



VIA ELECTRONIC TRANSMISSION

October 21, 2022

The Honorable Xavier Becerra
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Chiquita Brooks-LaSure
Administrator Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting; Proposed Rule - CMS-2440-P

Dear Secretary Becerra and Administrator Brooks-LaSure,

Thank you for the opportunity to comment on Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting; Proposed Rule - CMS-2440-P. The Georgetown University Center for Children and Families (CCF) is a nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes through Medicaid and CHIP. These comments are focused on the Child Core Set and the behavioral health measures on the Adult Core Set of Health Care Quality Measures (herein referred to as the Behavioral Health Core Set).

Summary of Overall Comments

Mandatory reporting – Mandatory reporting of the Child Core Set, the Behavioral Health Core Set, and the Health Home Core Set of Health Care Quality Measures in Medicaid and CHIP as required in statute, beginning in the reporting year 2024, is a major step toward transparency and accountability. Until 2024, state reporting on the core sets is voluntary. And while reporting has improved over time, many states still lag in reporting these key data. A mandatory requirement to measure and report on the quality of care is critical for states and Medicaid and CHIP stakeholders to identify areas in need of improvement and take steps to improve the



quality of care. However, we are concerned that the proposed regulatory structure does not accomplish full mandatory reporting, beginning in the reporting year 2024, as required in statute at Sections 1139A(a)(4)(b) and 1139B(b)(3)(B).

Specifically, the proposed rule would give the Secretary discretion to delay state reporting of mandatory measures. We do not believe Congress intended to grant such authority to the Secretary given the plain reading of the statute that states must report on “all” of the Child Core Set and Behavioral Health Core Set measures beginning with fiscal year 2024 annual state reports. We do believe the Secretary may have more flexibility to phase in national publication of state-level data, but we are concerned about the lack of urgency in achieving transparency in reporting state-level data for all mandated core measures. We suggest that any delay in national publication of state-level data be limited to no later than the third year.

This timeline reflects our understanding of the statutory requirements: The Secretary must publish the 2024 core sets, including changes and updates to the measures, by January 1, 2024. States are required to report all mandatory measures on the 2024 core sets, generally using calendar year 2023 data depending on the technical specifications of the measure, by January 1, 2025. The Secretary then has until September 30, 2025 to publish what the states report but is not obligated to report all measures. Our detailed comments and recommendations are based on this interpretation of the statute.

Stratification – The COVID-19 pandemic has further illuminated the health disparities that exist for people of color, who are enrolled disproportionately in Medicaid. Stratifying quality measures, particularly by race and ethnicity, is essential to improving [child, maternal, and behavioral health](#) and addressing [health disparities that exist people of color](#).^{1,2,3} However, we recognize that [states face challenges](#) in stratifying measures, particularly as it relates to race and ethnicity, and generally support the proposed rule’s phased-in approach to stratification.⁴

¹ Samantha Artiga et al., “Racial Disparities in Maternal and Infant Health: An Overview,” Kaiser Family Foundation, November 10, 2020, <https://www.kff.org/report-section/racial-disparities-in-maternal-and-infant-health-an-overview-issue-brief/>; Fadumo M. Abdi and Mavis Sanders, “Bridging the Mental Health Care Gap for Black Children Requires a Focus on Racial Equity and Access,” Child Trends, May 31, 2022, <https://www.childtrends.org/blog/bridging-the-mental-health-care-gap-for-black-children-requires-a-focus-on-racial-equity-and-access>.

² Caryn R.R. Rodgers et al., “Racial/Ethnic Disparity Trends in Children’s Mental Health Care Access and Expenditures From 2010-2017: Disparities Remain Despite Sweeping Policy Reform,” *Journal of the American Academy of Child & Pediatric Psychiatry* 61, no. 7 (July 2022): 915-925.

³ Fadumo M. Abdi and Mavis Sanders, “Bridging the Mental Health Care Gap for Black Children Requires a Focus on Racial Equity and Access,” Child Trends, May 31, 2022, <https://www.childtrends.org/blog/bridging-the-mental-health-care-gap-for-black-children-requires-a-focus-on-racial-equity-and-access>.

