Public Comments on the 2019 MAC Scorecard Draft Report

General Comments on the Draft Report

American Academy of Family Physicians
Sandy Pogones

The American Academy of Family Physicians (AAFP) thanks the NQF for this opportunity to comment on the Medicaid and CHIP (MAC) Scorecard. In general, the AAFP agrees with the recommendations contained in the report, with two exceptions, as discussed under Indivdual Measure Comments.

A continued frustration with use of public reporting, such as the scorecard, is the lack of consumer engagement in accessing this information. More effort needs to be directed at informing the public of performance measures and obaining public commitment and resources aimed at improving performance gaps. We agree with the Committee that "the goal should be not only to measure things, but also to fix them in an effort to improve quality."

American Occupational Therapy Association
Jeremy Furniss

The American Occupational Therapy Association (AOTA) appreciates the opportunity to comment on the MAC scorecard. We commend NQF for convening a multi-stakeholder group to review and make recommendations on the scorecard. We are happy to provide this feedback in collaboration with Joy Hammel, PhD, who was a part of the committee.

Childrens Hospital Association (CHA)
Sally Turbyville

Enhance Purpose of Scorecard**:** DRAFT report states, “The Scorecard is designed to increase the public’s access to performance data for the Medicaid and CHIP programs including health outcomes experienced by enrollees.” While true, encourage the addition of other stated uses. Specifically, incorporate Seema Verma “The Scorecard will be used to track and display progress being made throughout and across the Medicaid and CHIP programs so that others can learn from the successes of high performing states. By using meaningful data and fostering transparency, we will see the development of best practices that lead to positive health outcomes for our most vulnerable populations.” (https://www.cms.gov/newsroom/press-releases/cms-unveils-scorecard-deliver-new-level-transparency-within-medicaid-and-chip-program).

Statements attributed to the Committee Unpack Committee agreed-upon statements from discussions. Committee discussions do not always include dissenting input. It is important not to classify or frame Committee Discussions as Committee Statement unless the Committee understood that was the desired end-point. As a committee member, I don’t suggest striking these from the report, rather being careful about how discussions are framed.

~As a committee member, I don’t recall Committee Advise to CMS: “CMS was advised [by the Committee] to consider regulatory levers such as value-based payment to facilitate quality improvement efforts beyond just data collection.” May have discussed, and some may have touched on regulatory levers, I don’t recall when the Committee created and then provided this advice to CMS.

~The Draft REPORT states, “The MAC Scorecard Committee recommended that CMCS consider the phased addition of the following four measures (in order of priority)…” It is important to acknowledge that it is in CMS’ purview to decide whether or not (and how) these measure recommendations are implemented into the Scorecard. As a Committee member, I recollect that the Committee made no

attempt to infringe upon this purview, but rather recommended the four measures and prioritized measures to support decisions CMS makes about phasing in measures.

Regardless of CMS decisions of the timing of their implementation in the Scorecard, CHA strongly recommends that the Childhood Immunization Measure is implemented immediately. Immunizations are a critical part of high-quality care and ensuring the best health outcomes for all children and their well-being.

Community Catalyst
Kyle Stock

Thank you for the opportunity to provide input on the draft report on Strengthening the Medicaid and CHIP (MAC) Scorecard. Community Catalyst is a national non-profit advocacy organization that works to ensure that all individuals and communities can influence the local, state and national decisions that affect their health.

However, we are concerned about the Scorecard's lack of quality measures that holistically reflect patient outcomes and experience. We note that there are gaps in the Scorecard's measures particularly related to long-term services and supports (LTSS), substance use disorders and mental illness. Because Medicaid is the largest payer of long-term care in the country, we believe that the omission of any LTSS-focused measure is a substantial deficiency. LTSS scorecard measures should focus on home and community based services (HCBS), which comprise the majority of Medicaid LTSS spending and which consumers prefer. As we have noted in our past comments to the National Quality Forum, the most important HCBS quality indicators focus on quality of life and extent of engagement in community activities. Also important are those measures that focus on consumer choice, experience and satisfaction with services and supports, as well as beneficiary sense of control, autonomy and self-determination. For the scorecard, we encourage the Committee to adopt the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home & Community Based Services Survey, which has been endorsed by the National Quality Forum. We also urge the Committee to consider including elements of the National Core Indicators – Aging and Disability, and National Core Indicators - Intellectual and Developmental Disabilities in the Scorecard.

