Review of WSCMS – Combined Comments, as of 7.21.2025

Primary Care and Prevention – Children and Adolescents

(1) Audiological Evaluation No Later Than 3 months of age

- Important but could be under a well childcare sub-measure list.
- Remove to keep other pediatric metrics

(2) Child and Adolescent Well-Care Visits (WCV)

- Utilizes Administrative Data only
- Key step in child health.
- Meaningful to Tribal Members
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- High priority measure (Medicare 5 Star, Medicaid, etc)

(3) Childhood Immunization Status (CIS-E) Combo 10

- Utilizes multiple data sources: Administrative, WIIS, and birth certificate
- ECDS may be problematic for some practices, but immunizations are essential.
- Keep as will be deprioritized in new administration
- HRSA required; Very interesting how Oregon is only measuring 'Combo 3' for 2-year-olds instead of the trickier 'Combo 10', but with the state of outbreaks & low vaccine rates we agree this combo-10 is important to keep
- Meaningful to Tribal Members
- Recommended in Bree Collaborative Outpatient Infection Control guidelines
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- While a very important measure, this measure is very difficult to impact in the current environment. Achieving the 75th percentile is very hard to do; if you want it as a core measure set, may consider setting a % increase over the previous year vs. NCQA percentile goal. Recommend making it a voluntary or alternative measure.
- High priority measure (Medicare 5 Star, Medicaid, etc)
- This measure can be difficult to report because of the challenges in receiving data files from the State Immunization Registry that is managed by DOH. The flu indicator poses an additional challenge as not all entities who administer vaccines utilize the registry or report the member data.

(4) Immunizations for Adolescents (IMA)

- HPV vaccination is crucial in protecting people from a variety of cancers.
- Keep as will be deprioritized in new administration
- Meaningful to Tribal Members
- Recommended in Bree Collaborative Outpatient Infection Control guidelines
- While a very important measure, this measure is very difficult to impact in the current environment. Achieving the 75th percentile for it is very hard to do; if you want it as a core measure set, you may

consider setting a % increase over previous year vs. NCQA percentile goal. Recommend making it a voluntary or alternative measure.

- High priority measure (Medicare 5 Star, Medicaid, etc)
- This measure can be difficult to report because of the challenges in receiving data files from the State Immunization Registry that is managed by DOH.
- ECDS measure for 2025

(5) Primary Caries Prevention Offered by a Medical Provider

- This is a great idea but usually only done at some FQHCs and might be a burden to start the practice; also not sure how it is billed (if claims data are used to measure)
- In an integrated clinic, there isn't as much need to have a medical provider do caries prevention. Our dentists do this, and we have a robust hand off/referral process for this. If others want to keep it, recommend making it voluntary or alternative only.
- Ad-hoc reporting via Health Care Authority requests.

(6) Well-Child Visits in the First Thirty Months of Life (W30)

- Recommend this be made a sub-measure of 2 (Child & Adolescent Well Care Visits (WCV)
- Utilizes Administrative Data only
- This is below 25th percentile for both Medicaid & Commercial in WA and is vital for wellness / prevention / developmental outcomes & establishing a trusting provider relationship early on so I question overlooking this even as a core vs sub-measure
- High priority measure (Medicare 5 Star, Medicaid, etc)

(7) Youth Obesity

- BMI is a flawed measure, especially from survey data
- Is DOH still reporting this? Is BMI still a good measure for obesity?
- BMI is now discredited; survey method is not actionable at the practice level; therefore not useful for value based contracting
- Overly stigmatizing, BMI inaccurate
- This type of measure should be tracked separately by HCA from core system/provider outcome measures
- BMI on its own does not accurately reflect the health of an adolescent. I would look to the Youth Risk Behavior Survey data (CDC) instead. Focusing on BMI reinforces stigma rather than identifying effective population health interventions: Obesity Stigma: Important Considerations for Public Health - PMC
- I would recommend using in clinic measured BMI, not self-reported as self-reported tends to underestimate prevalence and surveys have low response rates.
- NA. We use NCQA HEDIS WCC measure that is compatible

(8) Youth Substance Use

- This info is useful at the population level but not actionable at the practice level, therefore not useful for value-based contracting
- This type of measure should be tracked separately by HCA from core system/provider outcome measures
- Meaningful to Tribal Members.
- Is this a DOH survey or one that the clinics administer? Are we talking about CRAFFT or NIDA?
- Youth SUD n/a. We use NCQA HEDIS IET measure that is compatible

