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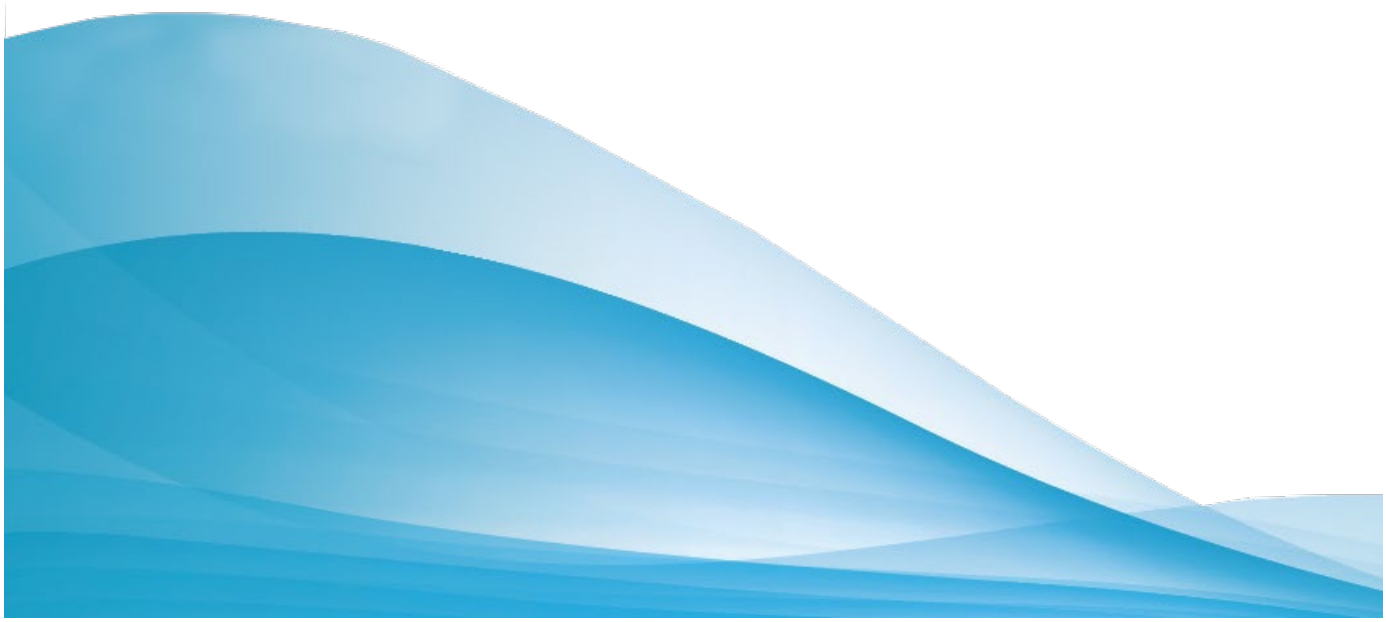
Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP

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

Final Report
June 2025



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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.

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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).The Workgroup was charged with assessing the

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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.

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.
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).

Exhibit ES.1 *(continued)*

Criteria for Removal of Existing Measures	
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.
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 presents the public comments submitted 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

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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.

Core Sets. The annual review includes input from various interested parties, including states, 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 includes public comments on the Workgroup recommendations.

Overview of the Child and Adult Core Sets

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included several provisions 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

[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.

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]

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.

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[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.

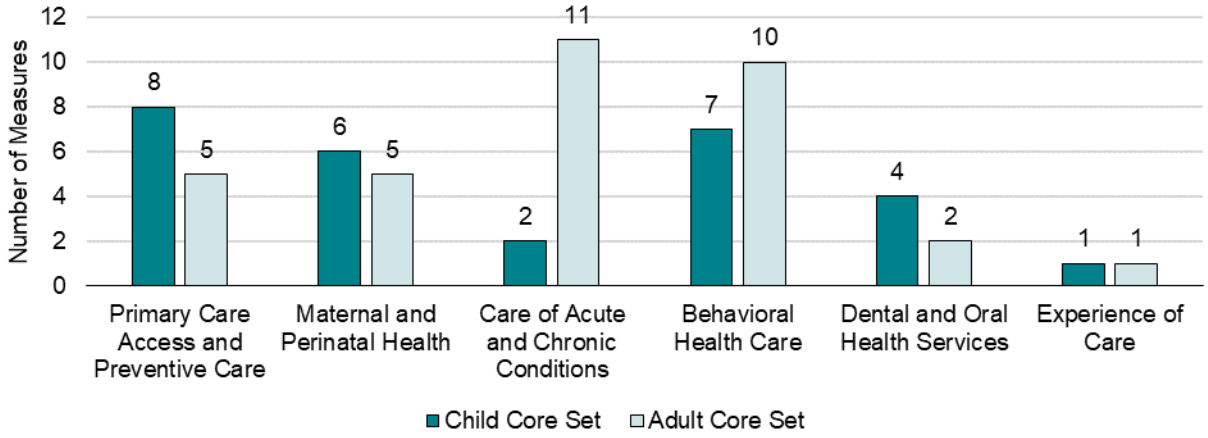
[12] Bipartisan Budget Act of 2018, P.L. 115-123, and Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, P.L. 115-271. On August 31, 2023, CMS released the Mandatory Medicaid and CHIP Core Set Reporting Final Rule (88 FR 60278), which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

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.

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

[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.

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.

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

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

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.

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.

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.

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.

- **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.)

Exhibit 3 *(continued)*

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.
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.

Exhibit 3 *(continued)*

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.

[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.

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, 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 (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.

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

[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.

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.[22]

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.[23]

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 Guideline for Prescribing Opioids for Pain[24] 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

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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] Public comments submitted on the *Evaluation of Hepatitis B and C* measure can be found in Appendix C.

[23] 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.

[24] 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.

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 of Pharmacy said the measure aligns well with an existing opioid initiative in Mississippi Medicaid that has significantly reduced opioid prescribing.[25]

[25] Public comments submitted on the *Initial Opioid Prescribing for Long Duration* measure can be found in Appendix C.

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.[26]

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,

[26] Public comments submitted on the *Adults with Diabetes—Oral Evaluation* measure can be found in Appendix C.

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.[27]

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

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

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.

A draft of this report was available for public comment from April 1, 2025 through May 1, 2025. Mathematica received 30 public comments. These comments are included in Appendix C. CMS will review the final report to inform decisions about updates to the 2027 Child and Adult Core Sets. In addition, CMS will obtain input from federal agencies and from state Medicaid and CHIP quality leaders to ensure that the Core Set measures are evidence-based and promote measure alignment within CMS and across federal agencies.[28] CMS expects to release the 2027 Core Set updates by the end of 2025.

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

Appendix A.
Child and Adult Core Set Measures

Exhibit A.1. 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),[29] who had evidence of response or remission within 120–240 days (4–8 months) of the elevated score. Three rates are reported for

[29] 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/.

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 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.[30] 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.

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

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 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.[31]

[31] Public comments submitted on the *Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit* measure can be found in Appendix C.

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.

Appendix C.
Public Comments on the Draft Report

The draft report was available for public review and comment from April 1, 2025 through May 1, 2025 at 8 p.m. Eastern Time, and comments were submitted to Mathematica via email. Mathematica received 30 public comments. Commenters included state agencies, professional associations, academic institutions, and other organizations and individuals. Mathematica appreciates the time and effort taken by commenters to prepare and submit their comments on the draft report.

Exhibit C.1 categorizes the public comments on the draft report by the following topics: (1) measures recommended for addition to the Core Sets, (2) measures discussed but not recommended for addition, and (3) other topics. The other topics covered include gap areas in the Core Sets, existing Core Set measures, and technical assistance needs. Comments that addressed more than one topic are listed under each applicable subject area. The verbatim public comments are included after the exhibit, organized in alphabetical order by commenter name (agency/organization or individual last name).

The majority of the public comments were related to the three measures the Workgroup recommended for addition to the 2027 Core Sets. The *Evaluation of Hepatitis B and C* measure received 21 comments, the *Initial Opioid Prescribing for Long Duration* measure received 4 comments, and the *Adults with Diabetes—Oral Evaluation* measure received 6 comments. In addition, Mathematica received comments on a measure considered by the Workgroup but not recommended for addition.

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

Topic	Commenter
Measures Recommended for Addition	
Evaluation of Hepatitis B and C	• Andrew Aronsohn, MD, FAASLD • Association for Community Affiliated Health Plans • Association of Asian Pacific Community Health Organizations • Maurizio Bonacini, MD, AGAF, FAASLD • California Department of Public Health • Pauli Gray • Hep B United • Hep Free Hawai'i • The Hepatitis B Coalition of Washington • The Hepatitis B Foundation • National Alliance of State and Territorial AIDS Directors • North East Medical Services • Pennsylvania Department of Human Services • Robert G. Gish Consultants, LLC • San Francisco Hep B Free – Bay Area • Nadine Shiroma • Society for Maternal-Fetal Medicine

Exhibit C.1 *(continued)*

Topic	Commenter
Evaluation of Hepatitis B and C *(continued)*	• Stanford University School of Medicine, Asian Liver Center • Deja Taliaferro, MPH • Texas Health and Human Services Commission • Treatment Action Group
Initial Opioid Prescribing for Long Duration	• American Medical Association • Association for Community Affiliated Health Plans • Pennsylvania Department of Human Services • Deja Taliaferro, MPH
Adults with Diabetes—Oral Evaluation	• Association for Community Affiliated Health Plans • Dental Quality Alliance • National Network for Oral Health Access • Pennsylvania Department of Human Services • Deja Taliaferro, MPH • Texas Health and Human Services Commission
Measures Discussed and Not Recommended for Addition	
Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit	• Dental Quality Alliance • National Network for Oral Health Access
Other Topics	
Gap Areas	• Richard Christopher Antonelli, MD, MS, FAAP • CareOregon • Dental Quality Alliance • Bethlyn Vergo Houlihan, MSW, MPH • Amy Houtrow, MD, PhD, MPH • Pennsylvania Department of Human Services, Office of Long-Term Living • ViiV Healthcare Company
Existing Core Set measures	• CareOregon • Viiv Healthcare Company
Technical Assistance	• Texas Health and Human Services Commission • ViiV Healthcare Company

Public Comment Text

The verbatim text of public comments received by Mathematica appears below in alphabetical order by the organization name or individual commenter's last name. Mathematica removed commenters' contact information and, in some cases, corrected typos or adjusted the formatting of comments to improve readability of the content. Mathematica did not independently verify the commenters' statements.

American Medical Association (provided by Koryn Rubin)

The American Medical Association (AMA) appreciates the opportunity to provide comments on the proposed addition of the Initial Opioid Prescribing for Long Duration measure to the 2027 Child and Adult Core Sets. The AMA is committed to improving patient access to high-quality pain care while minimizing the risks associated with opioid use. We support the development and implementation of evidence-based quality measures that promote individualized care and reduce opioid-related harms. However, the AMA strongly opposes the inclusion of the Initial Opioid Prescribing for Long Duration measure as proposed, given its reliance on outdated prescribing thresholds that have been shown to harm patients and undermine patient care. As explained in greater detail below, this measure is inconsistent with current evidence, clinical best practices, and federal guidance from the Centers for Disease Control and Prevention (CDC).

As proposed, the addition of the measure will hurt Medicaid participants who benefit from opioid therapy, further stigmatize a legitimate medical option for pain care, and inappropriately target physicians who prescribe opioid analgesics to patients with pain. We strongly oppose prescribing thresholds based on arbitrary, low-quality evidence that have demonstrated negative effects on patients. While the AMA supports the use of evidence-based, clinically flexible quality measures to improve opioid prescribing practices, we oppose the use of rigid thresholds that undermine individualized patient care.

We are extremely surprised that this measure seeks to justify use of a three-day or seven-day opioid prescription as the norm when the use of such thresholds was unequivocally repudiated by the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain.[i] We believe that this measure requires significant rework with input from the pain medicine specialists as well as patient advocates who were involved in the revisions to the 2022 CDC guideline.

As background, it is important to highlight that the 2022 CDC guideline removed from its recommendations the same numeric prescribing thresholds that this proposed measure seeks to use to evaluate physicians' prescribing. This updated CDC guideline emphasizes multiple times:

This clinical practice guideline provides voluntary clinical practice recommendations for clinicians that should not be used as inflexible standards of care. The recommendations are not intended to be implemented as absolute limits for policy or practice across populations by organizations, health care systems, or government entities.

The AMA appreciates that the proposed measure excludes patients with cancer, in hospice, with sickle cell disease or who receive palliative care. Nearly all inappropriate prescribing restriction laws and policies, however, use similar language, but all generally fail to ensure protection for all in these vulnerable populations. Since the publication of the original 2016 CDC guideline, the AMA has heard from numerous physicians and patients who treat patients with these diseases or in these situations about pain care being denied.

The proposed measure might say "individual," but the very fact of specific numeric thresholds will cause patients who benefit from dosages or quantities greater than three to seven days to be denied medication beyond those thresholds. Subjecting Medicaid participants and physicians to such a scheme is counterproductive to patient safety and high-quality care. The AMA opposes this measure because patient harm has been an undeniable result of the failed 2016 CDC guideline—including to patients with cancer, and who receive hospice and palliative care.

In the revised 2022 CDC guideline, the authors emphasize the misapplication of the 2016 one-size-fits-all approach. The 2022 guideline removed the numeric thresholds because they also proved impossible to implement with any sensitivity to vulnerable populations, including those with cancer, sickle cell disease, or in hospice or palliative care. CDC cited misapplications including "rapid opioid tapers and abrupt discontinuation without collaboration with patients, rigid application of opioid dosage thresholds, application of the guideline's recommendations for opioid use for pain to medications for opioid use disorder treatment (previously referred to as medication assisted treatment), duration limits by insurers and pharmacies, and patient dismissal and abandonment." It is not surprising that when a state law, pharmacy chain or health insurer policy uses a specific numeric limit, patients are denied anything above that limit—regardless whether the opioid analgesic is for acute, sub-acute or chronic pain. Measures, systems, algorithms and other policies or procedures have never demonstrated any sensitivities toward individualized pain care. CDC finally understood this and revised the 2016 guideline accordingly. It follows that the AMA strongly opposes using discredited hard, numeric thresholds as a quality measure because—not only are they not recommended by CDC—but they have a long history of causing patient harm.