Community Catalyst is also concerned that no outcomes measures are included for mental health or substance use disorders, despite the stated prioritization of such outcomes measures. Data from the National Survey of Children's Health shows that young children living in lower-income households had higher prevalence of mental, behavioral, or developmental disorders. Data also shows a significant prevalence of substance use disorders and mental illness among people with Medicaid coverage. This makes it particularly important to measure Medicaid's success in providing behavioral health care. Community Catalyst urges the Committee to consider the CAHPS Experience of Care and Health Outcomes (ECHO) Survey for behavioral health, which includes several critical outcome questions, and the Substance Abuse and Mental Health Services Administration National Outcomes Measures, which are currently being used by the New York Medicaid program. These measures track improvements in critical life activities, including education, employment and stable housing. These are the types of measures that are truly meaningful to consumers.

National Partnership for Women & Families
Carol Sakala

The National Partnership for Women & Families applauds the MAC Scorecard project as a response to Medicaid and CHIP program responsibility "for delivering high-quality healthcare to a significant portion of Americans" and applauds the project aim of increasing "the public's access to performance data for the Medicaid and CHIP programs." The clear volume-to-value trajectory of our health care system requires rigorous mechanisms for accountability. As Medicaid and CHIP are responsible for the health care of 73 million individuals and a tremendous expenditure of taxpayer dollars, it is essential to shape

the Scorecard into a highly effective, impactful tool for meaningful information, accountability and oversight.

The domain approach to a basket of Scorecard measures has value but by itself does not foster adequate responsibility for core Medicaid and CHIP populations. As the Medicaid Child Core Set is one of two feeder measure sets at present, children's health issues are well represented in the evolving set of Scorecard measures. However, the Scorecard lacks meaningful oversight regarding other large, crucial, vulnerable populations for which Medicaid has responsibility. For example, although there are several Contraceptive Care measures in the Core Sets, the current Scorecard composition offers nothing in the way of wellness, primary care and prevention for women of reproductive age. As the National Partnership discusses under "Measure-specific comments," the Scorecard is woefully inadequate for accountable maternal and newborn health care. Another key Medicaid population that is not well addressed is people requiring long-term services and supports.

A major limitation of Scorecard methodology is requiring that its measures be drawn from Core Set measures reported by 25 or more states. The eligible measures are thus disproportionately easy-to-collect measures that use claims data (and tend to be less meaningful than other data sources) and have been in the core sets for multiple years. Newer measures of value and measures that may be more meaningful than those derived from claims data are generally excluded from consideration, thus weakening this effort and arbitrarily limiting its impact. Notably, before learning of the 25-state restriction, Scorecard Committee members nominated 11 priority measures for addition to the Scorecard that were not considered as they are reported by fewer than 25 states. This restriction precludes inclusion of measures that are foundational for core Medicaid populations, such as Cesarean Birth and Contraceptive Care—Postpartum for childbearing women and newborns, and multiple Contraceptive Care measures for women of reproductive age. The National Partnership strongly encourage a methodology that enables CMS to include the strongest measures in and beyond the Core Sets with greatest opportunity for improvability.

RMAConsulting
Rhonda Anderson

The draft is very well done and captures the discussion we had in our face to face meeting.

Measure-Specific Comments

American Academy of Family Physicians
Sandy Pogones

Measure 1393 - The AAFP agrees this measure is important. Performance rates may depend at least partially on variations in coverage and co-pays among states. Emphasis needs to be placed on determining the root cause(s) of variation and low performance so improvements can be made.

Measure 2940 - The AAFP opposes this measure in general and recommends removal of this measure from the Scorecard for the following reasons: 1) Patients do not understand MME; 2) There is a lack of agreement in the scientific community on specific dosage threshold levels and different measures recommend different levels (i.e., no measure alignment); 3) The >120 mg MME cut-off level is somewhat arbitrary and may single out pre-existing patients that are stable at or above this level based on functional and other assessments. There are different conversion factors used than what is listed in the measure for methadone and hydromorphone. 4) None of the CDC recommendations on which the measure is based, reached the level of high quality evidence. Due to the poor evidence base, the recommendations are generally consensus and therefore are "good practice points" rather than category A recommendations. 5) The methodology included inconsistent inclusion and exclusions; 6) Measures that address specific milliequivalents are inconsistent among many payers and the AAFP

