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October 21, 2022

VIA ELECTRONIC TRANSMISSION

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services (CMS)
200 Independence Avenue, SW
Washington, D.C. 20201

Re: RIN0938-AU52
Mandatory Medicaid and Children's Health Insurance
Program (CHIP) Core Set Reporting

Dear Administrator Brooks-LaSure:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. For over fifty years, we have educated, advocated and litigated to advance health equity for all without bias or barriers. We appreciate the opportunity to provide these comments on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule, Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting.

We support efforts to strengthen data collection and quality reporting in the Medicaid and CHIP programs, including mandatory state reporting of outcomes measures important to individuals using the services. It is essential to include policy changes that aim to identify health disparities and improve health equity across these vital programs. We support robust, quality improvement practices and performance oversight in these programs, and recognize the urgent need to improve the identification and tracking of health disparities as a necessary first step to building a more equitable health system.

The COVID-19 pandemic revealed the woeful inadequacy of our health care data infrastructure to measure the disparate impact of the disease, as well as the disparate access to health care for certain marginalized groups. President Biden’s administration has clearly prioritized improving that infrastructure to inform policies that aim to lessen health inequities. While many gaps persist in the core measure sets, we appreciate that CMS has also for the first time proposed to phase-in required reporting of a group of core measures by key demographic characteristics, such as race and ethnicity, age, sex, and disability. We hope this represents the beginning of a paradigm shift that would establish such stratified reporting as an expected standard across these programs and would elevate beneficiaries’ perspectives in making decisions about what measures go into these Core Sets.

Our recommendations for this proposed rule track with five general points:

- Standardized reporting of required measures should be a mandatory floor for quality measurement, and expectations for that reporting should increase over time;
- Health equity should be a central goal and priority of quality improvement programs; CMS should act with greater urgency to require reporting of quality measures separated by key demographics and then design interventions that hold providers, health plans, and states accountable to its equity goals;
- The process for updating and defining core measures must include meaningful representation from beneficiaries of all ages and their advocates, including especially representation from underserved and marginalized communities;
- CMS should update and standardize data collection on various demographic categories, including race, ethnicity, preferred language, age, gender, sexual orientation, gender identity and sex characteristics, and disability status; and
- CMS should continue to improve quality reporting for groups that have historically been more challenging to measure, such as the 12.3 million dually eligible individuals, people who use long-term services and supports, people with substance use disorders, and people in FFS Medicaid in states that cover most people through managed care.

Section-by-Section Recommendations

§ 437.1(a) Basis, Scope, Purpose and Applicability

Enactment of the 2018 Bipartisan Budget Act and the SUPPORT Act mandated reporting of the Child Core Set and the behavioral health measures in the Adult Core Set. Separately, we understand that CMS has long had the independent authority to require states to report on specific quality measures under other provisions of the Medicaid Act to ensure the “proper and efficient operation of the plan.”¹

We support the inclusion of cross references to this other authority of the Social Security Act as the statutory basis for the Core measures and these implementing regulations. We recommend that CMS add a cross reference to § 1902(a)(4), which covers methods of administration, alongside (a)(6), which refers to reporting from states. Part of these regulations involve largely federal processes – such as the designation of Core Measures in each set – that are not strictly related to state reporting. Section 1902(a)(4) is also cited as a statutory basis for CMS’s authority to require States to include specific measures and performance improvement programs in their managed care reports.² This proposed rule rests upon the same authority to require reporting of the Health Home Core Set measures for individuals with chronic conditions.³

As noted in our discussion of proposed § 437.15 below, we also urge CMS to clarify in the regulations that required reporting on quality measures is not limited to the directives from the 2018 Bipartisan Budget Act (requiring reporting for the Child Core Set) and the 2018 SUPPORT Act (requiring reporting on the behavioral health measures in the Adult Core Set). The final regulations should establish that these provisions represent a Congressionally-mandated floor for required measures, but maintain that CMS can also expand required reporting to include other measures – such as other adult measures or HCBS Core measures – if the Secretary finds it necessary for the proper and efficient administration of the Medicaid program.