The AMA believes that it is absolutely critical to help improve patients' access to high quality care for pain-related conditions while also minimizing opioid overuse. Regrettably, this measure is not aligned with the evidence and has significant unintended negative consequences to patients. It is further inconsistent with revisions from the CDC and the clinical experience of physicians and best interests of patients.

For these reasons, the AMA respectfully urges that the Initial Opioid Prescribing for Long Duration measure not be adopted into the 2027 Child and Adult Core Sets. We would welcome the opportunity to collaborate on the development of alternative quality measures that are aligned with evidence, protect patient access to individualized care, and support the responsible prescribing of opioid analgesics.

Thank you for your consideration of these recommendations. If you have any questions, please contact Koryn Rubin, Assistant Director of Federal Affairs.

Citations

[i] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.

Richard Christopher Antonelli, MD, MS, FAAP

As a member of the [Core Sets Review] Work Group, I want to offer my strong support of the recommendation contained in Exhibit 5 (pages 18-19) of the DRAFT report: *Stratification of measures by population subgroups, including pregnant women, children and adolescents with disabilities, and adults with disabilities.*

We collectively recognize that current slate of quality measures related to care of persons with disabilities—across the entire age spectrum—lack specificity for the vast majority of chronic conditions and disabilities. Rather than waiting for measure development, specification, validation, and endorsement of measures that are disability or chronic condition specific, we could be much more efficient if we stratify existing relevant measures by disability group. Example, we could stratify the performance on this measure, Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH), on the basis of whether there is co-existing condition such as autism spectrum disorder.

Promoting a set of disability standards that is relevant to both adults and children/ youth could advance this effort immensely.

Andrew Aronsohn, MD, FAASLD

I would like to offer strong support for 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 across three populations: all adults, adults diagnosed with opioid use disorder (OUD), and pregnant women.

As we work towards HCV elimination, reliable data to understand the rate of disease and treatment rates of HCV is essential to directing resources and deploying micro elimination projects in communities in need of resources.

This measure is essential for ongoing efforts to diagnose and cure people with viral hepatitis.

Association for Community Affiliated Plans (provided by Margaret Murray)

The Association for Community Affiliated Plans (ACAP) is grateful for the opportunity to submit comments on the proposed recommendations for changes to the 2027 Child and Adult Core Sets. ACAP is a national association of 83 not-for-profit health plans. Collectively, ACAP health plans provide coverage to over 30 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), Medicare Special Needs Plans for dually eligible individuals, and Qualified Health Plans (QHPs) serving the health insurance Marketplaces. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon Medicaid, CHIP, and other publicly supported programs.

Below are our responses to specific measure recommendations.

Proposed Measures for Addition

Evaluation of Hepatitis B and C

Support with Modification/Concern.

ACAP plans cited support for testing of members with opioid use disorder (OUD) but raised concerns about some OUD providers' ability to gather and store data, as well as some having limited access to electronic health records or limited staffing/administrative support. Due to the higher risk of transmission, ACAP plans also support testing in members who are pregnant; however, as the base rate is lower in this population, a false positive rate is a concern.

ACAP plans expressed concern about testing all beneficiaries during the intake period. The United States Preventative Services Taskforce (USPSTF) and The Centers for Disease Control and Prevention (CDC) support universal once-in-a-lifetime screening (not testing) for Hep B. Because Medicaid beneficiaries move in and out of eligibility, a policy of intake testing will result in multiple screenings for low-risk beneficiaries with unacceptable false positive rates and poor stewardship of resources. ACAP plans support once-in-a-lifetime testing for low-risk beneficiaries, with acceptance of historical data or vaccine records as exclusions. ACAP plans also noted that Hep B has a vaccine for prevention.

Initial Opioid Prescribing for Long Duration

Support with Modification/Concern.

The majority of ACAP plans support the inclusion of this measure and noted that these data could be easily accessed via pharmacy claims. However, not all plans have access to pharmacy data when that benefit is carved out in their state.

Several plans recommended, as an alternative, using one of the existing NCQA HEDIS measures related to opioid use that plans are already reporting, such as Pharmacotherapy for Opioid Use Disorder (POD), Use of Opioids in High Dosage (HDO), Use of Opioids for Multiple Providers

(UOP), or Risk of Continued Opioid Use (COU), as opposed to this proposed measure. In particular, the Risk of Continued Opioid Use (COU) measure overlaps sufficiently with the proposed Initial Opioid Prescribing for Long Duration measure and would not be as administratively burdensome on Medicaid health plans. While intent to decrease opioid overprescribing is laudable, addiction research indicates that continued pressure to decrease opioid prescribing without an added focus on appropriate non-opioid pain control has not been an adequate strategy. ACAP also recommends that a better focus of effort would be a measure of effective non-opioid pain control.

Adults with Diabetes - Oral Evaluation

Support with Modification/Concern.

While ACAP plans support this measure in concept, concerns were raised from ACAP plans that dental is a separate coverage for Medicaid in many states, and that the incentives need to align for management to occur. Additionally, data are difficult to get from many dental providers. With all current and potential measures, ACAP recommends that CMCS be mindful of the burden of tracking down data for the plans and collecting/transmitting data from the providers. Unless there is a value-based payment associated with these, the mechanics of collecting and transmitting the data becomes an unfunded administrative burden on the providers. This is minimal for large hospital systems, but in the dental and behavioral health areas where providers are much smaller, the burden is greater.

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

Association of Asian Pacific Community Health Organizations (provided by Adam Carbullido)

The Association of Asian Pacific Community Health Organizations (AAPCHO) appreciates the opportunity to provide public comment on the draft report adding the Evaluation of Hepatitis B and C measure to the 2027 Adult Medicaid Core Set.

AAPCHO is a national nonprofit association of community-based health care organizations, primarily Federally Qualified Health Centers, that works to improve health access and outcomes of Asian Americans, Native Hawaiians, and Pacific Islanders (AA and NH/PIs). AAPCHO is a national voice to advocate for the unique and diverse health needs of AA and NH/PI communities and the community health providers that serve those needs. AAPCHO members are critical health access providers to nearly three quarters of a million vulnerable and low-income patients, providing linguistically accessible, culturally appropriate, and financially affordable health care services.

Hepatitis B and hepatitis C remain serious public health threats in the U.S., with more than 5 million people living with hepatitis B and/or hepatitis C. Despite strong community-led efforts, progress in identifying new infections has been slow. Since 2020, the U.S. Centers for Disease Control and Prevention (CDC) has recognized that previous risk-based testing and vaccination strategies have not been effective, and the CDC has updated clinical guidelines to recommend that all adults get tested and vaccinated for hepatitis B, and tested for hepatitis C. The success of these universal recommendations, however, requires extensive collaboration between public health professionals, the federal government, the community, and clinicians.

AAPCHO strongly supports the adoption of the Evaluation of Hepatitis B and C measure. Asian Americans, Native Hawaiians, and Pacific Islanders are disproportionately affected by hepatitis B. An estimated one in twelve Asian Americans live with chronic hepatitis B, and Asian Americans are more likely to develop liver cancer, which has a 5-year survival rate of only 22 percent. Chronic hepatitis B and hepatitis C are leading risk factors for developing liver cancer. Up to one in four people with untreated chronic hepatitis B will develop liver cancer, liver failure and/or cirrhosis, and according to the American Cancer Society, the liver cancer incidence rate has tripled and the liver cancer death rate has more than doubled in the United States since 1980. These statistics are exacerbated among AAPCHO members as a majority of AAPCHO member community health center patients are low income Medicaid beneficiaries.

The proposed new hepatitis B and C measure in the Adult Medicaid Core Set will improve the quality of services our patients receive and improve health outcomes by allowing AAPCHO members to better identify patients with hepatitis B and C, ensure that our patients with chronic viral hepatitis are appropriately linked to timely and comprehensive care and treatment, and identify susceptible patients who would benefit from hepatitis B vaccination to prevent infection. We appreciate the Workgroup’s diligence in recommending that this hepatitis B and C measure be added to the final 2027 Adult Medicaid Core Set.

Current Successes within Health Systems

Although no state Medicaid program has implemented hepatitis B testing measures, multiple health centers and health systems across the country have proven that implementing testing measures for hepatitis B services is practical, feasible, and actionable with proper guidance. North East Medical Services (NEMS), an AAPCHO member community health center in California, and Cooperman Barnabas Medical Center, a large health system in New Jersey, are two examples of institutions that have successfully enacted widespread hepatitis B testing measures to increase testing rates for the hepatitis B triple panel test (Hepatitis B surface Antigen, Hepatitis B surface Antibody, Hepatitis B core Antibody Total), identify new cases of hepatitis B, and link these patients to care. These health systems have demonstrated that the proposed hepatitis B and C evaluation measure in the 2027 Adult Medicaid Core Set has the potential to successfully achieve the goal of increasing viral hepatitis testing and improving linkage to care to improve health outcomes of people living with chronic hepatitis B and C – even in clinical settings that differ from one another.

Low Viral Hepatitis Testing Rates in the United States

In the United States, 32% of people living with chronic hepatitis B are aware of their infection and 60% of infected individuals are aware that they are living with hepatitis C. Lack of awareness of a person's viral hepatitis infection can be attributed to commonly absent symptoms in viral hepatitis and to low uptake of viral hepatitis testing in the United States.

Prior to the CDC's universal hepatitis B and C testing recommendations, risk-based testing often resulted in undercounting and underreporting of infections. Questions used in risk-based testing, such as country of origin, were not routinely asked or known during clinic visits, causing many patients from countries with a high prevalence of viral hepatitis to not receive recommended viral hepatitis testing. We strongly believe that implementing the CDC's universal hepatitis B and C testing guidelines and adding the proposed hepatitis B and C evaluation measure in the 2027 Adult Medicaid Core Set will alert clinicians caring for adult patients on Medicaid to universally screen for viral hepatitis, help appropriately link patients with chronic viral hepatitis to care, and lead to improved health outcomes.

Eliminating Viral Hepatitis in the United States

The United States Department of Health and Human Services (HHS) and the CDC have declared that viral hepatitis can be eliminated in the United States. The HHS Viral Hepatitis National Strategic Plan and HHS Viral Hepatitis Federal Implementation Plan list increased surveillance and tracking of viral hepatitis as core strategies to reach viral hepatitis elimination goals. The plans also list preventing new infections and improving viral hepatitis-related health outcomes as necessary steps to eliminating viral hepatitis and preventing deaths. Testing for hepatitis B and C is the first step to achieving these goals, as testing identifies a person's viral hepatitis status and

allows clinicians to link their patients to appropriate care, including completing additional testing and providing appropriate management, treatment, and/or vaccination.

The recommended Evaluation of Hepatitis B and C measure in the 2027 Adult Medicaid Core Set also focuses on two higher risk groups – adults diagnosed with opioid use disorder and pregnant women – that HHS also note as key populations to increase viral hepatitis testing and linkage to care. The Workgroup's recommendation to also focus on individuals living with opioid use disorder and pregnant Medicaid beneficiaries in order to increase hepatitis B and C testing and treatment strongly aligns with current efforts to eliminate viral hepatitis by federal agencies.

Widespread testing for hepatitis B and C and linking individuals to appropriate care is the best way to prevent complications associated with viral hepatitis, including cirrhosis and liver cancer. The Workgroup's recommended addition for the first time of the Evaluation of Hepatitis B and C measure in the 2027 Adult Medicaid Core Set provides a critical opportunity for states to increase viral hepatitis testing and treatment while aligning with current clinical guidelines and federal recommendations and efforts.

Thank you for the opportunity to comment on the draft report for the Annual Review of the Medicaid and CHIP 2027 Child and Adult Core Sets of Quality Measures. AAPCHO strongly supports the new addition of the Evaluation of hepatitis B and C measure for adults. Please do not hesitate to reach out with any questions, or to request additional information.

Maurizio Bonacini, MD, AGAF, FAASLD

I am a hepatologist and Fellow of the AASLD, concerned about the lack of progress in eliminating viral hepatitis. As you know, that is the WHO goal for 2030, and unfortunately this goal is not likely to be achieved with the current state of affairs.

I appreciate the opportunity to provide public comment on the draft report adding the *Evaluation of Hepatitis B and C* measure to the 2027 Adult Medicaid Core Set. Many in the communities impacted by hepatitis B rely on Medicaid for their healthcare, and the new measures will improve the quality of services they receive. We sincerely thank the Workgroup for recommending that this measure be added to the final 2027 Adult Core Set, so that Patients may **be tested AT NO COST.**

Hepatitis B and hepatitis C remain serious public health threats in the U.S., with more than 5 million people living with one of the viruses. Despite strong community-led efforts, progress in identifying new infections has been slow. Since 2020, the Centers for Disease Control and Prevention (CDC) has recognized that previous risk-based testing and vaccination strategies have not been fruitful, and have put forth recommendations to encourage all adults to get tested and vaccinated for hepatitis B, and tested for hepatitis C.[i,ii,iii] The success of these recommendations, however, requires extensive collaboration between public health workers, the federal government, the community, and providers.

I strongly support the adoption of the Evaluation of Hepatitis B and C measure for several reasons:

The triple test, if covered by CMS, will help adults receive better care or management as follows:

1. HBsAg: if positive, the patient has hepatitis B and should be linked to care to prevent further spread of the virus.
2. HBcAb: if positive, the patient is at risk for HBV reactivation if certain immunosuppressive agents are given. This should be flagged in the EHR.
3. HBsAb: if positive, the individual is immune to HBV and no further action is recommended. If negative, vaccination (or revaccination) should be discussed.

