



2026 Child, Adult, and Health Home Core Sets Reporting: Data Quality Checklist for States

This data quality checklist was developed to help states improve the completeness, accuracy, consistency, and documentation of data reported for the 2026 Child, Adult, and Health Home Core Set measures.¹ This will enable a more accurate understanding of differences across states due to variations from the technical specifications or unique aspects of a state’s Medicaid program, Children’s Health Insurance Program (CHIP), or Health Home Program. The checklist includes common issues noted in the data reported for previous years and applies to Child, Adult, and Health Home Core Sets reporting unless otherwise specified.² States can use the checklist below to assess their data as they report in the online reporting system.

For information on mandatory reporting requirements for the Child and Adult Core Sets, please review the “2026 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance” State Health Official letter and the Core Set final rule. For information on mandatory reporting for the Health Home Core Sets, please review the “Federal Fiscal Year 2026 Updates to the Health Home Core Quality Measure Sets” State Medicaid Director letter and the Core Set final rule.³ The lists of 2026 Core Set measures, including the acronyms used in this technical assistance resource, are available on Medicaid.gov.⁴

To obtain technical assistance with reporting the Child, Adult, and Health Home Core Set measures, please contact the TA mailbox at MACQualityTA@cms.hhs.gov.

¹ Throughout this TA resource, we refer to state reporting of Core Set measures. The term “states” includes the 50 states, the District of Columbia, and the territories. This TA resource also applies to states with approved Health Home Programs for Health Home Core Sets reporting. The term “beneficiaries” in this document also includes enrollees in Health Home Programs. For measures in the Health Home Core Sets, the term “beneficiary months” refers to the number of months of health home enrollment.

² The data quality checks included in this resource apply to state- and program-level reporting. They also apply to stratified data reported in the measure stratification section of the online reporting system, as applicable. Additional guidance on reporting stratified data is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/OMR-stratification-resource.pdf>.

³ The mandatory Medicaid and Children’s Health Insurance Program (CHIP) Core Set Reporting final rule is available at <https://www.federalregister.gov/d/2023-18669>. The 2026 Updates to the Child and Adult Core Health Care Quality Measurement Sets and Mandatory Reporting Guidance 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>. The Federal Fiscal Year 2026 Updates to the Health Home Core Quality Measure Sets is available at <https://www.medicaid.gov/federal-policy-guidance/downloads/smd25002.pdf>.

⁴ The 2026 Child Core Set measure list is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-child-core-set.pdf>. The 2026 Adult Core Set measure list is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-adult-core-set.pdf>. The 2026 1945 Health Home Core Set measure list is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945-health-home-core-set.pdf>. The 2026 1945A Health Home Core Set measure list is available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945a-health-home-core-set.pdf>.

