ACAP Comments on Recommendations for Improving the Core Sets of Health Care Quality Measures for Medicaid and CHIP
Submitted August 5, 2019

The Association for Community Affiliated Plans (ACAP) appreciates the opportunity to submit comments on proposed changes to Child and Adult Core Measures. ACAP is an association of 66 nonprofit and community-based Safety Net Health Plans located in 29 states. Collectively, ACAP health plans provide coverage to 20 million individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP), Medicare Special Needs Plans for dually-eligible individuals, and Qualified Health Plans (QHPs) serving the health insurance Marketplaces. ACAP plans are members of their communities, partnering with states to improve the health and well-being of their members who rely upon Medicaid and CHIP as well as other publicly-supported programs. We first will provide some general comments and then respond to specific measure recommendations below.

General Comments

Overall Criteria: ACAP member plans agree with overarching criteria for removing measures in which performance is going well and focusing on areas of known needed improvement. We also support the use of measures where they are populated via administrative data (encounters/claims) versus manual file review. Finally, we support selecting measures that are impactable and would encourage the use of strategic workgroups that include the provider community to be engaged with improving outcomes for select measures that remain challenging year-over-year.

Outcomes vs Process Measures: In general, ACAP understands and appreciates the interest in moving from process measures to outcomes measures. However, we know that peer-reviewed publications are providing increasing evidence that there are confounding variables (beyond the scope of influence by plans and providers) that impact outcomes measures more than they impact process measures. These confounding variables are issues related to social determinants of health (SDoHs). While Safety Net Health Plans (and other health plans) are moving into the realm of addressing SDoHs, it is uncharted territory. Until this new evidence matures, and interventions that effectively impact SDoHs are funded by state and federal sources, we are concerned that replacing all process measures with outcomes measures does not sufficiently recognize those SDoH-related confounding variables that may impact outcomes rates due to issues not in control of health plans.
Proposed Measures for Removal

Child and Adolescents’ Access to Primary Care Practitioners (CAP-CH)
Support.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index Assessment for Children/Adolescents (WCC-CH)
Support with Concern.

While ACAP supports the removal of this measure in general based on many of its limitations noted in the report, we remain concerned about the absence of a replacement measure that addresses obesity. We understand that simple measurement without a planned, evidence-based intervention may seem less impactful, but obesity is the major health problem in the U.S. and is increasing. Measuring BMI signals to primary care providers the importance of the issue and marks a place to start. As noted in the report, a federal liaison voicing support remarked that “…there is evidence to support BMI screening in the primary care setting and that BMI screening is part of American Academy of Pediatrics and USPSTF recommendations for both children and adults.” Indeed, this report, as evidenced by Exhibit 8, notes that “Obesity” is a potential gap area for future core set measures.

Pediatric Central Line–Associated Bloodstream Infections (CLABSI-CH)
Support.

Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)
Support.

Adult Body Mass Index Assessment (ABA-AD)
Support with Concern.

While ACAP supports the removal of this measure in general based on many of its limitations noted in the report, we remain concerned about the absence of a replacement measure that addresses obesity. We understand that simple measurement without a planned, evidence-based intervention may seem less impactful, but obesity is the major health problem in the U.S. and is increasing. Measuring BMI signals to primary care providers the importance of the issue and marks a place to start. As noted in the report, a federal liaison voicing support remarked that “…there is evidence to support BMI screening in the primary care setting and that BMI screening is part of American Academy of Pediatrics and USPSTF recommendations for both children and adults.” Indeed, this report, as evidenced by Exhibit 8, notes that “Obesity” is a potential gap area for future core set measures.
**Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD)**

*Support with Concern.*

While ACAP supports the removal of this measure in general based on many of its limitations noted in the report, this is an example of replacing a process measure with an outcomes measure (Comprehensive Diabetes Care: Hemoglobin A1c [HbA1c] Poor Control) where we have concerns as noted above. A valid hypothesis is that process measures may better measure the quality of the care provided, while outcomes measures are influenced by social determinants of health (SDoHs). It is important to measure SDoHs and develop interventions to address them, but until meaningful progress is made in addressing SDoHs, it is also desirable to minimize confounding variables in measuring the quality of care provided. Keeping the Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing (HA1C-AD) alongside the Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (HPC-AD) could allow comparison of the process and outcome measures which can help inform a better understanding of the effects of SDoHs. If the hypothesis proves true, the other unintended consequence of removing the process measure will be to penalize providers who provide care for the most needy and underserved (e.g., FQHCs) and could result in providers or managed care plans ‘cherry picking’ patients with fewer SDoHs in order to achieve better scores. This concern of possible confounding influence of SDoHs warrants analysis of process and outcomes measures to ensure they are measuring the factors they are intended to measure.

