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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 2027 Health Home Core Sets

Draft Report

November 2025

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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.

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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
COVID-19	Coronavirus disease 2019
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
MY	Measurement year
NCQA	National Committee for Quality Assurance
SMI	Serious mental illness
SPA	State plan amendment
SUD	Substance Use Disorder
TA	Technical assistance
TA/AS	Technical Assistance and Analytic Support
Td	Tetanus and diphtheria
Tdap	Tetanus, diphtheria, and acellular pertussis

Executive Summary

The Medicaid Health Home State Plan Option, authorized under 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 May 2025, 20 states[2] have a total of 33 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 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 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 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.

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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." May 2025. Available at https://www.medicaid.gov/resources-for-states/downloads/hh-spa-overview-may-2025.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 a 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.

CMS contracted with Mathematica to convene the 2027 Medicaid Health Home Core Sets Annual Review Workgroup. The Workgroup included 11 members, who represented a diverse array of affiliations, subject matter expertise, and experience in quality measurement and improvement (see page ii for a list of Workgroup members).

The Workgroup was charged with assessing the 2026 1945 and 1945A Health Home Core Sets and recommending measures for addition or removal, with the goal of strengthening and improving the 2027 Health Home Core Sets. Workgroup members were asked to discuss and vote on measures suggested by the public for removal from 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 states' goals for improving care delivery and health outcomes for Medicaid health home enrollees. Exhibit ES.1 shows the criteria that Workgroup members considered during the 2027 Health Home Core Sets Annual Review.

Exhibit ES.1. Criteria Considered for Addition of New Measures to and Removal of Existing Measures from the 2027 Health Home Core Sets

Criteria for Suggesting Measures for Addition
Minimum Technical Feasibility and Appropriateness
A1. 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).(Specifications must be provided as part of the submission.)
A2. The measure must have been tested in state Medicaid and/or Children's Health Insurance Program (CHIP) programs or be in use by one or more state Medicaid and/or CHIP programs according to measure specifications. (Documentation is required as part of the submission.)
A3. 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).
A4. The specifications and data source must allow for consistent calculations across health home programs (e.g., coding and data completeness).
A5. The measure aligns with current clinical guidance and/or positive health outcomes.
A6. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
Actionability
B1. The measure addresses a priority for improving health care delivery and outcomes in Medicaid Health Home Programs.
B2. The measure is able to be stratified by the required stratification categories included in the annual Core Sets guidance for the Medicaid and CHIP population. Considerations could include adequate sample and population sizes and available data in the required data source(s).
B3. 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).
B4. The measure would fill a gap in the Medicaid Health Home Core Sets or would add value to the existing measures in the Medicaid Health Home Core Sets.

Exhibit ES.1 *(continued)*

Other Considerations
C1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across Medicaid Health Home Programs, taking into account program population sizes and demographics.
C2. 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, Medicaid and CHIP Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
C3. Adding the measure to the Medicaid Health Home Core Sets does not result in substantial additional data collection burden for providers or Medicaid health home enrollees.
C4. All Medicaid Health Home Programs should be able to produce the measure for all Medicaid Health Home Program populations within two years of the measure being added to the Medicaid Health Home Core Sets.
C5. The code sets and codes specified in the measure must be in use by Medicaid programs or otherwise be readily available to Medicaid and CHIP programs to support calculation of the measure.
Criteria Considered for Suggesting Measures for Removal
Technical Feasibility
A1. 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).
A2. The majority of 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 health home enrollees (or the ability to link to an identifier).
A3. The specifications and data source do not allow for consistent calculations across Medicaid Health Home Programs (e.g., there is variation in coding or data completeness across states).
Actionability
B1. The measure is no longer aligned with priorities for improving health care delivery and outcomes in Medicaid Health Home Programs (e.g., priorities have shifted and this measure does not address the most pressing needs of health home program enrollees).
B2. The measure is not able to be stratified by all required stratification categories included in the annual Core Sets guidance for the Medicaid and CHIP population. Considerations could include lack of adequate sample and population sizes or lack of available data in the required data source(s).
B3. Measure performance for all populations is so high and unvarying that meaningful distinctions in improvements or performance can no longer be made.
B4. Improvement on the measure is outside the direct influence of Medicaid Health Home Programs/providers.
B5. The measure no longer aligns with current clinical guidance and/or positive health outcomes.
B6. Another measure is recommended for replacement which is: (1) more broadly applicable (across settings, populations, or conditions) for the topic, and/or (2) more proximal in time to desired beneficiary outcomes, and/or (3) more strongly associated with desired beneficiary outcomes. (Note that the replacement measure must also meet the minimum technical feasibility criteria to be considered by the Workgroup.)
Other Considerations
C1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful program-level results, taking into account program population sizes and demographics.
C2. The measure and measure specifications are not aligned with those used in other CMS programs (e.g., Core Quality Measures Collaborative Core Sets, Medicare Promoting Interoperability Program, Merit-Based Incentive Payment System, Medicaid and CHIP Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).