Data Completeness

<input type="checkbox"/>	<p>Numerators, denominators, and rates should be reported for all mandatory measures. For measures that the state does not report, please provide specific information on the reasons for not reporting the measure.</p>
<input type="checkbox"/>	<p>For measures that include multiple rates (for example, multiple age groups or rate categories), states should report numerators, denominators, and rates for all age groups and rate categories. This applies to the following measures:</p> <ul style="list-style-type: none"> • Child Core Set: ADD-CH, AMR-CH, APM-CH, APP-CH, CIS-CH, CCP-CH, CCW-CH, DEV-CH, FUA-CH, FUH-CH, FUM-CH, IMA-CH, OEV-CH, PDS-CH, PND-CH, PPC2-CH, PRS-CH, SFM-CH, TFL-CH, WCC-CH, WCV-CH, W30-CH. • Adult Core Set: AAB-AD, AIS-AD, AMR-AD, BCS-AD, CBP-AD, CCP-AD, CCW-AD, CDF-AD, COB-AD, COL-AD, , EDV-AD, FUA-AD, FUH-AD, FUM-AD, GSD-AD, HPCMI-AD, HVL-AD, IET-AD, OUD-AD, PDS-AD, PND-AD, PPC2-AD, PQI01-AD, PQI05-AD, PQI08-AD, PRS-AD. • 1945 Health Home Core Set: CBP-HH, CDF-HH, COL-HH, FUA-HH, FUH-HH, FUM-HH, IET-HH, OUD-HH, AIF-HH, IU-HH. • 1945A Health Home Core Set: CIS-HHA, IMA-HHA, IU-HHA, OEV-HHA, WCV-HHA, W30-HHA <p>If one or more rates within a measure cannot be reported, states should explain why the rate is not being reported in the “Additional Notes/Comments on Measure” section.</p>
<input type="checkbox"/>	<p>If a measure was calculated using the hybrid method only or a combination of administrative and hybrid method data, states should report as much information as possible about how the rate was calculated. Guidance for completing the “Numerator,” “Denominator,” “Sample Size,” and “Measure-Eligible Population” fields differs depending on what methodologies were used to calculate the rate. For more information about completing these fields, states should refer to the TA Brief: “Calculating State-Level Rates Using Data from Multiple Reporting Units,” available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/state-level-rates-brief.pdf.</p>
<input type="checkbox"/>	<p>The reported data for each measure should include the total measure-eligible population as defined by the Core Set Technical Specifications. The denominator should include the entire population eligible for the services or outcomes assessed in the measure.</p> <ul style="list-style-type: none"> • If the rate excludes eligible groups (such as programs, delivery systems, providers, or populations), states should select “No, this denominator does not represent the total measure-eligible population as defined by the Technical Specifications for this measure” and then describe (1) which populations are excluded and why, and (2) the size of the excluded populations. States should report this information for all applicable measures. • In the field “Which delivery systems are represented in the denominator?” states should select and provide information about each applicable delivery system in the state (fee-for-service, primary care case management, managed care, integrated care models, and other). For each delivery system, states should indicate whether or not the entire population is included in the measure. For any delivery system where the entire population is not included in the measure, states should provide an estimate of the percentage of measure-eligible beneficiaries from that delivery system included in the data for the measure in the associated textbox. For example, if the population included in the reported data represents half of the state’s fee-for-service beneficiaries, states should enter 50 percent for fee-for-service. If none of the beneficiaries from the delivery system are included, enter 0 percent. States should also enter the number of managed care plans included in the data. If some of the managed care plans are missing from a measure, the state should identify the number of missing managed care plans in the associated text field. States should report this information for each measure.

