

October 21, 2022

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

Attention: CMS-2440-P

Dear Administrator Brooks-LaSure:

On behalf of Nemours Children's Health, thank you for your consideration of our response to the August 2022 proposed rule for Mandatory Core Set Reporting for Medicaid and the Children's Health Insurance Program (CHIP).

ABOUT NEMOURS CHILDREN'S HEALTH

Nemours Children's Health is one of the nation's largest multistate pediatric health systems, which includes two free-standing children's hospitals and a network of more than 70 primary and specialty care practices. Nemours Children's seeks to transform the health of children by adopting a holistic health model that utilizes innovative, safe, and high-quality care, while also caring for the health of the whole child beyond medicine. Nemours Children's also powers the world's most-visited website for information on the health of children and teens, [Nemours KidsHealth.org](https://www.nemourskidshealth.org).

The Nemours Foundation, established through the legacy and philanthropy of Alfred I. duPont, provides pediatric clinical care, research, education, advocacy, and prevention programs to the children, families and communities it serves.

EXECUTIVE SUMMARY

Nemours Children's commends the Centers for Medicare and Medicaid Services (CMS) for its efforts to improve the quality of care provided to children under Medicaid and the Children's Health Insurance Program (CHIP). We strongly support standardized measurement across Medicaid and CHIP as well as mandatory reporting of the child core set. Measuring against these quality indicators will help to ensure that resource allocation from the federal, state, and institutional levels is based on data to achieve the most impact. Moreover, we are encouraged by the proposed rule's focus on measure stratification, which is critical to identifying and eliminating health disparities. We are supportive of the overall intent of the proposed rule and believe it will help to encourage innovation in pediatric quality measurement while enhancing transparency and accountability.

Nemours appreciates the opportunity to provide comments in response to this important proposed regulation. As outlined in our recommendations below, we urge CMS to:

- Provide further guidance on measure specification for the child core set to ensure stakeholder alignment and engagement.

- Allow more time for the field to achieve readiness to report child core set measures, including development, implementation and adoption efforts.
- Consider a longer phase-in period of more than five years for the stratification of child core set measures that are not currently widely reported.
- Consider additional guidance for standardizing definitions for strata such as race and ethnicity, rural, urban, and disability.
- Standardize and combine Medicaid and CHIP child core set reporting for states with separate CHIP programs and include pregnant individuals in child core set mandatory reporting.

RECOMMENDATIONS

Measure Specification and Reporting

Once again, Nemours applauds and recognizes the significance of mandatory reporting for the child core set for Medicaid and CHIP. Mandatory reporting of the measures will positively impact healthcare delivery for children for years to come. Additionally, it will generate more accountability and transparency and allow targeted resource allocation to close disparity gaps. Consistent, mandatory reporting across all states will allow the healthcare sector (including federal agencies) to monitor and improve state-level performance and measure the overall national quality of healthcare for children.

Medicaid and CHIP quality metrics pull substantially from administrative and claims data submitted by providers to the Medicaid agency or Managed Care Organization (MCO) providing coverage for services. Since child core set measures have never been mandatory, many states have not measured against or reported on these measures. Subsequently, children's hospitals have little to no experience understanding and applying measure specifications for some of the child core set measures. Further, some of the measures are not mature enough for electronic reporting (eCQMs) via the electronic health record (EHR), as vendors often have a lag or limited data set. To be successful with administrative data measurement, organizations will need to invest in additional technologies to review gaps in performance and focus on improvement. While we agree this is a positive step forward, allowing time for operational readiness is critical to gain adoption and the overall outcomes desired with this shift.

While this rule does not contemplate specific measures or measure specifications, we urge CMS to provide more guidance, either before or as part of the annual guidance outlined in the proposed rule, regarding measure specifications to ensure success. Further, we believe that additional time is needed for health systems, vendors, accreditation bodies, payers and states to achieve readiness to report child core set measure data. Currently, there is no alignment within and across sectors, including vendors, payers, states and accreditation bodies on measure reporting for the child core set. Without alignment, there is likely to be duplication among reporting programs and requirements, resulting in significant costs and burden to providers. Moreover, there needs to be ample time to achieve clinical buy-in for all measures in the core set as the "standard of care" so that implementation and adoption of measure reporting will move forward successfully.

