2023 Public Comments and Responses

Integrated Healthcare ASSOCIATION

#	Element Name	Org Type	Support Type	Comment	Response
				AMP Program Updates	
1	Alignment approach for the AMP measure set	PO	Support with Modifications	[We support] IHA's recommendation to align with [DHCS] and QTI program measures. We believe the strategy makes sense from both a sustainability and programs simplification standpoint. However, given the many changes this shift in strategy will represent, we ask IHA to intentionally strive for measure stability following this large change to the measure set. We would also like to point out a trend we are seeing with many plans significantly reducing program incentive maximums at $1 pmpm or $10 pmpy. We are concerned this trend makes it difficult for organizations to continue to keep the focus on the success of quality measures give the resources needed to promote that success and continuously improve on processes.	Thank you for your comment. IHA acknowledges the importance of year-to-year measure set stability, balanced with the need for an aligned, relevant, and parsimonious measure set. IHA and its committees will explore tactics to balance these needs in the years following MY 2024, given that this year includes a large number of changes. IHA also acknowledges variations in how plans implement the AMP value-based incentive design, and how some of these variations lead to reduced payment amounts. The new proposed incentive design in development by IHA and its committees is designed to focus on shared industry priorities to encourage standardization, with the intention of positively impacting payment amounts.
2	Alignment approach for the AMP measure set	Public Purchasers	Support with Modifications	We are very supportive of IHA's transition to a narrower AMP measure list for Commercial HMOs (and other product lines), in order to reduce provider reporting burden and to align with the DMHC's health equity and quality measure set and the major public purchasers' quality measure sets, as well as to drive improvement by focusing efforts. While we do support alignment across AMP product lines as much as possible, we also feel that product specific alignment with relevant external measurement programs is appropriate. In other words, providers in Commercial HMOs and Medi-Cal should not be held accountable to measures that are a part of CMS Star Ratings program (and not a part of the DMHC health equity and quality measure set and/or purchasers' quality measure sets) because that dilutes the focus for those providers and negates the aims of the narrower list. Finally, we do see value in retaining certain measures as 'report only' or 'informational only' because these measures can serve as bellwethers and tell us if the needs of a population are shifting.	Thank you for your comment and your support for the transition to a narrower AMP measure set. The IHA committees have carefully considered which measures are used for information only and which are used for accountability in the Final MY 2024 AMP Measure Set, with a focus on keeping the most aligned and impactful measures for accountability.
3	Alignment approach for the AMP measure set	PO	Do Not Support	On Depression screening and follow up for adolescents and adults (DSF-E): We do not support the proposed depression follow-up measure for adolescents and adults. This measure imposes a significant administrative burden due to the fragmented nature of behavioral health care, which is often treated as a separate benefit in commercial populations. This fragmentation leads to a lack of information for provider organizations. While health plans may have some insight, claims data is not easily accessible to provider organizations and frontline providers. Furthermore, requiring providers to demonstrate appropriate follow-up with HCPCS codes places a substantial time burden on already-burnt-out providers. The coding requirements, as currently written, do not provide an option to exclude patients based on clinical judgment. While we acknowledge the clinical importance of depression care screening and follow-up, the current format of this measure is not feasible for implementation at this time.	Thank you for your comment. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) is a voluntary testing measure in AMP for MY 2023. Following DSF-E's testing year, IHA will assess performance and anticipate performance results will identify and highlight any data gaps with PO self-reporting; however, we expect any such challenge will uniformly affect all organizations. As with all testing measures in AMP, IHA will carefully consider testing results as well as participants' experiences of data reporting before including DSF-E for any AMP accountability uses for POs such as incentive payments or awards. It is an AMP program policy to align with measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. Your feedback on this measure was shared with the measure steward, NCQA, who had the following response: >> The DSF-E measure was developed as an electronic clinical data systems (ECDS) measure for HEDIS, which supports the use of multiple data sources, including case management, health information exchange (HIE)/clinical registries, claims and electronic health record data. This particular measure shows high-utilization based on Electronic Health Record (EHR), Case Management data, and Health Information Exchange (HIE) data, with minimal data based on claims. The measure does require both a medical benefit to be eligible for denominator criteria; however, benefits are considered at the global level, thus any medical benefit would qualify members for the measure. We are continuing to analyze and collect feedback for any data challenges regarding the measure that will help improve submissions and reporting. At this time, there are no exclusions in place for clinical judgment. If you have recommendations that would help mitigate your concerns, or additional questions or comments, please feel free to forward to the NCQA AMP team at amp@nca.org to share with the measure team.