§ 437.1(c) – Purpose

We find the proposed purpose for the Child and Adult Core Sets does not accurately capture the aims embedded in the statutory language. Specifically, we believe the purpose should reference and prioritize the identification and reduction of health disparities,

¹ 42 U.S.C. § 1396a(a)(4), (6).

² 42 C.F.R. § 438.330(a)(2).

³ 87 Fed. Reg. 51306 [referring to the state plan option under § 1945 of the Social Security Act].



consistent with the statute, and emphasize that each core measure set must encourage comparative analysis at the national, state, program and provider levels.

Section 1139A of the Social Security Act defines the Child Core Set as “a group of valid, reliable, and evidence-based quality measures.”⁴ It further clarifies that an evidence-based quality measure “shall, at a minimum, be designed to identify and eliminate racial and ethnic disparities in child health and the provision of health care” and “ensure that the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level.”⁵ The statute again highlights both health disparities and comparative analysis in its requirement that the initial Child Core Set,

taken together, can be used to estimate the overall national quality of health care for children, including children with special needs, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.⁶

These explicit references to health equity and multi-level comparative analysis as elements defining Core Measures should be reflected in the regulations defining the purpose of both Child and Adult Core Sets.⁷ As written, the purpose can be construed as limited to national and state-level analysis, which does not reflect the importance of quality measures for measuring specific populations, evaluating program and plan performance, and ensuring that individual providers are also delivering high quality care.

RECOMMENDATION: Amend § 437.1(c) as follows:

(c) *Purpose.*

(1) The purpose of the Medicaid and CHIP Child Core Set and the Medicaid Adult Core Set is to measure the overall national quality of care for beneficiaries; monitor performance **and promote comparative analysis at multiple levels, including the State, program, plan and provider levels;** ~~the State-level,~~ **identify and eliminate health disparities across populations;** and improve the quality of health care.

⁴ 42 U.S.C. § 1320b-9a(a)(8).

⁵ 42 U.S.C. § 1320b-9a(b)(2).

⁶ 42 C.F.R. § 438.330(a)(3)(D).

⁷ The statute directs the Secretary to develop the Adult Core Set “in the same manner” as the Child Core Set. 42 U.S.C. § 1320b-9b(a), (b)(5).



§ 437.5 Definitions

We recommend revising the definition of behavioral health to include recovery services and name substance use disorders separately from mental health disorders. This would reflect the discussion in the preamble.

RECOMMENDATION: Insert the following additions into the definition of behavioral health:

Behavioral health means a beneficiary's whole emotional and mental well-being, which includes, but is not limited to, the prevention, ~~and~~ treatment, **and recovery** from mental disorders ~~including~~ **and** substance use disorders.

§ 437.10. Child, Adult, and Health Home Core Sets

A. Consultation with Stakeholders

In § 437.10(a), CMS lays out the stakeholder process for updating the Adult and Child Core Sets and defines the parties of interest. We cannot stress enough the importance of elevating the perspectives of beneficiaries and beneficiary advocacy groups in this critical consensus-based process. One component of the definition of the Core Measure Sets is to “allow purchasers, families, and health care providers to understand the quality of care.”⁸ Part of that understanding may come in the form of creating reports and comparative tools that let people compare plans and providers based on quality outcomes. But another side of understanding quality of care lies in the selection and reporting process itself. This means providing beneficiaries, their families, and advocacy groups the support necessary to actively, productively, and meaningfully engage with the technical side of quality measurement. The problems and shortcomings they identify should receive equal consideration.

In our experience, these stakeholders, while mandated a seat at the table, often get overwhelmed by providers, plan representatives, State officials, and expert measure developers in the process of developing recommendations for measure updates. This effect has been particularly salient in the disability and aging communities' long efforts to get some HCBS measures endorsed by the National Quality Forum, which is an important factor for inclusion into one of these Core Measure Sets.