Exhibit ES.1 *(continued)*

C3. Including the measure in the Health Home Core Sets results in substantial additional data collection burden for providers or Medicaid Health Home enrollees	
C4. All health home programs may not be able to produce the measure for all Medicaid Health Home populations within two years of the measure being added to the Health Home Core Sets.	

Workgroup members convened virtually on September 10, 2025, to review one measure suggested for addition to the 1945 Health Home Core Set—*Adult Immunization Status*. No measures were suggested for addition to the 1945A Health Home Core Set or 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 measure and recommended adding *Adult Immunization Status* to the 2027 Health Home Core Sets.

As of the 2027 Health Home Core Sets Annual Review cycle, Mathematica conducts a public Call for Measures. To help inform the 2028 public Call for Measures, the Workgroup discussed priority gap areas in the current Health Home Core Sets. This included measuring the effectiveness of care management; understanding health home enrollee experiences; and adding measures that focus on specific organ systems and conditions applicable to the health home population.

This report summarizes the 2027 Health Home Core Sets Annual Review Workgroup's review process, discussion, and recommendations. The draft report will be available for public comment from November 28, 2025, through January 12, 2026. CMS anticipates releasing the 2027 Health Home Core Sets by early 2026.

Introduction

The Medicaid Health Home State Plan Option, authorized under 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 May 2025, 20 states[10] have 33 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]

[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 Medicaid 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 Medicaid Health Home Programs as of May 2025 is available at https://www.medicaid.gov/resources-for-states/downloads/hh-spa-overview-may-2025.pdf.

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

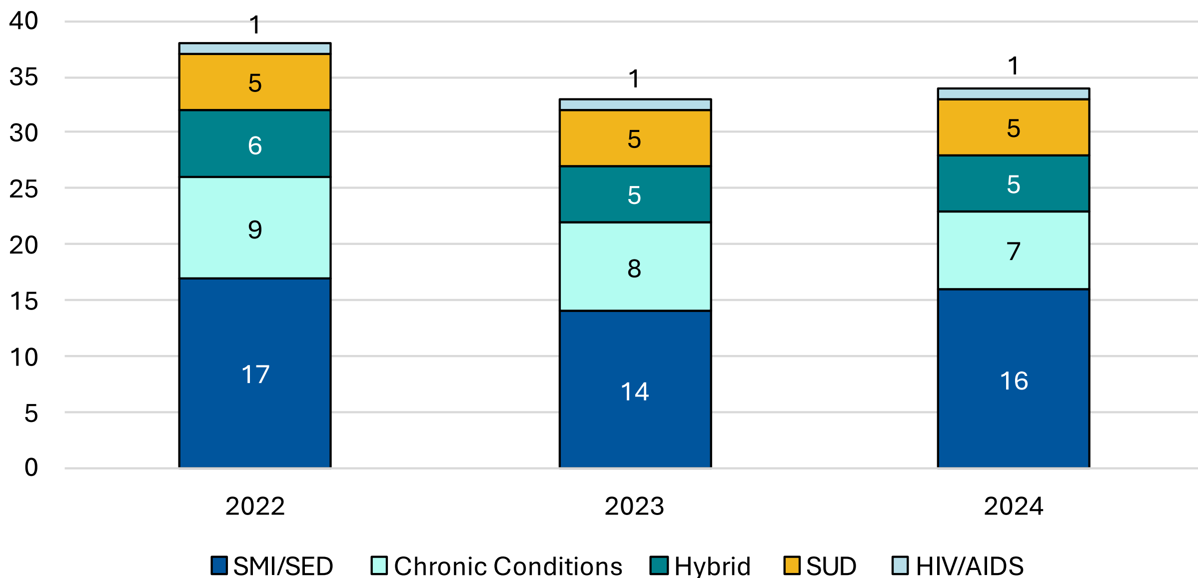
[13] Medicaid.gov. "Health Homes." n.d. https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html.

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 2022 to 2024. In 2024, 16 1945 health home programs served people with SMI; another seven 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, 2022−2024



Source: Centers for Medicare & Medicaid Services, Medicaid and Children's Health Insurance Program (CHIP) Core Set Technical Assistance and Analytic Support Program, January 2025.

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 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

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

collectively and differentiates them as the 1945 and 1945A Health Home Core Sets where appropriate.

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 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 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 2027 Medicaid Health Home Core Sets Annual Review Workgroup.[15, 16] The Workgroup included 11 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 2027 Health Home Core Sets Annual Review process, and summarizes the Workgroup's recommendations for improving the Health Home Core Sets.

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. The most recent year of completed Health Home Core Set reporting was for the 2024 Core Set, which generally covers services delivered in calendar year 2023. As a condition of receiving payment for Section 1945 health

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[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 2027 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.

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 with the most recent 2024 reporting, reporting of the Medicaid Health Home Core Sets is mandatory for all states with approved Health Home Programs in operation for at least six months of the reporting period.

Appendix A includes tables listing the 2026 Health Home Core Set measures and the history of measures included in the Health Home Core Set. Of the 11 measures in the 2026 Health Home Core Set, about half were part of the initial Health Home Core Set established in 2013.