Current Successes within Health Systems

Although no state Medicaid system has implemented hepatitis B testing measures, multiple health centers and health systems across the country have proven that implementing testing measures for hepatitis B services is practical, feasible, and actionable with proper guidance. North East Medical Services (NEMS), a federally qualified health center in California, and Cooperman Barnabas Medical Center, a large health system in New Jersey, are two examples of institutions that have successfully enacted widespread hepatitis B testing measures to increase

testing rates for the hepatitis B triple panel test (HBsAg, HBsAb, HBcAb), identify new cases of hepatitis B, and link them to care. These groups demonstrate that the recommended evaluation measure can achieve exactly what is sought – even in health systems that differ from one another.

Low Viral Hepatitis Testing Rates in the U.S.

In the U.S., just 32% of people living with chronic hepatitis B are aware of their infection, and just 60% of infected individuals are aware that they are living with hepatitis C.[iv,v,vi] Unawareness of a person's viral hepatitis status can be contributed to the infections' lack of symptoms and to low uptake of testing in the U.S. Prior to the universal testing recommendations for hepatitis B and C, risk-based testing often resulted in underreporting of infections to as individuals were required to share sensitive, stigmatizing information prior to being tested that they might not have been comfortable disclosing. Some risk-based questions, such as country of origin, were not standardly asked as a part of provider visits, which allowed even more people to miss the opportunity to be tested. Such issues have led to historical low rates and underreporting of viral hepatitis and have perpetuated myths that hepatitis B and C were not public health issues in the U.S. The recommended viral hepatitis measure alerts providers servicing the adult Medicaid population to the importance of testing their population regardless of risk and offers an opportunity to increase awareness of a person's viral hepatitis status.

Eliminating Viral Hepatitis in the U.S.

The United States Department of Health and Human Services (HHS) and the CDC have declared that viral hepatitis can be eliminated in the U.S. Both HHS' Viral Hepatitis National Strategic Plan and Viral Hepatitis Federal Implementation Plan list increased surveillance and tracking of viral hepatitis as core strategies to reaching elimination goals. The plans also list preventing new infections and improving viral-hepatitis-related health outcomes as necessary steps to eliminating viral hepatitis and preventing deaths. Testing for hepatitis B and C is the first step of these goals, as it identifies a person's viral hepatitis status and allows providers to link them to the proper care whether that is additional testing, management, treatment, or vaccination. The recommended measure also focuses on two higher risk groups – adults diagnosed with opioid use disorder and pregnant women – that HHS also note as key populations to address.[vii] Therefore, the Workgroup's recommendation strongly aligns with current efforts to eliminate viral hepatitis by federal agencies.

Thank you again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review. Please do not hesitate to reach out to Maurizio Bonacini with any questions, or to request additional information.

Citations

[i] Conners EE, Panagiotakopoulos L, Hofmeister MG, et al. Screening and Testing for Hepatitis B Virus Infection: CDC Recommendations — United States, 2023. MMWR Recomm Rep 2023;72(No. RR-1):1–25. DOI: http://dx.doi.org/10.15585/mmwr.rr7201a1.

[ii] Sandul AL, Rapposelli K, Nyendak M, Kim M. Updated Recommendation for Universal Hepatitis B Vaccination in Adults Aged 19–59 Years — United States, 2024. MMWR Morb Mortal Wkly Rep 2024;73:1106. DOI: http://dx.doi.org/10.15585/mmwr.mm7348a3.

[iii] Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. CDC Recommendations for Hepatitis C Screening Among Adults — United States, 2020. MMWR Recomm Rep 2020;69(No. RR-2):1–17. DOI: http://dx.doi.org/10.15585/mmwr.rr6902a1.

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[v] U.S. Department of Health and Human Services. 2020. Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025). Washington, DC.

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[vii] Ryerson AB, Schillie S, Barker LK, et al. Vital Signs: Newly reported acute and chronic hepatitis C cases – United States, 2009-2018. MMWR 2020; 69(14):399-404. doi:10.15585/mmwr.mm6914a2.

California Department of Public Health (provided by Rachel McLean)

I am writing to support the proposed 2027 Adult Medicaid Core Set measure for hepatitis B testing and hepatitis C testing and treatment from a public health perspective. Note: I do not represent our state Medicaid agency.[32]

Hepatitis B

Chronic hepatitis B can cause liver damage, liver cancer, liver failure, and death. Many people with chronic hepatitis B do not experience or exhibit symptoms; screening is the only way to know if a patient has hepatitis B. In a 2023 study, CDC found approximately 50% of people living with chronic hepatitis B were unaware of their infection status. As home to one-third of Asian Americans and Pacific Islanders in the United States, California has a special interest in promoting hepatitis B screening because AAPI communities are disproportionately affected by hepatitis B infection. In California, there are estimated to be 305,000 persons living with chronic hepatitis B, however, as of May 2023, fewer than 100,000 cases had been reported to CDPH. There is an important gap in clinical diagnosis that can be monitored and addressed with a screening measure.

Measuring hepatitis B screening would be more feasible if the USPSTF screening recommendations were universal rather than risk-based, and aligned with those of the U.S. Centers for Disease Control and Prevention (CDC).

Hepatitis C

Hepatitis C is a leading cause of liver disease and liver transplantation. Despite the availability of screening guidelines, diagnostic tests, and highly effective curative direct-acting antiviral medications for hepatitis C, national estimates suggest approximately four in ten people with hepatitis C are unaware of their infection and that only one in three people diagnosed with hepatitis C are cured. California's Medicaid program ("Medi-Cal") covers hepatitis C testing and has no prior authorization requirements for nearly all hepatitis C medications, yet gaps in care remain.

A Medi-Cal analysis of Screening, Diagnosis, and Treatment of Chronic Hepatitis C Virus Infection - September 2024[i] found room for improvement:

- Between 2017 and 2023, paid claims for HCV antibody screening tests increased by 143% and HCV RNA diagnostic tests increased by 41%. Paid claims for both tests increased each year since 2020, after a presumed pandemic-related dip. However, during the same time

[32] The California state Medicaid agency is the Department of Health Care Services, which operates separately from the Department of Public Health.

frame, there was a 35% decrease in members with a diagnosis of chronic HCV and a 34% decrease in members with a paid claim for HCV treatment.

- Despite improvements in HCV screening, the treatment rate for HCV infection among Medi-Cal members continues to remain relatively stagnant. However, among members newly diagnosed with chronic HCV in 2023, treatment rates in 2023 did appear higher (35.0%) than among all members diagnosed with chronic HCV (15.4%).

This analysis shows that Medi-Cal can use its claims and pharmacy data to measure hepatitis C testing and treatment among Medi-Cal beneficiaries.

With the passage of Assembly Bill 789[ii] (Low, Chapter 470, Statutes of 2021), California law now requires primary care facilities to offer hepatitis B and hepatitis C testing to adults consistent with USPSTF guidelines and to link those who test positive to follow up diagnostic testing and care. The addition of a hepatitis C testing and treatment measure in Medicaid would enable our state to increase the proportion of people with hepatitis C who are aware of their status and successfully treated and cured. This would help reduce hepatitis C transmission and liver-related complications, and lower our healthcare costs.

Citations

[i] https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/dur/educational-articles/dured_Screening_Diagnosis_Treatment_of_Chronic_Hepatitis_C_Infection.pdf.

[ii] https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB789.

CareOregon (provided by Safina Koreishi)

CareOregon is a community non-profit organization serving over 500,000 Oregonians covered by the Oregon Health Plan, the state Medicaid program. We have served Oregonians for over 30 years. CareOregon wholly owns two coordinated care organizations (CCOs), Jackson Care Connect and Columbia Pacific CCO. We are a founding member of Health Share of Oregon, managing an integrated community network and the behavioral health benefit for all Health Share of Oregon members in the Portland Metro area.

We are writing to share feedback on the 2027 Child and Adult Core Sets. Thank you for the work you have already put into reviewing and creating the draft.

Vaccinations

Two vaccine measures do not align with ACIP/CDC guidelines, CMIT #124 and #363. We request for consideration that components of the Childhood Immunization Status (CIS-CH) and Immunizations for Adolescents (IMA-CH) metric requirements align with the ACIP/CDC guidelines. We request this change to align with clinical best practice, to reduce administrative burden on providers, and to acknowledge providers and parents who are able to establish a healthy relationship that leads to adequate vaccination coverage.

CMIT # 124, Childhood Immunization Status (CIS-CH)

This measure only recognizes a completed pneumococcal series if at least four doses are administered on or before a child's second birthday. However, according to the CDC, children who start their pneumococcal series late may only need 3 doses before their second birthday. We value and support following the vaccine schedule as recommended by the ACIP and CDC based on evidence. We also celebrate when a provider has a quality relationship with their patient and patient's family that allows the family to accept vaccines at any point in time. We consider it of great value when a family chooses to vaccinate, and since the evidence shows that three doses of pneumococcal vaccine provide adequate protection to children who start the series at age 7 months or later, we request that the measure steward consider accepting three doses prior to the second birthday if the first dose was given at 7 months of age or later.

CMIT # 363, Immunizations for Adolescents (IMA-CH)

This measure only recognizes a completed HPV series if at least two doses are given between a child's 9th and 13th birthdays. However, according to the CDC, initial vaccination can occur between the 9th and 15th birthdays. We request that the measure steward consider broadening the age within which the initial vaccine series can occur, between the 9th and 15th birthdays.

CMIT # 581, Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD)

We request for consideration a technical change to the qualifying date range for Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD) metric. Specifically, we request that the date range for qualifying postpartum visits be expanded from 7 to 84 days after delivery discharge to 2 to 84 days after delivery.

The proposed expansion in qualifying postpartum visit date range is requested in order to align with update clinical guidance on optimal postpartum care published by The American College of Obstetricians and Gynecologists (ACOG). ACOG recommends people-centered postpartum care, which may include visits in the first 3-6 days postpartum. We request these encounters be included as a qualifying numerator encounter.

CMIT # 394, Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)

This is the measure about which we receive the most feedback from our community partners. While everyone acknowledges the importance of and supports increasing timely access to quality treatment for substance use disorders, the specifications have created a high level of frustration that has led to poor commitment to the measure itself. In other words, our community providers are working extremely hard to improve substance use care, but they do not feel this measure captures their very hard work.

The 14-day and 34-day time periods are an area of concern, and it is unclear if these are based on evidence. If they are, sharing the evidence behind these windows would be appreciated to help us understand. If they are not, lengthening the turn around times would help to increase buy-in.

The definitions and language are quite confusing. Simplifying the specifications would make it easier for providers to understand what they are trying to do for the measure beyond what they already do for their patients/clients. This is especially true given the barriers that 42 CFR Part 2 creates, which limit a provider's ability to see what is happening with their individual patients/clients, thereby inhibiting their timely interventions.

It would be beneficial to have a best-practice assessment of what is working well and what could be improved upon based on what various states are implementing. While the national focus has appropriately been on opioid use disorder for the last several years, alcohol causes more preventable deaths. Yet individuals with alcohol use disorder tend to take much longer than 14 or 34 days from the time of diagnosis to initiate and engage in care. Sharing positive experiences among states could be very helpful, especially related to alcohol use disorder, and even more so if the evidence behind the specifications is shared.

Mandatory Reporting

Given that the Child Core Set and now the Behavioral Health Care portion of the Adult Core Set are mandatory for states to report on to CMS, we are curious if the Workgroup has plans to make the entire Adult Core Set mandatory in the near future. If so, we request that there be advanced notice of at least two years so that states can prepare. It would also change the ideal number of measures in the core set, so it would be appreciated to allow time for public comment on which measures may be most appropriate to keep as mandatory. Thank you for considering this.

Gaps in Core Sets

We appreciate and agree with the Workgroup's assessment of particular gaps in the current Core Sets. In particular, we also see gaps for syphilis, anxiety, suicide, and lead screening in children. Thank you for considering effective ways in which these critical topics can be thoughtfully added.

Thank you for putting in the time and effort to create Core Sets that can unify our country around standardized ways of measuring quality in areas that we can improve.

Dental Quality Alliance (provided by Julie Reynolds)

The Dental Quality Alliance (DQA) welcomes the opportunity to comment on the draft report of the 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.

The DQA appreciates and strongly supports the Workgroup recommendations to add *"Adults with Diabetes – Oral Evaluation"* to the Adult Core Set. This measure focuses on adults with diabetes who are at increased risk for oral disease. Evidence supports a bidirectional relationship between diabetes and periodontal disease. Diabetes is associated with increased prevalence and severity of periodontal disease. Periodontal disease is associated with poor glycemic control. Oral evaluations are an important entry point into the dental care system. Diagnosis and treatment planning for the prevention and treatment of periodontal and other oral disease at these visits have the potential to improve diabetes outcomes. Thus, this measure supports efforts to improve both oral health and overall health outcomes and quality of life for Medicaid beneficiaries living with diabetes. More broadly, this measure directly addresses an identified gap by the workgroup: "coordination of care between dental and medical systems" (Exhibit 5 in the report). Additionally, it is aligned with the priority area of improving care quality and outcomes for adult beneficiaries with chronic conditions.

The DQA urges the Workgroup and CMS to reconsider inclusion of the DQA measure *"Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit"* which received support by 53% of workgroup members. Dental caries is the most common chronic disease of childhood with adverse impacts that may include pain, infections, and difficulty with eating, speaking, and learning. The American Academy of Pediatrics, American Public Health Association, American Academy of Pediatric Dentistry, and American Dental Association recommend that children visit a dentist by age 1 for timely prevention and identification of oral disease and to enable less invasive approaches to early childhood caries management. The American Academy of Pediatrics notes the importance of establishing care with a dental provider in early childhood through medical-dental coordination in addition to conducting oral health screenings and providing basic preventive services and anticipatory guidance within medical settings.

"Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit" focuses on pre-school aged children, who are much more likely to have a medical visit than a dental visit, which represents an opportunity to connect children accessing the medical care system to dental care. The primary concern raised by workgroup members who did not recommend this measure was related to accountability. Specifically, there was concern that primary care providers would be held responsible for the measure, and they may not be able to drive improvement when there are limited dental networks. The DQA note that this measure is designed for **system-level accountability** by Medicaid programs and managed care organizations and not individual practices or providers. Addressing dental provider network challenges is within the scope of a multi-faceted system-level improvement strategies. This

measure would promote not only improved oral health and overall health for young children, but also would directly address "coordination of care between dental and medical systems," which is a gap identified by the Workgroup (Exhibit 5 in the report).

The DQA also supports the Workgroup's recommendation that future core set measures include "patient-reported outcomes, including those related to oral health."

Dentistry has been committed to pursuing coordinated, meaningful, and parsimonious measurement through the Dental Quality Alliance (DQA), convened by the ADA at the request of the CMS. DQA is the only comprehensive multi-stakeholder organization in dentistry that develops dental quality measures through a consensus-based process. Thirty-six organizations with oral health experience participate in the DQA along with a public member.

Measuring performance is critical to improving quality of care – the DQA has created an oral healthcare quality dashboard[i] for reporting dental quality measures using Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files under a data use agreement with CMS. Both "Adults with Diabetes – Oral Evaluation" and "Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit" are included in the dashboard. All dashboard measures are reported with stratifications by beneficiary characteristics where data are sufficiently complete.

The DQA appreciates the Workgroup's consideration of these comments.

Citations

[i] https://www.ada.org/resources/research/dental-quality-alliance/dqa-improvement-initiatives.

Pauli Gray

My name is Pauli Gray. I am a person with lived experience of both hepatitis B and hepatitis C. I have been cured of Hep C (after many years) and made it through Hep B. I live with cirrhosis because of Hep C. This is not easy. It has had a huge and devastating effect on my life.

I strongly support the CMS recommendations to add new hepatitis B and hepatitis C quality measures.

- These Quality measures are an important tool to drive improvements in care.
- They incentivize best practices like screening, diagnosis, linkage to care, and treatment—critical steps toward viral hepatitis elimination. Incentives are a tool to help systems strengthen individual and population health outcomes for care. For hep C treatment, health economists have conducted studies showing reductions of negative health outcomes and major cost-savings for CMS.
- Right now, Medicaid lacks any viral hepatitis-specific quality measures.
- This leaves a major gap in efforts to improve early detection and treatment access for people at risk.
- Without better systems to ensure testing and care...people are undiagnosed or untreated until serious health problems develop. Hep C moves slowly in the body but is still deadly and so many times by the time people feel symptoms their liver is compromised, and they are in trouble.
- For these reasons and others I strongly recommend CMS finalizes and adopt these new measures.
- I also want to thank CMS for recognizing viral hepatitis as a public health priority.

Hep B United (provided by Frank Hood)

On behalf of Hep B United, national coalition dedicated to eliminating hepatitis B and the health disparities and inequities associated with hepatitis B and hepatitis delta among highly impacted communities across the United States, we greatly appreciate the opportunity to provide public comment on the draft report adding the *Evaluation of Hepatitis B and C* measure to the 2027 Adult Medicaid Core Set. Many in the communities disparately impacted by hepatitis B rely on Medicaid for their healthcare, and the new measures will improve the quality of services they receive. We sincerely thank the Workgroup for recommending that this measure be added to the final 2027 Adult Core Set.

Hepatitis B and hepatitis C remain serious public health threats in the U.S., with more than 5 million people living with one of the viruses. Despite strong community-led efforts, progress in identifying new infections has been slow. Since 2020, the Centers for Disease Control and Prevention (CDC) has recognized that previous risk-based testing and vaccination strategies have not been fruitful, and have put forth recommendations to encourage all adults to get tested and vaccinated for hepatitis B, and tested for hepatitis C.[i,ii,iii] The success of these recommendations, however, requires extensive collaboration between public health workers, the federal government, the community, and providers.

Hep B United strongly supports the adoption of the *Evaluation of Hepatitis B and C* measure for several reasons:

Current Successes within Health Systems

Although no state Medicaid system has implemented hepatitis B testing measures, multiple health centers and health systems across the country have proven that implementing testing measures for hepatitis B services is practical, feasible, and actionable with proper guidance. North East Medical Services (NEMS), a federally qualified health center in California, and Cooperman Barnabas Medical Center, a large health system in New Jersey, are two examples of institutions that have successfully enacted widespread hepatitis B testing measures to increase testing rates for the hepatitis B triple panel test (HBsAg, HBsAb, HBcAb), identify new cases of hepatitis B, and link them to care. These groups demonstrate that the recommended evaluation measure can achieve exactly what is sought – even in health systems that differ from one another.

Low Viral Hepatitis Testing Rates in the U.S.

In the U.S., just 32% of people living with chronic hepatitis B are aware of their infection, and just 60% of infected individuals are aware that they are living with hepatitis C.[iv,v,vi] Unawareness of a person's viral hepatitis status can be contributed to the infections' lack of symptoms and to low uptake of testing in the U.S. Prior to the universal testing recommendations for hepatitis B and C, risk-based testing often resulted in underreporting of infections to as individuals were

required to share sensitive, stigmatizing information prior to being tested that they might not have been comfortable disclosing. Some risk-based questions, such as country of origin, were not standardly asked as a part of provider visits, which allowed even more people to miss the opportunity to be tested. Such issues have led to historical low rates and underreporting of viral hepatitis and have perpetuated myths that hepatitis B and C were not public health issues in the U.S. The recommended viral hepatitis measure alerts providers servicing the adult Medicaid population to the importance of testing their population regardless of risk and offers an opportunity to increase awareness of a person's viral hepatitis status.

Eliminating Viral Hepatitis in the U.S.

The United States Department of Health and Human Services (HHS) and the CDC have declared that viral hepatitis can be eliminated in the U.S. Both HHS' Viral Hepatitis National Strategic Plan and Viral Hepatitis Federal Implementation Plan list increased surveillance and tracking of viral hepatitis as core strategies to reaching elimination goals. The plans also list preventing new infections and improving viral-hepatitis-related health outcomes as necessary steps to eliminating viral hepatitis and preventing deaths. Testing for hepatitis B and C is the first step of these goals, as it identifies a person's viral hepatitis status and allows providers to link them to the proper care whether that is additional testing, management, treatment, or vaccination. The recommended measure also focuses on two higher risk groups – adults diagnosed with opioid use disorder and pregnant women – that HHS also note as key populations to address.[vii] Therefore, the Workgroup's recommendation strongly aligns with current efforts to eliminate viral hepatitis by federal agencies.

Widespread testing for hepatitis B and C and linking the individuals to the appropriate care is the best way to prevent the diseases' consequences, such as cirrhosis and liver cancer. The Workgroup's recommended addition of the *Evaluation of Hepatitis B and C* measure provides a critical opportunity for states to increase viral hepatitis testing and treatment while aligning with current federal recommendations and efforts.

We thank you again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review. Please do not hesitate to reach out to Michaela Jackson, Program Director, Prevention Policy, with any questions, or to request additional information.

Citations

[i] Conners EE, Panagiotakopoulos L, Hofmeister MG, et al. Screening and Testing for Hepatitis B Virus Infection: CDC Recommendations — United States, 2023. MMWR Recomm Rep 2023;72(No. RR-1):1–25. DOI: http://dx.doi.org/10.15585/mmwr.rr7201a1.

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[vii] U.S. Department of Health and Human Services. 2020. Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025). Washington, DC.

Hep Free Hawai'i (provided by Heather Lusk)

On behalf of Hep Free Hawai'i, I thank you for adding the Evaluation of Hepatitis B and C measure to the draft 2027 Adult Medicaid Core Set. The communities most impacted by hepatitis B rely on Medicaid for their healthcare, and the new measures will improve the quality of services they receive.

Hepatitis B and hepatitis C remain serious public health threats in the U.S., with more than 5 million people living with one of the viruses. Despite strong community-led efforts, progress in identifying new infections has been slow. Since 2020, the Centers for Disease Control and Prevention (CDC) has recognized that previous risk-based testing and vaccination strategies have not been fruitful, and have put forth recommendations to encourage all adults to get tested and vaccinated for hepatitis B, and tested for hepatitis C.[i,ii,iii] The success of these recommendations, however, requires extensive collaboration between public health workers, the federal government, the community, and providers.

Hep Free Hawai'i strongly supports the adoption of the Evaluation of Hepatitis B and C measure for several reasons:

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Although no state Medicaid system has implemented hepatitis B testing measures, multiple health centers and health systems across the country have proven that implementing testing measures for hepatitis B services is practical, feasible, and actionable with proper guidance. North East Medical Services (NEMS), a federally qualified health center in California, and Cooperman Barnabas Medical Center, a large health system in New Jersey, are two examples of institutions that have successfully enacted widespread hepatitis B testing measures to increase testing rates for the hepatitis B triple panel test (HBsAg, HBsAb, HBcAb), identify new cases of hepatitis B, and link them to care. These groups demonstrate that the recommended evaluation measure can achieve exactly what is sought – even in health systems that differ from one another.

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Mahalo again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review.

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[vi] National Center for Health Statistics. National Health and Nutrition Examination Survey Data. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. https://wwwn.cdc.gov/Nchs/Data/Nhanes/Public/2015/DataFiles/HEQ_I.htm.

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The Hepatitis B Coalition of Washington (provided by Mohammed Abdul-Kadir)

The Hepatitis B Coalition of Washington (HBCW) greatly appreciates the opportunity to provide public comment on the draft report adding the Evaluation of Hepatitis B and C measure to the 2027 Adult Medicaid Core Set. Many in the communities disparately impacted by hepatitis B rely on Medicaid for their healthcare, and the new measures will improve the quality of services they receive. We sincerely thank the Workgroup for recommending that this measure be added to the final 2027 Adult Core Set.

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HBCW strongly supports the adoption of the Evaluation of Hepatitis B and C measure for several reasons:

1. Monitoring and Improving Care Quality
    - Evaluation measures create benchmarks for providers and health systems to track:
        - Screening rates
        - Linkage to care
        - Treatment uptake
        - Cure rates (for Hep C) or viral suppression (for Hep B)
    - These benchmarks allow for targeted quality improvement initiatives.
2. Data-Driven Public Health Response
    - Standardized evaluation enables the collection of comparable, high-quality data across regions and populations.
    - Data informs policy, funding, and public health interventions.

Current Successes within Health Systems

Although no state Medicaid system has implemented hepatitis B testing measures, multiple health centers and health systems across the country have proven that implementing testing measures for hepatitis B services is practical, feasible, and actionable with proper guidance. North East Medical Services (NEMS), a federally qualified health center in California, and

Cooperman Barnabas Medical Center, a large health system in New Jersey, are two examples of institutions that have successfully enacted widespread hepatitis B testing measures to increase testing rates for the hepatitis B triple panel test (HBsAg, HBsAb, HBcAb), identify new cases of hepatitis B, and link them to care. These groups demonstrate that the recommended evaluation measure can achieve exactly what is sought – even in health systems that differ from one another.

Low Viral Hepatitis Testing Rates in the U.S.

In the U.S., just 32% of people living with chronic hepatitis B are aware of their infection, and just 60% of infected individuals are aware that they are living with hepatitis C.[iv,v,vi] Unawareness of a person's viral hepatitis status can be contributed to the infections' lack of symptoms and to low uptake of testing in the U.S. Prior to the universal testing recommendations for hepatitis B and C, risk-based testing often resulted in underreporting of infections to as individuals were required to share sensitive, stigmatizing information prior to being tested that they might not have been comfortable disclosing. Some risk-based questions, such as country of origin, were not standardly asked as a part of provider visits, which allowed even more people to miss the opportunity to be tested. Such issues have led to historical low rates and underreporting of viral hepatitis and have perpetuated myths that hepatitis B and C were not public health issues in the U.S. The recommended viral hepatitis measure alerts providers servicing the adult Medicaid population to the importance of testing their population regardless of risk and offers an opportunity to increase awareness of a person's viral hepatitis status.

Eliminating Viral Hepatitis in the U.S.

The United States Department of Health and Human Services (HHS) and the CDC have declared that viral hepatitis can be eliminated in the U.S. Both HHS' Viral Hepatitis National Strategic Plan and Viral Hepatitis Federal Implementation Plan list increased surveillance and tracking of viral hepatitis as core strategies to reaching elimination goals. The plans also list preventing new infections and improving viral-hepatitis-related health outcomes as necessary steps to eliminating viral hepatitis and preventing deaths. Testing for hepatitis B and C is the first step of these goals, as it identifies a person's viral hepatitis status and allows providers to link them to the proper care whether that is additional testing, management, treatment, or vaccination. The recommended measure also focuses on two higher risk groups – adults diagnosed with opioid use disorder and pregnant women – that HHS also note as key populations to address.[vii] Therefore, the Workgroup's recommendation strongly aligns with current efforts to eliminate viral hepatitis by federal agencies.

Widespread testing for hepatitis B and C and linking the individuals to the appropriate care is the best way to prevent the diseases' consequences, such as cirrhosis and liver cancer. The Workgroup's recommended addition of the Evaluation of Hepatitis B and C measure provides a critical opportunity for states to increase viral hepatitis testing and treatment while aligning with current federal recommendations and efforts.

HBCW thanks you again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review. Please do not hesitate to reach out to Mohammed Abdulkadir with any questions, or to request additional information.

Citations

[i] Conners EE, Panagiotakopoulos L, Hofmeister MG, et al. Screening and Testing for Hepatitis B Virus Infection: CDC Recommendations — United States, 2023. MMWR Recomm Rep 2023;72(No. RR-1):1–25. DOI: http://dx.doi.org/10.15585/mmwr.rr7201a1.