⁸ 42 U.S.C. § 1320b-9a(a)(8)(C).



While most of the tasks listed in paragraph (a)(2) adhere closely to the statute, one of the criteria for including measures listed in subparagraph (iv) seems to privilege State interests in a manner we feel is not reflected in the statute. Specifically, we have concerns that requiring stakeholders to choose measures that “represent minimal additional burden to States” would create substantial barriers to adding new measures to the set or requiring states to report measures by specific populations or demographic characteristics. We could not find this language reflected in the statute, which describes a “consensus” process among various stakeholders, and we feel including it in the regulation would upset the balance of stakeholder voices by privileging State interests.⁹ While the “burden” of reporting will always be a consideration, beneficiaries also face substantial burdens if measures do not reflect their priorities and needs, especially if there is not adequate oversight to enforce care quality across the system. It is due to repeated complaints about administrative burden that we do not yet have regular reporting of health disparities in our Medicaid quality system. We urge CMS to delete this unjustified language in § 437.10(a)(2) and add a cross-reference emphasizing that consideration of health equity should be a priority in the development and advancement of core measures.

RECOMMENDATIONS:

Amend § 437.10(a)(2)(i) as follows:

- (i) Establish priorities for the development and advancement of the Core Sets ***consistent with 437.1(c) [as amended above]***

Amend § 437.10(a)(iv) as follows:

- (iv) Ensure that all measures included in the Core Sets reflect an evidence-based process including testing, validation, and consensus among interested parties; are meaningful for States; ***and*** are feasible for State-level and/or Health Home program level reporting as appropriate.; ~~and represent minimal additional burden to States.~~

We also identified what appears to be an oversight in the types of “interested parties” that CMS must consult as it updates each core measure set.¹⁰ The proposed regulation requires consultation with pediatricians, children’s hospitals, national consumer groups that represent children and national organizations representing purchasers of children’s health

⁹ 42 U.S.C. § 1320b-9a(b)(5).

¹⁰ 87 Fed. Reg. 51328 [proposed 42 CFR § 437.10(e)].



care, among others.¹¹ This parallels language from § 1139A(b)(3), but is specific to the Child Core Set.¹²

However, proposed § 437.10 creates standards for the Adult and Health Home Core Sets in addition to the Child Core Measure Set. Logically, the “interested parties” the Secretary must consult for the Adult Core Set should reflect organizations and providers appropriate for the **adult** Medicaid population just as interested parties for the Child Core Set reflect organizations appropriate for children and adolescents. The statute establishing the process for the Adult Core Set instructs the Secretary to create an Adult Medicaid Quality Measurement Program “in the same manner as the Secretary did for the pediatric quality measures program under section 1139A(b).”¹³ This does not mean the stakeholders must be identical but rather the process must be parallel.

As written, the proposed regulation does not directly require the Secretary to consult with national organizations that represent adults as part of the process to update the Adult Core Set. But it does require consultation with national organizations representing children for the Adult Core Set. We do not believe this was CMS’s (or Congress’) intent. The Supreme Court has found that “No rule of [statutory] construction necessitates our acceptance of an interpretation resulting in patently absurd consequences.”¹⁴

The regulation should identify interested parties appropriate to the populations covered by each measure set. We offer recommended language to accomplish this statutory requirement below.

RECOMMENDATION: Reorganize, renumber and amend § 437.10(e) as follows:

(e) For purposes of paragraph (a)(2) of this section, the Secretary must consult with interested parties as described in this paragraph to include the following:

- (1) States;
- (2) Voluntary consensus standards setting organizations and other organizations involved in the advancement of evidence-based measures of health care;
- (3) Dental professionals, including pediatric dental professionals;
- (4) National organizations representing consumers and ***purchasers of health care, including, for consultations related to pediatric measures,*** purchasers of children’s health care;

¹¹ *Id.*

¹² 42 U.S.C. § 1320b-9a(b)(3).

