed Research Network
NCQA	National Committee for Quality Assurance
OEV-CH	Oral Evaluation, Dental Services
OEVP-AD	Oral Evaluation During Pregnancy: Ages 21 to 44

OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer
OPA	Office of Population Affairs
OUD	Opioid use disorder
PDS-AD	Postpartum Depression Screening and Follow-Up: Age 21 and Older
PDS-CH	Postpartum Depression Screening and Follow-Up: Under Age 21
PHQ-9	Patient Health Questionaire-9
PND-AD	Prenatal Depression Screening and Follow-Up: Age 21 and Older
PND-CH	Prenatal Depression Screening and Follow-Up: Under Age 21
PQA	Pharmacy Quality Alliance
TA	Technical assistance
TA/AS	Technical Assistance and Analytic Support
USPSTF	U.S. Preventive Services Task Force

Executive Summary

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to more than 79 million people, including eligible children, pregnant women, low-income adults, older adults, and people with disabilities.[1] The Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services use various strategies to help ensure that people enrolled in state Medicaid and CHIP programs receive coverage that promotes access to and receipt of high-quality 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 by using a uniform set of health care quality measures.

CMS and states use the Child and Adult Core Set measures to monitor access to and quality of health care for beneficiaries, identify where improvements are needed, and develop and assess quality improvement initiatives. The 2026 Core Sets, which were released in 2024, will be reported by states to CMS in fall 2026 and mark the third year that states are required to report all Child Core Set measures and all behavioral health measures on the Adult Core Set.[2]

The secretary of the U.S. Department of Health and Human Services (HHS) must review and update the Child and Adult Core Sets each year.[3] The Core Sets Annual Review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Core Sets. The Annual Review includes collecting input from a variety of interested parties, such as states, managed care plans, health care providers, consumers, and quality experts.

CMS contracted with Mathematica to convene the 2027 Child and Adult Core Sets Annual Review Workgroup. The Workgroup included 35 members representing a wide array of affiliations, subject matter expertise, and quality measurement and improvement experience (see page ii for a list of Workgroup members).

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[1] The October 2024 Medicaid and CHIP Eligibility Operations and Enrollment Snapshot is available at https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-october2024.pdf. Numbers reflect preliminary Medicaid and CHIP enrollment data for October 2024, as of January 15, 2025, 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 describes the reporting requirements. More information can be found 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] The Children's Health Insurance Program Reauthorization Act of 2009 requires annual updates to the Child Core Set. The Affordable Care Act requires annual updates to the Adult Core Set. The Child Core Set has undergone these annual reviews since January 2013 and the Adult Core Set since January 2014.

The Workgroup was charged with assessing the existing Child and Adult Core Sets and recommending measures for removal or addition, with the goal of strengthening and improving the 2027 Core Sets. Workgroup members discussed and voted on measures suggested by the public for removal from or addition to the Child and Adult Core Sets, using several criteria. The 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 states' goals for improving care delivery and health outcomes for Medicaid and CHIP beneficiaries. Exhibit ES.1 shows the criteria Workgroup members considered during the 2027 Child and Adult Core Sets Annual Review.

Exhibit ES.1. Criteria for the Removal and Addition of Measures in the 2027 Child and Adult Core Sets

Criteria for Removal of Existing Measures	
Technical Feasibility	
A1.	The measure is being retired by the measure steward and will no longer be updated or maintained.
A2.	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).
A3.	The majority of 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).
A4.	The specifications and data source do not allow for consistent calculations across states (e.g., there is documented variation in coding or data completeness across states).
Actionability	
B1.	The measure is no longer aligned with strategic priorities for improving health care delivery and outcomes in Medicaid and CHIP (e.g., strategic priorities have shifted, and this measure does not address the most pressing needs of Medicaid and CHIP beneficiaries).
B2.	The measure is not able to be stratified by all the required stratification categories included in the annual Core Sets guidance. Considerations could include lack of adequate sample and population sizes or lack of available data in the required data source(s).
B3.	Measure performance for all populations is so high and unvarying that meaningful distinctions in improvements or performance can no longer be made.
B4.	Improvement on the measure is outside the direct influence of Medicaid and CHIP programs/providers.
B5.	The measure no longer aligns with current clinical guidance and/or positive health outcomes.
B6.	Another measure is recommended for replacement which is (1) more broadly applicable (across settings, populations, or conditions) for the topic, and/or (2) more proximal in time to desired beneficiary outcomes, and/or (3) more strongly associated with desired beneficiary outcomes. (Note that the replacement measure must also meet the minimum technical feasibility and appropriateness criteria to be considered by the Workgroup.)
Other Considerations	
C1.	The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful state-level results, taking into account Medicaid and CHIP population sizes and demographics.

Exhibit ES.1 *(continued)*

Criteria for Removal of Existing Measures	
C2.	The measure and measure specifications are not aligned with those used in other CMS programs (e.g., Core Quality Measures Collaborative Core Sets, Medicare Promoting Interoperability Program, Merit-Based Incentive Payment System, Medicaid and CHIP Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
C3.	Including the measure in the Core Sets results in substantial additional data collection burden for providers or Medicaid and CHIP beneficiaries.
C4.	All states may not be able to produce the measure for all Medicaid and CHIP populations within two years of the measure being added to the Core Sets.
Criteria for Addition of New Measures	
Minimum Technical Feasibility and Appropriateness (ALL criteria must be met)	
A1.	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).
A2.	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 according to measure specifications.
A3.	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).
A4.	The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness).
A5.	The measure aligns with current clinical guidance and/or positive health outcomes.
A6.	The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
Actionability	
B1.	The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP (e.g., it addresses the most pressing needs of Medicaid and CHIP beneficiaries).
B2.	The measure is able to be stratified by the required stratification categories included in the annual Core Sets guidance for the Medicaid and CHIP populations. Considerations could include adequate sample and population sizes and available data in the required data source(s).
B3.	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).
B4.	The measure would fill a gap in the Core Sets or would add value to the existing measures in the Core Sets.
Other Considerations	
C1.	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.
C2.	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).
C3.	Adding the measure to the Core Sets does not result in substantial additional data collection burden for providers or Medicaid and CHIP beneficiaries.
C4.	All states should be able to produce the measure for all Medicaid and CHIP populations within two years of the measure being added to the Core Sets.

Exhibit ES.1 *(continued)*

Criteria for Removal of Existing Measures	
C5.	The code sets and codes specified in the measure must be in use by Medicaid and CHIP programs or otherwise be readily available to Medicaid and CHIP programs to support calculation of the measure.

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

Workgroup members convened virtually on February 4 and 5, 2025, to review two measures suggested for removal and six measures suggested for addition. The eight measures were presented, discussed, and voted on, beginning with the two measures suggested for removal and then the six 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 for removal or addition.

In summary, the Workgroup recommended adding three measures to the 2027 Child and Adult Core Sets: *Evaluation of Hepatitis B and C*, *Initial Opioid Prescribing for Long Duration,* and *Adults with Diabetes—Oral Evaluation* (Exhibit ES.2). The Workgroup did not recommend removing any measures from the 2027 Core Sets. This report summarizes the Workgroup's discussion and rationale for these recommendations.

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2027 Child and Adult Core Sets

Measure Name	Measure Steward
Measures Recommended for Addition[a]	
Evaluation of Hepatitis B and C	Medicaid Outcomes Distributed Research Network (MODRN) Data Coordinating Center at the University of Pittsburgh
Initial Opioid Prescribing for Long Duration	Pharmacy Quality Alliance (PQA)
Adults with Diabetes—Oral Evaluation	American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA)

[a] CMS assigns new measures to a Core Set and domain as part of its annual updates.

To inform the 2028 Public Call for Measures, the Workgroup discussed gap areas in the current Child and Adult Core Sets. The Workgroup highlighted gaps across all current Core Set domains: Behavioral Health Care, Primary Care Access and Preventive Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, Dental and Oral Health Services, and Experience of Care. Workgroup members also expressed interest in (1) enhancing the stratification of Core Set measures to include populations not currently in the annual Core Sets guidance and (2) including a cross-cutting measure focused on social drivers of health.

In addition, the Workgroup reflected on opportunities to improve the process for the 2028 Child and Adult Core Sets Annual Review. The Workgroup's suggestions focused on clarifying and emphasizing that, during the public Call for Measures, submitters should closely review existing measures and, when suggesting a new measure, consider other, similar measures for removal. The Workgroup said this would enable Workgroup members to consider removing a measure

without potentially leaving a gap in the Core Sets. Relatedly, it also supports efforts to add new measures while maintaining parsimony in the Core Sets.

This report summarizes the Workgroup's review, discussion, and recommendations and describes the next steps for submitting public comments on the draft report. CMS will use the Workgroup's recommendations, public comments, and additional input from CMS's Quality Technical Advisory Group and federal liaisons to inform decisions about updates to the 2027 Child and Adult Core Sets. CMS expects to release the 2027 updates by the end of calendar year 2025.

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) provide health care coverage to more than 79 million people, including eligible children, pregnant women, low-income adults, older adults, and people with disabilities.[4] This represents more than one in five people in the United States.[5] In 2023, Medicaid and CHIP represented the second-largest source of health insurance in the United States behind employer-sponsored coverage, covering more people than Medicare.[6]

The Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various strategies to help ensure that people enrolled in state Medicaid and CHIP programs receive coverage that promotes access to and receipt of high-quality 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 the experience of care.[7] CMS and states use the Child and Adult Core Set measures to monitor access to and quality of health care for beneficiaries, identify where improvements are needed, and develop and assess quality improvement initiatives.