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4	Alignment approach for the AMP measure set	PO	Support with Modifications	We support a more aligned focused measures set. If you go to the limited / focused measure set it will be very important the measures are set up so the different stewards measures are all in sync with same value sets, med dictionaries, and specs (exclusions etc).	Thank you for your comment. NCQA is the steward for all measures in the core clinical quality measure set aligned with statewide health equity initiatives. IHA will continue to work with the stewards of all measures in AMP to maximize consistency as needed.
5	Alignment approach for the AMP measure set	HP	Support with Modifications	1. What feedback do you have on the direction of alignment with other external measure sets (DHCS MCAS MPL measures, CMS Star Ratings, and HEDIS Commercial Health Plan Accreditation) depicted in Table 3? Of note, the PGC did not reach consensus to retire the HEDIS accreditation measures in the bottom row of Table 3. >> [We agree] that the HEDIS accreditation measures should not be retired. 2. Is it more important for AMP to align measures internally across AMP product lines, or focus on product line-specific alignment with relevant external measurement programs? E.g., should providers be held accountable for CMS Star Ratings measures equally across all AMP product lines, or just for the AMP Medicare Advantage population? >> Focus on product line-specific alignment. Commercial HMO should not take into account CMS Star Ratings measures. 3. The Draft MY 2024 AMP Measure Set includes moving many measures to “Information Only” in AMP Commercial HMO and AMP Medi-Cal Managed Care. Does your organization prioritize “Information Only” measures differently than measures used for AMP accountability uses? Is there value to using “Information Only” measures in AMP, or should these measures be retired? >> Information Only measures are not used by [HP] and do not add value - recommend retirement for simplification purposes.	Thank you for your comment. The selected HEDIS accreditation measures (Appropriate Treatment for Pharyngitis (CWP), Avoidance of Antibiotic Treatment for Bronchitis (AAB) and Blood Pressure for Patients With Diabetes (BPD)) have been recommended for retirement based on their lack of alignment with other priority measure sets, concerns about validity of the measure to capture quality of care versus data quality (CWP, AAB), and redundancy of the measure with other high-priority measures (BPD). Thank you for your input on product-specific alignment and "Information Only" measures. Your feedback will help shape the AMP measure set in future years.
6	Alignment approach for the AMP measure set	HP	Support with Modifications	Re: What feedback do you have on the direction of alignment with other external measure sets (DHCS MCAS MPL measures, CMS Star Ratings, and HEDIS Commercial Health Plan Accreditation) depicted in Table 3? Of note, the PGC did not reach consensus to retire the HEDIS accreditation measures in the bottom row of Table 3. >> Upon reviewing Table 3 on pg.4 of the 2023 IHA Call for Public Comment documents, [we have] concerns with the proposed alignment of the Cervical Cancer Screening (CCS), Chlamydia Screening (CHL) and Prenatal Immunization Status (PRS-E) measures to the DHCS-MPL measure set. [Our] Commercial California plans currently follow NCQA HEDIS guidance for collection and reporting of rates for these measures. [Our clinical quality team] has concerns that using Medicaid benchmarking for these measures, while still maintaining accountability, will place Commercial health plans at a disadvantage in meeting quality performance metrics. Re: Is it more important for AMP to align measures internally across AMP product lines, or focus on product line-specific alignment with relevant external measurement programs? E.g., should providers be held accountable for CMS Star Ratings measures equally across all AMP product lines, or just for the AMP Medicare Advantage population. >> [We support] product line-specific alignment with relevant external measurements. Re: The Draft MY 2024 AMP Measure Set includes moving many measures to “Information Only” in AMP Commercial HMO and AMP Medi-Cal Managed Care. Does your organization prioritize “information only” measures differently than measures used for AMP accountability uses? Is there value to using “information only” measures in AMP, or should these measures be retired? >> [HP] follows NCQA HEDIS guidance for reporting quality metrics, and does not prioritize “information only” measures. However, [we have] no issues with leaving these measures in place.	Thank you for your comment. To clarify, AMP technical specifications for Cervical Cancer Screening (CCS), Chlamydia Screening in Women (CHL), and Prenatal Immunization Status (PRS-E) will continue to align with the measure steward NCQA and HEDIS. The TMC has recommended these measures' continued use in AMP based on their inclusion in DHCS MCAS MPL and applicability across commercial and Medi-Cal product lines. These measures would not be held to Medicaid benchmarks for accountability in Commercial HMO. In the current AMP value-based incentive design for Commercial HMOs, all clinical quality measures are compared against AMP Commercial benchmarks. The potential updated design would use whole number targets based on NCQA Quality Compass Commercial All LOB percentiles.

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7	Alignment approach for the AMP measure set	PO	Support with Modifications	Yes, agree with this alignment and agree with retiring Appropriate Treatment for Pharyngitis (CWP), Avoidance of Antibiotic Treatment for Bronchitis (AAB) and Blood Pressure for Patients With Diabetes (BPD). It is more important to align on AMP product line. [We prioritize] Information Only measures lower than measures used for AMP accountability unless there is potential to add them back as accountability measures. The proposed clinical quality measures are mostly aligned with our organization's priority measures. The one measure that does not currently align is the Depression Screening and Follow up for Adolescents – we would recommend this measure be removed. To provide more consistency, we would also recommend removing the Glycemic Status Assessment for Patients With Diabetes, 9% (GSD) measure.	Thank you for your comment. Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) and Glycemic Status Assessment for Patients With Diabetes, 9% (GSD) are considered high-priority measures due to their inclusion in the DMHC HEQ set.
8	Simplifying the AMP value-based incentive design	PO	Support with Modifications	[We are] strongly concerned about the move to the full-risk incentive design only as it does not have an attainment pathway, which we feel is critical in any incentive design. First, the improvement on just trend is difficult for PO's that do not have full-risk and would cause shared-risk PO's to be at a disadvantage. Further, we believe an attainment pathway for high performance is necessary for continued engagement of high-performing groups. Removing an attainment pathway and thresholds is going the wrong direction. We do support quality and patient satisfaction being the basis of payment and ARU no longer being the core basis of payment.	Thank you for your comment. To clarify, the proposed new incentive design model being developed by IHA staff and committees will reward attainment. The new model resembles the existing full risk incentive design in that it proposes to use clinical quality and patient experience performance as the basis of payment. The intention is for the new model to maintain both improvement and achievement (i.e., attainment) opportunities for POs and to ensure that high-performing POs are commensurately rewarded for achieving excellent performance, especially considering the investments in resources required to deliver high-quality care. Cost trend would likely only be used for additional upside shared savings potential for shared risk POs. IHA staff and committees will take your feedback into consideration as we continue to refine the model.
9	Simplifying the AMP value-based incentive design	Public Purchasers	Support	We are supportive of the changes that IHA proposes to simplify the incentive program, as well as to place more emphasis on clinical quality and patient experience measures, rather than appropriate resource use measures. We also think it makes sense to focus on clinical quality measures that are a part of the draft AMP measure set for accountability (rather than information only).	Thank you for your support.
10	Simplifying the AMP value-based incentive design	HP	Support with Modifications	How can the AMP incentive design best support your organization's efforts to meet regulatory and purchaser performance standards? >> Outline clear pathway to success and easy to understand performance reports by PO. This way a PO can see their performance on the scorecard.	Thank you for your comment. As part of IHA's efforts to reimagine the AMP value-based incentive design beginning in MY 2024, we intend to explore new approaches and tools for providing greater transparency into how the performance-based payments are calculated. Please reach out to IHA staff if you have any specific recommendations for what the future incentive design deliverables should look like.