¹³ *Id.*

¹⁴ *United States v. Brown*, 333 U.S. 18, 27 (1948).



- (5) National organizations and individuals with expertise in health quality measurement ***including, for consultations related to pediatric measures, pediatric health quality measurement;***
- (6) ***Other health care providers, as appropriate for the population being measured, including:***
- (i) Health care providers that furnish primary health care to ***individuals, children, and families who live in urban and rural medically underserved communities or who are member of distinct population sub-groups at heightened risk for poor health outcomes;***
 - (ii) ***For consultations related to pediatric quality measures, pediatricians, children’s hospitals, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children and adolescents, particularly children with special physical, mental, and developmental health care needs;***
 - (iii) ***For consultations related to adult quality measures, primary care physicians, hospitals, and other primary and specialized health care professionals (including members of the allied health professions) who specialize in the care and treatment of adults, particularly adults with disabilities and adults with behavioral health and other chronic conditions.***
- (7) National organizations representing ***the beneficiaries being measured, including:***
- (i) ***For consultations related to pediatric quality measures, national organizations representing children and/or adolescents, including children with disabilities and children with chronic conditions;***
 - (ii) ***For consultations related to adult quality measures, national organizations representing adults, including adults with disabilities and adults with chronic conditions and behavioral health conditions;***
 - (iii) ***For consultations related to health home measures, organizations representing the populations covered by the health home state plan option;***
- (8) With respect only to guidance on the Health Home Core Sets, providers of health home services under sections 1945 and 1945A of the Act; ***and***
- (9) Such other interested parties as the Secretary may determine appropriate.

B. Population-Level Reporting

Standardized quality measures across the Medicaid program are critical to ensuring high-quality care for recipients. To accomplish this goal, this proposed rule mandates the inclusion of measure data on specific populations historically excluded from reporting. Specifically, the rule would require the Secretary to annually define measures states must report for specific populations, including at least the population dually-enrolled in Medicare and Medicaid, people receiving services through specific delivery systems, and people receiving services in different types of healthcare settings or provider-types, such as Federally Qualified Health Centers and other safety-net providers. We strongly support this proposed provision as it could greatly enhance the specificity and comprehensiveness of Medicaid quality reporting.

Including the 12.3 million persons eligible for both Medicare and Medicaid in Core Set reporting will advance state-based efforts to identify beneficiaries' needs and develop complementary strategies to improve their health outcomes.¹⁵ This group accounts for a much larger share of Medicaid spending than its share of the Medicaid population and generally has significantly higher health needs. More granular analysis of quality measures is especially important for the dually eligible population, as unique needs stemming from the demographic diversity of dually eligible beneficiaries and poor coordination between the Medicare and Medicaid programs puts them at increased risk of poor health and utilization of high-cost services.

In a September 2021 analysis of HEDIS measures for persons enrolled in Medicare Advantage (MA) Plans, persons dually eligible for Medicare and Medicaid faced substantial, “widespread” disparities in clinical care with “worse results,” and they “often received worse clinical care” than Medicare-only MA enrollees.¹⁶ The largest disparities were in the HEDIS measures of follow-up after hospitalization for mental illness and potentially harmful drug disease interactions. Better reporting of the Medicaid Core sets will help reveal the full scope of these disparities and inform better care coordination for people who are dually eligible.

¹⁵ CMS, MMCO, *Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019* (2020), <https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf>.

¹⁶ CMS Off. of Minority Health, *Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for a Low-Income Subsidy*, vii-viii (Sept. 2021), <https://www.cms.gov/files/document/2021-delis-national-disparities-stratified-report.pdf>.



