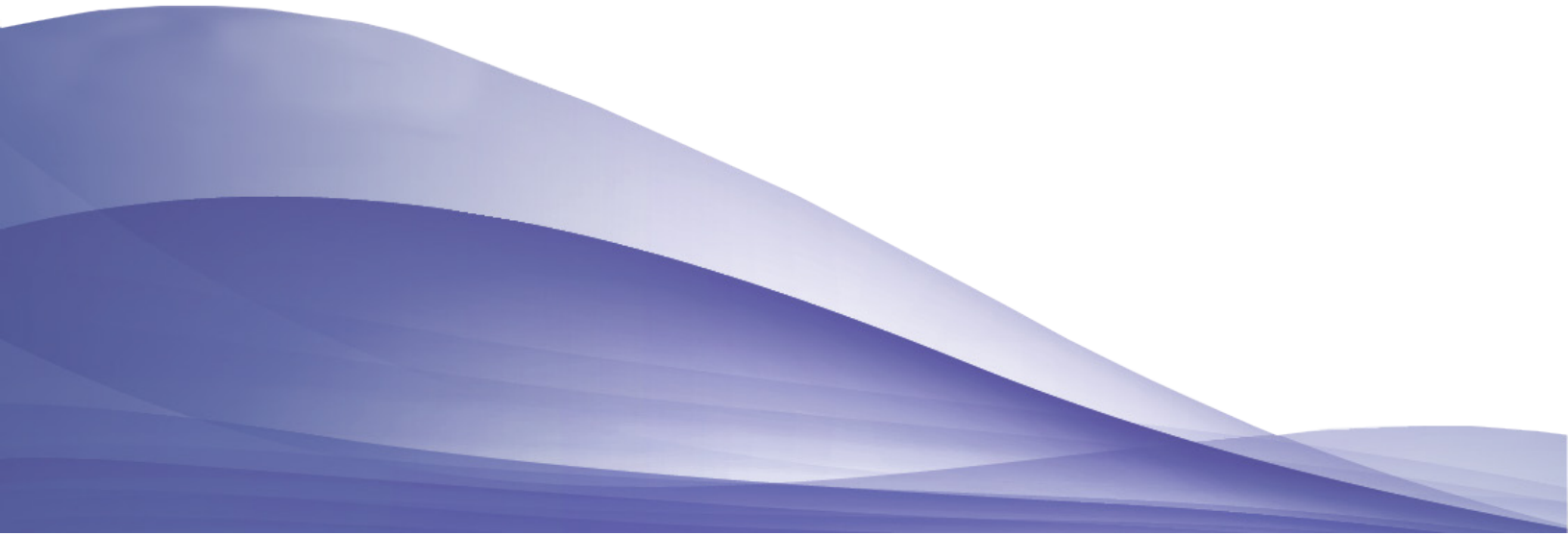
Mathematica®
Progress Together

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

Summary of a Workgroup Review of the 2025 Health Home Core Sets

Draft Report for Public Comment

September 2023



2025 HEALTH HOME CORE SETS ANNUAL REVIEW WORKGROUP MEMBERS

Voting Members (Affiliation as of December 2022)

Jeff Schiff, Co-Chair
AcademyHealth

Kim Elliot, Co-Chair
Health Services Advisory Group

Carrie Amero
AARP Public Policy Institute
Nominated by AARP

David Basel
Avera Medical Group
Nominated by South Dakota Department of Social Services

Jay Berry
Boston Children's Hospital

Dee Brown
UnitedHealthCare

Stacy Carpenter
ZERO TO THREE

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

Amy Houtrow
University of Pittsburgh School of Medicine
Nominated by American Academy of Pediatrics

Raina Josberger
New York State Department of Health

Arielle Kane
Families USA

Pamela Lester
Iowa Medicaid Enterprise
Nominated by Iowa Medicaid

Amy Salazar
New Mexico Human Services Department

Sara Toomey
Boston Children's Hospital
Nominated by Children's Hospital Association

Laura Vegas
National Association of State Directors of Developmental Disability Services
Nominated by National Association of State Directors of Developmental Disability Services

Jeannie Wigglesworth
Connecticut HUSKY Health Behavioral Health Administrative Services Organization

Federal Liaisons (Nonvoting)

Administration for Community Living, U.S. Department of Health and Human Services (HHS)

Agency for Healthcare Research and Quality, HHS

Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services, HHS

U.S. Department of Veterans Affairs

Health Resources and Services Administration, HHS

Office of Disease Prevention and Health Promotion, HHS

Office of Minority Health, HHS

Substance Abuse and Mental Health Services Administration, HHS

Acknowledgments

This report was developed by Mathematica as part of the Technical Assistance and Analytic Support for the Medicaid and CHIP Quality Measurement and Improvement Program, sponsored by the Center for Medicaid and CHIP Services. The 2025 Health Home Core Sets Annual Review Workgroup process and subsequent development of this report benefitted from the contributions of the entire team:

Project Director: Margo Rosenbach, Ph.D., Mathematica

Research, Analytics, and Logistics team: Ilse Argueta, Maria Dobinick, Talia Parker, Erin Reynolds, and Patricia Rowan, Mathematica

Communications Support: Christal Stone Valenzano and Derek Mitchell, Mathematica

Technical Writers: Megan Thomas, Jenneil Johansen, Sophie Leruth, and Vimbai Madzura, Aurrera Health Group

Mathematica also acknowledges the contributions of the Health Home Core Sets Annual Review Workgroup members. Each member brought an invaluable perspective that informed the recommendations for the 2025 Health Home Core Sets. In particular, we thank the Workgroup cochairs, Jeff Schiff and Kim Elliot, for their insightful leadership. We also appreciate the participation of the federal liaisons, who provided cross-agency insight during the meetings.

In addition, we express our gratitude to the measure stewards for providing information on the measures under consideration and thank them for responding to questions from the Workgroup during the meeting.

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

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

Contents

Exhibits

Acronyms

AHRQ	Agency for Healthcare Research and Quality
AIF-HH	Admission to a Facility from the Community
CBP-HH	Controlling High Blood Pressure
CDF-HH	Screening for Depression and Follow-Up Plan
CHIP	Children's Health Insurance Program
CMCS	Center for Medicaid and CHIP Services
CMS	Centers for Medicare & Medicaid Services
EHR	Electronic health record
FFY	Federal fiscal year
MLTSS	Managed long-term services and supports
MLTSS-2	Managed Long-Term Services and Supports Comprehensive Care Plan and Update
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PQI	Prevention Quality Indicator
PQI92-HH	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite
SDOH	Social drivers of health
SDOH-1	Screening for Social Drivers of Health
SPA	State plan amendment
TA	Technical assistance

Executive Summary

The Medicaid health home program, authorized under Section 2703 of the Affordable Care Act (Section 1945 of the Social Security Act), permits states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with complex needs. As of October 1, 2022, states can also submit state plan amendments (SPAs) for the new 1945A health home state plan option that allows states 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 March 2023, 19 states[2] have 33 approved health home programs, with some states submitting multiple SPAs to target different populations.[3,4,5]

To help ensure that health home enrollees receive high-quality and equitable care, the Centers for Medicare & Medicaid Services (CMS) and its Center for Medicaid and CHIP Services (CMCS) use various tools to measure and monitor the quality of care that health home enrollees receive and to drive improvement in terms of 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 health care and the quality of health care for health home enrollees, to identify where disparities exist and improvements are needed, and to 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.

---

[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: SPA Overview." March 2023. Available at https://www.medicaid.gov/resources-for-states/downloads/hh-spa-overview-mar-2023.pdf.

[4] A Medicaid and CHIP Services state plan is an agreement between a state and the federal government describing how the state administers its Medicaid and CHIP programs. When a state is planning to change its program policies or operational approach, the state submits an SPA to CMS for review and approval. More information on health home 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 2025 Medicaid Health Home Core Sets Annual Review Workgroup. The Workgroup included 16 members, who represented a diverse array of affiliations, subject matter expertise, and experience in quality measurement and improvement (see the inside front cover for a list of members).

The Workgroup was charged with assessing the 1945 Health Home Core Set[7] and CMS's proposed 1945A Health Home Core Set measures for the new state plan option. Workgroup members were asked to suggest measures for addition to or removal from the Health Home Core Sets based on several criteria; these criteria support the adoption of measures that are feasible and viable for reporting at the health home program level, are actionable by state Medicaid agencies, and represent strategic priorities for improving care delivery and health outcomes for Medicaid health home enrollees. See Exhibit ES.1 for the criteria that Workgroup members considered during the 2025 Health Home Core Sets Annual Review.

Exhibit ES.1. Criteria Considered for Addition of New Measures to and Removal of Existing Measures from the 2025 Health Home Core Sets

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

[7] To support states' efforts to meet the proposed 2024 mandatory reporting requirements, CMS released the 2024 1945 Health Home Core Set updates with the 2023 updates based on recommendations of the 2023 Workgroup. As a result, the 2025 Workgroup was charged with assessing the 2023 Core Set, and there was no separate review of the 2024 Core Set. More information about the annual review of the Health Home Core Sets is available at https://mathematica.org/features/hhcoresetreview.

Exhibit ES.1 *(continued)*

Other Considerations
1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across health home programs, taking into account Medicaid population sizes and demographics.
2. The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3. All health home programs should be able to produce the measure by the FFY 2024 Core Set reporting cycle and be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).
Criteria Considered for Removal of Existing Measures
Technical Feasibility
1. The measure is not fully developed and does not have detailed technical measure specifications, preventing production of the measure at the program level (e.g., numerator, denominator, and value sets).
2. States report significant challenges in accessing an available data source that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
3. The specifications and data source do not allow for consistent calculations across health home programs (e.g., there is variation in coding or data completeness across states).
4. The measure is being retired by the measure steward and will no longer be updated or maintained.
Actionability and Strategic Priority
1. Taken together with other Health Home Core Set measures, the measure does not contribute to estimating the overall national quality of health care in Medicaid health home programs.
2. The measure is not suitable for comparative analyses of disparities by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.
3. The measure does not address a strategic priority for improving health care delivery and outcomes in Medicaid health home programs (e.g., it does not promote effective care delivery, does not address the unique and complex needs of Medicaid beneficiaries, or there is a lack of evidence that this measure will lead to quality improvement).
4. The measure cannot be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure is topped out, trending is not possible, or improvement is outside the direct influence of Medicaid health home programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is not sufficient to produce reliable and meaningful results across health home programs, taking into account Medicaid population sizes and demographics.
2. The measure and measure specifications are not aligned with those used in other CMS programs, or another measure is recommended for replacement.
3. All health home programs may not be able to produce the measure within two years of the reporting cycle under review or may not be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).