Primary Care and Prevention – Adults

(9) Adult Immunization Status (AIS-E)

- Covers influenza below plus other immunizations
- Important for population health and public health, also actionable at the practice level. Could be left in the CMS or put into a sub-measure list for "immunizations". I think some plans use this for VBC.
- Less impactful than kids if need to remove one.
- While a very important measure, this measure is very difficult to impact in the current environment. Achieving the 75th percentile for it is very hard to do; if you want it as a core measure set, may consider setting a % increase over previous year vs. NCQA percentile goal. Recommend making it a voluntary or alternative measure.
- This measure can be difficult to report because of the challenges in receiving data files from the State Immunization Registry that is managed by DOH. Introduction of the COVID indicator in MY2026 poses an additional challenge as not all entities who administer vaccines utilize the registry or report the member data.

(10) Adult Obesity

- BMI is a flawed measure, especially from survey data
- Is BMI still a good measure for obesity?
- BMI is now discredited; survey method is not actionable at the practice level; therefore not useful for value based contracting
- This type of measure should be tracked separately by HCA from core system/provider outcome measures
- BMI on its own does not accurately reflect the health of adults, also body composition changes with older age (over age 65). BMI does not differentiate between muscle and fat. Advantages and Limitations of the Body Mass Index (BMI) to Assess Adult Obesity – PMC
- I would recommend using in clinic measured BMI, not self-reported as self-reported tends to underestimate prevalence and surveys have low response rates.
- NA. NCQA had a similar measure Adult BMI Assessment (ABA) that got retired in MY2020 since all health plans rate was super high – didn't provide any outcome value.

(11) Adult Tobacco Use

- Could also be derived from other sources, e.g., Clinical Data Repository
- This info is useful at the population level but not actionable at the practice level, therefore not useful for value-based contracting
- This type of measure should be tracked separately by HCA from core system/provider outcome measures
- KPNW and KPWA collect tobacco status data internally within the EHR. KPNW has a compatible tobacco measure under the OHA CCO reporting

(12) Breast Cancer Screening (BCS-E)

- Pick one of the cancer screening measures out of 12, 13, and 15
- Cancer screenings should be retained in the WACMS as effective, claims-based metrics that, if acted upon, can save lives.

- HRSA required; Screening rate gains made recently in community & across WA but still behind national average especially in Medicaid population; continues to be largest cancer incidence in women across almost all races/ethnicities
- Curious if the proposed revisions have been adopted, to include women aged 40-49 01.-BCS-E.pdf
- I appreciate that this measure is stratified by gender identity, good to track for our trans and non-binary patients if they are being screened.
- Recommended in Bree Primary Care Guidelines - All people with breast tissue 50-74 years of age have a mammogram to screen for breast cancer biannually.
- Revisions: use the USPSTF breast cancer screening and for transgender men and for transgender women who have had more than 5 years of gender affirming therapy with estradiol on or after 50 years of age.
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- Under the MCO programs, this can be difficult to get accurate as it is a multi-year measure, where patients may have completed this within the lookback period but with another insurer, requiring a manual care gap closure.
- Time in setting up EMR Electronic File Exchange and/or EMT access medical records supplemental data.

(13) Cervical Cancer Screening (CCS)

- Incidence of cervical cancer is lower than breast or colon, so I would prioritize the other two
- Pick one of the cancer screening measures out of 12, 13, and 15
- Cancer screenings should be retained in the WACMS as effective, claims-based metrics that, if acted upon, can save lives.
- HRSA required; risk is lower in comparison to BCS & COL and we perform relatively well here
- Meaningful to Tribal Members
- Recommended in Bree Collaborative Primary care guidelines, stratified by age groups, change definition to "all persons with a cervix"
- Under the MCO programs, this can be difficult to get accurate as it is a multi-year measure, where patients may have completed this within the lookback period but with another insurer, requiring a manual care gap closure.
- ECDS for 2025

(14) Chlamydia Screening (CHL)

- Utilizes Administrative Data only
- Keep as it's the only STD metric.
- WA state only 42nd in chlamydia prevalence, however screening rates below 25th percentile for both Medicaid & Commercial in WA so I see argument for adding at least as sub-measure but we are not suggesting it because it is a very small population
- Meaningful to Tribal Members
- Recommended in Bree Reproductive and Sexual Health guidelines
- Providers have expressed skepticism about the validity of the technical specs for this measure, which makes it challenging to prioritize in contracts.
- Providers are utilizing the CCL measure, prefer that to CHL.

