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October 14, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: CMS-2440-P: Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting

Dear Administrator Brooks-LaSure:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to comment on the notice of proposed rulemaking (NPRM) on Medicaid Program and CHIP: Mandatory Medicaid and Children's Health Insurance Program (CHIP) core set reporting published on August 22, 2022 (87 Fed. Reg., 51303).

The proposed rule establishes key requirements for mandatory state reporting of the child core set, adult core set behavioral health measures, and the core sets for health homes implemented under Sections 1945 and 1945A of the Social Security Act. The Bipartisan Budget Act of 2018 (P.L. 115-123) made state reporting on the child core set mandatory while the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 (P.L. 115-271) required states to report behavioral health measures in the adult core set.

The core set measures provide an important opportunity for states and the Centers for Medicare & Medicaid Services (CMS) to collect consistent information on a uniform set of measures. The measures can be used to identify trends in quality, disparities that must be addressed, and opportunities for improvement. Currently, core set reporting is optional for states and has increased over the years.

In its March 2020 report to Congress, MACPAC described a number of factors affecting state readiness for mandatory core set reporting. At the time, some states and CMS had taken some early steps to prepare for mandatory reporting, but more work was needed. Specifically, we noted the need for CMS to issue early and clear guidance to provide states sufficient time to plan for and make necessary policy and programmatic changes, and address challenges. Factors affecting states' ability to report core set measures beginning in FY 2024 included for example, challenges accessing data from certain data sources, data collection and reporting for certain populations, and state capacity.

Below we provide specific comments on provisions of the proposed rule.



Need for early and specific guidance

The issuance of the NPRM is an important step in publicizing expectations for mandatory core set reporting but the Commission is concerned that it lacks the specificity states require to prepare in earnest for reporting the FY 2024 core set. To enable states to submit and certify core set measures by December 31, 2024 as the NPRM requires, the Commission urges the Secretary of the U.S. Department of Health and Human Services (HHS) and CMS to issue specific guidance to states on core set reporting as soon as possible. The proposed rule requires the Secretary to issue annual reporting guidance that identifies which measures states must report, measures the Secretary will or can report on behalf of states, specifications for reporting, as well as requirements for stratified reporting (§ 437.10(a)(3)). However, the NPRM does not describe the timing of such guidance for FY 2024 reporting or for subsequent years.

Issuance of timely guidance that details the required measures and their technical specifications, and that gives states as much lead time as possible is needed. As described in MACPAC's March 2020 report and in the preamble to the proposed rule, states will need to address a range of challenges such as collecting data from non-Medicaid data sources (e.g., state immunization registries and electronic health records) or for populations that historically have been excluded from states' core set reporting (e.g., dually eligible individuals), depending on the required measure. In addition, states reported to MACPAC that data collection on behavioral health services is complicated by the often fragmented delivery of these services, which requires states to collect data from multiple care settings.

Reporting of certain core set measures by the Secretary on behalf of states should help reduce state burden. Identifying those measures as early as possible will allow states to focus their resources on the measures remaining in their purview. In addition, the Commission encourages the Secretary to assess whether there are other opportunities (e.g., minimizing changes between the FYs 2022 or 2023 core sets and the FY 2024 core set) to facilitate reporting for FY 2024, and their feasibility and potential implications.

Consistency of reporting

MACPAC concurs with requiring states to adhere to the annual reporting guidelines as described in proposed § 437.15(a)(3). Consistency of state reporting is a key objective of the core sets. Adherence to the guidelines, including those related to data collection methods and calculation of the measures, is needed to enable comparisons across states on quality performance and to calculate national performance rates for quality of care.

Given that CMS has historically accepted core set reporting when states have deviated from the technical specifications, we emphasize the need for the Secretary to provide states timely guidance and technical assistance on the specifications. Currently, states sometimes deviate from the CMS technical specifications to account for state-specific approaches for collecting data. For example, some states previously have described being unable to report age stratifications called for in the core set technical specifications because they differ from the HEDIS age ranges or they deviate from technical specifications to account for state-specific billing and coding practices (MACPAC 2020a).

