



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

Summary of a Workgroup Review of the 2028 Child and  
Adult Core Sets

Draft Report  
April 2026



# 2028 CHILD AND ADULT CORE SETS ANNUAL REVIEW WORKGROUP MEMBERS

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## 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
AMR-AD	Asthma Medication Ratio: Ages 19 to 64
AMR-CH	Asthma Medication Ratio: Ages 5 to 18
CAHPS®	Consumer Assessment of Healthcare Providers and Systems
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
CPT®	Current Procedural Terminology
ECDS	Electronic Clinical Data Systems
ED	Emergency department
GLP-1	Glucagon-like peptide-1
HCPCS	Healthcare Common Procedure Coding System
HEDIS®	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
LOINC	Logical Observation Identifiers Names and Codes
MSC-AD	Medical Assistance with Smoking and Tobacco Use Cessation
NCQA	National Committee for Quality Assurance
TA	Technical assistance
TA/AS	Technical assistance and analytic support

## Executive Summary

Medicaid and the Children’s Health Insurance Program (CHIP) provide health care coverage to more than 76 million people, including eligible children, pregnant women, low-income adults, older adults, and people with disabilities.<sup>1</sup> 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 areas for improvement, and develop and assess quality improvement initiatives. States are required to report all Child Core Set measures and all behavioral health measures on the Adult Core Set.<sup>2</sup>

The secretary of the U.S. Department of Health and Human Services must review and update the Child and Adult Core Sets each year.<sup>3</sup> 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 2028 Child and Adult Core Sets Annual Review Workgroup. The Workgroup included 28 members representing a wide array of affiliations, subject matter expertise, and quality measurement and improvement experience (see page ii for a list of Workgroup members).

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<sup>1</sup> The October 2025 Medicaid and CHIP Eligibility Operations and Enrollment Snapshot is available at <https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-oct2025.pdf>. Numbers reflect preliminary Medicaid and CHIP enrollment data for October 2025, as of January 30, 2026, as reported by 50 states and the District of Columbia.

<sup>2</sup> 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 is available at <https://www.federalregister.gov/documents/2023/08/31/2023-18669/medicaid-program-and-chip-mandatory-medicaid-and-childrens-health-insurance-program-chip-core-set>.

<sup>3</sup> The Children’s Health Insurance Program Reauthorization Act of 2009 requires annual updates to the Child Core Set. The Affordable Care Act requires annual updates to the Adult Core Set. The Child Core Set has undergone these annual reviews since January 2013 and the Adult Core Set since January 2014.

The Workgroup was charged with using established criteria to assess the existing Child and Adult Core Sets and recommend measures for removal or addition, with the goal of strengthening and improving the 2028 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. The measure assessment criteria support the adoption of measures that are feasible and viable for state-level reporting, can be acted on 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 2028 Child and Adult Core Sets Annual Review.

### Exhibit ES.1. Criteria for the Removal and Addition of Measures in the 2028 Child and Adult Core Sets

Criteria for Removal of Existing Measures
<b>Technical Feasibility</b>
<b>A1.</b> The measure is being retired by the measure steward and will no longer be updated or maintained.
<b>A2.</b> 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).
<b>A3.</b> 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).
<b>A4.</b> 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).
<b>Actionability</b>
<b>B1.</b> Measure performance for all populations is so high and unvarying that meaningful distinctions in improvements or performance can no longer be made.
<b>B2.</b> Improvement on the measure is outside the direct influence of Medicaid and CHIP programs or providers.
<b>B3.</b> The measure no longer aligns with current clinical guidance and/or positive health outcomes.
<b>B4.</b> 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).
<b>B5.</b> 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.)
<b>Other Considerations</b>
<b>C1.</b> 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.
<b>C2.</b> 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).
<b>C3.</b> Including the measure on the Core Sets results in substantial additional data collection burden for providers or Medicaid and CHIP beneficiaries.

Criteria for Removal of Existing Measures
<b>Other Considerations</b>
<b>C4.</b> Not all states may 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)
<b>A1.</b> 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). (Specifications must be provided as part of the submission.)
<b>A2.</b> 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. (Documentation is required as part of the submission.)
<b>A3.</b> 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).
<b>A4.</b> The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness).
<b>A5.</b> The measure aligns with current clinical guidance and/or positive health outcomes.
<b>A6.</b> The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
Actionability
<b>B1.</b> The measure would fill a priority gap in the Core Sets or would add value to the existing measures on the Core Sets.
<b>B2.</b> 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 or providers).
<b>B3.</b> The measure is able to be stratified by the required stratification categories included in the annual Core Sets guidance for the Medicaid and CHIP population. Considerations could include adequate sample and population sizes and available data in the required data source(s).
Other Considerations
<b>C1.</b> The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful state-level results, taking into account Medicaid and CHIP population sizes and demographics.
<b>C2.</b> The measure and measure specifications are aligned with those used in other CMS programs, where possible (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).
<b>C3.</b> Adding the measure to the Core Sets does not result in substantial additional data collection burden for providers or Medicaid and CHIP beneficiaries.
<b>C4.</b> 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.
<b>C5.</b> 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 3 and 4, 2026, to review two paired measures for removal and replacement as well as five other measures suggested for addition. The

seven measures were presented, discussed, and voted on, beginning with the two paired measures and then the five other 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 voting Workgroup members had to vote for removal or addition.

In summary, the Workgroup recommended adding four measures to the 2028 Child and Adult Core Sets: Follow-Up After Acute and Urgent Care Visits for Asthma, Tobacco Use Screening and Cessation Intervention, Social Need Screening and Intervention, and Adults’ Access to Preventive/Ambulatory Health Services (Exhibit ES.2). The Workgroup did not recommend removing any measures from the 2028 Core Sets. This report summarizes the Workgroup’s discussion related to these recommendations.

**Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2028 Child and Adult Core Sets**

Measure Name	Measure Steward
<b>Measures Recommended for Addition<sup>a</sup></b>	
Follow-Up After Acute and Urgent Care Visits for Asthma	National Committee for Quality Assurance
Tobacco Use Screening and Cessation Intervention	National Committee for Quality Assurance
Social Need Screening and Intervention	National Committee for Quality Assurance
Adults’ Access to Preventive/Ambulatory Health Services	National Committee for Quality Assurance

<sup>a</sup> CMS assigns new measures to a Core Set and domain as part of its annual updates.

To inform the 2029 public Call for Measures, the Workgroup discussed gap areas in the current Child and Adult Core Sets. The discussion had two parts. The Workgroup started with a targeted discussion about immunization measures that solicited feedback about (1) available metrics that incorporate person and family preferences or patient education related to vaccines and (2) considerations related to collecting and reporting information on person and family preferences and or patient education consistently and reliably.

Second, using a round-robin format, each Workgroup member shared a priority gap area. The Workgroup highlighted gaps across five current Core Set domains: Behavioral Health Care, Primary Care Access and Preventive Care, Maternal and Perinatal Health, Care of Acute and Chronic Conditions, and Experience of Care. Workgroup members also expressed interest in cross-cutting topics such as (1) increasing the use of electronic data and technology to produce outcome-oriented quality measures and (2) including a measure assessing the continuity and duration of Medicaid coverage for beneficiaries.

This report, which is being made available for public comment, summarizes the Workgroup’s review process, discussion, and recommendations. CMS will use the Workgroup’s recommendations, public comments, and additional input from CMS’s Quality Technical Advisory Group and federal liaisons to inform decisions about updates to the 2028 Child and Adult Core Sets. CMS expects to release the 2028 updates by the end of calendar year 2026.

Please submit public comments via email by **May 1, 2026, 8:00 p.m. ET** to [MACCoreSetReview@mathematica-mpr.com](mailto:MACCoreSetReview@mathematica-mpr.com) and include “2028 Child and Adult Core Sets Annual Review Public Comment” in the subject line.

## Introduction

Medicaid and the Children’s Health Insurance Program (CHIP) provide health care coverage to more than 76 million people, including eligible children, pregnant women, low-income adults, older adults, and people with disabilities.<sup>4</sup> This represents more than one in four people in the United States.<sup>5</sup> In 2024, Medicaid and CHIP represented the third-largest source of health insurance in the United States behind employer-sponsored coverage and Medicare.<sup>6</sup>

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.<sup>7</sup> CMS and states use the Child and Adult Core Set measures to monitor access to and quality of health care for Medicaid and CHIP beneficiaries, identify areas for improvement, 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.<sup>8</sup> 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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<sup>4</sup> The October 2025 Medicaid and CHIP Eligibility Operations and Enrollment Snapshot is available at <https://www.medicaid.gov/resources-for-states/downloads/eligib-oper-and-enrol-snap-oct2025.pdf>. Numbers reflect preliminary Medicaid and CHIP enrollment data for October 2025, as of January 30, 2025 as reported by 50 states and the District of Columbia.