Workgroup members convened virtually on July 11 and July 12, 2023, to review four measures suggested for removal from the 2025 1945 Health Home Core Set and one measure suggested for addition. No measures were suggested by Workgroup members for addition to or removal from the 1945A Health Home Core Set.

For a measure to be recommended for addition to or removal from the Health Home Core Sets, at least two-thirds of the Workgroup members eligible to vote had to vote in favor of removal or addition.

The Workgroup recommended removing two measures from the 2025 1945 Health Home Core Set: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH) and Screening for Depression and Follow-Up Plan (CDF-HH) (Exhibit ES.2). The Workgroup did not recommend adding any measures to the 2025 1945 Health Home Core Set.

Exhibit ES.2. Summary of Workgroup Recommendations for Updates to the 2025 1945 Health Home Core Set

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measure Recommended for Removal		
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	Agency for Healthcare Research and Quality (AHRQ)	NA
Screening for Depression and Follow-Up Plan (CDF-HH)	Center for Medicare & Medicaid Services (CMS)	0418*/0418e*

* This measure is no longer endorsed by NQF.

In addition to discussing the measures suggested for addition and removal, the Workgroup discussed two opportunities to advance health equity through the Health Home Core Sets during the Annual Review meeting: (1) screening for social drivers of health (SDOH) and referral for relevant social and community-based services and (2) leveraging measure stratification to advance health equity through the Health Home Core Sets. Workgroup members expressed broad support for screening for social drivers and determinants of health, as well as stratifying Health Home Core Set measures by categories including race and ethnicity but noted challenges of data collection as well as the need for improvements in follow-up after screening. To address these challenges, Workgroup members encouraged opportunities to leverage community partners to support data collection, reconsider the mode of data collection, and provide enrollee and provider education about the purpose of screening and the uses of information collected.

The Workgroup also discussed additional priorities for the Health Home Core Sets, including a desire to measure the effectiveness of care management; to consider how member and family trust in the health care system may impact a willingness to participate in screening or the accuracy of the information reported; and to include measures in the Health Home Core Sets that are specified for the health home population.

This report, which is being made available for public comment, summarizes the Workgroup's review process, discussion, and recommendations. CMS will use the Workgroup's recommendations, public comments, and additional input from federal liaisons to inform decisions about updates to the 2025 Health Home Core Sets. CMS will release the 2025 Health Home Core Sets by early 2024. Please submit public comments via email by **October 13, 2023, at 8 p.m. ET** to MHHCoreSetReview@mathematica-mpr.com and include "2025 Medicaid Health Home Core Sets Annual Review Public Comment" in the subject line. A final version of this report, which will include all public comments, will be released in November 2023.

Introduction

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Affordable Care Act (Section 1945 of the Social Security Act), allows states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries with complex needs.[8] 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.[9] 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).[10]

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.[11] As of March 2023, 19 states[12] have 33 approved health home programs, with some states submitting multiple SPAs to target different populations.[13,14]

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. 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

[8] Beginning October 1, 2022, states have the option to cover health home services for Medicaid-eligible children with medically complex conditions 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.

[9] 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.

[10] 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.

[11] A Medicaid and CHIP Services state plan is an agreement between a state and the federal government describing how the state administers its Medicaid and Children's Health Insurance Program (CHIP) programs. When a state is planning to change its program policies or operational approach, the state submits an SPA to CMS for review and approval. More information on health home programs is available at https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html.

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

[13] A list of all approved health home programs as of March 2023 is available at https://www.medicaid.gov/sites/default/files/2023-06/hh-spa-overview-mar-2023.pdf.

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

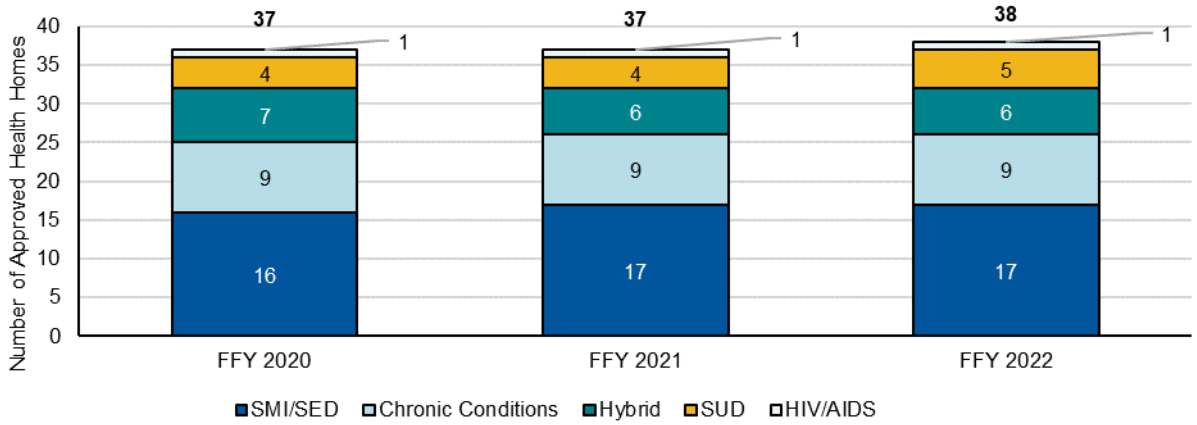
over 25). CMS might consider additional chronic conditions, such as human immunodeficiency virus / acquired immunodeficiency syndrome (HIV/AIDS), for approval.[15]

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 health home programs by target population from federal fiscal year (FFY) 2020 to FFY 2022. In FFY 2022, 17 health home programs served people with serious mental illness, and another nine programs served people with chronic conditions. Six hybrid health home programs had two or more focus areas.

Exhibit 1. Number of Approved 1945 Health Home Programs by Target Population, FFY 2020–FFY 2022



Source: Centers for Medicare & Medicaid Services, Medicaid and Children's Health Insurance Program (CHIP) Core Set Technical Assistance and Analytic Support Program, January 2023.
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 the publication of the 2020 Health Home Chart Pack.
FFY = federal fiscal year; SMI/SED = serious mental illness/serious emotional disturbance; SUD = substance use disorder.

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

1945A Health Home Programs

Section 1945A of the Social Security Act authorizes a new type of health home 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. While 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: 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. [16]

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

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

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

Health Home Quality Reporting

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

[16] 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 health care and the quality of health care for health home enrollees, to identify where disparities exist and improvements are needed, and to develop and assess quality improvement initiatives to drive improvement in the quality of care.

To ensure the Health Home Core Sets continue to reflect and respond to the needs of the health home population, the Health Home Core Sets Annual Review is designed to identify gaps in existing quality measures and suggest updates to strengthen and improve the Health Home Core Sets. The annual review includes input from a variety of groups, including but not limited to states, managed care plans, health care providers, and quality 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 2025 Medicaid Health Home Core Sets Annual Review Workgroup.[17,18] The Workgroup included 16 voting members, who represented a diverse array of affiliations, subject matter expertise, and experience in quality measurement and improvement (see the inside front cover of this report for a list of members).

The Workgroup was charged with assessing the 1945 Health Home Core Set[19] and CMS's proposed 1945A Health Home Core Set measures for the new state plan option. 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 2025 Health Home Core Set Annual Review process, summarizes the Workgroup's recommendations for improving the Health Home Core Sets, and specifies next steps for public comment.

---

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

[18] Mathematica also supported CMS by convening the Child and Adult Core Set Annual Review Workgroup to review and strengthen the 2023 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.

[19] To support states' efforts to meet the proposed 2024 mandatory reporting requirements, CMS released the 2024 1945 Health Home Core Sets updates with the 2023 updates based on recommendations of the 2023 Workgroup. As a result, the 2025 Workgroup was charged with assessing the 2023 Core Sets, and there was no separate review of the 2024 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 FFY 2013. States recently completed Health Home Core Set reporting for FFY 2021 and 2022, which generally covers services delivered in calendar year 2020 and 2021. As a condition of receiving payment for Section 1945 health home services, Medicaid health home providers are required to report quality measures to the state, and 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 states are expected to report the measures separately for each of their health home programs.

Appendix A includes tables listing the 2023 Health Home Core Set measures and the history of measures included in the Health Home Core Set. Of the 13 measures in the 2023 Health Home Core Set, about three-fifths were part of the initial Health Home Core Set established in 2013.

The 2023 and 2024 1945 Health Home Core Set

The 2023 and 2024 Health Home Core Set includes 13 measures, 10 of which are quality measures and three of which are utilization measures. All the measures can be calculated using an administrative data collection methodology.

CMS publicly reports data for Health Home Core Set measures that at least 15 health home programs reported and met CMS standards for data quality.[20] Highlights for FFY 2020 Health Home Core Set reporting,[21] the most recent year for which data are publicly available, include the following:

- Of the 37 health home programs expected to report Health Home Core Set measures for FFY 2020, 34 programs reported at least one measure. The other three programs did not submit data in time to be included in publicly reported data.
- States reported a median of 9 of the 12 Health Home Core Set measures for FFY 2020.
- Between FFY 2018 and FFY 2020, six measures were reported by at least two-thirds of the 26 health home programs that were expected to report in all three reporting years.
- Reporting remained consistent or increased for 24 of the 26 health home programs that reported for all three years from FFY 2018 to FFY 2020.

