Frequently Asked Questions: Medicaid and CHIP Core Sets Mandatory Reporting

Annual reporting of the Medicaid and Children's Health Insurance Program (CHIP) Child Core Set and the behavioral health measures on the Medicaid Adult Core Set is mandatory and began in the Fall of 2024.[1,2] The following frequently asked questions address mandatory reporting and will be updated as CMS receives additional questions. States and others are encouraged to visit the Performance Measurement page on Medicaid.gov for technical assistance (TA) resources on mandatory reporting. Please send questions to: MACQualityTA@cms.hhs.gov.

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[1] Core Set Final Rule: https://www.federalregister.gov/d/2023-18669
[2] Initial Core Set Mandatory Reporting Guidance State Health Official Letter: https://www.medicaid.gov/sites/default/files/2023-12/sho23005_0.pdf

General

Q1: What is the annual deadline for state reporting? Also, what service delivery period does the data reflect?

A1: Other than Core Set measures based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, states are required to submit data to CMS annually for all measures on the Child Core Set and the behavioral health measures on the Adult Core Set by December 31st of each year. If December 31st falls on a weekend, then the deadline moves to the next business day (e.g.; if December 31st falls on a Sunday, since January 1st is a federal holiday, the next business day would be Tuesday January 2nd and the reporting due date would be January 2nd). States are also encouraged to report on the non-mandatory measures on the Adult Core Set by December 31st each year.

For measures based on the CAHPS® Health Plan Survey, please refer to the CAHPS Fact Sheet for information on the reporting deadline for the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database, which is earlier in the calendar year than other Core Set reporting.[3]

Generally, Core Set data will reflect service utilization for the prior calendar year (i.e. Core Set data due for reporting on December 31, 2025 will generally reflect service utilization in calendar year 2024), but there may be exceptions for specific measures.[4,5]

Q2: How do states report measure data to CMS?

A2: States will report Core Sets measure results using CMS' Quality Measure Reporting (QMR) system. CMS expects the QMR system will open to accept Core Sets data each year in September, with all data required to be submitted by December 31st.

Q3: Which measures will CMS report on behalf of states?

A3: The annual Core Set State Health Official letter (SHO) will provide a list of the quality measures that CMS will report on behalf of states using alternate data sources.[6] For 2025 and 2026 reporting, CMS will report on the following quality measures for states using alternate data sources:

- Live Births Weighing Less Than 2,500 Grams (LBW-CH) measure – calculated using Centers for Disease Control and Prevention (CDC) data;
- Low-Risk Cesarean Delivery (LRCD-CH/AD) measure – calculated using CDC data;

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[3] CAHPS Fact Sheet: https://www.medicaid.gov/sites/default/files/2024-03/cahpsfactsheet.pdf
[4] See Child Core Set Measurement Period Table at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources
[5] See Adult Core Set Measurement Period Table at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-core-set-reporting-resources
[6] Historical Policy Guidance: 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

- Measures from the CAHPS® Health Plan Survey 5.1H – Child Version Including Medicaid and Children with Chronic Conditions Supplemental Items (CPC-CH) – calculated using the AHRQ CAHPS Database;
- Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) – calculated using the AHRQ CAHPS Database and data reported by states through QMR; and
- Measures from the CAHPS® Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD) — calculated using the AHRQ CAHPS Database.

CMS will also report the following measure using alternate data for 2025 Core Set reporting:

- National Core Indicators Survey (NCIIDD-AD) measure – calculated using data submitted to the National Core Indicators (NCI) National Team.[7]

Q4: What is the difference between voluntary and provisional Core Set measures?

A4: Voluntary measures refers specifically to measures in the Adult Core Set only that are not part of the behavioral health domain. The behavioral health measures on the Adult Core Set are mandatory for reporting. The reporting of voluntary measures is encouraged, but not required.

Provisional measures are measures that we expect will be added as mandatory to the to the Child Core Set or the behavioral health domain of the Adult Core Set in future years but are not currently considered part of the Child or Adult Core Sets. CMS adds these measures initially as provisional to give states time to prepare for reporting. Reporting of provisional measures is also voluntary and encouraged but not required.

Q5: Do states have to report both fee-for-service and managed care populations? If a measure is not reported by a managed care plan, will the state have to report it?

A5: Yes. States are required to report Core Set measures that include measure-eligible beneficiaries in in all applicable delivery systems, including both fee-for-service (FFS) and managed care populations for every mandatory measure.