(15) Colorectal Cancer Screening (COL-E)

- Pick one of the cancer screening measures out of 12, 13, and 15
- Cancer screenings should be retained in the WACMS as effective, claims-based metrics that, if acted upon, can save lives. CRC is especially critical at this time.
- HRSA required; WA screening rates low compared to national average, and extremely low in Medicaid population; Continues to be one of the top cancer incidences in WA residents across almost all races/ethnicities as well as one of the top cancer mortality rates
- Meaningful to Tribal Members
- Recommended in Bree Primary Care Guidelines - Patients 50-75 years of age have appropriate screening for colorectal cancer. (Interval dependent upon screening method) Same as Washington State Common Measures Set UDS CMS130v10)
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- Under the MCO programs, this can be difficult to get accurate as it is a multi-year measure, where patients may have completed this within the lookback period but with another insurer, requiring a manual care gap closure.
- QIPs, NCQA Health Plan Rating (HPR), Exchange HPR, and SEBB priority

(16) Contraceptive Care – Most & Moderately Effective Methods

- Let's let this one go.
- Keep as will be deprioritized in new administration
- Recommended in Bree Reproductive and Sexual Health guidelines
- Contraceptive Care: Significant resource burden to produce. OHA had a similar measure in the past that got retired since it didn't provide any outcome value.
- Ad-hoc reporting via Health Care Authority requests.

(17) Influenza Immunization

- Would like to see a different adult vaccine as the potential metric.
- This overlaps with PMCC measure # 3 (Childhood Immunization Status (CIS-E) Combination 10) and measure # 9 (Adult Immunization Status (AIS-E)*) Would provide new information for ages 2-18.
- Recommended in Bree Collaborative Outpatient Infection Control guidelines
- Influenza : NCQA removed this measure from the HOS survey. A similar replacement NCQA measure is AIS-E (Adult Immunization Status)
- Influenza immunizations are challenging for reporting as not all entities who administer vaccines utilize the registry or report the member data.
- Low response rate and challenges with data collection.

(18) Prenatal/Postpartum Care (PPC)

- Applies mostly to OB-GYN practices; seems more like a population- or public-health metric than a VBC metric. Could be placed on a pregnancy/birth sub-list.
- It is important to include one pregnancy metric especially with health disparities present.
- Since behavioral health is the primary cause of maternal mortality in our state, it seems like a missed opportunity not to focus on measures specifically addressing mental health screening (NCQA HEDIS: PND-E Prenatal Depression Screening and Follow Up or PDS-E Postpartum Depression Screening and Follow Up).
- Meaningful to Tribal Members

- Recommendations in Bree perinatal Behavioral health guidelines - Prenatal Care: Timeliness of Prenatal Care/post-partum care
- Current VBP measure in HCA contracts
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)
- This measure requires medical record review which does add significant resources. Statewide guidance and support for providers to reconcile global billing practices with NCQA HEDIS coding would be helpful.
- NCQA HPR, Exchange HPR, and SEBB priority.
- Hybrid measure

(19) Unintended Pregnancies

- More applicable as a public health measure.
- Think most/moderately effective contraception is more actionable than unintended pregnancy

Behavioral Health

General Feedback on this section:

This should also remain a priority topic due to the significant rise in mental illness, substance use disorders, and suicide. In the Native American communities, this is often linked to historical trauma and ongoing disparities. At CHPW, we are trying to promote the following:

- Provide increased awareness and training among staff and providers to understand the unique experiences and needs of Native American communities
- Utilizing telehealth to overcome geographic barriers and provide virtual access to mental health services
- Advocating for Traditional Indian Medicine as a reimbursable service that has documented positive health outcomes

(20) Depression Remission or Response for Adolescents and Adults (DRR-E)