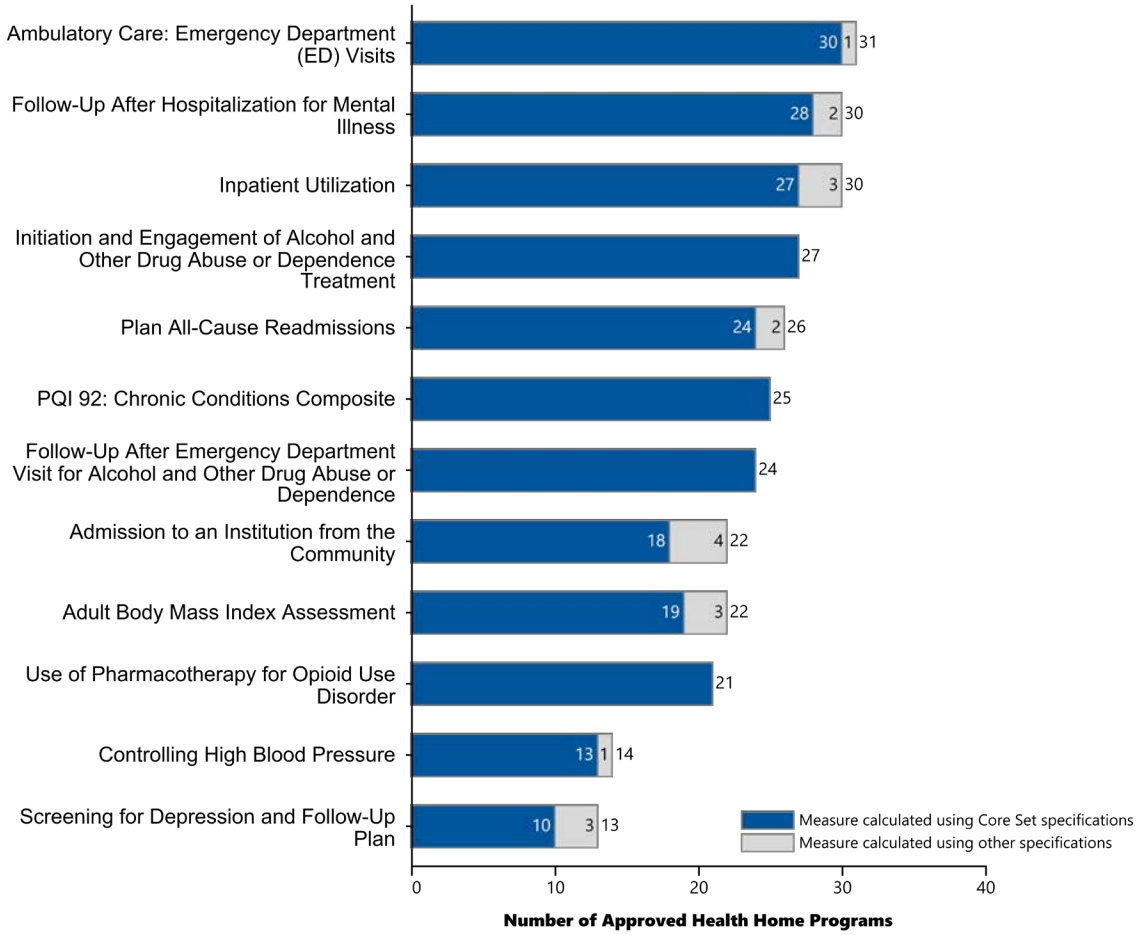
[20] More information about performance analysis and trending of Health Home Core Set measures is available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/health-home-core-set-methods-brief-nov-2021.pdf.

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

- Reporting increased for all nine measures included in both the FFY 2018 and FFY 2020 Health Home Core Sets.

Exhibit 2 summarizes the number of health home programs reporting the 1945 Health Home Core Set measures for FFY 2020. The most commonly reported measures reported for FFY 2020 were the Ambulatory Care: Emergency Department (ED) Visits measure, the Follow-Up After Hospitalization for Mental Illness measure, and the Inpatient Utilization measure. The least frequently reported measures for FFY 2020 were the Screening for Depression and Follow-Up Plan (CDF-HH) measure and the Controlling High Blood Pressure (CBP-HH) measure.

Exhibit 2. Number of Health Home Programs Reporting the 1945 Health Home Core Set Measures, FFY 2020



Source: Centers for Medicare & Medicaid Services, Medicaid and Children's Health Insurance Program (CHIP) Core Set Technical Assistance and Analytic Support Program, April 2021. Available at https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/downloads/2021-health-home-core-set-chart-pack-ffy-2020.pdf.

Notes: This chart includes all Health Home Core Set measures that states reported for the FFY 2020 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.

FFY = federal fiscal year; PQI = Prevention Quality Indicator.

Understanding challenges states encounter with reporting the Health Home Core Set measures is important in assessing the feasibility of calculating existing measures as well as those suggested for addition to the Health Home Core Set. The most common reasons states cited for not reporting a Health Home Core Set measure for FFY 2020 were that they did not collect the data or lacked the ability to link data sources to calculate the measure. Another common barrier included staff and budgetary constraints. Finally, small health home populations and continuous enrollment requirements limited the number of health home enrollees who were eligible for some of the measures.

The 2024 1945A Health Home Core Set

The 2024 1945A Health Home Core Set[22] includes seven measures, all of which can be calculated using an administrative data collection methodology. All the measures are also included in either the 1945 Health Home Core Set or the Child Core Set[23]. The first year that CMS would expect states to report 1945A Health Home Core Set measures would be for FFY 2024 if the health home program was approved and implemented no later than July 1, 2023.[24] 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.[25]

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.[26] CMS also continuously explores opportunities to increase the efficiency of reporting and reduce state reporting burden, streamline Health Home

[22] The 2024 1945A Health Home Core Set is available at https://www.medicaid.gov/media/146771.

[23] 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.

[24] 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.

[25] Chart packs, measure-specific 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.

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

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 technical assistance (TA) mailbox, one-on-one consultation, issue briefs, fact sheets, analytic reports, and webinars. The CMS Quality Conference also provides states with information to support their quality measurement and improvement efforts.

Description of the 2025 Health Home Core Sets Annual Review Process

This section describes the 2025 Health Home Core Sets Annual Review process, including the Workgroup composition, timeline, and meetings.

Workgroup Composition

The Workgroup for the 2025 Health Home Core Sets Annual Review included 16 voting members affiliated with state Medicaid agencies and other organizations from across the country. See the inside front cover of this report for a list of the Workgroup members. The Workgroup was initially selected through a call for nominations issued in February 2021 in conjunction with the 2022 Health Home Core Set Annual Review. New Workgroup members are identified, as needed, through outreach to nominating organizations. Of the 16 voting members on the 2025 Workgroup, seven were new members.

The 2025 Health Home Core Sets Annual Review Workgroup members offered expertise in health home quality measurement and improvement as well as subject matter expertise related to the needs of Medicaid health home enrollees, such as behavioral health and care of children with medically complex conditions. Although Workgroup members have individual affiliations, they agreed to participate as stewards of the Medicaid health home program as a whole and not from their individual points of view. They were asked to consider what measures would best drive improvement in care delivery and health outcomes for health home enrollees.

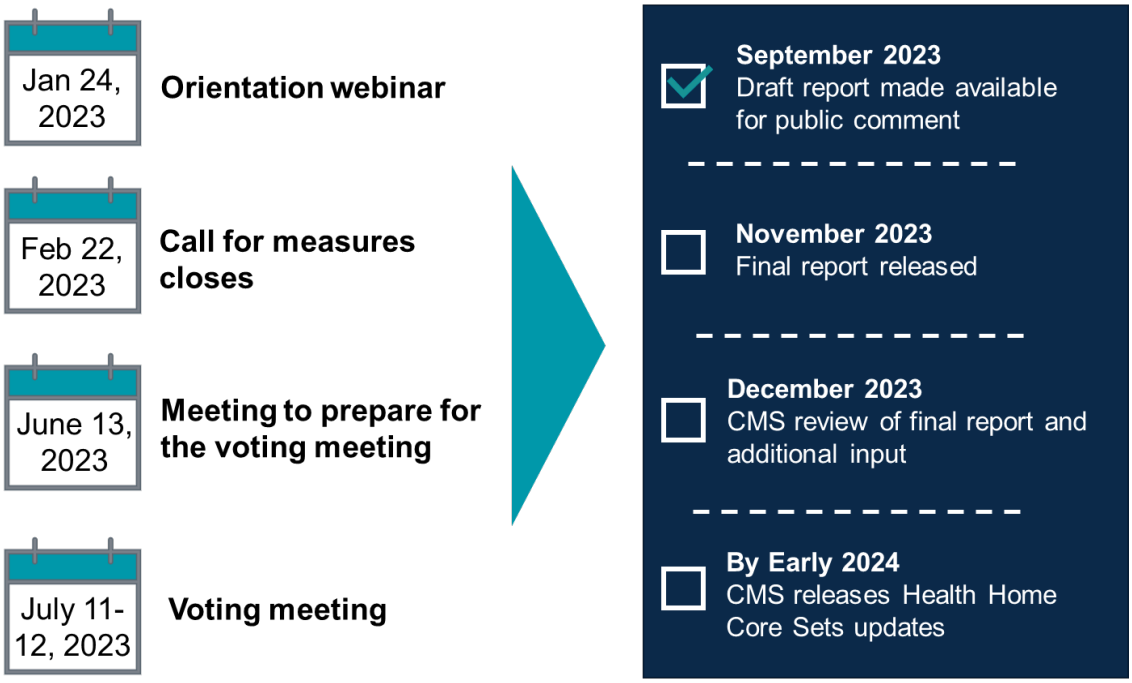
Workgroup members submitted a disclosure of interest form to report any interests, relationships, or circumstances over the past four years that could give rise to a potential conflict of interest, or the appearance of one, related to the current measures in the Health Home Core Sets or other measures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

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

Workgroup Timeline and Meetings

Mathematica held webinars in January 2023 and June 2023 to orient the Workgroup members to the review process and prepare them for the 2025 Health Home Core Sets Annual Review voting meeting, which took place virtually in July 2023 (Exhibit 3). All meetings were open to the public, and members of the public could comment during each meeting.

Exhibit 3. Timeline for the 2025 Health Home Core Set Annual Review Workgroup



Orientation Webinar

During the orientation webinar on January 24, 2023, Mathematica outlined the Workgroup charge, introduced the Workgroup members, and provided background on the Health Home Core Sets.

After providing an overview of the process for the 2025 Health Home Core Sets Annual Review, Mathematica summarized the outcomes of the 2023 Annual Review and discussed the gaps raised by the Workgroup during the meeting. Mathematica described the additional input that CMS will obtain during the 2025 Annual Review process, including input from federal partners and internal partners within CMS.