Stratification of measures

MACPAC supports requiring stratified reporting of core set measures (§ 437.10(b)(7)). As noted in our June 2022 report to Congress, complete and accurate data, including data on race and ethnicity, are needed to identify and shed light on disparities in care and outcomes for Medicaid beneficiaries of color compared to other enrollees (MACPAC 2022b). Stratified core set data may be especially useful to states for developing strategies and approaches to advance health equity. It is the Commission's view that ensuring consistency in state reporting and



stratification of core set measures should be a priority. Thus, the Secretary should identify which measures should be stratified and the factors for doing so.

In addition to stratifying core set measures by race, ethnicity, sex, age, urban or rural status, disability, and language, the Secretary should also require stratifying measures by managed care plan given the role of the plans in delivering care to individuals enrolled in Medicaid and CHIP. Plan-specific data is needed to identify trends in quality and can be used to advance state alternative payment methodologies. Plan-specific data may also be useful in oversight.

Given the challenge in collecting race and ethnicity data, a phase-in approach such as the one described at § 437.10(d) will provide states additional time to improve data collection. States and CMS will have to work through a number of issues including high rates of missing race and ethnicity data, which are difficult to collect, and improving the quality of data reported. In a recent assessment of the quality of state race and ethnicity data in the Transformed Medicaid Statistical Information System (T-MSIS), MACPAC found that 30 states had only low and medium data quality concerns and thus meet minimum data quality standards necessary for conducting analyses with the data (MACPAC 2022a).

Given the urgent need to identify and address health disparities, stratified core set reporting should be expedited to the greatest extent possible. As states and CMS continue to address data collection and quality challenges, we urge CMS and HHS to report stratified data as soon as the data are reasonably sufficient. For example, even if all states are not able to report stratified data for all populations or measures, CMS and HHS could consider reporting on the subset of states, populations, or measures for which reliable data are available. We note that CMS currently uses a similar approach for public reporting of state performance on core set measures. The agency reports measures that are reported by at least 25 states using the core set technical specifications, and that meet CMS standards for data quality (MACPAC 2020b). The Commission urges CMS and HHS to work with states now and during the phase-in period to improve data collection and other technical capacities needed for stratifying core set measures so that all states can meet the phase-in schedule.

Reporting of children enrolled in separate CHIP

MACPAC supports the proposed requirement that states report on children enrolled in separate CHIP and Medicaid separately, but using the same data collection and reporting methods (§§ 437.15(b) and 457.770(c)). Requiring separate reporting of children in separate CHIP and Medicaid would provide a more complete picture of quality and outcomes for children served by these programs than is currently available. Consistent data collection and reporting across the programs would allow for calculation of valid combined rates. We agree that the Secretary's annual guidance should specify the attribution rules for counting children who move between Medicaid and separate CHIP (§ 437.10(b)(6)).

Currently, individuals who churn on and off of coverage and those who transition between Medicaid and CHIP are excluded from measurement. The technical specifications for certain core set measures only include beneficiaries who have been enrolled continuously for 12 months. MACPAC found that in 2018, 16 percent of children enrolled in separate CHIP and 8 percent of children in Medicaid disenrolled and reenrolled in those programs within 12 months (MACPAC 2021). In addition, 47.4 percent of children who disenrolled from separate CHIP moved into Medicaid, and of those, 17.4 percent had a gap in coverage (MACPAC 2022c). We note that including children who have a gap in coverage could affect the validity of the measure, and may need to be addressed in the technical specifications.

In addition, we note that some states have relatively small separate CHIP enrollment compared to their child enrollment in Medicaid and Medicaid-expansion CHIP, or compared to large states. These states may experience



difficulty reporting on their separate CHIP programs, especially on measures for which stratified reporting is required. We urge CMS to work with these states to address data collection and calculation challenges.

Reporting of pregnant individuals enrolled in separate CHIP

MACPAC also supports counting pregnant individuals enrolled in separate CHIP, including those covered under the unborn child option, in core set measurement as proposed at § 457.770(a).¹ Given poor health outcomes for pregnant individuals, particularly among people of color, a complete picture of health quality and outcomes of those served by Medicaid and CHIP is needed and may help to identify opportunities for federal and state intervention. In addition, such reporting may also help to identify whether there are differences in outcomes for pregnant individuals in separate CHIP compared to Medicaid, as well as differences between pregnant individuals receiving comprehensive benefits compared to those receiving pregnancy-related benefits in Medicaid or separate CHIP.

