HEDIS Measurement Year (MY) 2027 Public Comment

The following template lists all public comment questions from the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures in the 2027 MY. Each question includes space for inputting answers.

Public Comment Questions

Question 1: Do you support the inclusion of the CGD-E measure in HEDIS MY 2027?

Response: Do not support. While Covered California, the Department of Health Care Services (DHCS) and the California Public Employees Retirement System (CalPERS) strongly support evidence-based tools that can help people achieve glycemic control, a process-focused measure on the use of Continuous Glucose Monitoring (CGM) risks diverting attention and resources away from the outcomes that matter: attaining and sustaining diabetes control, preventing complications, and reducing mortality. As CGM has long been underutilized as part of diabetes care for Black or African American and Hispanic or Latino populations, we appreciate the approach to stratified reporting for this measure (Underwood et al., Journal of Health Equity. 2025). However, a stand-alone utilization measure such as CGD-E, which evaluates the utilization of a particular technology without a requirement to achieve an HbA1c at goal, may exacerbate known disparities in CGM adoption without improving A1c control. The proliferation of process-oriented measures may increase cost and administrative burden for plans and providers, while offering limited incremental value for patients (Saraswathula et al., JAMA. 2023; Schneider E, BMJ Qual Saf. 2025). We recommend striving to reduce administrative burden for clinicians by aligning the measures across quality programs where clinically appropriate. While process-based and utilization measures (such as the proposed measure) can be useful in some instances, we would rather focus data collection and reporting efforts on an outcomes-based measure if it is available. In the case of diabetes, there is already a more outcomes-based measure (Glycemic Status Assessment for Patients With Diabetes - GSD), which already takes into account the data obtained from CGM. Covered California, DHCS, and CalPERS support an overall reduction in the number of measures and redoubling focus on continuous improvement on high impact metrics which reduce morbidity and improve health and well-being. We encourage the NCQA to apply a parsimonious, outcomes-first framework, prioritize a narrow set of high-impact outcome measures for diabetes, ensure that performance

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improvement is tied to better health and lower total cost of care, and decline to add measures that track the uptake of specific technologies or processes independent of demonstrable outcomes.

Question 2: Do you support the proposed age stratification (18-64; 65-75)? Is it meaningful given the proposed diabetes type stratification?

Response: Yes. The diabetes type is much more useful since the measure specifications and CGM recommendations are only intended for those on insulin therapy. Note that the current practice recommendation is that CGM should be offered while the measure tracks actual CGM utilization.

Question 3: What data sources does your organization use to identify CGM (medical claims/DME, pharmacy claims, EHR fields, vendor feeds), and can these be mapped to the value sets as specified?

Response: Data on CGM use will be difficult to obtain. While claims and encounters, and prescription data on CGM dispensing are available to state agencies, this measure will be impacted by the use of direct-to-consumer CGMs. LOINC Code is mentioned in the numerator specifications. DHCS does not have access to LOINC data, but Managed Care Plans (MCPs) do.

Question 4: Do you support the inclusion of the COF-E measure in HEDIS MY 2027?

Response: Do not support. While Covered California, the Department of Health Care Services (DHCS) and the California Public Employees Retirement System (CalPERS) absolutely agree with the importance of follow-up colonoscopy after a non-invasive positive colorectal cancer screen, we don’t support this as a new standalone measure. We would prefer not to increase the number of process measures that may divert attention and resources away from outcomes that matter. While we don’t support this as a standalone measure, we could support it if revised to be included as a part of the existing colorectal cancer screening measure (COL-E). For instance, it could be incorporated by modifying COL-E so that in the event a non-invasive screening method is used, the measure is considered ‘met’ only if the non-invasive screening result is negative, or if a positive non-invasive screening result has a subsequent colonoscopy performed. This would strengthen the existing COL-E measure and would not add an additional process measure. It would also ensure that follow-up colonoscopy results are

stratified by race and ethnicity, given the known disparities in follow-up colonoscopy after non-invasive screening

Question 5: Do you support the inclusion of the PVS-E measure in HEDIS MY 2027?