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

To operationalize these three components, Mathematica identified a comprehensive set of criteria used to assess measures during all phases of the Workgroup process. As Exhibit 4 shows, the Workgroup focused on measures that met the following criteria:

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

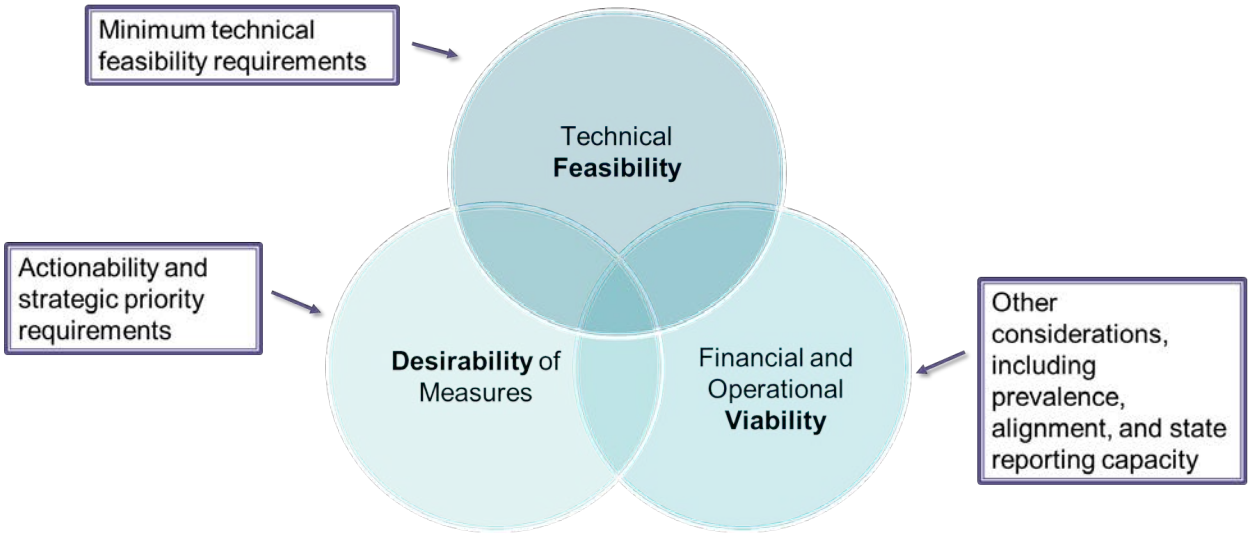
Workgroup Charge

The 2025 Health Home Core Sets Annual Review Workgroup is charged with assessing the existing 1945 Health Home Core Set and recommending measures for addition or removal in order to strengthen and improve the Medicaid Health Home Core Set. This year's review will also assess the proposed 1945A Health Home Core Set measures for the new state plan option.

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

With mandatory reporting of the Health Home Core Sets proposed to begin in FFY 2024, the Workgroup should consider the feasibility of reporting by states for all Medicaid populations enrolled in health home programs as well as opportunities for advancing health equity through stratification of Health Home Core Set measures where feasible.

Exhibit 4. Framework for Assessing Measures for the 2025 Health Home Core Sets



CMS 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. CMS noted the administration's desire to advance health equity and the importance of Core Set measures that can be stratified at the program level to improve care for all and close equity gaps.

Call for Measures

Following the orientation meeting, the Workgroup members and federal liaisons were invited to suggest measures for addition to or removal from the Health Home Core Sets to strengthen and improve the Core Sets for 2025. Workgroup members used an online form to submit their suggestions for addition or removal, and were asked to provide the following information about the measure(s):

- The rationale for the suggestion
- Information about the technical feasibility, actionability, and strategic priority of measures suggested for removal or addition
- Whether the measure is suitable for comparative analyses of disparities among Medicaid health home enrollees by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language
- Whether the measure was previously reviewed by the Workgroup and, if so, information that justifies discussing it again
- Whether removal of the measure would leave a gap in the Core Sets
- Whether another measure was proposed to replace the measure suggested for removal

- Whether a measure suggested for addition was intended to replace a current Core Set measure
- Potential barriers states could face in calculating the measures suggested for addition within two years of the reporting cycle under review

The Call for Measures was open from January 25 to February 22, 2023. Workgroup members and federal liaisons suggested two measures for addition to the 1945 Health Home Core Set and four measures for removal from it. The Workgroup did not suggest any measures for addition to or removal from the 1945A Health Home Core Set.

Mathematica conducted a preliminary assessment of the six measures.

Among the two measures suggested for addition, Mathematica determined that one measure suggested for addition, Screening for Social Drivers of Health (SDOH-1), would not be discussed by the Workgroup as it does not meet minimum technical feasibility criteria for testing in, or use by, a state Medicaid and/or CHIP program.

The Workgroup discussed five measures during the July voting meeting:

- **One measure for addition**, focused on comprehensive care planning
- **Four measures for removal**, focused on controlling high blood pressure, depression screening, admission to a facility, and hospitalization for chronic conditions

Appendix B provides the full list of measures suggested by Workgroup members and federal liaisons for addition to or removal from the 2025 1945 Health Home Core Set.

Webinar to Prepare for the Annual Review Meeting

The second webinar took place on June 13, 2023. To help Workgroup members prepare for the discussion at the 2025 Annual Review voting meeting, Mathematica provided a list of the five measures to be considered. Mathematica also identified the measure suggested for addition that would not be reviewed at the July meeting and noted why it would not be discussed.

Mathematica provided guidance to the Workgroup about how to prepare for the measure discussion, including the criteria that Workgroup members should consider for recommending a measure for addition to and removal from the 1945 Health Home Core Set and the resources available to facilitate their review. These resources included detailed measure information sheets for each measure, a worksheet to record questions and notes for each measure, links to chart packs and measure-specific tables, the 1945 Health Home Core Set Resource Manual and Technical Specifications, and a list of measures and measure gaps previously discussed by the Workgroup. Workgroup members were responsible for reviewing all materials related to the measures; completing the measure worksheet; and attending the Annual Review meeting

prepared with notes, questions, and preliminary votes on the measures proposed for addition and removal.

Annual Review Voting Meeting Webinar

The 2025 Health Home Core Sets Annual Review voting meeting took place virtually on July 11 and 12, 2023. Workgroup members, federal liaisons, measure stewards, and members of the public participated in the meeting.

CMS staff provided welcome remarks at the outset of the voting meeting. They started by thanking the Workgroup members for their time and acknowledged the diversity of backgrounds and experiences among Workgroup members. They also provided brief updates on the number of states choosing to implement 1945 health home programs and the relevance of the model to serve populations of Medicaid beneficiaries with serious mental illness and intellectual/developmental disabilities. Finally, they highlighted the importance of using the Health Home Core Sets to advance health equity through measure stratification particularly with the proposed mandatory reporting requirements beginning with FFY 2024 reporting.

Workgroup members discussed the measure suggested for addition first, followed by measures suggested for removal. Mathematica described the technical specifications of each measure proposed for addition or removal and summarized the rationale provided by Workgroup members for their addition or removal.

Mathematica then facilitated a discussion of the measures being reviewed. After presentation of a set of measures, Mathematica sought comments and questions from Workgroup members about each measure and asked the measure stewards to clarify the measure specifications when needed. Workgroup discussion was followed by an opportunity for public comment on the measures being discussed.

Voting took place after the Workgroup discussion and opportunity for public comment, with Mathematica facilitating the voting. Workgroup members voted electronically through a secure web-based polling application during specified voting periods. Workgroup members who experienced technical difficulties with the voting tool submitted their vote through the webinar question and answer (Q&A) feature, which was visible only to the Mathematica team.

For the measure suggested for addition, Workgroup members could select either “Yes, I recommend adding this measure to the Health Home Core Set” or “No, I do not recommend adding this measure to the Health Home Core Set.” For those suggested for removal, Workgroup members could select either “Yes, I recommend removing this measure from the Health Home Core Set” or “No, I do not recommend removing this measure from the Health Home Core Set.”

Measures were recommended for addition or removal if two-thirds of the eligible Workgroup members voted yes. The two-thirds voting threshold was adjusted according to the number of eligible Workgroup members present for each measure vote. Mathematica presented the voting

results immediately after each vote and reported whether the results met the two-thirds threshold for a measure to be recommended for addition or removal.

The Workgroup also discussed two opportunities to advance health equity through the Health Home Core Sets: (1) screening and referral for social drivers of health (SDOH) and (2) stratification of Health Home Core Set measures. Public comment was invited after the Workgroup discussion of these issues. A summary of the discussion appears later in this report.

Mathematica reviewed the frequently mentioned gaps identified during the 2021–2023 Annual Reviews and then asked the Workgroup to suggest priorities for future Core Sets, including high-priority gaps not previously identified.

Workgroup Recommendations for Improving the 2025 Health Home Core Sets

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

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

To be considered by the Workgroup, all measures suggested for addition must meet minimum technical feasibility criteria. As noted earlier, Mathematica conducted a preliminary assessment of suggested measures before the Annual Review meeting to ensure that measures discussed by the Workgroup adhered to the minimum technical feasibility criteria. Appendix B contains the full list of measures suggested by Workgroup members and federal liaisons for addition to or removal from the Core Sets, including those not discussed by the Workgroup during the Annual Review meeting.

Mathematica mentioned additional contextual factors to inform the Workgroup discussion:

- The Workgroup should consider alignment with current measures in CMS's Medicaid and CHIP Child and Adult Core Sets of health care quality measures (Child and Adult Core Sets) to achieve "multi-level alignment."
- The Workgroup should consider each measure on its own merits according to the criteria. There is no target number of measures—maximum or minimum—for the Health Home Core Sets.
- The Workgroup should review, discuss, and vote on the measure as it is currently specified by the measure steward.

- The Workgroup should consider the feasibility for all health home programs to report the measure within two years of the measure being added to the Health Home Core Sets.

Exhibit 5. Criteria Considered for Addition of New Measures to and Removal of Existing Measures from the 2025 Health Home Core Set

Criteria Considered for Addition of New Measures
Minimum Technical Feasibility Requirements
1. The measure must be fully developed and have detailed technical specifications that enable production of the measure at the program level (e.g., numerator, denominator, and value sets).
2. The measure must have been tested in state Medicaid and/or CHIP programs or be in use by one or more state Medicaid and/or CHIP programs.
3. An available data source or validated survey instrument exists that contains all the data elements necessary to calculate the measure, including an identifier for Medicaid beneficiaries (or the ability to link to an identifier).
4. The specifications and data source must allow for consistent calculations across health home programs (e.g., coding and data completeness).
5. The measure must include technical specifications (including code sets) that are provided free of charge for state use in the Health Home Core Sets.
Actionability and Strategic Priority
1. Taken together with other Health Home Core Set measures, the measure can be used to estimate the overall national quality of health care in Medicaid health home programs.
2. The measure should be suitable for comparative analyses of disparities by factors such as race, ethnicity, sex, age, rural/urban status, disability, and language.
3. The measure addresses a strategic priority for improving health care delivery and outcomes in Medicaid health home programs.
4. The measure can be used to assess progress in improving health care delivery and outcomes in Medicaid health home programs (e.g., the measure has room for improvement, performance is trendable, and improvement can be directly influenced by Medicaid health home programs/providers).
Other Considerations
1. The prevalence of the condition or outcome being measured is sufficient to produce reliable and meaningful results across health home programs, taking into account Medicaid population sizes and demographics.
2. The measure and measure specifications are aligned with those used in other CMS programs, where possible (e.g., Core Quality Measures Collaborative Core Sets, Medicaid Promoting Interoperability Program, Merit-Based Incentive Payment System, Qualified Health Plan Quality Rating System, Medicare Advantage Star Ratings, and/or Medicare Shared Savings Program).
3. All health home programs should be able to produce the measure by the FFY 2024 Core Set reporting cycle and be able to include all Medicaid health home populations (e.g., all age groups, eligibility categories, and delivery systems).