The secretary of the U.S. Department of Health and Human Services (HHS) must review and update the Child and Adult Core Sets each year.[8] The Core Sets Annual Review 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 various interested parties, including states,

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[4] The October 2024 Medicaid and CHIP Eligibility Operations and Enrollment Snapshot is available at https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-october2024.pdf. Numbers reflect preliminary Medicaid and CHIP enrollment data for October 2024, as of January 15, 2025 as reported by 50 states and the District of Columbia.

[5] Based on (1) Medicaid.gov. "Monthly Medicaid & CHIP Application Eligibility Determination, and Enrollment Reports & Data." Updated July 2024 data. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html; and (2) U.S. Census Bureau. "National Population by Characteristics: 2020–2024—Estimates of the Total Resident Population and Resident Population Age 18 Years and Older for July 1, 2024 (Table SCPRC-EST2024-18+POP)." 2024. https://www.census.gov/data/tables/time-series/demo/popest/2020s-national-detail.html.

[6] Keisler-Starkey, Katherine, and Lisa N. Bunch. "Health Insurance Coverage in the United States: 2023—Table 1." Current Population Reports P60-284. U.S. Census Bureau, September 2024. https://www.census.gov/library/publications/2024/demo/p60-284.html.

[7] Social Security Act, 42 U.S.C, Section 1139A and 1139B.

[8] The Children's Health Insurance Program Reauthorization Act of 2009 requires annual updates to the Child Core Set. The Patient Protection and Affordable Care Act requires annual updates to the Adult Core Set.

managed care plans, health care providers, consumers, and quality experts. The Child Core Set has undergone these annual reviews since January 2013 and the Adult Core Set since January 2014.

CMS contracted with Mathematica to convene the 2027 Child and Adult Core Sets Annual Review Workgroup. The Workgroup included 35 members who represent a diverse array of affiliations, subject matter expertise, and experience with quality measurement and improvement (see inside front cover for a list of Workgroup members).

The Workgroup was charged with assessing the existing Child and Adult Core Sets and recommending measures for removal or addition, with the goal of strengthening and improving the 2027 Core Sets.[9] Workgroup members discussed and voted 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 appropriate for state-level reporting, are actionable by state Medicaid and CHIP programs, and reflect state goals 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 2027 Core Sets Annual Review process, summarizes the Workgroup's recommendations for improving the Core Sets, and specifies next steps for public comment on the draft report.

Overview of the Child and Adult Core Sets

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included several provisions designed to improve the quality of health care for children enrolled in Medicaid and CHIP. CHIPRA required the secretary of HHS (1) to identify and publish a core set of children's health care quality measures—called the Child Core Set—for voluntary use by state Medicaid and CHIP programs and (2) to review and update the list annually. The initial Child Core Set, released for public comment in December 2009, included 24 measures that covered physical and behavioral health. In 2010, the Patient Protection and Affordable Care Act established the core set of health care quality measures for adults enrolled in Medicaid—the Adult Core Set—and required that it be updated in the same manner as the Child Core Set. The initial Adult Core Set, released in January 2012, included 26 measures.

Voluntary state reporting of the Child and Adult Core Set measures has increased over time, with all states[10] voluntarily reporting at least one 2023 Child Core Set measure and at least one 2023 Adult Core Set measure. Fifty states reported more Child Core Set measures for 2023 than for 2022, and 34 states reported more Adult Core Set measures for 2023 than for 2022.[11]

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[9] More information about the annual review of the Child and Adult Core Sets can be found at https://www.mathematica.org/features/MACCoreSetReview.

[10] The term "states" includes the 50 states, the District of Columbia, and Puerto Rico.

[11] The 2023 Core Sets are the most recent for which data are publicly available. More information is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-core-set-reporting.pdf.

The 2024 reporting year marked the first year that states were required to report the Child Core Set measures and the behavioral health measures on the Adult Core Set (other measures on the Adult Core Set remain voluntary for state reporting).[12] State reporting of data for the 2024 Core Sets was due December 31, 2024; CMS is now reviewing those data. CMS announced the updates to the 2025 and 2026 Core Sets in calendar year 2024. States are working to report the 2025 Core Set measures in the fall of 2025.

The 2026 Child and Adult Core Sets

The 2026 Child Core Set includes 28 measures across 6 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] Seventy-five percent (21) of the measures on the 2026 Child Core Set fall into the Primary Care Access and Preventive Care, Maternal and Perinatal Health, and Behavioral Health Care domains (Exhibit 1). About 79 percent (22) of the measures can be calculated using an administrative data collection methodology. In addition, there are two provisional Child Core Set measures: *Postpartum Depression Screening and Follow-Up: Under Age 21* (PDS-CH) and *Prenatal Depression Screening and Follow-Up: Under Age 21* (PND-CH). These provisional measures are voluntary for 2026 reporting and are not considered part of the Core Set. Appendix A lists the 2026 Child Core Set measures.

The 2026 Adult Core Set includes 34 measures across the same 6 domains used for the Child Core Set.[14] About 62 percent (21) of the measures fall into the Care of Acute and Chronic Conditions and Behavioral Health Care domains (Exhibit 1). Seventy-six percent (26) of the measures can be calculated using an administrative data collection methodology. There are also two provisional Adult Core Set measures that are not considered part of the Core Set: *Postpartum Depression Screening and Follow-Up: Age 21 and Older* (PDS-AD) and *Prenatal Depression Screening and Follow-Up: Age 21 and Older* (PND-AD). Appendix A lists the 2026 Adult Core Set measures.

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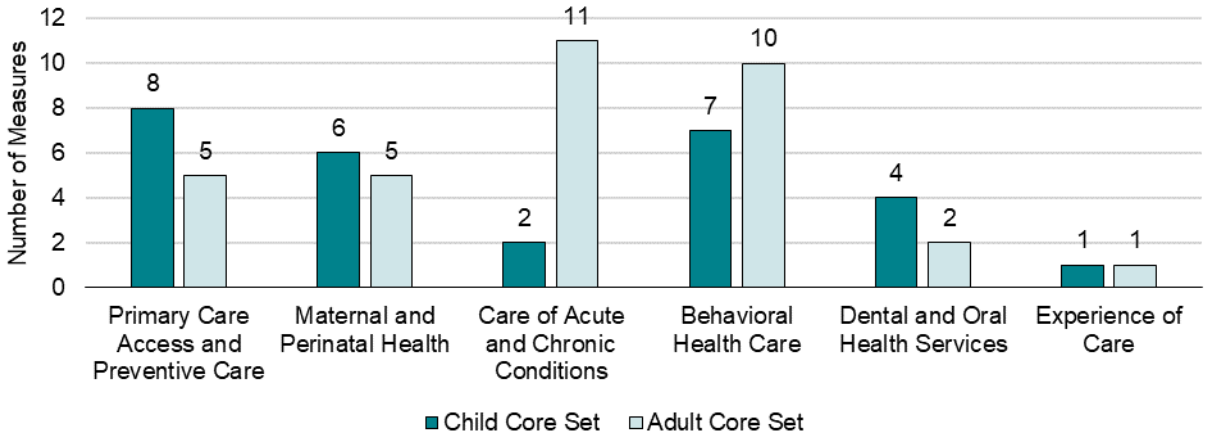
[12] Bipartisan Budget Act of 2018, P.L. 115-123, and Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, P.L. 115-271. On August 31, 2023, CMS released the Mandatory Medicaid and CHIP Core Set Reporting Final Rule (88 FR 60278), which describes the reporting requirements. More information can be found 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.

[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 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.

Exhibit 1. Distribution of 2026 Child and Adult Core Set Measures, by Domain



Note: The 2026 Child and Adult Core Sets each contain two provisional measures that are voluntary for 2026 reporting. The provisional measures are not considered part of the 2026 Core Sets and are not included in this figure.

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

CMS and states use the Child and Adult Core Sets to (1) monitor and improve the quality of care provided to Medicaid and CHIP beneficiaries at the national and state levels and (2) measure progress over time. CMS publicly reports information on state performance on the Child and Adult Core Sets through annual reporting products.[15] The Health Care Quality Performance section of the Medicaid and CHIP Scorecard also includes data for a subset of Child and Adult Core Set measures.[16]

Through its Technical Assistance and Analytic Support (TA/AS) Program, CMS helps states and their partners collect, report, and use the Core Set measures to drive improvement in Medicaid and CHIP.[17] CMS 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. CMS 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.

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[15] 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.

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

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

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 support to connect states with experts and resources, fact sheets, tool kits, analytic reports, and virtual learning opportunities. The CMS Quality Conference also provides states with learning opportunities to support their quality measurement and improvement.

CMS 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.[18] The TA/AS Program helps CMS and states design and implement such quality improvement initiatives focused on the Core Set measures through affinity groups, online training opportunities, one-on-one and group TA, and other approaches.

Description of the 2027 Child and Adult Core Sets Annual Review Process

This section describes the 2027 Child and Adult Core Sets Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2027 Child and Adult Core Sets Annual Review included 35 voting members from state Medicaid and CHIP programs, managed care plans, professional associations, universities, hospitals, health care companies, consumer groups, and other organizations across the country. The Workgroup members for the 2027 Annual Review are listed on page ii of this report.