MACPAC has previously reported that pregnant individuals in the United States are increasingly experiencing adverse health and birth outcomes (MACPAC 2020b). Approximately 700 women die annually in the United States from pregnancy or related complications; about 60 percent of these deaths may be preventable (Petersen et al. 2019a). The pregnancy-related mortality ratio (the number of deaths per 100,000 live births) has increased over the last 30 years, from 7.2 deaths per 100,000 live births in 1987 to 16.9 deaths per 100,000 live births in 2016. In addition, each year at least 50,000 women experience potentially life-threatening complications in childbirth; the rate of severe maternal morbidity doubled between 1998 and 2011 (Creanga et al. 2014). Preterm birth rates decreased from 2007 to 2014, but then began increasing; in 2018, the preterm birth rate was 10 percent (Martin et al. 2019, Ferré et al. 2016). The rate of preterm birth is higher among women of color (Martin et al. 2019). The percentage of low-birthweight infants has also been on the rise since 2014; in 2018, the rate was about 8 percent (Martin et al. 2019).

Significant racial and ethnic disparities also exist with Black, non-Hispanic women and American Indian and Alaska Native women having two to three times higher pregnancy-related death rates compared to white, non-Hispanic women (Petersen et al. 2019b).² Women of color are also at greater risk of maternal morbidity and giving birth to a preterm or low-birthweight infant (Martin et al. 2019). Black, non-Hispanic, and American Indian and Alaska Native women have heightened risk of maternal morbidity compared with white, non-Hispanic women (Admon et al. 2018a). An increasing number of pregnant women have chronic conditions that may require continued medical care in the postpartum period (Brown et al. 2020; CDC 2020; Admon et al. 2018b). Women living in rural areas also face greater maternal health risks than those residing in urban areas (Kozhimannil et al. 2019). Having core set data on the quality and health outcomes of pregnancy-related care for individuals in separate CHIP may help federal and state efforts to identify and mitigate adverse and disparate pregnancy outcomes.

Technical assistance

The Commission commends CMS and the Secretary for the range of technical assistance provided to states to support their reporting of core set measures. We urge CMS and the Secretary to continue providing technical assistance to states using a variety of formats, including on a one-on-one basis. Our March 2020 report highlighted a number of state-identified technical assistance needs such as data collection and measure calculation for beneficiaries enrolled in fee for service, strategies for accessing electronic health record data, and approaches for obtaining data from other entities (e.g., state immunization registries and Indian Health Service providers). As state and federal preparations for mandatory reporting in 2024 progress, additional technical assistance needs are likely to surface, including for example, those related to stratified reporting of measures.



Process for updating the core set

The Commission agrees with adopting the process currently used for updating the child and adult core sets. HHS and CMS have used this process since the development of the initial child and adult core sets in 2010 and 2012, respectively. That process engages a wide range of stakeholders to assess whether changes are warranted and there is an evidence for changing the core sets.

Thank you for the opportunity to comment on this proposed rule. We appreciate CMS's leadership in developing the core sets and its work with states to improve reporting of the measures. We look forward to future guidance regarding implementation of the core set reporting mandate.

Sincerely,



Melanie Bella, MBA
Chair

cc: The Honorable Ron Wyden, Chair, Senate Finance Committee
The Honorable Mike Crapo, Ranking Member, Senate Finance Committee
The Honorable Frank Pallone, Jr., Chair, House Energy and Commerce Committee
The Honorable Cathy McMorris Rodgers, Ranking Member, House Energy and Commerce Committee

Endnotes

¹ In general, MACPAC uses the term pregnant women as this is the term used in the statute and regulations. However, other terms are being used increasingly in recognition that not all individuals who become pregnant and give birth identify as women.

² The rates were 40.8 per 100,000, 29.7 per 100,000, 12.7 per 100,000, respectively (Petersen et al. 2019b).

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