Q6: When will CMS implement the Office of Management and Budget (OMB)'s Statistical Policy Directive No. 15 which updates race and ethnicity stratification reporting categories?

A6: Beginning with 2025 Core Set reporting, CMS will include both the 2024 Office of Management and Budget (OMB) Statistical Policy Directive No. 15 (Directive No. 15): Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity standards[8] and the 1997 OMB minimum race and ethnicity categories[9], as specified in the 2011

[7] Beginning with 2026 Core Set reporting, CMS transitioned the NCIIDD-AD measure from the Adult Core Set to the Home and Community Based Services Quality Measure Set.
[8] Statistical Policy Directive No.15: https://www.federalregister.gov/d/2024-06469
[9] 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity https://www.govinfo.gov/content/pkg/FR-1997-10-30/pdf/97-28653.pdf

HHS standards[10], as options for race and ethnicity stratification in the QMR system**.** States can choose to use either standard and will be prompted to choose a race and ethnicity reporting option for each measure, but are asked to use a single standard for reporting race/ethnicity stratifications within each measure in order for the data to be meaningful. States can change to use a different standard over time. For additional guidance please review the CMS TA resource on Reporting Stratified Results in the Quality Measure Reporting System for the 2025 Child, Adult, and Health Home Core Sets.

Methodology

Q7: If a state reports on the population enrolled in managed care using the hybrid method, can the state report on the FFS population using the administrative method?

A7: Yes, states can use different methodologies for different populations. Please refer to the TA resource on combining data sources across multiple reporting units to create a state-level rate. States are encouraged to document this information in the QMR system if they used different methodologies for different reporting units.

Q8: Are states able to utilize an aggregated rate, composed of the state's individual managed care plan (MCP) rates, to meet mandatory reporting requirements?

A8: A state can aggregate data from its individual MCP rates but will need to consider if this excludes any measure-eligible Medicaid or CHIP beneficiaries from the denominator. If measure-eligible beneficiaries are excluded from the aggregated MCP rates (for example, FFS populations or individuals who switched plans during the year but were enrolled in Medicaid or CHIP for the continuous enrollment period), the state must calculate a rate for the excluded individuals and report a state-level rate that includes all populations.

Additional guidance on calculating a state-level rate by combining rates from individual reporting units to a state-level rate can be found in this TA resource.

Q9: How should states calculate state-level stratified rates when combining information from multiple sources?

A9: States should follow the same process detailed in the TA resource on combining data sources across multiple reporting units to create a state-level stratified rate. For measures in which at least one reporting unit uses hybrid methodology, states have two options for reporting stratified data:

- The preferred option is to create a weighted state-level rate for each stratification category. This ensures the state-level stratified rate is proportional to the measure-eligible population in each reporting unit. For example, if Health Plan A has 1000 rural residents in the measure-eligible population and Health Plan B has 100 rural residents, the rate for Health Plan A should have more weight in the state-level rural rate. In this option, states

[10] 2011 HHS Data Standards: https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability

would follow the same process for calculating a state-level rate using a combination of data sources as detailed in the TA resource. To properly create a weighted state-level rate for each stratification category, the state will need the measure-eligible population for each stratification category and reporting unit.

- The state can also use administrative data only to report rates in the stratification section. The QMR system allows states to report stratified data separately from the overall performance measure data, so states can use a different methodology in the stratification section. If a state does so, they should provide additional context about their stratification methodology in the stratification open text field.

Q10: Some states do not have access to electronic health record (EHR) data and/or supplemental data (such as SNOMED[11], LOINC[12]) or may use codes that are not found in claims data to calculate measures. Are states required to use the hybrid method and/or to make system, policy, or data collection changes to report accurate data for measures which allow this data collection method? If so, what type of technical assistance is available to help states implement these changes?

A10: States are asked to collect data through one of the data collection methods that are specified in the measure's technical specifications. States are not required to prioritize hybrid or EHR as a data collection methodology if the measure is also specified for administrative data collection. However, states are strongly encouraged to utilize a data source and methodology that will provide the most accurate representation of the quality of care provided. Please email the technical assistance mailbox for assistance with reporting specific measures (MACQualityTA@cms.hhs.gov).

Q11: Are states required to adhere to the technical specifications issued by CMS for the Core Set measures, including reporting the Core Set age groups when Core Set age groups differ from Healthcare Effectiveness Data and Information Set (HEDIS) specifications?