The 2026 1945 Health Home Core Set

The 2026 Health Home Core Set includes 11 measures, nine of which are quality measures and two of which are utilization measures. Of the measures, 10 can be calculated using an administrative data collection methodology and one uses the electronic clinical data systems (ECDS) methodology.

CMS publicly reports data for Health Home Core Set measures that were reported by at least 15 health home programs and met CMS standards for data quality.[17] Highlights for 2023 Health Home Core Set reporting,[18] the most recent year for which data are publicly available, include the following:

- Of the 33 Health Home Programs expected to report the 2023 Health Home Core Set measures, 30 programs reported at least one measure. The other three programs did not submit data in time to be included in public reporting.
- States reported a median of 11 of the 13 Health Home Core Set measures for 2023.
- Between 2021 and 2023, seven measures were reported by at least two-thirds of the 27 Health Home Programs expected to report in all three reporting years.
- Reporting remained consistent or increased for 24 of the 27 Health Home Programs that reported for all three years from 2021 to 2023.

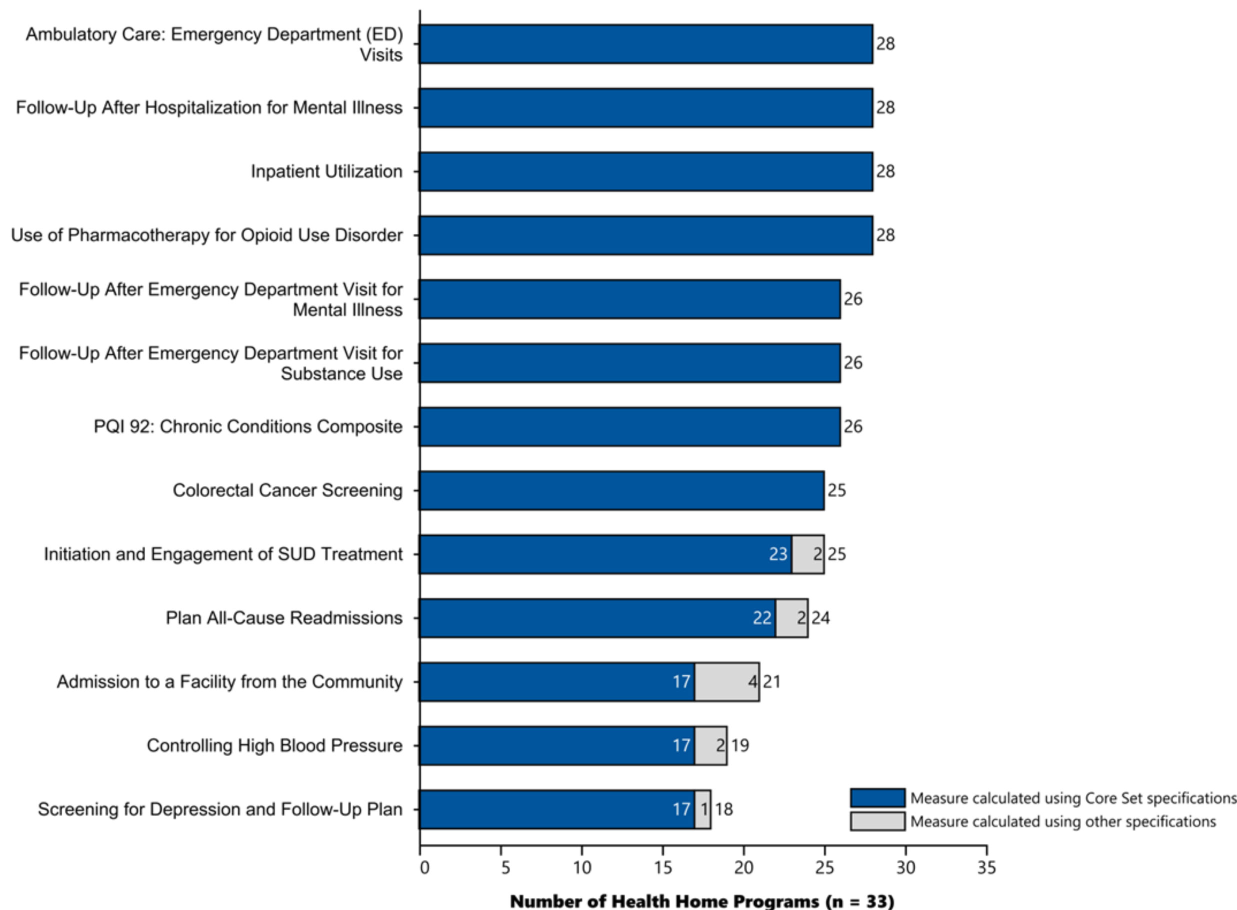
Exhibit 2 summarizes the number of Health Home Programs reporting the 1945 Health Home Core Set measures for 2023. The most commonly reported measures reported for 2023 were the Ambulatory Care: Emergency Department (ED) Visits measure, the Follow-Up After Hospitalization for Mental Illness measure, the Inpatient Utilization measure and the Use of

[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.