	<p><i>(Continued)</i></p> <ul style="list-style-type: none"> In addition to reporting the populations included in each measure, states should provide information in the “Delivery System” section of the Core Set Qualifiers screen about the delivery systems used to provide services to beneficiaries. This information provides important context about the population included in and excluded from the reported measure. The percentage of beneficiaries in each delivery system should sum to 100 percent in each column of the delivery system question (which corresponds to program [Medicaid or CHIP] in the Child Core Set, program and age group in the Adult Core Set, and age group in the Health Home Core Sets. For example, a state might indicate that 60 percent of its Adult Medicaid population under Age 65 is enrolled in managed care and 40 percent is covered under fee-for-service, and that 100 percent of its Adult Medicaid population age 65+ is enrolled in managed care (in other words, each column sums to 100 percent). If beneficiaries are enrolled in an “other” delivery system, please describe this delivery system in the associated textbox.
<input type="checkbox"/>	<p>Data collection methods should be reported for each measure in the “Data Collection Method” section and should adhere to the measure’s specifications. Data collection methods may include administrative data (such as Medicaid Management Information System, immunization registry/immunization information system, and vital records), electronic health records, medical records, personal health records, health information exchanges, and case management systems. The hybrid method uses a combination of administrative and medical records data. The Electronic Clinical Data System method uses a combination of electronic health records, personal health records, health information exchanges, clinical registries, case management systems, and administrative data. Any deviations to data sources and methods should be described in the “Variations from Measurement Specifications” section and states should explain how their data source or method differed from Core Set technical specifications.</p> <ul style="list-style-type: none"> For each data collection method selected, states should identify which reporting entities used each method (e.g., health plans, fee-for-service) in the associated textbox. If the methods differed across health plans or delivery systems, states should identify the number of plans that used each method. For example, a state might note that administrative data were used for the fee-for-service population and by 3 Managed Care Organizations (MCOs), and the hybrid method was used by 2 MCOs.
<input type="checkbox"/>	<p>If the status of the data reported is provisional, please indicate this in the “Status of Data Reported” section and include additional context in the associated textbox about when the data will be final and if your state plans to modify the data reported in the web-based reporting system. Note that changes made to the data after the reporting deadline will not be incorporated into public reporting.</p>
<input type="checkbox"/>	<p>If any of the Core Set measures were audited or validated, please indicate this in the “Audit or Validation of Measures” section on the Core Set Questions screen. Indicate who conducted the audit or validation and then select which measures were audited or validated. If multiple entities audited or validated measures, select “Add Another” and then enter an additional entity and select the applicable measures.</p>
Data Accuracy	
<input type="checkbox"/>	<p>Reported rates must be calculated according to the Core Set Technical Specifications for each measure.</p> <ul style="list-style-type: none"> If the state used “Other” specifications to report a measure, the “Other” specifications should be described in the “Measurement Specification” section and should explain how the state’s methodology differs from the Core Set specifications. If a state used “Other” specifications, the state’s rate for the measure will not be included in public reporting. All variations from Core Set specifications should be described in the “Variations from Measurement Specifications” section.
<input type="checkbox"/>	<p>For most measures, the numerators should be less than or equal to denominators. For the EDV-AD, AIF-HH, IU-HH/HHA, and PQI measures (PQI01-AD, PQI05-AD, PQI08-AD, PQI15-AD), the numerator could be greater than the denominator.</p>

<input type="checkbox"/>	<p>Rates should be rounded and reported to one decimal point for all measures except PCR-AD and PCR-HH. (See guidance below for PCR-AD and PCR-HH.) For example, if a state calculates a rate of 74.13, then 74.1 is the correct format for reporting, and 74 and 74.0 are incorrect.</p> <ul style="list-style-type: none"> For PCR-AD and PCR-HH, the Count of Expected 30-Day Readmissions should be reported to four decimal points, for example 971.2125.
<input type="checkbox"/>	<p>For all measures using administrative data only (except for PCR-AD and PCR-HH), a rate will be automatically calculated to one decimal point based on the reported numerator and denominator. States should review this rate during data entry.</p> <ul style="list-style-type: none"> For PCR-AD and PCR-HH, the Observed Readmission Rate, Expected Readmission Rate, and O/E Ratio will automatically be calculated to four decimal points based on the reported Count of Index Hospital Stays, Count of Observed 30-Day Readmissions, and Count of Expected 30-Day Readmissions. <p>For all measures using any data source other than administrative data only (e.g., administrative data + an additional data source or any other data source besides administrative data), the system will automatically calculate a rate, but the calculated rate can be overwritten by the user. States may need to overwrite the calculated rate if their state used a weighting methodology to obtain a state-level rate.</p> <p>For most measures, rates should be reported as percentages in the range of 0.0 to 100.0 and calculated using the following formula: $(\text{numerator}/\text{denominator}) * 100$.</p> <ul style="list-style-type: none"> For AAB-AD and AAB-CH, the measure is calculated as an inverted rate $[1 - (\text{numerator}/\text{eligible population})]$. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the percentage of episodes that did not result in an antibiotic dispensing event). The rate should be multiplied by 100 and reported as a percentage. For AIF-HH and IU-HH/HHA, rates should be reported per 1,000 beneficiary months and calculated using the following formula: $(\text{Number of services [e.g., admissions, emergency department visits, or inpatient stays and services]}/\text{number of beneficiary months}) * 1,000$. For EDV-AD, PQI01-AD, PQI05-AD, PQI08-AD, and PQI15-AD, rates should be reported per 100,000 beneficiary months and calculated using the following formula: $(\text{Number of services [e.g., ED months, hospital admissions]}/\text{number of beneficiary months}) * 100,000$.
<p>Data Consistency</p>	
<input type="checkbox"/>	<p>For selected Core Set measures that have denominators based on beneficiary months of enrollment, the denominators should be the same:</p> <ul style="list-style-type: none"> EDV-AD, PQI01-AD, and PQI08-AD: The denominators for these measures should be the same within each age group across the three measures.