A11: As finalized in § 437.15(a)(3) of the final rule, States are required to report on the mandatory measures in accordance with CMS Core Set Reporting Guidance. This includes reporting according to the specified age groups. Adherence to the reporting guidance is essential for providing effective comparisons across states on standardized quality measure performance and for deriving national performance rates for the care provided to Medicaid and CHIP beneficiaries. States are also encouraged to adhere to the specified age ranges for the non-mandatory measures on the Adult Core Set.

Q12: Should an MCP be excluded from the aggregate rate for any reason, including receiving a Do Not Report finding as part of its Performance Measure Validation?

A12: States are required to report all available data and include data for all Medicaid and CHIP beneficiaries that meet the measure-eligibility criteria for all mandatory measures. If an MCP receives a "Do Not Report" finding for a particular rate, the state should coordinate with CMS to

[11] Systematized Nomenclature of Medicine (SNOMED): a comprehensive, international, and multilingual set of healthcare terminology designed for electronic health records.
[12] Logical Observation Identifiers Names and Codes (LOINC): a universal code system for tests, measurements, and observations.

provide additional context about the "Do Not Report" finding and determine whether the data should be included in state-level reporting.

Q13: Can states report rates from a similar National Committee for Quality Assurance (NCQA) HEDIS measure as a substitute for a measure on the Core Set?

A13: No. States should report the Core Set measures according to the Core Set specifications, without substitutions.

For example, states may not substitute the NCQA Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) measure for the Screening for Depression and Follow-Up Plan (CDF-CH, CDF-AD, or CDF-HH) measures that are on the Child, Adult, and Health Home Core Sets or the NCQA's Use of Opioids at High Dosage (HDO) measure for the Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) measure that is on the Adult Core Set (OHD-AD will be retired from the Core Set beginning with 2026 Adult Core Set reporting).

States are encouraged to review the TA resources and/or contact CMS (MACQualityTA@cms.hhs.gov) for additional TA for assistance with reporting Core Set measures.

Q14: **There are mandatory measures that are now specified only for the Electronic Clinical Data Systems (ECDS) methodology. We have administrative data for the full population for these measures. Since administrative data is a type of ECDS data, can we use only administrative data and the ECDS specifications for these and future ECDS-only measures?**

A14: Yes. ECDS reported measures can incorporate data from electronic health records, clinical registries and health information exchanges, case management systems and administrative claims. There is no requirement that all data sources listed in the ECDS specifications must be used; therefore, entities can report results based solely on administrative data while they evolve their access to additional data sources.

For the purpose of Core Set reporting, states should report the ECDS reported measures using the specifications provided in the Core Set resource manuals. The technical specifications include value set directories and medication list directories that can be used to calculate ECDS reported measures using administrative data alone. When reporting ECDS reported measures in the QMR system, states should select "ECDS" as a data source and then select "Administrative" in the field for designating the specific data sources that were used.

Please note that for some ECDS measures, the ability to use administrative data alone will depend on whether the services being assessed in the measure are reliably documented in claims data.

Sampling

Q15: For Adult Core Set measures that are broken out by age group (e.g., ages 18 to 64 and age 65 and older), are separate samples required to report the measure?

A15: When using the hybrid methodology to report a Core Set measure, a state must consider the size of the measure-eligible population in each age stratification. For example, if the Ages 65 to 85 population is very small in a state, it will be necessary to draw a separate sample to get sufficient representation to be able to report a separate rate for this age group. Information on reporting small numbers and cell suppression is provided in Q23.

Q16: For reporting of measures using the hybrid methodology, are states required to use two different samples for reporting Medicaid and CHIP rates separately?

A16: Yes, states should separately sample the Medicaid, inclusive of Title XXI-funded Medicaid expansion CHIP (Titles XIX and XXI) and separate CHIP (Title XXI) populations for Core Set reporting when using the hybrid methodology (see related Q18).

States can use different methodologies for different populations. A state could choose to use the hybrid methodology to calculate the measure for one or both populations or calculate the measure for the either of these populations using another data collection method allowed in the technical specifications for that measure. Please refer to the TA resource on combining data sources across multiple reporting units to create a state-level rate.

Q17: For the Prenatal and Postpartum Care (PPC2) measure, will CMS require separate samples for beneficiaries under age 21 and for those age 21 and older if utilizing the hybrid methodology for calculating and reporting? Or will one sample that is stratified by these age ranges meet CMS' requirements?