Measure Stratification

We are concerned with the proposed five year phased-in approach for stratifying new measures in the child core set. Children's hospitals that have never reported on many of the measures in the child core set will need time to understand measure specifications and work with vendors to ensure their EHR technology is engineered to collect and report this data. Further, uptake and implementation of new measures require unique skill sets across technical, clinical and business teams to test and

validate measure performance. Finally, children's hospitals will have to establish and implement new, multi-disciplinary clinical workflows to ensure data is collected accurately and consistently. For these reasons, early stratification of newer measures could erode the quality of data reported to CMS and cause undue burden on providers. However, within the child core set, some measures offer an opportunity to make early progress on stratification.

For new measures in the child core set, we recommend that CMS extend the timeframe for stratification beyond five years to ensure that providers and other stakeholder groups will have ample time to achieve readiness to report stratified data on new measures. Additionally, we recommend that CMS target widely reported measures, such as body mass index (BMI) percentile, immunization rates, and/or lead screening for stratification in the first five 5 years. We suggest that the Secretary consult with key stakeholders in addition to states - including children's health systems, EHR vendors, and Health IT stakeholders - on which measures to stratify each year and by what factors.

For future measure stratification, it will be important to clearly define the parameters of commonly but inconsistently used strata. Whereas quality measures are driven by national consensus, socio-demographic definitions differ by state and/or institution. Standard definitions are needed to ensure data is captured consistently and accurately while maintaining flexibility for further granulation to accommodate community context. It is also important that the stratified data reported by MCOs to the state should be consistent with the stratified data collected by providers. We strongly encourage CMS to consider further defining the following factors for stratification:

- Regarding race and ethnicity, we note that these terms refer to social constructs that are not biologically defined. Yet, we recognize the importance of identifying disparities among subpopulations. We also note that there is much ambiguity in an individual's race and ethnicity. To assist in data collection and reporting, we propose that CMS create a mutually exclusive stratum for race/ethnicity and combine Hispanic ethnicity as well as a few other categories. For example:
 - o Hispanic or Latino
 - o American Indian or Alaska Native, non-Hispanic
 - o Asian, non-Hispanic
 - o Black or African American, non-Hispanic
 - o Native Hawaiian or Other Pacific Islander, non-Hispanic
 - o White, non-Hispanic
 - o Some other race, non-Hispanic
 - o Two or more races, non-Hispanic
 - o Missing/Not Reported
- Regarding rural and urban status, there are currently no standard definitions or parameters for these terms across federal agencies or in the field. It is important to clearly define these terms. If the goal is to capture differences in access to services and amenities across geographies, the definitions selected to distinguish rural, suburban, ex-urban, and urban settings need to incorporate specific measures of resources and access, which also vary across areas separate from urbanicity. CMS needs to clearly define the logic model in capturing information on population density and urbanicity as it impacts health outcomes or processes of care for these strata to be useful in identifying and addressing unmet healthcare needs or disparities in health and health care across geographies and populations.

- Regarding disability status, we are unclear what, if any, claims data would represent disability status, making reporting a challenge. Further, disability status can be subjective from a patient's point of view. We recommend that CMS provide more context around this term and consider delaying its inclusion for stratified measures until a standardized definition is adopted.

Consistent Measures Across Programs

As suggested in the proposed rule, Nemours supports aligning measure reporting across Medicaid and CHIP, and recommends that for states with separate CHIP programs, CMS combine Medicaid and CHIP child core set reporting. Harmonizing measures in the child core set for Medicaid and separate CHIP programs will help to account for children who transition between programs. Additionally, we support the inclusion of pregnant individuals in child core set mandatory reporting. Reporting this small sub-group of CHIP beneficiaries could illuminate additional disparities in prenatal care, particularly around access and prevention. However, we recognize that most pregnant individuals receive care outside of pediatric health systems and therefore urge CMS to consider comments from other providers and health systems that offer obstetric care regarding this topic.

CONCLUSION

Nemours strongly supports mandatory reporting of the child core set, which will help identify and address disparities and provide more transparency and accountability in health care. Thank you for your consideration of our recommendations. Please do not hesitate to reach out to Daniella Gratale, Director of the Office of Child Health Policy and Advocacy, at Daniella.Gratale@nemours.org with questions or requests for additional information.

Sincerely,



Kara Odom Walker, MD, MPH, MSHS
Executive Vice President
Chief Population Health Officer
Nemours Children's Health