<sup>5</sup> Based on (1) Medicaid.gov. “Monthly Medicaid & CHIP Application Eligibility Determination, and Enrollment Reports & Data.” Updated July 2025 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: 2020–2025—Estimates of the Total Resident Population and Resident Population Age 18 Years and Older for July 1, 2025 (Table SCPRC-EST2024-18+POP).”

<sup>6</sup> Bunch, Lisa N., and Halelujha Ketema. “Health Insurance Coverage in the United States: 2024—Figure 1.” Current Population Reports P60-288. U.S. Census Bureau, September 2025. <https://www.census.gov/library/publications/2025/demo/p60-288.html>.

<sup>7</sup> Social Security Act, 42 U.S.C., Section 1139A and 1139B. The Child and Adult Core Sets do not include measures of quality for long-term services and supports. The quality of long-term services and supports is captured by the Home and Community-Based Services Quality Measure Set.

<sup>8</sup> 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 representatives from state Medicaid agencies, 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 2028 Child and Adult Core Sets Annual Review Workgroup. The Workgroup included 28 members who represent a diverse array of affiliations, subject matter expertise, and experience with quality measurement and improvement (see page ii for a list of Workgroup members).

The Workgroup was charged with using established criteria to assess the existing Child and Adult Core Sets and recommending measures for removal or addition, with the goal of strengthening and improving the 2028 Core Sets.<sup>9</sup> Workgroup members discussed and voted on measures suggested by the public for removal from or addition to the Child and Adult Core Sets. The measure assessment criteria support the adoption of measures that are feasible and viable for state-level reporting, can be acted on by state Medicaid and CHIP programs, and represent states' 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 2028 Core Sets Annual Review process, summarizes the Workgroup's recommendations for improving the Core Sets, and specifies next steps for public comment on the draft report.

## Overview of the Child and Adult Core Sets

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) included several provisions designed to improve the quality of health care for children enrolled in Medicaid and CHIP. CHIPRA required the secretary of HHS to (1) 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) 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.

State reporting of the Child and Adult Core Set measures has increased over time, with 41 states reporting all measures on both the 2024 Child and Adult Core Sets. The 2024 reporting year was 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

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<sup>9</sup> More information about the Annual Review of the Child and Adult Core Sets is available at <https://www.mathematica.org/features/MACCORESETREVIEW>.

for state reporting).<sup>10</sup> State reporting of data for the 2025 Core Sets was due December 31, 2025; CMS is now reviewing those data. The 2027 Core Sets are the most recent Core Sets that have been announced by CMS.

## 2027 Child and Adult Core Sets

The 2027 Child Core Set includes 24 measures across six domains: (1) Primary Care Access and Preventive Care, (2) Maternal and Perinatal Health, (3) Care of Acute and Chronic Conditions, (4) Behavioral Health Care, (5) Dental and Oral Health Services, and (6) Experience of Care.<sup>11</sup> In all, 75 percent (18) of the measures on the 2027 Child Core Set fall into the Primary Care Access and Preventive Care, Maternal and Perinatal Health, and Behavioral Health Care domains (Exhibit 1). About 96 percent (23) of the measures can be calculated using administrative data. In addition, there are two provisional measures and three utilization measures for children that are voluntary for state reporting. The provisional and utilization measures are not considered part of the 2027 Core Set. [Appendix A](#) lists the 2027 Child Core Set measures, along with the provisional and utilization measures for children.

The 2027 Adult Core Set includes 33 measures across the same six domains used for the Child Core Set.<sup>12</sup> About 58 percent (19) of the measures fall into the Care of Acute and Chronic Conditions and Behavioral Health Care domains (Exhibit 1). About 97 percent (32) of the measures can be calculated using administrative data. There are also two provisional measures and one utilization measure for adults that are voluntary for state reporting. [Appendix A](#) lists the 2027 Adult Core Set measures, along with the provisional and utilization measures for adults.

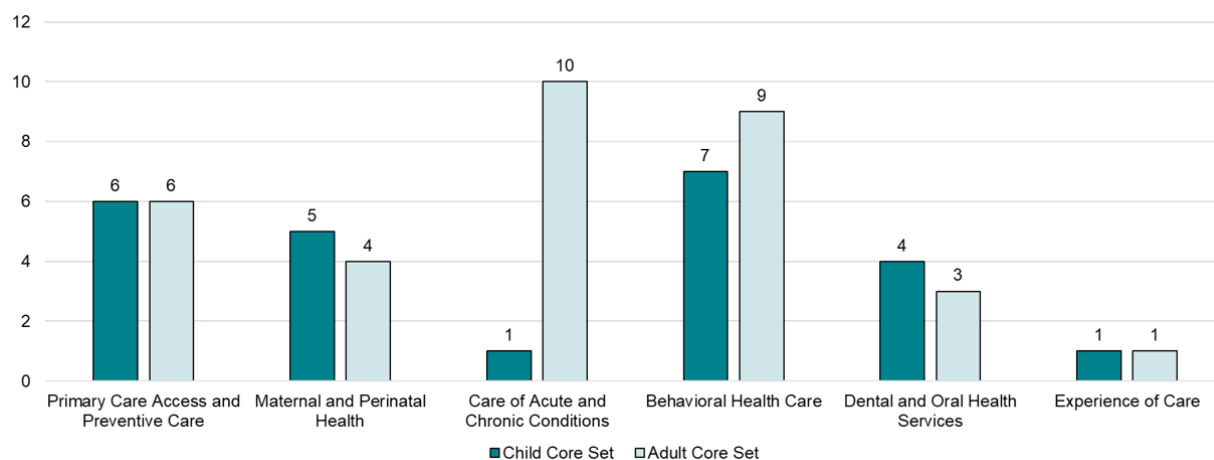
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<sup>10</sup> Bipartisan Budget Act of 2018, P.L. 115-123, and Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018, P.L. 115-271. On August 31, 2023, CMS released the Mandatory Medicaid and CHIP Core Set Reporting Final Rule (88 FR 60278), which describes the reporting requirements. More information is available at <https://www.federalregister.gov/documents/2023/08/31/2023-18669/medicaid-program-and-chip-mandatory-medicaid-and-childrens-health-insurance-program-chip-core-set>.

<sup>11</sup> 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>.

<sup>12</sup> More information about the Adult Core Set is available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html>.

## Exhibit 1. Distribution of 2027 Child and Adult Core Set Measures, by Domain



Note: For 2027, there are also two provisional measures and three utilization measures for children that are voluntary for state reporting. There are two provisional measures and one utilization measure for adults. The provisional and utilization measures are not considered part of the 2027 Core Sets, so they 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 performance over time. CMS publicly reports information about states' performance on the Child and Adult Core Sets through annual reporting products.<sup>13</sup> 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.<sup>14</sup>

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.<sup>15</sup> CMS has several goals for state reporting: maintaining or increasing the number of states that report the Core Set measures, maintaining or increasing the number of measures reported by each state, improving the quality and completeness of the data reported, and increasing state reporting of stratified data. CMS also explores opportunities to increase the efficiency of reporting and reduce states' reporting burden, streamline Core Set reporting for states, and improve the transparency and comparability of the data reported across states.

<sup>13</sup> An interactive data dashboard, 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>.

<sup>14</sup> More information about the Medicaid and CHIP Scorecard is available at <https://www.medicaid.gov/state-overviews/scorecard/index.html>.

<sup>15</sup> More information about the TA/AS program is available at <https://www.medicaid.gov/media/4691>.

## Description of the 2028 Child and Adult Core Sets Annual Review Process

This section describes the 2028 Child and Adult Core Sets Annual Review process, including the Workgroup composition, timeline, and meetings.

### Workgroup Composition

The Workgroup for the 2028 Child and Adult Core Sets Annual Review included 28 voting members from state Medicaid and CHIP programs, managed care plans, professional associations, universities, hospitals, health care providers, consumer groups, and other organizations across the country. The Workgroup members for the 2028 Annual Review are listed on page ii of this report. Mathematica held a public call for nominations between May 12, 2025, and June 6, 2025 to identify new members for the Workgroup.<sup>16</sup> Of the 28 voting members on the 2028 Workgroup, 11 were new members.

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 or organizational points of view. The Workgroup was charged with considering which measures would best drive improvement in care delivery and health outcomes for Medicaid and CHIP beneficiaries.

Mathematica required Workgroup members to submit a disclosure of interest form to report any interests, relationships, or circumstances over the past four years that could create a conflict of interest (or the appearance of one) related to the current Child and Adult Core Set measures or other measures reviewed during the Workgroup process. Mathematica reviewed the disclosures and did not identify any Workgroup members deemed to have an interest in a measure under consideration.<sup>17</sup>

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.