⁴ Medicaid and CHIP Payment and Access Commission, “State Readiness to Report Mandatory Core Set Measures” (Washington: Medicaid and CHIP Payment and Access Commission, March 2020), <https://www.macpac.gov/publication/state-readiness-to-report-mandatory-core-set-measures/>



We also agree with the proposed rule at §437.10(d) that the Secretary should specify which measures must be stratified in order to promote consistency and comparability across states rather than allowing states to choose. We urge the Secretary to prioritize how stratification is phased in based on the areas of most urgent need, including maternal and behavioral health. We also recommend that stratification by health plan, as required in the statute at §1139A(b)(2)(C), be stipulated in the regulation. A majority of Medicaid beneficiaries are enrolled in managed care plans but there is [limited public data assessing access and the quality of care](#), which varies widely across different states and health plans.⁵ We believe it's important that stratification by health plan be stipulated in the regulation.

Duration of coverage measure – We also want to take this opportunity to point out that while the statutory language specifies different types of services, treatments and settings to be measured, there is only one specific measure noted in the statute – the duration of children's health insurance coverage over a 12-month time period (§1139A(a)(3)(A)). Most health quality measures require a minimum period of coverage continuity and yet there [continues to be a high rate of churn in Medicaid and CHIP](#) in many states.⁶ As a result, quality reporting is incomplete and does not always reflect the experience of enrollees who churn off coverage. A duration of coverage measure is needed to evaluate the extent to which the reporting data may be incomplete. A duration of coverage measure, stratified by age, will be particularly important to put in context the [potential impact of gaps in coverage](#) for infants and toddlers at a time when frequent well child checkups and developmental screenings are recommended to ensure a [child's healthy development](#).^{7,8,9}

As of the 2020 Child Core Set, 11 years after the initial core set was published, there is no duration or continuity of coverage measure on the core sets. We urge the Secretary to take action to meet this statutory obligation and ensure that such a measure is developed, tested, and added to the Child Core Set as soon as possible and no later than mandatory reporting for 2024.

⁵ Allie Corcoran et al. "Transparency in Medicaid Managed Care: Findings from a 13- State Scan," Georgetown University Center for Children and Families, September 2021, <https://ccf.georgetown.edu/wp-content/uploads/2021/09/MCO-13-state-scan-v3.pdf>

⁶ Medicaid and CHIP Payment and Access Commission, "An Updated Look at Rates of Churn and Continuous Coverage in Medicaid and CHIP" (Washington: Medicaid and CHIP Payment and Access Commission, October 2021), <https://www.macpac.gov/wp-content/uploads/2021/10/An-Updated-Look-at-Rates-of-Churn-and-Continuous-Coverage-in-Medicaid-and-CHIP.pdf>

⁷ First Focus on Children, "Issue Brief: Early Childhood Continuous Eligibility," (Washington: First Focus on Children, December 2021), https://firstfocus.org/wp-content/uploads/2021/12/PolicyBrief_Early-Childhood-Continuous-Coverage.pdf

⁸ Lindsey Leininger and Helen Levy, "Child Health and Access to Medical Care," *Future Child* 25, no. 1 (2015): 65-90.

⁹ Elisabeth Wright Burak, "Promoting Youth Children's Healthy Development in Medicaid and the Children's Health Insurance Program (CHIP)," Georgetown University Center for Children and Families, October 2018, <https://ccf.georgetown.edu/wp-content/uploads/2018/10/Promoting-Healthy-Development-v5-1.pdf>



Detailed comments follow.

Mandatory state reporting and Secretary's authority

The proposed rule at §437.10(c) would allow the Secretary to phase in mandatory reporting for certain measures, and this discretion is further proposed in §437.15(b)(1)(v) and §437.15(a)(4). This is inconsistent with the statutory requirements mandating state reporting of all Child Core Set and all Behavioral Health Core Set measures beginning with the 2024 annual mandatory reporting. Section 1139A(a)(4)(B), entitled "Mandatory Reporting," stipulates that beginning with 2024 reporting "the Secretary shall require states to use the initial core measurement set and any updates or changes to that set to report information..." Furthermore, Section §1139A(c)(1), which delineates the requirements of the annual state reports under which such information is required to be reported, specifically specifies that this includes "all" measures. "Each State . . . shall annually report to Secretary on the – (A) State-specific child health quality measures applied by the States under such plans, including measures described in subparagraphs (A) and (B) of subsection (a)(6) and, beginning with the annual report on fiscal year 2024, **all** of the core measures described in subsection (a) and any updates or changes to those measure."