Exhibit 5 *(continued)*

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

Summary of Workgroup Recommendations

The Workgroup recommended removing two measures from the 2025 1945 Health Home Core Set: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH) and Screening for Depression and Follow-Up Plan (CDF-HH) (Exhibit 6). The Workgroup did not recommend adding any measures to the 2025 1945 Health Home Core Set. Because there were no measures suggested for addition to or removal from the 1945A Health Home Core Set, this section focuses on the discussion and recommendations for the 1945 Health Home Core Set.

Appendix C provides information about the measures discussed but not recommended for removal from or addition to the 1945 Health Home Core Set. Measure information sheets for each measure are available on the Mathematica Health Home Core Set Review website.

Exhibit 6. Summary of Workgroup Recommendations for Updates to the 2025 1945 Health Home Core Set

Measure Name	Measure Steward	National Quality Forum # (if endorsed)
Measures Recommended for Removal		
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	Agency for Healthcare Research and Quality (AHRQ)	NA
Screening for Depression and Follow-Up Plan (CDF-HH)	Centers for Medicare & Medicaid Services (CMS)	0418*/ 0418e*

*This measure is no longer endorsed by NQF.

Measures Recommended for Removal

Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite, or PQI92-HH, measures hospitalizations for ambulatory care sensitive chronic conditions per 100,000 health home enrollee months for enrollees age 18 and older. The measure steward is the Agency for Healthcare Research and Quality (AHRQ), and the data collection method is administrative. For the purposes of Health Home Core Set reporting, states are asked to calculate and report the measure for two age groups as applicable—ages 18 to 64 and age 65 and older—and a total rate for enrollees age 18 and older. The Workgroup member who suggested removing this measure expressed concerns about the technical feasibility of this measure due to states' challenges and limitations accessing the appropriate data source, which contains all the data elements necessary to calculate this measure.

The Workgroup discussion of PQI92-HH centered primarily on concerns about the measure's small sample size and the ability of health home program managers to interpret and act on the results. Two Workgroup members noted that while they did not have difficulty calculating the measure, the results were not actionable for states or health home care managers. One Workgroup member said that the small sample size of the measure precludes them from performing year-to-year comparisons, rendering the measure "not very usable." They described efforts in their state to monitor measures of preventive care for health home enrollees, and suggested there may be other measures more appropriate for the Health Home Core Sets than PQI92-HH, such as measures focused on diabetes. The other Workgroup member said that existing measures on the Health Home Core Set, such as the Plan All-Cause Readmissions (PCR-HH) measure, capture what PQI92-HH is intended to assess, chiefly, the number of health home enrollees that have been hospitalized and the number of those hospitalizations for chronic conditions.

Workgroup members also discussed the fit of the measure for the Health Home Core Sets given the increasing focus on the management of ambulatory care sensitive conditions in the hospital setting. Two Workgroup members felt that quality measurement programs for hospitals have

increased attention on the population with ambulatory care sensitive conditions, so neither the removal nor retention of PQI92-HH would affect the attention paid to individuals with those conditions.

Another Workgroup member reflected on the tension between the strategic priority and actionability of PQI92-HH. Describing PQI92-HH as a "preventive measure of avoidable admissions," this member acknowledged the importance of a measure focused on preventing admissions for the specific diagnoses assessed through the measure and questioned whether these admissions are being prevented when looking at more global measures of admissions and readmissions. They also noted the importance of ensuring that health home care managers are connecting enrollees to care that may prevent hospitalizations but also acknowledged that work on avoidable admissions will continue through both hospitals and health home programs regardless of the absence of this measure on the Core Set. The Workgroup member suggested education to help health home program care managers better understand the measure and how the program's performance on it is connected to their day-to-day work. Given these concerns, this Workgroup member was unsure whether PQI92-HH should remain in the 1945 Health Home Core Set.

Screening for Depression and Follow-Up Plan

The Screening for Depression and Follow-Up Plan (CDF-HH) measure assesses the percentage of health home enrollees age 12 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter. The measure is included in the Child and Adult Core Sets. It is also included in a set of measures called the Universal Foundation, which intends to align measures across CMS's quality programs to drive quality improvement and care transformation.[27] The Workgroup recommended removal of the CDF-HH measure during the 2022 Health Home Core Set Annual Review, but CMS decided to retain the measure in the Core Set to align with other quality measurement programs in Medicaid and CHIP. The measure steward is CMS, and the data collection method is administrative or electronic health records (EHRs). For the purposes of Health Home Core Set reporting, states calculate and report the measure for three age groups as applicable—ages 12 to 17, ages 18 to 64, and age 65 and older—and a total rate for enrollees age 12 and older. The Workgroup member who suggested removing this measure expressed concerns about the technical feasibility of the measure due to states' limitations concerning the data extraction required to report it, specifically as it relates to documentation of a follow-up plan.

During the discussion, Workgroup members echoed the sentiments of the Workgroup member who suggested removing the measure and discussed the feasibility of the measure for program-level reporting. Several Workgroup members shared that they had processes in place to conduct

[27] More information about CMS's Universal Foundation is available at https://www.nejm.org/doi/full/10.1056/NEJMp2215539.

depression screenings during types of encounters with health home enrollees that are not part of the measure's visit type requirements. One member shared that their providers conduct depression screenings in various settings—not just during an outpatient visit—which makes it difficult to use CDF-HH to fully capture what is being done in their programs. They speculated that this measure was more appropriate in medical settings rather than behavioral health models, like many health home programs. Two Workgroup members added that the measure's exclusion of enrollees who have been diagnosed with depression or bipolar disorder limits the relevance of the measure since many health home programs serve these populations specifically. One of these Workgroup members pointed to this exclusion as one of the reasons the Workgroup recommended removing CDF-HH during the 2022 Annual Review.

One Workgroup member offered two examples of how health home programs they were familiar with conduct depression screenings. They shared that their state has integrated the Patient Health Questionnaire-9 into their health home program by mandating the quarterly administration of the questionnaire for all health home enrollees. They likewise noted that depression screenings are included as part of patient-centered medical home model requirements and are mandated for all new enrollees under an integrated medical-behavioral health model implemented in their state, as well as in others.

After the Workgroup discussion, federal liaisons emphasized that the inclusion of CDF in the 1945 Health Home Core Set aligns with other quality measurement programs. A federal liaison from the Health Resources and Services Administration (HRSA) noted that the CDF measure is required under HRSA's Bureau of Primary Health Care program. A liaison from the Substance Abuse and Mental Health Services Administration (SAMHSA) shared that it is also required for Certified Community Behavioral Health Clinic (CCBHC) model, which they presumed overlaps with several health home programs.

There were no public comments during the discussion of either measure recommended for removal.

Discussion of Health Home Core Sets Measure Gaps

During the 2025 Health Home Core Sets Annual Review, the Workgroup discussed gaps in measures or measure concepts in the Health Home Core Sets. To inform the discussion, Mathematica provided an overview of gaps and common themes raised during the 2023 Health Home Core Set Annual Review, which included the desire to assess social determinants and drivers of health and measure the effectiveness of care coordination. Mathematica then asked the Workgroup to suggest priorities for future Health Home Core Sets, including gap areas previously identified by the Workgroup; additional high-priority gaps not previously identified; and opportunities for future measure development, testing, and refinement. Exhibit 7 synthesizes the gaps mentioned during Workgroup discussion. The exhibit does not prioritize the suggested gaps or assess their feasibility or fit for the Health Home Core Sets.

As reflected throughout the voting meeting and during the discussion on gaps, the Workgroup continued to emphasize the importance of addressing SDOH and encouraged measure stewards and federal partners to identify opportunities to test a measure that captures screening and referrals for SDOH within the health home population. Given that one of CMS's key priorities is to advance health equity, Mathematica set aside time during the voting meeting to discuss how screening for SDOH can advance health equity. A summary of the Workgroup discussion on this topic appears later in the report.

Workgroup members discussed the desirability and feasibility of including measures related to care planning and coordination in the Health Home Core Sets, given that these services are required by CMS for health home programs. While the Workgroup expressed hesitation about the appropriateness of the Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update (MLTSS-2) measure for the Health Home Core Sets, and ultimately did not vote to recommend the measure for addition, they stressed the need for a person-centered comprehensive care plan measure specified for the health home population that incorporates elements such as screening for and addressing SDOH and health home enrollee-driven goals. Workgroup members also noted the importance of understanding the effectiveness of care management, including whether health home enrollees can access care and if their needs are being met. They discussed potential ways of measuring how health home enrollees and caregivers feel about care coordination and service receipt, including through patient surveys and other tools, such as the Patient Activation Measure®.

Workgroup members also discussed gaps in measures for distinct health home populations, such as children with complex needs and enrollees with chronic conditions. Gaps identified for children included measures of trauma-responsive care, developmental screening, and primary and preventive care, such as well-child visits and immunizations.[28] Workgroup members also highlighted an opportunity to align with the Adult Core Set by considering measures of diabetes management for enrollees with chronic conditions.

Finally, Workgroup members raised methodological considerations for closing gaps in the Health Home Core Sets. One Workgroup member spoke about challenges related to data sharing between providers, states, and health home program managers in the context of consent for data sharing, noting that this may affect the actionability of measures that require sharing sensitive information. Another Workgroup member expressed concerned about variation in the feasibility of reporting across states due to differing health home program data, populations, and operations; they noted the importance of harmonization across Core Set measures to facilitate the feasibility of reporting. Workgroup members also discussed how health home enrollee and family trust in providers might impact data collection and reporting of measures.

[28] The 1945A Health Home Core Set includes Well-Child Visits in the First 30 Months of Life, Child and Adolescent Well-Care Visits, Child Immunization Status, and Immunizations for Adolescents.

The Workgroup's reflections about gaps in the Health Home Core Sets provide a strong starting point for future discussions about updates as well as longer-term planning for the Health Home Core Sets.

