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Recommendations for Improving the Medicaid Health Home Core Sets of Health Care Quality Measures

Summary of a Workgroup Review of the 2026 Health Home Core Sets

Final Report

October 2024

2026 HEALTH HOME CORE SETS ANNUAL REVIEW WORKGROUP MEMBERS

Voting Member (Affiliation as of June 2024)

Kim Elliot, PhD, CPHQ, CHCA, Co-Chair
Health Services Advisory Group

Jeff Schiff, MD, MBA, Co-Chair
AcademyHealth

David Basel, MD
Avera Medical Group

Macy Daly, MPA
Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals

Ari Houser, PhD
AARP Public Policy Institute

Amy Houtrow, MD, PhD, MPH, FAAP
University of Pittsburgh School of Medicine

Pamela Lester, RN, BSN, MSHS
Iowa Medicaid Enterprise

Elizabeth Nichols, PhD, MS
New York State Department of Health

Kayla Romero. MPH
New Mexico Human Services Department

Pamela Tew, MSS, LSW
ZERO TO THREE

Sara Toomey, MD, MPhil, MSc
Boston Children's Hospital

Laura Vegas, MPS
National Association of State Directors of Developmental Disability Services

Jeannie Wigglesworth. MS
Connecticut HUSKY Health Behavioral Health Administrative Services Organization

Federal Liaisons (Nonvoting)

Administration for Community Living, DHHS

Agency for Healthcare Research and Quality, DHHS

Center for Clinical Standards and Quality, CMS, DHHS

Department of Veterans Affairs

Health Resources and Services Administration, DHHS

Office of Disease Prevention and Health Promotion, DHHS

Office of Minority Health, DHHS

Substance Abuse and Mental Health Services Administration, DHHS

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Project Director: Rosemary Borck, Mathematica

Research, analytics, and logistics team: Emily Costello, Maria Dobinick, Talia Parker, Patricia Rowan, Kalidas Shanti, and Madelaine Spiering, Mathematica

Communications Support: Christal Stone Valenzano and Derek Mitchell, Mathematica

Technical Writers: Reatha Conn, Vimbai Madzura, and Megan Thomas, Aurrera Health Group

Mathematica also acknowledges the contributions of the Health Home Core Sets Annual Review Workgroup members. Each Workgroup member brought an invaluable perspective that informed the recommendations for the 2026 Health Home Core Sets. In particular, we thank the Workgroup co-chairs, Jeff Schiff and Kim Elliot, for their insightful leadership. We also appreciate the participation of the federal liaisons, who provided cross-agency insights during the meetings.

In addition, we express our gratitude to the measure stewards who made themselves available throughout the review process. We appreciate the information they provided on the measures under consideration and thank them for responding to questions from the Workgroup during the meeting.

Mathematica also appreciates the comments provided by members of the public during the Workgroup meetings. The diversity of perspectives enriched the discussion about strengthening the Health Home Core Sets.

Finally, we thank the staff in the Medicaid Benefits and Health Programs Group and the Division of Quality and Health Outcomes at CMCS for their input and guidance.

Contents

Exhibits

Acronyms

AHRQ	Agency for Healthcare Research and Quality
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
DHHS	United States Department of Health and Human Services
ECDS	Electronic Clinical Data Systems
EHR	Electronic Health Record
HEDIS	Healthcare Effectiveness Data and Information Set®
LOINC®	Logical Observation Identifiers Names and Codes
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
QTAG	CMCS's Quality Technical Advisory Group
SMI	Serious mental illness
SPA	State plan amendment
SUD	Substance Use Disorder
TA	Technical assistance
TA/AS	Technical Assistance and Analytic Support

Executive Summary

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Affordable Care Act (Section 1945 of the Social Security Act), permits states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with complex needs. As of October 1, 2022, states can also submit state plan amendments (SPAs) to cover health home services for children with complex medical conditions under Section 1945A of the Social Security Act.[1] Health homes integrate physical and behavioral health (including both mental health and substance use) and long-term services and supports for high-need, high-cost Medicaid populations. As of June 2024, 20 states[2] have a total of 34 approved 1945 Health Home Programs with some states submitting multiple SPAs to target different populations or phase in implementation.[3,4,5] As of the publication of this report, no 1945A health home programs have been approved.

To help ensure that health home enrollees receive high-quality and equitable care, the Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various tools to measure and monitor the quality of care that health home enrollees receive, and drive improvement in care delivery and health outcomes. The Medicaid Health Home Core Sets[6] of health care quality measures are key tools in this effort.

The purpose of the Health Home Core Sets is to estimate the overall quality of care for Medicaid health home enrollees based on a uniform set of health care quality measures. CMS and states use the Health Home Core Sets to monitor access to and the quality of health care for health home enrollees, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives.

To ensure the Health Home Core Sets continue to reflect and be responsive to the needs of the health home population, the Health Home Core Sets Annual Review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Health Home

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[1] As defined in Section 1945A(i) of the Social Security Act. More information is available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd22004.pdf.

[2] In this document, the term "states" includes the 50 states and the District of Columbia.

[3] Centers for Medicare & Medicaid Services. "Medicaid Health Homes: State Plan Amendment Overview." June 2024. Available at https://www.medicaid.gov/resources-for-states/downloads/hh-spa-overview-jun-2024.pdf.

[4] A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid program. When a state is planning to change its program policies or operational approach, it submits an SPA to CMS for review and approval. More information on health home SPAs is available at https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html.

[5] Health Home Core Set measures are reported at the program (SPA) level.

[6] Collectively, the Health Home Core Sets refer to quality measures for 1945 Medicaid Health Home Programs and a separate set of quality measures for 1945A Medicaid Health Home Programs. This report refers to the Health Home Core Sets when referencing both measure sets collectively and differentiates them as the 1945 and 1945A Health Home Core Sets where appropriate.

Core Sets. The annual review includes input from a variety of groups, including but not limited to states, managed care plans, health care providers, and quality experts.

CMS contracted with Mathematica to convene the 2026 Medicaid Health Home Core Sets Annual Review Workgroup. The Workgroup included 13 members, who represented a diverse array of affiliations, subject matter expertise, and experience in quality measurement and improvement (see the inside front cover for a list of Workgroup members).

The Workgroup was charged with assessing the 2025 1945 and 1945A Health Home Core Sets and recommending measures for addition or removal, with the goal of strengthening and improving the 2026 Health Home Core Sets. Workgroup members were asked to suggest, discuss, and vote on measures for removal or addition to the Health Home Core Sets based on several criteria. These criteria support the adoption of measures that are feasible and viable for reporting at the health home program level, are actionable by state Medicaid agencies, and represent strategic priorities for improving care delivery and health outcomes for Medicaid health home enrollees. See Exhibit ES.1 for the criteria that Workgroup members considered during the 2026 Health Home Core Sets Annual Review.

Exhibit ES.1. Criteria Considered for Addition of New Measures to and Removal of Existing Measures from the 2026 Health Home Core Sets

Criteria for Suggesting Measures for Addition	
Minimum Technical Feasibility Requirements	
1.	The measure must be fully developed and have detailed technical specifications that enable production of the measure at the program level (e.g., numerator, denominator, and value sets).
2.	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.
3.	An available data source or validated survey instrument exists that contains all of the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
4.	The specifications and data source must allow for consistent calculations across health home programs (e.g., coding and data completeness).
5.	The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Health Home Core Set.
Actionability and Strategic Priority	
1.	Taken together with other Health Home Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid health home programs.
2.	The measure should be suitable for comparative analyses of disparities by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.
3.	The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid health home programs.
4.	The measure can be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid health home programs/providers).

Exhibit ES.1 *(continued)*

Other Considerations
1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across health home programs, taking into account Medicaid population sizes and demographics.
2. The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3. All health home programs should be able to produce the measure for Core Set reporting within two years of the measure being added to the Core Set and be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).
Criteria Considered for Suggesting Measures for Removal
Technical Feasibility
1. The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the program level (e.g., numerator, denominator, and value sets).
2. States report significant challenges in accessing an available data source that contains all of the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
3. The specifications and data source do not allow for consistent calculations across health home programs (e.g., there is variation in coding or data completeness across states).
4. The measure is being retired by the measure steward and will no longer be updated or maintained.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid health home programs.
2. The measure is not suitable for comparative analyses of disparities by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.
3. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid health home programs (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
4. The measure cannot be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure is topped out, trending is not possible, or improvement is outside of the direct influence of Medicaid health home programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across health home programs, taking into account Medicaid population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All health home programs may not be able to produce the measure within two years of the reporting cycle under review or may not be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).

Workgroup members convened virtually on June 25 and June 26, 2024, to review one measure suggested for addition to the 1945 Health Home Core Set—*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*—and two measures suggested for addition to both the 1945 and 1945A Health Home Core Sets—*Metabolic Monitoring for Children and Adolescents on Antipsychotics* and *Social Needs Screening and Intervention*. No measures were suggested for removal from either of the Health Home Core Sets.

For a measure to be recommended for addition to the Health Home Core Sets, at least two-thirds of the Workgroup members eligible to vote had to vote in favor of addition. The Workgroup discussed the measures and did not recommend adding any measures to the 2026 Health Home Core Sets.

Beginning with the 2027 Health Home Core Sets Annual Review cycle, Mathematica will conduct a public call for measures. To help inform the 2027 public call, the Workgroup discussed priority gap areas in the current Health Home Core Sets. Workgroup members also discussed the criteria for measure submission during the public call. This discussion concentrated on three themes: (1) actionability and strategic priority, (2) balance of measures to address the whole person, and (3) the need for informational resources to support the public call.