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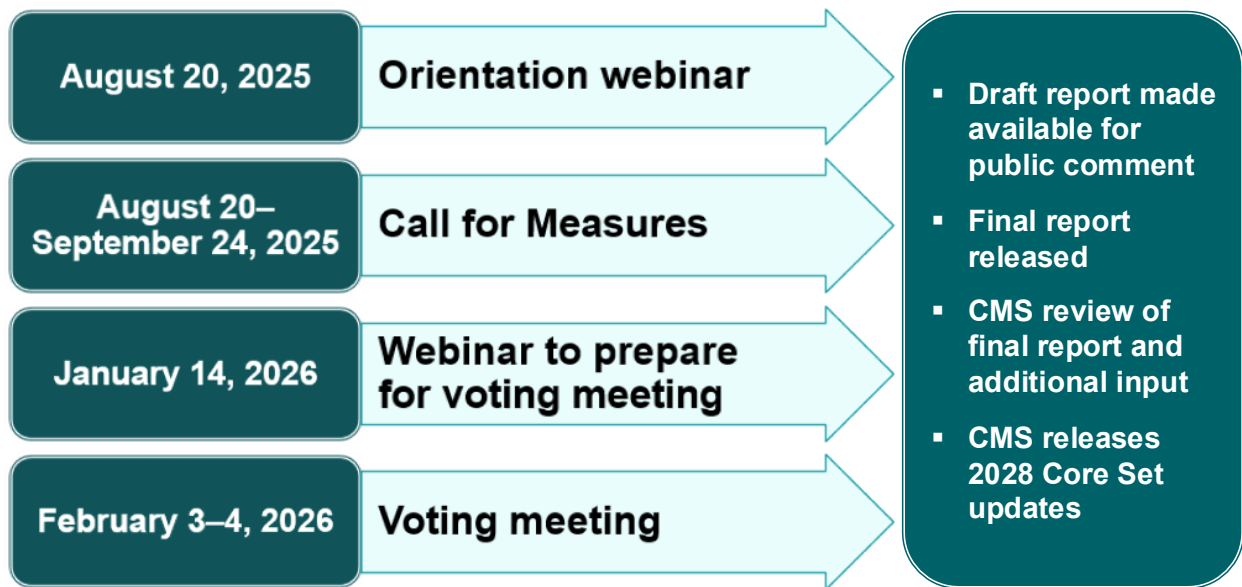
<sup>16</sup> Additional Workgroup members were identified through outreach to nominating organizations when former Workgroup members resigned during the review cycle because of career transitions.

<sup>17</sup> Workgroup members deemed to have an interest in a measure would be recused from voting on the measure.

## Workgroup Timeline and Meetings

Mathematica held virtual meetings via webinar in August 2025 and January 2026 to orient Workgroup members to the 2028 Child and Adult Core Sets Annual Review process and to prepare them for the voting meeting, which took place in February 2026 (Exhibit 2). All meetings were open to the public, with public comment encouraged during each meeting.

### Exhibit 2. Timeline for 2028 Child and Adult Core Sets Annual Review Workgroup



CMS = Centers for Medicare & Medicaid Services.

## Orientation Meeting

During the orientation meeting on August 20, 2025, Mathematica introduced the Workgroup members and described the disclosure-of-interest process, the Workgroup charge, and the timeline and process for the 2028 Annual Review. Next, Mathematica provided background on the Child and Adult Core Sets and summarized the recommendations from the 2027 Annual Review.

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 2028 Child and Adult Core Sets Annual Review's Call for Measures on those that are a good fit for the Core Sets, Mathematica presented the criteria for addition and removal in four areas.

The following is a high-level overview of the criteria.

Exhibit 3 on the following page contains the full list of the

criteria shared with the Workgroup and the public to guide the Call for Measures.

### **Workgroup Charge**

The Child and Adult Core Sets Workgroup for the 2028 Annual Review was charged with assessing the existing Core Sets and recommending measures for removal or addition to strengthen and improve the Core Sets for Medicaid and CHIP. The Workgroup should recommend measures that are actionable, feasible, and appropriate for state-level reporting to ensure the measures can meaningfully drive improvement in health care delivery and outcomes in Medicaid and CHIP.

- **Technical feasibility and appropriateness criteria.** Workgroup members and the public should consider the measure's technical feasibility and clinical appropriateness when suggesting the removal of an existing measure or the addition of a new measure. The specific criteria and requirements differ, however, 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 for the Workgroup to consider them. 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 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 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
<b>Technical Feasibility</b>
<b>A1.</b> The measure is being retired by the measure steward and will no longer be updated or maintained.
<b>A2.</b> 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).
<b>A3.</b> 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).
<b>A4.</b> 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).
<b>Actionability</b>
<b>B1.</b> Measure performance for all populations is so high and unvarying that meaningful distinctions in improvements or performance can no longer be made.
<b>B2.</b> Improvement on the measure is outside the direct influence of Medicaid and CHIP programs or providers.
<b>B3.</b> The measure no longer aligns with current clinical guidance and/or positive health outcomes.
<b>B4.</b> 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).
<b>B5.</b> 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.)
<b>Other Considerations</b>
<b>C1.</b> 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.

<b>Criteria for Removal of Existing Measures</b>
<b>C2.</b> 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).
<b>C3.</b> Including the measure on the Core Sets results in substantial additional data collection burden for providers or Medicaid and CHIP beneficiaries.
<b>C4.</b> Not all states may be able to produce the measure for all Medicaid and CHIP populations within two years of the measure being added to the Core Sets.
<b>Criteria for Addition of New Measures</b>
<b>Minimum Technical Feasibility and Appropriateness (ALL criteria must be met)</b>
<b>A1.</b> 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). (Specifications must be provided as part of the submission.)
<b>A2.</b> 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. (Documentation is required as part of the submission.)
<b>A3.</b> 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).
<b>A4.</b> The specifications and data source must allow for consistent calculations across states (e.g., coding and data completeness).
<b>A5.</b> The measure aligns with current clinical guidance and/or positive health outcomes.
<b>A6.</b> The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
<b>Actionability</b>
<b>B1.</b> The measure would fill a priority gap in the Core Sets or would add value to the existing measures on the Core Sets.
<b>B2.</b> 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 or providers).
<b>B3.</b> The measure is able to be stratified by the required stratification categories included in the annual Core Sets guidance for the Medicaid and CHIP population. Considerations could include adequate sample and population sizes and available data in the required data source(s).
<b>Other Considerations</b>
<b>C1.</b> The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful state-level results, taking into account Medicaid and CHIP population sizes and demographics.
<b>C2.</b> The measure and measure specifications are aligned with those used in other CMS programs, where possible (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).
<b>C3.</b> Adding the measure to the Core Sets does not result in substantial additional data collection burden for providers or Medicaid and CHIP beneficiaries.
<b>C4.</b> 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.
<b>C5.</b> 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.

## 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. Individuals 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 had to select one or more reasons for removal from a list and then explain their rationale. 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 form also asked submitters to assess whether removal of the measure would leave a gap in the Core Sets. This year, submitters were provided with the option to suggest a replacement measure for an existing Core Set measure using a single additions form. (Previously, submitters were required to submit two forms, one for the measure suggested for addition and another for the measure suggested for removal.) This change streamlined the submission process and allowed two measures to be “paired” and considered together during the review process.

The Call for Measures was open from August 20, 2025 to September 24, 2025. Workgroup members, federal liaisons, and members of the public suggested two paired measures for addition and removal as well as five other measures for addition. Mathematica conducted a preliminary assessment of the seven measures and determined that all the measures met the criteria for Workgroup review and discussion at the voting meeting.

## Meeting to Prepare for the 2028 Review

The second webinar took place on January 14, 2026, to prepare Workgroup members for the discussion at the 2028 Annual Review voting meeting. Mathematica shared a list of the seven measures submitted in the public call for measures. 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 Core Sets History Table, the Medicaid and CHIP data products page, the Core Set Resource Manuals and Technical Specifications, and a list of measure gaps previously discussed by the Workgroup.<sup>18</sup>

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<sup>18</sup> Most of these resources were also made available to the public in the 2028 Resources tab of the Child and Adult Core Sets Review website: <https://mathematica.org/features/MACCORESETREVIEW>.

Mathematica also shared the Medicaid and CHIP Core Set Data Dashboard, which shows detailed measure-specific information on state performance for publicly reported Core Set measures.<sup>19</sup> 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 seven measures.

### Meeting to Review Measures for the 2028 Child and Adult Core Sets

The voting meeting for the 2028 Child and Adult Core Sets Annual Review took place virtually on February 3 and 4, 2026. 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. CMS also provided brief welcome remarks to kick off the meeting on February 3 and provide context about the targeted gaps discussion on February 4.

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 then facilitated a discussion of the measures. Mathematica solicited comments and questions from Workgroup members about each measure and asked measure stewards to clarify measure specifications when needed. When applicable, Mathematica invited Workgroup members with experience using the suggested measure in state Medicaid or CHIP programs 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. 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

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<sup>19</sup> The Medicaid and CHIP Core Set Data Dashboard is available at <https://www.medicaid.gov/medicaid/quality-of-care/core-set-data-dashboard/welcome>.

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 2029 public Call for Measures. A summary of the discussion about those gap areas appears later in this report.