anticipates unintended consequences (patients being stopped abruptly, physicians refusal to accept OUD patients). 7) use of MME in quality measures is too prescriptive, difficult to locate in the EHR, and inadvisable for use in performance measures. Dosage requirements need to be tailored to individuals; 8) Expert speakers at the 2019 CMS Quality Conference Speakers Master Class on Opioid Use stated that efforts focused on reducing all patients to [specific MMEs] are misguided." They encouraged focus instead on quarterly pain and functional assessment, counseling on the risks and benefits of opioids, urine drug testing, and counseling/prescription for naloxone.

While the AAFP does not disagree with the need to monitor levels of opioid use, the lack of scientific agreement on specific dosage thresholds leaves us unconvinced that the evidence is strong enough to support a specific MME level for use in performance measurement at this time. Other quality measures for opioid use may be more effective and more feasible to collect. Feeding information to physicians in real time to bring awareness of high use levels of opioid use is necessary and a critical need that must be addressed prior to implementing a dosage-based performance measure.

SAA-AD - The AAFP recommends removing this measure. As stated, the measure applies to a very small portion of the population and is not appropriate for inclusion as a publicly reported measure. The scorecard should focus on more impactful measures.

American Occupational Therapy Association
Jeremy Furniss

AOTA strongly supports the recommended addition of the measure NQF 1448 Developmental Screening in the First Three Years of Life. We strongly agree with the rationale expressed in the draft report including that it “is of vital importance because of the downstream consequences of not capturing developmental delays in a timely manner.” AOTA also supports the addition of measure 1768 Plan All-Cause Readmissions for the reasons stated in the report, especially in light of the need for discharge and transition planning as part of patient-centered care.

Childrens Hospital Association (CHA)
Sally Turbyville

CHA strongly recommends that the Childhood Immunization Measure is implemented immediately. Immunizations are a critical part of high-quality care and ensuring the best health outcomes for all children and their well-being.

Community Catalyst
Kyle Stock

Community Catalyst appreciates the work being done to improve health outcomes and increase public transparency of Medicaid and CHIP performance data. We support the addition of the following measures recommended by the Committee: Developmental Screening in the First Three Years of Life and Childhood Immunization Status. We also support the Committee’s recommendation to retain the following measures: Prenatal and Postpartum Care: Postpartum Care; Well-Child Visit: First 15 Months; Adolescent Well-Child Visit: Ages 12 through 21.

GlaxoSmithKline
Tilithia McBride

NQF # 1768: Plan All-Cause Readmissions measure – the measure owner/steward, NCQA, is modifying the measure in Healthcare Effectiveness Data and Information Set (HEDIS), its measurement set. The measure assesses the percentage of hospital discharges resulting in unplanned readmissions within 30 days of discharge. The noted changes to be made by NCQA include:

Adding observation stays as hospital discharges and readmissions in the denominator and the numerator; and

Removing individuals with high frequency hospitalizations.

NCQA has stated removing individuals with high frequency hospitalizations from the measure calculation allows the readmissions rates not to be skewed by this population. GSK is concerned with the removal of any patient population from the measure, as this may unintentionally remove patients with chronic conditions in need of hospital readmission prevention programs, care coordination for discharged patients and post-discharge home medication reconciliation assistance or medication therapy management (MTM). Upon further research, we've noted that NCQA defines frequent hospitalizations as "Medicare and Medicaid members with four or more index hospital stays during the measurement year and commercial members with three or more index hospital stays during the measurement year."[1]

While GSK supports the goal of ensuring that the data underlying performance measurement can capture meaningful changes in quality performance, we are concerned that the proposed changes to the measure may inadvertently exclude patients with chronic conditions, such as chronic obstructive pulmonary disease (COPD), who could benefit from appropriate care management programs and potentially improve patients' quality of life and reducing hospitalization rates. Before making this change, additional assessments should be undertaken to better understand which patient populations are being removed from the measure with the proposed changes. In addition, further study should be done to understand how keeping the Plan All-Cause Readmission measure as-is (i.e., allowing individuals with high frequency hospitalizations to remain in the measure) skew readmission rates. NCQA should also detail the diagnoses to be removed from the measure, as using quantity to define outliers may capture patients in need of greater care coordination and management.