Workgroup members also discussed additional priorities for the Health Home Core Sets, including understanding and measuring the effectiveness of care management; identifying and addressing unmet health and community-based needs; and including measures in the Core Sets specified for the health home population, such as condition-specific measures or those related to whole person care for young children with complex medical needs.

This report summarizes the 2026 Health Home Core Sets Annual Review Workgroup's review process, discussion, and recommendations. The draft report was made available for public comment from August 30, 2024, through October 15, 2024, and one public comment was received. CMS will use the final report and additional input from federal liaisons to inform decisions about updates to the 2026 Health Home Core Sets. CMS will release the 2026 Health Home Core Sets by early 2025.

Introduction

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Affordable Care Act (Section 1945 of the Social Security Act), allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with complex needs. As of October 1, 2022, states can also submit state plan amendments (SPAs) for the new 1945A health home state plan option that allows states to provide health home services for children with complex medical conditions under Section 1945A of the Social Security Act.[7] Health homes integrate physical and behavioral health (including both mental health and substance use) and long-term services and supports for high-need, high-cost Medicaid populations. States interested in implementing a health home program must submit an SPA to the Centers for Medicare & Medicaid Services (CMS).[8]

1945 Health Home Programs

States choosing to implement a health home program under Section 1945 of the Social Security Act (referred to as "1945 health home programs") are able to target enrollment based on condition and geography but cannot limit enrollment by age, delivery system, or dual eligibility status. Each health home program requires a separate SPA.[9] As of June 2024, 20 states[10] have 34 approved health home programs, with some states submitting multiple SPAs to target different populations.[11, 12]

To qualify for 1945 Medicaid Health Home services, beneficiaries must meet one of the following criteria: have a diagnosis of two chronic conditions, have a diagnosis of one chronic condition and be at risk for a second, or have a diagnosis of a serious mental illness (SMI). Section 1945(h)(2) of the Social Security Act defines "chronic condition" to include mental health conditions, substance use disorder (SUD), asthma, diabetes, heart disease, and overweight (body mass index over 25). CMS might consider additional chronic conditions, such as human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), for approval.[13]

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[7] As defined in Section 1945A(i) of the Social Security Act. More information is available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd22004.pdf.

[8] More information on Medicaid Health Home Programs is available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html.

[9] A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid program. When a state is planning to change its program policies or operational approach, the state submits an SPA to CMS for review and approval. More information on Health Home Programs is available at https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html.

[10] In this document, the term "states" includes the 50 states and the District of Columbia.

[11] A list of all approved Health Home Programs as of June 2024 is available at https://www.medicaid.gov/resources-for-states/downloads/hh-spa-overview-jun-2024.pdf.

[12] Health Home Core Set measures are reported at the program (SPA) level.

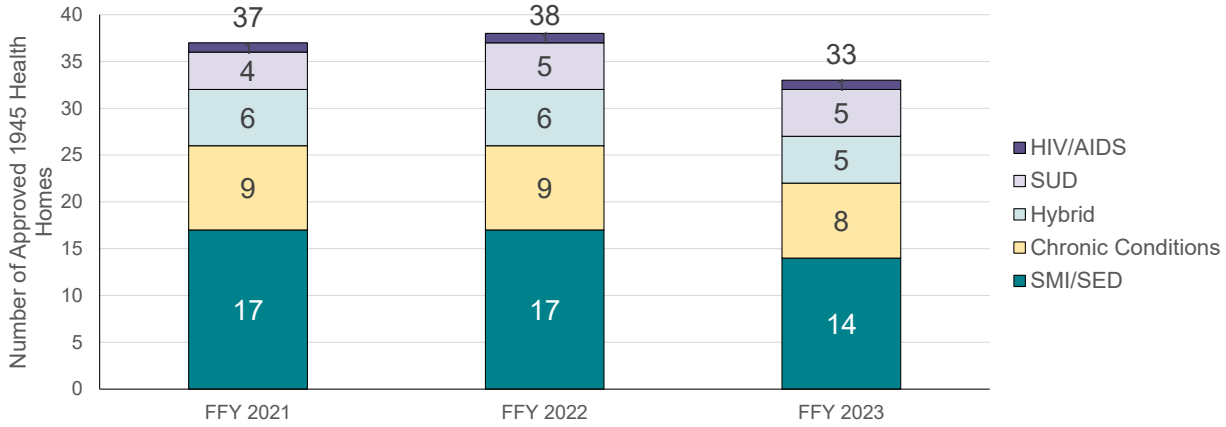
[13] Medicaid.gov. "Health Homes." n.d. https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html.

Additionally, Medicaid health home programs must provide the following core services to enrollees:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
- Individual and family support services
- Referral to community and social services
- The use of health information technology to link services, as feasible and appropriate

Exhibit 1 shows the distribution of approved 1945 health home programs by target population from 2021 to 2023. In 2023, 14 1945 health home programs served people with SMI; another eight programs served people with chronic conditions. Five hybrid health home programs had two or more focus areas.

Exhibit 1. Number of Approved 1945 Health Home Programs by Target Population, 2021–2023



Source: Centers for Medicare & Medicaid Services, Medicaid and Children's Health Insurance Program (CHIP) Core Set Technical Assistance and Analytic Support Program, January 2024.
Notes: Hybrid health home programs refer to those that have two or more areas of focus (for example, SUD and SMI/SED). Focus areas may have been updated since January 2024.
HIV/AIDS = human immunodeficiency virus/acquired immunodeficiency syndrome; SMI/SED = serious mental illness/serious emotional disturbance; SUD = substance use disorder.

1945A Health Home Programs

Section 1945A of the Social Security Act authorizes a health home state plan option for children with medically complex conditions and allows states to design health home programs to support

a family-centered system of care for those children. Although 1945 health home programs cannot limit enrollment by age, 1945A health home programs are for children up to 21 years of age.

To qualify for 1945A health home services, beneficiaries must be eligible for medical assistance under the state plan or an applicable waiver. They must also meet specific diagnostic criteria, which include one or more chronic conditions that cumulatively affects three or more organ systems and severely reduces cognitive or physical functioning (such as the ability to eat, drink, or breathe independently) and that also requires the use of medication, durable medical equipment, therapy, surgery, or other treatments; or one life-limiting illness or rare pediatric disease as defined by the Federal Food, Drug, and Cosmetic Act. [14]

1945A health home programs must provide the following core services to enrollees:

- Comprehensive care management
- Care coordination, health promotion, and the provision of access to the full range of pediatric specialty and subspecialty medical services, including services from out-of-state providers, as medically necessary
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
- Member and family support (including support of authorized representatives)
- Referral to community and social services, if relevant
- Use of health information technology to link services, as feasible and appropriate

As of the publication of this report, no 1945A health home programs have been approved.

Health Home Quality Reporting

To help ensure that health home enrollees receive high-quality and equitable care, CMS and its Center for Medicaid and CHIP Services (CMCS) use various tools to measure and monitor the quality of care that health home enrollees receive and to drive improvement in care delivery and health outcomes. The Health Home Core Sets of health care quality measures are key tools in this effort. Collectively, the Health Home Core Sets refer to quality measures for 1945 Medicaid health home programs and a separate set of quality measures for 1945A Medicaid health home programs. This report refers to the Health Home Core Sets when referencing both measure sets collectively and differentiates them as the 1945 and 1945A Health Home Core Sets where appropriate.

[14] More information about 1945A health home programs is available at https://www.medicaid.gov/sites/default/files/2022-08/smd22004_0.pdf.

The purpose of the Health Home Core Sets is to estimate the overall quality of care for Medicaid health home enrollees based on a uniform set of health care quality measures. CMS and states use the Health Home Core Set measures to monitor access to and the quality of health care for health home enrollees, identify where disparities exist and improvements are needed, and develop and assess quality improvement initiatives to drive improvement in the quality of care.

To ensure the Health Home Core Sets continue to reflect and respond to the needs of the health home population, the Health Home Core Sets Annual Review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Health Home Core Sets. The annual review includes input from a variety of groups, including but not limited to states, managed care plans, health care providers, and quality measurement experts. The 1945 Health Home Core Set has undergone these annual reviews since 2021; the 2025 Annual Review was the first review cycle for the 1945A Health Home Core Set.

CMS contracted with Mathematica to convene the 2026 Medicaid Health Home Core Sets Annual Review Workgroup.[15, 16] The Workgroup included 13 voting members, who represented a diverse array of affiliations, subject matter expertise, and experience in quality measurement and performance improvement (see the inside front cover of this report for a list of members).

The Workgroup was charged with assessing the Health Home Core Sets. Workgroup members were asked to suggest, discuss, and vote on measures for addition to or removal from the Health Home Core Sets based on several criteria that support the use of the Health Home Core Set measures to meaningfully drive improvement in care delivery and health outcomes for Medicaid health home enrollees.

This report provides an overview of the Health Home Core Sets, describes the 2026 Health Home Core Sets Annual Review process, and summarizes the Workgroup's recommendations for improving the Health Home Core Sets. A draft of this report was made available for public comment from August 30, 2024, through October 15, 2024, and one public comment was received which is included as Appendix B.

[15] More information about the annual review of the Health Home Core Sets is available at https://www.mathematica.org/features/hhcoresetreview.