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

Themes from Cross-Cutting Gap Discussions
Measure Concepts Related Health Home Program Delivery
• Comprehensive care plans that use a person-centered approach and address the social drivers of health • Care coordination and the member and family care-coordination experience • Care management effectiveness • Beneficiaries' ability to access services and whether their health and community-based needs are met • Patient and caregiver engagement (e.g., Patient Activation Measure® and Caregiver Activation Measure) • Measures of unmet health and community-based needs
Measure-Specific Gaps
• Well-child visits and immunizations • Screening for social drivers of health and connection to services to address identified needs • Measures for children with special health care needs • Screenings for resiliency, adverse childhood experiences, and social-emotional needs • Developmental screening • Diabetes management
Methodological Considerations
• Data sharing between providers, health home program managers, and states • Harmonization of Core Set measures to facilitate feasibility of reporting • Address member and caregiver relationships with providers as a barrier to complete and accurate data collection

Opportunities to Advance Health Equity Through the Health Home Core Sets

Against the backdrop of CMS's efforts to advance health equity in Medicaid and CHIP, Mathematica engaged the Workgroup in two discussions about how to drive health equity through the Health Home Core Sets. The first discussion focused on screening and referral for SDOH and the second focused on opportunities and considerations for stratifying Health Home Core Set measures to advance health equity.

Screening and Referral for Social Drivers of Health

While the Screening for Social Drivers of Health (SDOH-1) measure did not meet minimum technical feasibility requirements to be considered during the 2025 Annual Review, Mathematica recognized that measuring screening and referrals for SDOH continues to be a high priority for

the Workgroup. To that end, Mathematica invited Workgroup members to share and discuss how health home programs and providers are screening and referring enrollees for SDOH, how the outcomes of SDOH screenings are measured, and what additional resources may be needed to advance this work.

A panel of four Workgroup members representing state and provider perspectives shared their experiences and underscored the importance of screening and referral for SDOH while acknowledging the challenges associated with data collection and follow-up. All four Workgroup members discussed their experiences implementing different SDOH screening tools, with two of them noting that the tools they have used include questions on topics such as housing, food insecurity, and transportation. Another Workgroup member emphasized that screening for SDOH should be promoted for health home programs, as it helps drive the delivery of high-quality care. The fourth Workgroup member added that without screening, providers will be unable to fully support the needs of health home enrollees and their families.

The Workgroup members also explained their data collection and monitoring processes. One Workgroup member shared that data from screenings are reported annually to the state by the health homes. Another Workgroup member explained that each of their providers tracks components of SDOH differently, but some components are collected at the state level. They added that they also collect some SDOH data through claims but noted that since SDOH claims are non-billable, very few are entered into the system.

One Workgroup member raised several considerations when thinking about screening and referral for SDOH. They emphasized the importance of universal screenings, as that practice allows for consistency and helps identify health home enrollees and families in need of support without bias. They also reminded the Workgroup that due to the often-sensitive nature of the screening questions, combined with a potential lack of trust in the health care system, health home enrollees and families may not always be honest and forthright in their responses. This member highlighted the need to consider how health homes are implementing workflows and how they should collect and evaluate SDOH data through their EHR systems. They noted that it is essential for the whole system to be represented in the decision-making process, adding that staff should be educated on the value of screening to achieve consistency.

In addition to supporting the implementation of SDOH screening in health home programs, Workgroup members recognized that improvements are needed in referral for social and community-based services after screening. For example, one Workgroup member commented that it can be difficult to help individuals and families overcome the challenges they disclose during screening due to the limited availability of accessible resources. Tracking the outcomes of referrals can also be difficult if providers or health home care managers do not have two-way communication with social service providers.

Following the panel's remarks, the broader Workgroup was invited to join the discussion. The full Workgroup recognized that despite the strategic importance of addressing SDOH, feasibility remains a challenge.

Workgroup members discussed several barriers to collecting SDOH data, emphasizing the need to reduce administrative burden, increase standardization, and promote interoperability across systems. One Workgroup member speculated that it would take several years for an SDOH screening measure to be included in the Health Home Core Sets given the factors that still need to be considered, such as the advantages and disadvantages of different screening tools and how best to collect the data in a standardized way for program-level reporting. Several Workgroup members noted that data collection will continue to be a challenge until the services are reimbursable, explaining that health home providers face both administrative burdens and competing priorities when coordinating and providing supports and services. In response to a Workgroup member's question about whether states are considering SDOH screening as part of the Medicaid application, another Workgroup member stated that some states are looking at a universal application for social and medical services, noting that such an application could provide an opportunity to get a fuller picture of health home enrollees.

Workgroup members reiterated that screening for SDOH can make individuals and families feel vulnerable, as they are asked to share information that may cause discomfort. One Workgroup member expressed hesitancy in conducting screenings until there is a strategy in place to support individuals and families based on screening results. They added that system-level challenges, such as administrative burden and fragmented networks of care, makes it difficult to address health home enrollee needs, which may place additional burdens on individuals and families. Another Workgroup member agreed, suggesting that screenings administered by trusted community members may be a more effective way to collect SDOH data. They added that it is important to reflect on whether the screening is being done for surveillance or to support families, and recommended collecting the data through other means, such as using claims rather than directly asking individuals and families, if data are being collected for surveillance purposes.

Measure Stratification

Increasing stratification of the Health Home Core Set measures is a key priority for CMS, which encourages states to stratify Core Set data as part of its efforts to advance health equity in Medicaid and CHIP. To better understand how CMS can drive this work, the Workgroup discussed opportunities to apply stratification to Health Home Core Set data. Mathematica provided context about the stratification categories currently available for reporting Core Set data, including race, ethnicity, sex, and geography. The Workgroup then discussed how stratified Core Set data can be used to advance health equity in the health home program; key challenges to collecting, reporting, and using stratified data; and the additional resources needed to advance this effort.

A panel of three Workgroup members representing state and beneficiary perspectives provided opening remarks, emphasizing the importance of stratification to understand the needs of health home enrollees and identify where disparities may exist. The Workgroup members shared an overview of their efforts to stratify data to address health inequities, including efforts in specific state programs and in other programs like Medicare Advantage. One Workgroup member, of the three, who discussed challenges associated with stratification, expressed concern about the implications for reporting of small sample sizes in the health home population for reporting. They encouraged standardization in how demographic categories are defined and noted that missing or unknown data continues to be a challenge for their state.

Following the panel's remarks, Mathematica invited the broader Workgroup to join the discussion. The Workgroup expressed clear agreement on the importance of stratification while acknowledging challenges around small sample sizes and collecting demographic data for stratification. As many Workgroup members described challenges around missing or unknown data, the discussion focused largely on opportunities to improve data collection.

Workgroup members noted that race and ethnicity questions in the Medicaid application are optional, making it difficult to collect this information at enrollment. One Workgroup member suggested that CMS investigate how and where race and ethnicity data are collected. A few Workgroup members suggested using other data sources, such as EHRs or birth records, to increase states' capacity for stratification but acknowledged that these sources may come with their own challenges and considerations. Another Workgroup member wondered if states could learn from what hospitals are doing, explaining that providers in their hospital have started to collect demographic data through modes other than face-to-face collection and allow individuals to update their data if needed. Their hospital also implemented training and developed educational materials to educate staff, patients, and families about why collecting demographic information is important and how the information is used. Another Workgroup member wondered if there may be an opportunity to require the race/ethnicity data element fields in claims forms to improve collection.

Workgroup members also suggested additional opportunities to stratify Health Homes Core Set measures to advance health equity. One Workgroup member suggested stratifying Health Home Core Set data by socioeconomic status, and suggested using Medicaid as primary versus supplemental coverage as a proxy for socioeconomic status. Another Workgroup member expressed interest in stratifying the data by the current categories available for Core Set reporting along with SDOH categories in order to understand inequities in the environment in which people live and how they impact health outcomes.

Cross-Cutting Themes During the 2023 Health Home Core Set Annual Review

Several cross-cutting themes emerged from the Workgroup's review of the one measure suggested for addition and four existing measures suggested for removal from the Health Home Core Set, as well as from the discussions about measure gaps and opportunities to use the Core Sets to advance health equity. Workgroup members expressed a strong desire to include measures in the Health Home Core Sets that are: (1) feasible for program-level reporting; (2) actionable to support program effectiveness and drive health care quality; and (3) appropriate for populations served in health home programs.

Workgroup members placed considerable weight on the feasibility of measures suggested for removal from the Health Home Core Sets. During the discussions of the CDF-HH and Controlling High Blood Pressure (CBP-HH) measures, for example, Workgroup members discussed states' challenges and limitations with accessing the appropriate data sources needed to calculate them. Additionally, when discussing the Admission to a Facility from the Community (AIF-HH) and CBP-HH measures, Workgroup members raised examples of workarounds states use to enable reporting of the measures, with some questioning the measure's viability if some states must deviate from the measure specifications to meet reporting requirements.

The Workgroup also reflected on the interplay between feasibility and other factors, such as actionability and desirability, in their review of the measures suggested for removal and addition. During the discussion of the PQI92-HH measure, for example, Workgroup members noted that the measure was feasible to report, but ultimately voted to recommend its removal due to its limitations in actionability. Workgroup members expressed concerns about the technical feasibility of AIF-HH, but were reluctant to recommend its removal due to the desirability of the measure in the Health Home Core Sets and the potential gap that would be left in its absence. Similarly, the Workgroup noted concerns about the feasibility of the CBP-HH measure, but recommended retaining it in part due to the importance of the measure for the health home population.

Finally, the Workgroup also emphasized the fit of measures in the Health Home Core Sets during their deliberations. In addition to its actionability, they discussed the placement of the PQI92-HH measure in the Health Home Core Set, given the focus on ambulatory care sensitive conditions in the hospital setting. During the discussion of the Managed Long-Term Services and Supports Comprehensive Care Plan and Update (MLTSS-2) measure for addition to the Health Home Core Set, Workgroup members raised concerns that the measure may not be appropriate for the health home population given that it was specified for long-term services and supports. Nonetheless, while the measure was ultimately not recommended for addition to the 1945 Health Home Core Set, Workgroup members noted the desirability of a comprehensive care plan to support person-centered and comprehensive care management.

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 reporting Health Home Core Set measures. The Workgroup made several suggestions:

- Offer opportunities to convene representatives from health home programs serving similar populations to better inform opportunities to address measurement gaps
- Offer TA to help states capture additional data sources for reporting, such as EHR or case management data
- Provide TA and guidance around stratification of measures and opportunities to capture more complete race and ethnicity data in administrative data sources
- Offer clearer guidance on the populations and eligibility criteria for each measure in the Health Home Core Sets, including the population of children with medical complexity or special health care needs that would qualify for 1945A health home programs
- Explore opportunities for pilot testing SDOH measures in health home programs in partnership with CMS or other federal partners
- Provide targeted TA related to measures that have not met the criteria for public reporting, such as guidance on the use of specific Current Procedural Terminology® codes for data collection

Suggestions for Improving the Health Home Core Sets Annual Review Process

Workgroup members also suggested enhancements to the Health Home Core Sets Annual Review process.

