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Health Home Core Sets Annual Review Workgroup:

Measures Suggested for Addition to the 2026 Health Home Core Sets

June 2024

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MEASURE INFORMATION SHEET

HEALTH HOME CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2025 CORE SETS

Measure Information	
Measure name	**DIABETES SCREENING FOR PEOPLE WITH SCHIZOPHRENIA OR BIPOLAR DISORDER WHO ARE USING ANTIPSYCHOTIC MEDICATIONS**
Description	The percentage of members 18 to 64 years of age with schizophrenia, schizoaffective disorder, or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Measure steward	National Committee for Quality Assurance (NCQA)
CMIT number	202
Meaningful Measures area(s)	Behavioral Health
Measure type	Process
Addition of measure to which Core Set(s)?	1945 Health Home Core Set
Recommended to replace current measure?	No
Is the measure on the Child or Adult Core Set?	Yes – Adult Core Set

Technical Specifications	
Ages	Ages 18 to 64 as of December 31 of the measurement year.
Data collection method	Administrative.
Denominator	Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year. • At least one acute inpatient encounter with any diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. Either of the following code combinations meet criteria: – Behavioral Health (BH) Stand Alone Acute Inpatient Value Set with (Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set). – Visit Setting Unspecified Value Set with Acute Inpatient POS Value Set with Schizophrenia Value Set, Bipolar Disorder Value Set, Other Bipolar Disorder Value Set.

Technical Specifications	
Denominator (continued)	• At least two of the following, on different dates of service, where both encounters have any diagnosis of schizophrenia or schizoaffective disorder (Schizophrenia Value Set) or both encounters have any diagnosis of bipolar disorder (Bipolar Disorder Value Set, Other Bipolar Disorder Value Set). – An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set). – An outpatient visit (BH Outpatient Value Set). – An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with POS code 52). – An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set). – A community mental health center visit (Visit Setting Unspecified Value Set with POS code 53). – Electroconvulsive therapy (Electroconvulsive Therapy Value Set). – An Emergency Department (ED) visit (ED Value Set). – An ED visit (Visit Setting Unspecified Value Set with POS code 23). – A nonacute inpatient encounter (BH Stand Alone Nonacute Inpatient Value Set). – A nonacute inpatient encounter (Visit Setting Unspecified Value Set with Nonacute Inpatient POS Value Set). – A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set). – A telephone visit (Telephone Visits Value Set). – An e-visit or virtual check-in (Online Assessments Value Set).
Numerator	A glucose test (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or an HbA1c test (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set) performed during the measurement year. Do not include codes with a modifier (CPT CAT II Modifier Value Set) or from laboratory claims (claims with POS code 81).
Exclusions	Exclude members who met any of the following criteria: • *Members with diabetes.* There are two ways to identify members with diabetes: by claim/encounter data and by pharmacy data. The organization must use both methods to identify members with diabetes, but a member need only be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. • *Claim/encounter data*. Members who had at least two diagnoses of diabetes (Diabetes Value Set) on different dates of service during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81).

Technical Specifications	
Exclusions (continued)	• *Pharmacy data*. Members who were dispensed insulin or hypoglycemics/ antihyperglycemics during the measurement year or the year prior to the measurement year (Diabetes Medications List) and have at least one diagnosis of diabetes (Diabetes Value Set) during the measurement year or the year prior to the measurement year. Do not include laboratory claims (claims with POS code 81). • Members who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted. • *Claim/encounter data*. An antipsychotic medication (Long-Acting Injections Value Set). • *Pharmacy data*. Dispensed an antipsychotic medication (SSD Antipsychotic Medications List). • Members who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement year. Organizations that use the Monthly Membership Detail Data File to identify these members must use only the run date of the file to determine if the member elected to use a hospice benefit during the measurement year. • Members who die any time during the measurement year.
Continuous enrollment period	The measurement year.
Level of reporting for which specifications were developed	State-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2024 Vol. 2 for current measure specifications. See the Adult Core Set Resource Manual for FFY 2024 Adult Core Set measure specifications: https://www.medicaid.gov/media/156226.
Information on testing or use at state Medicaid/CHIP level	According to the Workgroup member (WGM), this is an Adult Core Set Measure.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM suggested this measure for the 1945 Health Home Core Set and indicated this measure would not work for child-only programs (i.e., 1945A Health Home Programs), as the HEDIS specification age range is 18-64.