We strongly support the analysis of quality measures inclusive of dually eligible individuals by key demographic factors, such as race and ethnicity, as well as by delivery systems and provider types to allow for the deployment of targeted strategies that better account for the needs of these beneficiaries. Compared to Medicare-only recipients, persons dually eligible are more likely to be female, Black or Latino, experience higher rates of chronic disease, utilize high-cost emergency services, and be limited in English proficiency.¹⁷ We also suggest expanded data disaggregation, beyond the scope of this proposed rule, of Medicare and Medicaid data by demographic characteristics and delivery systems to better understand utilization, access, and quality for beneficiaries.

As indicated in this proposed rule, states face barriers such as “additional work to obtain and analyze Medicare utilization data” that can hinder reporting compliance.¹⁸ Ongoing challenges surrounding states’ ability to link and analyze Medicare and Medicaid data currently prevent robust analysis of service quality. Insufficient data coordination makes designing appropriate services for beneficiaries harder, often resulting in poorer quality of care. States must develop the capacity to link Medicare and Medicaid data, not solely for the core measures outlined in this proposed rule, but to further integration efforts for dually eligible individuals. But they cannot do this alone. CMS should encourage states to develop the data infrastructure needed to link Medicare and Medicaid datasets promptly.

States need CMS to provide technical assistance to help states develop the data infrastructure needed to link Medicare and Medicaid datasets. The suggestions outlined in the proposed rule, including one-on-one sessions, written guidance, measure specification, coding assistance, site visits, webinars, learning collaboratives, and shared best practices from states, can help ensure state compliance with reporting requirements. We also encourage CMS to explore technological interventions, such as open-source tools, that could be implemented at the federal and state levels to facilitate the integration of Medicare and Medicaid databases.

To make such reporting possible for the numerous important demographic categories, standards for data collection and expectations of complete records must improve. HHS should promptly review and update the 2011 Data Standards and ensure comparability of data across states. We recommend that HHS broaden the race and ethnicity options to include language to describe MENA and Latine populations; add standards related to sexual orientation, gender identity, and variations in sex characteristics (SOGISC); and

¹⁷ ATI Advisory and Arnold Ventures, *A Profile of Medicare-Medicaid Dual Beneficiaries* (2022), <https://atiadvisory.com/wp-content/uploads/2022/06/A-Profile-of-Medicare-Medicaid-Dual-Beneficiaries.pdf>.

¹⁸ 87 Fed. Reg. 51317 [proposed 42 C.F.R. § 437.10(b)].



ensure there are corresponding T-MSIS fields for this demographic data. Data on people with disabilities should be based on a more standardized, comprehensive set of disability questions asked on applications and renewals. This would allow for better tracking of health disparities among the adult Medicaid population with disabilities. The current minimum standard for identifying Medicaid beneficiaries with disabilities is limited because it centers on eligibility groups. Millions of people with disabilities become Medicaid eligible through categories that are not specific to disability, such as expansion adults and parents and caretaker groups.¹⁹

CMS should evolve away from the current limited method for defining the Medicaid population with disabilities, because it limits our ability to understand how health disparities manifest across the whole scope and types of people with disabilities. With better demographic data on disability, stratified reporting of Core quality measures by disability could highlight groups that face higher barriers to accessing health care. This could start with the inclusion of more comprehensive disability questions on Medicaid applications and redeterminations.²⁰

We strongly recommend that CMS collect demographic information of program participants on program applications. For example, CMS should require state Medicaid agencies to collect demographic data of applicants on the Medicaid and CHIP application. Collecting this information at the application stage allows information to be stored in the applicant's file and shared with relevant entities, such as insurers, providers, and facilities, for planning and accessibility purposes.²¹ Having demographic information at the outset facilitates interactions with individuals who may need language access services or other

¹⁹ David Machledt, Nat. Health Law Prog., *The Faces of Medicaid Expansion: Filling Gaps in Coverage* (2017), <https://healthlaw.org/resource/the-faces-of-medicaid-expansion-filling-gaps-in-coverage/>.