[16] Mathematica also supported CMS by convening the Child and Adult Core Set Annual Review Workgroup to review and strengthen the 2025 Child and Adult Core Sets. More information about the annual review of the Child and Adult Core Sets is available at https://www.mathematica.org/features/MACCoreSetReview.

Overview of the Health Home Core Sets

CMS established the Health Home Core Set of Quality Measures in January 2013 for the purpose of ongoing monitoring and evaluation across all 1945 health home programs. States reported Health Home Core Set measures for the first time for 2013. States most recently completed Health Home Core Set reporting for 2023, which generally covers services delivered in calendar year 2022. As a condition of receiving payment for Section 1945 health home services, Medicaid health home providers are required to report quality measures to the state; states are expected to report these measures to CMS (42 U.S.C. Section 1945(g)). States are expected to report all Health Home Core Set measures, regardless of the health home program focus area, and also the measures separately for each of their health home programs. Beginning in 2024, reporting of the Medicaid Health Home Core Sets will be mandatory for states with approved health home programs in operation for at least six months of the reporting period.

Appendix A includes tables listing the 2025 Health Home Core Set measures and the history of measures included in the Health Home Core Set. Of the 11 measures in the 2025 Health Home Core Set, about half were part of the initial Health Home Core Set established in 2013.

The 2025 1945 Health Home Core Set

The 2025 Health Home Core Set includes 11 measures, nine of which are quality measures and two of which are utilization measures. All of the measures can be calculated using an administrative data collection methodology.

CMS publicly reports data for Health Home Core Set measures that at least 15 health home programs reported and met CMS standards for data quality.[17] Highlights for 2022 Health Home Core Set reporting,[18] the most recent year for which data are publicly available, include the following:

- Of the 38 health home programs expected to report the 2022 Health Home Core Set measures, 34 programs reported at least one measure. The other four programs did not submit data in time to be included in publicly reported data.
- States reported a median of 10.5 of the 13 Health Home Core Set measures for 2022.
- Between 2020 and 2022, six measures were reported by at least two-thirds of the 26 health home programs expected to report in all three reporting years.

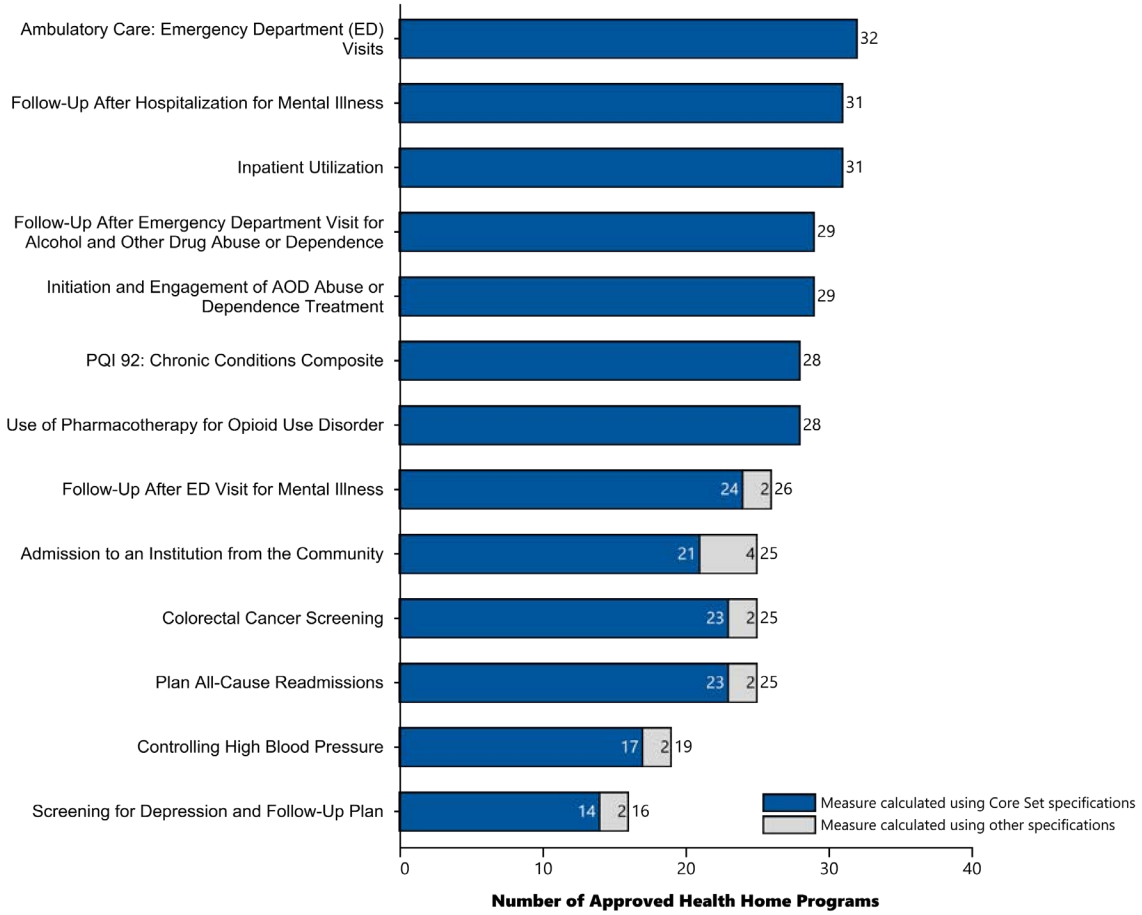
[17] More information about performance analysis and trending of Health Home Core Set measures is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/health-home-core-set-methods-brief-nov-2021.pdf.

[18] More information on health home quality reporting is available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html.

- Reporting remained consistent or increased for 23 of the 30 health home programs that reported for all three years from 2020 to 2022.

Exhibit 2 summarizes the number of health home programs reporting the 1945 Health Home Core Set measures for 2022. The most commonly reported measures reported for 2022 were the Ambulatory Care: Emergency Department (ED) Visits measure, the Follow-Up After Hospitalization for Mental Illness measure, and the Inpatient Utilization measure. The least frequently reported measures for 2022 were the Screening for Depression and Follow-Up Plan (CDF-HH) measure and the Controlling High Blood Pressure (CBP-HH) measure.

Exhibit 2. Number of Health Home Programs Reporting the 2022 1945 Health Home Core Set Measures



Source: Centers for Medicare & Medicaid Services, Medicaid and Children's Health Insurance Program (CHIP) Core Set Technical Assistance and Analytic Support Program, March 2024. https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2022-health-home-chart-pack.pdf.

Notes: This chart includes all Health Home Core Set measures that states reported for the 2022 reporting cycle. Unless otherwise specified, states used Health Home Core Set specifications to calculate the measures. Some states calculated Health Home Core Set measures using "other specifications." Measures were denoted as using other specifications when the state deviated substantially from the Health Home Core Set specifications, such as using alternate data sources, different populations, or other methodologies.

AOD = alcohol or other drugs; PQI = Prevention Quality Indicator.

Understanding challenges states encounter with reporting the Health Home Core Set measures is important in assessing the feasibility of calculating existing measures as well as those suggested for addition to the Health Home Core Set. The most common reasons states cited for not reporting a Health Home Core Set measure for 2022 were that they did not collect the data or lacked the ability to link data sources to calculate the measure. Another common barrier was staff and budgetary constraints. Finally, small health home populations and continuous enrollment requirements limited the number of health home enrollees eligible for some of the measures.

The 2025 1945A Health Home Core Set

The 2025 1945A Health Home Core Set[19] includes six measures, all of which can be calculated using an administrative data collection methodology. All of the measures are also included in either the 1945 Health Home Core Set or the Child Core Set.[20] CMS would expect states to report 2025 1945A Health Home Core Set measures for any health home programs approved no later than July 1, 2024.[21] As of the publication of this report, no 1945A health home programs have been approved.

Use of the Health Home Core Sets for Quality Measurement and Improvement

CMS and states use the Health Home Core Sets to monitor and improve the quality of care provided to Medicaid beneficiaries enrolled in health homes and to measure progress over time. CMS publicly reports information on state performance on the Health Home Core Set annually through chart packs and other resources.[22]

Through its Technical Assistance and Analytic Support (TA/AS) Program, CMCS supports states and their partners in collecting, reporting, and using the Health Home Core Set measures to drive improvement in Medicaid health home programs while striving to achieve several goals for reporting. These goals include maintaining or increasing the number of health home programs that report the Health Home Core Set measures, maintaining or increasing the number of measures that states report for each of their health home programs, and improving the quality

[19] The 2025 1945A Health Home Core Set is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/2025-1945a-health-home-core-set.pdf.

[20] 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.

[21] States are expected to report the Health Home Core Set measures when their approved health home programs have been in effect for six or more months of the measurement period.

[22] Chart packs, measure performance tables, facts sheets, and other Health Home Core Set annual reporting resources are available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html.

and completeness of the data reported.[23] CMS also continuously explores opportunities to increase the efficiency of reporting and reduce state reporting burden, streamline Health Home Core Set reporting for states, and improve the transparency and comparability of the data reported across health home programs. The TA/AS Program offers states various opportunities to address technical issues related to collecting and reporting the Health Home Core Set measures, including a TA mailbox, one-on-one consultation, issue briefs, fact sheets, analytic reports, and webinars. The CMS Quality Conference also provides states with information to support their quality measurement and improvement efforts.