Actionability and Strategic Priority	
How measure contributes to measuring the overall national quality of health care in Medicaid health home programs, taken together with other Health Home Core Set measures	The WGM noted there is a gap in measures on the 1945 Health Home Core Set that focus on integrated primary and behavioral health. Additionally, during the FFY 2025 Health Home Core Sets Annual Review, Workgroup, members discussed diabetes management as a gap area and identified an opportunity to align with the Adult Core Set by considering measures of diabetes management for enrollees with chronic conditions in future Workgroups.[1]
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	HEDIS MY 2024 Vol. 2 contains general guidelines about how to categorize Medicaid members by race and ethnicity; however, the current technical specifications for SSD does not include guidelines for any stratifications. The measure steward notes that they are committed to promoting health equity through ongoing review and modification of its measure specifications. However, there are no specific planned or proposed changes pending for SSD stratification at this time. This measure has not been identified for mandatory stratification for FFY 2025 Adult Core Set Reporting.
How measure addresses the unique and complex needs of Medicaid health home enrollees and promotes effective care delivery	The WGM stated that this measure prioritizes behavioral health, integrated physical and behavioral healthcare, chronic conditions, and evidenced-based healthcare. These priority areas align with the criteria Medicaid Beneficiaries must meet to qualify for 1945 Health Home services as qualifying chronic conditions, including those with a mental health condition as well as those with diabetes.
Evidence that measure could lead to improvement in quality of health care for Medicaid health home enrollees	According to the WGM, the cost of care for enrollees with diabetes and heart conditions is high. Additionally, individuals with uncontrolled diabetes, who also have schizophrenia and bipolar diagnoses, are prone to poor outcomes, so there is an urgency for direct focus to this population.
How measure can be used to monitor improvement	The WGM reported that this measure can be monitored through gaps in care reports within electronic medical records and at the health plan level. More frequent measurement of this can occur to support quicker Plan-Do-Study-Act's within the Health Home Programs.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid beneficiaries	The WGM shared National Institute of Health (NIH) statistical summary pages which include summary statistics on the prevalence on bipolar disorder and schizophrenia. Specifically, the NIH reports indicate between 2001-2003, an estimated 2.8% of U.S. adults had bipolar disorder and an estimated 82.9% of people with bipolar disorder had serious impairment, the highest of any mood disorder."[2] Additionally, "estimates of the prevalence of schizophrenia and related psychotic disorders in the U.S. range between 0.25% and 0.64%. Schizophrenia is one of the top 15 leading causes of disability worldwide."[3] Research also indicates that diabetes is two to three times more prevalent for individuals with a serious mental illness (SMI) such as bipolar disorder or schizophrenia than the general population. Antipsychotic medications, such as those generally prescribed for the treatment of SMIs, contribute to this disparity as they increased risk for diabetes.[4]
Use of measure in other CMS programs	This measure is used in the following CMS programs: • Adult Core Set
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM did not identify any barriers that states could face in calculating this measure for the 1945 Health Home Core Set.
Summary of prior Workgroup discussion	This measure has not been discussed previously by the Workgroup.
Other	

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MEASURE INFORMATION SHEET

HEALTH HOME CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2025 CORE SETS

Measure Information	
Measure name	**METABOLIC MONITORING FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS**
Description	The percentage of children and adolescents ages 1 to 17 with two or more antipsychotic prescriptions who had metabolic testing. Three rates are reported: • Percentage of children and adolescents on antipsychotics who received blood glucose testing; • Percentage of children and adolescents on antipsychotics who received cholesterol testing; • Percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.
Measure steward	National Committee for Quality Assurance (NCQA)
CMIT number	448
Meaningful Measures area(s)	Behavioral Health
Measure type	Process
Addition of measure to which Core Set(s)?	Both 1945 and 1945A
Recommended to replace current measure?	NA
Is the measure on the Child or Adult Core Set?	Yes – Child Core Set

Technical Specifications	
Ages	Ages 1 to 17 as of December 31 of the measurement year.
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS). (Note: ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.)
Denominator	Beneficiaries with at least two antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year.