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11	Simplifying the AMP value-based incentive design	HP	Support with Modifications	Re: Treatment of different risk types - moving away from the shared risk model for shared risk POs and instead of moving to a single model for both shared risk and full risk POs drawing from the current full risk model. >>This would be a significant shift in the model and moves away from paying for outcome performance for clinical efficiency. How does clinical quality performance translate to dollar value savings for the health plan vs. clinical efficiency outcomes? Re: Basis for incentive payments - Incentives being calculated on individual clinical quality and patient experience measures adjusted based on performance on cost? Is there concern about no longer using Appropriate Resource Use measures as basis for payment? Quality measures will be double weighted if included in multiple regulatory and purchaser programs. >>The shift seems to get away from the purchasers' focus on both cost and quality with a greater emphasis on quality. Re: Composite scores - Today, IHA uses a Quality Composite Score as a performance gate for payment. What concerns (if any) does [your organization] have on no longer calculating a QCS composite score? >>There should still be some performance gate based on total quality, not just meeting a select few measures. Re: Payment Targets - Today, payment is tied to percentile targets (75th, 90th percentiles). What concerns (if any) does [your organization] have on having payments tied to a continuous scale of performance to recognize POs who achieve beyond targets? New targets to be based on national standards and would be stable for 3 years. >>The shift seems to get away from the purchasers' focus on both cost and quality with a greater emphasis on quality. Are purchasers supportive of paying for quality and without regard for cost? Re: What feedback do you have on increasing the emphasis on clinical quality and patient experience in the AMP incentive design, and decreasing emphasis on appropriate resource use? Does this approach align with your organizations performance priorities? >>A balanced approach continues to be the most prudent to align with the performance priorities of purchasers. The structure of the Full risk PO arrangements incentivize to manage total cost and therefore changing to a more heavily weighted model paying for quality. Re: When considering individual performance on clinical quality measures as a basis for payment, are the measures included for accountability in the Draft MY 2024 AMP Measure Set (marked with an "X as opposed to "Info Only") the appropriate measures to use? Would you remove or add any clinical quality measures for use in payments? >>[We follow] NCQA methodology for collection of all HEDIS measures designated for accountability, and agrees with this selection. TCOC, HALOS both make sense. GRX is a layup for all groups and seems less relevant now. [We have] no further recommendations on adding/removing any other clinical quality measures. Re: How can the AMP incentive design best support your organizations efforts to meet regulatory and purchaser performance standards? >>AMP is not supporting meeting any regulatory requirements at this time but for a couple of purchasers that require health plan participation, it is meeting those requirements.	Thank you for your comments and feedback. The proposal to use clinical quality and patient experience performance as the basis of incentive payments was informed by the performance requirements instituted by large public purchasers, including Covered California and DHCS, as well as DMHC, which all heavily emphasize clinical quality performance with potential financial risk to health plans. IHA and its committees sought to amplify the industry's focus on these targets through updates to the AMP incentive design, including the measures used as the basis for payments. Your question about the application of a performance gate based on overall quality performance is one of the topics being discussed and determined by the IHA committees. Although we are elevating how clinical quality and patient experience performance are used in the incentive design, Total Cost of Care (TCOC) remains an essential priority of the healthcare value equation. We recognize that investments in clinical quality performance may not generate immediate dollar value savings that can be realized by both health plans and POs. To address this concern, IHA is working with its committees to agree upon the appropriate level of funding and strategies for financial sustainability for AMP incentive opportunities over time. Furthermore, IHA and its committees are continuing discussions on mechanisms for promoting cost containment, including through performance gates, incentive amount adjusters, and/or opportunities for TCOC-based shared savings. Modifications based on PO risk arrangement and a glidepath for two-sided risk are also potential areas for further exploration.
12	Simplifying the AMP value-based incentive design	PO	Support	*No additional comment.*	Thank you for your support.

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13	Simplifying the AMP value-based incentive design	PO	Do Not Support	We are not in favor of eliminating ARU measures or the clinical quality and PE measures to be double weighted. Removing the ARU measures does not support our organization's systemwide performance improvement plan for the upcoming years. Our organization focus is increasingly looking at our quality care as a whole from ambulatory care through hospital inpt care and after/home care.	Thank you for your comment. Offering AMP value-based incentive payments based on clinical quality and patient experience measures intends to serve two purposes: (1) greater alignment of the incentive design with regulator and purchaser programs, which heavily emphasize and may attribute financial risk to clinical quality and patient experience performance; and (2) greater actionability for POs, many of which have voiced that their organizations have greater control in enhancing value-based care through quality-based approaches. IHA and its committees appreciate your organization's perspective and recognize that the ARU measures potentially offer value as indicators of both quality and cost performance to AMP program participants. We will discuss your feedback as we refine the future incentive design model, in particular, the potential to include ARU measures in the incentive design as markers of quality.
				Measure Retirements	
14	Ambulatory Care: ED visits (AMB)	PO	Support	*No additional comment.*	Thank you for your support.
15	Ambulatory Care: ED visits (AMB)	HP	Support	*No additional comment.*	Thank you for your support.
16	Appropriate Treatement for Pharyngitis (CWP)	PO	Support	*No additional comment.*	Thank you for your support.
17	Appropriate Treatement for Pharyngitis (CWP)	HP	Support	*No additional comment.*	Thank you for your support.
18	Appropriate Treatment for Pharyngitis (CWP)	PO	Support	*No additional comment.*	Thank you for your support.
19	Appropriate Treatment for Pharyngitis (CWP)	HP	Do Not Support	Prefer to keep CWP, AAB and BPD as inform only measures	Thank you for your comment. Appropriate Treatment for Pharyngitis (CWP), Avoidance of Antibiotic Treatment for Bronchitis (AAB) and Blood Pressure for Patients With Diabetes (BPD) have been recommended for retirement based on their lack of alignment with other high-priority measure sets, concerns about validity of the measure to capture quality of care versus data quality (CWP, AAB), and redundancy of the measure with other high-priority measures (BPD).
20	Avoidance of Antibiotic Treatment for Bronchitis (AAB)	PO	Support	We support the retirement of the HEDIS commercial plan accreditation measures.	Thank you for your support.
21	Avoidance of Antibiotic Treatment for Bronchitis (AAB)	PO	Support	*No additional comment.*	Thank you for your support.
22	Avoidance of Antibiotic Treatment for Bronchitis (AAB)	PO	Support	We support the removal of the resp measures AAB and CWP	Thank you for your support.
23	Avoidance of Antibiotic Treatment for Bronchitis (AAB)	HP	Support	*No additional comment.*	Thank you for your support.
24	Blood Pressure for Patients With Diabetes (BPD)	PO	Support	We support the retirement of the HEDIS commercial plan accreditation measures.	Thank you for your support.