[1] National Committee for Quality Assurance. "HEDIS®1 2019 Volume 2: Technical Update."2018. Accessible at: https://www.ncqa.org/wp-content/uploads/2018/10/HEDIS-2019-Volume-2-Technical-Update.pdf. Accessed December 20, 2018.

Health Watch USA
Kevin Kavanagh

Health Watch USA feels that measurement of opioid usage in the Medicaid population is of utmost importance. Opioid usage is currently the number one U.S. public health problem and most of those addicted to these medications started with prescription opioids.

We recommend that this measure be modified to report the number of Medicaid participants on opioids for chronic pain, regardless of the dosage given. The current measure may give the impression that opioids should be a mainstream treatment for chronic pain. Opioids have been shown to have only minor effectiveness in chronic pain and evidence indicates they are no better than non-opioid alternatives but carry much higher risks. A recent Meta-analysis concluded:

"In this meta-analysis of RCTs of patients with chronic noncancer pain, evidence from high-quality studies showed that opioid use was associated with statistically significant but small improvements in pain and physical functioning, and increased risk of vomiting compared with placebo. Comparisons of opioids with nonopioid alternatives suggested that the benefit for pain and functioning may be similar, although the evidence was from studies of only low to moderate quality."

1) Busse JW, et al. Opioids for Chronic Noncancer Pain. A Systematic Review and Meta-analysis. JAMA, Dec 18, 2018 Vol 320, Number 23 2448

https://jamanetwork.com/journals/jama/article-abstract/2718795

A number of states have filed lawsuits, e.g., Massachusetts attorney general, and have instigated investigations regarding opioid indications and the lack of efficacy in the treatment of chronic pain.

1) Armstrong D. Document: Facing blame for seeding the opioid crisis, Purdue explored its next profit opportunity-treating addiction. STAT Jan. 30, 2019.

https://www.statnews.com/2019/01/30/purdue-pharma-oxycontin-maker-explored-addiction-treatment/

2) Willmsen C, Bebinger M. Lawsuit Details How The Sackler Family Allegedly Built An OxyContin Fortune. NPR. Feb 1, 2019. https://www.npr.org/sections/health-shots/2019/02/01/690556552/lawsuit-details-how-the-sackler-family-allegedly-built-an-oxycontin-fortune

Numerous news investigations are also centering on this indication and how these drugs were approved by the FDA without submitted evidence. The most prominent was broadcasted by 60 mins.

https://www.cbsnews.com/news/the-opioid-epidemic-who-is-to-blame-60-minutes/

Those currently receiving opioids for chronic pain may well have to be managed with opioids due to tolerance and lower pain thresholds. However, rarely should a new patient with chronic pain be started on these dangerous drugs.

Thus, tracking of overall usage is imperative but the arbitrary cut off of >120 mg MME tends to not only mitigate the problem but may give the impression that lower dosages of opioids are the treatment of choice for chronic pain.

National Partnership for Women & Families
Carol Sakala

(First of two measure-specific comments from National Partnership for Women & Families.)

The Scorecard Committee considered recommending removal of Prenatal and Postpartum Care: Postpartum Care (formerly NQF 1517) from the Scorecard. This measure lost NQF endorsement, including because expert consensus level of evidence no longer meets NQF standards. The Committee recognized that this measure of the mere fact of a visit is weak and provides no information about the visit's content, outcomes, experiences or resource use. The fact of a visit at the end of this prolonged, consequential, costly episode is completely inadequate as the sole measure to provide any accountability for the 43% of pregnancies and births covered by Medicaid. The National Partnership for Women & Families finds this inadequacy especially troubling in light of the nation's ongoing maternal health crisis with rising maternal mortality and severe maternal morbidity, persistent egregious racial disparities and Medicaid's disproportionate responsibility for vulnerable childbearing women and newborns.

Two specification-related matters further limit the value of this measure and the current sole maternal-newborn Scorecard measure. First, the measure disincents appropriate early visits (e.g., for wound care, breastfeeding support, maternal mood concerns) by not counting office visits during the first three weeks postpartum. Second, the use of claims data to calculate this measure greatly overestimates the proportion of women with no postpartum visit, as many billing codes do not specifically document a postpartum visit. Whereas surveys of childbearing women estimate about one woman in ten has no postpartum visit, the measure produces estimates many-fold higher, figures that are not interpretable given the invalid data source. The Committee recognized these shortcomings and supported retention of this measure as a placeholder to signify the importance of the population of childbearing women and newborns and with the expectation that better measures will be added for this population.