Technical Specifications	
Numerator	Beneficiaries who received at least one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year. Beneficiaries who received at least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year. Beneficiaries who received both the following during the measurement year on the same or different dates of service: • At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set). • At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).
Exclusions	Exclude beneficiaries who meet either of the following criteria: • Beneficiaries in hospice or using hospice services any time during the measurement year. For additional information, refer to the hospice exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set. • Beneficiaries who died any time during the measurement year. For additional information, refer to the deceased beneficiaries exclusion guidance in Section II. Data Collection and Reporting of the Child Core Set.
Continuous enrollment period	The measurement year.
Level of reporting for which specifications were developed	State-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2024 Vol. 2 for current measure specifications. See the Child Core Set Resource Manual for FFY 2024 Child Core Set measure specifications: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf.
Information on testing or use at state Medicaid/CHIP level	According to the Workgroup member (WGM), this is a Child Core Set Measure.

Minimum Technical Feasibility Criteria	
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM suggested indicated this measure would only be appropriate for Health Home Programs that include children, as the HEDIS specification age range is 1-17. It is important to note that 1945 Health Home Programs cannot limit health homes by criteria such as age.[5] 1945A Health Home Programs are for Medicaid-eligible children under age 21.[6]

Actionability and Strategic Priority	
How measure contributes to measuring the overall national quality of health care in Medicaid health home programs, taken together with other Health Home Core Set measures	The WGM noted that there is a gap in measures on the 1945A Health Home Core Set that focus on integrated primary and behavioral health. Additionally, during the FFY 2025 Health Home Core Sets Annual Review Workgroup, members discussed diabetes management as a gap area and identified this as an area for consideration for future Workgroups.[7]
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	HEDIS MY 2024 Vol. 2 contains general guidelines about how to categorize Medicaid members by race and ethnicity; however, the current technical specifications for the APM measure include only stratifications by age and product line. The measure steward notes that this measure is under review for potential race/ethnicity stratification for MY 2026 which corresponds to FFY 2027 Core Set reporting.
How measure addresses the unique and complex needs of Medicaid health home enrollees and promotes effective care delivery	The WGM indicated that while the measure prioritizes behavioral health, integrated physical and behavioral healthcare, chronic conditions, and evidenced-based healthcare can be included.
Evidence that measure could lead to improvement in quality of health care for Medicaid health home enrollees	The WGM noted antipsychotic medications can elevate a child's risk for developing serious metabolic health complications[8] Specifically, "Antipsychotic use is associate with weight gain, increased fasting lipids (total cholesterol, LDL, and triglyceride levels), and impaired glucose tolerance in pediatric patients. Subsequently, this population is at an increased risk of obesity, metabolic syndrome, and type 2 diabetes. Although, pediatric patients are more vulnerable to these adverse side effects, they are less likely to have their metabolic parameters monitored during AP [antipsychotic] treatment."[9]
How measure can be used to monitor improvement	The WGM noted this measure can be monitored through gaps in care reports within Electronic Medical Records and at the health plan level. More frequent measurement of this can occur to support quicker Plan-Do-Study-Act's within the Health Homes.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid beneficiaries	The WGM shared a National Institute of Health summary page, which includes summary statistics on the prevalence of mental health issues among young adults.[10] Specifically, "An estimated 49.5% of adolescents had any mental disorder. Of adolescents with any mental disorder, an estimated 22.2% had severe impairment and/or distress. DSM-IV based criteria were used to determine severity level."
Use of measure in other CMS programs	This measure is used in the following CMS programs: • Child Core Set.
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM did not report any potential barriers.
Summary of prior Workgroup discussion	This measure has not been discussed previously by the Workgroup.
Other	The measure steward changed this measure to an ECDS only measure for HEDIS MY2024 (Core Set FFY 2025). Previous versions of the measure allowed for data collection via Administrative or ECDS methods.