Likewise, the statutory authority for mandatory reporting of the Behavioral Health Core Set at §1139B(b)(3)(B), entitled "Mandatory Reporting with Respect to Behavioral Health Measures," stipulates that "Beginning with the State report required under subsection (d)(1) for 2024, the Secretary shall require States to use **all** behavioral health measures included in the core set of adult health quality measures and any updates or changes to such measures to report information..." And similarly at §1139(d)(1)(A) when describing the requirements of the state annual reports specifies that states shall report to the Secretary on "State-specific adult health quality measures applied by the State under such plan, including measures described in subsection (b)(5) and, beginning with the report for 2024, **all** behavioral health measures included in the core set of adult health quality measures maintained under such subsection (b)(5) and any updates or changes to such measures (as required under subsection (b)(3))."

Recommendation

Delete §437.10(c) and redesignate the following paragraphs accordingly.

Publication by the Secretary

The statutory authority for the core sets at 1139A(c)(2) and 1139B(d)(2) requires the Secretary to collect, analyze, and make publicly available, by September 30 of each year, the information reported in the annual state reports described in 1139A(c)(1) and 1139B(d)(1). Yet there is no regulatory reference to this requirement or the specified deadline. Moreover, as noted at



§437.10(c) above, the statutory language does not allow the Secretary to identify only a subset of measures that states must report under statutory mandates, as proposed in §437.10(b)(1)(v).

However, the Secretary may have more latitude to phase in national publication of state-level data. The statute requires the Secretary to “collect, analyze, and make publicly available the information reported by the states annually” by September 30. Phasing in national publication of state mandatory reporting would be helpful particularly when new measures are added to the core sets, or when a measure’s technical specifications are significantly altered, as states may need time to implement, test and refine reporting. However, we believe any phase-in of national publication of mandatory reporting should be strictly limited to no later than the third year after the measure is added to the mandatory core sets measures or the technical specifications are significantly changed. To clarify the requirements for publication by the Secretary, *we recommend adding a new §437.18.*

§437.18 Publication by the Secretary

- (a) *Subject to paragraph (b), the Secretary shall publish the measures reported annually by each State under §437.15(a)(1), and the measures for which the Secretary completed reporting on behalf of each State under § 437.10(b)(1)(iv), no later than September 30 of the year following the year in which the annual State report is due. Publication shall include posting of the measures on the Medicaid.gov website.*
- (b) *The Secretary may withhold a measure reported by a State from publication if the Secretary determines that the measure as reported is incomplete or unreliable, but in no case for longer than three years after the year in which the measure is first identified in the annual reporting guidance described in §437.10(b)(1).*

Conforming amendments:

Delete §437.15(a)(4)

Delete §437.10(b)(1)(v)

Currently, the Department of Health and Human Services (HHS) only publishes state-level data if at least 25 states report the measure, yet there is no public information on the basis for establishing the 25-state threshold for reporting purposes. *We recommend that the Secretary minimally report all state-level data even if there are too few reporting states to conduct more comparative analysis and report quartile rankings as is current practice.*

Annual updates to the core sets

The proposed rule at §437.10(a)(1) requires the Secretary to identify and annually update the quality measures to be included in the core sets. However, there is no specified timeline for such updates in the proposed rule. Section 1139A(b)(5) requires the Secretary to publish recommended changes to the core measures beginning no later than January 1, 2013, and



annually thereafter. Therefore, we recommend that the §437.10(a)(1) be amended to include the required January 1 deadline for annual updates to the Child Core Set.

Recommendation:

Revise §437.10(a)(1) as follows: Identify and update ~~annually~~, no later than January 1 of each year, the quality measures to be included in the core sets.