## Workgroup Recommendations for Improving the 2028 Child and Adult Core Sets

The Workgroup recommended adding four measures to the 2028 Child and Adult Core Sets: Follow-Up After Acute and Urgent Care Visits for Asthma, Tobacco Use Screening and Cessation Intervention, Social Need Screening and Intervention, and Adults’ Access to Preventive/Ambulatory Health Services (Exhibit 4). The Workgroup did not recommend removing any measures from the 2028 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 Mathematica’s Core Sets Review website.<sup>20</sup>

### Exhibit 4. Workgroup Recommendations for Updates to the 2028 Child and Adult Core Sets

Measure Name	Measure Steward
<b>Measures Recommended for Addition<sup>a</sup></b>	
Follow-Up After Acute and Urgent Care Visits for Asthma	National Committee for Quality Assurance
Tobacco Use Screening and Cessation Intervention	National Committee for Quality Assurance
Social Need Screening and Intervention	National Committee for Quality Assurance
Adults’ Access to Preventive/Ambulatory Health Services	National Committee for Quality Assurance

<sup>a</sup> CMS assigns new measures to a Core Set and domain as part of its annual updates.

### Measure Recommended for Addition: Follow-Up After Acute and Urgent Care Visits for Asthma

The Workgroup recommended adding the *Follow-Up After Acute and Urgent Care Visits for Asthma* measure, which assesses the percentage of persons ages 5 to 64 with an urgent care visit, acute inpatient discharge, observation stay discharge, or emergency department (ED) visit with a diagnosis of asthma that had a corresponding outpatient follow-up visit with a diagnosis of asthma within 30 days. The measure steward is the National Committee for Quality Assurance

<sup>20</sup> 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>.

(NCQA) and the measure uses the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) Electronic Clinical Data Systems (ECDS) data collection method. The measure is not currently in use by state Medicaid and CHIP programs, as it was only recently released in August 2025, but was tested using claims data from multiple state Medicaid agencies. The Workgroup recommended adding this measure to the Core Sets to address a gap related to the management of asthma following the measure steward's retirement of the *Asthma Medication Ratio: Ages 5 to 18* (AMR-CH) and *Ages 19 to 64* (AMR-AD) measure and its subsequent removal from the 2027 Child and Adult Core Sets.<sup>21</sup>

The individual who suggested the measure emphasized that adding the measure would address the gap in the Core Sets created by retiring the AMR-CH/AD measure. The individual highlighted that asthma is a serious chronic lung disease resulting in a combined 94,560 hospitalizations and 986,453 ED visits among U.S. children (younger than age 18) and adults (age 18 and older) in 2020.<sup>22</sup> The individual noted that research underscores the importance of care continuity and timely outpatient follow-up in preventing exacerbations among individuals with asthma. They explained that the measure is intended to incentivize health plans to ensure that beneficiaries receive appropriate outpatient care after an acute asthma episode and to help identify and address barriers to care continuity following an acute asthma episode.

Workgroup members expressed broad support for the feasibility of this measure. Despite this being a first-year measure, multiple Workgroup members representing state Medicaid and CHIP programs and external quality review organizations described plans to incorporate the measure into existing measure sets and performance incentive programs. One Workgroup member said that their organization has added the measure to their managed care monitoring set for measurement year 2026. Another Workgroup member said that their state Medicaid program plans to add this measure to their managed care Performance Incentive Plans and to their list of Advanced Primary Care Program quality measures. Another Workgroup member commented that the measure seems feasible to calculate using claims data and the ECDS methodology.

Workgroup members also endorsed the measure's value and potential impact within Medicaid and CHIP programs. Several Workgroup members noted the high prevalence of asthma among Medicaid and CHIP beneficiaries, particularly children, and emphasized the importance of maintaining quality monitoring in this area. One Workgroup member said that the measure's focus on follow-up demonstrates actionability because states may engage with their managed care plans to promote the importance of follow-up care for asthma with their providers. The testing results also indicate room for improvement on the measure. Another Workgroup member

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<sup>21</sup> CMS State Health Official letter (SHO #25-005) describes updates to the 2026 and 2027 Child and Adult Core Sets. More information is available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho25005.pdf>.

<sup>22</sup> <https://www.cdc.gov/asthma-data/about/most-recent-asthma-data.html>.

said that this measure could drive improvements in care that may ultimately reduce ED visits and hospitalizations.

Although several Workgroup members acknowledged the importance of filling the gap in asthma-related quality measurement, others commented on their limited experience with this measure because it is new. One Workgroup member expressed concern about the 30-day follow-up time frame, as their state program requires two-week follow-up for inpatient discharges. In addition, the Workgroup member said that they often do not receive notice from providers that follow-ups from urgent care visits have occurred, making it difficult to track this measure in real time. The Workgroup member also noted that other factors contributing to asthma flares, such as viral infections and environmental exposures, may not be fully addressed through follow-up visits alone. In response, another Workgroup member noted that although other factors may exacerbate a patient's asthma, assessing follow-up care after an acute episode can help ensure that the patient is educated on their condition and administered the correct medication.

During the public comment period, an individual supported the measure's addition to the Child and Adult Core Sets. They cited the substantial burden of asthma nationwide and emphasized the importance of timely follow-up care in improving asthma management. The commenter also reemphasized that the retirement of the AMR-CH/AD measure creates a gap in quality measurement related to asthma management and urged the Workgroup to adopt the measure to ensure continued oversight, particularly because of the higher prevalence of asthma among Medicaid beneficiaries compared to people who have private insurance.

## Measure Recommended for Addition: Tobacco Use Screening and Cessation Intervention

The Workgroup recommended adding the *Tobacco Use Screening and Cessation Intervention* measure, which assesses the percentage of persons 12 years of age and older who were screened for commercial tobacco product use at least once during the measurement period and who received tobacco cessation intervention if identified as a tobacco user. The measure has two rates: (1) tobacco use screening and (2) cessation intervention. The measure steward is NCQA, and the measure uses the HEDIS ECDS data collection method. The measure is not currently in use by state Medicaid and CHIP programs because it was only recently released for HEDIS measurement year 2026 but was tested in Medicaid using data from a California health plan. The Workgroup recommended adding this measure to the Core Sets to address a gap in tobacco-related quality measurement following the measure steward's retirement of the *Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)* measure and its subsequent removal from the 2027 Adult Core Set.<sup>23</sup>

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<sup>23</sup> CMS State Health Official letter (SHO #25-005) describes updates to the 2026 and 2027 Child and Adult Core Sets. More information is available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho25005.pdf>.

Two individuals suggested adding the measure, noting that tobacco use is a leading cause of preventable morbidity and mortality in the United States and that prevalence is higher among adults covered by Medicaid compared to adults with other types of coverage.<sup>24</sup> They stated that adding the measure would support universal screening and referral to cessation intervention and could help state Medicaid and CHIP programs identify populations not receiving screening or treatment as well as gaps in care such as lack of referrals to counseling or prescriptions for pharmacotherapy. They also indicated that the measure could be used to inform quality improvement initiatives and support use of evidence-based tobacco cessation methods.

During the Workgroup discussion, several Workgroup members focused on the feasibility considerations related to the Logical Observation Identifiers Names and Codes (LOINC) that are needed to determine whether a tobacco use screening occurred. Multiple Workgroup members noted that LOINC codes are not typically included on claims and that many states rely on claims data to calculate Core Set measures. They explained that, to report the measure, states may need to work directly with managed care organizations or fee-for-service providers to obtain supplemental clinical data, which would require additional administrative effort. Some Workgroup members expressed concern that states and managed care organizations may vary in their readiness to report the measure and that differences in data infrastructure could affect the reliability and comparability of rates, particularly in the early years of implementation. One Workgroup member observed that screening rates reported during testing appeared lower than expected and asked whether this reflected underreporting because of coding challenges or gaps in clinical practice. A representative from NCQA indicated that testing sites acknowledged potential underreporting and cited system-level factors, including workflow and documentation practices, that may have contributed to lower performance rates.

While acknowledging the feasibility challenges, several Workgroup members emphasized that the field is moving toward greater use of digital quality measures and that this transition is consistent with broader measurement strategies. One Workgroup member noted that digital quality measures are intended to reduce reliance on billing codes and may, over time, lessen documentation burden on providers. Another Workgroup member suggested that care management or health risk assessment databases that managed care organizations maintain could serve as alternate data sources for reporting the measure.

Multiple Workgroup members underscored the importance of measuring tobacco use screening and cessation intervention for the Medicaid and CHIP populations. Workgroup members cited increasing use of commercial nicotine products among adolescents and young adults and the absence of a tobacco-related measure on the 2027 Core Sets as reasons to prioritize this measure. Several Workgroup members stated that including the measure on the Core Sets could incentivize states and managed care plans to dedicate resources to the data mapping and

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<sup>24</sup> Cornelius ME, Loretan CG, Jamal A, et al. Tobacco Product Use Among Adults – United States, 2021. *MMWR Morb Mortal Wkly Rep.* 2023;72:475–483. doi: <http://dx.doi.org/10.15585/mmwr.mm7218a1>.

infrastructure required to accurately calculate the measure. Another Workgroup member noted that the measure could support population-level analysis of tobacco use and facilitate collaboration between Medicaid and CHIP agencies and cessation programs.