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MEASURE INFORMATION SHEET

HEALTH HOME CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2026 CORE SETS

Measure Information	
Measure name	**Social Need Screening and Intervention**
Description	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.** The percentage of members who were screened for food insecurity. 2. **Food Intervention.** The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for food insecurity. 3. **Housing Screening.** The percentage of members who were screened for housing instability, homelessness or housing inadequacy. 4. **Housing Intervention.** The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for housing instability, homelessness or housing inadequacy. 5. **Transportation Screening.** The percentage of members who were screened for transportation insecurity. 6. **Transportation Intervention.** The percentage of members who received a corresponding intervention within 30 days (1 month) of screening positive for transportation insecurity.
Measure steward	National Committee for Quality Assurance (NCQA)
CMIT number	To be determined by CMS
Meaningful Measures area(s)	Equity
Measure type	Process
Addition of measure to which Core Set(s)?	Both: 1945 Health Home Core Set and 1945A Health Home Core Set
Recommended to replace current measure?	No
Is the measure on the Child or Adult Core Set?	The Child and Adult Core Sets Annual Review Workgroup discussed, but did not recommend, the measure for addition to the 2026 Child and Adult Core Sets.[11]

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Technical Specifications	
Ages	Members of any age. Results are reported using the following age stratifications: • ≤17 years. • 18–64 years. • 65 and older. The total rate is the sum of the numerators for each age band divided by the sum of the denominators for each age band.
Data collection method	HEDIS® Electronic Clinical Data Systems (ECDS). (Note: ECDS includes data from administrative claims, electronic health records, case management systems, and health information exchanges/clinical registries.)
Denominator	The measure includes denominators for six rates: 1. **Denominator 1 – Food Screening.** Members of any age enrolled at the start of the measurement period who also meet criteria for participation.* 2. **Denominator 2 – Food Intervention.** All members in numerator 1 with a positive food insecurity screen finding between January 1 and December 1 of the measurement period. 3. **Denominator 3 – Housing Screening**. Members of any age enrolled at the start of the measurement period who also meet criteria for participation.* 4. **Denominator 4 – Housing Intervention.** All members in numerator 3 with a positive housing instability, homelessness, or housing inadequacy screen finding between January 1 and December 1 of the measurement period. 5. **Denominator 5 – Transportation Screening.** Members of any age enrolled at the start of the measurement period who also meet criteria for participation.* 6. **Denominator 6 – Transportation Intervention.** All members in numerator 5 with a positive transportation insecurity screen finding between January 1 and December 1 of the measurement period. ***** Participation is defined as the identifiers and descriptors for each organization's coverage used to define members' eligibility for measure reporting. Participation includes both allocation and continuous enrollment: • Allocation criteria: The member was enrolled with a medical benefit throughout the measurement period (January 1 – December 31) and was enrolled on the last day of the measurement period. • Continuous enrollment criteria: See below.

Technical Specifications	
Numerator	The measure includes numerators for six rates: 1. **Numerator 1 – Food Screening.** Members in denominator 1 with a documented result for food insecurity screening performed between January 1 and December 1 of the measurement period. 2. **Numerator 2 – Food Intervention.** Members in denominator 2 who received a food insecurity intervention on or up to 30 days after the date of the first positive food insecurity screen (31 days total). 3. **Numerator 3 – Housing Screening.** Members in denominator 3 with a documented result for housing instability, homelessness, or housing inadequacy screening performed between January 1 and December 1 of the measurement period. 4. **Numerator 4 – Housing Intervention.** Members in denominator 4 who received an intervention corresponding to the type of housing need identified on or up to 30 days after the date of the first positive housing screen (31 days total). 5. **Numerator 5 – Transportation Screening.** Members in denominator 5 with a documented result for transportation insecurity screening performed between January 1 and December 1 of the measurement period. 6. **Numerator 6 – Transportation Intervention.** Members in denominator 6 who received a transportation insecurity intervention on or up to 30 days after the date of the first positive transportation screen (31 days total). **Screening numerator notes:** Screening numerators count only screenings completed using one of the instruments included in the measure specification (the list of eligible screening instruments is provided below). However, NCQA recognizes that organizations might need to adapt or modify instruments to meet the needs of their membership. • The measure specification does not prohibit cultural adaptations or linguistic translations from being counted toward the measure's screening numerators. • Tool developers have varying policies with regard to cultural adaptation and translations. NCQA urges organizations to refer to the tool developer for information about adaptations or translations that are available or allowed. • Only screenings documented using the LOINC codes in the measure specification count toward the measure's screening numerators (LOINC codes do not distinguish between original and adapted or translated instruments).

