



MEDICARE-MEDICAID COORDINATION OFFICE

DATE: November 17, 2025

TO: Medicare-Medicaid Plans

FROM: Nishamarie Mills
Acting Deputy Director, Medicare-Medicaid Coordination Office

SUBJECT: Revised Core and State-Specific Measure Reporting Expectations for Medicare-Medicaid Plans

The purpose of this memorandum is to announce changes to the measures Medicare-Medicaid Plans (MMPs) participating in the Medicare-Medicaid Financial Alignment Initiative are required to submit for the remainder of reporting period. Effective as of this memo, MMPs are only expected to report data for the core and state-specific measures that will be used for the quality withhold analysis for CY 2025. More information on the quality withhold methodology is available at: <https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-quality-withhold-methodology-technical-notes>.

Please see below for a complete list of the remaining core and state-specific measures MMPs should submit associated with the period of performance ending December 31, 2025, organized by state capitated model demonstration. For each measure, the corresponding quality withhold measure number from the Core and State-Specific Quality Withhold Technical Notes is provided in parentheses. MMPs are expected to report both the standard withhold measures and the alternative withhold measures.

This change will not result in revised Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements or Value Sets Workbooks. MMPs should continue to reference the latest Core and State-Specific Reporting Requirements and Value Sets Workbooks for the technical specifications, value sets, and other guidance on reporting these measures, available at: <https://www.cms.gov/medicare/medicaid-coordination/plans/mmp-reporting-requirements>. Additionally, this change does not affect required reporting by the MMPs through other vehicles or venues, such as HEDIS® and CAHPS®, including other measures that will be used for the CY 2025 quality withhold analysis.

Should you have any questions, please contact the Medicare-Medicaid Coordination Office at mmcocapsreporting@cms.hhs.gov.

LIST OF REQUIRED MEASURES

Illinois

- Core 2.3: Members with an annual reassessment (AW1)
- Core 5.3: Establishment of consumer advisory board or inclusion of consumers on a preexisting governance board consistent with contractual requirements (AW2)
- IL3.6: Movement of members within service populations (ILW10)

Massachusetts

- Core 2.1: Members with an assessment completed within 90 days of enrollment (MA7)
- Core 2.3: Members with an annual reassessment (AW1)
- Core 5.3: Establishment of consumer advisory board or inclusion of consumers on a preexisting governance board consistent with contractual requirements (AW2)
- Core 9.3: Minimizing Facility Length of Stay (MA12)
- MA5.1: MMP Centralized Enrollee Record (MA8)

Michigan

- Core 2.3: Members with an annual reassessment (AW1)
- Core 5.3: Establishment of consumer advisory board or inclusion of consumers on a preexisting governance board consistent with contractual requirements (AW2)
- Core 9.3: Minimizing Facility Length of Stay (MIW9)
- MI2.6: Timely transmission of care transition record to health care professional (MIW4)
- MI5.6: Care for Adults – Medication Review (MIW5)
- MI7.3: Annual Dental Visit (MIW8)

New York FIDA-IDD

- Core 2.3: Members with an annual reassessment (AW1)
- Core 5.3: Establishment of consumer advisory board or inclusion of consumers on a preexisting governance board consistent with contractual requirements (AW2)
- IDD2.3: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFIID) Diversion (IDDW4)
- IDD4.3: Annual Dental Visit (IDDW3)

Ohio

- Core 2.3: Members with an annual reassessment (AW1)
- Core 5.3: Establishment of consumer advisory board or inclusion of consumers on a preexisting governance board consistent with contractual requirements (AW2)
- Core 9.3: Minimizing Facility Length of Stay (OHW5)

Rhode Island

- Core 2.3: Members with an annual reassessment (AW1)

- Core 5.3: Establishment of consumer advisory board or inclusion of consumers on a preexisting governance board consistent with contractual requirements (AW2)
- RI4.5: Skilled nursing facility discharges to the community (RIW12)
- RI4.6: Skilled nursing facility hospital admissions (RIW13)

South Carolina

- Core 2.3: Members with an annual reassessment (AW1)
- Core 5.3: Establishment of consumer advisory board or inclusion of consumers on a preexisting governance board consistent with contractual requirements (AW2)
- SC2.4: Members with first follow-up visit within 30 days of hospital discharge (SCW7)

Texas

- Core 2.3: Members with an annual reassessment (AW1)
- Core 5.3: Establishment of consumer advisory board or inclusion of consumers on a preexisting governance board consistent with contractual requirements (AW2)
- Core 9.3: Minimizing Facility Length of Stay (TXW7)
- TX1.4: Members whose Integrated Plan of Care (IPC) is updated annually before the expiration date (TXW6)