Pharmacotherapy for Opioid Use Disorder measure. The least frequently reported measures for 2023 were the Screening for Depression and Follow-Up Plan measure and the Controlling High Blood Pressure measure.

Exhibit 2. Number of Health Home Programs Reporting the 2023 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, December 2024. https://www.medicaid.gov/resources-for-states/downloads/2023-health-home-chart-pack.zip.

Notes: This chart includes all Health Home Core Set measures that states reported for the 2023 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 Sets. The most common reasons states cited for not reporting a Health Home Core Set measure for 2023 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 2026 1945A Health Home Core Set

The 2026 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 2026 1945A Health Home Core Set measures for any Health Home Programs approved no later than June 30, 2025.[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 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

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[19] Information about the 2026 1945A Health Home Core Set is available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd25002.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.

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

reports, and webinars. The CMS Quality Conference also provides states with information to support their quality measurement and improvement efforts.

Description of the 2027 Health Home Core Sets Annual Review Process

This section describes the 2027 Health Home Core Sets Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2027 Health Home Core Sets Annual Review included 11 voting members from state Medicaid and CHIP programs, professional associations, and other health care organizations from across the country. The Workgroup members for the 2027 Health Home Core Sets Annual Review are listed on page ii of this report. Of the 11 voting members on the 2027 Workgroup, three were new members.

The 2027 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 care and care of children with medically complex conditions. Although Workgroup members had individual subject matter expertise, and some were nominated by an organization, 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. The Workgroup was charged with considering which measures would best drive improvement in care delivery and health outcomes for health home enrollees.

Mathematica required Workgroup members to submit a disclosure of interest form to report any interests, relationships, or circumstances over the past four years that could create a conflict of interest (or the appearance of one) related to the current Health Home Core Sets measures or other measures reviewed during the Workgroup process. No Workgroup members were deemed to have an interest in a measure under consideration from voting on that measure. Had any conflicts been identified, Mathematica would have recused the Workgroup member from the vote.

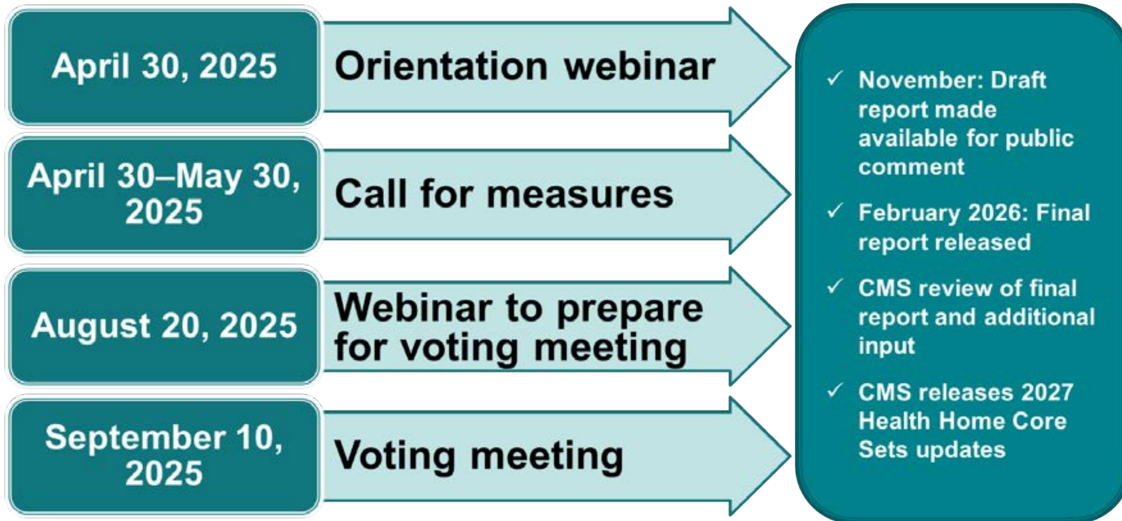
The Workgroup also included nonvoting federal liaisons representing seven federal agencies (see page ii of this report). The inclusion of federal liaisons reflects CMS's commitment to promoting quality measurement alignment and partnering with other federal agencies to collect, report, and use the Core Set measures to drive improvement in care delivery and health outcomes for Medicaid health home enrollees.

Workgroup Timeline and Meetings

Mathematica held virtual meetings via webinar in April and August 2025 to orient Workgroup members to the 2027 Health Home Core Sets Annual Review process and to prepare them for the

voting meeting, which took place in September 2025 (Exhibit 3). All meetings were open to the public, with public comment encouraged during each meeting.

Exhibit 3. Timeline for the 2027 Health Home Core Set Annual Review Workgroup



Orientation Webinar

During the orientation meeting on April 30, 2025, Mathematica introduced the Workgroup members and described the disclosure-of-interest process, the Workgroup charge, and the timeline and process for the 2027 Health Home Core Sets Annual Review. Next, Mathematica provided background on the Health Home Core Sets, and summarized the recommendations and gaps identified from the 2026 Annual Review.