During the public comment period, multiple speakers expressed support for adding the measure to the Child and Adult Core Sets. Commenters emphasized the burden of tobacco-related disease, the higher prevalence of tobacco use among Medicaid beneficiaries compared with the general population, and the importance of early identification and treatment. Commenters also expressed appreciation that the measure includes adolescents and captures use of all commercial tobacco and nicotine products. One commenter described experience testing the measure in their state and highlighted its potential use for supporting proactive engagement with beneficiaries identified as using tobacco. Others emphasized that adoption of the measure could help prioritize tobacco cessation efforts within Medicaid programs and align with ongoing transitions to digital quality measurement.

### Measure Recommended for Addition: Social Need Screening and Intervention

The Workgroup recommended adding the *Social Need Screening and Intervention* measure, which assesses the percentage of persons of any age who were screened using prespecified instruments, or assessed by a provider, for unmet food, housing, and transportation needs at least once during the measurement period as well as the percentage who received a corresponding intervention within 30 days of a positive screen or identified need. The measure includes six reported rates: food screening, food intervention, housing screening, housing intervention, transportation screening, and transportation intervention. The measure steward is NCQA, and the measure uses the HEDIS® ECDS data collection method. The measure is currently in use by several state Medicaid and CHIP programs, including California, Georgia, Kentucky, New Jersey, New York, and Pennsylvania.

The individual who suggested the measure said it encourages systematic identification of unmet food, housing, and transportation needs and promotes timely follow-up by requiring interventions within a defined time frame. They stated that unmet social needs are closely linked to poorer disease control and referenced a National Alliance to Impact the Social Determinants of Health issue brief that highlights that Medicaid beneficiaries experience a high prevalence of unmet social needs that contribute to worse health outcomes and elevated utilization and costs.<sup>25</sup>

Workgroup members who commented on the measure generally acknowledged the importance of addressing health-related social needs and supported tracking screening and intervention activities. Several Workgroup members expressed support for adding the measure, stating that social needs are significant drivers of health outcomes. Some Workgroup members noted that the

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<sup>25</sup> [https://nasdoh.org/wp-content/uploads/2021/10/10-21-NASDOH-Medicaid-and-Social-Needs-Issue-Brief\\_FINAL.pdf](https://nasdoh.org/wp-content/uploads/2021/10/10-21-NASDOH-Medicaid-and-Social-Needs-Issue-Brief_FINAL.pdf).

measure could help elevate attention to unmet needs at the system level and encourage development of infrastructure to support screening and referral processes.

Workgroup members with experience reporting the measure described it as feasible and noted progress over time as managed care plans and providers become more familiar with coding requirements and data collection processes. However, several Workgroup members cited ongoing feasibility and operational considerations, including the need for reliable data capture using LOINC to identify screenings, as well as efforts to ensure consistent documentation across providers and plans.

Several Workgroup members raised concerns about the intervention rates in the measure. Some noted that counting referral or education as an intervention may not ensure that identified needs are fully addressed. They noted that documentation of a referral or inclusion of information in after-visit materials may not necessarily result in successful connection to services. Others described variability in the availability of community-based organizations and resources, particularly in areas in which services may be limited or frequently changing, which can make it challenging to ensure that referrals lead to meaningful assistance.

In response to these concerns, other Workgroup members noted that referral and discussion of identified needs can represent a meaningful and appropriate first step in addressing social needs particularly in cases where there are limitations in community capacity and available services. One Workgroup member said that establishing a standard expectation for screening and follow-up—even if follow-up begins with referral—may promote further system development and collaboration over time. Several Workgroup members emphasized that the measure could support broader efforts to build coordinated resource networks and strengthen partnerships between health plans, providers, and community-based organizations.

A few Workgroup members cited potential challenges related to measure implementation. Two noted that some screening tools included in the specifications are proprietary and may have associated costs for state Medicaid agencies. Another was concerned that the measure could be used to penalize individual physicians and practices if it is tied to payment arrangements.

During the public comment period, one commenter from a state Medicaid agency expressed support for adding the *Social Need Screening and Intervention* measure to the Core Sets but cautioned that their state may have difficulties with the measure because they require their managed care plans to use a state-standardized screening tool that does not align with the instruments specified in the measure.

## Measure Recommended for Addition: Adults' Access to Preventive/Ambulatory Health Services

The Workgroup recommended adding the *Adults' Access to Preventive or Ambulatory Health Services* measure, which assesses the percentage of persons 20 years of age and older who had an ambulatory or preventive care visit during the measurement period. The measure steward is

NCQA, and the data collection method is administrative. NCQA is aware of six states that are currently using the measure in Medicaid or CHIP: New Hampshire, South Carolina, Tennessee, Texas, Virginia, and Washington.

The individual who suggested the measure noted that preventive and ambulatory health services are critical to individual and community health and emphasized the role of health plans in ensuring access to care. They indicated that individuals who do not receive preventive health care are at greater risk of advanced or preventable disease, often leading to higher personal and financial costs. They cited research demonstrating that clinical preventive services delivered in ambulatory settings reduce illness and mortality<sup>26</sup> and that primary care visits increase the likelihood that patients receive recommended preventive services.<sup>27</sup> The individual who suggested the measure also asserted that the broadness of the measure would be helpful for state reporting, contrasting it with condition-specific Adult Core Set measures with smaller denominators such as *Colorectal Cancer Screening* and *Chlamydia Screening: Ages 21 to 24*.

During the Workgroup discussion, Workgroup members from several states shared their experience using the measure in Medicaid and noted that it is feasible for state reporting. One Workgroup member said that their state removed the measure from its accountability set to reduce reporting burden and that the change was not because of feasibility concerns. Another Workgroup member described the measure as helpful in assessing how many adults are accessing primary care ambulatory services. Another Workgroup member said their state publicly reports the measure and reviews it alongside emergency room visit measures.

Beyond feasibility, several Workgroup members emphasized the importance of a measure focused on adult primary care access. One Workgroup member stated that preventive visits create opportunities to deliver and reinforce recommended services such as cancer screenings and support early identification and management of chronic conditions, which are more prevalent among Medicaid beneficiaries. Another Workgroup member noted that the measure may help states identify access gaps for Medicaid beneficiaries by highlighting regions with limited primary care provider networks.

Although the measure received broad support from the Workgroup, a few Workgroup members expressed concerns about the actionability of the measure. One Workgroup member commented that performance rates in their state are consistently high because of the broad variety of visits that qualify for the numerator and expressed concern that the measure may have limited room for improvement. Another Workgroup member requested clarification about the types of visits included in the numerator, specifically whether visits with specialty providers are included.

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<sup>26</sup> Silverstein MD, Ogola G, Mercer Q, Fong J, Devol E, Couch CE, Ballard DJ. Impact of clinical preventive services in the ambulatory setting. *Proc (Bayl Univ Med Cent)*. 2008 Jul;21(3):227-35. doi: 10.1080/08998280.2008.11928400.

<sup>27</sup> Hostetter J, Schwarz N, Klug M, Wynne J, Basson MD. Primary care visits increase utilization of evidence-based preventative health measures. *BMC Fam Pract*. 2020 Jul;21(1):151. doi: 10.1186/s12875-020-01216-8.

NCQA confirmed that the numerator focuses primarily on ambulatory or preventive care visits, more specifically office visits related to primary care and telehealth visits. Visits with specialists such as obstetricians/gynecologists or cardiologists could satisfy this measure, but provider type must be identified using the value sets included in the measure specifications. NCQA is not currently able to stratify the measure by provider specialty, though states may be able to conduct additional analyses using their own data.

During public comment, an individual supported the measure's addition, saying that although the measure is broad and may not isolate primary care visits, it provides a useful overall indicator of access to ambulatory services and creates continuity with the Child Core Set measure that focuses on well-child visits. The commenter also agreed with the measure submitter that the measure would be a useful complement to the preventive care measures currently on the Adult Core Set that focus on specific screenings and interventions.

## **Workgroup Discussion of Gaps in Child and Adult Core Sets**

During the 2028 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 2029 Core Sets. The Workgroup discussion included targeted feedback to CMS to inform the development of new immunization measures along with a broader conversation about other priority gap areas in the Child and Adult Core Sets. Mathematica and CMS invited members of the Health Home Core Sets Annual Review Workgroup and representatives from other state Medicaid and CHIP programs who attended the meeting to contribute to the discussion around immunization measures. The discussion of other priority gap areas was limited to members of the Child and Adult Core Sets Annual Review Workgroup, followed by a public comment period.

The reflections that follow provide a foundation for developing the 2029 Call for Measures and inform longer-term planning for the Core Sets, including highlighting potential areas for measure development and refinement.