Response: Support. Covered California, the Department of Health Care Services (DHCS) and the California Public Employees Retirement System (CalPERS) support the addition of this measure. As stated in the measure background material, California health plans and providers have made concerted efforts to screen for IPV. Given the impact IPV can have on a patient, we support screening and follow-up for IPV. Additionally, given the disparities outlined, we recommend NCQA consider stratification by race/ethnicity and sexual orientation/gender identity. Individuals with different identities experience different forms of IPV. This would allow organizations to understand the disparities in their populations and implement targeted initiatives that address the IPV experienced by different populations.

Question 6: What is the best approach to integrating the CUES framework (which includes confidentiality, universal education and supports) in the quality measure?

Response: CUES can be included as a best practice framework for screening and providing follow-up care; however, organizations should have the flexibility to use other validated/widely recognized best practices to conduct screening and follow-up. Other than an EHR attestation that CUES (or similar framework) was used, there is no clear practical way to incorporate the use of CUES in the actual measure. EHR attestation would be too much of a lift operationally. The potential best way to incorporate CUES is to provide a toolkit on how to administer this measure, which would include the CUES framework for MCPs and providers. Of note, Blue Shield Foundation of California is currently running a Learning Collaborative with MCPs about how to do IPV screening at the plan level and working with providers. The collaborative discusses the CUES framework for both internal MCP use and for provider education. We recommend implementing IPV Screening with Adolescent Well-Child Visits during the portion where the PCP meets alone with the adolescent to discuss sexual health, substances, and symptoms of depression/anxiety. Introducing this type of screening as a part of discussion of being in healthy relationships vs. unhealthy relationships could be a good segue to the IPV questions so patient has context for the questions. We also recommend an IPV screening when distributing PHQ-9, GAD-7, etc., in primary care settings since elevated scores on these validated screening tools can be related to IPV.

Implementation of IPV screening is also important in Emergency Departments, where victims often show up. Health clinics on college campuses would also be a key environment for IPV screening.

Question 7: What follow-up time window should be specified (7 or 30 days) at the health plan level?

Response: 7. Covered California, DHCS, and CalPERS support the intent of the proposed IPV Screening and Follow-Up measure and agree that appropriate follow-up after a positive screen is essential to ensuring patient safety. At the same time, we recommend that NCQA provide clearer guidance on what constitutes "appropriate follow-up," recognizing that clinically appropriate care can take multiple forms. This could entail another primary care appointment, behavioral health (BH) referral, and another encounter with an IPV ICD-10 code. The heightened risk of injury and or mortality in partners who experience IPV, and the data on increased suicidal ideation and suicide attempts in women with a history of IPV, strongly support the 7-day measure follow-up window as currently proposed to expedite referrals to needed care and support services in many primary care and outpatient settings. Clinicians may address safety concerns during the same encounter, conduct a warm handoff to behavioral health, or develop a safety plan with the patient. In these situations, a distinct follow-up encounter within 7 days may not be clinically necessary, particularly when patients decline additional services. These approaches are consistent with trauma-informed care principles and the CUES model, both of which emphasize meeting patients where they are. For these reason, we support retaining the proposed 7 day follow-up window when follow-up is clinically indicated, while ensuring the measure does not inadvertently penalize clinicians who provide appropriate, patient-centered interventions within the initial encounter.

Question 8: Should we consider including people with a date of death to help identify missed opportunities for intimate partner violence screening and follow-up?

Response: Yes. Yes, those with a date of death (or even on hospice) should be included in this metric to identify missed opportunities. Not only is this just a general missed opportunity for screening, but homicides as a result of IPV are not uncommon. Nearly half of all homicides of women under 45 years of age are killed by a current or former intimate partner, with 15% of victims being pregnant or recently pregnant. For those homicides that occur as a result of IPV, it would be important to know if these individuals were screened for IPV before a penultimate event. Previous studies have

indicated that IPV-related deaths are undercounted as a result of limited IPV assessment. (Campbell JC et al. Intimate partner homicide: Review and implications of research and policy. Trauma Violence Abuse, 2007; 8(3):246–269). This could be beneficial in light of the impacts IPV has on life expectancy and could further contribute to the growing body of literature that supports a strong connection between IPV and lethal outcomes in women. Because data on IPV and lethal outcomes among men is limited, collecting this information could help improve our understanding of the scope and significance of this issue. Additionally, just because someone is in hospice does not mean they should be excluded from IPV screening, as these individuals may be at increased risk of IPV, similar to the way older individuals are at risk of adult abuse, financial abuse, and neglect. There should be no exclusions in this group.