> **Workgroup Charge**
>
> The 2027 Health Home Core Sets Annual Review Workgroup is charged with assessing the Health Home Core Sets and recommending measures for addition or removal to strengthen and improve the Core Sets.
>
> The Workgroup should focus on recommending measures that are feasible and viable for program-level quality measurement and improvement. Workgroup members should consider whether all Health Home Programs can report a measure within two years of its addition to the Core Sets.

Mathematica also explained the Call for Measures process, through which Workgroup members, federal liaisons, and members of the public suggest measures for removal from or addition to the Health Home Core Sets. Mathematica asked Workgroup members to consider the following criteria when considering measures for removal or addition: (1) minimum technical feasibility and appropriateness of measures, (2) the actionability of measures, and (3) other considerations. The following is a high-level overview of the criteria. Exhibit 4 on the following page contains the full list of criteria shared with the Workgroup and the public to guide the public Call for Measures:

- **Technical feasibility and appropriateness criteria.** Workgroup members and the public should consider the measure's technical feasibility and clinical appropriateness when suggesting either the removal of an existing measure or the addition of a new measure. However, the specific criteria and requirements differ by type of suggestion (removal or addition).
  - **Technical feasibility criteria** (applies to measures suggested for removal). A measure could be suggested for removal if the submitter identifies significant feasibility challenges for Core Sets reporting. For example, if (1) most states report significant challenges in accessing a data source that includes all data elements needed to calculate the measure or, (2) if the specifications and data source do not allow for consistent calculations across health home programs.
  - **Minimum technical feasibility and appropriateness criteria** (applies to measures suggested for addition). Measures suggested for addition must meet all minimum technical feasibility and appropriateness requirements to be considered by the Workgroup. For example, measures must have detailed technical specifications that enable production of the measure at the program level and must have been field tested or used in a state Medicaid or CHIP program according to the technical specifications. Measures must also align with current clinical guidance or positive health outcomes.
- **Actionability criteria** (applies to measures suggested for addition or removal). For example, measures suggested for addition should provide useful and actionable results that can be used to drive improvement in health care delivery and outcomes in Medicaid Health Home Programs, and they should fill a gap in, or add value to, the existing measures on the Core Sets. Conversely, a measure could be suggested for removal if improvement on the measure is outside the influence of Medicaid Health Home Programs/providers, or if a stronger replacement measure is available with broader applicability or closer alignment with desired outcomes.
- **Other considerations** (applies to measures suggested for addition or removal). For example, measures suggested for addition should align with measures used in other CMS programs and should not result in substantial additional data collection burden for providers or Medicaid Health Home enrollees. Conversely, a measure could be removed if the condition or outcome measured is not prevalent enough to produce reliable and meaningful program-level results, or if all Health Home Programs might not be able to produce the measure for all Medicaid Health Home populations within two years of it being added to the Core Sets.

Exhibit 4. Criteria Considered for Addition of New Measures to and Removal of Existing Measures from the 2027 Health Home Core Sets

Criteria for Suggesting Measures for Addition
Minimum Technical Feasibility and Appropriateness
A1. 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).
A2. 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 according to specifications.
A3. 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).
A4. The specifications and data source must allow for consistent calculations across health home programs (e.g., coding and data completeness).
A5. The measure aligns with current clinical guidance and/or positive health outcomes.
A6. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Core Sets.
Actionability
B1. The measure addresses a priority for improving health care delivery and outcomes in Medicaid Health Home Programs.
B2. The measure is able to be stratified by the required stratification categories included in the annual Core Sets guidance for the Medicaid and CHIP population. Considerations could include adequate sample and population sizes and available data in the required data source(s).
B3. 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).
B4. The measure would fill a gap in the Medicaid Health Home Core Sets or would add value to the existing measures in the Medicaid Health Home Core Sets.
Other Considerations
C1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across Medicaid Health Home Programs, taking into account program population sizes and demographics.
C2. 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, Medicaid and CHIP Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
C3. Adding the measure to the Medicaid Health Home Core Sets does not result in substantial additional data collection burden for providers or Medicaid health home enrollees.
C4. All Medicaid Health Home Programs should be able to produce the measure for all Medicaid Health Home Program populations within two years of the measure being added to the Medicaid Health Home Core Sets.
C5. The code sets and codes specified in the measure must be in use by Medicaid programs or otherwise be readily available to Medicaid and CHIP programs to support calculation of the measure.