The Workgroup offered expertise in behavioral health and substance use, dental and oral health, care of acute and chronic conditions, maternal and perinatal health, primary care access and preventive care, and care for people with disabilities and special health care needs. Although Workgroup members had individual areas of subject matter expertise, and some were nominated by an organization, they were asked to participate as stewards of Medicaid and CHIP as a whole and not represent their individual organizational points of view. The Workgroup was charged with considering which measures would best drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

Mathematica required Workgroup members to submit a disclosure of interest form to report any interests, relationships, or circumstances over the past four years that could create a conflict of interest (or the appearance of one) related to the current Child and Adult Core Set measures or other measures reviewed during the Workgroup process. We recused any Workgroup members deemed to have an interest in a measure under consideration from voting on that measure.

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

The Workgroup also included nonvoting federal liaisons representing eight agencies (see page iii of this report). The inclusion of federal liaisons reflects CMS's commitment to promoting quality measurement alignment and partnering 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

Mathematica held virtual meetings via webinar in August 2024 and January 2025 to orient Workgroup members to the 2027 Child and Adult Core Sets Annual Review process and to prepare them for the voting meeting, which took place in February 2025 (Exhibit 2). All meetings were open to the public, with public comment encouraged during each meeting.

Exhibit 2. Timeline for 2027 Child and Adult Core Sets Annual Review Workgroup

CMS = Centers for Medicare & Medicaid Services.

Orientation Meeting

During the orientation meeting on August 21, 2024, Mathematica introduced the Workgroup members and described the disclosure-of-interest process, the Workgroup charge, and the timeline and process for the 2027 Annual Review. Next, we provided background on the Child and Adult Core Sets and summarized the recommendations from the 2026 Annual Review. We also presented gaps identified during the previous annual review meeting.

Mathematica explained the Call for Measures process, through which Workgroup members, federal liaisons, and members of the public suggest measures to add to or remove from the Child and Adult Core Sets. To focus the Call for Measures for the 2027 Child and Adult Core Sets Annual Review on measures that are a good fit for the Core Sets, Mathematica presented the criteria for addition and removal in four areas.

The following is a high-level overview of the criteria. Exhibit 3 on the following page contains the full list of the criteria shared with the Workgroup and the public to guide the public Call for Measures.

Workgroup Charge

The Child and Adult Core Sets Workgroup for the 2027 Annual Review was charged with assessing the existing Core Sets and recommending measures for removal or addition to strengthen and improve the Core Sets for Medicaid and CHIP.

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

- **Technical feasibility and appropriateness criteria.** Workgroup members and the public should consider the measure's technical feasibility and clinical appropriateness when suggesting either the removal of an existing measure or the addition of a new measure. However, the specific criteria and requirements differ by type of suggestion (removal or addition).
  - **Technical feasibility criteria** (applies to measures suggested for removal). A measure could be suggested for removal if the submitter identifies significant feasibility challenges for Core Sets reporting. For example, if (1) most states report significant challenges in accessing a data source that includes all data elements needed to calculate the measure or (2) if the specifications and data source do not allow for consistent calculations across states.
  - **Minimum technical feasibility and appropriateness criteria** (applies to measures suggested for addition). As noted in Exhibit 3, measures suggested for addition must meet all minimum technical feasibility and appropriateness requirements to be considered by the Workgroup. For example, measures must have detailed technical specifications that enable production of the measure at the state level and must have been field tested or used in a state Medicaid or CHIP program according to the technical specifications. Measures must also align with current clinical guidance or positive health outcomes.
- **Actionability criteria** (applies to measures suggested for addition or removal). For example, measures suggested for addition should provide useful and actionable results that can be used to drive improvement in health care delivery and outcomes in Medicaid and CHIP, and they should fill a gap in, or add value to, the existing measures on the Core Sets. Conversely, a measure could be suggested for removal if improvement on the measure is outside the influence of Medicaid and CHIP providers or programs, or if a stronger replacement measure is available with broader applicability or closer alignment with desired outcomes.
- **Other considerations** (applies to measures suggested for addition or removal). For example, measures suggested for addition should align with measures used in other CMS programs and should be specified using code sets and codes available to Medicaid and CHIP programs. Conversely, a measure could be removed if the condition or outcome measured is not

prevalent enough to produce reliable and meaningful state-level results, or if all states might not be able to produce the measure for all Medicaid and CHIP populations within two years of it being added to the Core Sets.

Exhibit 3. Criteria for the Removal and Addition of Measures in the 2027 Child and Adult Core Sets

Criteria for Removal of Existing Measures
Technical Feasibility
A1. The measure is being retired by the measure steward and will no longer be updated or maintained.
A2. 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).
A3. The majority of 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).
A4. The specifications and data source do not allow for consistent calculations across states (e.g., there is documented variation in coding or data completeness across states).
Actionability
B1. The measure is no longer aligned with strategic priorities for improving health care delivery and outcomes in Medicaid and CHIP (e.g., strategic priorities have shifted, and this measure does not address the most pressing needs of Medicaid and CHIP beneficiaries).
B2. The measure is not able to be stratified by all the required stratification categories included in the annual Core Sets guidance. Considerations could include lack of adequate sample and population sizes or lack of available data in the required data source(s).
B3. Measure performance for all populations is so high and unvarying that meaningful distinctions in improvements or performance can no longer be made.
B4. Improvement on the measure is outside the direct influence of Medicaid and CHIP programs/providers.
B5. The measure no longer aligns with current clinical guidance and/or positive health outcomes.
B6. Another measure is recommended for replacement which is (1) more broadly applicable (across settings, populations, or conditions) for the topic, and/or (2) more proximal in time to desired beneficiary outcomes, and/or (3) more strongly associated with desired beneficiary outcomes. (Note that the replacement measure must also meet the minimum technical feasibility and appropriateness criteria to be considered by the Workgroup.)
Other Considerations
C1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful state-level results, taking into account Medicaid and CHIP population sizes and demographics.
C2. The measure and measure specifications are not aligned with those used in other CMS programs (e.g., Core Quality Measures Collaborative Core Sets, Medicare Promoting Interoperability Program, Merit-Based Incentive Payment System, Medicaid and CHIP Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
C3. Including the measure in the Core Sets results in substantial additional data collection burden for providers or Medicaid and CHIP beneficiaries.
C4. All states may not be able to produce the measure for all Medicaid and CHIP populations within two years of the measure being added to the Core Sets.

Exhibit 3 *(continued)*

Criteria for Addition of New Measures
Minimum Technical Feasibility and Appropriateness (ALL criteria must be met)
A1. 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).
A2. 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 according to measure specifications.
A3. 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).
A4. The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness).
A5. The measure aligns with current clinical guidance and/or positive health outcomes.
A6. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
Actionability
B1. The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid and CHIP (e.g., it addresses the most pressing needs of Medicaid and CHIP beneficiaries).
B2. The measure is able to be stratified by the required stratification categories included in the annual Core Sets guidance for the Medicaid and CHIP populations. Considerations could include adequate sample and population sizes and available data in the required data source(s).
B3. 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).
B4. The measure would fill a gap in the Core Sets or would add value to the existing measures in the Core Sets.
Other Considerations
C1. 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.
C2. 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).
C3. Adding the measure to the Core Sets does not result in substantial additional data collection burden for providers or Medicaid and CHIP beneficiaries.
C4. All states should be able to produce the measure for all Medicaid and CHIP populations within two years of the measure being added to the Core Sets.
C5. The code sets and codes specified in the measure must be in use by Medicaid and CHIP programs or otherwise be readily available to Medicaid and CHIP programs to support calculation of the measure.

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

CMS provided introductory remarks about the Workgroup's charge, underscoring the importance of considering updates to the Core Sets to improve delivery of high-quality care and to enhance health outcomes for Medicaid and CHIP beneficiaries. Improving outcomes in these programs depends on the ability to measure state performance to (1) support innovation and adoption of

targeted interventions and initiatives and (2) orient payment and delivery system reforms to close performance gaps.

Public Call for Measures

After the orientation meeting, Workgroup members, federal liaisons, and members of the public were invited to suggest measures for removal from or addition to the Child and Adult Core Sets. This was the first year the Call for Measures was not limited to Workgroup members and federal liaisons but was instead open to all interested parties. Members of the public used online forms to submit their suggestions for removal or addition. The submission forms were structured to collect key information about each measure and assess the extent to which it aligned with the criteria for measure submissions, as described previously. For example, individuals who suggested adding a measure were asked to provide the name and contact information for the measure steward, a link to or copy of the technical specifications, a rationale for the submission, information about whether the measure had been tested in or is currently used by state Medicaid and CHIP programs, and a description of the potential challenges states could face in calculating the measure. Individuals who suggested removing a measure were asked to select one or more reasons for removal from a set list and then to explain their rationale. The form also asked them to assess whether removal of the measure would leave a gap in the Core Sets. For measures suggested for both addition and removal, the form asked submitters whether the Workgroup had reviewed the measure previously and, if so, to provide information that would justify discussing the measure again.