Annual review process

The proposed rule at §437.10(a)(2) codifies current practice of consulting with states and “interested parties” to establish priorities for measure development, identify gaps, recommend measures to be added or removed, and ensure that all measures reflect an evidence-based process including testing, validation, and consensus among “interested parties (see comment below).” This process has improved over time, becoming more rigorous in setting minimum standards before changes to the core measures are considered and vetted by a cross-sector stakeholder group. *We support the codifying this process.*

Interested parties

The list of “interested parties” that are specified at §437.10(e) only includes those included in the statute at §1139A(b)(3) and providers of health home services under sections 1945 and 1945A. Section §1139B that mandates reporting on the Behavioral Health Measures directs the Secretary to establish a review program in the “same manner” as required under §1139A(b). *We therefore recommend the following revision to §437.10(e):*

Recommendation:

Insert a new paragraph (8) as follows:

“(8) National organizations and individuals representing people with disabilities and behavioral health conditions.”

Redesignate §437.10(e)(8) as §437.10(e)(9) accordingly.

Annual guidance on the core set reporting

The proposed rule at §437.10(a)(3) requires the Secretary to develop and annually update reporting guidance. The guidance is key a resource addressing the Secretary’s statutory requirement under §1139A(a)(7) to provide technical assistance to the states in adopting and utilizing the core sets. Importantly, the current annual review process, as noted in our comments, gathers and documents technical specifications and describes how the measure is actionable and contributes to quality. The process also requires that recommended measures meet other standards, including minimum technical feasibility and testing in Medicaid and CHIP. This advance work assists the Secretary in updating the core sets and is foundational to the Secretary’s reporting guidance. In order to foster timely mandatory reporting by the states,



we recommend that a deadline for such guidance be aligned with §437.10(a)(1) requiring the Secretary to publish annual updates to the core sets no later than January 1.

Recommendation:

Revise §437.10(a)(3) as follows: In consultation with the States, develop and update, no later than January 1 of each year, the reporting guidance described in paragraph (b) of this section.

Content of the annual guidance

The proposed provisions at §437.10(b) describe the content of annual guidance that the Secretary would be required to provide to states in reporting core set data. *We generally support the provisions in this subpart.* However, as noted in our summary comments and discussed in detail above, we do not agree that the Secretary has statutory authority to require that mandatory reporting be limited to a subset of the Child Core Set or Behavioral Health Core Set as discussed under our recommendations to delete §437.10(b)(1)(v) and §437.10(c) above.

Measures HHS will complete on behalf of states

Section 437.10(b)(1)(iv) requires the Secretary to include in guidance the measures that HHS will complete reporting on behalf of the states and the measures for which states may elect to have the Secretary report on their behalf. Centers for Medicare and Medicaid Service (CMS) requests comment on the use of T-MSIS and other data sources for core sets reporting and on CMS reporting on states' behalf. *We support efforts by the Secretary to report measures on behalf of states in order to alleviate the burden of reporting on the states and to ensure consistency and timeliness in the calculation of measures.*

Reporting measures in a standardized format

Section 437.10(b)(3) would require states to comply with the Secretary's guidance for reporting measure data in a standardized format. Standardized format for reporting measure data is necessary to comply with statutory requirements at §1139A(a)(4) and §1139B(b)(3). In the 2020 Quality of Care for Children in Medicaid and CHIP Chart Pack, states collectively reported nearly 1,000 measures, of which only 16 deviated from technical specifications. States should be required to adhere to the guidance and technical specifications documented for all measures. This is consistent with the statutory language at §1139A(a)(4) and §1139B(b)(3) to ensure that the data required for such measures is collected and reported in a standardized format. *We support codifying this requirement.*

Stratification

The proposed rule at §437.10(b)(7) requires the Secretary to provide guidance on the subset of measures that must be stratified by race, ethnicity, sex, age, rural/urban, disability, language, and other such factors. We support a phased-in approach to stratifications and urge the