[23] More information about the CMCS TA/AS Program is available at https://www.medicaid.gov/medicaid/quality-of-care/downloads/tafactsheet.pdf.

Description of the 2026 Health Home Core Sets Annual Review Process

This section describes the 2026 Health Home Core Sets Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2026 Health Home Core Sets Annual Review included 13 voting members from state Medicaid and CHIP programs, managed care plans, professional associations, universities, hospitals, consumer advocacy groups, and other organizations from across the country. The Workgroup members for the 2026 Health Home Core Sets Annual Review are listed on the inside front cover of this report. Of the 13 voting members on the 2026 Workgroup, four were new members. Prior to the launch of the 2026 review cycle, additional Workgroup members were identified through outreach to nominating organizations when former Workgroup members resigned due to career transitions.

The 2026 Health Home Core Sets Annual Review Workgroup members offered expertise in health home quality measurement and improvement as well as subject matter expertise related to the needs of Medicaid health home enrollees, such as behavioral health and care of children with medically complex conditions. Although Workgroup members had individual subject matter expertise, they were asked to participate as stewards of the Medicaid health home program as a whole and not represent their individual or organizational points of view. They also were asked to consider what measures would best drive improvement in care delivery and health outcomes for health home enrollees.

Workgroup members were required to submit a Disclosure of Interest form to report any interests, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest, or the appearance of one, related to the current measures in the Health Home Core Sets or other measures reviewed during the Workgroup process. Workgroup members deemed to have an interest in a measure recommended for consideration were required to recuse themselves from voting on that measure.

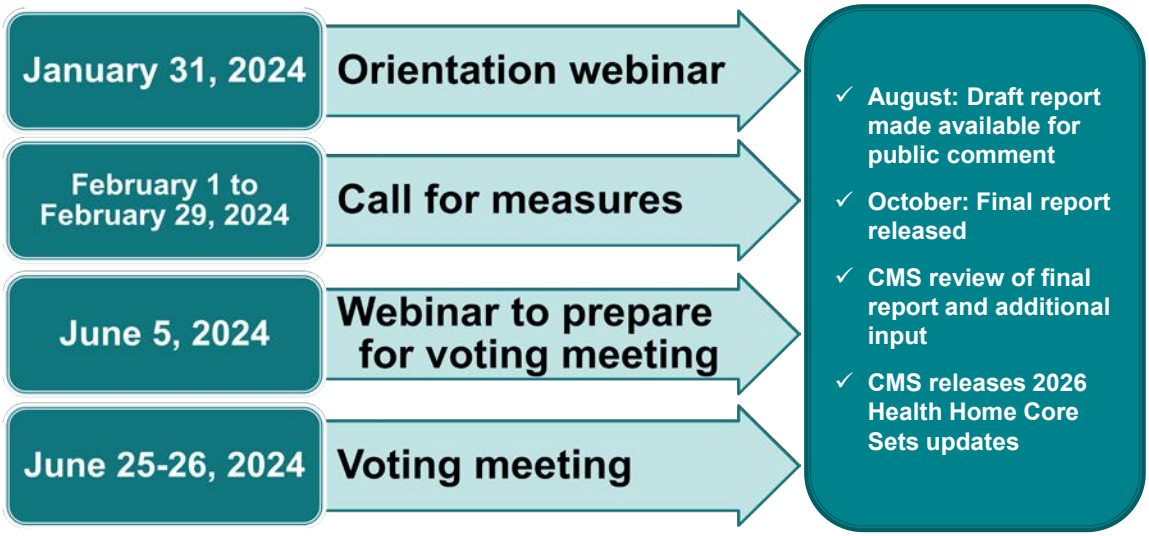
The Workgroup also included nonvoting federal liaisons representing eight federal agencies (see the inside front cover). The inclusion of federal liaisons reflects CMCS's commitment to promoting quality measurement alignment and working in partnership with other federal agencies to collect, report, and use the Health Home Core Sets to drive improvement in care delivery and health outcomes for Medicaid health home enrollees.

Workgroup Timeline and Meetings

As shown in Exhibit 3, Mathematica held webinars in January and June 2024 to orient Workgroup members to the review process and prepare them for the 2026 Health Home Core Sets Annual Review voting meeting, which took place virtually in June 2024. The two webinars

and the 2026 Annual Review voting meeting were open to the public, with public comment invited during each meeting.

Exhibit 3. Timeline for the 2026 Health Home Core Set Annual Review Workgroup



Orientation Webinar

During the orientation webinar on January 31, 2024, Mathematica introduced the Workgroup members; discussed the Disclosure of Interest process; outlined the Workgroup charge; described the timeline for the 2026 Health Home Core Sets Annual Review; and described additional input that CMCS will obtain during the 2026 Annual Review process, including input from internal partners within CMS and other federal partners.

After providing an overview of the 2026 Health Home Core Sets Annual Review, Mathematica provided background on the Health Home Core Sets, including an overview of Sections 1945 and 1945A and an update that CMS will release the 2025 Core Sets in early 2024 based on the recommendation of the 2025 Annual Review. Mathematica also presented the timeline for mandatory reporting of the

Workgroup Charge

The 2026 Health Home Core Sets Annual Review Workgroup is charged with assessing the Health Home Core Sets and recommending measures for addition or removal in order to strengthen and improve the Core Sets.

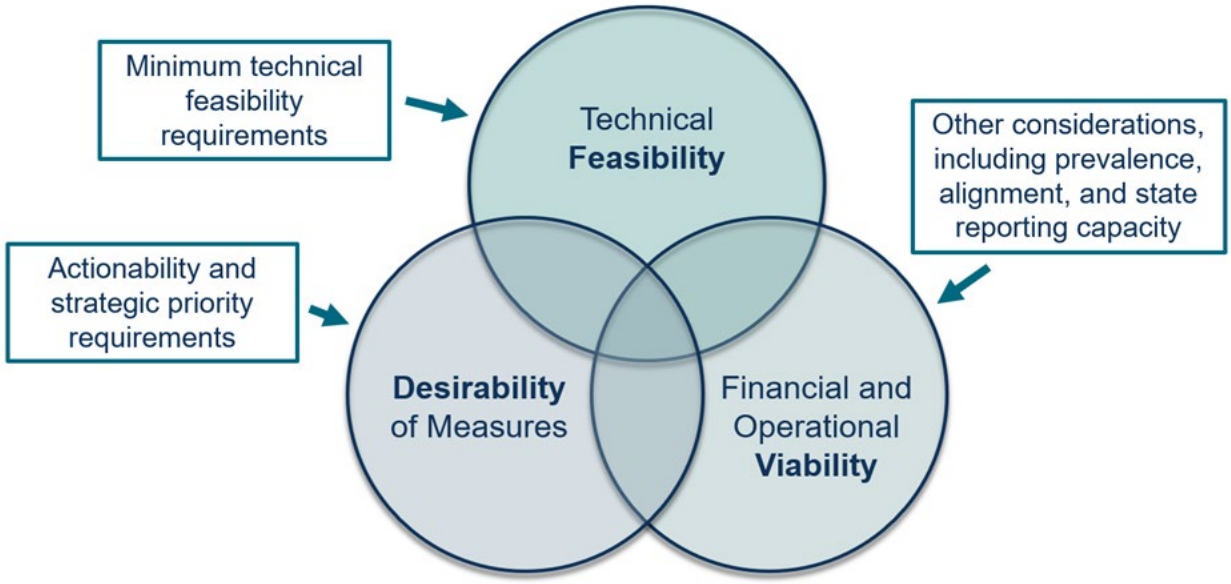
The Workgroup should focus on recommending measures that are actionable, aligned, and appropriate for program-level reporting to ensure the measures can meaningfully drive improvement in health care delivery and outcomes for Medicaid Health Home Program enrollees.

With mandatory reporting requirements beginning in 2024, the Workgroup should consider the feasibility of reporting by states for all Medicaid populations enrolled in Health Home Programs, as well as opportunities for advancing health equity through stratification of Health Home Core Set measures where feasible.

Health Home Core Sets starting in 2024, requirements for states to stratify measures by various demographics categories, and gaps in the Core Sets identified during previous Annual Review meetings.

Mathematica also explained the call for measures process, through which Workgroup members and federal liaisons could suggest measures for removal from or addition to the Health Home Core Sets. Mathematica asked Workgroup members to balance three interdependent components when considering measures for removal or addition: (1) the technical feasibility of measures, (2) the desirability of measures, and (3) the financial and operational viability for states (Exhibit 4, next page).

Exhibit 4. Framework for Assessing Measures for the 2026 Health Home Core Sets



Mathematica then presented the criteria used to assess measures during all phases of the Workgroup process:

- **Minimum technical feasibility requirements.** Availability of detailed technical specifications that enable production of the measure at the program level; evidence of field testing or use in a state Medicaid program; availability of a data source with all of the necessary data elements to produce consistent calculations across health home programs; and technical specifications provided at no charge for state use.
- **Actionability and strategic priority requirements.** Contributes to estimating the overall national quality in Medicaid health home programs together with other measures in the Health Home Core Sets; allows for comparative analyses of disparities by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language; provides useful and actionable results to drive improvement in care delivery and health outcomes; and addresses a strategic performance measurement priority.

- **Other considerations.** Sufficient prevalence of the condition or outcome being measured to produce meaningful and reliable results across health home programs; alignment with measures used in other CMS programs; and capacity for all health home programs to report the measure within two years of the measure being added to the Core Sets.