[ii] Sandul AL, Rapposelli K, Nyendak M, Kim M. Updated Recommendation for Universal Hepatitis B Vaccination in Adults Aged 19–59 Years — United States, 2024. MMWR Morb Mortal Wkly Rep 2024;73:1106. DOI: http://dx.doi.org/10.15585/mmwr.mm7348a3.

[iii] Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. CDC Recommendations for Hepatitis C Screening Among Adults — United States, 2020. MMWR Recomm Rep 2020;69(No. RR-2):1–17. DOI: http://dx.doi.org/10.15585/mmwr.rr6902a1.

[iv] Weinbaum CM, Williams I, Mast EE, et al.; CDC. Recommendations for identification and public health management of persons with chronic hepatitis B virus infection. MMWR Recomm Rep 2008;57(No. RR-8):1–20. PMID:18802412.

[v] U.S. Department of Health and Human Services. 2020. Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025). Washington, DC.

[vi] National Center for Health Statistics. National Health and Nutrition Examination Survey Data. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. https://wwwn.cdc.gov/Nchs/Data/Nhanes/Public/2015/DataFiles/HEQ_I.htm.

[vii] Ryerson AB, Schillie S, Barker LK, et al. Vital Signs: Newly reported acute and chronic hepatitis C cases – United States, 2009-2018. MMWR 2020; 69(14):399-404. doi:10.15585/mmwr.mm6914a2.

The Hepatitis B Foundation (provided by Michaela Jackson)

On behalf of the Hepatitis B Foundation, a national nonprofit organization dedicated to finding a cure and improving the quality of life for people affected by hepatitis B worldwide, we greatly appreciate the opportunity to provide public comment on the draft report adding the *Evaluation of Hepatitis B and C* measure to the 2027 Adult Medicaid Core Set. We sincerely thank the Workgroup for recommending that this measure be added to the final 2027 Adult Core Set.

Hepatitis B and hepatitis C remain serious public health threats in the U.S., with more than 5 million people living with one of the viruses. Despite strong community-led efforts, progress in identifying new infections has been slow. Since 2020, the Centers for Disease Control and Prevention (CDC) has recognized that previous risk-based testing and vaccination strategies have not been fruitful, and have put forth recommendations to encourage all adults to get tested and vaccinated for hepatitis B, and tested for hepatitis C.[i,ii,iii] The success of these recommendations, however, requires extensive collaboration between public health workers, the federal government, the community, and providers.

The Hepatitis B Foundation strongly supports the adoption of the Evaluation of Hepatitis B and C measure for several reasons:

Current Successes within Health Systems

Although no state Medicaid system has implemented hepatitis B testing measures, multiple health centers and health systems across the country have proven that implementing testing measures for hepatitis B services is practical, feasible, and actionable with proper guidance. North East Medical Services (NEMS), a federally qualified health center in California, and Cooperman Barnabas Medical Center, a large health system in New Jersey, are two examples of institutions that have successfully enacted widespread hepatitis B testing measures to increase testing rates for the hepatitis B triple panel test (HBsAg, HBsAb, HBcAb), identify new cases of hepatitis B, and link them to care. These groups demonstrate that the recommended evaluation measure can achieve exactly what is sought – even in health systems that differ from one another.

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hepatitis and have perpetuated myths that hepatitis B and C were not public health issues in the U.S. The recommended viral hepatitis measure alerts providers servicing the adult Medicaid population to the importance of testing their population regardless of risk and offers an opportunity to increase awareness of a person's viral hepatitis status.

Eliminating Viral Hepatitis in the U.S.

The United States Department of Health and Human Services (HHS) and the CDC have declared that viral hepatitis can be eliminated in the U.S. Both HHS' Viral Hepatitis National Strategic Plan and Viral Hepatitis Federal Implementation Plan list increased surveillance and tracking of viral hepatitis as core strategies to reaching elimination goals. The plans also list preventing new infections and improving viral-hepatitis-related health outcomes as necessary steps to eliminating viral hepatitis and preventing deaths. Testing for hepatitis B and C is the first step of these goals, as it identifies a person's viral hepatitis status and allows providers to link them to the proper care whether that is additional testing, management, treatment, or vaccination. The recommended measure also focuses on two higher risk groups – adults diagnosed with opioid use disorder and pregnant women – that HHS also note as key populations to address.[vii] Therefore, the Workgroup's recommendation strongly aligns with current efforts to eliminate viral hepatitis by federal agencies.

Widespread testing for hepatitis B and C and linking the individuals to the appropriate care is the best way to prevent the diseases' consequences, such as cirrhosis and liver cancer. The Workgroup's recommended addition of the *Evaluation of Hepatitis B and C* measure provides a critical opportunity for states to increase viral hepatitis testing and treatment while aligning with current federal recommendations and efforts.

We thank you again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review. Please do not hesitate to reach out to Michaela Jackson, Program Director, Prevention Policy with any questions, or to request additional information.

Citations

[i] Conners EE, Panagiotakopoulos L, Hofmeister MG, et al. Screening and Testing for Hepatitis B Virus Infection: CDC Recommendations — United States, 2023. MMWR Recomm Rep 2023;72(No. RR-1):1–25. DOI: http://dx.doi.org/10.15585/mmwr.rr7201a1.

[ii] Sandul AL, Rapposelli K, Nyendak M, Kim M. Updated Recommendation for Universal Hepatitis B Vaccination in Adults Aged 19–59 Years — United States, 2024. MMWR Morb Mortal Wkly Rep 2024;73:1106. DOI: http://dx.doi.org/10.15585/mmwr.mm7348a3.

[iii] Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. CDC Recommendations for Hepatitis C Screening Among Adults — United States, 2020. MMWR Recomm Rep 2020;69(No. RR-2):1–17. DOI: http://dx.doi.org/10.15585/mmwr.rr6902a1.

[iv] Weinbaum CM, Williams I, Mast EE, et al.; CDC. Recommendations for identification and public health management of persons with chronic hepatitis B virus infection. MMWR Recomm Rep 2008;57(No. RR-8):1–20. PMID:18802412.

[v] National Center for Health Statistics. National Health and Nutrition Examination Survey Data. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. https://wwwn.cdc.gov/Nchs/Data/Nhanes/Public/2015/DataFiles/HEQ_I.htm.

[vi] Ryerson AB, Schillie S, Barker LK, et al. Vital Signs: Newly reported acute and chronic hepatitis C cases – United States, 2009-2018. MMWR 2020; 69(14):399-404. doi:10.15585/mmwr.mm6914a2.

[vii] U.S. Department of Health and Human Services. 2020. Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025). Washington, DC.

Bethlyn Vergo Houlihan, MSW, MPH

The content in the middle bullet below ("Stratification of measures by population subgroups, including pregnant women, children and adolescents with disabilities, and adults with disabilities") is relevant to efforts in our work related to advancing access and care quality for children and youth with disabilities. Per page 19 Core Set Review Draft Report:

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

I have a strong interest in performance measurement for children and youth with disabilities and support this approach to tiering and stratification. This would allow the nation to use existing measures to be implemented but specifically linked to quality of care received by persons with disabilities. It allows us to begin performance measurement in the near term; I would also strongly recommend as a next step building upon this with the development of new measures that are specific to children and youth with complex, chronic conditions.

Amy Houtrow, MD, PhD, MPH

We need measuring/screening and then actual referral/follow-up/coordination around SDoH and adverse childhood experiences.

Consider the data on stratification.

National Alliance of State and Territorial AIDS Directors (NASTAD) (provided by Stephen Lee)

On behalf of NASTAD and our membership, I am writing to express strong support for the recommendation made by the 2027 Child and Adult Core Sets Annual Review Workgroup to add the "**Evaluation of Hepatitis B and C (EHBC)**" measure to the 2027 Medicaid Adult Core Set. We commend the Workgroup and CMS for considering this crucial measure.

NASTAD, the National Alliance of State and Territorial AIDS Directors, is a leading non-partisan non-profit association that represents state public health officials who administer HIV and hepatitis programs across the country.

The inclusion of the EHBC measure is a significant step forward in addressing the ongoing public health challenges posed by cases of hepatitis B (HBV) and hepatitis C (HCV) within the Medicaid population. As highlighted in the Workgroup's report and the measure's technical specifications, this measure aligns well with current national public health priorities and clinical guidelines, including those from the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC).

We support the addition of the EHBC measure for the following key reasons:

1. **Addresses a Critical Public Health Need:** Viral hepatitis, particularly HBV and HCV, represents a significant burden on public health, leading to serious liver disease, including cirrhosis and liver cancer, if undiagnosed and untreated. Medicaid beneficiaries often face a higher risk for these diseases and left untreated result in worsening health outcomes and substantially higher health care costs to Medicaid programs. The CMS Office of the Actuary (OACT) estimates that the cost per Medicaid beneficiary with hepatitis C was about $18,800, in 2021, which was approximately 180 percent higher than the cost of care for those without the infection.[i]
2. **Fills a Gap in the Medicaid Adult Core Set:** Currently, there is a gap in the Adult Core Set regarding the management of hepatitis. The EHBC measure directly addresses this gap, providing valuable data on state performance in combating these diseases, which are costly to Medicaid programs and detrimental to beneficiaries' health and wellbeing if they go undetected and untreated. Health care cost models estimate HCV direct-acting antivirals (curative therapies) generated a net savings to Medicaid of $9.8 billion in 2021 and will have generated over $43 billion in savings for their cumulative use in the program between 2023 and 2026.[ii]
3. **Aligns with Clinical Guidelines:** The proposed EHBC measure reflects current recommendations for universal HBV and HCV screening in adults and specific populations, as well as timely linkage to effective HCV treatment, promoting person-centered care and cure.

4. **Actionability for States:** The measure utilizes administrative data, making it feasible for state reporting. As noted by the Workgroup, testing in several states has demonstrated its viability and highlighted significant opportunities for improvement in testing, treatment and curative rates. This data empowers states to develop targeted quality improvement initiatives.
5. **Supports National Goals:** Adding this measure supports broader national efforts aimed at eliminating viral hepatitis as a public health threat.
6. **Promotes Targeted Population Health Management Interventions:** The measure's focus on populations at particularly high risk for viral hepatitis, including Americans are risk of overdose, individuals diagnosed with Opioid Use Disorder (OUD) and pregnant women, is critically important. These groups experience disproportionately higher rates of HBV and HCV. Including this measure will encourage targeted interventions at the state, health plan, and provider levels and help monitor progress in reducing gaps in screening and treatment access for these vulnerable populations.

We acknowledge the Workgroup's discussion regarding the feasibility of the postpartum HCV treatment component in states without extended postpartum coverage. However, with the majority of states having implemented 12-month postpartum coverage, we believe the measure remains highly relevant and its inclusion will further encourage comprehensive care during this critical period.

In conclusion, NASTAD and its membership strongly urge CMS to adopt the Workgroup's recommendation and finalize the addition of the Evaluation of Hepatitis B and C (EHBC) measure to the 2027 Medicaid Adult Core Set. This measure represents a vital tool for improving the health outcomes of millions of Medicaid beneficiaries by driving improvements in hepatitis B and C prevention, diagnosis, and care and cure.

Thank you for the opportunity to comment on this important matter. Please do not hesitate to contact us if you require further information.

Citations

[i] US Centers for Medicare and Medicaid Services. (2024, June 14). *Estimated impacts of proposed National Hepatitis C Elimination Program on Medicaid and Medicare*. https://www.cms.gov/files/document/estimated-impacts-proposed-national-hepatitis-c-elimination-program-medicaid-and-medicare.pdf.

[ii] Roebuck, M.C. (2024). *Impact of direct-acting antiviral use for chronic hepatitis C on health care costs in Medicaid: Economic model update*. *American Journal of Managed Care*, 28(12), 630–631. https://doi.org/10.37765/ajmc.2022.89273.

National Network for Oral Health Access (NNOHA) (provided by Ramona English and Cheryl Parker)

Background

NNOHA's Quality Committee & NNOHA's Executive Committee support the following positions:

- Measure Suggested for Addition: Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit.
- Measure Suggested for Addition: Adults with Diabetes – Oral Evaluation

Introduction

For over 30 years, NNOHA has provided technical assistance to safety-net oral health programs, reaching beyond its 5,400 members to over 19,000 oral health professionals across more than 1,100 health centers nationwide. In 2023 alone, NNOHA members cared for over 6 million patients across over 14 million dental visits, reflecting a continued commitment to increasing access to high quality oral health care for all. NNOHA's membership are leaders in implementing quality improvement science and delivering care in integrated systems; they are early adopters of dental best practices and are frequent participants in innovation projects. Through this work, we have seen the impact of integrated, preventive oral health strategies and the power of measurement in driving quality improvement.

NNOHA strongly supports the addition of the *Early Childhood Oral Evaluation by a Dental Provider Following a Medical Preventive Service Visit* and *Adults with Diabetes – Oral Evaluation* to the CMS Core set. These measures represent essential steps in improving oral health access, fostering medical-dental integration, and promoting whole-person health for all populations.

Actionability and Impact

Both measures have been rigorously tested for validity, reliability and feasibility and align with CMS priorities on medical-dental integration and preventive care. By adding these measures to the Core Set, CMS will:

- Improve early childhood oral health outcomes by leveraging medical visits to drive earlier dental care engagement
- Advance chronic disease management by promoting dental visits for adults with diabetes, which can support improved glycemic control and reduce long-term healthcare costs.
- Enhance access to preventive oral health care among Medicaid and CHIP beneficiaries.

- Provide states with actionable data to develop targeted interventions, like successful models in the states that participated in the measures testing.

Maintaining oral health as a key component of overall health is a critical public health goal. With the inclusion of these measures, the CMS Core Set Workgroup can ensure continued progress in addressing the medical-dental divide, a divide that hurts patients and increased the cost of care. We appreciate your consideration and remain committed to working collaboratively to advance evidence-based, integrated care models that improve health outcomes for children and adults nationwide.