²⁰ Many groups recommend starting with the functional disability questions on the American Community Survey, but we would recommend at least adding a question on speech-related disabilities, which are not covered under the current ACS questions.

²¹ See Ruben D. Vega Perez et al., *Improving Patient Race and Ethnicity Data Capture to Address Health Disparities: A Case Study from a Large Urban Health System*, 14 CUREUS 1 (2022) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8815799/>; Colin Planalp, State Health Access Data Assistance Ctr. (SHADAC), *New York State of Health Pilot Yields Increased Race and Ethnicity Question Response Rates*, State Health & Value Strategies (Sept. 9, 2021), <https://www.shvs.org/new-york-state-of-health-pilot-yields-increased-race-and-ethnicity-question-response-rates/>; Elizabeth Lunkenen and Emily Zylla, *Exploring Strategies to Fill Gaps in Medicaid Race, Ethnicity, and Language Data*, State Health Access Data Assistance Ctr. (SHADAC) (2020), <https://www.shvs.org/exploring-strategies-to-fill-gaps-in-medicaid-race-ethnicity-and-language-data/>.

communication services, and it removes the need for entities further down the line to ask for duplicative information. It also allows programs to track disparities not just in access to enrolled services, but in eligibility and access to programs generally.

C. Length of Phase-in for Reporting by Population Groups

This proposed rule allows five years for states to build their capacity to report measures separately for key populations and demographic characteristics, and grants considerable discretion to the Secretary to define the scope of those required measures. We realize that it will take time to implement some of these required changes and bring states up to speed, but we also recognize the urgency of the ongoing disproportionate and frankly discriminatory impacts of our health care system. To direct resources effectively to inform actions to alleviate health inequities and track their progress, we need much better and more comprehensive quality reporting. Yet it has been over 12 years since the passage of the ACA § 4302 that – had it been funded – would have required reporting of health disparities in Medicaid at the state and federal level. In the intervening years, progress has come in baby steps. The time for gradual phase-ins should be long past.

Given the general 90% federal match for upgrading systems to do this kind of stratified reporting, we feel that it would not be overly burdensome to establish a tighter window for phasing in reporting on health disparities. NCQA, which is also implementing required demographic level reporting for HEDIS measures, planned on a three-year phase-in for a total of 15 measures.²² We think a comparable period would appropriately match the technical challenges with the urgent need to use valid health disparities data to inform interventions that strengthen health equity.

§ 437.15. Annual Reporting on the Child, Adult, and Health Home Core Sets

We strongly support frequent public reporting of core measures, at least annually. We encourage the Secretary to publish standardized core measures with appropriate national benchmarks that permit comparisons across states and over time. While the child and adult Medicaid populations differ substantially across states due to varying eligibility thresholds, it is important to establish expected standards. Better demographic reporting may also make it easier to make cross-state comparisons that account for coverage differences.

²² Margaret E. O’Kane et al., *The Future of HEDIS*[®], 26 (June 22, 2021), <https://www.ncqa.org/wp-content/uploads/2021/06/2021-0622-Future-of-HEDIS.pdf>.



As CMS improves demographic data collection through T-MSIS and its ability to report some of the Core measures for the states, we also encourage focused reports that highlight population disparities, including analysis of disparities for beneficiaries with intersectional identities who may face increased health inequities, such as Black women with disabilities or Latine transgender men. Most current reporting on disparities is limited to single factors that do not account for compound discrimination. Getting a better understanding of how multiple identities affect access to and quality of health care could inform better ways to direct resources to improve Medicaid and CHIP programs.