CMCS also provided introductory remarks regarding the Workgroup's charge, underscoring the importance of ensuring a robust and reportable set of measures to drive improvements in health outcomes and the delivery of high-quality care to Medicaid health home enrollees. CMCS noted the administration's desire to look at measures that are feasible for program-level reporting, especially as mandatory reporting begins. CMCS also highlighted the importance of stratifying and examining measures that may address disparities and meet the needs of all beneficiaries.

Call for Measures

Following the orientation meeting, Workgroup members and federal liaisons were invited to suggest measures for removal from or addition to the Health Home Core Sets to strengthen and improve the Health Home Core Sets. Workgroup members used an online form to submit their suggestions for removal or addition and were asked to provide the following information about the measure(s):

- The rationale for the suggestion
- Information about the technical feasibility, actionability, and strategic priority of measures suggested for removal or addition
- Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language
- Whether the measure was previously reviewed by the Workgroup and, if so, information that justifies discussing it again
- Whether removal of the measure would leave a gap in the Core Sets
- Whether another measure was proposed to replace the one suggested for removal
- Potential barriers states could face in calculating the measures suggested for removal or addition within two years of the reporting cycle under review

The call for measures was open from February 1 to February 29, 2024. Workgroup members and federal liaisons suggested four measures for addition. Mathematica determined that one measure—*Emergency Department Visits for Chronic: Ambulatory Care Sensitive Conditions*—would not be discussed because it did not meet the minimum technical feasibility criteria of testing in state Medicaid and/or CHIP programs, or use by one or more state Medicaid and/or CHIP programs. No measures were suggested for removal.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on June 5, 2024. To help Workgroup members prepare for the discussion at the 2026 Annual Review meeting, Mathematica provided a list of the three measures to be considered for addition. Mathematica also identified the measure suggested for addition that would not be reviewed at the voting meeting and noted why the Workgroup would not discuss it. Mathematica provided guidance to the Workgroup about how to prepare for the measure discussions, including the criteria that Workgroup members should consider for recommending measures for addition to the Health Home Core Sets and the resources available to facilitate their review. These resources included detailed measure information sheets for each measure, a worksheet to record questions and notes for each one, the Medicaid and CHIP Beneficiary Profile, the Health Home Core Set History Table, links to the CMS Health Home Information Resource Center, Chart Packs and Measure Performance Tables, Health Home Measure Summaries, and the Health Home Core Set Resource Manual and Technical Specifications. Workgroup members were responsible for reviewing all materials related to the measures under consideration and attending the Annual Review meeting prepared with notes, questions, and preliminary votes on the three measures proposed for addition.

Annual Review Meeting Webinar

The 2026 Health Home Core Sets Annual Review voting meeting took place virtually on June 25 and 26, 2024. Workgroup members, federal liaisons, measure stewards, and members of the public participated in the meeting.

CMCS staff provided welcome remarks at the outset of the meeting and offered initial reflections on CMCS priorities and visioning for the Health Home Core Sets meeting. They then highlighted the importance of using the Health Home Core Sets to advance health equity through measure stratification, particularly with the mandatory reporting requirements beginning with 2024 reporting and mandatory stratification of select measures beginning in 2025. CMCS also shared the need to capture data to evaluate the effectiveness of health homes to ensure they meet all beneficiaries' needs.

The discussion then shifted to the measures suggested for addition. For each measure, Mathematica provided an overview, noted the key technical specifications of each, and summarized the rationale provided by the Workgroup member who suggested the measure.

Mathematica then facilitated a discussion of the measures. Mathematica sought comments and questions from Workgroup members about each measure and asked measure stewards to clarify measure specifications when needed. For each measure, an opportunity for public comment followed the Workgroup discussion before voting.

Mathematica facilitated voting on the measures suggested for addition. Workgroup members voted electronically through a secure web-based polling application during specified voting periods.

For each measure suggested for addition, Workgroup members could select either "Yes, I recommend adding this measure to the Core Set" or "No, I do not recommend adding this measure to the Core Set." For those measures suggested for both the 1945 and the 1945A Health Home Core Sets, Workgroup members voted on the measure twice—once for each Core Set.

Measures were recommended for addition if two-thirds of the eligible Workgroup members voted yes. The two-thirds voting threshold was adjusted according to the number of eligible Workgroup members present for each measure vote. Mathematica presented the voting results immediately after each vote and reported whether the results met the two-thirds threshold for a measure to be recommended for addition.

After voting on the final measure suggested for addition to the Core Sets, the Workgroup discussed priority gap areas and criteria for the 2027 public call for measures. A summary of the discussions about these priority gap areas and criteria for the public call for measures are presented later in this report.

Workgroup Recommendations for Improving the 2026 Health Home Core Sets

Criteria Considered for Removal of Existing Measures and Addition of New Measures

To focus the Workgroup discussion on measures that would be a good fit for the Health Home Core Sets, Mathematica specified detailed criteria for measures suggested for addition or removal. These criteria are classified into three areas: (1) technical feasibility, (2) actionability and strategic priority, and (3) other considerations (Exhibit 5).

To be considered by the Workgroup, all measures suggested for addition must meet minimum technical feasibility criteria. As noted earlier, Mathematica conducted a preliminary assessment of suggested measures before the Annual Review meeting to ensure that measures discussed by the Workgroup adhered to the minimum technical feasibility criteria.

Mathematica cited additional contextual factors to inform the Workgroup discussion:

- The Workgroup should consider each measure on its own merits according to the criteria. There is no target number of measures—maximum or minimum—for the Health Home Core Sets.
- The Workgroup should review, discuss, and vote on all measures as they are currently specified by the measure steward.

Exhibit 5. Criteria Considered for Removal of Existing Measures and Addition of New Measures to the 2026 Health Home Core Sets

Criteria for Suggesting Measures for Addition	
Minimum Technical Feasibility Requirements (all requirements must be met)	
1.	The measure must be fully developed and have detailed technical specifications that enable production of the measure at the program level (e.g., numerator, denominator, and value sets).
2.	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.
3.	An available data source or validated survey instrument exists that contains all of the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
4.	The specifications and data source must allow for consistent calculations across health home programs (e.g., coding and data completeness).
5.	The measure must include technical specifications (including code sets) provided free of charge for state use in the Core Set.
Actionability and Strategic Priority	
1.	Taken together with other Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid health home programs.

Exhibit 5 *(continued)*

Criteria for Suggesting Measures for Addition
2. The measure should be suitable for comparative analyses of disparities by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.
3. The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid health home programs.
4. The measure can be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid health home programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across health home programs, taking into account Medicaid population sizes and demographics.
2. The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3. All health home programs should be able to produce the measure for Core Set reporting within two years of the measure being added to the Core Set and be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).
Criteria for Suggesting Measures for Removal
Technical Feasibility
1. The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the program level (e.g., numerator, denominator, and value sets).
2. States report significant challenges in accessing an available data source that contains all of the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
3. The specifications and data source do not allow for consistent calculations across health home programs (e.g., there is variation in coding or data completeness across states).
4. The measure is being retired by the measure steward and will no longer be updated or maintained.
Actionability and Strategic Priority
1. Taken together with other Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid health home programs.
2. The measure is not suitable for comparative analyses of disparities by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.
3. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid health home programs (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
4. The measure cannot be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure is topped out, trending is not possible, or improvement is outside of the direct influence of Medicaid health home programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across health home programs, taking into account Medicaid population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.

Exhibit 5 *(continued)*

Criteria for Suggesting Measures for Addition	
3.	All health home programs may not be able to produce the measure within two years of the reporting cycle under review or may not be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).

Summary of Workgroup Recommendations

The Workgroup discussed one measure suggested for addition to the 1945 Health Home Core Set—*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*—and two measures suggested for addition to both the 1945 and 1945A Health Home Core Sets—*Metabolic Monitoring for Children and Adolescents on Antipsychotics,* and *Social Needs Screening and Intervention* (Exhibit 6). The Workgroup did not recommend adding these measures and therefore did not recommend any changes to the 2026 Health Home Core Sets. Because there were no measures recommended for addition to the 2026 1945 and 1945A Health Home Core Sets, this section focuses on the discussion of the measures suggested, but not recommended, for addition. It summarizes the discussion related to the measures considered for addition and the rationale for the Workgroup's decision not to recommend the measures to the 1945 and 1945A Health Home Core Sets.

Measure Information Sheets for each measure are available on the Mathematica Health Home Core Set Review Website.[24]

Exhibit 6. Measures Considered and Not Recommended for Addition to the 2026 Health Home Core Sets

Measure Name	Measure Steward
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA
Social Needs Screening and Intervention	NCQA

NCQA=National Committee for Quality Assurance

Measure Considered and Not Recommended for Addition: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication

The Workgroup did not recommend the addition of *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication* to the 1945 Health Home Core Set. The measure assesses the percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic

[24] The Measure Information Sheet for the measures suggested for addition is available at https://mathematica.org/-/media/internet/features/2024/health-home-core-set/misffy-2026-health-home-core-sets.pdf.

medication and had a diabetes screening test during the measurement year. The measure steward is the National Committee for Quality Assurance (NCQA); the data collection method is administrative.

The Workgroup member who suggested this measure for addition identified an opportunity to address gaps in integrated primary care and behavioral health in the 1945 Health Home Core Set. The Workgroup member shared that the cost of care for enrollees with diabetes is high, and individuals with uncontrolled diabetes who also have schizophrenia and bipolar diagnoses are prone to poor outcomes. The Workgroup member also noted an opportunity for alignment with the Adult Core Set, emphasizing diabetes management as a gap area for health home enrollees with chronic conditions.