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

This measure would be the first Child Core Set measure to explicitly support coordination between medical and dental systems. We know that dental caries is the most common chronic disease in children in the U.S., and untreated caries can result in serious complications, including pain, speech difficulties, and increased emergency department (ED) utilization. Research demonstrates that early dental visits significantly reduce treatment needs and improve long-term oral health outcomes.

Young children are far more likely to have a medical visit than a dental visit, making medical visits a key opportunity for connecting children to dental care. Among Medicaid-enrolled 1- to 2-year-olds in 2021, 79% had a medical visit, while only 26% had a dental visit.[i] The existing gap presents a clear opportunity for medical providers to facilitate earlier access to dental care, reducing the burden of untreated caries. NNOHA members that participated over the years in the Integration of Oral Health into Primary Care Practice Learning Collaboratives and Perinatal and Infant Oral Health Quality Improvement projects were able to increase the percentage of 1-2 year olds with a dental visit up to 60% through innovative initiatives such as same day medical dental visits for 0-3 year olds, embedded dental providers in medical practice, utilization of community health workers for outreach and care coordination, along with leveraging integrated electronic health systems to optimize referrals and scheduling.

The measure aligns with recommendations from the American Academy of Pediatrics, American Academy of Pediatric Dentistry, and the American Public Health Association, all of which emphasize the importance of dental visits by age one. The measure has undergone robust testing in six states, with performance rates ranging from 19% to 34%, highlighting the need for improvement and actionability.

With respect to workgroup members' concerns about a robust participating dental provider network available for referrals, the Washington state ABCD program and the San Francisco Dental Transformation Initiative have demonstrated promising practices to expanding Medicaid dental provider networks through incentives, care coordination support and training. It would be beneficial for similar programs to expand. This measure could catalyze expanded dental provider

networks further down the road along with improved patient outcomes and cost savings through upstream, preventive interventions.

Adults with Diabetes – Oral Evaluation

NNOHA supports the *Adults with Diabetes – Oral Evaluation* measure due to the bidirectional relationship between diabetes and oral health and the evidence that periodontal treatment improves glycemic control and reduces long term healthcare cost. Despite these well-established connections, 60% of adults with diabetes have a medical visit but no dental visit.[ii] Hundreds of NNOHA member health centers across multiple states participate each year in Learning Collaboratives. In 2020 NNOHA started offering the Integration of Diabetes and Oral Health (IDOH) Learning Collaborative and is currently on its 5th cohort. Multidisciplinary teams from more than 70 health centers have participated so far in this 9-month long collaborative looking at increasing dual medical dental care for patients with diabetes, timely A1c testing, self-management goal setting and increased patient and provider experience. Overall, the Learning Collaboratives have demonstrated improvements by up to 30% in the number of dual medical-dental patients with diabetes through provider education, electronic referrals, integrated scheduling, warm handoffs, point-of-care A1c testing in dental settings and case management efforts. The benefits of the Adults with Diabetes – Oral Evaluation measure go beyond increased access to dental care. Through the IDOH Collaboratives NNOHA learned that patients with diabetes also received safer dental care and benefited from improved patient – provider communication and self-management.

NNOHA surveys Learning Collaborative participants after each learning session and we would like to share a quote from a member at the completion of the program: “initially, there has to be a buy in and a change in mindset. I would encourage others coming behind us to look at those we serve through a holistic lens and to then begin to make changes within their organizations to treat the entire patient. This will look different in different places, but the initial change remains the same. That's the biggest take away that I've experienced.” Adding the Adults with Diabetes – Oral Evaluation measure to the Core is a great motivator for this work to continue to improve outcomes for patients with diabetes even in the context of limited adult Medicaid benefits in some states. (40 states have expanded Medicaid dental benefit for adults per DQA)

Citations

[i] Centers for Medicare and Medicaid Services. 2023. “Early and Periodic Screening, Diagnosis, & Treatment” Annual EPSDT Reporting Using the Form CMS-415, FY 2021 National Data. Accessed May 1, 2025.

[ii] Wei L, Griffin SO, Parker M, Thornton-Evans G. Dental health status, use, and insurance coverage among adults with chronic conditions: implications for medical-dental integration in the United States. J Am Dent Assoc. 2022;153(6):563–571. doi: 10.1016/j.adaj.2021.12.012.

North East Medical Services (provided by Amy Tang)

On behalf of North East Medical Services (NEMS), we greatly appreciate the opportunity to provide public comment on the draft report adding the Evaluation of Hepatitis B and C measure to the 2027 Adult Medicaid Core Set. NEMS is a Federally Qualified Health Center (FQHC) in the San Francisco Bay Area serving over 82,000 annually. Over 74% of our patients rely on Medicaid, and over 70% of our patients were born in areas where hepatitis B infection is endemic. Due to the increased risk that hepatitis B infection poses to our patients and community, NEMS has implemented various hepatitis B care management programs over the years. While there is significant potential to address hepatitis B and C in the primary care setting, guidance and support at the Medicaid level is crucial to scaling and sustaining these efforts. As such, we sincerely thank the Workgroup for recommending that this measure be added to the final 2027 Adult Core Set.

Hepatitis B and hepatitis C remain serious public health threats in the U.S., with more than 5 million people living with one of these viruses. Despite strong community-led efforts, progress in identifying new infections has been slow. Since 2020, the Centers for Disease Control and Prevention (CDC) has recognized that risk-based testing and vaccination strategies alone have been insufficient and has recommended that all adults get tested and vaccinated for hepatitis B, and tested for hepatitis C. However, achieving these recommendations requires strong collaboration between public health organizations, federal programs, providers, and the community.

NEMS strongly supports the adoption of the Evaluation of Hepatitis B and C measure for several reasons:

Over the past several years, NEMS has significantly expanded its hepatitis B prevention and care efforts. Since 2020, NEMS has implemented universal adult hepatitis B (HBV) and hepatitis C (HCV) screening across our clinics. Today, our adult hepatitis B surface antigen (HBsAg) screening rate is 86%, our hepatitis B triple panel screening rate (HBsAg, HBsAb, HBcAb) is 66%, and our hepatitis C antibody screening rate is over 70%. Through these efforts, we have identified and linked patients to appropriate care and treatment, helping to reduce the risk of liver cancer, cirrhosis, and other hepatitis-related complications in our community.

Our experience demonstrates that universal screening is both feasible and highly effective in the FQHC setting. However, these initiatives have largely depended on internal prioritization and grant support. Without broader systemic incentives, including formal Medicaid quality measures, it is challenging to ensure that universal hepatitis B and C testing is implemented consistently across all health systems. Medicaid-level guidance and requirements will be critical in driving widespread adoption, helping to address gaps in care, and ensuring that all patients — regardless of where they receive care — have equitable access to hepatitis screening, treatment, and vaccination.

Current Successes within Health Systems

Although no state Medicaid system has implemented hepatitis B testing measures, health centers like ours and other large systems such as Cooperman Barnabas Medical Center in New Jersey have proven that implementing widespread hepatitis B testing is practical, feasible, and results in real-world improvements. The addition of the Evaluation of hepatitis B and C measure to the Medicaid Core Set offers an opportunity to replicate these successes nationwide to achieve

Low Viral Hepatitis Testing Rates in the U.S.

In the U.S., only 32% of people living with chronic hepatitis B are aware of their infection, and just 60% of infected individuals are aware that they are living with hepatitis C. This gap largely results from historic reliance on risk-based screening, which can miss individuals who are unaware of their risk factors or unwilling to disclose stigmatizing information. The Evaluation of hepatitis B and C measure encourages universal testing by breaking down these barriers that hepatitis is a rare concern in the U.S. Prior to the universal testing recommendations for hepatitis B and C, risk-based testing also resulted in underreporting of infections. Some risk-based questions, such as country of origin, were not standardly asked as part of a provider visit, which allowed more people to miss the opportunity to be tested. Such issues have also contributed to historical low rates and underreporting of viral hepatitis. The recommended viral hepatitis measure alerts providers servicing the adult Medicaid population to the importance of testing their population regardless of risk and offers an opportunity to increase awareness of a person's viral hepatitis status.

Eliminating Viral Hepatitis in the U.S.

The U.S. Department of Health and Human Services (HHS) and the CDC have laid out national strategic plans for the elimination of viral hepatitis, with increased surveillance, testing, and treatment identified as core strategies. The recommended measures directly support these federal goals, particularly by focusing on key populations such as adults with opioid use disorder and pregnant individuals. As such, testing for hepatitis B and C is the first step of these goals, as it identifies a person's viral hepatitis status and allows providers to link them to the proper care whether that is additional testing, management, treatment, or vaccination. Therefore, the Workgroup's recommendation strongly aligns with current efforts to eliminate viral hepatitis issued by federal agencies.

Widespread testing and appropriate linkage to care are essential to prevent hepatitis B and C and the best way to prevent the diseases' consequences, such as cirrhosis and liver cancer. Adding the evaluation of hepatitis B and C measure to the Medicaid Adult Core Set will advance national and local efforts to eliminate viral hepatitis and protect the health of Medicaid beneficiaries. The Workgroup's recommended addition of the Evaluation of Hepatitis B and C measure provides a critical opportunity for states to increase viral hepatitis testing and treatment while aligning with current federal recommendations and efforts.

We thank you again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review. Please do not hesitate to reach out to Dr. Amy Tang with any questions, or to request additional information.

Pennsylvania Department of Human Services (provided by Bridget Gill-Gibson)

Thank you for allowing states the opportunity to review and comment on recommended changes to the upcoming FFY 2027 Child and Adult Core Set measures. We reviewed and **support** the three measures recommended for addition: *Evaluation of Hepatitis B and C, Initial Opioid Prescribing for Long Duration, and Adults with Diabetes—Oral Evaluation.*

Pennsylvania Department of Human Services, Office of Long-Term Living (provided by Jennifer Baumgardner)

The Pennsylvania Department of Human Services, Office of Long-Term Living (PA DHS/OLTL) would like to provide feedback on the draft report, ***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***. PA DHS/OLTL has reviewed the draft report and we would like to provide a public comment item. PA DHS/OLTL is continuing to see an increase in our 66 + population and we are advocating for an increased focus on older adults. There is a HEDIS measure called Care for Older Adults (COA). PA DHS/OLTL would like to recommend a COA measure for consideration for future Core Set measures. Within Exhibit 5, under Domain-Specific Gap Areas, Care of Acute and Chronic Conditions, the first bullet states "Care for clinical conditions affecting adults with disabilities (such as falls, urinary tract infections, or wounds)." This looks like an opportunity to highlight the older adult population. Tracking conditions such as falls, urinary tract infections, and wounds could provide important information related to quality of care. Other areas that could be covered under COA could include advanced care plans, medication reconciliation, and vaccines.

Thank you for this opportunity to provide feedback and we look forward to working with you in the future.

Robert G. Gish Consultants, LLC (provided by Robert Gish)

Thank you for the opportunity to provide public comment on the draft report adding the Evaluation of Hepatitis B and C measure to the 2027 Adult Medicaid Core Set.

My name is Robert G. Gish MD, and I have served as the Medical Director of the liver transplant program at the California Pacific Medical Center, UCSD, helped to start a liver transplant center at St. Joseph's Hospital and Medical Center in Phoenix, Arizona, and served over 35,000 patients at outreach clinics with Stanford University, CPMC and UCSD. I am currently the Medical Director of the Hepatitis B Foundation, a Physician at the La Maestra Community Health Centers in San Diego (an FQHC), an Adjunct Professor of Medicine at the University of Nevada Las Vegas School of Medicine, UCSD School of Pharmacy and Pharmaceutical Sciences, as well as a Professor of Medicine at Loma Linda University.

Many in the communities disparately impacted by hepatitis B rely on Medicaid for their healthcare, and the new measures will improve the quality of services they receive. We sincerely thank the Workgroup for recommending that this measure be added to the final 2027 Adult Core Set.

Hepatitis B and hepatitis C remain serious public health threats in the U.S., with more than 5 million people living with one of the viruses. Despite strong community-led efforts, progress in identifying new infections has been slow. Since 2020, the Centers for Disease Control and Prevention (CDC) has recognized that previous risk-based testing and vaccination strategies have not been fruitful, and have put forth recommendations to encourage all adults to get tested and vaccinated for hepatitis B, and tested for hepatitis C.[i,ii,iii] The success of these recommendations, however, requires extensive collaboration between public health workers, the federal government, the community, and providers.

I strongly support the adoption of the Evaluation of Hepatitis B and C measure for several reasons:

Current Successes within Health Systems

Although no state Medicaid system has implemented hepatitis B testing measures, multiple health centers and health systems across the country have proven that implementing testing measures for hepatitis B services is practical, feasible, and actionable with proper guidance. North East Medical Services (NEMS), a federally qualified health center in California, and Cooperman Barnabas Medical Center, a large health system in New Jersey, are two examples of institutions that have successfully enacted widespread hepatitis B testing measures to increase testing rates for the hepatitis B triple panel test (HBsAg, HBsAb, HBcAb), identify new cases of hepatitis B, and link them to care. These groups demonstrate that the recommended evaluation measure can achieve exactly what is sought – even in health systems that differ from one another.

Low Viral Hepatitis Testing Rates in the U.S.

In the U.S., just 32% of people living with chronic hepatitis B are aware of their infection, and just 60% of infected individuals are aware that they are living with hepatitis C.[iv,v,vi] Unawareness of a person's viral hepatitis status can be contributed to the infections' lack of symptoms and to low uptake of testing in the U.S. Prior to the universal testing recommendations for hepatitis B and C, risk-based testing often resulted in underreporting of infections to as individuals were required to share sensitive, stigmatizing information prior to being tested that they might not have been comfortable disclosing. Some risk-based questions, such as country of origin, were not standardly asked as a part of provider visits, which allowed even more people to miss the opportunity to be tested. Such issues have led to historical low rates and underreporting of viral hepatitis and have perpetuated myths that hepatitis B and C were not public health issues in the U.S. The recommended viral hepatitis measure alerts providers servicing the adult Medicaid population to the importance of testing their population regardless of risk and offers an opportunity to increase awareness of a person's viral hepatitis status.