One Workgroup member questioned the impetus behind the criterion requiring that a measure be tested in, or in use by, a state Medicaid and/or CHIP program to be considered for addition to the Health Home Core Sets. The Workgroup member suggested that CMS consider opportunities to fast track the testing of measures given the rapidly changing nature of health care, perhaps by permitting measures to be tested on smaller samples of the population.

A few Workgroup members commented on the logistical aspects of the meeting, expressing appreciation for the pre-work Mathematica put in the Core Set Review process as well as the resources supplied to help the Workgroup prepare for the meeting. One Workgroup member noted that they liked the voting platform, describing it as an improvement over the platform used in previous years.

Next Steps

The 2025 Health Home Core Sets Annual Review Workgroup recommended removing two measures from the Health Home Core Sets. The Workgroup considered multiple factors when making its recommendations, including the feasibility for program-level reporting, actionability to drive improvement in care delivery and health outcomes, and the fit of measures for the Health Home Core Sets.

During the Annual Review meeting, the Workgroup discussed opportunities to advance health equity through the Health Home Core Sets. Workgroup members balanced a desire to bring SDOH measures to the Health Home Core Sets with the need to address challenges in these efforts. The Workgroup also highlighted the importance of stratification of measures in the Health Home Core Sets to advance health equity, described efforts to use the Core Sets to drive improvement in care delivery and health outcomes for health home enrollees, and raised considerations for TA to help overcome data collection challenges.

Workgroup members also discussed additional priorities for the Health Home Core Sets, including desires to measure the effectiveness of care management; to identify and address unmet health and community-based needs; to consider how methodological issues, such as member and family trust and individual consent, impact data collection and reporting; and to include measures in the Core Sets that are specified for the health home population, such as measures for children with special health care needs and measures of person-centered care planning and coordination. Finally, Workgroup members suggested opportunities to support states in reporting measures in the Health Home Core Sets, including TA with data capture and identifying eligible populations and partnership with CMS to explore the technical feasibility of adding an SDOH measure to the Health Home Core Sets.

This report, which is being made available for public comment, summarizes the 2025 Health Home Core Sets Annual Review Workgroup's review process, discussion, and recommendations. Please submit public comments via email by **October 13, 2023, at 8 p.m. ET** to MHHCoreSetReview@mathematica-mpr.com and include "2025 Medicaid Health Home Core Sets Annual Review Public Comment" in the subject line. A final version of this report, which will include all public comments, will be released in November 2023.

Appendix A:
2023 Health Home Core Set Measures

Exhibit A.1. 2023 and 2024 Core Set of Health Care Quality Measures for 1945 Medicaid Health Home Programs (1945 Health Home Core Set)

NQF #	Measure Steward	Measure Name	Data Collection Method
Core Set Measures			
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	Administrative or EHR
0018	NCQA	Controlling High Blood Pressure (CBP-HH)	Administrative, hybrid, or EHR
0034	NCQA	Colorectal Cancer Screening (COL-HH)*	Administrative or EHR[a]
0418*/ 0418e*	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	Administrative or EHR
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	Administrative
1768*	NCQA	Plan All-Cause Readmissions (PCR-HH)	Administrative
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)	Administrative
3488	NCQA	Follow-Up After Emergency Department Visit for Substance Use (FUA-HH)	Administrative
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)*	Administrative
NA	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	Administrative
Utilization Measures			
NA	CMS	Admission to a Facility from the Community (AIF-HH)	Administrative
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	Administrative
NA	CMS	Inpatient Utilization (IU-HH)	Administrative

* This measure is no longer endorsed by NQF.

[a] The Colorectal Cancer Screening measure is also specified for Electronic Clinical Data System (ECDS) reporting. ECDS specifications are not currently available for Health Home Core Set reporting.

AHRQ = Agency for Healthcare Research and Quality; CMS = Centers for Medicare & Medicaid Services; EHR = electronic health record; NA = measure is not NQF endorsed; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.

Exhibit A.2. Core Set of Health Home Quality Measures for 1945 Medicaid Health Home Programs (1945 Health Home Core Set), 2013–2024

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023/2024
Core Set Measures													
0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)	X	X	X	X	X	X	X	X	X	X	X
0018	NCQA	Controlling High Blood Pressure (CBP-HH)	X	X	X	X	X	X	X	X	X	X	X
0034	NCQA	Colorectal Cancer Screening (COL-HH)[a]	--	--	--	--	--	--	--	--	--	X	X
0418*/ 0418e*	CMS	Screening for Depression and Follow-Up Plan (CDF-HH)	X	X	X	X	X	X	X	X	X	X	X
0576	NCQA	Follow-Up After Hospitalization for Mental Illness (FUH-HH)	X	X	X	X	X	X	X	X	X	X	X
1768*	NCQA	Plan All-Cause Readmissions (PCR-HH)	X	X	X	X	X	X	X	X	X	X	X
3400	CMS	Use of Pharmacotherapy for Opioid Use Disorder (OUD-HH)[b]	--	--	--	--	--	--	--	X	X	X	X
3488	NCQA	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH)[c]	--	--	--	--	--	--	--	X	X	X	X
3489	NCQA	Follow-Up After Emergency Department Visit for Mental Illness (FUM-HH)[d]	--	--	--	--	--	--	--	--	--	X	X
NA	NCQA	Adult Body Mass Index Assessment (ABA-HH)[e]	X	X	X	X	X	X	X	X	--	--	--
NA	AHRQ	Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	X	X	X	X	X	X	X	X	X	X	X

Exhibit A.2 *(continued)*

NQF #	Measure Steward	Measure Name	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023/2024
Utilization Measures													
0648	AMA/PCPI	Care Transition – Timely Transmission of Transition Record (CTR-HH)[f]	X	X	X	X	X	X	--	--	--	--	--
NA	CMS	Admission to an Institution from the Community (AIF-HH)[g]	--	--	--	--	--	--	X	X	X	X	X
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-HH)	X	X	X	X	X	X	X	X	X	X	X
NA	CMS	Inpatient Utilization (IU-HH)	X	X	X	X	X	X	X	X	X	X	X
NA	CMS	Nursing Facility Utilization (NFU-HH)[g]	X	X	X	X	X	X	--	--	--	--	--

Note: X = included in Health Home Core Set; -- = not included in Health Home Core Set. More information on 2022 updates to the Health Home Core Health Care Quality Measurement Sets is available at https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/health-home-quality-reporting/index.html.

* This measure is no longer endorsed by NQF.

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

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

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

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

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

[f] The 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 because states faced challenges reporting it.

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

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

Appendix B: Measures Suggested for Review at the 2025 Health Home Core Sets Annual Review

Exhibit B.1. Measures Suggested for Review at the 2025 Health Home Core Set Annual Review

Measure Name	Measure Steward	NQF#	Data Collection Method	Age Range	Included in 2023 Child or Adult Core Sets
Measures Suggested for Addition					
Medicaid Managed Long-Term Services and Supports Comprehensive Care Plan and Update (MLTSS-2)	CMS	NA	Case manage-ment record review	Age 18 and older	A similar measure, CPU-AD, is included in the Adult Core Set
Screening for Social Drivers of Health (SDOH-1) This measure was not discussed because it did not meet minimum technical feasibility criteria for testing in state Medicaid and/or CHIP programs or use by one or more state Medicaid and/or CHIP programs	CMS	NA	Administrative, EHR, or hybrid	Age 18 and older	No
Measures Suggested for Removal					
Controlling High Blood Pressure (CBP-HH)	NCQA	0018	Administrative, EHR, or hybrid	Ages 18 to 85	Adult Core Set
Screening for Depression and Follow-Up Plan (CDF-HH)	CMS	0418[a]/ 0418e[a]	Administrative, EHR, or hybrid	Age 12 and older	Adult Core Set; Child Core Set
Admission to a Facility from the Community (AIF-HH)	CMS	NA	Administrative	Age 18 and older	No
Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite (PQI92-HH)	AHRQ	NA	Administrative	Age 18 and older	No; however, the Adult Core Set includes four components of this composite measure (PQI 01, PQI 05, PQI 08, and PQI 15).

AHRQ = Agency for Healthcare Research and Quality; CHIP= Children's Health Insurance Program; CMS = Centers for Medicare & Medicaid; CPU-AD = Long-Term Services and Supports Comprehensive Care Plan and Update; EHR = electronic health record; NA = measure is not endorsed by the National Quality Forum; NCQA = National Committee for Quality Assurance.

Appendix C: Summary of 2025 Health Home Core Sets Annual Review Workgroup Discussion of Measures Not Recommended for Removal or Addition

This appendix summarizes the discussion of measures considered by the Workgroup and not recommended for addition to or removal from the 2025 Health Home Core Sets. The discussion took place during the Workgroup meeting that was held on July 11 and 12, 2023. The summary is organized by the order in which the measures were discussed. For more information about the measures discussed and not recommended for removal or addition, please refer to Exhibit C.1 at the end of this appendix. Exhibit C.1 includes the measure name, measure steward, National Quality Forum (NQF) number (if endorsed), measure description, data collection method, and key points of the Workgroup's discussion about each measure.

Measure Discussed and Not Recommended for Addition to the 2025 1945 Health Home Core Set

Managed Long-Term Services and Supports Comprehensive Care Plan and Update (MLTSS-2)

The Workgroup discussed but did not recommend addition of Managed Long-Term Services and Supports Comprehensive Care Plan and Update (MLTSS-2). This measure assesses the percentage of Medicaid managed long-term services and supports (MLTSS) participants age 18 and older who have documentation of a long-term services and supports comprehensive care plan in a specified timeframe that includes documentation of core elements. Two performance rates are reported for this measure: (1) a care plan with core elements and (2) care plan with supplemental elements. Two exclusion rates are also reported: (1) participant could not be contacted and (2) participant refused care planning. The data collection method for the measure is a case management record review. The measure steward is CMS. The Adult Core Set includes the NCQA version of this measure. The measure is included in the CMS home and community based services (HCBS) Quality Measure Set.

The Workgroup member who suggested adding this measure said it was designed to assess quality of care for members that qualify for MLTSS but also has the potential for use in health home programs given that comprehensive care management and care coordination are required health home services.