We also urge CMS to reconsider its policy to limit public reporting of voluntary Core measures to measures that are reported by at least 25 states.²³ This arbitrary threshold reduces transparency and may also create barriers to more widespread adoption of some quality measures. We recommend a much lower threshold for public reporting, perhaps 10 states. The statute only requires that core measures are “in use,” not that they are used by a majority of the states.²⁴

Finally, we recommend that CMS streamline the language in § 437.15(a). The statute refers to voluntary reporting on the initial Adult Core Set, and it requires reporting on behavioral health measures in the Adult Core Set by 2024.²⁵ It does not, however, preclude CMS from using its authority under § 1902(a)(4) to require reporting on other Adult Core measures, or other quality measures generally. For example, we believe that at a future date, CMS could and should require reporting on specific measures in the HCBS Core Measure Set or on adult vaccinations and preventive care using its authority under § 1902(a)(4) and (6).

We urge CMS to clarify its authority to require states to report specific Core quality measures independent of specific Congressional mandates for required reporting, such as the two 2018 laws. The proposed language at § 437.15(a)(i) and (iii) would classify all non-behavioral health adult core measures as “voluntary” and appears to limit CMS’s ability to require adult measures beyond those related to behavioral health. The fix is concise and clear. Specifically, § 437.15(a)(i) needs only a cross reference to capture all the Secretary-defined mandatory measures pursuant to § 437.10(b)(1)(iii). The direct references to the Child Core Set and behavioral health measures in the Adult Core Set in that clause are wholly redundant. Our recommended change would set the 2018 required reporting as a federal floor and retain CMS’s authority to require additional measures if necessary to ensure the proper and efficient administration of the Medicaid program.

²³ 87 Fed. Reg. 51308.

²⁴ 42 U.S.C. § 1320b-9a(a)(2).

²⁵ 42 U.S.C. § 1320b-9b(b)(3).



RECOMMENDATION: Delete the following phrase from § 437.15(a)(i):

- (i) Must report annually, by December 31st, on all measures ~~on the Child Core Set and the behavioral health measures in the Adult Core Set that are~~ identified by the Secretary pursuant to § 437.10(b)(1)(iii) of this subpart.

§ 437.20 State Plan Requirements

While this section requires attestations that generally authorize CMS to withhold Medicaid funding from states that do not comply with quality reporting requirements, CMS should develop clearer guidance outlining specific, graduated enforcement mechanisms for states that remain out of compliance.²⁶ In other areas of oversight, compliance has been delayed due to a lack of clear consequences, and the urgency of these needed oversight mechanisms demands prompt state action.

Conclusion

As quality measurement grows increasingly important with ongoing shifts toward capitated managed care and value-based payment initiatives linked to performance metrics, CMS must ensure that Core Measure Sets fairly represent marginalized groups. With this proposed rule, CMS has taken important steps to both expand the scope of quality measurement to encompass smaller, often overlooked groups of Medicaid and CHIP beneficiaries and codified the process to identify and track key health disparities for specific demographics.

CMS thus taken critical steps to renew focus on identifying health disparities and advancing health equity. We feel even more urgency is needed. In guidance and implementation, we urge CMS to reinforce the need to rapidly develop better stratified quality reporting at multiple levels for different populations. These steps, if quickly implemented, are needed to inform future targeted interventions to improve health equity.

In the meantime, we hope CMS accepts our recommendations to implement these changes in Medicaid and CHIP quality reporting.

Our comments include citations to supporting research and documents for the benefit of HHS in reviewing our comments. We direct HHS to each of the items cited and made available to the agency through citations and active hyperlinks, and we request that HHS

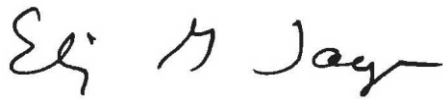
²⁶ 87 Fed. Reg. 51319 [Discussion explaining CMS's authority to withhold Medicaid funding for noncompliance].



consider these, along with the full text of our comments, part of the formal administrative record on this proposed rule.

If you have any questions, please contact David Machledt, National Health Law Program (machledt@healthlaw.org).

Sincerely,

A handwritten signature in black ink that reads "Elizabeth Taylor". The signature is written in a cursive style with a long horizontal flourish at the end.

Elizabeth Taylor
Executive Director
National Health Law Program