Eliminating Viral Hepatitis in the U.S.

The United States Department of Health and Human Services (HHS) and the CDC have declared that viral hepatitis can be eliminated in the U.S. Both HHS' Viral Hepatitis National Strategic Plan and Viral Hepatitis Federal Implementation Plan list increased surveillance and tracking of viral hepatitis as core strategies to reaching elimination goals. The plans also list preventing new infections and improving viral-hepatitis-related health outcomes as necessary steps to eliminating viral hepatitis and preventing deaths. Testing for hepatitis B and C is the first step of these goals, as it identifies a person's viral hepatitis status and allows providers to link them to the proper care whether that is additional testing, management, treatment, or vaccination. The recommended measure also focuses on two higher risk groups – adults diagnosed with opioid use disorder and pregnant women – that HHS also note as key populations to address.[vii] Therefore, the Workgroup's recommendation strongly aligns with current efforts to eliminate viral hepatitis by federal agencies. Widespread testing for hepatitis B and C and linking the individuals to the appropriate care is the best way to prevent the diseases' consequences, such as cirrhosis and liver cancer. The Workgroup's recommended addition of the Evaluation of Hepatitis B and C measure provides a critical opportunity for states to increase viral hepatitis testing and treatment while aligning with current federal recommendations and efforts.

Thank you again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review.

Citations

[i] Conners EE, Panagiotakopoulos L, Hofmeister MG, et al. Screening and Testing for Hepatitis B Virus Infection: CDC Recommendations — United States, 2023. MMWR Recomm Rep 2023;72(No. RR-1):1–25. DOI: http://dx.doi.org/10.15585/mmwr.rr7201a1.

[ii] Sandul AL, Rapposelli K, Nyendak M, Kim M. Updated Recommendation for Universal Hepatitis B Vaccination in Adults Aged 19–59 Years — United States, 2024. MMWR Morb Mortal Wkly Rep 2024;73:1106. DOI: http://dx.doi.org/10.15585/mmwr.mm7348a3.

[iii] Schillie S, Wester C, Osborne M, Wesolowski L, Ryerson AB. CDC Recommendations for Hepatitis C Screening Among Adults — United States, 2020. MMWR Recomm Rep 2020;69(No. RR-2):1–17. DOI: http://dx.doi.org/10.15585/mmwr.rr6902a1.

[iv] Weinbaum CM, Williams I, Mast EE, et al.; CDC. Recommendations for identification and public health management of persons with chronic hepatitis B virus infection. MMWR Recomm Rep 2008;57(No. RR-8):1–20. PMID:18802412.

[v] U.S. Department of Health and Human Services. 2020. Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025). Washington, DC.

[vi] National Center for Health Statistics. National Health and Nutrition Examination Survey Data. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016. https://wwwn.cdc.gov/Nchs/Data/Nhanes/Public/2015/DataFiles/HEQ_I.htm.

[vii] Ryerson AB, Schillie S, Barker LK, et al. Vital Signs: Newly reported acute and chronic hepatitis C cases – United States, 2009-2018. MMWR 2020; 69(14):399-404. doi:10.15585/mmwr.mm6914a2.

San Francisco Hep B Free - Bay Area (provided by Richard So)

SF Hep B Free - Bay Area greatly appreciates the opportunity to provide public comment on the draft report adding the *Evaluation of Hepatitis B and C* measure to the 2027 Adult Medicaid Core Set. Many in the communities disparately impacted by hepatitis B rely on Medicaid for their healthcare, and the new measures will improve the quality of services they receive. We sincerely thank the Workgroup for recommending that this measure be added to the final 2027 Adult Core Set.

Hepatitis B and hepatitis C remain serious public health threats in the U.S., with more than 5 million people living with one of the viruses. Despite strong community-led efforts, progress in identifying new infections has been slow. Since 2020, the Centers for Disease Control and Prevention (CDC) has recognized that previous risk-based testing and vaccination strategies have not been fruitful, and have put forth recommendations to encourage all adults to get tested and vaccinated for hepatitis B, and tested for hepatitis C.[i,ii,iii] The success of these recommendations, however, requires extensive collaboration between public health workers, the federal government, the community, and providers.

SF Hep B Free – Bay Area strongly supports the adoption of the *Evaluation of Hepatitis B and C* measure for several reasons:

SF Hep B Free – Bay Area was founded in 2007 to increase awareness, screening, and linkage to care for hepatitis B in the San Francisco Bay Area. Since then, we have screened hundreds of thousands, educated millions, and become one of the premier hepatitis B advocacy organizations in the USA. Despite our success, hepatitis B is still significantly underdiagnosed using risk-based approaches, and universal screening in health systems is still not common. However, to my knowledge, the adoption of quality measures almost always leads to improved care on the measure that is being enacted. It almost always leads to improved standardization across health systems and improved data collection that allows for future analysis and improvement in care related to that measure. For hepatitis B, this will surely improve the surveillance and quality of the data collected, which will better inform policymakers at the health system and legislative levels to enact effective policies, often saving both lives and costs.

Current Successes within Health Systems

Although no state Medicaid system has implemented hepatitis B testing measures, multiple health centers and health systems across the country have proven that implementing testing measures for hepatitis B services is practical, feasible, and actionable with proper guidance. North East Medical Services (NEMS), a federally qualified health center in California, and Cooperman Barnabas Medical Center, a large health system in New Jersey, are two examples of institutions that have successfully enacted widespread hepatitis B testing measures to increase testing rates for the hepatitis B triple panel test (HBsAg, HBsAb, HBcAb), identify new cases of hepatitis B, and link them to care. These groups demonstrate that the recommended evaluation

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Widespread testing for hepatitis B and C and linking the individuals to the appropriate care is the best way to prevent the diseases' consequences, such as cirrhosis and liver cancer. The Workgroup's recommended addition of the *Evaluation of Hepatitis B and C* measure provides a critical opportunity for states to increase viral hepatitis testing and treatment while aligning with current federal recommendations and efforts.

We thank you again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review. Please do not hesitate to reach out to me with any questions, or to request additional information.

Citations

[i] Conners EE, Panagiotakopoulos L, Hofmeister MG, et al. Screening and Testing for Hepatitis B Virus Infection: CDC Recommendations — United States, 2023. MMWR Recomm Rep 2023;72(No. RR-1):1–25. DOI: http://dx.doi.org/10.15585/mmwr.rr7201a1.

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[iv] Weinbaum CM, Williams I, Mast EE, et al.; CDC. Recommendations for identification and public health management of persons with chronic hepatitis B virus infection. MMWR Recomm Rep 2008;57(No. RR-8):1–20. PMID:18802412.

[v] U.S. Department of Health and Human Services. 2020. Viral Hepatitis National Strategic Plan for the United States: A Roadmap to Elimination (2021–2025). Washington, DC.

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Nadine Shiroma

I appreciate the opportunity to provide public comment on the draft report adding the *c*. Many in the communities disparately impacted by hepatitis B virus (HBV) rely on Medicaid for their healthcare, and the new measures will improve the quality of services they receive. I thank the Workgroup for recommending that this measure be added to the final 2027 Adult Core Set.

Between 1981 -- when the first HBV vaccine was approved -- and 1994, the Centers for Disease Control and Prevention (CDC) incrementally recommended HBV vaccinations for youth and infants under 19 years and ONLY FOR ADULT PATIENTS IDENTIFIED BY THEIR PROVIDERS AS BEING "AT-RISK" FOR HBV infection. BUT FOR FORTY YEARS AFTER 1981, MOST INFECTED OR "AT-RISK" ADULTS WERE NOT IDENTIFIED, SCREENED OR VACCINATED. THIS ACCOUNTED FOR THE INCREASED NUMBERS OF ADULT CHRONIC HBV CASES AND HIGH-MORTALITY LIVER CANCER CASES CAUSED BY CHRONIC HBV AND/OR HEPATITIS (HCV) – another serious bloodborne virus that infects the liver and for which there is NO vaccine. HBV AND HCV ACCOUNT FOR 80% OF U.S. LIVER CANCER CASES, WHICH TRIPLED BETWEEN 1980 AND 2022.[i]

To understand why silent, chronic HBV infections have been under-diagnosed in the U.S. for so long, one must consider the lack of appropriate, broad based HBV public health education; the emergence of AIDS/HIV in the early 1980's and discovery of hepatitis C (HCV) in 1989; the millions of working poor who lacked health care insurance prior to passage of the Affordable Care Act; providers who were ill-equipped or simply failed to implement "at-risk" HBV preventive care; and the fact that 100% of the adults born before 1945, along with the very large U.S. baby boomer generation born between 1946 and 1964 and most of their children WERE EXCLUDED FROM the youth population for whom most school districts mandated HBV vaccinations.

The reality is that many students who were infected with HBV at birth or in early childhood were later vaccinated but not screened prior to entering school. And the same occurred for adults employed in "at-risk" environments after the vaccine was approved -- e.g., teachers, health care workers, police, firefighters. Sadly, some of these vaccinated-chronic-HBV- infected individuals have not learned of their HBV liver disease or liver cancer until organ damage was irreversible. This happened to my cousin's husband – a third-generation Asian American baby boomer with no family history of HBV, who broke down in despair on his death bed, because he would not live to witness the high school graduations of his five grandchildren – three of them born in the same year -- for whom he and his wife had provided daily infant and toddler care.

ANOTHER IMPORTANT REASON TO INCLUDE HEPATITIS B TESTING QUALITY MEASURES IN MEDICAID: Vaccination against hepatitis B <u>prior to</u> HBV infection is the only way to prevent hepatitis D (HDV) infection, an inflammation of the liver that requires HBV for its replication. HDV infection cannot occur in the absence of HBV infection, and HDV-HBV co-infection is considered the most severe form of chronic viral hepatitis due to more rapid

progression toward hepatocellular carcinoma and liver-related death.[ii] For those already living with HBV, the hepatitis B vaccine does NOT provide protection against hepatitis D.

Widespread testing for hepatitis B and C and linking individuals to appropriate care is the best way to prevent the worst disease consequences of both viruses. The Workgroup's recommended addition of the *Evaluation of Hepatitis B and C* measure provides a critical opportunity for states to increase viral hepatitis testing and treatment while aligning with current federal recommendations and efforts.

Thank you again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review.

Citations

[i] https://cancerblog.mayoclinic.org/2024/12/05/liver-cancer-rates-are-increasing-rapidly-mainly-due-to-liver-damage/#:~:text=While%20it's%20less%20common%20in,to%20the%20National%20Cancer%20Institute.

[ii] https://www.who.int/news-room/fact-sheets/detail/hepatitis-d#:~:text=Hepatitis%20D%20infection%20cannot%20occur,method%20to%20prevent%20HDV%20infection.

Society for Maternal-Fetal Medicine (provided by Brenna Hughes and Naima Joseph)

On behalf of the Society for Maternal-Fetal Medicine (SMFM), which represents more than 6,500 members dedicated to optimizing the health of pregnant women with high-risk pregnancies and their babies, we thank the Child and Adult Core Sets Workgroup and Mathematica for this opportunity to comment Medicaid and CHIP Quality Measures. We support the workgroup recommendation to add the evaluation of hepatitis B and C to the 2027 Core Set. The proposed addition of this measure will help to drive and ensure increased hepatitis testing and treatment rates in pregnant patients and other vital populations. Prioritizing testing and treatment can improve health outcomes by reducing risk for maternal-fetal transmission and long-term health consequences associated with hepatitis infection.

Perinatal and neonatal infection with hepatitis B and C is a recognized public health issue with serious, long-term health complications. With increased cases of viral hepatitis infection in pregnant women seen in the last decade, there are missed opportunities to perform risk-based screening, identify cases with urgency, provide timely treatment where appropriate, and prevent adverse maternal, fetal, and neonatal health outcomes. Continued gaps in perinatal hepatitis B screening, hepatitis C screening, and treatment for hepatitis C may compound an already growing public health problem and increase risk for maternal-fetal transmission of viral hepatitis. Adoption of this measure is a step forward in enhancing maternal and neonatal outcomes.

As obstetrician-gynecologists and maternal-fetal medicine subspecialists, we strongly support adoption of the Evaluation of Hepatitis B and C in the 2027 Core Set:

1. We support testing for hepatitis B and C for all pregnancies where there is no documentation or known history of previous screening
2. We support hepatitis B and C screening for all pregnant patients who are at risk for infection
3. We support linkage to postpartum care, such as close monitoring with a specialist, for pregnant patients whose screens are positive

SMFM and its members strongly urge the workgroup to adopt this recommendation to support pregnant women in Medicaid state programs. Implementation of the hepatitis B and hepatitis C measures would increase screening and treatment rates to close the gaps on missed opportunities for pregnant patients who would benefit from protection against infection and close postpartum care.

SMFM thanks you, the Child and Adult Core Sets Workgroup, and Mathematica, again, for your work on preparing this report and for the opportunity to provide public comment. Please direct questions to Lamiya Ahmed, Manager of Public Health Initiatives.

Stanford University School of Medicine, Asian Liver Center (provided by Samuel So)

My name is Dr. Samuel So, the director of the Asian Liver Center at Stanford University and Professor of Surgery. I am writing to strongly support the addition of the "Evaluation of Hepatitis B and C" Measure to the 2027 Adult Medicaid Core Set.

I would like to applaud the working group for including hepatitis B in the measure. Despite the successful infant hepatitis B immunization and adolescent catch-up immunization programs, US born and non-US born adults who did not receive the hepatitis B vaccine when they were infants are at risk of living with chronic hepatitis B infection. Among the estimated 700,000 to 2.4 million people living with chronic hepatitis in the United States, only 33-50% are aware of their infection. Approximately 75-80% are non-US born Black and Asian and Pacific Islander. Without long-term monitoring and suppressive antiviral therapy 15-25% of the people living with chronic hepatitis B will die of liver cirrhosis or hepatocellular carcinoma. According to CDC and OMH, Asian Americans are 9x and Black Americans are 2.5x more likely to die from hepatitis B than White Americans.