## **Feedback to Inform Development of New Immunization Measures**

In the State Health Official letter announcing updates to the 2026 and 2027 Child and Adult Core Sets, CMS removed four pediatric and prenatal immunization measures from the Core Sets and stated that it would “explore options to facilitate the development of new vaccine measures that capture information about whether parents and families were informed about vaccine choices, vaccine safety and side effects, and alternate vaccine schedules.”<sup>28</sup> CMS also announced plans to

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<sup>28</sup> CMS State Health Official letter (SHO #25-005) describes updates to the 2026 and 2027 Child and Adult Core Sets. More information is available at <https://www.medicaid.gov/federal-policy-guidance/downloads/sho25005.pdf>.

engage stakeholders to inform the development of measures that reflect person and family vaccine preferences.

As part of this effort, CMS asked the Workgroup to discuss their experiences with alternate vaccine measures and potential data sources. CMS leadership opened the discussion by outlining the types of information it seeks to better understand and potentially measure, including the content of vaccine-related patient-provider encounters (e.g., information shared), how these discussions are documented in the clinical record, and what would be required to develop measures capturing person and family vaccine preferences.

Several Workgroup members suggested using surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>), to capture patient-reported experiences with vaccine counseling or education. They noted that self-reporting through surveys may be more feasible than reviewing medical records or electronic health records for assessing whether information was shared and how families perceived those discussions. However, one Workgroup member raised concerns about historically low CAHPS response rates and emphasized the need to improve participation if CAHPS were used for this purpose.

Workgroup members also described existing documentation practices related to vaccine encounters. Beyond capturing counseling and preferences, Workgroup members discussed the value of tracking state-level vaccination rates and collecting information on reasons for declining vaccines. They suggested that understanding why individuals decline vaccines could complement information about person and family preferences. They noted that medical records commonly include documentation of vaccine discussions, such as signed forms indicating vaccine receipt or refusal. A state Medicaid representative shared that their state collects religious and medical exemption forms, which could be a data source for measure development. Another Workgroup member said that, in their state, vaccine exemptions are issued by county health departments rather than individual providers; using these data would reduce provider burden but would require data linkages for measurement.

Workgroup members further noted that vaccine education is embedded in routine clinical practice, including provision of Vaccine Information Statements and other educational materials. One Workgroup member said that they believe that states participating in the Vaccines for Children program may collect data related to safety monitoring of vaccines, vaccine administration, and informed consent that could serve as an additional data source.

Several Workgroup members and other representatives from state Medicaid programs discussed the potential to use existing billing codes to capture vaccine counseling. They referenced Healthcare Common Procedure Coding System (HCPCS) code G0312 (immunization counseling when no vaccine is administered) along with other codes related to vaccine counseling and

administration.<sup>29</sup> These codes could support development of a counseling-focused vaccine measure using claims data.

Across data sources, Workgroup members noted limitations of currently available data for developing measures that account for person and family preferences. They emphasized variation in documentation practices and billing code use across states and providers. In some states, vaccine counseling codes are reimbursed separately; in others, they are incorporated into preventive visits or reimbursed only in conjunction with vaccine administration. One Workgroup member cautioned that inconsistent coding could limit measure reliability until billing and documentation practices are more consistent and complete. At the same time, several Workgroup members stressed the importance of minimizing additional administrative burden on providers when designing new measures.

## Other Priority Gap Areas

During the discussion of other priority gap areas in the Core Sets, Mathematica asked each Workgroup member to mention one gap area they think is a priority to address or to endorse a gap area mentioned by another Workgroup member. Exhibit 5 synthesizes the gaps mentioned during the discussion, organized by Core Sets domain, and shows 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.

### Exhibit 5. Synthesis of Workgroup Discussion About Gap Areas for the Public Call for Measures for the 2029 Child and Adult Core Sets

Domain-Specific Gap Areas
<b>Behavioral Health Care</b>
<ul style="list-style-type: none"><li>• Access to mental health services, especially during the perinatal period and for individuals with disabilities</li><li>• Child mental health safety, including psychotropic medication oversight and use of seclusion and restraints in inpatient settings</li><li>• Impact of behavioral health conditions on physical health outcomes</li><li>• Medication management for individuals with substance use disorders</li><li>• Screen time and its impact on youth mental health</li><li>• Screening and treatment for anxiety, suicide risk, loneliness, and isolation</li></ul>

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<sup>29</sup> Representatives from state Medicaid programs provided the following additional codes related to vaccine administration and counseling during and after the meeting: (1) Current Procedural Terminology (CPT®) codes 90460-90461: for pediatric patients, used when counseling is provided and the vaccine is administered; (2) CPT codes 90482-90484: stand-alone immunization counseling codes used when recommended vaccines are declined or postponed; (3) CPT modifier 25: preventive medicine visit modifier appended to Evaluation and Management codes to indicate that extensive vaccine counseling was provided as a separately identifiable service provided; (4) HCPCS G0310-G0315: standalone immunization counseling by a physician or other qualified health professional; and (5) International Classification of Diseases, 10th Revision Z71.85: diagnosis code for “Encounter for immunization safety counseling.”

Domain-Specific Gap Areas
<b>Primary Care Access and Preventive Care</b>
<ul style="list-style-type: none"> <li>• Access to primary care</li> <li>• Assessing food insecurity and healthy food access to inform nutritional interventions</li> <li>• Assessing provision of preventive and lifestyle-based health care</li> <li>• Screening and counseling around nutrition and physical activity</li> <li>• Comprehensive vaccine access and uptake measures that account for counseling</li> </ul>
<b>Maternal and Perinatal Health</b>
<ul style="list-style-type: none"> <li>• Care for high-risk pregnancies, including case management, access to specialists, and remote blood pressure monitoring</li> <li>• Content and timing of prenatal and postpartum visits, including receipt of recommended screenings and immunizations</li> <li>• Continuity of coverage across the perinatal period</li> <li>• Interbirth intervals and factors that could impact health outcomes during subsequent pregnancies</li> <li>• Maternal morbidity and mortality</li> <li>• Medication-assisted treatment for substance use disorders during pregnancy</li> </ul>
<b>Care of Acute and Chronic Conditions</b>
<ul style="list-style-type: none"> <li>• Allergy management in children and adults</li> <li>• Chronic disease management, including distribution of continuous glucose monitors and home blood pressure cuffs for adults with diabetes or hypertension</li> <li>• Continuous glucose monitor access and disparities in pediatric populations</li> <li>• Gynecologic conditions in older women (for example, menopause, osteoporosis, urinary incontinence)</li> <li>• Interventions for high body mass index other than counseling, including weight management programs, GLP-1 medications, and other evidence-based strategies</li> <li>• Management of chronic pain</li> </ul>
<b>Experience of Care</b>
<ul style="list-style-type: none"> <li>• Patient-centered outcomes in terms of physical activity, nutrition, and chronic pain</li> <li>• Person-centered goal attainment for the general adult population</li> </ul>
Cross-Cutting Gap Areas
<ul style="list-style-type: none"> <li>• Adverse childhood experiences screening and follow-up</li> <li>• Care coordination and support for people with intellectual and developmental disabilities and medical complexity</li> <li>• Continuity and duration of Medicaid coverage, including monitoring effects of coverage gaps on denominator sizes for Core Set measures</li> <li>• Financial strain in accessing health care</li> <li>• Increased use of electronic data and technology to produce outcome-oriented quality measures and to assess the clinical validity of the care provided</li> <li>• Outcomes of social need screenings, including repeat screenings, closed-loop referrals, and links to case management</li> <li>• Quality and safety oversight of artificial intelligence in care delivery</li> </ul>

GLP-1 = Glucagon-like peptide-1. GLP-1 medications are a class of medications that help manage blood sugar levels in people with Type 2 diabetes. Some GLP-1 medications can also help treat obesity.

## Next Steps

The 2028 Child and Adult Core Sets Annual Review Workgroup recommended adding four measures to the Child and Adult Core Sets. Two of these measures reflect opportunities to address gaps created by the retirement of existing Core Set measures related to asthma and tobacco use disorder, both highly prevalent conditions among the Medicaid and CHIP populations. The remaining measures recommended for addition by the Workgroup reflect a new focus on wellness and prevention measures (in alignment with HHS priorities) and a continued commitment to measure and assess the factors that may contribute to a beneficiary's health outcomes. The Workgroup also provided feedback to inform the development of new immunization measures and suggested domain-specific and cross-cutting gap areas to be considered for the 2029 public Call for Measures.

The 2028 Child and Adult Core Sets Annual Review took place against the backdrop of an increasing number of digital quality measures in the Core Sets and other quality measurement programs. The Workgroup discussions revealed that although the feasibility of reporting measures remains an important consideration, Workgroup members are becoming more confident in states' and health plans' ability to report measures that incorporate non-claims digital data sources.

This report, which is being made available for public comment, summarizes the Workgroup's review process, discussion, and recommendations. CMS will use the Workgroup's recommendations, public comments, and additional input from CMS's Quality Technical Advisory Group and federal liaisons to inform decisions about updates to the 2028 Child and Adult Core Sets. CMS expects to release the 2028 updates by the end of 2026. Please submit public comments via email by **May 1, 2026, 8:00 p.m. ET** to [MACCoreSetReview@mathematica-mpr.com](mailto:MACCoreSetReview@mathematica-mpr.com). Include "2028 Child and Adult Core Sets Annual Review Public Comment" in the subject line.