National Partnership for Women & Families
Carol Sakala

(Second of two measure-specific comments from National Partnership for Women & Families.)

We alert Scorecard personnel that the National Committee for Quality Assurance has proposed a re-specified version of the postpartum measure in response to recent more robust postpartum care guidelines from the American College of Obstetricians and Gynecologists. A comment period recently closed, and next steps for this measure within HEDIS are unknown. However, likely changes to the underlying measure are a future matter for the Medicaid Core Sets and the Scorecard.

The National Partnership strongly encourages future inclusion in the Scorecard of more robust measures for this population, including Cesarean Birth, Contraceptive Care-Postpartum and two endorsed Joint Commission Core Set measures that are not presently in the Medicaid Core Sets: Exclusive Breast Milk Feeding and Unexpected Complications of Term Newborns. Especially in the context of the maternal health crisis, the Scorecard is an important opportunity and responsibility to ramp up accountability for the various stakeholders that impact maternal-newborn care.

PQA Alliance
Lisa Hines

As the developer/steward of NQF 2940 Use of Opioids at a High Dosage in Persons without Cancer, we reviewed the draft MAC Scorecard report. We would greatly appreciate the opportunity to make some clarifications related to the notes of the discussion regarding the measure (excerpted below).

NQF 2940 Use of Opioids at a High Dosage in Persons without Cancer The Committee agreed that addressing the opioid crisis on the Scorecard is of high importance. Additionally, various government agencies are beginning to hold state Medicaid programs accountable for opioid use amongst beneficiaries. Given the current national opioid crisis in the U.S., the Scorecard Committee agreed to keep the measure on the Scorecard until a better outcome-based measure is available while signaling the significance of addressing this issue on the Scorecard. Committee members questioned whether a dosage of 120mg per day is an appropriate cutoff for this measure, and expressed that they would like to see more alignment with guidelines and/or evidence-based dosage information. In response to this concern, the developer acknowledged that the measure dosage lacked a robust evidence-base, and they are now aligning the measure with CDC guidelines as one approach to address this concern. One state representative commented that NQF 2940 might mistakenly capture therapeutic use of narcotics for opioid use disorder (buprenorphine, methadone, etc.); however, the developer clarified that such medication assisted treatment (MAT) for opioid use disorder is not a part of the numerator calculation for this measure. Another member noted that the measure is limited because it only addresses legal supply and does not address illegal distribution. Ultimately, the Committee noted that NQF 2940 is a suitable measure that captures the opioid crisis at multiple levels. A few Committee members noted that more measures are currently being developed in this space.

1. The measure's dosage threshold is represented in the NQF document as 120 mg per day; however, it should be >120 Morphine Milligram Equivalents (MME)/day. We realize this is a recap of committee discussion but would like the measure to be accurately represented to avoid confusion.

2. The measure is evidence-based, so the highlighted statement above that the measure dosage lacked a robust evidence-base is not accurate. The measure was developed prior to the publication of the CDC guidelines, so the evidence, guidelines, and standards that existed in 2015 supported the >120 MME/day threshold. PQA updated the 2019 measure specifications to ≥90 MME/day to align with the recommendations in the CDC guideline.

3. Opioids that are indicated for medication assisted treatment (MAT) are not part of the measure (denominator or numerator).

RMAConsulting
Rhonda Anderson

In the meeting we removed the pregnancy measure. I would recommend that a measure around prenatal and post natal care be considered in the future since so many pregnant women are in the Medicaid programs and don't have timely prenatal care.

Comments on Strategic Issues

American Academy of Family Physicians
Sandy Pogones

The AAFP agrees that the burden of documentation must be addressed, and with the Committee's suggestion that financial assistance be given to clinicians for collecting data. Documenting data in an electronic-prescribed format does not currently align with workflow of physicians and is an added task to their work. Alternatively, data should be obtained from claims or other databases (such as geospatial applications) and/or clinical data extracted from electronic health record with no burden on the part of physicians. We understand the technology to do so is not currently widely available, but physicians should not be expected to fill current technology gaps by expending their own time, effort, and resources for quality measurement and reporting, with little, if any, return on investment.