A17: CMS consulted with the measure steward who advised that if states use the hybrid methodology for the PPC2 measure, they will need to draw separate samples by age for the purpose of Core Set reporting, to submit results for the Child Core Set (under age 21) and Adult Core Set (age 21 and over).

Additionally, the final rule established that states with a separate CHIP program must report on Child Core Set measures in two categories: separate CHIP (Title XXI) and Medicaid inclusive of Title XXI-funded Medicaid expansion CHIP (Titles XIX and XXI). Therefore, states with a separate CHIP program would need to draw separate samples for the Child Core Set for the Medicaid inclusive of Title XXI-funded Medicaid expansion CHIP and separate CHIP populations.

Populations

Q18: Do states with a separate CHIP have to report separately for Medicaid and CHIP child populations? Who should be included in each report in the QMR system?

A18: According to 42 CFR 457.770(c), states with both separate CHIP and Title XXI-funded Medicaid expansion CHIP are required to report in two categories: 1) Medicaid inclusive of Title XXI-funded Medicaid expansion CHIP; and (2) separate CHIP adopted under Title XXI of the Social Security Act (see related Q16). States that only have Title XXI-funded Medicaid expansion CHIP are required to report in one category: Medicaid inclusive of Title XXI-funded Medicaid expansion CHIP. For each measure, states should select all applicable populations

included in reporting.

Consistent with 42 CFR 457.770(b), CHIP reporting is voluntary but encouraged for the Adult Core Set to account for children enrolled in Title XXI-funded Medicaid expansion CHIP ages 18-21 and/or separate CHIP children ages 18-19, as well as pregnant women over the age of 19 enrolled in separate CHIP, if applicable. Additionally, for states that cover the "from-conception-to-end of pregnancy" (FCEP) population in separate CHIP, this population should be reported on the Adult Core Set rather than the Child Core Set to the extent that the FCEP group meets measure-eligible population criteria as outlined in related Q25.

Q19: Are states required to include CHIP populations when reporting on the mandatory behavioral health measures in the Adult Core Set?

A19: For CHIP programs, reporting of the behavioral health measures in the Adult Core Set is voluntary but encouraged.

States must include CHIP populations for all Child Core Set measures. Through the final rule, CMS amended the quality reporting provisions in Part 457 to include requirements for reporting on health care quality measures, which only apply to state CHIP programs.

Q20: Can states be granted an exemption from reporting CHIP separately for Child Core Set measures calculated using the hybrid data collection method?

A20: There are no measures on the Core Sets for which hybrid (a combination of administrative data and medical records) is the only data collection method, though CMS recognizes that the hybrid method may be the preferred and more accurate method of data collection for calculating selected measures. A state could choose to use the hybrid methodology to calculate the measure for the CHIP population or calculate the measure for the CHIP population using another data collection method allowed in the technical specifications for that measure.

Q21: What is the expected timeframe for requiring reporting on the dually eligible Medicare and Medicaid population and the third-party coverage population?

A21: In the 2025 and 2026 Core Set State Health Official (SHO) letters, CMS indicated it will exempt states from 2025 and 2026 Core Set reporting on: (1) beneficiaries who have other insurance coverage as a primary payer before Medicaid or CHIP, including individuals dually eligible for Medicare and Medicaid; and (2) individuals whose Medicaid or CHIP coverage is limited to payment of third-party coverage premiums and/or cost sharing. These exemptions are due to the lack of data available for these populations. At this time, CMS has not specified the timeline for required reporting on these populations but will continue to provide technical assistance to states and assess state readiness to report.

CMS will annually issue sub regulatory guidance that details the requirements and expectations for compliance with mandatory reporting for the upcoming year of Core Set reporting. This guidance will include any exemptions from the mandatory populations.

Q22: Would not having timely access to Medicare FFS data be a reason to request a 1-year exemption on reporting for duals? How would this work operationally? Alternatively, is it possible to report results for Duals without access to Medicare FFS claims?

A22: Yes, not having access to Medicare data would be a reason for a state to request an exemption from including the population of individuals dually eligible for Medicare and Medicaid in Core Set reporting. Please note: The 2025 and 2026 SHO letters exempt states from reporting on individuals dually eligible for Medicare and Medicaid for 2025 and 2026 reporting. Therefore, it is not necessary to request an exemption for this population for 2025 and 2026 reporting. States that choose to include dually eligible beneficiaries who are covered on an FFS-basis for Medicare services should note that they will not be able to report complete results for these individuals without access to Medicare FFS claims.