Question 9: Testing showed very small sample sizes for the Medicare population. Should we consider expanding the current measure to individuals aged 12-64 within the Medicare product line?

Response: Yes. As noted in the measurement workup, individuals with disabilities are at increased risk for all forms of IPV and associated adverse health outcomes and can benefit from targeted interventions to reduce this disparity. Despite having small sample sizes, exclusion would not be appropriate for a measure that should be performed universally. It is important from a prevention/early intervention strategy to help young adults be more informed about healthy vs. unhealthy relationships. Also, children who are exposed to IPV in the home often experience trauma which impacts their mental health, physical health, and social functioning. Intimate Partner Violence: Role of the Pediatrician | Pediatrics | American Academy of Pediatrics As such, we support expansion of the current measure to include individuals aged 12-64 in Medicare.

Question 10: Are there unintended consequences we should consider, particularly related to the disclosure of patient sensitive information and the subsequent documentation in the clinical record?

Response: Considering the potential for harm to an individual who discloses positive findings on an IPV screening tool, providers should be encouraged to review their privacy practices to ensure no patient data is accidentally disclosed. If a family member (partner, parent, adult child, etc.) has access to the medical record and IPV is not within a sensitive/confidential portion of the medical record, then we are putting the patient at risk if this information is released to anyone other than the patient. Ideally, these results could be filed as sensitive. We would be concerned about data integrity in discrete data fields. It is likely unreliable and often times documented in confidential locations or not

documented at all. However, as with all medical care and associated records, the value of providing the care is worth documenting the screening and follow-up care.

Question 11: Do you support the inclusion of the new PCO measures in HEDIS MY 2027?

Response: Support with modifications. Covered California, the Department of Health Care Services (DHCS) and the California Public Employees Retirement System (CalPERS) appreciate the thoughtful approach NCQA has taken with the Person-Centered Outcome (PCO) measures including first field testing. It has long been a goal to move towards capture of achievement of patient goals. Field testing in Special Needs Plans, where delivery of patient-centered and patient-driven outcomes is critical, was the right approach. We also are pleased to see the feasibility of data capture but were concerned that it was primarily occurring through care management workflows. In order to derive full value from articulated patient goals, they must be easily accessible at the point of care for those attempting to make joint clinical and non-clinical decisions. This has been perhaps best demonstrated with advanced care plans, where standardized workflows, easy to find documentation, and salience of the information are critical to provide care aligned with patient's goals (Lakin et al. Journal of Palliative Medicine. 2016;19(6):632-638., Wilson et al. Journal of Palliative Medicine. 2013;16(9):1089-1094, Turley et al. Perm J 2016 Spring;20(2):43-48). We, therefore, recommend a measured implementation of PCO including delay in public reporting and not expanding to other populations at this time. If PCO is included for SNPs only, we would advise continued monitoring, focus groups surveying both plans and delivery systems, and additional audits to assess whether this is yet another "check-the-box" measure or if meaningful integration of patient's goals is occurring across the care team.

Question 12: Do you support the inclusion of the PSF-E measure in HEDIS MY 2027?

Response: Support. In California, from 2014 to 2023, female all stages syphilis cases increased over 545% and congenital syphilis cases increased 394%, from 104 cases in 2014 to 514 cases in 2023. Given this, Covered California, the Department of Health Care Services (DHCS) and the California Public Employees Retirement System (CalPERS) support measure development for screening for syphilis in all pregnant persons and appreciate that the new measure also prioritizes appropriate follow-up and not just screening without subsequent action for positive results.

Question 13: Should this measure include universal rescreening during third trimester and delivery in accordance with ACOG recommendation?