The Call for Measures was open from August 21, 2024, to September 25, 2024. Workgroup members, federal liaisons, and members of the public suggested two measures for removal and eight measures for addition. Mathematica conducted a preliminary assessment of the eight measures suggested for addition and determined that the Workgroup would not discuss two of these measures because they did not meet minimum technical feasibility and appropriateness requirements. The two measures are as follows:

- The *Human Immunodeficiency Virus (HIV) Screening* measure has not been tested or used by one or more state Medicaid or CHIP programs according to the technical specifications.
- The *Social-Emotional Screening Birth to Three* measure is not fully developed and does not have detailed technical specifications that enable production of the measure at the state level.

The Workgroup discussed eight measures during the February voting meeting:

- Two measures suggested for removal from both the Child and Adult Core Sets
- Six measures suggested for addition to the Child and Adult Core Sets

Meeting to Prepare for the 2027 Review

The second webinar took place January 15, 2025, to help Workgroup members prepare for the discussion at the 2027 Annual Review voting meeting. Mathematica shared a list of the two measures considered for removal and the six measures considered for addition. Mathematica

provided guidance to the Workgroup about how to prepare for the measure discussions, including the criteria that Workgroup members should consider when making recommendations about measures and the resources available to facilitate their review. These resources included detailed Measure Information Sheets for each measure, a measure review worksheet, the Medicaid and CHIP Beneficiary Profile, the Core Sets History Table, Core Set Chart Packs and Measure Performance Tables, the Trends in State Performance resource, the Core Set Resource Manuals and Technical Specifications, and a list of measure gaps previously discussed by the Workgroup.[19] Mathematica also shared the Core Sets Data Dashboard, which shows detailed measure-specific information on state performance across the Core Sets. Workgroup members were asked to review all materials related to the measures; complete the measure review worksheet; and attend the Annual Review meeting prepared with notes, questions, and preliminary votes on the eight measures.

Meeting to Review Measures for the 2027 Child and Adult Core Sets

The 2027 Child and Adult Core Sets Annual Review voting meeting took place virtually on February 4 and 5, 2025. Workgroup members, measure stewards, and members of the public participated in the meeting. Representatives from CMS and other federal agencies attended the meeting to listen to the discussion. Workgroup co-chairs provided welcome remarks at the beginning of the meeting and offered reflections on the Core Sets.

For each measure the Workgroup discussed, Mathematica provided an overview of the measure, noted key details from the technical specifications, and summarized the rationale provided by the individuals who suggested adding or removing the measure. Mathematica advised the Workgroup not to focus on domain assignments during the meeting because CMS will select the domain and Core Set most appropriate for any added measures.

Mathematica then facilitated a discussion of the measures. Mathematica elicited comments and questions from Workgroup members about each measure and asked measure stewards to clarify measure specifications when needed. Where applicable, Mathematica invited Workgroup members with experience using the suggested measure in their state Medicaid or CHIP program to share their perspective on the feasibility and actionability of the measure. For each measure, an opportunity for public comment followed the Workgroup discussion.

Voting took place after the Workgroup discussion and public comment period for each measure. 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.

For each measure suggested for removal, Workgroup members could select "Yes, I recommend removing this measure from the [Child/Adult] Core Set" or "No, I do not recommend removing this measure from the [Child/Adult] Core Set." For each measure suggested for addition,

[19] Most of these resources were also made available to the public, in the 2027 Resources tab of the Child and Adult Core Sets Review website: https://mathematica.org/features/MACCoreSetReview.

Workgroup members could select "Yes, I recommend adding this measure to the Core Sets" or "No, I do not recommend adding this measure to the Core Sets."

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. Mathematica adjusted the two-thirds voting threshold according to the number of eligible Workgroup members present for each measure vote. Mathematica presented the voting results immediately after each vote and reported whether the results met the two-thirds threshold.

On the second day of the meeting, the Workgroup also discussed gap areas for the 2028 public Call for Measures. A summary of the discussions about the gap areas for the public Call for Measures is presented later in this report.

Workgroup Recommendations for Improving the 2027 Child and Adult Core Sets

The Workgroup recommended adding three measures to the 2027 Child and Adult Core Sets: *Evaluation of Hepatitis B and C*, *Initial Opioid Prescribing for Long Duration*, and *Adults with Diabetes—Oral Evaluation* (Exhibit 4). The Workgroup did not recommend removing any measures from the 2027 Core Sets. This section summarizes the Workgroup's discussion and rationale for these recommendations. Appendix B provides information about the measures discussed during the voting meeting that were not recommended for removal from or addition to the Child and Adult Core Sets. Measure Information Sheets for each measure the Workgroup considered are available on the Mathematica Core Sets Review website.[20]

Exhibit 4. Workgroup Recommendations for Updates to the 2027 Child and Adult Core Sets

Measure Name	Measure Steward
Measures Recommended for Addition[a]	
Evaluation of Hepatitis B and C	Medicaid Outcomes Distributed Research Network's (MODRN) Data Coordinating Center at the University of Pittsburgh
Initial Opioid Prescribing for Long Duration	Pharmacy Quality Alliance (PQA)
Adults with Diabetes—Oral Evaluation	American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA)

[a] CMS assigns new measures to a Core Set and domain as part of its annual updates.

[20] The Measure Information Sheets for measures suggested for addition and removal are available at https://www.mathematica.org/-/media/internet/features/2025/child-and-adult-core-set/coresetreview-2027-additions.pdf and https://www.mathematica.org/-/media/internet/features/2025/child-and-adult-core-set/coresetreview-2027removals.pdf.

Measure Recommended for Addition: Evaluation of Hepatitis B and C

The Workgroup recommended adding the *Evaluation of Hepatitis B and C* measure, which assesses the number and percentage of adult, non-dually eligible Medicaid beneficiaries tested for hepatitis B, tested for hepatitis C, and treated for hepatitis C. Nine rates are reported for this measure across three populations: all adults, adults diagnosed with opioid use disorder (OUD), and pregnant women. The measure steward is the Medicaid Outcomes Distributed Research Network's (MODRN) Data Coordinating Center at the University of Pittsburgh, and the measure uses an administrative data collection method.

The individual who suggested this measure said it is not currently in use by any state Medicaid or CHIP programs but was tested in seven state Medicaid programs, as well as in subpopulations (pregnant women and adults with OUD) and demographic subgroups within those state programs. They noted that measure testing results showed that hepatitis screening and treatment rates are low and suggested that state Medicaid programs could use the measure to drive increases in screening and treatment rates, particularly for beneficiaries living with OUD and pregnant beneficiaries.

Workgroup members appreciated the measure's actionability, expressing eagerness for the opportunity to improve rates of hepatitis B and C testing, particularly for the two subpopulations in the measure's technical specifications, and to close a gap in the Core Sets. One Workgroup member said their state's addiction recovery and treatment program has tracked similar measures to evaluate their managed care organizations and found opportunities for improvement, particularly for beneficiaries diagnosed with a substance use disorder. Another Workgroup member said there has been a significant increase in the prevalence of hepatitis C in pregnant women over the last 20 years and that this measure might reduce the transmission rate from mother to infant. Two Workgroup members said interested parties in their states strongly supported adding a measure of hepatitis testing and treatment to the Core Sets. Several Workgroup members also appreciated the ability to stratify the measure across demographic subgroups.

One Workgroup member requested clarification about including hepatitis B testing in the measure's technical specifications. Mathematica and a Workgroup member cited a 2023 Centers for Disease Control and Prevention (CDC) recommendation of universal hepatitis B screening. Another Workgroup member said the U.S. Preventive Services Task Force (USPSTF) recommends screening for hepatitis B in high-risk populations. The Workgroup member then requested clarification on the rationale for universal screening for the general population, given the expectation that most people under age 30 have been vaccinated for hepatitis B. In response, a Workgroup member said this is a testing measure rather than a screening measure and is not intended to capture everyone. They added that hepatitis B testing rates were low across states where the measure was tested, highlighting an opportunity to develop targeted testing strategies. Another Workgroup member said the measure might present an opportunity to gather critical data that could help promote hepatitis B immunizations in children.

A Workgroup member requested more information on the measure's feasibility, specifically whether states that have not expanded postpartum coverage up to 180 days would be able to calculate the hepatitis C treatment rate during the postpartum period. The measure steward acknowledged that some states do not have 180 days of postpartum coverage and said the denominator will be smaller in those states due to the requirement of continuous enrollment for the first six months postpartum. Mathematica added that, as of January 2025, 48 states, the District of Columbia, and the U.S. Virgin Islands have extended postpartum coverage for 12 months after delivery. Only Arkansas, Wisconsin, Puerto Rico, and Guam have not extended postpartum coverage.[21] Despite the feasibility concerns for a small number of states, a Workgroup member emphasized the importance of testing pregnant women, adding that a few states have indicated increasing screening and treatment rates as one of their priorities.

A member of the public who represented the Hepatitis B Foundation supported adding the measure to the Core Sets, highlighting a rise in hepatitis B cases, particularly due to the opioid epidemic. They stressed the urgency of early diagnosis to avoid serious liver complications that could have been prevented through adequate testing, screening, and treatment. In response to the Workgroup's discussion about the USPSTF recommendations, they said the most recent USPSTF recommendations on this topic were published in 2020 and that they expect USPSTF to revisit these recommendations.