#	Element Name	Org Type	Support Type	Comment	Response
25	Blood Pressure for Patients With Diabetes (BPD)	PO	Support	*No additional comment.*	Thank you for your support.
26	Blood Pressure for Patients With Diabetes (BPD)	PO	Support	*No additional comment.*	Thank you for your support.
27	Blood Pressure for Patients With Diabetes (BPD)	HP	Do Not Support	[We are] in support of retiring all of the measures with the exception of Blood pressure for patients with Diabetes (BPD). [We have] concerns with retiring the Blood pressure for patients with Diabetes (BPD) measure, as this counts towards NCQA Health Plan Ratings (HPR) for Commercial health plans.	Thank you for your comment. Blood Pressure for Patients With Diabetes (BPD) has been recommended for retirement based on its lack of alignment with other priority measure sets, as well as its redundancy with the high-priority measure Controlling High Blood Pressure (CBP).
28	Cervical Cancer Overscreening (CCO)	PO	Support	*No additional comment.*	Thank you for your support.
29	Cervical Cancer Overscreening (CCO)	PO	Support	*No additional comment.*	Thank you for your support.
30	Cervical Cancer Overscreening (CCO)	HP	Support	*No additional comment.*	Thank you for your support.
31	Concurrent Use of Opioids and Benzodiazepines (COB)	Public Purchasers	Support	Support retirement of two opioid related measures (Concurrent use of opioids and benzodiazepines (COB) and Opioids at high dosage (HDO)) due to clinical concerns around unintended consequences, as well as the testing of Pharmacotherapy for opioid use disorder (POD), which also aligns with CCA, CalPERS and DHCS' measures. Support retirement of appropriate respiratory treatment measures due to the ability to "game" the measures so that they are not reflective of intended or actual ccscare. Support retirement of Blood Pressure for patients with Diabetes (BPD) due to eligible population overlap with Controlling High Blood Pressure (CBP), a component of the DMHC list and the 3 large public purchasers' programs. Support the retirement of the rest of the highlighted measures (CMS e-measures, cervical cancer over screening, and ED visits and Inpatient Utilization)	Thank you for your support.
32	Concurrent Use of Opioids and Benzodiazepines (COB)	PO	Support	*No additional comment.*	Thank you for your support.
33	Concurrent Use of Opioids and Benzodiazepines (COB)	PO	Support	*No additional comment.*	Thank you for your support.
34	Concurrent Use of Opioids and Benzodiazepines (COB)	HP	Support	*No additional comment.*	Thank you for your support.
35	Concurrent Use of Opioids and Benzodiazepines (COB)	HP	Do Not Support	Keep as Inform Only until MY2026 (when POD measure benchmarks are available).	Thank you for your comment. Concurrent Use of Opioids and Benzodiazepines (COB) has been recommended for retirement based on its lack of alignment with priority measure sets, as well as concerns raised about adverse impacts on patient care.
36	e-Measure: Controlling High Blood Pressure (ECBP)	PO	Support	*No additional comment.*	Thank you for your support.

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37	e-Measure: Controlling High Blood Pressure (ECBP)	PO	Support	*No additional comment.*	Thank you for your support.
38	e-Measure: Controlling High Blood Pressure (ECBP)	HP	Support	*No additional comment.*	Thank you for your support.
39	e-Measure: Screening for Depression & Follow Up Plan (PREV-12)	PO	Support	*No additional comment.*	Thank you for your support.
40	e-Measure: Screening for Depression & Follow Up Plan (PREV-12)	PO	Support	*No additional comment.*	Thank you for your support.
41	e-Measure: Screening for Depression & Follow Up Plan (PREV-12)	HP	Support	*No additional comment.*	Thank you for your support.
42	Inpatient Utilization: General Hospital/Acute care (IPU)	PO	Support	*No additional comment.*	Thank you for your support.
43	Inpatient Utilization: General Hospital/Acute care (IPU)	PO	Support	*No additional comment.*	Thank you for your support.
44	Inpatient Utilization: General Hospital/Acute care (IPU)	HP	Support	*No additional comment.*	Thank you for your support.
45	Use of Opioids at High Dosage (HDO)	PO	Support	*No additional comment.*	Thank you for your support.
46	Use of Opioids at High Dosage (HDO)	PO	Support	*No additional comment.*	Thank you for your support.
47	Use of Opioids at High Dosage (HDO)	HP	Support	*No additional comment.*	Thank you for your support.