Response: Yes. We should be using ACOG recommendations for initial, third trimester, and delivery screening due to the rise in congenital syphilis (This is also the SMFM Guidelines). Newborn syphilis cases have been increasing, and this is a public health concern. CDC Reports Latest National Data on Syphilis in Newborns and Sexually Transmitted Infections (STIs) | CDC Newsroom; CDC: Congenital syphilis cases rose 740% over a decade | AAP News | American Academy of Pediatrics. This USPSTF updated evidence report indicates that "approximately 5% of congenital syphilis cases occurred in pregnancies that initially screened negative for syphilis…about one-half of congenital syphilis cases might be prevented with third trimester repeat screening and adequate treatment, whereas the third study estimated that about one-fourth of cases might be preventable." In the national sample, 40.6% of these cases occurred in Black women, 28.4% occurred in Hispanic or Latina women, and 19.8% occurred in White women, which reiterates the health disparities in those seeing these outcomes. While we generally agree with the recommendations, there are some practical nuances to consider. The time window for the third trimester re-screening may be difficult to define in technical specifications. The recommended window for re-screening is ~28-32 weeks. However, because routine labs are being ordered at 24-28 weeks for anemia and diabetes, often syphilis screening is added to this set to minimize blood draws for patients. We are not aware of any evidence of different capture rates of 24-28 weeks versus 28-32 weeks. We agree that adopting the more robust screening recommendations by ACOG would be a best practice but would want to confirm if the purpose of the proposed measure is whether it aligns with best practice or to capture any screening that is occurring. If the latter, then we would recommend a flexible approach to counting numerator hits while still encouraging the best practice of screening for syphilis at three distinct points during pregnancy.

Question 14: Does your organization have access to syphilis screening results that could be mapped onto SNOMED CT codes?

Response: No. In DHCS' experience, administrative data does not include LOINC or SNOMED information and DHCS would not be able to report screening results. It is our understanding that California Department of Public Health (CDPH) reports on congenital syphilis cases and not syphilis screening results. We otherwise would defer on this response to health plans, systems, and providers who would be collecting this data and reporting this measure. Covered California and CalPERS have no comment on this particular question.

Question 15: Do you have any concerns about the alignment of this measure with state congenital syphilis screening mandates?

Response: The state of California requires “every licensed health care professional engaged in providing prenatal care or attending a birthing patient at the time of delivery, shall provide syphilis screening and testing” but no specific requirements outside of alignment with the state public health department. State recommendations are currently aligned with ACOG for screening of pregnant persons, with an added recommendation to screen during emergency department or urgent care visits that occur during pregnancy. Generally, this measure is in alignment with state direction. Additional Commentary The specifications define follow-up as the percent of deliveries with “appropriate follow-up care.” The specifications list penicillin treatment on or within 14 days of the first positive syphilis screening. Depending on the diagnosis, syphilis is treated with either one dose of PCN or three doses of PCN. The measure does not seem to evaluate whether an individual has been treated with the appropriate number of doses. Over 40% of congenital syphilis cases are due to inadequate treatment compared to no treatment at all (11%), as described here: Vital Signs: Missed Opportunities for Preventing Congenital Syphilis — United States, 2022. If the measure does not take into account an appropriate number of doses of treatment, there will be an overestimate of how well states/plans are doing at adequately treating perinatal syphilis. Additionally, there is a significant lack of provider knowledge in evaluating the diagnosis of early versus latent syphilis, which determines the 1 versus 3 doses of penicillin. Often, individuals are mis-diagnosed and thus receive inappropriate treatment and follow-up as a result. Again, treatment must occur less than 30 days prior to delivery to reduce congenital syphilis rates, and so this represents a missed opportunity to account for whether birthing individuals are getting appropriate care.

Question 16: Do you support the proposed changes to the AIS-E measure for HEDIS MY 2027?

Response: Support. Covered California, the Department of Health Care Services (DHCS) and the California Public Employees Retirement System (CalPERS) agree with the minor proposed changes to pneumococcal vaccine to align with 2024 ACIP and AAFP immunization schedules, noting that the specific age stratification would apply to pneumococcal and zoster vaccinations. The advent of pneumococcal conjugate vaccines which can cover up to 80% of strains responsible for invasive disease in adults shows that administration starting at age 50 can reduce disease incidence, reduce health disparities, and be cost-effective. Cost-Effectiveness of Revised US Pneumococcal Vaccination Recommendations in Underserved Minority Adults <65-Years-Old – PMC

Question 17: Do you support publishing the EDU measure for the Medicaid product line starting in HEDIS MY 2027?