**Annual Monitoring for Patients on Persistent Medications (MPM-AD)**

*Support.*

**Proposed Measures for Addition**

**Appropriate Antibiotic Prophylaxis for Children with Sickle Cell Anemia**

*Support.*

**Metabolic Monitoring for Children and Adolescents on Antipsychotics**

*Support.*

**Use of Pharmacotherapy for Opioid Use Disorder**

*Do not support.*

ACAP is concerned that plans will not be able to access full data relating to this measure. First, plans may have trouble identifying plan enrollees with opioid use disorders, as services for those members are carved out to the state, county, or subcontracted managed behavioral health/substance use disorder organizations in some jurisdictions. For the same reason, it may not be possible for plans to track the full range of services provided. While in
these jurisdictions some medication assisted treatment may be provided by the plan, it would be difficult or impossible for those plans to collect and deliver a full picture of the data required under this proposed measure.

Second, regardless of whether behavioral health and substance use disorder services are carved in or out of a Medicaid managed care plan, outdated federal regulations that pre-date current models of care create significant barriers to holistic care for people with SUD and impact the ability for health plans to capture the data needed to inform measures related to that care. These barriers – found in 42 CFR Part 2 and requiring individualized and specific patient consent before providers and plans can disclose a SUD to coordinate care – undermine efforts to integrate behavioral and physical health services for people with SUD, ultimately leading to worse health outcomes. We harbor concerns that the prohibitions on sharing data in 42 CFR Part 2 will severely hinder plans’ efforts to report on any measure related to opioid overuse treatment or any other SUD treatment.

**National Core Indicators (NCI)**

*Do not support.*

While ACAP supports the eventual addition of these indicators, our plans are concerned about their ability to immediately adhere to this measure. Given that these measures are collected via a survey, they are time-intensive for the Medicaid beneficiary and expensive to conduct. In addition, the implementation of this survey may involve contract modifications between state Medicaid agencies and health plans. Overall, we would recommend a staged addition of these measures would be preferable to their proposed immediate inclusion.

We do note that these surveys are currently being conducted in a substantial number of states. If the surveys were to be administered through other mechanisms, organizations, or agencies rather than through Medicaid managed care plans, we would withdraw our “Do not support” position as that position is primarily based on financial, operational, and timeline concerns.

While not of direct concern with regard to the use by the CMCS of the NCI survey to evaluate the state, our plans would like further clarification on its potential impact on them and how the state Medicaid agencies may use the results of that survey in their evaluation of the MCOs—we understand this may be a state-by-state concern.
National Core Indicators for Aging and Disabilities Adult Consumer Survey (NCI-AD)

Do not support.

While ACAP supports the eventual addition of these indicators, our plans are concerned about their ability to immediately adhere to this measure. Given that these measures are collected via a survey, they are time-intensive for the Medicaid beneficiary and expensive to conduct. In addition, the implementation of this survey may involve contract modifications between state Medicaid agencies and health plans. Overall, we would recommend a staged addition of these measures would be preferable to their proposed immediate inclusion.

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While not of direct concern with regard to the use by the CMCS of the NCI-AD survey to evaluate the state, our plans would like further clarification on its potential impact on them and how the state Medicaid agencies may use the results of that survey in their evaluation of the MCOs—we understand this may be a state-by-state concern.

Additional Comments: Other Measures Discussed but Not Recommended for Addition

Two other measures discussed by the Workgroup but ultimately not recommended for adoption included Continuity of Insurance: Informed Participation and Health-Related Social Needs (HRSN) Screening. Upon review of the discussion text, we understand and appreciate the concerns raised by numerous Workgroup members.

ACAP member plans continue to be interested in being able to track issues related to coverage churn and being able to measure continuity of insurance, including Medicaid coverage. ACAP believes it is critical that some measure of the churning issue be included in the measurement set as soon as possible. Churning has a direct impact on quality and the potential success of quality improvement efforts. We would urge CMS and AHRQ to specifically undertake a study of the impact of churning on the reliability and state-to-state comparability of the measurement set. In addition, our plans see the value in better measuring the screening and assessment of members’ social determinants of health. As such, we would urge CMCS to encourage measure developers to continue to work on improving potential measures that address these two issues with an expectation that they may be considered for future inclusion in the Core Measures.
Again, we thank you for this opportunity to comment on these important proposed modifications to the Core Measures. Please feel free to contact me (mmurray@communityplans.net, 202-204-7509), or Enrique Martinez-Vidal, Vice President for Quality and Operations (emartinez-vidal@communityplans.net, 202-204-7527), if you would like to discuss any of these issues in greater depth.

Sincerely,

/s/

Margaret A. Murray
Chief Executive Officer