#	Element Name	Org Type	Support Type	Comment	Response
				Testing Measures	
48	Pharmacotherapy for Opioid Use Disorder (POD)	PO	Do Not Support	On Pharmacotherapy for Opioid Use Disorder (POD): We do not support the proposed measure for pharmacotherapy for opioid use disorder (POD). Patients diagnosed with opioid use disorder are often seen in behavioral health carve-outs, which are frequently not integrated into large healthcare systems. The lack of fully integrated electronic health systems across physical and behavioral health entities would result in a significant administrative burden, particularly for gathering multiple data points over time. Holding medical groups responsible for reporting the metric as currently written would be exceedingly challenging.	Thank you for your comment. As with all testing measures in AMP, IHA will carefully consider testing results for POD as well as participants' experiences of data reporting before including the measure for any AMP accountability uses for POs such as incentive payments or awards. Your comment was reviewed by the measure steward, NCQA, who provided the following response: We are aware of this challenge and are working to better understand the related implications and plausible solutions. The intent of the measure is to ensure continuity of pharmacotherapy after initiation of OUD medication, and is aimed to encourage the necessary sharing and integration of data to support the oversight and monitoring of this process. The measure does require both a medical and pharmacy benefit to be eligible for denominator criteria; however, benefits are considered at the global level, thus any medical and any pharmacy benefit would qualify members for the measure. The challenges around data collection for the measure are likely experienced across organizations with behavioral health carve-outs, so we are continuing to collect feedback and identify any updates to the measure that would help improve reporting. If you have recommendations that would help mitigate your concerns, please feel free to forward them to the NCQA AMP team to share with the measure team. The AMP program will align the specification based on any future revisions to the HEDIS measure.
49	Pharmacotherapy for Opioid Use Disorder (POD)	PO	Support with Modifications	We support IHA introducing POD in testing mode, and hope that it will be kept as a testing measure while we advocate to NCQA for improvements to the technical specifications to the measure. [Our HP] strongly supports opioid use disorder (OUD) prevention and treatment. A critical aspect to treating OUD is access to medications for OUD (MOUD). Tracking access to medication and adherence to long-term medication use are worthy clinical quality measures. However, we have multiple concerns about the POD measure as currently designed and therefore encourage NCQA to modify the measure's specifications to better align with the measure's intent. It does not accurately correlate with long term adherence past 90 days, as the 8-day gap is more likely to be due to tapering rather than true non-compliance. As such, the measure actually penalizes programs that offer more flexibility for patients past 90 days. It will ultimately disincentivize promoting higher levels of access to buprenorphine (in Emergency Departments, or for harm reduction, for example) because those patients are far less likely to remain adherent on buprenorphine, even though studies have shown benefit for exposing these patients to MOUD. (https://www.annemergmed.com/article/S0196-0644(22)00065-8/fulltext#) We recommend that NCQA either increase the allowed gap to much longer than 8 days, OR as a better means of assessing adherence, use "percent days covered" as a measure, that does not depend on any specific gap in medication coverage. Eliminate from the denominator any MOUD starts occurring in the ED or inpatient setting, including inpatient medication dispensing events. This is not to state that medications started in the ED or inpatient setting should NOT be continued for 180 days, or that maintenance treatment is not appropriate; however, it is clear from data that pressing forward to increase buprenorphine starts in the ER will bring down average POD rates and it would be counterproductive to have a clinically important treatment strategy be discouraged because of how it might impact a quality measure. NCQA should consider including a negative medication history of 365 days so that a patient may only trigger the POD measure once per calendar year. NCQA could also consider creating a 'fill rate' for receiving drug therapy similar to other adherence metrics (SPD, SPC).	Thank you for your comment and feedback. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. Your comments were forwarded to the NCQA measure team, and are being reviewed for the next re-evaluation of the measure. The AMP program will align specifications based on any future revisions to the HEDIS measures.