Secretary to prioritize stratification of measures based on their potential for addressing health disparities. We also note that the statutory language at §1139A(b)(2)(C) stipulates that “the data required for such measures is collected and reported in a standard format that permits comparison of quality and data at a State, plan, and provider level.” The proposed rules do not fully capture stratifications at the health plan and provider levels, although the Secretary may require stratification based on “other factors” beyond those specified in the proposed rule at §437.10(b)(7). Stratification by health plan is particularly necessary to promote accountability in Medicaid and CHIP. The majority (over 70 percent) of Medicaid and CHIP enrollees receive care through managed care plans, yet there is [no consistent data source to compare](#) the quality of care delivered at the health plan level, which can vary significantly.¹⁰ Disaggregated data by health plan is essential for promoting accountability for the billions of tax payer dollars paid to health plans annually. Additionally, it may be helpful for certain measures to be stratified on a multi-level basis – for example, health plan data disaggregated by race, ethnicity, and other factors. Therefore, we recommend that this provision be amended as follows:

Recommendation

Revise §437.10(b)(7) as follows: The subset of measures among the measures in the Child Core Set, Behavioral Health Core Set, and the Health Home Core Set that must be stratified by race, ethnicity, sex, age, rural/urban status, disability, language, health plan, or such other factors as may be specified by the Secretary and informed by annual consultation with States and interested parties in accordance with paragraphs (a)(2) and (d) of this section.

Section 1139A(a)(3)(D) requires the Secretary to publish a Child Core Set that includes “the types of measures that, taken together, can be used to estimate the overall national quality of health care for children, including children with special needs, and to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.” The proposed rule at 437.10(d) provides more details on stratification, noting that it must be based on valid statistical methods and without risking a violation of beneficiary privacy. For measures obtained from surveys – stratification would only be possible if the original survey instrument collects the needed information. *We support this provision.* Section 437.10(d) also allows an initial phase-in of five years before states must stratify all measures as required by the Secretary. We believe this is reasonable for the initial phase-in considering that reporting stratified measures is not currently required. [We also know that states need time](#) to continue to improve the collection of race, ethnicity, and language

¹⁰ Andy Schneider and Allie Corcoran, “Medicaid Managed Care in 2021: The Year that Was,” Georgetown University Center for Children and Families, December 2021, <https://ccf.georgetown.edu/2021/12/21/medicaid-managed-care-in-2021-the-year-that-was/#:~:text=The%20federal%20government%20and%20states,80%20percent%20of%20child%20beneficiaries>



data in order to comply with the requirement for stratification.¹¹ We support the regulatory language that requires states to stratify measures specified by the Secretary during the phase-in period. CMS requested comment on whether states should be allowed to choose which measures it reports to meet these standards, which would not promote consistency or comparability across states. *We do not support giving states the flexibility to determine which measures to stratify during the phase-in period. However, we do have one recommended change to this provision.* We suggest that the share of measures required to be stratified are phased in evenly over years two through five and evenly distributed, as follows: 25 percent by year two; 50 percent in year three; 75 percent in year four; and 100 percent in year five. To further clarify stratification rules, we recommend the follow change:

Recommendation

Revise §437.10(d) as follows:

- (1) In specifying which measures, and by which factors, States must report stratified measures consistent with paragraph (b)(7) of this section, the Secretary shall require that States at a minimum report those stratified measures necessary to perform comparative analyses of pediatric health care quality and racial, ethnic, and socioeconomic disparities in child health and health care for children.*
- (2) The Secretary shall require that States report additional stratified measures taking into account whether stratification can be accomplished based on valid statistical methods and without risking a violation of beneficiary privacy and, for measures obtained from surveys, whether the original survey instrument collects the variables necessary to stratify the measures, and such other factors as the Secretary determines appropriate.*
- (3) The Secretary shall require stratification of the measures described in paragraph (1) by the second year of annual reporting after the effective date of these regulations.*
- (4) The Secretary shall require stratification of 25 percent of the measures on each of the Core Sets (the Child Core Set, behavioral health measures within the Adult Core Set, and Health Homes Core Sets) for which the Secretary has specified that reporting should be stratified under paragraph (2) by the second year of annual reporting after the effective date of these regulations, 50 percent of such measures for the third year of annual reporting after the effective date of these regulations, 75 percent of such measures for the fourth year of annual reporting after the effective date of these regulations, and 100 percent of measures beginning in the fifth year of annual reporting after the effective date of these regulations; and*