**Appendix A.**  
**Child and Adult Core Set Measures**

**Exhibit A.1. 2027 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) - Mandatory Child Core Set Measures**

CMIT # <sup>a</sup>	Measure Steward	Measure Name	Data Collection Method
<b>Behavioral Health Care</b>			
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
<b>Primary Care Access and Preventive Care</b>			
760	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	Administrative, hybrid, or EHR
128	NCQA	Chlamydia Screening: Ages 16 to 20 (CHL-CH)	Administrative or EHR
761	NCQA	Well-Child Visits in the First 30 Months of Life (W30-CH)	Administrative
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)	ECDS
<b>Maternal and Perinatal Health</b>			
413	CDC/NCHS	Live Births Weighing Less Than 2,500 Grams (LBW-CH) <sup>b</sup>	State vital records
581	NCQA	Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)	Administrative or hybrid
166	OPA	Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	Administrative
1002	OPA	Contraceptive Care – All Women Ages 15 to 20 (CCW-CH)	Administrative
508	CDC/NCHS	Low-Risk Cesarean Delivery: Under Age 20 (LRCD-CH) <sup>b</sup>	State vital records
<b>Care of Acute and Chronic Conditions</b>			
84	NCQA	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years (AAB-CH)	Administrative
<b>Dental and Oral Health Services</b>			
897	DQA (ADA)	Oral Evaluation, Dental Services (OEV-CH)	Administrative
1672	DQA (ADA)	Topical Fluoride for Children (TFL-CH)	Administrative

Exhibit A.1 (continued)

CMIT # <sup>a</sup>	Measure Steward	Measure Name	Data Collection Method
830	DQA (ADA)	Sealant Receipt on Permanent First Molars (SFM-CH)	Administrative
1783	DQA (ADA)	Oral Evaluation During Pregnancy: Ages 15 to 20 (OEV-CH)	Administrative
<b>Experience of Care</b>			
151 <sup>c</sup>	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 2027 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/compilation-of-annual-updates-child-and-adult-core-health-care-quality-measurement-sets>. 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.

<sup>a</sup> 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>.

<sup>b</sup> This measure is calculated by CMS on behalf of states.

<sup>c</sup> 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. 2027 Child Provisional Measures (Voluntary for 2027 Reporting)**

CMIT # <sup>a</sup>	Measure Steward	Measure Name	Data Collection Method
1781	NCQA	Postpartum Depression Screening and Follow-Up: Under Age 21 (PDS-CH)	ECDS
1851	NCQA	Prenatal Depression Screening and Follow-Up: Under Age 21 (PND-CH)	ECDS

More information on Updates to the 2027 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/compilation-of-annual-updates-child-and-adult-core-health-care-quality-measurement-sets>. 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>.

<sup>a</sup> 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>.

CHIP = Children's Health Insurance Program; 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. 2027 Child Utilization Measures (Voluntary for 2027 Reporting)**

CMIT # <sup>a</sup>	Measure Steward	Measure Name	Data Collection Method
124	NCQA	Childhood Immunization Status (CIS-CH) <sup>b</sup>	ECDS or EHR
363	NCQA	Immunizations for Adolescents (IMA-CH) <sup>b</sup>	ECDS
1782	NCQA	Prenatal Immunization Status: Under Age 21 (PRS-CH) <sup>b</sup>	ECDS

More information on Updates to the 2027 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/compilation-of-annual-updates-child-and-adult-core-health-care-quality-measurement-sets>. 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>.

<sup>a</sup> 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>.

<sup>b</sup> These measures were removed from the 2026 Child Core Set. Although not part of the Child Core Set, states may voluntarily report on the results of these three utilization measures to CMS to allow CMS to maintain a longitudinal dataset.

CHIP = Children's Health Insurance Program; CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; ECDS = Electronic Clinical Data Systems; NCQA = National Committee for Quality Assurance.

**Exhibit A.4. 2027 Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set) - Mandatory Adult Core Set Measures**

CMIT # <sup>a</sup>	Measure Steward	Measure Name	Data Collection Method
<b>Behavioral Health Care</b>			
394	NCQA	Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	Administrative or EHR
672	CMS	Screening for Depression and Follow-Up Plan: Age 18 and Older(CDF-AD)	Administrative or EHR
268	NCQA	Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD)	Administrative
202	NCQA	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	Administrative
196	NCQA	Diabetes Care for People with Serious Mental Illness: 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 <sup>b</sup>	NCQA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD)	Administrative

More information on Updates to the 2027 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/compilation-of-annual-updates-child-and-adult-core-health-care-quality-measurement-sets>. 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.

<sup>a</sup> 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>.

<sup>b</sup> 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.5. 2027 Voluntary Adult Core Set Measures

CMIT # <sup>a</sup>	Measure Steward	Measure Name	Data Collection Method
<b>Primary Care Access and Preventive Care</b>			
118	NCQA	Cervical Cancer Screening (CCS-AD)	ECDS or EHR
128	NCQA	Chlamydia Screening: 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
1852	MODRN	Evaluation of Hepatitis B and C (EHBC-AD) <sup>b</sup>	Administrative
<b>Maternal and Perinatal Health</b>			
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) <sup>c</sup>	State vital records
<b>Care of Acute and Chronic Conditions</b>			
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
325	HRSA	HIV Viral Load Suppression (HVL-AD)	Administrative or EHR
150	PQA	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	Administrative
<b>Dental and Oral Health Services</b>			
1783	DQA (ADA)	Oral Evaluation During Pregnancy: Ages 21 to 44 (OEV-AD)	Administrative
1784	DQA (ADA)	Ambulatory Care Sensitive Emergency Department Visits for Non-Traumatic Dental Conditions in Adults (EDV-AD)	Administrative
1850	DQA (ADA)	Adults with Diabetes – Oral Evaluation (DOE-AD) <sup>b</sup>	Administrative

Exhibit A.5 (continued)

CMIT # <sup>a</sup>	Measure Steward	Measure Name	Data Collection Method
<b>Experience of Care</b>			
152 <sup>d</sup>	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 2027 Child and Adult Core Health Care Quality Measurement Sets is available at <https://www.medicare.gov/medicare/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/compilation-of-annual-updates-child-and-adult-core-health-care-quality-measurement-sets>. A resource that provides a history of the measures included in the Child and Adult Core Sets is available at <https://www.medicare.gov/medicare/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.

<sup>a</sup> 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>.

<sup>b</sup> This measure was added to the 2027 Adult Core Set.

<sup>c</sup> This measure is calculated by CMS on behalf of states.

<sup>d</sup> 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; MODRN = Medicaid Outcomes Distributed Research Network's Data Coordinating Center at the University of Pittsburgh; NCQA = National Committee for Quality Assurance; OPA = U.S. Office of Population Affairs; PQA = Pharmacy Quality Alliance.

## Exhibit A.6. 2027 Adult Provisional Measures (Voluntary for 2027 Reporting)

CMIT # <sup>a</sup>	Measure Steward	Measure Name	Data Collection Method
1781	NCQA	Postpartum Depression Screening and Follow-Up: Age 21 and Older (PDS-AD)	ECDS
1851	NCQA	Prenatal Depression Screening and Follow-Up: Age 21 and Older (PND-AD)	ECDS

More information on Updates to the 2027 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/compilation-of-annual-updates-child-and-adult-core-health-care-quality-measurement-sets>. 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>.

<sup>a</sup> 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.7. 2027 Adult Utilization Measure (Voluntary for 2027 Reporting)

CMIT # <sup>a</sup>	Measure Steward	Measure Name	Data Collection Method
1782	NCQA	Prenatal Immunization Status: Age 21 and Older (PRS-AD) <sup>b</sup>	ECDS

More information on Updates to the 2027 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/compilation-of-annual-updates-child-and-adult-core-health-care-quality-measurement-sets>. 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>.

<sup>a</sup> 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>.

<sup>b</sup> This measure was removed from the 2026 Adult Core Set. Although not part of the Adult Core Set, states may voluntarily report on the results of this utilization measure to CMS to allow CMS to maintain a longitudinal dataset.

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 2028 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 2028 Child and Adult Core Sets. The discussion took place during the Workgroup voting meeting on February 3 and 4, 2026. The summary is organized into two sections: the paired measures considered for removal and replacement, followed by the one other measure considered and not recommended for addition, *Measuring the Value-Functions of Primary Care: Continuity of Care*.

## Paired Antibiotic Measures

Through the Call for Measures, an individual suggested removing 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 from the Child and Adult Core Sets. This individual suggested replacing the measure with the *Antibiotic Utilization for Respiratory Conditions* measure.

Workgroup members discussed the paired antibiotic measures and then voted separately on each measure suggestion. The Workgroup did not recommend removing AAB-CH or AAB-AD from either Core Set, nor did it recommend adding the proposed replacement measure.