<input type="checkbox"/>	<p>For measures with multiple rates, reporting should be consistent for all rates:</p> <ul style="list-style-type: none"> • ADD-CH: The denominator for the Initiation phase should be greater than or equal to the denominator for the Continuation and Maintenance phase. • AIS-AD: The denominators of the Influenza and Td/Tdap rates should be the same within each age group. The denominators for the Zoster and Pneumococcal rates should be the same for age 65 and older. • AMR-CH/AD, APP-CH, DEV-CH, OEV-CH/HHA, TFL-CH, WCV-CH/HHA: Numerators and denominators for the age groups should sum to the total numerator and denominator. • APM-CH and WCC-CH: Within each of the three rate categories, numerators and denominators for the age groups should sum to the total numerator and denominator. Within each age group, denominators for each of the three rate categories should be the same. • CCP-CH/AD: The 90-day rate should be greater than or equal to the 3-day rate for both “Most or Moderately Effective Contraception” and “Long-Acting Reversible Contraception (LARC).” The “Most or Moderately Effective Contraception” rate should be greater than or equal to the LARC rate for both 3 days postpartum and 90 days postpartum, since LARC is a subset of most or moderately effective contraception methods. The denominators for all 4 rates in the measure should be the same. • CCW-CH/AD: The “Most or Moderately Effective Contraception” rate should be greater than or equal to the Long-Acting Reversible Contraception (LARC) rate, since LARC is a subset of most or moderately effective contraceptive methods. The denominators for both rates in the measure should be the same. • CIS-CH/HHA, IMA-CH/HHA, PRS-CH/AD: Denominators for all rates within each of the measures should be the same. • FUH-CH/AD/HH, FUA-CH/AD/HH, FUM-CH/AD/HH: The 30-day rate should be greater than or equal to the 7-day rate and the denominator for both rates should be the same (within each age group). • GSD-AD: Within each age group, denominators for the “Glycemic Status <8.0%” and “Glycemic Status >9.0%” rates should be the same. • IET-AD/HH: The Initiation rates should be greater than or equal to the Engagement rates and the denominator for both rates should be the same within each of the three SUD diagnosis cohorts and the total rates for each age group. The numerators and denominators for each diagnosis cohort should sum to the total numerator and denominator. • PDS-CH/AD, PND-CH/AD: The “Depression Screening” denominator should be greater than or equal to the “Follow-Up on Positive Screen” denominator. • PPC2-CH/AD: Within each age group, denominators for the Timeliness of Prenatal Care rate and Postpartum Care rate should be the same. • SFM-CH: Rate 1 (at least one sealant) should be greater than or equal to Rate 2 (all molars sealed) and the denominator for both rates should be the same. • TFL-CH: Rate 1 (Dental or oral health services) should be greater than or equal to Rate 2 (Dental services) and Rate 3 (Oral health services) and the denominator for all three rates should be the same within each age group.
<input type="checkbox"/>	<p>For the Child and Adult Core Sets, the reporting method for measures included in both Core Sets (AAB, AMR, CCP, CCW, CDF, CHL, FUA, FUH, FUM, OEVP, PDS, PND, PPC2, PRS) should be consistent:</p> <ul style="list-style-type: none"> • If the measure is reported for one Core Set (that is, Child or Adult), it should also be reported for the other Core Set. If not, the reason for not reporting should be noted in the “Please explain why you are not reporting on the measure” section. • The same method (administrative, hybrid) should be used to calculate the measure in both Core Sets. • The denominators should be calculated consistently in both Core Sets.
<input type="checkbox"/>	<p>For each measure in the Health Home Core Sets, within each rate, the numerators and denominators for each age group should sum to the total age group numerator and denominator for that rate.</p>