Measure Recommended for Addition: Initial Opioid Prescribing for Long Duration

The Workgroup recommended adding the *Initial Opioid Prescribing for Long Duration* measure, which assesses the percentage of individuals age 18 years and older with at least one initial opioid prescription for more than seven cumulative days' supply. A lower rate indicates better performance. The measure steward is the Pharmacy Quality Alliance (PQA), and the measure uses an administrative data collection method. PQA tested the measure using data from four states (Utah, Tennessee, Pennsylvania, and West Virginia). The Workgroup suggested adding this measure to the Adult Core Set to replace *Use of Opioids at High Dosage in Persons Without Cancer* (OHD-AD), which was retired from the 2026 Adult Core Set based on recommendations from the 2026 Child and Adult Core Sets Annual Review Workgroup.[22]

The individual who suggested adding the measure noted that, as of 2017, Medicaid beneficiaries account for almost 40 percent of the roughly two million adults ages 18 to 64 with OUD in the nation. They also cited evidence that greater duration of initial opioid exposure is associated with a higher likelihood of high-risk and long-term opioid use, misuse, and overdose. In addition, the individual said the measure was developed to align with the 2016 CDC Clinical Practice

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[21] CMS. "States and Territories That Have Extended Postpartum Coverage." n.d. https://www.medicaid.gov/medicaid/quality-of-care/downloads/map-states-that-have-extended-postpartum-coverage.png. Accessed March 13, 2025.

[22] CMS State Health Official letter (SHO #24-007) describes updates to the 2026 Child and Adult Core Sets. More information is available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho24007.pdf.

Guideline for Prescribing Opioids for Pain[23] and that it does not penalize subsequent fills of greater duration, but rather ensures appropriate follow-up and evaluation instead of potentially dangerous initial prescriptions. They added that *Initial Opioid Prescribing for Long Duration* is responsive to Workgroup-stated desires for a more upstream measure focused on opioid-related quality, filling a gap in the Core Sets.

Workgroup members that commented on the measure generally acknowledged that *Initial Opioid Prescribing for Long Duration* encourages safe prescribing and signals the importance of ongoing vigilance around prescribing amid the evolving opioid epidemic. Although the measure is not currently in use in any state represented in the Workgroup, several Workgroup members commented on their states' efforts related to safe opioid prescribing, including the positive impacts on reducing opioid use; they supported adding the measure to help remind states to encourage providers to prescribe according to the guidelines and ensure appropriate follow-up. Another Workgroup member reiterated that measurement of this type of opioid-prescribing limitation is standard practice in Medicare Part D quality reporting programs (such as the Medicare Part D Display Page and Medicare Part D Patient Safety Reports), and reporting the measure effectively promotes alignment across government programs. Another Workgroup member said reporting the measure could motivate states that have not looked at the measure to begin discussing it and working to follow the recommendations.

One Workgroup member requested clarification on the medications that would be excluded under the measure, specifically buprenorphine. A representative from the measure steward, PQA, said the measure does not include medications indicated for medication-assisted treatment, such as buprenorphine. The representative said this exclusion applies to buprenorphine formulated primarily for pain control as well. They added that the measure includes methadone identified using outpatient prescription claims, but it excludes methadone used for medication-assisted treatment.

During the public comment period, representatives from Kaiser Permanente and the University of Mississippi School of Pharmacy expressed support for adding the *Initial Opioid Prescribing for Long Duration* measure to the Core Sets. The Kaiser Permanente representative said addressing the root causes of chronic opioid use is essential to mitigating the risk of long-term dependence, and the measure fills a recognized need in opioid measurement and uncovers opportunities to reduce the number of beneficiaries who progress from an initial opioid prescription to chronic opioid use. They also said Kaiser Permanente is tracking performance on the measure and they believe, having seen continued year-over-year improvement, that there are opportunities for performance improvement on the measure. The commenter echoed Workgroup comments that the addition of this measure would promote harmonization across quality measurement programs. In addition, the representative from the University of Mississippi School

[23] Dowell, D., T.M. Haegerich, and R. Chou. "CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016." *MMWR Recommendations and Reports*, vol. 65, no. 1, 2016, pp. 1–49.

of Pharmacy said the measure aligns well with an existing opioid initiative in Mississippi Medicaid that has significantly reduced opioid prescribing.

Measure Recommended for Addition: Adults with Diabetes—Oral Evaluation

The Workgroup recommended adding the *Adults with Diabetes—Oral Evaluation* measure, which assesses the percentage of enrolled adults age 18 years and older with diabetes who received a comprehensive or periodic oral evaluation or a comprehensive periodontal evaluation within the reporting year. The measure steward is the American Dental Association on behalf of the Dental Quality Alliance (DQA), and the measure uses an administrative data collection method. The Workgroup previously discussed this measure during the 2020 Core Sets Annual Review meeting. The Workgroup did not recommend adding the measure to the 2020 Core Sets as it was still undergoing testing and because Workgroup members believed other Core Set measures already addressed care for people with diabetes.

In response to concerns raised during the 2020 Core Sets Annual Review meeting, the individual who suggested adding *Adults with Diabetes—Oral Evaluation* to the 2027 Core Sets said DQA has since finished testing the measure in Medicaid, and the measure now has finalized specifications and is in use in Oregon's Coordinated Care Organization Quality Incentive Program. The individual said this measure would fill a gap in the Core Sets because it supports improved integration and coordination of care between medical and dental care systems that promote whole-person health. They also said evidence from testing demonstrates a performance gap in Medicaid, noting statistically significant variations in measure performance across demographics.

Woven throughout the Workgroup's discussion about the *Adults with Diabetes—Oral Evaluation* measure was acknowledgement of the importance of interprofessional collaborative practice, given that periodontal disease is considered a complication of diabetes. Multiple Workgroup members expressed support for the addition of this measure to the Core Sets, saying regular dental care is part of diabetes management as it can help prevent, delay, or manage periodontal disease. Two Workgroup members said *Adults with Diabetes—Oral Evaluation* helps capture and identify the needs of a special population—in this case, beneficiaries with a chronic disease or disability—which had been a gap area identified by prior Workgroups. One Workgroup member said a lot of work has been done with managed care organizations in their state to address the needs of people with diabetes; they said those efforts have extended to training dental students on chronic disease management, such as for diabetes, and interprofessional collaborative practice to manage diseases.

A few Workgroup members asked how many state Medicaid programs have comprehensive adult dental benefits versus limited or no benefits, as this could affect states' ability to report the measure. A representative from the measure steward, DQA, said over 40 states offer an adult dental benefit. Mathematica also reminded Workgroup members that because the *Adults with Diabetes—Oral Evaluation* measure would be added to the Adult Core Set and is not a behavioral health measure, reporting on the measure would be voluntary.

One Workgroup member asked for clarification about the upper age band for *Adults with Diabetes—Oral Evaluation* (age 85 and older) given that most diabetes-related measures on the Adult Core Set end at age 75. A Workgroup member responded from a clinical perspective, saying that oral health is important for people of all ages, including the upper age bands included in the measure. The same Workgroup member also responded from a feasibility perspective, noting that for states that are not able to obtain data for dually-eligible beneficiaries, the population in the upper age bands will decrease, resulting in smaller denominators. The Workgroup member who asked the clarifying question said although they recognize the importance of evaluating oral health in aging populations, they were considering the reporting burden on physicians.

During the public comment period, representatives from the American Dental Hygienists' Association, American Association of Public Health Dentistry, American Academy of Periodontology, and DQA expressed their support for adding the *Adults with Diabetes—Oral Evaluation* measure to the Adult Core Set. Public commenters emphasized the relationship between diabetes and oral health and the importance of collaboration between primary care and dental providers to improve overall health. A representative from the American Dental Hygienists' Association said that good dental hygiene is linked to successful long-term management of chronic diseases such as diabetes and that poor oral health can lead to further complications of diabetes.

There was consensus among public commenters that the *Adults with Diabetes—Oral Evaluation* measure is actionable and would give states the opportunity to improve the overall health of patients who are especially high risk. According to one public commenter, during measure testing, DQA found that over two-thirds of adult Medicaid beneficiaries with diabetes had not had a recent dental checkup. They said this measure could be actionable for state Medicaid programs or managed care plans by identifying members with diabetes who have not had a dental checkup and helping get this population into care to ensure their diabetes is better controlled, they have established care, and their overall health improves.

Workgroup Discussion of Gaps in Child and Adult Core Sets

During the 2027 Child and Adult Core Sets Annual Review, Mathematica asked Workgroup members to discuss gap areas in the current Core Sets to inform the public Call for Measures and ultimately improve the 2028 Core Sets.

Mathematica provided a high-level overview of the gaps identified by the Workgroup during the previous year's Core Sets Annual Review. Mathematica then asked each Workgroup member to mention one gap area they think is a priority to address or to endorse a gap area mentioned by another Workgroup member. Exhibit 5 synthesizes the gaps mentioned during the discussion, organized by Core Sets domain, followed by a list of cross-cutting gap areas. The exhibit does not assess the feasibility or fit of the suggested gap areas for the Child and Adult Core Sets. The Workgroup's reflections about gap areas provide a foundation for developing the 2028 Call for

Public Measures and further considerations for longer-term planning for the Core Sets, including potential areas for measure development and refinement.