AAB-CH/AD assesses the percentage of episodes with a diagnosis of acute bronchitis/bronchiolitis that did not result in an antibiotic dispensing event for beneficiaries ages 3 months to 17 years (on the Child Core Set) and for beneficiaries age 18 and older (on the Adult Core Set). This measure is reported as an inverted rate. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (that is, the proportion of episodes that did not result in an antibiotic dispensing event). The suggested replacement measure, *Antibiotic Utilization for Respiratory Conditions*, assesses the percentage of episodes for persons three months and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. The measure steward advises organizations to use this measure for internal evaluation only, as it does not view higher or lower service counts as indicating better or worse performance. For both measures, the measure steward is the National Committee for Quality Assurance, and the data collection method is administrative.

The individual who suggested replacing the AAB-CH/AD measure with the *Antibiotic Utilization for Respiratory Conditions* measure said the replacement measure includes a wider spectrum of acute respiratory conditions, reducing reliance on precise diagnostic coding and instead captures overall antibiotic prescribing patterns. They noted that the broader denominator would make the measure less susceptible to natural, random variation, facilitating the identification of prescribing variability and outliers among clinicians. They concluded that the suggested measure could have a greater impact on reducing unnecessary antibiotic use compared with the AAB-CH/AD measure, which targets individual conditions in which antibiotics are rarely appropriate. The suggested measure is currently in use by several state Medicaid and Children's Health Insurance Program (CHIP) agencies, including in Louisiana, New Hampshire, and New York.

During the discussion, multiple Workgroup members voiced support for removing the AAB-CH/AD measure from the Core Sets, saying this measure might have reached a performance ceiling and no longer provides actionable data states can use to drive quality improvement.

Although some Workgroup members liked the potential of the *Antibiotic Utilization for Respiratory Conditions* measure due to its broader scope, there was general concern about the measure's usefulness, interpretability, and actionability at the state and health-plan levels. Workgroup members suggested that state-level reporting of the measure would not, by itself, provide actionable insight because the measure lacks the granularity needed to identify inappropriate prescribing. Specifically, several Workgroup said the measure's denominator combines conditions for which antibiotics are typically appropriate, sometimes appropriate, and typically not appropriate, which could complicate interpretation and comparability of state-level rates. In addition, several Workgroup members said the measure might be more useful for directing quality improvement efforts at the provider or health-system level than at the state or health-plan level, as providers and health systems have access to more detailed, patient-level diagnostic data. One Workgroup member also highlighted practical challenges for providers in assessing the appropriateness of each antibiotic prescription and expressed concern about the feedback from the measure making its way back to the prescribing provider in a timely manner.

Several Workgroup members asked states already using the *Antibiotic Utilization for Respiratory Conditions* measure about its real-world performance and whether it provides actionable data. A Workgroup member from a state Medicaid agency said their state recently retired the measure because health plans felt it was not useful in tracking quality of care. As a result, that Workgroup member questioned whether this measure is the most suitable replacement for the AAB-CH/AD measure. In contrast, another Workgroup member said that their state tracks and reports the measure at the state and health-plan levels, though it is not included in the state's pay-for-performance programs. This Workgroup member shared that the data is used for overall tracking of antibiotic prescription rates and trending for insight into provider-level behavior. During the public comment period, a representative from the measure steward said they have received feedback that the measure has been particularly useful for longitudinal analyses of antibiotic prescribing.

Throughout the discussion, Workgroup members confirmed the importance of reducing unnecessary antibiotic use and expressed interest in replacing AAB-CH/AD due to its limited utility. But most Workgroup members expressed hesitation about adding the proposed replacement measure in its current form.

During the public comment period, multiple commenters from hospitals and health systems expressed support for the *Antibiotic Utilization for Respiratory Conditions* measure and provided examples of how their organizations had used the measure for tracking or quality improvement. However, one commenter from a health system echoed several of the Workgroup's concerns about the granularity of the measure and its limitations for quality improvement.

## Measuring the Value-Functions of Primary Care: Continuity of Care

The Workgroup considered but did not recommend adding the *Measuring the Value-Functions of Primary Care: Continuity of Care* measure to the Core Sets. This measure assesses the percentage of a physician's patients who have a continuity index score of 0.7 or higher (among patients with at least two primary care visits during a one-year measurement period). Although calculated at the physician level, results can be aggregated to the health plan and state levels.

The measure applies only to physicians; the specifications do not include advanced practice providers such as nurse practitioners or physician associates. It uses a previously validated, patient-level continuity index to quantify the extent to which patients receive care from the same primary care provider across visits.<sup>30</sup> The measure steward is the American Board of Family Medicine. The measure can be calculated using administrative claims, electronic health records, or clinical registry data (each as a standalone data source). It is not currently in use by state Medicaid or CHIP programs.

The individual who suggested adding this measure said continuity of care is a core function of primary care that has been consistently associated with improved health outcomes, reduced costs, and greater patient satisfaction, making it a high-impact measure for Medicaid and CHIP populations. The individual cited research showing that higher continuity is linked to significantly lower health care expenditures and fewer hospitalizations.<sup>31</sup> Measure testing also revealed a performance gap, with Medicaid beneficiaries experiencing lower continuity of care compared with Medicare beneficiaries and enrollees in some types of commercial health plans. The individual who suggested the measure said Medicaid and CHIP programs could use it to identify differences in measure performance and develop targeted interventions to improve continuity, such as empanelment and continuity-focused scheduling guidelines, in areas with the lowest continuity scores.

Workgroup members generally agreed that continuity of care and strong primary care relationships are important, but they raised concerns about the measure's physician-focused design, its appropriateness for Medicaid populations, and workforce challenges. Several Workgroup members expressed concern that the measure is limited to physician providers and does not account for the primary care delivered by advanced practice providers, including nurse practitioners and physician associates, who often play a critical role in providing care to Medicaid beneficiaries. Several Workgroup members said the measure could discourage team-based care, noting that having a team that knows the patient well is a more meaningful metric,

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<sup>30</sup> Dai M, Pavletic D, Shuemaker JC, Solid CA, Phillips RL Jr.. Measuring the value functions of primary care: physician-level continuity of care quality measure. *Ann Fam Med*. 2022 Nov-Dec;20(6):535-540. doi: 10.1370/afm.2880.

<sup>31</sup> Bazemore A, Petterson S, Peterson LE, Bruno R, Chung Y, Phillips RL. Higher primary care physician continuity is associated with lower costs and hospitalizations. *Ann Fam Med*. 2018 Nov;16(6):492-497. doi: 10.1370/afm.2308.

especially considering workforce shortages. Another Workgroup member acknowledged these workforce challenges but expressed support for the overall direction of the measure, saying it could help drive the health care system toward care models supported by research, rather than shaping quality measures around current system constraints. The measure steward also said the measure would not penalize the use of team-based care, as patient visits with advanced practice providers are excluded from the continuity index calculations.

In addition to workforce considerations, Workgroup members raised operational and technical concerns. Multiple Workgroup members acknowledged the measure's potential value but said they would like to see it tested more extensively in Medicaid programs, across different states and settings, before recommending its addition to the Core Sets. Two Workgroup members from state Medicaid programs expressed concern about the measure's administrative burden and potential redundancy, citing its similarity to the *Adults' Access to Preventive/Ambulatory Health Services* measure, which was recommended for addition to the Core Sets immediately before the discussion about this measure. Another Workgroup member said the measure could be difficult for managed care plans to implement because provider incentive programs typically assign members to a specific provider panel, whereas the measure attributes continuity based on the provider a member sees most frequently.

The Workgroup also discussed whether the measure appropriately supports patient preferences. One Workgroup member said that the measure would ensure physicians are held accountable only for the patients with whom they meaningfully engage, ultimately improving provider satisfaction and aligning care with patients' preferred physicians. Other Workgroup members questioned whether all patients value continuity with a single provider, saying some patients might place a higher value on being able to determine when and where they are seen. Similarly, another Workgroup member said continuity requires stability, and suggested that the measure could discourage flexible care models (such as open walk-in hours) that are critical for some patients.

One Workgroup member expressed strong support for the measure, saying it allows for team-based care and is not restrictive, as the 0.7 index threshold only requires patients to see the same provider most of the time. This Workgroup member added that the measure is not intended to diminish the importance of advanced practice providers but rather to ensure that Medicaid beneficiaries maintain continuity with a physician, as many of them might be at greater risk of experiencing fragmented care.

During the public comment period, two commenters expressed support for promoting continuity of care within the Medicaid and CHIP populations, but they questioned whether the *Measuring the Value-Functions of Primary Care: Continuity of Care* measure was the right fit for the Core Sets. One commenter, from a state Medicaid and CHIP agency, said the measure would be administratively burdensome to calculate because managed care plans are not already reporting it through the Healthcare Effectiveness Data and Information Set (HEDIS®). The other commenter

expressed concern that the measure could hold physicians responsible for something that is not fully within their control.

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