A Workgroup member raised several questions about the measure technical specifications. The Workgroup member inquired about the prevalence of schizophrenia versus bipolar disorder within the measure denominator and whether the measure could be stratified by these conditions to understand the prevalence of each separately. The Workgroup member also asked about whether the numerator allows for both glucose and hemoglobin A1C testing, as well as the accuracy and frequency of each method, noting a significant difference in accuracy between the tests in determining whether someone has pre-diabetes or is at risk for diabetes. The measure steward responded that the measure is not typically stratified by condition, but that they might have data from the initial development of the measure. The measure steward offered a similar response to the question about the allowable diabetes screening tests and indicated that this information might be available from the initial measure development or obtainable in the future.

Several Workgroup members shared their perspectives on the benefits and limitations of the measure. One Workgroup member acknowledged the importance of screening this high-risk subpopulation but questioned whether this measure is the best option for national use. Another Workgroup member voiced concerns about the relevance and adequacy of the measure in representing a large enough patient population in most states. Another Workgroup member, voicing concern about adding new measures without removing others, and stressing the importance of prioritizing measures to avoid diluting resources, said that “if everything is a priority, then nothing is a priority.”

Conversely, a Workgroup member highlighted that they liked this measure because it addresses the increased risk of diabetes for individuals prescribed certain medications. The Workgroup member added that testing for diabetes or pre-diabetes, especially among health home enrollees, helps control the condition and is valuable for improving the quality of life and overall health outcomes of the population. Another Workgroup member said that their state uses the measure as part of their HEDIS measure set targeting their population with SMI. The Workgroup member shared that the state has not stratified the measure by schizophrenia and bipolar disorder, and finds the measure valuable because these conditions fall under SMI diagnoses.

The Workgroup also discussed the role of health homes in facilitating screening and care coordination. One Workgroup member noted that although health homes can encourage screenings, the measure focuses on whether screening occurs and questioned whether it is fair to measure health homes on this basis. Additionally, a Workgroup member shared that in their state, behavioral health and medical providers play a key role in encouraging medical appointments and screening for the SMI population.

There were no public comments during the discussion.

The Workgroup did not recommend this measure for addition.

Measure Considered and Not Recommended for Addition: Metabolic Monitoring for Children and Adolescents on Antipsychotics

The Workgroup did not recommend the addition of *Metabolic Monitoring for Children and Adolescents on Antipsychotics* to the 1945 or 1945A Health Home Core Sets. The measure assesses the percentage of children and adolescents ages 1 to 17 with two or more antipsychotic prescriptions who had metabolic testing. Three rates are reported:

1. Percentage of children and adolescents on antipsychotics who received blood glucose testing
2. Percentage of children and adolescents on antipsychotics who received cholesterol testing
3. Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing

The measure steward is NCQA; the data collection method is the HEDIS® Electronic Clinical Data Systems (ECDS), which includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.

The Workgroup member who suggested this measure for addition shared that there are gaps in the measures on the 1945 and 1945A Health Home Core Sets that focus on integrated primary care and behavioral health. The Workgroup member also noted that antipsychotic medications can elevate a child's risk for developing serious metabolic health complications.

A Workgroup member initiated the discussion by raising the rationale for recommending this measure for addition to the Home Health Core Sets when a similar measure for adults (*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication*) had just been discussed and not recommended for addition. One Workgroup member responded by highlighting that antipsychotics are used broadly in pediatrics for various conditions, making children a vulnerable population. The Workgroup member also emphasized the importance of early screening for metabolic disorders as a necessary component of treatment. Another Workgroup member reinforced this point, noting the potential long-term health impacts of not conducting metabolic testing for children on antipsychotics. The Workgroup member emphasized differences between children and adults in prescribing practices and routine

screening, underscoring the importance of metabolic monitoring to prevent lifelong complications from metabolic syndromes. Another Workgroup member stressed the importance of the measure due to the rise in off-label antipsychotic use in children without proper follow-up, which they said increases the risk of chronic conditions such as coronary artery disease and diabetes. They also said that early metabolic monitoring could prevent these conditions, reduce health care costs, and improve health outcomes. Another Workgroup member emphasized the potential significance of this measure in impacting children's health, noting that it may benefit the 1945A health home population more than the 1945 health home population.

Workgroup members also discussed potential implementation concerns. Another Workgroup member added concerns around being able to assess the burden of the measure on states because there are not yet any 1945A health home programs in operation. A Workgroup member acknowledged this Workgroup member's concerns, adding that because *Metabolic Monitoring for Children and Adolescents on Antipsychotics* is an ECDS measure and the data sources would be different, including use of case management records and other sources, its use would increase the resources needed to report the measure.

There were no public comments during the discussion.

The Workgroup did not recommend this measure for addition.

While the draft report was available for public comment, the American Academy of Pediatrics acknowledged and agreed with the implementation concerns raised by the Workgroup and strongly opposed inclusion of the measure in the Health Home Core Sets. They noted that the testing for metabolic monitoring referenced in the proposed measure included blood glucose, which differs from other clinical guidance in pediatrics where hemoglobin A1C is recommended for dysglycemia monitoring. They noted that antipsychotic medications are prescribed by subspecialists outside of the primary care medical home and if the measure were approved in the future, the use of the National Library of Medicine tool (RxNorm) should be investigated as a resource to account for the multiple medication formulations and newly approved medications in this class.

Measure Considered and Not Recommended for Addition: Social Needs Screening and Intervention

The Workgroup considered and did not recommend the addition of the *Social Needs Screening and Intervention* measure to the 1945 or 1945A Health Home Core Sets. This measure assesses the percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing, and transportation needs, and received a corresponding intervention if they screened positive. Six rates are reported:

1. Food screening
2. Food intervention

3. Housing screening
4. Housing intervention
5. Transportation screening
6. Transportation intervention

The measure steward is NCQA; the data are specified for NCQA's HEDIS ECDS data collection method.

The Workgroup member who suggested this measure for addition acknowledged challenges around data collection but emphasized the improvements that have been made due to the inclusion of alternative data sources, such as case management records. They also noted the measure's actionability and alignment with CMCS's strategic priorities. They added that social needs have been linked to lack of utilization of preventive, screening, and well care, as well as increased incidence of chronic disease and inappropriate utilization of services. The Workgroup member stated that health plans have been working consistently, and with increasing frequency, on health-related social needs to improve care, service delivery, and outcomes for members. They noted that although this measure involves a newer area for measurement, there is significant room for improvement to address social needs.

The Workgroup's discussion of *Social Needs Screening and Intervention* highlighted the tension between desirability of the measure and concern about its validity and feasibility. Two Workgroup members had questions about the studies on the validity of the measure and expressed a desire to see validation studies or additional evidence related to what interventions are being used and their effectiveness. In response, the measure steward highlighted efforts to conduct validity testing through a first-year analysis of the measure and collect information from health plans to assess the feasibility of data collection. Workgroup members also asked questions about the measure's technical specifications, including about how Logical Observation Identifiers Names and Codes (LOINC®) codes can be used and their association with the screening tools. The measure steward confirmed that the screening tools have been mapped to a LOINC® code so a code is associated with a specific question. The measure steward also confirmed that while LOINC® codes are traditionally lab codes, these codes are associated with the screening tool and can live in electronic health record data. The measure steward also emphasized that the measure specifications were developed to support standardization and improved data collection. Another Workgroup member expressed concern with how programs may interpret what it means to connect enrollees to services and how it may affect the accuracy of reporting.

Some Workgroup members expressed concerns about the challenges states and programs may face in implementing the measure. They discussed the timing and potential for burden on programs to implement the measure. More specifically, one Workgroup member highlighted the challenges associated with tracking and reporting the measure, indicating it could take years to implement properly. Another Workgroup member also expressed the need for more information

on potential implementation challenges and system utilization because the measure is so new. Another Workgroup member also raised concerns about the timing of adding the measure and determining when a measure is ready to be implemented, suggesting that it could result in a missed opportunity to focus on more direct and impactful interventions.

Although some Workgroup members questioned states' readiness and ability to implement the measure, others emphasized its desirability and actionability, noting the opportunity to drive change in how programs address social needs for health home enrollees. One Workgroup member expressed support for the measure due to its inclusion of screening tools that have been tested and validated, as well as the potential to use the measure to assess care coordination efforts. Some Workgroup members noted that making this measure mandatory for state reporting could help expedite system changes and improve data collection efforts related to addressing social needs. One Workgroup member recounted their state's experience with the use of the measure in its Medicaid program and how being required to implement the measure helped to drive system change quickly.

In addition, a Workgroup member inquired about the timeline for the inclusion of dual-eligible members in reporting as well as expectations around stratification. Mathematica responded that CMS mandated requirements for mandatory reporting includes reporting for all health home populations, including dual-eligible individuals.

An opportunity for public comment followed the Workgroup discussion of the measure. A representative from a behavioral health system in Connecticut shared that many of the systems using NCQA measures have to separate and stratify Medicaid and Medicare dual-eligible beneficiaries and Medicaid commercial dual-eligible beneficiaries. They added that it is easier to stratify the measures by population than to combine these groups.

Although the Workgroup ultimately did not recommend the measure for addition to the Health Home Core Sets, Workgroup members acknowledged the importance of the measuring health related social needs and the continued need to assess how to support and address social needs for health home program enrollees.