- This is important as it is a mental health outcome measure. It would require EHR data to report and also requires tracking and re-assessing of patients. I don't know if it's required in any VBP arrangements. Either add to CMS or to a sub-list.
- Only remission is measured by HRSA UDS, not this newer complex 3-part measure. This is still very difficult to measure for us and others in our CHC network and with BH shortage & PCP access. We recommend removing this measure until it is improved. It is too onerous.
- Recommended in Bree guidelines for – primary care, BH integration, Suicide Care
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- This has been very hard to move the needle on even with significant resources directed towards it. In addition, we see great fluctuation in this measure as people improve for a while and then get worse again before the 8 month window is over.
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)
- Ability to fully report on this measure for all providers is very challenging. Many providers are not equipped to provide data extracts to all payers to support depression screening rates and scores.
- Providers continue to have challenges coding to claims and pulling data out of their EMRs for supplemental data submission

(21) Depression Screening and Follow Up for Adolescents and Adults (DSF-E)

- Recommend this be made a sub-measure of 20 (Depression Remission or Response for Adolescents and Adults (DRR-E)
- Process measure, therefore easier to produce and more likely to be used than remission or response, in VBP although I don't know to what extent it is used. Put in CMS or a sub-list.
- HRSA required; Prevention & care coordination focused
- Recommended in Bree guidelines 0418 (NQF 0418) for – primary care, diabetes care (DMS-E), Behavioral Health Integration, suicide care
- On Primary Care Measure Set
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)
- Ability to fully report on this measure for all providers is very challenging. Many providers are not equipped to provide data extracts to all payers to support depression screening rates and scores.
- Providers continue to have challenges coding to claims and pulling data out of their EMRs for supplemental data submission.

(22) Follow-Up After ED Visit for Substance Use (FUA)

- Proxy for measuring access and system capacity?
- Utilizes Administrative Data only
- Although important, it requires HIE or other ability to know if there's been an ED visit. Could remove.
- Interesting how Massachusetts does not have any ED/hospital f/u on their core or menu metric sets. We appreciate that transitions of care are an important metric, but we do not think we have systems in place to support this work so recommend not including for providers. We would be fine with a more general ED visit follow up or ED utilization measure, but not MH/SUD specific.
- This is one of the four SDPP metrics for hospitals.
- Bree guidelines – Addiction and Dependence treatment
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- Recommend as voluntary or alternative as this requires systems be in place to receive timely information from the hospitals in order to act appropriately.

(23) Follow-up After Emergency Department Visit for Mental Illness (FUM)

- Proxy for measuring access and system capacity?
- Utilizes Administrative Data only
- Although important, it requires HIE or other ability to know if there's been an ED visit. Could remove.
- We appreciate that transitions of care are an important metric, but we do not think we have systems in place to support this work so recommend not including for providers. We would be fine with a more general ED visit follow up or ED utilization measure, but not MH/SUD specific.
- Bree recommendations – Behavioral Health Integration
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- Recommend as voluntary or alternative as this requires systems be in place to receive timely information from the hospitals in order to act appropriately.

(24) Follow-Up After Hospitalization for Mental Illness (FUH)

- Proxy for measuring access and system capacity?

- Utilizes Administrative Data only
- Let's keep this one as the representative of follow up care for mental health, although it requires HIE or other ability to know there's been a hospitalization
- This is one of the four SDPP metrics for hospitals
- Bree recommendations – Behavioral Health Integration
- Current VBP measure in HCA contracts
- Recommend as voluntary or alternative as this requires systems be in place to receive timely information from the hospitals in order to act appropriately.

(25) Follow-Up Care for Children prescribed ADHD Medication (ADD-E)

- Not sure we need this.
- Keep as will be deprioritized in new administration
- Bree recommendation – Pediatric psychotropic prescribing
- Current VBP measure in HCA contracts
- Both rates for WSCMS and HPR

(26) Mental Health Service Rate (Broad Version)

- Seems important, but as a population based metric. Don't know if it is used by any plan in VBP arrangements. We could remove it, in the interest of paring down the set. It could be put into a sub-list if HCA is required to report on it and would need to be in the WACMS.
- From a high-level view this would be good for health plans/large health system monitoring, not health care providers.
- Very useful for understanding what services are actually available for patients with Medicaid, but only if real action comes from the data
- Bree recommendation – Behavioral Health Integration
- As a general rule we would recommend not WA custom measures and align with standard HEDIS measures to reduce the burden on Providers.
- Health plan is unable to reliably recreate RDA measures
- This is not a meaningful measure, and the data lag makes it difficult to determine which interventions may be impactful in improving BH Care and reducing symptoms.
- This measure is not a measure of quality and is flawed as a measure of access given that it does not account for individuals who recover or have short-term, acute needs.
- Ad-hoc reporting via Health Care Authority requests.