Exhibit 4 *(continued)*

Criteria Considered for Suggesting Measures for Removal
Technical Feasibility
A1. 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).
A2. The majority of 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 health home enrollees (or the ability to link to an identifier).
A3. The specifications and data source do not allow for consistent calculations across Medicaid Health Home Programs (e.g., there is variation in coding or data completeness across states).
Actionability
B1. The measure is no longer aligned with priorities for improving health care delivery and outcomes in Medicaid Health Home Programs (e.g., priorities have shifted and this measure does not address the most pressing needs of health home program enrollees).
B2. The measure is not able to be stratified by all required stratification categories included in the annual Core Sets guidance for the Medicaid and CHIP population. Considerations could include lack of adequate sample and population sizes or lack of available data in the required data source(s).
B3. Measure performance for all populations is so high and unvarying that meaningful distinctions in improvements or performance can no longer be made.
B4. Improvement on the measure is outside the direct influence of Medicaid Health Home Programs/providers.
B5. The measure no longer aligns with current clinical guidance and/or positive health outcomes.
B6. Another measure is recommended for replacement which is: (1) more broadly applicable (across settings, populations, or conditions) for the topic, and/or (2) more proximal in time to desired beneficiary outcomes, and/or (3) more strongly associated with desired beneficiary outcomes. (Note that the replacement measure must also meet the minimum technical feasibility criteria to be considered by the Workgroup).
Other Considerations
C1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful program-level results, taking into account program population sizes and demographics.
C2. The measure and measure specifications are not aligned with those used in other CMS programs (e.g., Core Quality Measures Collaborative Core Sets, Medicare Promoting Interoperability Program, Merit-Based Incentive Payment System, Medicaid and CHIP Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
C3. Including the measure in the Health Home Core Sets results in substantial additional data collection burden for providers or Medicaid Health Home enrollees.
C4. All health home programs may not be able to produce the measure for all Medicaid Health Home populations within two years of the measure being added to the Health Home Core Sets.

Mathematica 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. Mathematica noted the importance of selecting measures that are valuable, reflect whole-person care, and feasible for program-level reporting. Mathematica also relayed CMS's expectation that measures should be able to be stratified by required categories.

Public Call for Measures

After the orientation meeting, Workgroup members, federal liaisons, and members of the public were invited to suggest measures for removal from or addition to the Health Home Core Sets. This was the first year the Call for Measures was not limited to Workgroup members and federal liaisons but was instead open to all interested parties. Members of the public used online forms to submit their suggestions for removal or addition. The submission forms were structured to collect key information about each measure and assess the extent to which it aligned with the criteria for measure submissions, as described previously. For example, individuals who suggested adding a measure were asked to provide the name of and contact information for the measure steward, a link to or copy of the technical specifications, a rationale for the submission, information about whether the measure had been tested in or is currently used by state Medicaid and CHIP programs, and a description of the potential challenges states could face in calculating the measure. Individuals who suggested removing a measure were asked to select one or more reasons for removal from a set list and then to explain their rationale. The form also asked them to assess whether removal of the measure would leave a gap in the Core Sets. For measures suggested for both addition and removal, the form asked submitters whether the Workgroup had reviewed the measure previously and, if so, to provide information that would justify discussing the measure again.

The Call for Measures was open from April 30 to May 30, 2025. Workgroup members, federal liaisons, and members of the public suggested one measure, *Adult Immunization Status*, for addition to the 1945 Health Home Core Set. The Workgroup discussed this measure during the September voting meeting.

Meeting to Prepare for the 2027 Review

The second webinar took place on August 20, 2025, to help Workgroup members prepare for the discussion at the 2027 Annual Review voting meeting. Mathematica shared the one measure to be considered for addition. Mathematica provided guidance to the Workgroup about how to prepare for the measure discussions, including the criteria that Workgroup members should consider when making recommendations about the measure and the resources available to facilitate their review. These resources included a detailed measure information sheet, a worksheet to record questions and notes for the measure, 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 asked to review all materials related to the measure; complete the measure review worksheet; and attend the Annual Review meeting prepared with notes, questions, and preliminary votes on the suggested measure.

Meeting to Review Measure for the 2027 Health Home Core Sets

The 2027 Health Home Annual Review voting meeting took place virtually on September 10, 2025. Workgroup members, the measure steward, and members of the public participated in the meeting. Representatives from CMS and other federal agencies attended the meeting to listen to the discussion. Workgroup co-chairs provided welcome remarks at the beginning of the meeting and offered reflections on the Core Sets.

For the one measure discussed, Mathematica provided an overview of the measure, noted key details from the technical specifications, and summarized the rationale provided by the individual who suggested adding the measure.

Mathematica then facilitated a discussion of the measure. Mathematica elicited comments and questions from Workgroup members about the measure and asked the measure steward to clarify measure specifications when needed. Where applicable, Mathematica invited Workgroup members with experience using the suggested measure in their state Medicaid or CHIP program to share their perspective on the feasibility and actionability of the measure. An opportunity for public comment followed the Workgroup discussion.

Voting took place after the Workgroup discussion and public comment period for the measure. Mathematica facilitated the voting on the measure suggested for addition. Workgroup members voted electronically through a secure, web-based polling application during the specified voting period.

For the 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 a measure to be recommended for addition, at least two-thirds of the eligible Workgroup members must vote 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 measure suggested for addition to the Core Set, the Workgroup discussed gap areas for the 2028 public Call for Measures. A summary of the discussions about the gap areas for the public Call for Measures is presented later in this report.

Workgroup Recommendations for Improving the 2027 Health Home Core Sets

Summary of Workgroup Recommendations

The Workgroup recommended adding one measure to the 1945 Health Home Core Set: *Adult Immunization Status* (Exhibit 5). The Workgroup did not discuss adding any measures to the 1945A Health Home Core Set or removing any measures from the 1945 or 1945A Health Home Core Sets. This section summarizes the Workgroup's discussion and rationale for this recommendation.