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50	Pharmacotherapy for Opioid Use Disorder (POD)	PO	Support with Modifications	We would need better data exchange of our pharmacy claims data from health plans for us to support this measure.	Thank you for your comment. As with all testing measures in AMP, IHA will carefully consider testing results for POD as well as participants' experiences of data reporting before including the measure for any AMP accountability uses for POs such as incentive payments or awards.
51	Pharmacotherapy for Opioid Use Disorder (POD)	HP	Support	[We are] currently collecting data for both RDM adn POD in accordance with NCQA guidelines.	Thank you for your support.
52	Race/Ethnicity Diversity of Membership (RDM)	Public Purchasers	Support	We provide comments on both POD and RDM - We support the testing of POD as it aligns with the three public purchasers. While we had discussion around the R/E Diversity of Membership measure, we feel we can support it as a testing measure to help verify the R/E stratification of the measures on the DMHC HEC list.	Thank you for your support.
53	Race/Ethnicity Diversity of Membership (RDM)	PO	Support with Modifications	On Race & Ethnicity Diversity of Membership (RDM): We support the collection and understanding RDM data in healthcare organizations and health plans, but need better insight on how this measure will be used in the future for performance metric purposes. Populations with very small race-ethnicity minority groups may face challenges with performance measures, especially those aimed at promoting health equity. This could inadvertently lead to underreporting of RDM demographic data and potentially result in a change in distribution of resources in more homogenous populations. Given the diversity of populations, this measure would benefit from reporting at the health plan level.	Thank you for your comment. The intention of testing Race & Ethnicity Diversity of Membership (RDM) in AMP is to understand overall race and ethnicity data completeness at the provider level and to use results to help address data gaps. Review of testing results will assess completeness in both provider and plan reporting. Pending testing results, RDM may be included as a pay-for-reporting measure in AMP, with incentives or recognition tied to completeness. IHA acknowledges that small race-ethnicity minority group sizes impact the validity of comparisons in performance measure results between race-ethnicity groups at the provider level. In MY 2022, AMP began collecting performance measures stratified by race and ethnicity in alignment with HEDIS, and will collect more stratified HEDIS measures in upcoming years. IHA is working with its committees to develop strategies for reporting stratified results and, if appropriate, including them in AMP acountability uses, given challenges related to small group sizes.
54	Race/Ethnicity Diversity of Membership (RDM)	PO	Do Not Support	We do not support this measure in addition to the race and ethnicity strats added to most of the individual measures. Either this measure or the strats to the measures-- not both. Would recommend removing the strats from each individual measure and just have the one race and ethnicity measure.	Thank you for your comment. Testing Race & Ethnicity Diversity of Membership (RDM) and stratifying individual measures by race and ethnicity serve closely related but different purposes in AMP. The intention of testing RDM is to understand overall race and ethnicity data completeness for an entire patient population. The intention of stratifying individual measures by race and ethnicity is to understand disparities in the quality of care received. Pending testing results, RDM results may be used to help validate race and ethnicity stratifications in individual measures, and may also be used as a pay-for-reporting measure in the AMP value-based incentive design.
55	Race/Ethnicity Diversity of Membership (RDM)	HP	Support	[We are] currently collecting data for both RDM and POD in accordance with NCQA guidelines. However, data for the RDM measure is limited. Medicare Advantage plans receive race/ethnicity data from CMS, and Medicaid plans obtain this data from CMS and state data. In contrast, Commercial plans are dependent upon employer group enrollment data or other sources, where collection of the data is required.	Thank you for your support. The intention of testing Race & Ethnicity Diversity of Membership (RDM) in AMP is to understand overall race and ethnicity data completeness at the provider level and to use results to help address data gaps. IHA anticipates that participants will continue to face data completeness challenges, and that use of RDM will help to address these challenges in the coming years.
				Measures Adopted for Accountability	
56	Child and Adolescent Well-Care Visits (WCV)	PO	Support	We support the measures adopted for accountability and believe they are the right measures.	Thank you for your support.
57	Child and Adolescent Well-Care Visits (WCV)	Public Purchasers	Support with Modifications	On behalf of [public purchaser], we absolutely see the value in these 4 (or 3, since Child and Adolescent Well Visits is on the new proposed AMP measure list given alignment with the [DMHC] HEC) additional measures, though it does increase the proposed Commercial HMO list from 12 to 15, which is significant. Given this, we suggest adding Cervical Cancer Screening and Chlamydia Screening to the 'Information Only' list to maintain the alignment and narrow focus of the list. We fully support the addition of Child and Adolescent Well Child Visits and Prenatal Immunization Status to the accountability list.	Thank you for your comment. To clarify, only the overall indicator for Prenatal Immunization Status (PRS-E) will be used for accountability in AMP, similar to how other immunization measures are used for accountability in AMP. Thus, the PRS-E overall indicator will be the only new non-DMHC HEC measure proposed to be added for accountability in AMP Commercial HMO in MY 2024, minimizing the impact to measure set parsimony.

#	Element Name	Org Type	Support Type	Comment	Response
58	Child and Adolescent Well-Care Visits (WCV)	PO	Support	*No additional comment.*	Thank you for your support.
59	Child and Adolescent Well-Care Visits (WCV)	HP	Support	[We have] no concerns with these measures being used as proposed, as applicable by line of business.	Thank you for your support.
60	Kidney Health Evaluation for Patients With Diabetes (KED)	PO	Support	*No additional comment.*	Thank you for your support.
61	Kidney Health Evaluation for Patients With Diabetes (KED)	PO	Support	*No additional comment.*	Thank you for your support.
62	Kidney Health Evaluation for Patients With Diabetes (KED)	HP	Support	[We have] no concerns with these measures being used as proposed, as applicable by line of business.	Thank you for your support.
63	Prenatal Immunization Status (PRS-E)	PO	Support	*No additional comment.*	Thank you for your support.
64	Prenatal Immunization Status (PRS-E)	HP	Support	[We have] no concerns with these measures being used as proposed, as applicable by line of business.	Thank you for your support.
				Measures Moving to "Information Only"	
65	Eye Exam for Patients With Diabetes (EED)	PO	Do Not Support	[We are] concerned about the potential removal of DM eye exam and KED from the commercial accountability set. These measures are clinically important early screening measures that prevent complications from diabetes. Behavioral patterns show a de-emphasis on measures and decline in performance when removed from the measure set, which will adversely impact patients.	Thank you for your comment. Your feedback was discussed at the November 13 TMC meeting. TMC members agreed with the value of maintaining EED for accountability, based on the measure's clinical importance, its role in public reporting of AMP results through the Center for Data Insights and Innovation (CDII), and concerns about impacts to data collection and submission if the measure is moved to "information only". As such, the TMC recommended that EED be maintained for accountability in AMP Commercial HMO and AMP Medi-Cal Managed Care in the Final MY 2024 AMP Measure Set.
66	Eye Exam for Patients With Diabetes (EED)	PO	Do Not Support	We are concerned that the OPA Commercial Report Cards Diabetes category would only include HBD (Hemoglobin A1c Control for Patients with Diabetes) if EED and KED are moved to 'info only'. In addition to glycemic control, attention to the appropriate monitoring and treatment of microvascular complications of diabetes, including nephropathy and ophthalmopathy, is a central part of diabetes care. Removing the EED and KED measures from the Commercial HMO accountability also serves no purpose in reducing measurement burden, since these measures are already reported for Medicare Advantage.	Thank you for your comment. Your feedback was discussed at the November 13 TMC meeting. TMC members agreed with the value of maintaining EED for accountability, based on the measure's clinical importance, its role in public reporting of AMP results through the Center for Data Insights and Innovation (CDII), and concerns about impacts to data collection and submission if the measure is moved to "information only". As such, the TMC recommended that EED be maintained for accountability in AMP Commercial HMO and AMP Medi-Cal Managed Care in the Final MY 2024 AMP Measure Set.
67	Eye Exam for Patients With Diabetes (EED)	PO	Support	We would support if still can report in order to track our performance in a well vetted system/program.	Thank you for your support.
68	Eye Exam for Patients With Diabetes (EED)	HP	Support	[We have] no concerns with moving these measures to “information only”.	Thank you for your support.