(27) Psychiatric Inpatient Readmissions (30-day)

- Recommend this be made a sub-measure of the All-Cause Readmission measure # 54
- Same as above. More useful at the population level and requires HIE or other ability to know if a person has been hospitalized and readmitted.
- Bree recommendation – Behavioral Health Integration
- Some plans to do not participate in Medicaid LOB.

(28) Substance Use Disorder Treatment Rate

- Seems like a good and actionable one that addresses the state's and individual practices' needs; if only used by HCA then consider putting in a sub-list.
- Add as a plan/system/state monitored but not for providers

- Could be useful for understanding what services are actually available for patients with Medicaid
- Bree guidelines – OUD diagnosis, initiation to treatment, retention to treatment
- This is not a meaningful measure, and the data lag makes it difficult to determine which interventions may be impactful in improving BH Care and reducing symptoms.
- This measure is not a measure of quality and is flawed as a measure of access given that it does not account for individuals who recover or have short-term, acute needs.
- Some plans do not participate in MCD LOB.

Behavioral Health: Opioid Prescribing

General feedback on this section:

Prescription opioids are no longer the primary driver of overdose deaths or the development of opioid use disorder. It is related to its role in appropriate pain management. If there is a desire to have measures for SUD it would be much better served by focusing on metrics focused on screening, SUD diagnosis, and connection to SUD care. (NCQA HEDIS: ASF-E Unhealthy Alcohol Use Screening and Follow-Up or IET Initiation and Engagement of Substance Use Disorder Treatment – the latter is used in the Oregon measure set).

Recommendation: Update section title to: *Provider Prescribing: Opioid Prescribing*

(29) New Opioid Patient Days Supply of First Opioid Prescription

- Supported by data – need to limit patient days' supply at the outset to impact risk of addiction.
- Think should keep one Bree measure
- Good for system & internal monitoring but not contract
- Opioid prescribing is not behavioral health.
- This measure includes compliant prescriptions (pediatrics 3 days or less and adults 7 days or less). Opioids are still appropriate in some cases. A more actionable measure would be to look only at new prescribing above HCA guidelines stratified by age group.
- Recommended in the Bree guidelines - Opioid RX for Older Adults, dental prescribing, Long-term opioid management, low back pain, prescribing metrics, palliative care, perioperative prescribing
- Ad-hoc reporting via Health Care Authority requests.

(30) New Opioid Patients Transitioning to Chronic Opioids

- Good for system & internal monitoring but not contract
- Opioid prescribing is **not** behavioral health
- Recommended in the Bree guidelines - Opioid RX for Older Adults, dental prescribing, Long-term opioid management, low back pain, prescribing metrics, palliative care, perioperative prescribing
- Ad-hoc reporting via Health Care Authority requests.

(31) Patients Prescribed High-Dose Chronic Opioid Therapy

- Suggest making a sub-measure of 32
- Good for system & internal monitoring but not contract
- Opioid prescribing is **not** behavioral health.
- While prescribing of opioids for adults within HCA guidelines has improved, we must acknowledge that patients on long-term opioids present a more complex management issue. This measure encourages the reduction in long-term (>60 days) opioids without a balancing measure for example increased transition to non-opioid pain management or opioid tapering plan.

- Recommended in the Bree guidelines - Opioid RX for Older Adults, dental prescribing, Long-term opioid management, low back pain, prescribing metrics, palliative care, perioperative prescribing
- Ad-hoc reporting via Health Care Authority requests.

(32) Use of Opioids at High Dosage (HDO)

- Utilizes Administrative Data only (Pharmacy)
- Could be added to an opioid sub-measure list.
- Good for system & internal monitoring but not contract
- Opioid prescribing is **not** behavioral health
- Bree recommendations – long term opioid management, low back pain, palliative care, perioperative prescribing

Effective Management Of Chronic Illness In The Outpatient Setting

(33) Asthma Medication Ratio (AMR)

- Utilizes Administrative Data only
- WA Medicaid is performing in 75th-90th national percentile so I'm not sure I see enough reason to continue to keep this, unless it was a monitoring metric
- Recommended in the Bree Pediatric Asthma Report
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- Proposed for NCQA retirement in 2026, once retired, will not continue to track
- Not a good outcome measure. NCQA is planning to retire AMR measure for MY2026. Replacement measure is being proposed – Follow-Up After Acute Care Visits for Asthma (AAF-E)