Exhibit 5. Measure Recommended for Addition to the 2027 Health Home Core Sets

Measure Name	Measure Steward
Adult Immunization Status (AIS)	NCQA

NCQA = National Committee for Quality Assurance.

Measure Recommended for Addition: Adult Immunization Status

The Workgroup recommended adding the *Adult Immunization Status (AIS)* measure, which assesses the percentage of members 19 years of age and older who are up to date on recommended routine vaccines, including influenza, tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, pneumococcal, hepatitis B, and coronavirus disease 2019 (COVID-19). Six rates are reported for this measure, each with specific age-based denominators and numerator criteria: (1) influenza for members ages 19 and older, (2) Td/Tdap for members ages 19 and older, (3) zoster for members ages 50 and older, (4) pneumococcal for members ages 65 and older, (5) hepatitis B for members ages 19 to 59, and (6) COVID-19 for members ages 65 and older. The measure steward is the National Committee for Quality Assurance (NCQA), and the data collection method is NCQA's Healthcare Effectiveness Data and Information Set (HEDIS)® Electronic Clinical Data Systems (ECDS). The eligible data sources used for ECDS reporting are administrative claims, electronic health records (EHRs), case management systems, health information exchanges, and clinical registries.

The individual who suggested *Adult Immunization Status* emphasized the importance of disease prevention for all populations and particularly for health home enrollees, who qualify for a Medicaid Health Home Program based on having multiple or serious chronic conditions, which may include serious and persistent mental health conditions. They also noted that the United States has recently seen an increased prevalence of individuals who are either non-vaccinated or not fully vaccinated being exposed to and diagnosed with vaccine-preventable conditions. The individual noted that for measurement year (MY) 2023, 85.6 percent (238 of 270) of Medicaid plans reported this measure to NCQA. They also noted that the measure can be trended over time and that stratification of the measure may identify quality improvement initiatives to increase adult immunization rates.

During the discussion, Workgroup members raised several technical and feasibility considerations. Workgroup members raised questions about the nine-year look-back used for the Td/Tdap rate and data availability concerns. Two Workgroup members noted that health care organizations and states retain only a few years of administrative claims data, making the nine-year look-back challenging. The measure steward acknowledged the concern, explaining that the specification aligns with the recommended 10-year interval for the Td/Tdap vaccine (one Td/Tdap vaccine every 10 years), and noted that most plans supplement administrative claims data with immunization registry and EHR data. One Workgroup member expressed additional feasibility concerns with collecting immunization registry and EHR data. Another Workgroup member explained that their state uses two immunization registries and links them to Medicaid enrollment data to calculate the measure; however, they noted that while the approach is feasible, linking across systems can be complex and may lead to undercounting immunization rates.

Two Workgroup members discussed limiting the COVID-19 rate to adults ages 65 and older, noting that clinical recommendations apply to all adults.[24] They also noted that data for this population may not be readily available in Medicaid systems, as many adults in this age group are dually eligible for Medicare and Medicaid and their data may reside primarily in Medicare systems. Two Workgroup members expressed concern that excluding adults ages 19 to 64 overlooks a high-risk group of health home enrollees, who are often younger adults with multiple chronic conditions. The measure steward stated that *Adult Immunization Status* was originally tested for adults ages 19 and older but based on expert feedback, including the Advisory Committee on Immunization Practices, the COVID-19 indicator was limited to ages 65 and older. The measure steward also explained the COVID-19 indicator for ages 65 and older was added for MY 2026; therefore, Medicaid plan-level data are not yet available. However, the measure steward explained that Medicaid health plans have historically been able to report the measure, and more specifically, the pneumococcal indicator which is also for ages 65 and older.

One Workgroup member highlighted the preventive and wellness value of *Adult Immunization Status*, noting that the Health Home Core Set has relatively few prevention-focused measures and that *Adult Immunization Status* could support optimal health for enrollees.

Discussion of Priority Gap Areas in the Health Home Core Sets

During the 2027 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 2028 public Call for Measures to strengthen and improve the Core Sets. Mathematica 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 quality

[24] As of the writing of the draft report, Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States has been issued by the CDC and is available here: https://www.cdc.gov/covid/hcp/vaccine-considerations/index.html

of care provided to health home enrollees, and inform the development of targeted improvement efforts. Mathematica asked each Workgroup member to mention a priority gap area or emphasize a gap area mentioned by another Workgroup member. Exhibit 6 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 6. Synthesis of Workgroup Discussions About Priority Gaps in the Health Home Core Sets

Themes from Priority Gap Areas Discussion
Measures Related to Organ Systems
• Circulatory/Cardiovascular health and prevention
Patient-Reported Outcomes and Experience of Care
• Patient experience of care • Patient-reported encounters with access to care and care management • Effectiveness of care coordination • Dental health access and care coordination • Patient trust in providers
Condition-Specific Gaps
• Diabetes screening and management • Cardiometabolic conditions, including cardiovascular disease • Metabolic syndrome prevention and screening
Prevention and screenings
• Preventive care • Behavioral health screenings and treatment
Other Gap Areas Mentioned by the Workgroup
• Tobacco cessation • Measure development for special needs population
Methodological Considerations
• Stratification of value-based care to determine impact on outcomes

Workgroup members raised several priority gaps and areas for measure development and refinement. Throughout the discussion, Workgroup members emphasized the importance of preventive care, such as screenings, for a wide variety of health conditions affecting health home enrollees. Workgroup members shared a desire for measures oriented toward specific organ systems, including the circulatory and cardiovascular systems, and pointed to gaps related to diabetes, metabolic syndromes, and behavioral health.