Response: Support with modifications. The Department of Health Care Services is in support of expanding this measure to Medicaid given the removal of AMB-ED. NCQA could also consider including pediatric and behavioral health ED visits. However, the following factors would need to be considered when interpreting this measure in the Medicaid population. These systemic issues mean that higher ED utilization among Medicaid members often reflects structural barriers rather than inappropriate use. Any measure expansion should consider these factors when interpreting performance and designing interventions. - Access barriers drive ED use for non-emergent issues. Many Medicaid members use the ER because primary care appointments are difficult to obtain, and in some cases, the ER is physically closer than a clinic with sooner access to care. - Coverage churn worsens continuity of care. Annual redetermination often results in members being dropped from one plan and reassigned to another, which disrupts established provider relationships. This leads to patients seeking medication refills and routine care in the ER. - Complex plan assignments create confusion. For example, a patient may be assigned to one MCP but be empaneled to different hospital systems. When they are re-enrolled in Medi-Cal, they may not return to the same provider group, creating additional fragmentation and reliance on the ER.

Question 18: Do you support the proposed changes to the PCE measure for HEDIS MY 2027?

Response: Support with modifications. Covered California, the Department of Health Care Services (DHCS) and the California Public Employees Retirement System (CalPERS) are supportive of the inclusion of outpatient urgent care and non-urgent care ambulatory visits. However, it is unclear why there has to be a threshold of two visits in the outpatient setting (inclusive of ED presentations) to qualify for the denominator. It is also unclear why hospital discharges are being removed as a triggering event for the denominator. A hospital discharge, ED visit, urgent care visit, or outpatient visit should trigger the denominator.

Question 19: Do you support the use of any claim position to identify COPD exacerbation events among members in the denominator?

Response: No. Covered California, DHCS and CalPERS are concerned about using a general COPD claim in any diagnosis position across all care settings. The proposed

technical specifications cite the Chronic Obstructive Pulmonary Diseases value set (2.16.840.1.113883.3.464.1004.2463), which encompasses COPD in general rather than narrowing to values for COPD exacerbation. There are already appropriate diagnosis codes available to identify true COPD exacerbations in any setting. Allowing COPD to count in any claim position for emergency and urgent care is overly broad. Clinically, a patient may have a history of COPD but present for an unrelated acute issue. If the provider addresses the acute problem and simply confirms that the patient's COPD is stable without prescribing new COPD treatment, the provider would still document COPD as part of the visit. This leads to coding for COPD even when no actual exacerbation occurred.

Question 20: Do you have any questions or additional feedback for NCQA about HEDIS?

Response: With CMS proposing to remove the Childhood Immunization Status (CIS) and Immunizations for Adolescents (IMA) measures from Medicaid and potentially Exchange programs, it is critical that NCQA maintain strong national collection and benchmarking of these measures through Quality Compass and its reporting infrastructure. Eliminating national benchmarking for childhood and adolescent immunizations would not be a neutral technical change. It would weaken accountability for one of the most effective public health interventions in modern medicine and would predictably lead to declining vaccination coverage and preventable harm to children. The consequences of falling vaccination rates are well established. The United States is already experiencing renewed outbreaks of diseases such as measles linked to declining childhood vaccination coverage, with most cases occurring among unvaccinated children. Removing national accountability for CIS and IMA would signal to health plans and providers that childhood immunization performance is no longer a priority, increasing the risk of preventable disease and widening disparities in vaccination coverage. The importance of CIS as an accountability measure is widely recognized by major purchasers. In California, the California Public Employee Retirement System (CalPERS), Covered California, and the Department of Health Care Services (DHCS) that together cover almost 46% of Californians, all designate CIS as one of four core performance measures and hold health plans accountable for results because of its strong evidence base and central role in preventing infectious disease. For these reasons, we urge NCQA in the strongest possible terms to continue prioritizing CIS and IMA within Quality Compass and its national benchmarking infrastructure. If NCQA were to discontinue benchmarking for these measures, we would need to pursue alternative mechanisms and partnerships capable of sustaining rigorous measurement and evidence-based accountability for quality. Given that over 200 organizations have endorsed the American Academy of Pediatrics' vaccine

schedule, Covered California, DHCS and CalPERS expect NCQA to be clear that they will do the same by: 1) using the AAP schedule as NCQA's base for vaccine measure specifications; 2) continuing to publicly report national results and benchmarks on childhood and adolescent vaccine data; and 3) continuing to hold health plans accountable to childhood and adolescent vaccine results as a part of its health plan ratings and other programs.

Question 21: If the changes proposed in this survey are implemented, to what extent do you expect it will improve quality outcomes in your organization?

Response: Too early / insufficient information