(34) Blood Pressure Control for Patients with Diabetes (BPD)

- I think there should be one diabetes-related measure, but I'm not sure which one
- Pick one of the outcome measures related to Diabetes management out of 34, 36, 37, and 39
- It should be a subset of CBP.
- Recommended in the Bree Diabetes Care guidelines Blood Pressure Control for Patients with Diabetes (BPD) (HEDIS) NQF# 0061, by race, ethnicity/language, insurance status.
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)
- Hybrid measure

(35) Controlling Blood Pressure (CBP)

- Utilizes Administrative Data only
- Requires either CPT2, ICD 10 coding or clinical data to report; the coding is incomplete at this time and the clinical data would depend on an HIE or other method/pipeline for accepting EMR data. Nevertheless it is very important.
- HRSA required; health equity disparities are clearly present & prevalence continue to increase in WA & US
- Recommended in Bree Diabetes care Guidelines
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)
- Hybrid measure

(36) Eye Exam for Patients with Diabetes (EED)

- Pick one of the outcome measures related to Diabetes management out of 34, 36, 37, and 39
- Problems with ability to report: if referred out, would be billed under vision care (and would not come through the medical plan claims); referrals depend on closing the loop and being able to document if this is done. It is obviously important, but very hard to get done/get credit for. Could go under a DM set.
- Rates are lower, especially Medicaid, and the care pathway could use improvement so definitely argument for adding this at least as a sub-measure
- Required reporting for Medicare.
- Recommended in Bree Diabetes care Guidelines
- Current VBP measure in HCA contracts
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)
- Measure moved to administrative MY2025 from Hybrid

(37) Glycemic Status Assessment for Patients with Diabetes (GSD)

- Pick one of the outcome measures related to Diabetes management out of 34, 36, 37, and 39
- Utilizes Administrative and supplemental data.
- Requires either CPT2, ICD 10 coding or clinical data to report; the coding is incomplete at this time and the clinical data would depend on an HIE or other method/pipeline for accepting EMR data. Nevertheless it is very important.
- HRSA required; Prevalence of DM continues to be significant & increase in WA & US, & health equity disparities are clearly present; Recommend also adding a prediabetes measure as a sub-measure due to prevalence & risk: The USPSTF recommends screening all overweight and obese adults between the age of 35 and 70 every three years for prediabetes and type 2 diabetes. The American Diabetes Association recommends screening elevated-risk patients for diabetes every three years using a fasting plasma glucose, non-fasting glucose, HgbA1c, or two-hour glucose tolerance test. ADV_2023_State_Fact_sheets_all_rev_Washington.pdf
- Meaningful to Tribal Members
- Bree Recommendations Diabetes care guidelines- Screening for Abnormal Blood Glucose - Percentage of patients aged 40 years and older with a BMI ≥ 25 who are seen for at least two office visits or at least one preventive visit during the 12-month period who were screened for abnormal blood glucose at least once in the last 3 years AND/OR Percent of members/patients with diabetes receiving testing for Hemoglobin A1c
- On Primary Care Measure Set
- Current VBP measure in HCA contracts
- HBA1C poor control is the most common version of this measure that we have to report on
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)
- Hybrid measure

(38) HIV Viral Load Suppression (HVL-AD)

- This measure is part of the CMS adult core set, NQF endorsed, aligns with Ending the HIV epidemic and Treatment as prevention initiative, as well as state quality strategies. Holds providers accountable – i.e. proxy for good doctors or providers. Utilizes administrative and Lab testing data.
- Need an HIV-related metric; however, not known if used in VBP arrangements.
- Keep as will be deprioritized in new administration

- Ad Hoc reporting to HCA

(39) Kidney Health Evaluation for Patients with Diabetes (KED)

- Pick one of the outcome measures related to Diabetes management out of 34, 36, 37, and 39
- Utilizes Administrative Data only
- Important and often neglected; elements included in many VBP arrangements.
- Required reporting for Medicare.
- Recommended in Bree Diabetes Care guidelines
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)

(40) Member Experience: HP-CAHPS Health Plan Survey Composite - How Well Providers Communicate with Patients