#	Element Name	Org Type	Support Type	Comment	Response
69	Kidney Health Evaluation for Patients With Diabetes (KED)	PO	Do Not Support	[We are] concerned about the potential removal of DM eye exam and KED from the commercial accountability set. These measures are clinically important early screening measures that prevent complications from diabetes. Behavioral patterns show a de-emphasis on measures and decline in performance when removed from the measure set, which will adversely impact patients.	Thank you for your comment. Your feedback was discussed at the November 13 TMC meeting. TMC members agreed with the value of maintaining KED for accountability, based on the measure's clinical importance, its potential role in public reporting of AMP results through the Center for Data Insights and Innovation (CDII), and concerns about impacts to data collection and submission if the measure is moved to "information only". As such, the TMC recommended that KED be maintained for accountability in AMP Commercial HMO and AMP Medi-Cal Managed Care in the Final MY 2024 AMP Measure Set.
70	Kidney Health Evaluation for Patients With Diabetes (KED)	PO	Do Not Support	We are concerned that the OPA Commercial Report Cards Diabetes category would only include HBD (Hemoglobin A1c Control for Patients with Diabetes) if EED and KED are moved to 'info only'. In addition to glycemic control, attention to the appropriate monitoring and treatment of microvascular complications of diabetes, including nephropathy and ophthalmopathy, is a central part of diabetes care. Removing the EED and KED measures from the Commercial HMO accountability also serves no purpose in reducing measurement burden, since these measures are already reported for Medicare Advantage.	Thank you for your comment. Your feedback was discussed at the November 13 TMC meeting. TMC members agreed with the value of maintaining KED for accountability, based on the measure's clinical importance, its potential role in public reporting of AMP results through the Center for Data Insights and Innovation (CDII), and concerns about impacts to data collection and submission if the measure is moved to "information only". As such, the TMC recommended that KED be maintained for accountability in AMP Commercial HMO and AMP Medi-Cal Managed Care in the Final MY 2024 AMP Measure Set.
71	Kidney Health Evaluation for Patients With Diabetes (KED)	PO	Support	We would support if still can report in order to track our performance in a well vetted system/program.	Thank you for your support.
72	Kidney Health Evaluation for Patients With Diabetes (KED)	HP	Support	[We have] no concerns with moving these measures to “information only”.	Thank you for your support.
73	Proportion of Days Covered by Medications: Diabetes-All Class (PDCD)	HP	Support	[We have] no concerns with moving these measures to “information only”.	Thank you for your support.
74	Proportion of Days Covered by Medications: Diabetes-All Class (PDCD)	PO	Support	*No additional comment.*	Thank you for your support.
75	Proportion of Days Covered by Medications: Renin Angiotensin System Antagonists (PDCA)	HP	Support	[We have] no concerns with moving these measures to “information only”.	Thank you for your support.
76	Proportion of Days Covered by Medications: Renin Angiotensin System Antagonists (PDCA)	PO	Support	*No additional comment.*	Thank you for your support.
77	Proportion of Days Covered by Medications: Statins (PDCS)	HP	Support	[We have] no concerns with moving these measures to “information only”.	Thank you for your support.

#	Element Name	Org Type	Support Type	Comment	Response
78	Proportion of Days Covered by Medications: Statins (PDCS)	PO	Support	*No additional comment.*	Thank you for your support.
79	Statin Therapy for Patients With Cardiovascular Disease (SPC)	PO	Support	*No additional comment.*	Thank you for your support.
80	Statin Therapy for Patients With Cardiovascular Disease (SPC)	HP	Support	[We have] no concerns with moving these measures to “information only”.	Thank you for your support.
81	Statin Therapy for Patients With Diabetes (SPD)	PO	Support	*No additional comment.*	Thank you for your support.
82	Statin Therapy for Patients With Diabetes (SPD)	HP	Support	[We have] no concerns with moving these measures to “information only”.	Thank you for your support.
				Measure Specification Updates	
83	Colorectal Cancer Screening (COL) update to an ECDS measure (COL-E)	HP	Support	*No additional comment.*	Thank you for your support.
84	Race and ethnicity stratification (RES) for additional measures	PO	Support	[We agree] on the measures in consideration for retirement, and support the move toward DEI measures for the testing measures.	Thank you for your support.
85	Race and ethnicity stratification (RES) for additional measures	PO	Do Not Support	We do not support continuing to add this strat to the individual measures - just have the one measure - such as the test measure. It is making the reporting of the individual measures very difficult / messy / too easy for errors to occur.	Thank you for your comment. Race and ethnicity stratification (RES) has been added to AMP measures in alignment with HEDIS in an effort to understand health disparities. Reporting on RES is a key dimension of aligning AMP with statewide health equity intiatives. While the testing measure Race & Ethnicity Diversity of Membership (RDM) is intended to provide an overall view of data completeness, only stratification on individual measures can provide information on disparities in the quality of care received. Thank you for sharing your organization's experience reporting RES. IHA acknowledges that RES reporting has introduced new challenges in the data submission process and is exploring how to simplify submission in future years.
86	Race and ethnicity stratification (RES) for additional measures	HP	Support	[We] will continue to support race and ethnicity stratification of HEDIS measures, based on NCQA guidance for Commercial plans.	Thank you for your support.
87	Specification updates to align with measure steward	PO	Support with Modifications	Please remove GLP-1s and SGLT-2s from the classes of medications used to identify patients with diabetes. These drugs now have clinical indications for use other than diabetes. Notably they are prescribed for weight loss and for patients with Heart Failure with Reduced Ejection Fraction. Including these drugs places patients in the denominator for diabetes when they don’t have diabetes.	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. For the HEDIS diabetes measures (GSD, EED, KED, and SPD), the denominator was revised in MY 2024 so the pharmacy approach looks to see if at least one diabetes medication was dispensed and there is at least one diagnosis of diabetes (in any setting). The revised method mitigates the inclusion of individuals who are taking medications for reasons other than diabetes (e.g., weight loss).