Workgroup members shared their perspectives on the differences between care management services in long-term services and supports and health home programs, and thus why MLTSS-2 may not be appropriate for the 1945 Health Home Core Set. For example, one Workgroup member said that there are both differences in care plan elements between states as well as how enrollees access care management services in MLTSS versus health home programs. There was also some concern about potential duplication of services since states vary in their health home program design and administration alongside their MLTSS programs. Another Workgroup member noted that the core elements of MLTSS-2 were developed for long-term services and supports and may include elements that are not appropriate for health homes. They also expressed the importance of using measures that have been tested and validated in the population in which they are intended for use. Another Workgroup member added that there may be other

ways to measure the effectiveness of care planning without implementing a measure that was developed for a different program and may not be easily substitutable for the health home population.

Workgroup members also discussed how the measure's technical specifications would need to be adapted for the health home population. Mathematica clarified that the measure would be adapted to make the unit of measurement specific to the health home population, but that other components of the specifications, such as the core and supplemental elements, would not change. One Workgroup member said that this could be a significant change due to the potential for a larger denominator among the health home population. Other members asserted that the sample size of the health home population may be too small for the measure to be reliable.

Workgroup members also highlighted concerns about the feasibility and viability of the MLTSS-2 measure. One Workgroup member raised concerns that this measure could require states to modify required program elements and levels of training for providers. Another Workgroup member shared concerns that the measure is more focused on activities such as documentation of past medical history and less on the actions of care planning. They added that the time clinicians would spend trying to adhere to the measure would detract from activities to optimize health home enrollee well-being.

Several Workgroup members discussed the potential difficulty of collecting this measure since collection requires case management record review. One Workgroup member said that measures requiring chart review are difficult, noting a preference for administrative measures. Another Workgroup member said that this measure would be difficult for their state to collect due to the use of different EHRs and documentation practices across providers. A Workgroup member noted that it may be difficult for a health home program to calculate this measure without the assistance of either the state or a managed care organization. Another Workgroup member acknowledged the difficulty of collecting this information and shared how Tennessee made a single care plan software available to all of the health home programs, which has been beneficial in supporting data tracking.

Despite noted concerns, some Workgroup members expressed support for the measure, highlighting the opportunity to better align care planning activities across programs. For example, one Workgroup member noted that this measure could provide an opportunity for a member to have a single, comprehensive care plan across the different services they receive. Another Workgroup member discussed that a potential benefit of the measure is that the supplemental requirements of the measure could expand upon the core elements to support care management for health home enrollees. One Workgroup member said the measure aligns with work in Iowa and could help add robust elements to the care management process that support health home enrollees in developing more person-centered goals.

Measures Discussed and Not Recommended for Removal from the 2025 1945 Health Home Core Set

Admission to a Facility from the Community (AIF-HH)

The Workgroup discussed but did not recommend removal of Admission to a Facility from the Community (AIF-HH), which measures the number of admissions to a facility among health home enrollees age 18 and older residing in the community for at least one month. The three performance rates, short-term stay (1 to 20 days), medium-term stay (21 to 100 days), and long-term stay (greater than or equal to 101 days), are reported across four age groups: ages 18 to 64, ages 65 to 74, ages 75 to 84, and age 85 and older. The number of short-term, medium-term, or long-term admissions is reported per 1,000 enrollee months. Enrollee months reflect the total number of months each enrollee is enrolled in the program and residing in the community for at least one day of the month. The measure steward is CMS, and the data collection method is administrative.

The Workgroup member who suggested this measure for removal had concerns about its technical feasibility due to limitations around data extraction, such as challenges identifying Medicaid beneficiary transitions of care and admissions to an institution from the community. This Workgroup member did not suggest a replacement.

The Workgroup expressed mixed opinions about recommending AIF-HH for removal, reflecting on the tension between the feasibility and desirability of the measure. Workgroup members discussed challenges noted by health home programs in reporting the measure. For example, a Workgroup member shared that they report AIF-HH using a modified specification and questioned how many other health home programs were doing the same. They questioned the value of the measure if states were deviating from the measure's technical specifications. Mathematica confirmed that four of the 22 programs that reported AIF-HH for FFY 2020 deviated from the Core Set specifications. In contrast, emphasizing the desirability of the measure, a Workgroup member said they considered AIF-HH to be a measure of the effectiveness or outcomes of the health home program, with another adding that no other measures in the Health Home Core Sets assess the level of care represented by this measure.

Other Workgroup members expressed concerns about the potential gaps that might result from removing AIF-HH from the 1945 Health Home Core Set. One Workgroup member discussed the value of the measure for the population dually eligible for Medicare and Medicaid, noting that they see wide variability in facility length of stays for the health home programs they oversee. The Workgroup member shared that they believe the measure results are helpful and suggested that other Workgroup members reflect on whether its removal would leave a gap. Another Workgroup member discussed concerns over acute events that may result in long stays because an enrollee lacks support to remain in the community. They stated that if enrollees want to remain in the community, their ability to have their needs met is important, but that removal of the AIF-HH might make it more difficult for health home programs to assess if individuals with high needs are able to thrive in the community setting.

Workgroup members also discussed the three performance rates across four age groups that are required as part of reporting AIF-HH. One Workgroup member questioned why three of the four age groups reported are among older adults. Mathematica responded that this might be related to risk adjustment and controlling for age distribution. Another Workgroup member added that as Medicaid and Medicare align their programs, it is important to have information by age group for the aging population that is being managed within health home programs and is dually eligible for Medicare and Medicaid, as well as for adults under age 64.

Controlling High Blood Pressure (CBP-HH)

The Workgroup discussed but did not recommend removal of the Controlling High Blood Pressure (CBP-HH) measure, which assesses the percentage of health home enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year. The measure steward is NCQA and the data collection is administrative, hybrid, or EHR. The Workgroup member who suggested this measure for removal cited limitations on data extraction and the burden of reporting measures that require a medical record review.

A Workgroup member began the discussion noting that while CBP-HH was suggested for removal in part due to limitations of data extraction requiring medical record review, the measure steward, NCQA, modified this measure to allow for the use of Current Procedural Terminology (CPT®) Category II (CPT-II) codes to collect the data. At the same time, the Workgroup member said that since the use of CPT-II codes requires a clinician to collect the blood pressure measurement, this measure may be difficult for health home programs that do not have clinicians to report because they will be reliant on providers outside the health home for the data. Another Workgroup member said that states may also have difficulty reporting the measure since the data may come through supplemental data sources submitted by providers for which states may not always have access for reporting purposes.

One Workgroup member questioned the utility of collecting this measure if it does not meet CMS's threshold for public reporting. Several Workgroup members and federal liaisons discussed how they use the measure in their programs. One Workgroup member shared how they created an administrative data collection system to support their state's health home programs in reporting the measure. While the Workgroup member noted that the state is not able to report the measure per the specifications, they expressed support for the measure because the state is focused on metabolic syndrome and contributing factors. Another Workgroup member said that blood pressure is a significant chronic condition for enrollees on psychotropic medications, as well as those with diabetes and obesity, which may be important to consider when evaluating this measure.

A Workgroup member expressed support for the measure, noting that it is aligned with other quality programs in which they participate, such as those within Medicare. The Workgroup member discussed how their health system has worked with clinicians to do what is clinically

appropriate when working with older adults with high blood pressure and noted that this approach has been used within the Medicare population and has not resulted in challenges for their health system. Two federal liaisons shared the use of this measure in their programs. A federal liaison from HRSA shared that this is part of their Bureau of Primary Health Care program. A federal liaison from SAMHSA shared that this measure will be one of the optional measures for CCBHCs reported at the clinic level and used for informational purposes.

Another Workgroup member questioned whether the measure is sensitive to hypertension among older adults, noting that some literature explains how a higher blood pressure measurement can be acceptable for certain elderly populations. While NCQA responded that the measure specifications have an exclusion for frailty, the Workgroup member expressed concern that the specifications may not always get translated well to individual clinicians, which may be an important consideration when determining whether to recommend removing or retaining it.

Exhibit C.1. Measures Discussed by the 2025 Health Home Core Sets Annual Review Workgroup and Not Recommended for Removal or Addition

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Measure Discussed and Not Recommended for Addition to the 2025 Health Home Core Sets			
Managed Long-Term Services and Supports Comprehensive Care Plan and Update (MLTSS-2) Measure steward: CMS	Not endorsed	The percentage of Medicaid managed long-term services and supports (MLTSS) participants age 18 and older who have documentation of a long-term services and supports comprehensive care plan in a specified timeframe that includes documentation of core elements. Data collection method: Case management record review	• Suggested for addition because of the potential to assess the quality of care for health home enrollees • Suggested for addition because the measure focuses on the existence and timeliness of a care plan to ensure coordinated care for members receiving services • Concern that care coordination and care management elements are distinct for MLTSS vs. health home programs and require further differentiation and separate care planning • Concern about the feasibility of collecting the measure as it requires case management record review • Concern that the measure specifications are not appropriate for and have not been tested and validated in the health home population • Support for adding the measure because the core elements can support better alignment in care planning and allow for the use of a single care plan between different care management programs
Measures Discussed and Not Recommended for Removal from the 2025 1945 Health Home Core Set			
Admission to a Facility from the Community (AIF-HH) Measure steward: CMS	Not endorsed	The number of admissions to a facility among health home enrollees age 18 and older residing in the community for at least one month. Data collection method: Administrative	• Suggested for removal because of challenges in data collection • Concern about value of the measure if states deviate from the measure technical specifications • Hesitation to remove the measure because of the need for measurement related to effectiveness of health home programs • Discussion about potential gaps that might result from removing the measure, such as difficulty assessing if individuals with high needs are able to remain in the community setting with appropriate supports

Exhibit C.1 *(continued)*

Measure Name and Measure Steward	NQF #	Measure Description and Data Collection Method	Key Workgroup Discussion Points
Controlling High Blood Pressure (CBP-HH) Measure steward: NCQA	0018	Percentage of health home enrollees ages 18 to 85 who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year. Data collection method: Administrative, hybrid, or EHR	• Suggested for removal because of challenges with data extraction and reporting measures that require medical record review • Concern about programs' and states' ability to collect the measure due to challenges accessing the data and consistent use among clinicians of relevant codes • Support for retaining the measure, given alignment with other quality programs • Discussion about whether the measure is sensitive to the nuances of hypertension, particularly for older adults

CMS = Centers for Medicare & Medicaid; EHR = electronic health record; NCQA = National Committee for Quality Assurance; NQF = National Quality Forum.

Mathematica Inc.

Our employee-owners work nationwide and around the world.

Find us at **mathematica.org** and **edi-global.com**.