Please note: These comments were submitted electronically via a dashboard function. Because of the preferred submission style, a formal, signed letter from AAP leadership was not included with these comments.

Measure Specific Recommendations and Gaps

- Measures recommended for phased inclusion:
  - Both measures recommended for phased addition to the child core set related to contraceptive access are subject to large variation based on factors not controllable by practitioners, e.g. culture, religious beliefs. MAP noted “potential ethical implications” and “strong agreement that the target rate…would be well below 100%.” The fact that the adjustment factors might be difficult to discern from medical records or claims data would make these measures not just difficult to compute, but also could be misinterpreted by the public. While the AAP supports contraception access for adolescents, as currently written the AAP does not support these measures.
  - “Use of multiple concurrent antipsychotics in children and adolescents”: AAP is concerned about overuse of antipsychotic medications for children/adolescents, and recognizes that overuse is a problem in some regions and populations. Depending on the operational definition, AAP would consider supporting the inclusion of a metric to address this.
  - “Audiological Evaluation No Later Than 3 Months of Age (EHDI-3)” (NQF 1360): AAP supports the addition of this measure
  - “Pediatric All-Condition Readmission Measure” (NQF 2393): AAP supports the addition of this measure

- Gaps
  - AAP agrees with the identification of care coordination as a current gap area for quality measurement, advocates for the endorsement and inclusion of objective care coordination measures. This is a high priority for the AAP, especially as payment and practice models for primary care services evolve.
  - Objective measures related to mental health are also a high priority for the AAP. Care coordination will require a high degree of interaction with behavioral health services, so patient access to and utilization of these services impacts care coordination measures.
  - Overuse/medically unnecessary care is currently under the purview of payers. However, carefully crafted measures for providers could potentially be helpful. Overuse of CT scans is often measured by payers, and sometimes requires prior authorization, so overuse of CT scans may not be a priority starting point. Other issues, such as antibiotic use for hospitalized patients, may have more impact.
  - Use of durable medical equipment (DME) is typically measured by payers as one of the cost items for providers. AAP’s support of additional measures related to this would depend on the operational definitions of those measures. This would not necessarily be a high priority from the AAP’s perspective.
  - Other gap areas identified in this report lack the specificity necessary for the AAP to make concrete recommendations. However, the AAP recognizes the potential for a positive impact on child health of clinically relevant, rigorously developed measures for child abuse/neglect, screening, trauma, sickle cell disease, and other topics outlined in the gap analysis.
Strategic issues

- The AAP anticipates that the MIPS/APM method of reimbursement that Medicare has set in motion will address many of the issues in the alignment discussion. Although not currently directed at pediatrics, we expect that these approaches will spread to private and Medicaid payers to become germane for pediatrics.
- The point that overemphasized alignment could create perseveration on specific measures is correct, but ultimately fails to address the exigency that providers respond to payers’ incentives, and if a particular measure set becomes generally accepted by payers, providers will concentrate efforts in those areas. In a way, that focus is helpful, because providers typically don’t have the resources to “boil the ocean”, but inevitably some issues will be neglected. The AAP will continue to push the important childhood concerns to the public and to payers so that the “orphan” problems aren’t ignored.
- The document notes that states are burdened as new measures become a priority with CMS, but it ignores the same issues for providers. Providers also must get their vendors to make IT system changes to capture new data or modify the collection of existing data, requiring time and funding. The document should reflect the burden on providers for changes in measures, as well as the problems faced by the states.
- The points made in the reproductive health discussion are well-taken, but the text ignores the marked cultural and religious variation regarding the use of contraception in some regions and among some constituencies in the US. MAP needs to include some alternate viewpoints in the discussion to mitigate some of the resistance it will likely face as these measures are developed.
- The problems associated with disparities in care based on socioeconomic factors are being studied by CMS and are the subject of some Medicare Advantage metrics and incentives. The use of these factors for understanding disparities in other populations, e.g. Medicaid and commercial pediatric populations, would greatly benefit child health care. The AAP strongly supports the recommendation that rational subgrouping by socioeconomic or clinical factors should be implemented for many measures of access to and outcomes of care.
- Benchmarks are helpful, and the observation that unrealistically high or low benchmarks are not useful is accurate. However, one way for an organization to deal with these issues is to benchmark internally between business units or use trends to set benchmark performance. In some instances, external benchmark data are not available, and so using internal benchmarks or trends to set goals can provide a useful alternative.