Exhibit 5. Synthesis of Workgroup Discussion About Gap Areas for the Public Call for Measures for the 2028 Child and Adult Core Sets

Domain-Specific Gap Areas
Behavioral Health Care
• Screening and follow-up for suicide risk • Suicide prevention interventions in the emergency department • Screening and referral to treatment for anxiety disorders, especially for children and adolescents • Screening for loneliness and isolation • Training and referral to treatment for depression • Measures that are diagnostically cross-cutting and focus on general wellness
Primary Care Access and Preventive Care
• Refinement of existing immunization measures to understand barriers in access to care • Lung cancer screenings • Screening for syphilis
Maternal and Perinatal Health
• Maternal morbidity and mortality, including closing gaps in outcomes • Maternal care coordination • Measures to assess whether patient-centered contraceptive counseling was provided
Care of Acute and Chronic Conditions
• Care for clinical conditions affecting adults with disabilities (such as falls, urinary tract infections, or wounds) • Measures related to the HIV "cascade of care"[a] • Measures related to follow-up and treatment for positive developmental delay screenings • Lifestyle modifications to manage chronic conditions such as diabetes and high blood pressure
Dental and Oral Health Services
• Coordination of care between dental and medical systems
Experience of Care
• Consumer experience measures assessing respectful care and patients' perceptions of providers valuing their needs and priorities • Patient-reported outcomes, including those related to oral health • Experience of care for children and adolescents with special health care needs and/or intellectual and developmental disabilities

Exhibit 5 *(continued)*

Cross-Cutting Gap Areas
• Screening, referral, and care coordination related to social drivers of health • Stratification of measures by population subgroups, including pregnant women, children and adolescents with disabilities, and adults with disabilities • Assessment of adverse childhood experiences and positive childhood experiences

[a] The "cascade of care" refers to a framework used in health care to monitor systemwide effectiveness and performance across key stages of care for chronic diseases, from initial diagnosis to treatment completion.
HIV = human immunodeficiency virus.

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

The meeting closed with an opportunity to provide feedback on the Child and Adult Core Sets Annual Review process:

- Throughout the Annual Review voting meeting, a few Workgroup members noted that they were hesitant to recommend adding a measure without removing a similar measure from the Core Sets, if one existed. Two Workgroup members suggested that during the public Call for Measures, Mathematica should encourage submitters to closely review existing measures and, when suggesting a new measure, to consider also suggesting the removal of a similar measure.
- One Workgroup member suggested a brief orientation for new Workgroup members to review technical aspects of the Annual Review voting meeting and to troubleshoot technical issues in advance.

Next Steps

The 2027 Child and Adult Core Sets Annual Review Workgroup recommended adding three measures to the Child and Adult Core Sets. Two of these measures reflect opportunities to address gaps in the Core Sets for specific conditions, and the remaining measure reflects a continued commitment to addressing the opioid epidemic. The Workgroup also suggested domain-specific and cross-cutting gap areas to be considered for the 2028 public Call for Measures.

The 2027 Child and Adult Core Sets Annual Review took place against the backdrop of (1) the end of the first year of mandatory reporting of the Child Core Set measures and the behavioral health measures on the Adult Core Set and (2) the first public Call for Measures. Workgroup members' discussions revealed that mandatory reporting has heightened the importance of measure feasibility. This was reflected in how the Workgroup sought to strike a balance between the feasibility of reporting measures and the desire to improve the quality of health care delivery and health outcomes for Medicaid and CHIP beneficiaries. In addition, 2027 was the first review cycle during which members of the public could suggest measures to add to or remove from the Core Sets. This new approach encouraged more public engagement and broadened the voices

represented in submitting measures to help fill gaps in the Core Sets and ultimately drive improvement in the quality of care.

This report, which is being made available for public comment, summarizes the Workgroup's review process, discussion, and recommendations. CMS will use the Workgroup's recommendations, public comments, and additional input from CMS's Quality Technical Advisory Group and federal liaisons to inform decisions about updates to the 2027 Child and Adult Core Sets. CMS expects to release the 2027 updates by the end of 2025. Please submit public comments via email by May 1, 2025, 8:00 p.m. (ET), to MACCoreSetReview@mathematica-mpr.com. Include "2027 Child and Adult Core Sets Annual Review Public Comment" in the subject line.

Appendix A.
Child and Adult Core Set Measures

Exhibit A.1. 2026 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) - Mandatory Child Core Set Measures

CMIT #[a]	Measure Steward	Measure Name	Data Collection Method
Behavioral Health Care			
271	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	ECDS or EHR
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)	ECDS
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
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)	ECDS or EHR
761	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)	Administrative
363	NCQA	Immunizations for Adolescents (IMA-CH)	ECDS
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)[b]	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
1782	NCQA	Prenatal Immunization Status: Under Age 21 (PRS-CH)[c]	ECDS
508	CDC/NCHS	Low-Risk Cesarean Delivery: Under Age 20 (LRCD-CH)[b]	State vital records

Exhibit A.1 *(continued)*

CMIT #[a]	Measure Steward	Measure Name	Data Collection Method
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
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
1783	DQA (ADA)	Oral Evaluation During Pregnancy: Ages 15 to 20 (OEVP-CH)	Administrative
Experience of Care			
151[d]	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 2026 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.

[a] 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.

[b] This measure is calculated by CMS on behalf of states.

[c] This measure was added to the 2026 Child Core Set.

[d] 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.

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); ECDS = Electronic Clinical Data Systems; 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. 2026 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) - Provisional Child Core Set Measures (Voluntary for 2026 Reporting)

CMIT #[a]	Measure Steward	Measure Name	Data Collection Method
1781	NCQA	Postpartum Depression Screening and Follow-Up: Under Age 21 (PDS-CH)	ECDS
TBD	NCQA	Prenatal Depression Screening and Follow-Up: Under Age 21 (PND-CH)	ECDS

More information on Updates to the 2026 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.

[a] 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.

CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; ECDS = Electronic Clinical Data Systems; NCQA = National Committee for Quality Assurance.

Exhibit A.3. 2026 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) - Mandatory Adult Core Set Measures

CMIT #[a]	Measure Steward	Measure Name	Data Collection Method
Behavioral Health Care			
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
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: Glycemic Status > 9.0% (HPCMI-AD)	Administrative or hybrid
750	SAMHSA	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[b]	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	Administrative

More information on Updates to the 2026 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.

[a] 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.

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

CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; EHR = Electronic Health Record; NCQA = National Committee for Quality Assurance; SAMHSA = Substance Abuse and Mental Health Services Administration.

Exhibit A.4. 2026 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) - Voluntary Adult Core Set Measures

CMIT #[a]	Measure Steward	Measure Name	Data Collection Method
Primary Care Access and Preventive Care			
118	NCQA	Cervical Cancer Screening (CCS-AD)	ECDS or EHR
128	NCQA	Chlamydia Screening in Women Ages 21 to 24 (CHL-AD)	Administrative or EHR
139	NCQA	Colorectal Cancer Screening (COL-AD)	ECDS or EHR
93	NCQA	Breast Cancer Screening (BCS-AD)	ECDS or EHR
26	NCQA	Adult Immunization Status (AIS-AD)	ECDS
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
508	CDC/NCHS	Low-Risk Cesarean Delivery: Age 20 and Older (LRCD-AD)[b]	State vital records
1782	NCQA	Prenatal Immunization Status: Age 21 and Older (PRS-AD)	ECDS
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
1820	NCQA	Glycemic Status Assessment for Patients with Diabetes (GSD-AD)	Administrative or hybrid
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
150	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Administrative

Exhibit A.4 *(continued)*

CMIT #[a]	Measure Steward	Measure Name	Data Collection Method
Dental and Oral Health Services			
1783	DQA (ADA)	Oral Evaluation During Pregnancy: Ages 21 to 44 (OEVP--AD)	Administrative
1784	DQA (ADA)	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-AD)	Administrative
Experience of Care			
152[c]	AHRQ	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)	Survey

More information on Updates to the 2026 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.

[a] 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.

[b] This measure is calculated by CMS on behalf of states.

[c] 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.

AHRQ = Agency for Healthcare Research & Quality; CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); ECDS = Electronic Clinical Data Systems; EHR = Electronic Health Record; HRSA = Health Resources and Services Administration; NCQA = National Committee for Quality Assurance; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance.

Exhibit A.5. 2026 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) - Provisional Adult Core Set Measures (Voluntary for 2026 Reporting)

CMIT #[a]	Measure Steward	Measure Name	Data Collection Method
1781	NCQA	Postpartum Depression Screening and Follow-Up: Age 21 and Older (PDS-AD)	ECDS
TBD	NCQA	Prenatal Depression Screening and Follow-Up: Age 21 and Older (PND-AD)	ECDS

More information on Updates to the 2026 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.

[a] 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.

CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; ECDS = Electronic Clinical Data Systems; NCQA = National Committee for Quality Assurance.

Appendix B.
Summary of 2027 Child and Adult Core Sets
Annual Review Workgroup Discussion of Measures Not Recommended for Removal or Addition

This appendix summarizes the discussion of measures considered by the Workgroup and not recommended for removal from or addition to the 2027 Child and Adult Core Sets. The discussion took place during the Workgroup voting meeting on February 4 and 5, 2025. The summary is organized by measures considered for removal, followed by those considered for addition.