- Let's pare down the patient experience list a bit. This one is at the health plan level and not as amenable to action as compared with the provider level metric. Would delete from the set.
- Just keep one of these provider communication metrics
- Required reporting for Medicare.
- Current VBP measure in HCA contracts
- The health plan may do this survey, but we use a different survey than CAHPS internally
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)

(41) Patient Experience with Primary Care: How Well Providers Communicate with Patients

- Sub measure of 40 – for use by Primary Care Transformation related initiatives
- See above. We need at least one patient experience measure and this one is likely the most actionable.
- Just keep one of these provider communication metrics
- Good measure to include well rounded metrics to be inclusive of pt experience
- Current VBP measure in HCA contracts
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)

(42) Patient Experience with Primary Care: How Well Providers Use Information to Coordinate Patient Care

- Sub measure of 40 – for use by Primary Care Transformation related initiatives
- Remove in the interest of paring down the list.
- Required reporting for Medicare.
- Current VBP measure in HCA contracts
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)

(43) Statin Therapy for Patients with Cardiovascular Disease (SPC)

- This could be under a sub-list if one is created for cardiovascular conditions, otherwise keep it on the CMS
- Required reporting for Medicare.
- Current VBP measure in HCA contracts
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)

Ensuring Appropriate Care – Avoiding Overuse

(44) Antibiotic Utilization for Respiratory Conditions (AXR)

- Utilizes Administrative Data only

- Important in terms of reducing antimicrobial resistance; current performance isn't topped out. We need one of these two.
- Recommended in Bree Collaborative Outpatient Infection Control guidelines

(45) Appropriate Testing for Pharyngitis (CWP)

- Utilizes Administrative Data only
- Important in terms of reducing antimicrobial resistance; current performance isn't topped out. We need one of these two.
- Recommended in Bree Collaborative Outpatient Infection Control guidelines

(46) Potentially Avoidable Use of the Emergency Room

- Proxy for healthcare cost, which are being measured and reported on by the Health Care Cost Transparency Board
- I like this metric but it pertains more to cost of care than to quality.
- This measure is only useful as a measure of community and primary care access. It is not a measure of ED processes or quality
- Bree recommendations – Heat and wildfire smoke guidelines
- How is this being defined? Depending on difficulty, this could be good to include.
- Part of our GOC for cost utilization

(47) Use of Imaging for Lower Back Pain (LBP)

- Utilizes Administrative Data only
- I like this metric but it pertains more to cost of care than to quality.
- Bree recommendations – Lower back pain
- May be retired by NCQA

(48) 30-Day All-Cause Risk-standardized Mortality Rate Following Acute Myocardial Infarction (AMI) Hospitalization

- Not sure. We could put this in a sub-measure set. These mortality measures are subject to upcoding.
- Does not participate in the Medicare LOB.

Effective Hospital-Based Care

(49) Cesarean Birth (NTSV C-Section)

- Recommend replacing with a maternal mortality outcome measure, as a sub-measure of 48, which could be reflective of outcomes for birthing people.
- A no-brainer. Keep it.
- From a high-level view this would be good for health plans/large health system monitoring, not health care providers.
- This is one of the four SDPP metrics for hospitals.
- Bree recommendations – obstetrics
- Current VBP measure in HCA contracts

(50) Catheter-Associated Urinary Tract Infections

- This one could go in the interest of paring down the list.

(51) Falls with Injury

- Falls are very hard to mitigate and especially so in this time of chronic understaffing. In the interest of paring down, would remove.

(52) Patient Experience with Hospital Care: Discharge Information and Communication About Medicines

- Do we need an inpatient PX measure? Maybe not.
- Note: the HCAHPS survey has been updated, starting Jan 1, 2025, there are new questions. Please ensure you are selecting the most relevant questions for this measure, it's possible the previous questions regarding medications and discharge plans have been changed. Crosswalk of HCAHPS Survey to Updated HCAHPS Survey

(53) Patient Safety for Selected Indicators (composite measure)

- Let's keep this composite.
- From a high-level view this would be good for health plans/large health system monitoring, not health care providers

(54) Plan All-Cause Readmissions (30-day) (PCR)

- This metric is susceptible to coding and takes a great deal of coordination (and an HIE, ideally) to create improvements. Experts like Bob Wachter think it's time to stop the HRRP at CMS.
- Important metric for care management, cost utilization, & helps support coordinated care across the system.
- This is one of the four SDPP metrics for hospitals.
- High priority measure for KPNW & KPWA (Medicare 5 Star, Medicaid, etc)