While the draft report was available for public comment, the American Academy of Pediatrics agreed with the many major implementation concerns raised by the Workgroup, including challenges with electronic health record (EHR) data capture. They strongly encouraged inclusion of screening tools that have been specifically validated in the pediatric population with corresponding availability of these tools in common EHRs. They noted significant and pervasive limitations in the availability of effective interventions for social needs and the ability to track the outcomes of a referral and these issues must be addressed for measurement to be feasible.

Discussion of Priority Gap Areas in the Health Home Core Sets

During the 2026 Health Home Core Sets Annual Review, Mathematica asked Workgroup members to discuss priority gap areas in the current Health Home Core Sets that could be addressed by the 2027 public call for measures to strengthen and improve the Core Sets. Mathematica reminded the Workgroup that the 2027 public call for measures is expected to broaden the potential measures for the Core Sets and encouraged the Workgroup to focus on the purposes and uses of the Core Sets. That is, the Health Home Core Sets are intended to estimate and understand the overall national quality of health care provided in Medicaid Health Home programs, assess access for and care provided to health home enrollees, identify and improve understanding of disparities experienced by health home enrollees, and inform the development of targeted improvement efforts to advance health equity. Mathematica asked each Workgroup member to mention a priority gap area or emphasize a gap area mentioned by another Workgroup member. Exhibit 7 synthesizes the gaps mentioned during the discussion, organized by the high-level themes that emerged. The exhibit does not assess the feasibility or fit of the suggested gap areas for the Health Home Core Sets.

Exhibit 7. Synthesis of Workgroup Discussions About Priority Gaps in the Health Home Core Sets

Themes from Priority Gap Areas Discussion
Health Equity and Social Drivers of Health
• Measurement of screening for social determinants of health or interventions • Stratification of measures by populations including individuals with medical complexity
Patient-Reported Outcomes and Experience of Care
• Patient and family-reported quality of life • Patient and family experiences on the effectiveness of care coordination and health home services delivery • Whole-person care for young children
Condition-Specific Gaps
• Diabetes screening and measurement • Sepsis prevalence and management
Other Gap Areas Mentioned by the Workgroup
• Effectiveness of care coordination • Access to dental care
Methodological Considerations
• Focus on quality improvement infrastructure • Consideration of variability in target populations across health home programs • Support providers' investment in quality improvement efforts • Alignment of measures across federal quality measurement programs and initiatives

Workgroup members raised several priority gaps and areas for measure development and refinement. Throughout the discussion, Workgroup members emphasized the importance of looking at the measure sets as a whole and thoughtfully and effectively prioritizing the measures to drive meaningful change. Although the Workgroup did not recommend adding *Social Needs Screening and Intervention* to the Core Sets, several Workgroup members still noted a gap in measures related to social determinants of health, noting that these areas are central to the health home program and well-being of health home enrollees. One Workgroup member expressed a desire to stratify measures by disability and medical complexity, in addition to race and ethnicity and language, to gain a better understanding of access and quality for the entire population.

Workgroup members highlighted an opportunity to use the Core Sets to drive quality improvement. One Workgroup member shared that the addition of a quality improvement focus to measurement supports a data-driven approach to improve outcomes for members. A Workgroup member also emphasized the importance of considering the burden on providers in reporting, and finding ways to encourage providers to be more invested in quality improvement efforts.

In addition, Workgroup members expressed the need for measures related to family and beneficiary quality of life, care coordination, and member experience on the effectiveness of care coordination and health home services delivery. One Workgroup member highlighted a desire to see a balance between measures of acute health care services versus quality-of-life outcomes.

Workgroup members shared a desire for measures oriented toward specific health conditions, including diabetes, sepsis, and oral health. Several Workgroup members highlighted a gap in diabetes-related measures, noting the high prevalence of diabetes and pre-diabetes in the United States.

Some Workgroup members also discussed the challenges of understanding and addressing the variability of target populations served by 1945 health home programs. A Workgroup member noted that there are different populations served by 1945 health home programs and it is important to consider how to measure improvement among populations that may have very different clinical and support needs. Workgroup members also emphasized the importance of collaboration and alignment across different quality measurement programs and initiatives to better understand overall gaps and work toward common goals.

While the draft report was available for public comment, the American Academy of Pediatrics recommended that a measure related to primary care encounters should be considered in the future, as access to primary care is important for decreasing emergency department and inpatient utilization among children with complex care needs. They also noted that in addition to the existing follow-up measures included in the 1945 Health Home Core Set – which are limited to follow-up after hospitalization for mental illness or emergency department visits for substance

use disorder – children, adolescents, and adults with other complex health care needs require follow-up to ensure timely and safe transition to home care.

The Workgroup's reflections and public comment about priority gap areas provided a foundation for informing the 2027 public call for measures and further considerations for longer-term planning for the Health Home Core Sets, including potential areas for measure development and refinement.

Public Call for Measures to update the 2027 Health Home Core Sets

Beginning with the 2027 Health Home Core Sets Annual Review cycle, Mathematica will conduct a Public Call for Measures. This is a departure from previous approaches to suggest measures to strengthen the Health Home Core Sets. In the past, only Workgroup members and federal liaisons were able to suggest measures for addition or removal. The discussion of priority gap areas summarized above will help to inform the criteria for measure submission during the Public Call for Measures.

Criteria for the Public Call for Measures for the 2027 Health Home Core Sets

Mathematica engaged the Workgroup in a discussion about the measure criteria for the public call for measures. To start the discussion, Mathematica reviewed the criteria for suggesting measures for addition used during the 2026 call for measures (recall Exhibit 5). Mathematica then asked Workgroup members what changes or additional criteria they would suggest incorporating into the 2027 public call for measures. The Workgroup discussion concentrated on three themes: (1) actionability and strategic priority; (2) balance of measures to address the whole person; and (3) the need for informational resources to support the public call for measures.

In the context of the actionability and strategic priority of measures, one Workgroup member suggested that the submission process include a request for the actionable entity (e.g., the health home program or provider) that is responsible for, or most impacted by, the data reported. Other comments were not specific to the criteria for the public call for measures, but rather broader suggestions related to the measure submission process. One Workgroup member expressed that the criteria are effective and noted that a key consideration for submission may be more specific and unique to health home programs, such as the prevalence of a condition or outcome being measured. Some Workgroup members encouraged consideration of the balance of measures across the Health Home Core Sets. One Workgroup member shared that several measures are more focused on areas such as chronic illness or behavioral health, and there is a need for more balance across the measures to address the whole person and support enrollees' overall quality of health and life. Workgroup members also noted that more information and understanding of different health home programs and populations will aid the public in making informed measure suggestions that speak to the diverse needs and conditions of the health home population. For example, one Workgroup member suggested providing information on health home programs across states and the populations served by each to support the public call for measures.

Suggestions for Improving the Health Home Core Sets Annual Review Process

Workgroup members also suggested enhancements to the Health Home Core Sets Annual Review process. One Workgroup member suggested reconsidering the structure of the meeting to enable video and allow for self-control of audio to promote more dialogue, interaction, and collegiality among the Workgroup. This Workgroup member also suggested ensuring that the meeting was accessible to individuals with disabilities by having accommodations such as live captioning or sign language interpretation.

Next Steps

The 2026 Health Home Core Sets Annual Review Workgroup did not recommend adding any measures to the 2026 Health Home Core Sets. The Workgroup considered multiple factors when discussing the measures, including the feasibility for program-level reporting in the context of mandatory reporting, actionability to drive improvement in care delivery and health outcomes, alignment across federal quality measurement programs, and the fit of measures across health home programs.

Workgroup members also discussed additional priorities for the Health Home Core Sets, including the desire to understand and measure the effectiveness of care management; identify and address unmet health and community-based needs; and include measures in the Core Sets specified for the health home population, such as condition-related measures. In addition, Workgroup members expressed the importance of reviewing measures holistically and finding balance in the Core Sets to meet the diverse needs of enrollees across health home programs.

A draft of this report was made available for public comment from August 30, 2024, through October 15, 2024, and one public comment was received. CMS will review the final report to inform decisions about whether and how to modify the 2026 Health Home Core Set. Additionally, CMS will obtain input from federal agencies to ensure that the Health Home Core Set measures are evidence-based and promote measure alignment within CMS and across the federal government. CMS will release the 2026 Health Home Core Set in early 2025.

Appendix A.
2025 Health Home Core Set Measures

Exhibit A.1. 2025 Core Set of Health Care Quality Measures for 1945 Medicaid Health Home Programs (1945 Health Home Core Set)

CMIT #*	Measure Steward	Measure Name	Data Collection Method
Core Set Measures			
394	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Administrative or EHR
167	NCQA	Controlling High Blood Pressure (CBP-HH)	Administrative, hybrid, or EHR
139	NCQA	Colorectal Cancer Screening (COL-HH)	Administrative or EHR[a]
672	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	Administrative or EHR
268	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Administrative
561	NCQA	Plan All-Cause Readmissions (PCR-HH)	Administrative
750	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)	Administrative
264	NCQA	Follow-Up After Emergency Department Visit for Substance Use (FUA-HH)	Administrative
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)	Administrative
Utilization Measures			
20	CMS	Admission to a Facility from the Community (AIF-HH)	Administrative
397	CMS	Inpatient Utilization (IU-HH)	Administrative

* 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.