Technical Specifications	
Numerator (continued)	Eligible screening instruments include: • Instruments that assess food, housing, and transportation insecurity: – Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool. – American Academy of Family Physicians (AAFP) Social Needs Screening Tool. – American Academy of Family Physicians (AAFP) Social Needs Screening Tool—short form. – Health Leads Screening Panel®.* – Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE)®.* – WellRx Questionnaire. • Food insecurity instruments: – Hunger Vital Sign™* (HVS). – Safe Environment for Every Kid (SEEK)®.* – U.S. Household Food Security Survey (U.S. FSS). – U.S. Adult Food Security Survey (U.S. FSS). – U.S. Child Food Security Survey (U.S. FSS). – U.S. Household Food Security Survey–Six-Item Short Form (U.S. FSS). – We Care Survey. • Housing instability and homelessness or housing inadequacy instruments: – Children's Health Watch Housing Stability Vital Signs™.* – Norwalk Community Health Center Screening Tool (NCHC). – We Care Survey. • Transportation insecurity instruments: – Comprehensive Universal Behavior Screen (CUBS). – Inpatient Rehabilitation Facility - Patient Assessment Instrument (IRF-PAI)—version 4.0 (CMS Assessment). – Outcome and assessment information set (OASIS) form—version E—Discharge from Agency (CMS Assessment). – Outcome and assessment information set (OASIS) form—version E—Resumption of Care (CMS Assessment). – Outcome and assessment information set (OASIS) form—version E—Start of Care (CMS Assessment). – PROMIS®.* * Proprietary; may be cost or licensing requirement associated with use.

Technical Specifications	
Numerator (continued)	**Intervention numerator notes:** The intervention must correspond to the type of need identified to count towards the numerator (e.g., a positive food insecurity screen finding must be met by a food insecurity intervention) identified on or up to 30 days after the first positive screening during the measurement period. Interventions may include any of the following categories: assistance, assessment, counseling, coordination, education, evaluation of eligibility, provision or referral.
Exclusions	All measure rates exclude the following populations: • Members who use hospice services or elect to use a hospice benefit any time during the measurement period. • Members who die any time during the measurement period. • Medicare members 66 years of age and older by the end of the measurement period who meet either of the following: – Enrolled in an Institutional Special Needs Plan (I-SNP) any time during the measurement period. – Living long-term in an institution any time during the measurement period.
Continuous enrollment period	No more than one gap in enrollment of up to 45 days during the measurement period. For Medicaid members where enrollment is verified monthly, the member may not have a gap of more than 30 days.
Level of reporting for which specifications were developed	Plan-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	See HEDIS MY 2024 Vol. 2 for current measure specifications.
Information on testing or use at state Medicaid/CHIP level	The measure steward indicated that pilot testing of the measure was conducted on a national Medicaid sample (n=24,728) from one health plan in 2022. They indicated that during measure testing, performance for the screening rates was low, which was expected since it is a new measurement area. They did not identify differences in performance rates based on the data sources used, since the variety of data sources used for testing was limited. They noted that they plan to review first year measure results, for measurement year (MY) 2023, in summer 2024. New York Medicaid is using the measure with their managed care plans for MY 2023; data collection was in process at the time this measure information sheet was developed. The Workgroup Member (WGM) who suggested the measure mentioned that Pennsylvania is also testing the measure and will have results in summer 2024.