The AAFP disagrees with the statement, "It is important to note that data for the Scorecard are collected at the state level, but the greatest opportunity for improving the quality of healthcare delivery is at the provider and health plan level" (page 14). Numerous studies have demonstrated that health is determined primarily by factors outside the healthcare system, with healthcare influencing only 20% or less of health outcomes. Our focus on performance of healthcare providers is out-of-balance with root causes of poor health. Holding states and federal programs accountable for addressing social determinants of health would have a much greater impact than our continued focus on the minutiae of healthcare. The Pareto Principle would tell us to focus efforts and resources there. Potential measures that may better indicate value for inclusion in a scorecard may include primary care spend (i.e., a higher spend on primary care has been demonstrated to improve health and lower costs); health of the community (food desserts, public access to transportation, tobacco use) financial barriers to access, drivers of high cost (e.g., pharmaceutical, hospital/ED, waste, duplication), coordination, and patient engagement.

American College of Nurse-Midwives
Diana Jolles

Thank you for your attention to measure alignment, parsimony and impact.

In reading the report- I continue to be struck by how there are too many measures, with far too little mandatory reporting.

It seems wise to focus on cross cutting, high impact population health measures-

Things that are EASY to fix, are subject to unwarranted variation in care (e.g. geographic variations, institutional, state level, etc.)

For example- exclusive breastfeeding is a high impact measure, with known systems level variations, clear corrective actions can be taken to improve performance. Improved performance influences life course health- of both mother and baby-

I am surprised to see this omitted.

American Occupational Therapy Association
Jeremy Furniss

While we understand that for the scorecard to be effective, parsimony is necessary, AOTA encourages NQF to consider the addition of person satisfaction or experience of care measure and a measure of function or functional independence. We believe that understanding the experience of the person receiving services is critically important. Reporting feedback to providers in this area signals that person centered care is a priority. A publically reported measure of function ("patient" reported or otherwise) can be an important overall outcome measure.

AOTA is a strong advocate for understanding, measuring, and reporting function and the person's experience of care. As the report notes, publically reported measures are not used as frequently or to the extent as would be ideal. We believe that including meaningful and simple to understand measures of function and experience can be a driver for more widescale adoption by consumers.

Finally, we believe that NQF should examine and consider measures related to long-term care utilization (e.g., number of people in long term care or other institutional settings compared to the number who are living in the community with waiver/community living supports).

Childrens Hospital Association (CHA)
Sally Turbyville

CHA encourages CMS to finalize and communicate the mid- and long-term accountability scheme (continued public reporting, financial incentives or penalties for Medicaid State Agencies…) for the Scorecard. Will financial incentives or penalties be attached to state Scorecard performance? If so, starting in what year? And how will the state health system performance pillar be used in that type of scheme?

CHA encourages CMS to have an active role in establishing and supporting the learning environment. Strategies should include within and across states (as suggested by the CMS Administrator) and providers. It is important that the learning environment includes actionable information for the states and providers of care.

The Draft report states: "It is important to note that data for the Scorecard are collected at the state level, but the greatest opportunity for improving the quality of healthcare delivery is at the provider and health plan level." This statement may be interpreted as very narrow in scope that discounts the ongoing efforts of states and Medicaid agencies. States and the Medicaid agencies are important innovators and influencers that do and can enable multidisciplinary initiatives to address social risk factors associated with health outcomes.

The draft report states, "However, Medicaid Core Set data are based on voluntary state reporting, whereas the MAC Scorecard will likely evolve into a mandatory public reporting tool. This disconnect in actual use of the measures as well as the opportunity to flourish based on past reporting experiences directed the discussion by the MAC Scorecard Committee." As a member of the committee, it is not clear to me what the implications are of this statement. For example, the Scorecard is already publicly reported and reportedly (by CMS at the meeting) will only draw on information already reported to CMS by the states (like what is reported on Core Sets); thus, I am unsure of the implication of the statement that the Scorecard will likely become a mandatory public reporting tool.

