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ACAP Comments on Proposed Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults [CMS–2420–NC]

The Association of Community Affiliated Plans (ACAP) is an association that represents 54 non-profit, safety net health plans in 26 states serving over 7 million individuals. We would like to commend AHRQ and CMS on the measure development process. Moreover, ACAP appreciates being given the opportunity to participate in the Subcommittee activities and to comment today on the proposed Medicaid adult health core measurement set, as published in the December 30, 2010 Federal Register.

1. **ACAP supports comparable quality measurement across the entire Medicaid delivery system.**

ACAP is extremely supportive of improved quality measurement for beneficiaries served by the Medicaid program. Managed Care Plans have long embraced the need for strong quality measurement as a core component of quality improvement and accountability. In fact, quality measurement has been a mainstay of managed care since its inception. Applying comparable quality measurement to all aspects of the Medicaid delivery system is a welcomed and needed advancement.

2. Initial core measurement set should be limited to a stratified set of HEDIS measures.

We support the use of existing HEDIS measures as the foundation for the initial core measurement set as a means of supporting consistency and building on a well-regarded, well-tested and well-understood measurement set. The use of HEDIS measures following the HEDIS specifications without modification allows standardized and specified definitions. We believe that measures, such as HEDIS, that are in use extensively should be given preference as a cost-effective means for developing and implementing a core measurement set, especially in the current budget environment. We do not support the inclusion of non-HEDIS measures in the initial core measurement set.

Of course, one concern with the use of HEDIS data is the fact that it is not risk adjusted. Therefore, we would recommend the use of stratified measures to ensure that the information being used to compare the performance of different state Medicaid programs, or different entities within those programs, adjusts for differences in the health condition of the population being served.

Although we support comparability through the use of HEDIS measures, we do not believe that data should be degraded solely as a means to allow standardization. For example, when available, health plans will usually utilize the hybrid method of data collection including a chart review to ensure that the data reported is as accurate and complete as possible. If a state decides to only collect data administratively for the same measure, we would not want to see the more comprehensive health plan data ignored because the state was only able or willing to report administrative data for the fee-for-service or primary care case management delivery systems.

3. **A smaller, more targeted subset of the proposed measures should be included in the initial core measurement set.**

While we support including measures in the 5 domains addressed in the proposal (preventive and health promotion, management of acute conditions, management of chronic conditions, family experience with care, and availability), we believe the total number of measures and the number of measures per domain are overly ambitious. We do not believe enough attention has been paid to the overall reporting burden and costs for states, health plans and providers, especially when considered concurrently with the child health core measurement set. Moving from no defined measurement sets to almost 80 measures is overreaching for an initial core set. If left unchanged, states will end up picking and choosing among the voluntarily reported measures resulting in a lack of comparable data across all states and defeating the intent.

For non-HEDIS measures, there are also a number of issues that need to be worked out before the measures could or should be adopted for statewide reporting. First, many of the measures were designed for different settings than proposed in the regulations and need to be modified and tested before implemented for statewide population-based reporting.

Second, for a number of measures, we are concerned about the data source for the reporting. Based on the current code and diagnosis sets in use today, it would not be possible to collect this information directly from claims data. With the expected roll-out of meaningful use of EMRs on a wider scale, this may be doable for a future measurement set. However, ACAP does not believe that the state of the EHR adoption supports the inclusion of such measures at this time. The level of data collection based on current capabilities would either require additional chart reviews that States will probably not undertake (especially for fee for service and PCCM-enrolled beneficiaries) or the development of interim systems to support direct reporting from the hospitals and physicians in the State, at the very time that states are working to implement meaningful use of EHR and health reform related activities.

Third, the practicality of each measure should be re-evaluated prior to adoption. For example, a number of individuals with severe mental illness are dual eligibles. In this case, Medicare may be paying for the bulk of the acute care services such as drugs and labs. Without complete integration of Medicare and Medicaid data, reporting of measures based on Medicaid data alone is going to give a skewed and inaccurate picture of the quality of care provided unless the individual is excluded from the denominator.

ACAP advocates for a smaller number of more tightly focused measures for the initial core set. This would also allow CMS and AHRQ to provide tightly focused technical assistance, like that proposed for the child health measures, and work through issues raised above and other issues yet to be identified through the more rigorous use of techniques such as field testing of measures.

4. Both the adult and child CAHPS should NOT be expected to be done annually.

Concerning the inclusion of CAHPS, unless States are going to fund and conduct a single statewide survey, we do not support the use of HEDIS CAHPS Adult Version including supplements in addition to the CAHPS Child Version already included in the CHIPRA core measurement set. If CAHPS is part of the core measurement set, we strongly suggest that either adult or child CAHPS be conducted on an alternating basis, as is the case under the NCQA health plan accreditation requirements. This would recognize the cost and effort associated with fielding multiple statewide surveys and support comparable measurement across states.

5. **It is critical that a state-level measure of churning be developed and the impact of churning on the measurement set by studied and quantified.**

Finally, as stressed in earlier comments on the core child health measurement set, 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 to consider Leighton Ku's work on the measurement of churning, as outlined in the previously supplied report entitled *IMPROVING MEDICAID'S CONTINUITY OF COVERAGE AND QUALITY OF CARE* prepared by Leighton Ku and Patricia MacTaggert of the George Washington University Department of Health Policy on behalf of ACAP, that could be used at least as a stop gap measure. In addition, 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.

Again, thank you for this opportunity to comment on this critical issue. Please feel free to contact ACAP directly if you have any questions on the comments submitted.

Sincerely,

Deborah Kilstein

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