The Hepatitis B and C Measure is important to identify the gaps in CDC and ACIP recommended hepatitis B and C testing, and the care cascade of the chronically infected adults enrolled in Medicaid.

A study from our Center in collaboration with CDC found even among pregnant women with commercial health insurance who gave birth, 14.5% did not receive antenatal hepatitis B testing to prevent mother-to-child transmission.

The Hepatitis B and C Measure is consistent with the goal of the HHS Viral Hepatitis National Strategic Plan to eliminate viral hepatitis as a public health threat by 2030. And the vision that "the U.S. will be a place where new viral hepatitis infections are prevented, every person knows their status, and every person regardless of socioeconomic circumstance, race and ethnicity with viral hepatitis has high quality health care and treatment and lives free from stigma and discrimination."

Thank you for the opportunity to submit my comments in support of the Evaluation of Hepatitis B and C Measure.

Deja Taliaferro, MPH

My name is Deja Taliaferro, and I am happy to submit comments regarding changes in the 2027 Child and Adult Core Set. I am submitting these comments as an individual and not on behalf of any organization or entity.

Workgroup Recommendation 1: Workgroup recommends adding three new measures to the 2027 Core Sets:

Evaluation of Hepatitis B and C

Based on feedback from plans and providers, NC Medicaid believes we should be consolidating the Core Sets, rather than adding new measures each year. The Core Set already includes *Childhood Immunization Status (CIS) – Combo 10* and the *Adult Immunization Status (AIS)* measures, both of which include rates for the Hepatitis B vaccine. Even though this new measure assesses rates of Hepatitis B and C, not the vaccination rate, it still feels slightly redundant to have both in the Core Set. Additionally, due to the relatively small number of Medicaid beneficiaries across the country living with Hepatitis B or C, the measure does not feel broad reaching or impactful enough to be included in the Core Set.

Initial Opioid Prescribing for Long Duration

We know opioid prescribing patterns are central to the opioid epidemic and are important for states to track and analyze. However, if the Workgroup intends to add the *Initial Opioid Prescribing for Long Duration* measure, could they also consider removing another opioid related measure to decrease redundancy and plan/provider reporting burnout? Currently, the Core Set also includes the *Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)*, and the *Concurrent Use of Opioids and Benzodiazepines (COB-AD)* measure.

Adults with Diabetes – Oral Evaluation

NC Medicaid sees no need to add another measure related to oral health and diabetes, as the Core Set already includes measures related to both topics. The Core Set includes *Oral Evaluation (OEV), Topical Fluoride for Children (TFL-CH), Sealant Receipt on Permanent First Molars (SFM-CH), Oral Evaluation During Pregnancy (OEVP), Diabetes Short Term Complications Admissions Rate (PQI 01),* and *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications (SSD)*. To increase alignment and reduce burden, CMS should shorten the list of measures in the Core Set, not add to it. The Core Set is meant to help states focus quality improvement initiatives and prioritize certain measures. By adding three new measures this year, with no removals, we are adding to reporting burden and spreading out focus and investment instead of targeting it.

Texas Health and Human Services Commission (provided by Charles Spells)

Please find Texas's comments regarding the proposed 2027 Child and Adult Core Set measures:

1. Dually Eligible Members

We note there has been no discussion regarding the inclusion of dually eligible members in the 2027 Core Sets. The previous State Health Official (SHO) letter from December 2024 indicated that dually eligible members would be exempt through the 2026 Core Sets. We request clarification on whether this exemption will be extended through 2027. Texas has had challenges obtaining timely Medicare data for inclusion in Core Measure reporting. Additional years of exemption would be helpful as we continue to work towards this.

2. Hepatitis B and C Measure (Medicaid Outcomes Distributed Research Network - MODRN)

Texas was unable to locate measure specifications from MODRN for this proposed measure and, therefore, cannot adequately assess implementation feasibility. We respectfully request that complete measure specifications be provided when recommending any measure for inclusion in mandatory and/or voluntary reporting requirements.

3. Adults with Diabetes-Oral Evaluation (American Dental Association/Dental Quality Alliance)

Please note that dental services are not a covered benefit for adults in Texas Medicaid. Implementation of this measure would be problematic given the misalignment with our current covered benefits structure.

Treatment Action Group (provided by Elizabeth Lovinger)

Treatment Action Group (TAG) greatly appreciates the opportunity to provide public comment on the draft report adding the Evaluation of Hepatitis B and C measure to the 2027 Adult Medicaid Core Set. Many people in the communities we work are disparately impacted by hepatitis C, and rely on Medicaid for their healthcare, and the new measures will improve the quality of services they receive. We sincerely thank the Workgroup for recommending that this measure be added to the final 2027 Adult Core Set.

Hepatitis B and hepatitis C remain serious public health threats in the U.S., with more than 5 million people living with one of the viruses. Despite strong community-led efforts, progress in identifying new infections has been slow. Since 2020, the Centers for Disease Control and Prevention (CDC) has recognized that previous risk-based testing and vaccination strategies have not been fruitful, and have put forth recommendations to encourage all adults to get tested and vaccinated for hepatitis B, and tested for hepatitis C. The success of these recommendations, however, requires extensive collaboration between public health workers, the federal government, the community, and providers.

TAG strongly supports the adoption of the Evaluation of Hepatitis B and C measure because CMS and states use the Child and Adult Core Sets to monitor and improve the quality of care provided to Medicaid and CHIP beneficiaries at the national and state levels, and measure progress over time, and this helps states and their partners collect, report, and use the Core Set measures to drive improvement in Medicaid and CHIP.

Low Viral Hepatitis Testing and Treatment Rates in the U.S.

In the U.S., about 40% of people with hepatitis C are unaware of their status, and less than 1 in 3 people with health insurance get direct-acting antiviral (DAA) treatment for hepatitis C within a year of diagnosis.[i] Unawareness of a person's viral hepatitis status can be attributed to the asymptomatic nature of viral hepatitis for 1-2 decades and to low uptake of testing in the U.S. Prior to the universal testing recommendations for hepatitis B and C, risk-based testing often resulted in underreporting of infections as individuals were required to share sensitive and stigmatizing information —they might otherwise not be comfortable disclosing — prior to being tested. Some risk-based questions, such as country of origin, were not standardly asked as a part of provider visits, which allowed even more people to miss the opportunity to be tested. Such issues have led to historical low rates and underreporting of viral hepatitis and have perpetuated myths that hepatitis B and C were not public health issues in the U.S. The recommended viral hepatitis measure alerts providers servicing the adult Medicaid population to the importance of testing this population regardless of risk and offers an opportunity to increase awareness of a person's viral hepatitis status.

However, individual state-level sobriety requirements for treatment will significantly hinder the efficacy of testing. If an individual cannot access treatment due to ongoing substance use

disorder and drug use, they will have little incentive to access testing and will lose this important opportunity to engage with care. This will worsen epidemics of viral hepatitis for all people, including those who use drugs. Any perceived risk of reinfection is not sufficient cause to deny care; this logic would undermine all preventive care for infectious diseases. Furthermore, if successfully engaged in treatment and harm reduction interventions, people who use drugs can minimize their risk of reinfection. Therefore, we urge state Medicaid programs to eliminate sobriety requirements for treatment in order to maximize the efficacy of testing initiatives.

In addition, cumbersome requirements like genotype testing before treatment and viral load monitoring during treatment could be eliminated given that approved and available HCV treatments are pangenotypic and have efficacy rates of over 95%.

Following the recent approval of the first point-of-care (POC) hepatitis C virus RNA test in June 2024 , working with health facilities to assess the cost effectiveness of having this platform — and supporting facilities in purchasing the platform — as it enables the diagnosis of HCV during a single facility visit is key. This will ensure that people with confirmed HCV viremia are initiated on treatment in a timely manner and greatly reduce loss to follow-up.

Eliminating Viral Hepatitis in the U.S.

The United States Department of Health and Human Services (HHS) and the CDC have set goals for viral hepatitis elimination in the U.S. Both HHS' Viral Hepatitis National Strategic Plan and Viral Hepatitis Federal Implementation Plan list increased surveillance and tracking of viral hepatitis as core strategies to reaching elimination goals. The plans also list preventing new infections and improving viral-hepatitis-related health outcomes as necessary steps to eliminating viral hepatitis and preventing deaths. Testing for hepatitis B and C is the first step to meeting these goals, as it allows providers to link people to care whether that is additional testing, management, treatment, or vaccination. The recommended measure also focuses on two higher risk groups – adults diagnosed with opioid use disorder or people who inject drugs and pregnant women – that HHS also note as key populations to address. Therefore, the Workgroup's recommendation strongly aligns with current efforts to eliminate viral hepatitis by federal agencies.

This much-needed focus on testing during pregnancy draws attention to the dire need for research inclusive of pregnant and lactating populations. While we enthusiastically welcome the Workgroup's recommendation, we are concerned that a positive test result during pregnancy will leave pregnant patients with no real options for a treatment that has been studied and has demonstrated safety and efficacy. While the responsibility for addressing this issue primarily lies with developers and manufacturers to engage in post-marketing studies, we encourage Medicaid programs to collect anonymized observational data on treatment outcomes and adverse events related to treatment during pregnancy so as to inform the update treatment guidelines to hopefully include treatment during pregnancy and breastfeeding. Widespread testing for hepatitis B and C and linking the individuals to the appropriate care is the best way to prevent the

diseases' consequences, such as cirrhosis and liver cancer. The Workgroup's recommended addition of the Evaluation of Hepatitis B and C measure provides a critical opportunity for states to increase viral hepatitis testing and treatment while aligning with current federal recommendations and efforts.

We thank you again for the opportunity to comment on the draft report for the 2027 Child and Adult Core Sets Annual Review. Please do not hesitate to reach out with any questions, or to request additional information.

Citations

[i] Centers for Disease Control and Prevention. New CDC Vital Signs report finds that too few people diagnosed with hepatitis C are being treated, despite availability of medications capable of curing this viral infection. https://archive.cdc.gov/#/details?url=https://www.cdc.gov/media/releases/2022/s0809-hepatitis-treatment.html. August 2022.

ViiV Healthcare (provided by Kristen Tjaden)

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

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

Medicaid programs have a significant impact on people with HIV, so it is essential that they continue to address quality of care to improve outcomes for this population. ViiV appreciates the opportunity to comment on the Workgroup's recommendations for measure additions, removals, and gaps in the Core Sets. Specifically:

- ViiV encourages CMS to support initiatives that enhance state reporting capabilities of the HIV Viral Load Suppression (HVL) measure
- ViiV encourages the Workgroup to further consider how to close gaps in HIV prevention measurement

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

There is an opportunity to increase reporting of the HVL measure within state Medicaid programs. Only seventeen states reported on the HVL measure through the Medicaid Adult Core Measure Set in FY2023.[ii] Although the uptake of this measure has steadily increased since its implementation in the Core Set, including an increase in six states reporting the measure from 2022 to 2023, states continue to face barriers, particularly in obtaining data needed to calculate the measure. We are encouraged by the work of the National Alliance of State & Territorial AIDS Directors (NASTAD) to provide technical assistance[iii] as well as by the actions from the Centers for Medicaid and CHIP Services (CMCS) Technical Assistance and Analytic Support (TA/AS) Program to improve state capacity to report.[iv] However, ViiV urges CMS and the CMCS to continue to support similar efforts that create partnerships among Medicaid, other

federal agencies, and public health entities to help states gain access to laboratory data required to measure viral load suppression. Coordinated, high-quality care for people with HIV requires sophisticated data use and sharing capabilities between Medicaid agencies, surveillance divisions, and state health departments of HIV programs.

Organizations like CMS, the Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA) recognize that sharing clinical and health care utilization data between Medicaid and state health department HIV programs is an important first step in reporting HIV quality measures.[v] Data-sharing can support people who are not virally suppressed and help link them to care, enhance HIV quality measurement, and drive providers and health plans to make improvements across the HIV care continuum. Bolstering state reporting will allow for public reporting of state-level HVL measure performance, thus supporting greater transparency and accountability for state Medicaid programs in caring for people with HIV.

ViiV encourages the Workgroup to further consider how to close gaps in HIV prevention measurement. The use of HIV-related quality measures will promote standards of health care coverage that support adherence to current HIV clinical and federal guidelines.[vi] We echo discussions from Workgroup members, highlighting HIV measurement that addresses key aspects of the care continuum, from screening to engagement in care, as a prominent gap area in the Adult Core Set. Specifically, discussions related to the need for a "cascade of care" measure for HIV, that supports comprehensive care from prevention to treatment.

There are several quality measures used in federal reporting programs, such as the Merit-based Incentive Payment System (MIPS) program, to evaluate quality of care and outcomes across the HIV care continuum. Notably, the HIV Screening measure promotes early detection of HIV[vii], a critical step in prevention. However, there is a clear gap in measures that support engagements in care following screening, and the existing HIV Screening measure is currently misaligned with up-to-date clinical guidelines, recommending annual HIV screenings and routine follow-ups for individuals disproportionately affected by HIV. We agree with the Workgroup that there needs to be a greater focus on quality measures that promote ongoing HIV prevention and care in the Adult Core Set. ViiV continues to support HIV quality measure initiatives that improve accountability and transparency in HIV care at the state level and align with current standards of HIV care.

ViiV Healthcare appreciates CMS's and the Workgroup's consideration of these comments and applauds them for their commitment to improving health outcomes for individuals disproportionately impacted by HIV. We look forward to working with CMS, CMCS, and other stakeholders, to ensure Medicaid recipients have access to quality HIV care and prevention. Please feel free to contact Kristen Tjaden at ViiV Healthcare should you have any questions.

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