Community Catalyst
Kyle Stock

We encourage the prioritization of patient experience measures, patient-reported outcome measures and patient goals-directed measures. We also support quality measurement that elicits information on

health disparities. Data should be disaggregated and stratified by race, ethnicity, primary language, gender identity, sexual orientation, and disability status to measure progress on reducing disparities.

Community Catalyst would also like to note that quality measurement work is less successful when consumers and communities are not involved, or when they have been involved superficially. When consumers and communities notice that the process is not working well for them, they are less likely to support implementation and use of quality measures. In our experience, consumer engagement in all stages of quality measurement can address these concerns, but success depends on both measurement leaders and consumer advocates. For additional information and detailed recommendations, see our report (available here: https://www.communitycatalyst.org/resources/publications/document/Resource-for-Advocates-on-Quality-Measurement-Recommendations-Final.pdf).

GlaxoSmithKline
Tilithia McBride

GSK appreciates the opportunity to provide comments on the future direction of the Medicaid and CHIP (MAC) Scorecard Project, specifically on the current criteria used for measure selection. The Scorecard is designed to increase the public's access to performance data for the Medicaid and CHIP programs including health outcomes experienced by enrollees.[1] We encourage a change the methodology of only recommending the public reporting of measures from the Adult Medicaid Core set that have been reported by 25 or more states. Under this approach, states may continue to deprioritize vulnerable populations, such as those with human immunodeficiency virus (HIV) and fail to demonstrate the quality of care provided to all Medicaid beneficiaries.

State governments are important partners in preventing and combating HIV. Medicaid has played a critical role in HIV care since the epidemic began, and it is the second largest source of coverage for people living with HIV.[2]

GSK encourages the use of HIV quality measures to drive the advancement of high-quality care through adherence to clinical guidelines, improvements in care coordination and care transitions, patient engagement, and a focus on achieving outcomes. Specifically, we support the adoption of NQF #2082 HIV Viral Load Suppression measure for public reporting on the Medicaid and CHIP (MAC) Scorecard. The implementation of this outcome measure across state quality programs will help realize HHS' plan of Ending the HIV Epidemic: A Plan for America in the next 10 years.[3] Additionally, viral load suppression is the gold standard in HIV treatment and means that the virus has been reduced to an undetectable level in the body with standard tests.[4] The primary advantage of implementing outcome measures generally, and the viral load suppression measure, specifically, is that they directly measure what patients care about—namely, whether their interaction with the health care system improved their health or led to an adverse event.

[1] CMS. Medicaid & CHIP Scorecard website. https://www.medicaid.gov/state-overviews/scorecard/index.html. Accessed March 2019.

[2] Kaiser Family Foundation. State Health Facts. Medicaid and HIV. https://www.kff.org/hivaids/fact-sheet/medicaid-and-hiv/.

[3] Department of Health and Human Services. 2019. "Ending the HIV Epidemic: A Plan for America." Accessible at: https://www.hhs.gov/sites/default/files/ending-the-hiv-epidemic-fact-sheet.pdf.

[4] National Institutes of Health (NIH) "Ten things to Know about HIV Suppression" https://www.niaid.nih.gov/news-events/10-things-know-about-hiv-suppression.

National Partnership for Women & Families
Carol Sakala

The Scorecard report states that the Scorecard composition aims for a "balanced set of measures that address health and well-being across an individual's life span." To do this, the National Partnership for Women & Families recommends an assessment of Scorecard measures created by arraying the current domains and measures within them by the larger core Medicaid and CHIP subpopulations to display in grid format the measures that fall within the various domains and promote quality care for the core populations. At minimum, across the life span, these populations include: children, women of reproductive age, childbearing women and newborns, and individuals requiring long-term services and supports.

Taking stock of the Scorecard measures in this way will identify crucial and unacceptable gaps given the responsibilities of the Medicaid and CHIP programs. To address these gaps, we encourage adjusting the criteria for eligible Scorecard measures to be able to promote accountability and value-based care for core subpopulations as part of the fiduciary responsibility of the Center for Medicaid and CHIP Services for the health care of one-quarter of the population and a disproportionately vulnerable population. This would also address the CMCS fiduciary responsibility for the wise expenditure of a large proportion of taxpayer dollars. The National Partnership strongly encourages wiser spending on high-value care versus reducing access to care, an approach that can improve rather than threaten health outcomes. The Scorecard can play a crucial role in such a strategy.