#	Element Name	Org Type	Support Type	Comment	Response
88	Specification updates to align with measure steward	PO	Support with Modifications	For the diabetes quality metrics, patients who don't have a diagnosis of diabetes but are on SGLT2 inhibitors and GLP 1 agonist medications are included in the denominator. But many of these patients use these medications for kidney and cardiovascular conditions or weight loss. Therefore it is not clinically indicated or cost effective to have them all get yearly dilated eye exams, urine microalbumin creatinine ratios, be prescribed a statin, or some of the other diabetic quality measures. Please do not include patients in the diabetic denominator who are on SGLT2/GLP1 medications that do not have a diagnosis of diabetes.	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. For the HEDIS diabetes measures (GSD, EED, KED, and SPD), the denominator was revised in MY 2024 so the pharmacy approach looks to see if at least one diabetes medication was dispensed and there is at least one diagnosis of diabetes (in any setting). The revised method mitigates the inclusion of individuals who are taking medications for reasons other than diabetes (e.g., weight loss).
89	Specification updates to align with measure steward	PO	Do Not Support	Use of glp1 drugs should not be used as an identifier for diabetes because these meds are so often used for another purpose alone, weight control. Further, folks who use these drugs for diabetes will always be identified by other means	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. For the HEDIS diabetes measures (GSD, EED, KED, and SPD), the denominator was revised in MY 2024 so the pharmacy approach looks to see if at least one diabetes medication was dispensed and there is at least one diagnosis of diabetes (in any setting). The revised method mitigates the inclusion of individuals who are taking medications for reasons other than diabetes (e.g., weight loss).
90	Specification updates to align with measure steward	PO	Support	*No additional comment.*	Thank you for your support.
91	Specification updates to align with measure steward	HP	Support	*No additional comment.*	Thank you for your support.
92	Update to specifications for Encounter Format (ENFMT) (beginning in MY 2023)	HP	Support	*No additional comment.*	Thank you for your support.
				All Other Comments	
93	All other comments	PO	Support with Modifications	According to UpToDate, "Certain skeletal locations, including the skull, cervical spine, hands, feet, and ankles, are not associated with fragility fractures. Stress fractures are also not considered fragility fractures, as they are due to repetitive injury." Please remove these types of fractures from the denominator.	Thank you for your comment. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts. The intent of the current Fractures Value Set specified for the Osteoporosis Management in Women Who Had a Fracture (OMW) measure is to identify fractures that, given the age of the population, could potentially warrant further assessment or treatment for osteoporosis. While it may be difficult to specifically identify if a fracture of the cervical spine, hands, feet, and ankles is the result of trauma or fragility, there still may be underlying osteoporosis that could be detected through screening. The measure does exclude some fractures that are almost always associated with trauma, including skull, face, finger and toe fractures. These value sets have been reviewed by multiple NCQA expert panels, which include geriatricians and other clinical experts.
94	All other comments	PO	Support with Modifications	On Breast Cancer Screening measure: We support the changes in the breast cancer screening measure, and would also like to inquire: What is the evidence of about breast cancer risk in individuals undergoing hormonal treatment for gender reassignment? The measure revisions now appropriately includes the provisions for breast cancer screening for females assigned at birth who are either transgender males or cisgender females. The evidence and risk of breast cancer risk for populations undergoing hormonal treatment for gender reassignment is not discussed in the proposed measure changes. We encourage addressing this in future iterations of the breast cancer screening measure.	Thank you for your comment. While we recognize some clinical guidelines include cancer screening recommendations for individuals receiving estrogen therapy, there is not agreement on the appropriate length of time for estrogen therapy exposure and recommendations are mostly consensus-based or not graded strongly. Therefore, exposure to estrogen therapy is not an inclusion criteria for the HEDIS measure at this time. However, this does not mean such screening is inappropriate, rather that such cases should be determined based on clinician assessment and shared-decision making. NCQA will continue to monitor evidence and guidelines on breast cancer risk for individuals receiving estrogen therapy and consider updates to the measure as needed. For more information on NCQA's experience navigating guidelines for the care of gender-diverse patients and incorporating newer data standards for collecting sex and gender data in the Breast Cancer Screening measure, please see this report: https://www.ncqa.org/wp-content/uploads/Cervical-and-Breast-Cancer-Screening-Evidence-and-Guidelines-to-Support-Inclusive-Quality-Measures.pdf

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95	All other comments	PO	Support with Modifications	BCS-E: After the Task force finalized the change, we would support the age range change in order to keep in line with the task force recommendations. If HEDIS updates their BCS-E measure to start screening at 40 in early 2024 (once the task forces finalized their recommendation). We would recommend not be making the age range change until MY 2025 since the draft specs for MY 2024 are out already. Most vendors (which we are required to use for reporting) are slow to update the specs in their system, therefore it is hard to educate providers/staff to the age change when specs that are used to run reports are still set to the old recommendations.	Thank you for your comment. If the U.S. Preventive Services Task Force (USPSTF) releases its final recommendation before spring 2024, NCQA will seek approval to publish the revised measure in the HEDIS Technical Update, which will apply the changes for MY 2024. If the draft recommendation is not final before spring 2024, NCQA will consider changes to the measure after MY 2024. Your comment was forwarded to the NCQA measure team, and will be reviewed for consideration. It is an AMP program policy to align with the measure steward's specifications whenever possible, to further enable alignment with regional and national performance measurement and benchmarking efforts.