[a] The Colorectal Cancer Screening measure is also specified for ECDS reporting. ECDS specifications are not currently available for Health Home Core Set reporting.
CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; EHR = electronic health record; NCQA = National Committee for Quality Assurance.

Exhibit A.2. 2025 Core Set of Health Care Quality Measures for 1945A Medicaid Health Home Programs (1945A Health Home Core Set)

CMIT#*	Measure Steward	Measure Name	Data Collection Method
761	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Administrative
24	NCQA	Controlling High Blood Pressure (CBP-HH)	Administrative
124	NCQA	Colorectal Cancer Screening (COL-HH)	Administrative, hybrid, or EHR[a]
363	NCQA	Screening for Depression and Follow-Up Plan (CDF-HH)	Administrative or hybrid[a]

Exhibit A.2 *(continued)*

CMIT#*	Measure Steward	Measure Name	Data Collection Method
897	DQA (ADA)	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Administrative
397	CMS	Plan All-Cause Readmissions (PCR-HH)	Administrative

* 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.

[a]The Childhood Immunization Status and Immunizations for Adolescents measures are also specified for ECDS reporting. ECDS specifications are not currently available for Health Home Core Set reporting.

CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; DQA (ADA) = Dental Quality Alliance (American Dental Association); EHR = electronic health record; NCQA = National Committee for Quality Assurance.

Exhibit A.3. Core Set of Health Home Quality Measures for 1945 Medicaid Health Home Programs (1945 Health Home Core Set), 2013–2025

CMIT #*	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023/2024	2025
Core Set Measures														
394	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	X	X	X	X	X	X	X	X	X	X	X	X
137	NCQA	Controlling High Blood Pressure (CBP-HH)	X	X	X	X	X	X	X	X	X	X	X	X
139	NCQA	Colorectal Cancer Screening (COL-HH)[a]	--	--	--	--	--	--	--	--	--	X	X	X
672	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	X	X	X	X	X	X	X	X	X	X	X	X
268	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	X	X	X	X	X	X	X	X	X	X	X	X
561	NCQA	Plan All-Cause Readmissions (PCR-HH)	X	X	X	X	X	X	X	X	X	X	X	X
750	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)[b]	--	--	--	--	--	--	--	X	X	X	X	X
264	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH)[c]	--	--	--	--	--	--	--	X	X	X	X	X
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)[d]	--	--	--	--	--	--	--	--	--	X	X	X
25	NCQA	Adult Body Mass Index Assessment (ABA-HH)[e]	X	X	X	X	X	X	X	X	--	--	--	--
593	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)[f]	X	X	X	X	X	X	X	X	X	X	X	--

Exhibit A.2 *(continued)*

CMIT #*	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023/2024	2025
Utilization Measures														
NA	AMA/PCPI	Care Transition – Timely Transmission of Transition Record (CTR-HH)[g]	X	X	X	X	X	X	--	--	--	--	--	--
20	CMS	Admission to an Institution from the Community (AIF-HH)[h]	--	--	--	--	--	--	X	X	X	X	X	X
49	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	X	X	X	X	X	X	X	X	X	X	X	--
397	CMS	Inpatient Utilization (IU-HH)	X	X	X	X	X	X	X	X	X	X	X	X
1612	CMS	Nursing Facility Utilization (NFU-HH)[i]	X	X	X	X	X	X	--	--	--	--	--	--

Note: X = included in Health Home Core Set; -- = not included in Health Home Core Set. More information on 2025 updates to the Health Home Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html.

* 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.

[a] The Colorectal Cancer Screening (COL-HH) measure was added to the 2022 Health Home Core Set to address gaps in care and health disparities and to align with the Adult Core Set.

[b] The Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH) measure was added to the 2020 Health Home Core Set to help states meet the new reporting requirements for states with an approved SUD-focused health home under Section 1945(c)(4)(B) of the SUPPORT Act and to align with the Adult Core Set.

[c] The Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH) measure was added to the 2020 Health Home Core Set to promote alignment across the Adult and Health Home Core Sets and to broaden the scope of SUD measures in the Health Home Core Set.

[d] The Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH) measure was added to the 2022 Health Home Core Set because it addresses priority areas of access and follow-up care for adults with mental health issues or SUDs.

[e] The Adult Body Mass Index Assessment (ABA-HH) measure was retired from the 2021 Health Home Core Set because the measure steward retired it.

[f] The Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH) measure was retired from the 2025 Health Home Core Set because states reported the results were not actionable and were difficult to trend with reliability.

[g] The Care Transition—Timely Transmission of Transition Record (CTR-HH) measure was retired from the 2018 Health Home Core Set because few states had reported this measure over time and states faced challenges in reporting it.

[h]The Ambulatory Care: Emergency Department (ED) Visits (AMB-HH) measure was retired from the 2025 Health Home Core Set because it was retired by the measure steward

[i] The Admission to an Institution from the Community (AIF-HH) measure changed for 2019 from a measure of Nursing Facility Utilization (NFU-HH) to a measure that includes multiple rates and is based on a broader definition of institutional admissions.

AHRQ = Agency for Healthcare Research and Quality; AMA = American Medical Association; CMS = Centers for Medicare & Medicaid Services; NA = measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum; PCPI = Physician Consortium for Performance Improvement; SUD = substance use disorder.

Appendix B.
Public Comment on the Draft Report

The draft report was available for public review and comment from August 30, 2024, through October 15, 2024 at 8 p.m. Eastern Time. One comment was submitted to Mathematica via email from the American Academy of Pediatrics (AAP). Mathematica appreciates the time and effort taken by the AAP to submit comments on the draft report.

Exhibit B.1 categorizes the public comments received on the draft report by the following topics: measures discussed but not recommended for addition and other topics. The verbatim public comments are included after the exhibit, organized in alphabetical order by commenter name (agency/organization name).

In summary, the public comment addressed both measures discussed, but not recommended for addition as well as measure criteria for addition and consideration for future measures.

Exhibit B.1 Summary of Public Comments by Topic and Commenter

Topic	Commenter
Measures Discussed and Not Recommended for Addition	
Metabolic Monitoring for Children and Adolescents on Antipsychotics	American Academy of Pediatrics
Social Needs Screening and Intervention	American Academy of Pediatrics
Other Topics	
Measure Criteria for Addition Consideration for Future Measures	American Academy of Pediatrics

Public Comments Listed Alphabetically by Agency/Organization Name

American Academy of Pediatrics (Dr. Benjamin Hoffman)

The American Academy of Pediatrics (AAP) is pleased to have the opportunity to comment on the draft report of the Recommendations for Improving the Medicaid Health Home Core Sets of Health Care Quality Measures. On behalf of the AAP and its over 67,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists, we commend efforts to review and update the Medicaid Health Home Core Sets of Quality Measures for 2026.

The Academy appreciates the workgroup's determination regarding two proposed new measures relevant to pediatrics that were considered and not recommended for inclusion in the 1945A core set and would like to provide the additional following feedback.

Measures Considered and Not Recommended for 2026 Cores Sets

a. **Metabolic Monitoring for Children and Adolescents on Antipsychotics:** We acknowledge and agree with the implementation concerns raised and strongly oppose inclusion. The testing for metabolic monitoring referenced in the proposed measure included blood glucose which differs from other clinical guidance in pediatrics where hemoglobin A1C is recommended for dysglycemia monitoring. Other details must be clarified including the attribution of the clinician responsible for monitoring; in pediatrics, antipsychotic medications are prescribed by subspecialists outside of the primary care medical home. Additionally, if such a measure were approved in the future, the use of Rx Norm should be investigated to account for the multiple medication formulations and newly approved medications in this class.
b. **Social Needs Screening and intervention:** Measuring child and family health related social needs and addressing them is a very important issue for health home program enrollees. We acknowledge that the measure was not recommended and strongly agree with the many major implementation concerns raised, including challenges with Electronic Health Record (EHR) data capture. We strongly encourage inclusion of screening tools that have been specifically validated in the pediatric population with corresponding availability of these tools in EHRs. There are significant and pervasive limitations in the availability of effective interventions for social needs and the ability to track the outcomes of a referral. These issues must be addressed for measurement to be feasible.

Measure Criteria for Addition

We appreciate the recommendation to include measures that are suitable for equity analysis in Exhibit ES.1 including data elements such as race, ethnicity, sex, age, and language. Barriers may still limit the collection of data that would be needed to comprehensively assess disparities including, but not limited to, the ability to identify disabilities, rural versus urban settings, and

home and community-based service waivers. Measures must also contemplate the feasibility of electronic reporting from structured fields. For example, while there may be validated survey instruments that are required for a measure, the availability of structured fields to capture survey processes and responses varies across EHRs and presents significant challenges in reporting.

Consideration for Future Measures

A measure related to primary care encounters should be considered in the future. Access to high quality primary care plays an important role in longitudinal and comprehensive care and in decreasing preventable acute care utilization, including Emergency Department and Inpatient health service utilization among children with complex care needs.

The existing measures in the 1945 core set that specify follow-up after hospitalization for mental illness and follow-up after Emergency Department Visit for alcohol and substance use encounters are important. In addition, for children, adolescents, and adults with complex health care needs, there are other medical conditions that require follow-up to ensure timely and safe transition to home care. These medical conditions should be considered for inclusion in future measures.

Thank you for the opportunity to comment. Please do not hesitate to contact Cathleen Guch (cguch@aap.org), Senior Manager of Quality Improvement and Certification Initiatives, with any questions on these comments.

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