Minimum Technical Feasibility Criteria	
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM indicated data collection can create some challenges as only specific instruments to assess social needs are included, and only with LOINC codes, which have historically been challenging for States to collect and use. However, the WGM noted much improvement has been made in collection this type of data due to the inclusion of case management systems as a data source. States that require plans to collect data for and report on managed long-term services and supports (MLTSS) and long-term services and supports (LTSS) measures have improved their use of alternate data sources, such as case management systems. The WGM adds this has improved their capacity and ability to report social needs measures. The WGM suggests technical assistance could be offered on how this information could be collected, stored, and used for measure reporting.

Actionability and Strategic Priority	
How measure contributes to measuring the overall national quality of health care in Medicaid health home programs, taken together with other Health Home Core Set measures	The WGM noted social needs have been linked to lack of utilization of preventive, screening, and well-care. This may result in later diagnosis of health care conditions, reducing the ability to effectively treat the condition. Social needs, such as food, housing, transportation, and utility insecurities have been associated with increased incidence of chronic disease and inappropriate utilization of services, such as accessing emergency departments/inpatient settings for a source of food or heat/air conditioning.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM noted that the measure specifications allow for stratification by program (commercial, Medicare, Medicaid) and by age (> = 17 years, 18-64 years, and 65 and older). Depending on the accuracy and completeness of race and ethnicity data, plans may be able to stratify (though not included for reporting) to address and develop interventions related to health equity issues. HEDIS MY 2024 Vol. 2 contains general guidelines about how to categorize Medicaid members by race and ethnicity; however, the current technical specifications for the Social Need Screening and Intervention measure include only stratifications by age and product line. The measure steward indicated that they considered other stratification categories during measure testing, but determined that was not feasible, either because the denominators were too small to stratify, or the test data did not include the necessary data elements. They noted that they currently have different workstreams focused on developing standardized stratifications, such as race, ethnicity, sexual orientation and gender identity (SOGI), and disability. They have not established a timeline for adding these stratification categories to the measure specification.

Actionability and Strategic Priority	
How measure addresses the unique and complex needs of Medicaid health home enrollees and promotes effective care delivery	The WGM indicated that by definition, Medicaid health home enrollees are diagnosed with chronic conditions, mental/behavioral health conditions, HIV/AIDS, etc. These populations may be at increased risk for health-related social needs.
Evidence that measure could lead to improvement in quality of health care for Medicaid health home enrollees	The WGM cited evidence from the Accountable Health Communities (AHC) Model which tested whether connecting Medicare and Medicaid beneficiaries to community resources for their health-related social needs improved health care utilization outcomes and reduced costs.[12]
How measure can be used to monitor improvement	The WGM noted that while this measure involves a newer area for measurement, the issue itself is not new. Health plans have consistently and with increasing frequency, been working on health-related social needs to improve care and service delivery and outcomes for members. Because it is a new measurement area, there is significant room for improvement. In addition, dedicated resources to address social needs is also an evolving and improving area within health plans and State Medicaid programs. Therefore, there is significant room for improvement.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid beneficiaries	The WGM indicated that because of the conditions included in the Health Home Programs (for example, complex chronic conditions, mental health/behavioral health, and HIV/AIDS) it is anticipated that the prevalence of health-related social needs is significant. One study cited that 44.6 percent of HRSN screenings completed within a Medicaid Accountable Care Organization were positive for at least one social risk factor.[13]
Use of measure in other CMS programs	No other programs were listed in CMS's Measure Inventory Tool or reported by the measure steward. The WGM indicated, and measure steward confirmed, that the advance notice for the Medicare Advantage program identified this measure in the category of "Potential New Measure Concepts and Methodological Enhancements for Future Years."[14]
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM noted States may need technical assistance to implement the measure. They would need the ability to capture and use LOINC codes; ability to require use of the approved screening tools to capture the data necessary to report the measure; information on what can be done within the Medicaid program to address health-related social needs.
Summary of prior Workgroup discussion	This measure has not been discussed previously by the Workgroup.