(55) Stroke Care (STK-04): Thrombolytic Therapy

- In the interest of keeping some inpatient measure, particularly relevant to CAHs who don't have easy access to other definitive treatments

Washington State Health Care Spending

(56) Annual State-Purchased health Care Spending Growth Relative to State GDP

- Healthcare cost growth is now measured and reported by the Health Care Cost Transparency Board
- Let's move this and the other two into a sub-list under "State healthcare spend". I don't think that provider settings or even the health plans see this as actionable, let alone add to VBP. **We could remove all three of these from the list entirely as long as HCA continues to be able to measure it without being designated as on the WACMS**
- Measurement of primary care spending recommended in Bree Primary Care guidelines
- Don't know about this (measure)

(57) Medicaid Per Enrollee Spending

- Healthcare cost growth is now measured and reported by the Health Care Cost Transparency Board
- See above.
- Don't know about this (measure)

(58) Public Employee and Dependent per Enrollee Spending

- Healthcare cost growth is now measured and reported by the Health Care Cost Transparency Board
- See Above.
- Measurement of primary care spending recommended in Bree Primary Care guidelines
- Don't know about this (measure)

Social Recovery

(59) Arrest Rate for Medicaid Beneficiaries with an Identified Behavioral Health Need

- These four measures are very unlikely to be used in any VBP arrangements, even though they are essential for evaluating the health and healthcare of very specific populations. **They could be moved into a sub-list, or we could remove all four of these from the list entirely as long as HCA continues to be able to measure these items without being designated as on the WACMS**

(60) Timely Receipt of Substance Use Disorder Treatment for Medicaid Beneficiaries Released from a Correctional Facility

- Suggest combining with 61 and making this a sub-measure
- See above.
- Check alignment with 1115waiver programming focused on re-entry patients with SUD; MAT is mandatory pre-release in this program https://www.hca.wa.gov/assets/program/sursac-waiver-reentry.pdf

(61) Timely Receipt of Mental Health Treatment for Medicaid Beneficiaries Released from a Correctional Facility

- Suggest combining with 60 and making this a sub-measure
- See above.

(62) Homelessness (Broad and Narrow) (HOME-B and HOME-N)

- See above.
- This measure is limited to data generated by individuals seeking services at DSHS. Many people experiencing housing instability do not seek services. A better measure would be to look at SDOH screening (documented by ICD-10 Z-codes) in the Medicaid population managed by HCA.
- Meaningful to Tribal Members

Additional comments:

- One health plan currently tracks and provides a quality measures report to the following organizations:
    - Urban Indian Organizations
    - Community Health Centers (within CHNW)

- **Maternal Health:** Recommend that this remain a priority topic, as we know that maternal health is facing a crisis. The maternal mortality rate is significantly higher for Black and AI/AN women, who continue to experience disproportionately higher maternal mortality rates compared to White, Hispanic, and Asian women.
    - ***Factors that contribute to Maternal Mortality:***
        - Lack of Access to comprehensive care

        - Health inequities
        - Chronic health conditions
        - Gestational diabetes
        - Hypertension
    - ***Efforts to improve Maternal Health:***
        - Focus on prevention
        - Improve access to prenatal/postpartum care
        - Doulas, Midwifery services
        - Education to promote healthy behaviors
        - Address systemic barriers

- **Meaningful to Tribal Members:**
    - Child and Adolescent Well Care Visits
    - Child/Adolescent Immunizations
    - Youth Substance Use
    - Breast Cancer Screening
    - Cervical Cancer Screening
    - Chlamydia Screening
    - Colorectal Cancer Screening
    - Prenatal/Postpartum Care (PPC)
    - Diabetes (A1c)
    - Homelessness

- **Rural:** There are several challenges facing our members who live in rural areas, with the primary challenges faced including limited access to health care services and significant social determinants of health, such as housing and food insecurities, as well as transportation barriers. Addressing these issues requires a multifaceted approach that includes providing comprehensive resources, targeted education, and accessible information. By equipping individuals with knowledge about available services and support systems, we can empower them to navigate these obstacles and improve their overall well-being. Enhancing accessibility to transportation will also play a crucial role in ensuring that community members can reach vital services, thereby fostering a healthier, more resilient population.