Data Documentation

<input type="checkbox"/>	<p>For measures that the state is not reporting, states should identify the reason(s) for not reporting from the options listed for the question “Why are you not reporting on this measure?” States can also select “other” and provide additional context in the associated textbox.</p>
<input type="checkbox"/>	<p>For each measure, states should confirm the measurement period that was used to calculate the denominator for that measure. For many measures, the 2026 Core Set denominator measurement period corresponds to calendar year 2025 (January 1, 2025–December 31, 2025). Some measures also require states to review utilization or enrollment prior to this period to identify the measure-eligible population. The measurement periods for denominators and numerators for each measure are posted on Medicaid.gov.⁵</p> <ul style="list-style-type: none">• The 2026 Child Core Set measurement periods for denominators and numerators for each measure are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-child-core-set-measurement-periods.pdf.• The 2026 Adult Core Set measurement periods for denominators and numerators for each measure are available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-adult-core-set-measurement-periods.pdf.• The 2026 1945 Health Home Core Set measurement periods for denominators and numerators for each measure are available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/1945-hh-core-set-measurement-period-table-2026.pdf. <p>If a state defined the measurement period according to the Core Set specifications, as defined in the measurement period tables, the state should select “Yes, our state adhered to Core Set specifications in defining the measurement period for calculating this measure” in the Date Range field.</p> <ul style="list-style-type: none">• For example, for 2026, the ADD-CH measurement specifications instruct states to identify beneficiaries with an Attention-Deficit/Hyperactivity Disorder prescription dispensing date in the 12-month window beginning March 1 of the year prior to the measurement year and ending the last calendar day of February of the measurement year. However, states will also need to review the beneficiary’s medication history from four months before the earliest prescription dispensing date to confirm the negative medication history. Although states will need to review data from 2023 for the negative medication review, the denominator is based on prescriptions from March 2024 to February 2025. States that followed 2026 Child Core Set specifications (that is, calculated the denominator using prescriptions from March 2024 to February 2025) should select “Yes, our state adhered to Core Set specifications in defining the measurement period for calculating this measure.”• For any measures where a state used a different measurement period, a state should select “No, our state used a different measurement period” and report the measurement period in the “Start Date” and “End Date” fields.• Any variations from the specified measurement period for the denominator or the numerator of a measure should be explained in the “Variations from Measure Specifications” section.

⁵ Information related to the measurement periods for the 1945A Health Home Core Set is included in the 1945A Medicaid Health Home Core Set Summary Reporting Resource available at <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2026-1945a-hh-summary-resource.pdf>.

□	<p>States should compare their 2026 Core Set data to data reported for previous years. If denominators or rates have changed by 10 percent or more for a measure, please review the data reported for the measure to ensure that it is correct.</p> <p>When assessing performance and comparing performance to previous reporting years, states should be aware that lower rates are better for the following measures:</p> <ul style="list-style-type: none">• Child Core Set: LBW-CH, and LRCD-CH.⁶• Adult Core Set: COB-AD, EDV-AD, GSD-AD (Glycemic Status >9.0% only), HPCMI-AD, LRCD-AD, PCR-AD, PQI01-AD, PQI05-AD, PQI08-AD, and PQI15-AD.• 1945 Health Home Core Set: PCR-HH <p>For PCR-AD and PCR-HH, the Observed Readmissions/Expected Readmissions (O/E) ratio is interpreted as “lower-is-better.” An O/E ratio < 1.0 means there were fewer readmissions than expected given the case mix. An O/E ratio = 1.0 means that the number of readmissions was the same as expected given the case mix. An O/E ratio > 1.0 means that there were more readmissions than expected given the case mix.</p>
---	---

⁶ To reduce state burden and report consistently across all states, CMS will calculate the LBW-CH, LRCD-CH, and LRCD-AD measures on behalf of states using National Vital Statistics System Natality data that are submitted by states and obtained through CDC Wide-ranging Online Data for Epidemiologic Research (WONDER) for the 2026 Core Sets.