Measures Considered and Not Recommended for Removal

Workgroup members discussed two measures included on both the Child and Adult Core Sets: (1) *Contraceptive Care – Postpartum Women*: *Ages 15 to 20* (CCP-CH) and *Ages 21 to 44* (CCP-AD) and (2) *Contraceptive Care – All Women*: *Ages 15 to 20* (CCW-CH) and *Ages 21 to 44* (CCW-AD). The Workgroup voted on whether to remove each measure from the Child or Adult Core Sets and did not recommend removing the measures from either Core Set. Four rates are reported for the CCP-CH/AD measure: the percentage of women (ages 15 to 20 and ages 21 to 44) who had a live birth that were provided (1) a most effective or moderately effective method of contraception within 3 days of delivery, (2) a most effective or moderately effective method of contraception within 90 days of delivery, (3) a long-acting reversible method of contraception (LARC) within 3 days of delivery, and (4) a LARC within 90 days of delivery. Two rates are reported for the CCW-CH/AD measure: the percentage of women (ages 15 to 20 and ages 21 to 44) at risk of unintended pregnancy that were provided (1) a most effective or moderately effective method of contraception and (2) a LARC. For both measures, the measure steward is the U.S. Department of Health and Human Services Office of Population Affairs (OPA), and the data collection method is administrative.

The individual who suggested removing the measures said the measures no longer align with current clinical guidance or positive health outcomes. They explained that the measures include contraceptives identifiable only through claims data, excluding other effective methods that might be more culturally appropriate for some populations. They added that this exclusion might result in providers coercing patients to use methods misaligned with the patients' preferences. They also noted that the measures reinforce the idea that contraception is solely a woman's responsibility and felt the *Person-Centered Contraceptive Counseling* measure might be a better indicator of whether a patient needs contraceptives.

Several Workgroup members indicated they were not in support of removing CCP-CH/AD and CCW-CH/AD, stressing that the intent of the measures is to prevent high-risk pregnancies and to monitor states' ability to provide timely access to contraception, particularly considering the ongoing maternal health crisis. They emphasized that because Medicaid covers almost half of births in the United States, the measures are a valuable tool for combatting the crisis. Two Workgroup members added that the measures do not prevent providers from delivering culturally competent care and should not impact the shared decision making between a provider and patient.

Workgroup members acknowledged concerns about the potential for coercion that might result from inappropriate use of the measures but expressed reluctance to remove the measures without

adding a replacement measure. Three Workgroup members from state Medicaid agencies noted that because of coercion concerns, they use the measures to monitor overall program performance but do not use them in provider-level pay-for-performance programs. A Workgroup member questioned whether the measures align with current clinical guidance, as raised by the individual who suggested the measures for removal. Another Workgroup member surmised that the individual who suggested removing the measures might have been referring to the tiered-effectiveness approach, which designates LARCs as the most effective birth control method. The Workgroup member added that this approach might lead providers to coerce patients who might not prefer LARCs to use them as their birth control method. However, the Workgroup member noted that the tiered effectiveness approach is no longer in favor; rather, providers are encouraged to adopt a patient-centered approach and participate in shared decision making with their patients.

Measures Considered and Not Recommended for Addition

The Workgroup members discussed but did not recommend adding three measures to the Child and Adult Core Sets.

Antibiotic Utilization for Respiratory Conditions

The Workgroup considered and did not recommend the addition of the *Antibiotic Utilization for Respiratory Conditions* measure, which assesses the percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. The measure steward is the National Committee on Quality Assurance (NCQA), and the data collection method is administrative. The measure is designed to capture the frequency of antibiotic utilization for respiratory conditions. NCQA advises organizations to use this information for internal evaluation only. It does not view higher or lower service counts as indicating better or worse performance.

The individuals who suggested this measure for addition acknowledged an existing Child and Adult Core Sets measure related to prescribing antibiotics, *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years* (AAB-CH) and *Age 18 and Older* (AAB-AD). However, they noted that the AAB-CH/AD measure focuses on antibiotic use associated with a specific diagnosis, providing limited insights into how providers are prescribing antibiotics overall for patients with acute respiratory conditions. One individual said the *Antibiotic Utilization for Respiratory Conditions* measure will provide a more comprehensive view of overall prescribing practices for a key group of diagnoses that currently contribute to overall antibiotic prescribing. Further, they said this measure will minimize concerns that changes in measure performance are due to diagnosis shifting.

Workgroup members discussed the suggested measure largely in the context of the existing AAB-CH/AD measure. They expressed concerns about gaming and inaccuracy in AAB-CH/AD, with one Workgroup member saying their state Medicaid program replaced AAB-CH/AD with *Antibiotic Utilization for Respiratory Conditions* in response to such concerns. Another

Workgroup member asked whether AAB-CH/AD has led to improved outcomes, adding that lack of improvement might be a reason to consider *Antibiotic Utilization for Respiratory Conditions* for addition. A Workgroup member from a state Medicaid agency said their state saw a four-percentage-point increase in measure rates among children (reflecting performance improvement) and a slight decrease in the rates among adults (reflecting declining performance) over the past three years on the AAB-CH/AD measure. They added that there was large variation in rates by health plan, highlighting an opportunity for improvement. A few other Workgroup members shared their results for both measures and reiterated that potential overuse of antibiotics is an area in need of improvement in their states.

A few Workgroup members expressed concerns over the intended use of the *Antibiotic Utilization for Respiratory Conditions* measure, highlighting the measure steward's note that higher or lower service counts are not indicative of better or worse performance. In response, a Workgroup member encouraged states to think about other ways to use their data, such as assessing whether there are types of care, care settings, or providers that might be prescribing beyond normal ranges for their state. Two Workgroup members expressed concerns over physicians being held accountable for this measure and commented that they would like to see better measures assessing appropriate use of antibiotics on the Core Sets. Several Workgroup members said they saw the value of the measure for internal use but did not support reporting the measure on the Core Sets at a state or national level.

Workgroup members also expressed concern about adding another antibiotic utilization measure to the Core Sets, particularly when there are other gap areas that exist in the Core Sets. One Workgroup member said they find the existing *Asthma Medication Ratio: Ages 19 to 64* (AMR-AD) measure on the Adult Core Set more valuable and in alignment with their state's priorities given that AMR-AD assesses medication utilization in for a specific type of respiratory condition (asthma). No members of the public commented on this measure.

Depression Remission or Response for Adolescents and Adults

The Workgroup considered and did not recommend the addition of the *Depression Remission or Response for Adolescents and Adults* measure to the Core Sets. This measure assesses the percentage of members 12 years of age and older with a diagnosis of depression and an elevated score on the Patient Health Questionnaire-9 (PHQ-9),[24] who had evidence of response or remission within 120–240 days (4–8 months) of the elevated score. Three rates are reported for this measure: (1) the percentage of members who have a follow-up PHQ-9 score documented within 120–240 days (4–8 months) after the initial elevated PHQ-9 score; (2) the percentage of members who achieved remission within 120–240 days (4–8 months) after the initial elevated PHQ-9 score; and (3) the percentage of members who showed response within 120–240 days (4–8 months) after the initial elevated PHQ-9 score. The measure steward is NCQA, and the

[24] The Patient Health Questionnaire (PHQ) is a three-page questionnaire that assesses several mental health disorders. The PHQ-9 is the nine-item depression module from the full PHQ. More information and the full list of questions is available at https://pmc.ncbi.nlm.nih.gov/articles/PMC1495268/.

measure uses NCQA's Healthcare Effectiveness Data and Information Set (HEDIS)® Electronic Clinical Data Systems (ECDS) data collection method. The eligible data sources used for ECDS reporting are administrative claims, electronic health records (EHR), health information exchanges and clinical registries, and case management systems.

The individual who suggested this measure for addition acknowledged that existing Core Set measures, such as *Screening for Depression and Follow-Up Plan: Ages 12 to 17* (CDF-CH) and *Age 18 and Older* (CDF-AD), assess whether a depression screening and follow-up occurred. However, they emphasized that *Depression Remission or Response for Adolescents and Adults* is an outcome measure that provides the results of depression screenings and assesses the efficacy of the follow-up on positive screening results. They noted that depression and suicide rates for adolescents have continued to rise since the COVID-19 pandemic, yet the effectiveness and outcomes of mental health services may be unmeasured and unreported. They also indicated the measure will help determine whether the treatment that results from screening is lowering depression rates and potentially suicide rates of adolescents covered by Medicaid and the Children's Health Insurance Program (CHIP).

Multiple Workgroup members shared concerns about the feasibility of the measure for state reporting, while acknowledging the desire for an outcome-based depression measure. Workgroup members expressed challenges with small denominators and the ability to meaningfully report or stratify the measure. One Workgroup member indicated that although the PHQ-9 is used for most people, it is not a required screening tool for depression and that there are tools that might be more appropriate for certain subpopulations, such as postpartum women. They also cited challenges integrating the measure properly into EHR systems to allow for reporting. A Workgroup member from a state Medicaid agency acknowledged that despite low performance rates and the difficulties with reporting the measure, including getting access to Logical Observation Identifiers Names and Codes (LOINC) that are needed to calculate the measure, they are committed to reporting the measure and are starting by including the measure's follow-up PHQ-9 rate as part of a pay-for-performance program. Another Workgroup member said that given that there are already three depression measures on the Core Sets, this outcome measure should not be added until the process-based depression measures are well established and could be removed. Another Workgroup member said feasibility often becomes a concern when moving from process to outcome measures.

Two Workgroup members expressed concerns with data interpretation. One Workgroup member discussed the relatively large time window of four to eight months for the follow-up screening and noted that attrition could occur during this window making it difficult to assess quality of care. They also noted that if a patient's depression symptoms do not improve during this window, it could indicate poor care or that the patient is treatment resistant. Another Workgroup member echoed these concerns with how well the measure reflects the quality of care as an outcome measure. No members of the public commented on this measure.

Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit

The Workgroup considered and did not recommend adding the *Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit* measure to the Core Sets. This measure assesses the percentage of enrolled children ages 6 months through 5 years who received a comprehensive or periodic oral evaluation with a dental provider within 6 months following a medical preventive service visit. The measure steward is the American Dental Association (ADA) on behalf of the Dental Quality Alliance (DQA), and the measure uses the administrative data collection method. The measure was approved at DQA's June 2024 Membership Meeting but has not yet been implemented by state Medicaid or CHIP programs.

The individual who suggested this measure for addition noted that delays in the first dental visit increase the likelihood of early childhood caries and consequent adverse effects on child health and quality of life, yet most young Medicaid and CHIP beneficiaries do not have a visit with a dental provider. They cited federal fiscal year 2021 Early and Periodic Screening, Diagnostic, and Treatment reporting (Form CMS-416), which notes that 79 percent of children ages 1 to 2 years had a medical visit compared with 26 percent who had a dental visit. Among children ages 3 to 5 years, 63 percent had a medical visit, and 49 percent had a dental visit.[25] They noted that the high rates of medical visits in early childhood represent an opportunity to connect children accessing the medical system to dental care. The individual asserted that this measure would add value to the Core Sets because there are currently no measures on the Core Sets that support improvement in integrating and coordinating care between medical and dental care systems for children.

The Workgroup's discussion of the *Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit* measure supported the goal of improving early childhood oral health through better medical and dental provider coordination. Several Workgroup members cited the ADA's recommendation for oral health visits by age 1 and the opportunities that exist for medical providers to refer parents and caregivers to dentists during regular well-child visits. Two Workgroup members noted that they have observed that when medical providers are recommending a service or making a referral, parents are more likely to take their child to the dentist. Several Workgroup members noted there are key opportunities for medical and dental care coordination, particularly in federally qualified health centers.

A Workgroup member asked for clarification on the difference between this measure and the *Oral Evaluation, Dental Services* (OEV-CH) measure included on the Child Core Set to understand whether it is redundant. The measure steward, DQA, explained that the suggested measure complements OEV-CH and was developed in response to requests from interested parties for a measure focused on children seen in a medical setting but without a dental visit, as a means to improve coordination between medical and dental care. They further explained the

[25] https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html.

suggested measure focuses on the youngest children, who are the least likely to have established care with a dental provider, while OEV-CH includes a wider age band.

Several Workgroup members raised concerns regarding accountability for performance on this measure and challenges with interpreting the data in the context of dental provider access challenges. One Workgroup member said they do not want the primary care provider held responsible for this measure because of the deficiencies in several state Medicaid and CHIP dental networks. They further explained that although primary care providers can refer patients to a dentist, the measure assesses whether a dental visit occurred following the primary care appointment, not that the referral was made. Two other Workgroup members echoed this sentiment, noting that even if a referral is made, the lack of access to Medicaid and CHIP dental providers is a challenge for care coordination. Another Workgroup member, from a state Medicaid agency, raised concerns that measure rates in their state would reflect dental network challenges rather than the efforts of primary care providers.

During the public comment period, representatives from the American Academy of Pediatrics (AAP), ADA, DQA, the American Academy of Pediatric Dentistry (AAPD), the American Dental Hygienists' Association, the American Association of Public Health Dentistry, the National Network for Oral Health Access, and an oral health think tank expressed support for adding the *Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit* measure to the Core Sets. Several public commenters cited the AAP, ADA, and AAPD recommendations for children to see a dentist by age 1 as reasons to support this measure, as well as the opportunity for this measure to be the first Core Sets measure that supports coordination between medical and dental providers. Public commenters also noted that the measure has a low reporting burden, the measure produces practical data, and state Medicaid agencies could use the data to improve the integration of medical and dental care for young children.

Exhibit B.1. Measures Discussed by the 2027 Child and Adult Core Sets Annual Review Workgroup and Not Recommended for Removal or Addition

Measure Name	Measure Steward	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measures Discussed and Not Recommended for Removal from the 2027 Core Sets			
Contraceptive Care – Postpartum Women: Ages 15 to 20 (CCP-CH) and Ages 21 to 44 (CCP-AD)	OPA	Among women ages 15 to 20 (CCP-CH) or ages 21 to 44 (CCP-AD) who had a live birth, the measure assesses the percentage that were provided: 1. A most or moderately effective method of contraception within 3 days of delivery 2. Almost or moderately effective method of contraception within 90 days of delivery 3. A LARC within 3 days of delivery 4. A LARC within 90 days of delivery Data collection method: Administrative	• Discussed in conjunction with CCW-CH/AD • Suggested for removal because the measures include only contraceptive methods identifiable through claims data and could result in coercion to use methods misaligned with the patient's preference • Support for retaining the measures to monitor states' ability to provide timely access to contraception, particularly within the context of the maternal health crisis • Reluctance to remove the measures without adding a replacement measure • Discussion about the potential for coercion and agreement that the measures should not be used in provider-level pay-for-performance programs • Comments that the measures do not preclude shared decision making between a provider and patient
Contraceptive Care – All Women: Ages 15 to 20 (CCW-CH) and Ages 21 to 44 (CCW-AD)	OPA	Among women ages 15 to 20 (CCW-CH) or ages 21 to 44 (CCW-AD) at risk of unintended pregnancy, the percentage that were provided: 1. A most effective or moderately effective method of contraception 2. A LARC Data collection method: Administrative	• Discussed in conjunction with CCP-CH/AD; see the table cell above for key points

Exhibit B.1 *(continued)*

Measure Name	Measure Steward	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measures Discussed and Not Recommended for Addition to the 2027 Core Sets			
Antibiotic Utilization for Respiratory Conditions	NCQA	This measure assesses the percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. Note: This measure is designed to capture the frequency of antibiotic utilization for respiratory conditions. Organizations should use this information for internal evaluation only. NCQA does not view higher or lower service counts as indicating better or worse performance. Data collection method: Administrative	• Discussed largely in the context of the Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH) and Age 18 and Older (AAB-AD) measure on the 2026 Child and Adult Core Sets • Suggested for addition to provide a more comprehensive view of antibiotic prescribing practices for respiratory conditions than AAB-CH/AD, and to address concerns that changes in measure performance are due to diagnosis shifting • Comment that one state Medicaid program replaced AAB-CH/AD with *Antibiotic Utilization for Respiratory Conditions* in response to concerns around gaming and inaccuracy in AAB-CH/AD • Concerns about how the measure would be used and whether physicians would be held accountable for performance, given the note that higher or lower service counts are not indicative of better or worse performance • Concerns about adding another antibiotic utilization measure to the Core Sets when there are gap areas that could be prioritized

Exhibit B.1 *(continued)*

Measure Name	Measure Steward	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Depression Remission or Response for Adolescents and Adults	NCQA	This measure assesses the percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 120–240 days (4–8 months) of the elevated score. The following rates are reported: (1) Follow-Up PHQ-9—The percentage of members who have a follow-up PHQ-9 score documented within 120−240 days (4–8 months) after the initial elevated PHQ-9 score (2) Depression Remission—The percentage of members who achieved remission within 120−240 days (4–8 months) after the initial elevated PHQ-9 score (3) Depression Response—The percentage of members who showed response within 120−240 days (4–8 months) after the initial elevated PHQ-9 score Data collection method: ECDS	• Suggested for addition because depression and suicide rates for adolescents have continued to rise since the COVID-19 pandemic, and the measure could move beyond depression screening process measures on the 2026 Child and Adult Core Sets to provide the results of depression screenings and assess the efficacy of the follow-up • Acknowledgment that an outcome-based depression measure is desirable for the Core Sets • Concerns about feasibility, including small denominators and challenges obtaining the codes and clinical data needed • Comment that although the PHQ-9 is widely used, there are other depression screening tools that providers may use • Comment that an outcome measure should not be added until the process-based depression measures are well established and could be removed from the Core Sets • Concerns with data interpretation and how well the measure results reflect the quality of care, since a failure to achieve remission or response might indicate that the patient is treatment resistant

Exhibit B.1 *(continued)*

Measure Name	Measure Steward	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit	DQA (ADA)	This measure assesses the percentage of enrolled children ages 6 months through 5 years who received a comprehensive or periodic oral evaluation with a dental provider within 6 months following a medical preventive service visit. Data collection method: Administrative	• Suggested for addition to support improvement in the integration and coordination of care between medical and dental care systems, and because most Medicaid and CHIP beneficiaries ages 1 to 2 years do not have a visit with a dental provider • Acknowledgement of the importance of improving early childhood oral health through better medical and dental provider coordination • Concerns about whether primary care providers would be held accountable for performance on the measure, because they can make a referral but cannot ensure the follow-up care is provided • Discussion of challenges with pediatric dental provider access within Medicaid and CHIP and how this might impact measure rates • Concerns about potential overlap with the *Oral Evaluation, Dental Services* (OEV-CH) measure on the 2026 Child Core Set

CHIP = Children's Health Insurance Program; DQA (ADA) = Dental Quality Alliance (American Dental Association); ECDS = Electronic Clinical Data Systems; LARC = long-acting reversible method of contraception; NCQA = National Committee for Quality Assurance; OPA = U.S. Office of Population Affairs; PHQ-9 = Patient Health Questionnaire-9.

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