Q23: Do states have to report on all populations for all quality measures or just measures that are reported using the administrative methodology?

A23: The requirement to include all populations applies to all mandatory measures, regardless of the data collection method. However, states can use different methodologies for different populations. Please refer to the TA resource on combining data sources across multiple reporting units to create a state-level rate. States are encouraged to document in the QMR system if they used different methodologies for different reporting units.

Q24: Is there a minimum denominator size for data reported to CMS?

A24: CMS encourages states to report data in the QMR system for measures and rates with small cell sizes. These data will be suppressed for state-level public reporting in accordance with the CMS cell-size suppression policy, which prohibits the direct reporting of beneficiary and record counts of 1 to 10 and values from which users can derive values of 1 to 10.[13] Furthermore, CMS will suppress rates with a denominator less than 30 due to reliability concerns. That being said, CMS recognizes that some states prohibit the reporting of small cell sizes due to privacy concerns. CMS advises these states to provide an explanation in the QMR system noting that these rates are not reported due to the state's small cell size policy.

Q25: For Child Core Set reporting, is a state required to report its separate CHIP population if the state's separate CHIP only serves a population with limited benefits, such as the "from-conception-to-end of pregnancy" (FCEP) population?

A25: States should evaluate whether any beneficiaries in the separate CHIP population meet the measure-eligible population criteria for each measure. If any beneficiaries meet the criteria, the state must report the data for this population. In conducting this assessment, consider the following:

1. **Does this population meet the continuous enrollment criteria for a measure?** For example, some measures require 12 months continuous enrollment. Other measures have

[13] https://resdac.org/articles/cms-cell-size-suppression-policy

shorter continuous enrollment timeframes, such as the 30 days after the qualifying visit. This information is included in the "eligible population" table of the technical specifications.

2. **Is this population eligible to receive the services assessed in the numerator?** If a beneficiary is not eligible to receive the services assessed in the measure, the beneficiary should not be included in the denominator for the measure."

If your state has a separate CHIP population and determines that the population does not meet the measure eligibility criteria for any measures, the state should still complete the separate CHIP report in the QMR system. In this scenario, the state would select "Not Reporting" for each measure and indicate in the "Reasons for not Reporting" field that there are no measure-eligible beneficiaries for the measure. States are expected to complete and submit a report for every measure.

Audit/ Validation of Data

Q26: Are states permitted to report draft measure rates in cases where measure rates have not been fully validated?

A26: States should use the most complete data available at the time of reporting to calculate measure rates. Any measure rates or other data that are submitted after the reporting deadline may not be incorporated into Core Set public reporting. At this time, states are not required to conduct validation of Core Set measure rates.

Q27: For measures with HEDIS-based specifications, are states required to have NCQA HEDIS certification to calculate and report the measures?

A27: States do not need to have NCQA HEDIS certification for Core Set reporting.

Exemption Requests

Q28: Is there a template for the one-year population exemption request?

A28: There is no template for exemption requests. States should submit a letter to CMS identifying the exemption(s) that they are requesting, and their plans to address this in future years.

Each exemption request must:

- identify the specific population for which the state cannot report and for which measure(s) the exemption is being requested;
- include details on why the exemption(s) is/are necessary;
- demonstrate that the state has made a reasonable effort to obtain the required data by the reporting deadline;
- provide a reasonable timeline of the actions underway to resolve the issue so that the population can be included in state reporting in future years; and
- be submitted only for the current reporting year.

Before submitting an exemption, states should review Core Set specifications to determine whether the population in question is eligible for measure reporting. Most measures require a beneficiary to receive full benefits, so beneficiaries who receive partial benefits (such as transportation or emergency services only) would not be included in Core Set reporting. Each measure identifies the eligible population in the Core Set specifications, and states should not submit an exemption request for populations that are not measure-eligible.

State exemption requests must be submitted annually by September 1st to MACQualityTA@cms.hhs.gov. If September 1st falls on a weekend or federal holiday the due date will move to the next business day. The exemption request letter, signed by the state Medicaid or CHIP director, should be sent to the following mailbox: MACQualityTA@cms.hhs.gov. CMS is happy to review and provide comments on draft requests prior to formal submission.

Q29: Does a state need to submit a separate one-year exemption request for each population?

A29: No, states can include requests to exempt more than one population in the single official exemption request letter. While states may submit more than one exemption request per reporting year, we encourage states to make each request as comprehensive as possible.