Additional Information for Consideration	
Other	The measure steward, NCQA, has indicated that they are adding a fourth domain to this measure beginning MY 2026: utility insecurity. The addition of these domains would continue to allow for addressing additional factors that impact appropriate utilization of services.

Measure That Will Not Be Reviewed

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HEALTH HOME CORE SETS REVIEW WORKGROUP: MEASURES SUGGESTED FOR ADDITION TO THE 2026 CORE SETS

Measure Information	
Measure name	**Emergency Department Visits for Chronic Ambulatory Care Sensitive Conditions (PQE 02)**
Description	Emergency department (ED) visits for chronic ambulatory care sensitive conditions, for individuals age 40 years and older, per 100,000 population. Includes asthma, chronic obstructive pulmonary disease (COPD), heart failure, acute diabetic hyper- and hypoglycemic complications, and chronic kidney disease. A principal (first-listed) diagnosis of lower respiratory infection with a second-listed diagnosis of COPD or asthma is also included.
Measure steward	Agency for Healthcare Research and Quality (AHRQ)
CMIT number	To be determined by CMS
Meaningful Measures area(s)	Chronic conditions
Measure type	Outcome
Addition of measure to which Core Set(s)?	1945 Health Home Core Set
Recommended to replace current measure?	Yes, Ambulatory Care: Emergency Department (ED) Visits (AMB-HH) which is planned for removal from the 2025 Health Home Core Set because it is being retired by the measure steward.
Is the measure on the Child or Adult Core Set?	No

Technical Specifications	
Ages	Age 40 and older.
Data collection method	Administrative (claims/encounter data only).
Denominator	Population age 40 years and older in the metropolitan area[15] or county. Visits in the numerator are assigned to the denominator based on the metropolitan area or county of the patient residence, not the metropolitan area or county of the hospital where the discharge occurred.
Numerator	ED visits of patients age 40 years and older residing in a community who visit any ED (within state) with ANY of the following principal diagnoses: Asthma, COPD, heart failure, acute diabetic hyper- and hypoglycemic complications, or chronic kidney disease. Also included is a principal diagnosis of lower respiratory infection with a second-listed diagnosis of COPD or asthma.
Exclusions	Exclude visits with missing gender, age, principal diagnosis, or county.
Continuous enrollment period	Not specified.

Technical Specifications	
Level of reporting for which specifications were developed	Area-level.

Minimum Technical Feasibility Criteria	
Link to current technical specifications	Technical specifications and appendices are available at https://qualityindicators.ahrq.gov/measures/ED_PQI_TechSpec.
Information on testing or use at state Medicaid/CHIP level	According to the Workgroup member (WGM) who suggested the measure for addition, Medicaid claims data were used during measure development. However, to their knowledge, no state has tested or used this measure in a Medicaid program. Additional information about measure development, including benchmarks, parameter estimates, and downloadable public-use software, is available at: https://qualityindicators.ahrq.gov/measures/ed_pqi_resources.
Description of any barriers, limitations, or variations in the required data source and data elements that could affect consistency of calculations	The WGM indicated the measure would require hospital and ED claims data for a Health Home program's enrolled population. The WGM believes that state Medicaid programs could report the necessary data, but they are uncertain if this is true.

Actionability and Strategic Priority	
How measure contributes to measuring the overall national quality of health care in Medicaid Health Home Programs, taken together with other Health Home Core Set measures	The WGM noted that this measure is risk adjusted and developed based on a nearly complete billing database that represents most hospitals and EDs in the U.S. Thus, the measure can provide nationally and state-benchmarked rates of ED visits for ambulatory care sensitive conditions.
Whether the data source allows for stratification by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language	The WGM noted that when the necessary administrative data are available, the measure can be stratified by age, sex, race and ethnicity, urban/rural status, disability, and English/non-English language preference.
How measure addresses the unique and complex needs of Medicaid Health Home enrollees and promotes effective care delivery	The WGM indicated that if Health Home Programs use the measure as an indicator that flags potentially avoidable ED visits, the measure would allow programs to link to additional data that might help them understand issues that potentially contributed to specific ED visits and thus develop strategies to reduce risk of future ED visits.