In addition, Workgroup members expressed the need for measures related to enrollee experience, including access to care, enrollee-provider relationships, and the effectiveness of care coordination.

In addition, Workgroup members expressed the need for measures related to enrollee experience, including access to care, enrollee-provider relationships, and the effectiveness of care coordination.

One member suggested using CMS's value-based care focus as a stratification to assess how incentives influence health outcomes, and a public commenter noted that value-based incentives can spur innovative quality improvement.

The Workgroup's reflections and public comment about priority gap areas provide a foundation for informing the 2028 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.

Suggestions for Technical Assistance to Support State Reporting of the Health Home Core Sets

Workgroup members discussed opportunities for technical assistance (TA) to support states in collecting, reporting, and using the Health Home Core Sets measures. The following was suggested:

- A separate working group to discuss how states can prepare for the reporting of electronic measures, including the collection and use of standard and non-standard supplemental data.
- Population-specific Health Home Core Sets benchmarks (e.g., serious mental illness health home benchmarks) to allow states to easily compare themselves to similar health home programs in other states.
- Measure specification interpretation support. A representative from Mathematica indicated measure specification questions can be sent to the TA mailbox.

Next Steps

The 2027 Health Home Core Sets Annual Review Workgroup recommended adding *Adult Immunization Status* to the 2027 1945 Health Home Core Set. The Workgroup considered multiple factors when discussing the measure, including the feasibility for program-level 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 measuring the effectiveness of care management, understanding enrollee experience, and including measures focused on prevention and on organ systems or conditions applicable across health home populations.

This report, which is being made available for public comment, summarizes the Workgroup's review process, discussion, and recommendations. CMCS will use the Workgroup's recommendations, public comments, and additional input from CMCS's partners and federal liaisons to inform decisions about updates to the 2027 Health Home Core Sets. CMCS has indicated a goal to release the updates to the 2027 Health Home Sets by early 2026. Please submit public comments via email by 8:00 p.m. ET, January 12, 2026, to MHHCoreSetReview@mathematica-mpr.com and include "2027 Health Home Core Sets Annual Review Public Comment" in the subject line.

Appendix A.
2026 Health Home Core Set Measures

Exhibit A.1. 2026 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 Substance Use Disorder 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)	ECDS
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.

CMIT = CMS Measures Inventory Tool; CMS = Centers for Medicare & Medicaid Services; ECDS= electronic clinical data systems; EHR = electronic health record; NCQA = National Committee for Quality Assurance.

Exhibit A.2. 2026 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	Well-Child Visits in the First 30 Months of Life (W30-HHA)	Administrative
24	NCQA	Child and Adolescent Well-Care Visits (WCV-HHA)	Administrative
124	NCQA	Childhood Immunization Status (CIS-HHA)	Administrative, hybrid, or EHR[a]
363	NCQA	Immunizations for Adolescents (IMA-HHA)	Administrative or hybrid[a]
897	DQA (ADA)	Oral Evaluation, dental services (OEV-HHA)	Administrative
394	CMS	Inpatient Utilization (IU-HHA)	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 1945A 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), 2013–2026

CMIT #*	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023/ 2024	2025	2026
Core Set Measures															
394	NCQA	Initiation and Engagement of Substance Use Disorder Treatment (IET-HH)	X	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	X
139	NCQA	Colorectal Cancer Screening (COL-HH)[a]	--	--	--	--	--	--	--	--	--	X	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	X
268	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	X	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	X
750	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)[b]	--	--	--	--	--	--	--	X	X	X	X	X	X
264	NCQA	Follow-Up After Emergency Department Visit for Substance Use (FUA-HH)[c]	--	--	--	--	--	--	--	X	X	X	X	X	X
265	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)[d]	--	--	--	--	--	--	--	--	--	X	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	--	--
Utilization Measures															

Exhibit A.3 *(continued)*

CMIT #*	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023/ 2024	2025	2026
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	X
49	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)[i]	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	X
1612	CMS	Nursing Facility Utilization (NFU-HH)[h]	X	X	X	X	X	X	--	--	--	--	--	--	--

Note: X = included in Health Home Core Set; -- = not included in Health Home Core Set. More information on 2026 updates to the Health Home Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd25002.pdf.

* 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 needs 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 it was retired by the measure steward.

[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 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.

[i] 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

AHRQ = Agency for Healthcare Research and Quality; AMA = American Medical Association; CMS = Centers for Medicare & Medicaid Services; NCQA = National Committee for Quality Assurance; PCPI = Physician Consortium for Performance Improvement; SUD = substance use disorder.

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