Common Health Coalition

Last updated January 28, 2026

Explainer: The Impact of the New Federal Childhood Immunization Schedule on Quality Measures

What are the recent changes?

- On January 5, 2026, HHS announced changes to the CDC U.S. childhood and adolescent immunization schedule. These changes follow a Presidential Memorandum, representing a shift from previous recommendations being provided by the Advisory Committee on Immunization Practices (ACIP).
- Read here for more information about the changes.

What We Know:

On December 30, 2025, the Centers for Medicare & Medicaid Services (CMS) issued guidance removing four immunization-related measures from the 2026 Child and Adult Core Set quality measures that states must report to CMS. These were previously mandatory.

The specific immunization measures removed from required reporting include:

- Childhood Immunization Status (CIS-CH)
- Immunizations for Adolescents (IMA-CH)
- Prenatal Immunization Status: Under Age 21 (PRS-CH)
- Prenatal Immunization Status: Age 21 and Older (PRS-AD)

These quality measures are used widely by health plans, clinics, and public health agencies to assess the quality of preventive care. These are used across Medicaid and CMS programs, including the CMS Child Core Set and CMS' Universal Foundation Set.

Importantly, states may still voluntarily report these measures to CMS to maintain longitudinal data, but they are *no longer required.* Public and private payers and providers can similarly continue to include these quality measures in their contracts.

The Childhood Immunization Status (CIS-CH) and Immunizations for Adolescents (IMA-CH) are standardized quality measures created by the National Committee for Quality Assurance (NCQA) that track whether children receive a recommended set of vaccines by their 2nd birthday and 13th birthday, respectively.

Childhood Immunization Status (CIS-CH)	Immunizations for Adolescents (IMA-CH)
• DTaP – Diphtheria, Tetanus, and acellular Pertussis (4 doses) • IPV – Inactivated Polio Vaccine (3 doses) • MMR – Measles, Mumps, and Rubella (1 dose) • HiB – Haemophilus influenzae type B (3 doses) • HepB* – Hepatitis B (3 doses) • VZV – Varicella (Chickenpox) (1 dose) • PCV – Pneumococcal Conjugate Vaccine (4 doses) • HepA* – Hepatitis A (1 dose) • RV* – Rotavirus (2 or 3 doses) • Influenza* – Flu Vaccine (2 doses)	• Meningococcal ACWY* (1 dose) • Tdap - Tetanus, diphtheria, and acellular pertussis (1 dose) • HPV - Human papillomavirus (2 or 3 doses)#

*Vaccines shifted from routine recommendation to recommended for high risk groups (HepB, HepA, meningococcal ACWY and B) and/or shared clinical decision making (RV, influenza, meningococcal ACWY and B)
HPV vaccine is now recommended as a single dose vaccine

New HHS Childhood Immunization Schedule: On January 5, 2026, HHS announced changes to the CDC U.S. childhood and adolescent immunization schedule. These changes follow a Presidential Memorandum, representing a shift from previous recommendations being provided by the Advisory Committee on Immunization Practices (ACIP).

The AAP 2026 childhood immunization schedule: Released on Jan 26, the AAP schedule remains consistent with the childhood and adolescent immunization quality measures.

Why these quality measures matter:

- ***Health benefits*:** At a time in their lives when they are most vulnerable to disease, childhood vaccines protect them from a number of serious and potentially life-threatening diseases (e.g., diphtheria, measles, meningitis, polio, tetanus, whooping cough). High CIS & IMA performance also supports herd immunity, protecting the youngest babies and people who can't be vaccinated for medical reasons.
- ***Impacts health care finance*:** As a Medicaid core child set measure, CIS & IMA performance are often linked to financial incentives.
- ***Drives health system priorities & investments*:** Clinics and health plans use CIS & IMA results to improve reminder systems, follow-up, and care coordination.

Potential impacts of not having data from these quality measures:

Because Medicaid and CHIP cover a large share of U.S. children, particularly children from low-income families and historically marginalized communities, eliminating required reporting on how many children receive recommended immunizations reduces federal visibility into vaccination coverage trends and inequities. Without these data, it may become harder for states to monitor trends over time, identify gaps in uptake, and deploy strategies to help increase coverage where it's most needed at the local level. Additionally, researchers and policymakers may lose a national, deidentified dataset on childhood immunization rates. States may have less standardized data across Medicaid/CHIP to compare performance across providers or regions, or evaluate the effectiveness of interventions.

What can health leaders do to protect access to these measures:

Payers	**Risks:** Loss of standardized data; weaker incentives for vaccination **Actions:** • Continue using CIS-CH, IMA-CH, and prenatal immunization measures in Medicaid and commercial contracts • Maintain financial incentives tied to immunization performance • Clearly signal to providers that immunization measures remain a priority despite CMS changes
Providers & health care systems	**Risks:** Deprioritization of immunizations; erosion of reminder/recall and care coordination systems **Actions:** • Continue tracking immunization quality measures internally • Maintain EHR prompts, reminder/recall, and outreach workflows • Align clinical practice with AAP-consistent immunization schedules

Public health	**Risks:** Reduced visibility into vaccination trends and inequities; weaker coordination across stakeholders **Action:** ● Voluntarily continue reporting immunization measures to CMS ● Use IIS and Medicaid data to monitor coverage gaps ● Convene payers and providers to sustain alignment on immunization quality measures