Actionability and Strategic Priority	
Evidence that measure could lead to improvement in quality of health care for Medicaid Health Home enrollees	This is a newly developed measure that was released in Fall 2023. The WGM is not aware of published evidence for its use in quality improvement initiatives currently.
How measure can be used to monitor improvement	Measure specifications will be updated annually to account for changes in ICD-10-CM definitions, to update risk-adjustment parameters, and to integrate innovations in approaches for measuring quality of care. AHRQ provides public use software to calculate the measures without charge. Thus, Health Homes and state Medicaid programs could use the measure to monitor risk-adjusted rates over time.

Additional Information for Consideration	
Prevalence of condition or outcome being measured among Medicaid beneficiaries	The WGM noted that overall rates for potentially avoidable ED visits for chronic conditions are ~2,700 visits per 100,000 population. Rates among adults ages 40 to 64, ages 65 to 74, and 75 years and older in the general population are ~1,900, ~3,100, and ~5,600 ED visits per 100,000 population, respectively.[16]
Use of measure in other CMS programs	None.
Potential barriers states could face in calculating measure and recommended technical assistance resources	The WGM noted that the primary barrier is obtaining Medicaid claims data from hospitals and EDs and correctly attributing individuals from the claims data to specific Health Home programs. However, the WGM believes that States should be able to collect the data from hospitals and EDs but is uncertain how easily States would be able to match hospital/ED claims to Health Home enrollees.
Summary of prior Workgroup discussion	This measure has not been discussed previously by the Workgroup.
Other	Specifications for this measure are at the area-level of reporting. This means that indicators are based on hospital data to provide insight into access to care within a defined service area. In addition, this measure was released by AHRQ in Summer 2023 and has not been tested or used by state Medicaid programs to assess feasibility and reliability of adapting to the state or program level. AHRQ confirms that additional testing is being completed and updates to the measure are expected in Summer 2024.

Citations and Notes

[1] https://mathematica.org/-/media/internet/features/2023/health-home-core-set/2025healthhomecoresetsrevfinalreport.pdf
[2] https://www.nimh.nih.gov/health/statistics/bipolar-disorder
[3] https://www.nimh.nih.gov/health/statistics/schizophrenia
[4] https://link.springer.com/article/10.1007/s11606-016-3712-4
[5] https://www.medicaid.gov/resources-for-states/downloads/hh-overview-fact-sheet-mar-2024.pdf
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[7] https://mathematica.org/-/media/internet/features/2023/health-home-core-set/2025healthhomecoresetsrevfinalreport.pdf
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7994286/%23:~:text=Antipsychotic%20use%20is%20associated%20with,syndrome%20and%20type%202%20diabetes
[9] https://www.nimh.nih.gov/health/statistics/mental-illness#part_2555
[10] https://www.mathematica.org/features/MACCoreSetReview
[11] https://www.mathematica.org/features/MACCoreSetReview
[12] https://www.cms.gov/priorities/innovation/data-and-reports/2023/ahc-second-eval-rpt-fg
[13] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9675191/
[14] https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf
[15] The term "metropolitan area" (MA) was adopted by the U.S. Census in 1990 and referred collectively to metropolitan statistical areas (MSAs), consolidated metropolitan statistical areas (CMSAs), and primary metropolitan statistical areas (PMSAs). In addition, "area" could refer to either (1) FIPS county, (2) modified FIPS county, (3) 1999 OMB Metropolitan Statistical Area, or (4) 2003 OMB Metropolitan Statistical Area. Micropolitan Statistical Areas are not used in the AHRQ QI software.
[16] https://qualityindicators.ahrq.gov/Downloads/Modules/ED_PQI/V2023/Version_2023_Benchmark_Tables_ED_PQI.pdf