Attribution rules

¹¹ Medicaid and CHIP Payment and Access Commission, “Report to Congress on Medicaid and CHIP” (Washington: Medicaid and CHIP Payment and Access Commission, March 2020), <https://www.macpac.gov/wp-content/uploads/2020/03/March-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf>



Section 437.10(b)(6) requires the Secretary to provide guidance on attribution rules for determining how states must report for beneficiaries who are included in more than one population; for example, a child who was transitioned between Medicaid and CHIP during the year. *We support this provision in order to promote consistency in how states report the data and avoid duplicative reporting.*

State adherence to the guidance

Section 437.15(a)(3) requires states to adhere to the Secretary's guidance. CMS seeks comment on this provision. As noted previously, we believe that states should be required to adhere to the guidance in order to promoted consistency and comparability. *We support this provision.*

Separate child health insurance programs

Section 437.15 (b)(1) relates to reporting of Medicaid and CHIP beneficiaries in states that have implemented separate CHIP programs. The preamble of the proposed rule states that "... it is important that Child Core Set measures are reported for all populations covered in both Medicaid and CHIP." We believe it is also important to monitor and analyze quality performance in separate CHIPs independently from Medicaid programs to allow for comparison of performance between the programs. Therefore, we propose at §437.15(b) that states with a separate CHIP report on Child Core Set measures in three categories: Medicaid and CHIP combined; Medicaid inclusive of CHIP-funded Medicaid expansion (Titles XIX and XXI); and separate CHIP (Title XXI)." However, we do not agree that drafted language at §437.15(b)(ii) and (ii) conveys this requirement. There, we recommend that §437.15(b) be revised as follows:

Recommendation:

Revise §437.15(b) as follows: (b) Reporting of Medicaid and CHIP beneficiaries. In states that have implemented a separate child health program ("separate CHIP") under part 457 of this chapter:

- (i) the total number of Medicaid and CHIP enrollees (including CHIP-funded Medicaid) in the age range to which the measure applies;*
- (ii) the number of Medicaid enrollees ((including CHIP-funded Medicaid) in the age range to which the measure applies; and*
- (iii) the number of enrollees in the separate CHIP program to which the measure applies.*

Enforcement

The proposed rule would create a new §437.20, which would require that states amend their state Medicaid plans to specify that the state Medicaid agency will report on the Child and Adult Core Sets in accordance with the Secretary's guidance under section §437.15. (States offering Health Home services would be subject to a similar requirement in relation to the Health Home Core Set). The purpose of this requirement is to give CMS clear authority to



enforce the core set reporting requirements by withholding federal Medicaid payments under section 1904 of the Act in the event of noncompliance by a state. *We strongly support this provision.*

There is no question that Congress, in enacting sections 1139A and 1139B of the Act, required that states report all Child Core Set and Behavioral Health Core Set measures annually, beginning in 2024. The Congress did not enact an enforcement mechanism specifically for these requirements. Rather, it assumed and expected that the Secretary would enforce them using the enforcement authority available to him. The Secretary's enforcement authority in the case of noncompliance with statutory requirements is the withholding of federal funds under section 1904 of the Act. The proposed 437.20 clarifies that mandatory core set reporting, like other federal requirements, is subject to enforcement through the section 1904 compliance process.

To further clarify the Secretary's enforcement authority, we recommend adding a conforming change to 42 CFR 431.16, Reports, which implements section 1902(a)(6) of the Act. This section of the statute gives the Secretary plenary authority to require state Medicaid agencies to "make such reports, in such form and containing such information," as the Secretary "may from time to time" require. Now is the time for the Secretary to require states to report on the core sets as directed by the Congress in sections 1139A and 1139B. Modifying 431.16 to clarify that the state plan requirements include the reporting of the core sets specified in sections 1139A and 1139B would underscore the importance of state compliance.

Thank you again for the opportunity to make the above comments in support of the proposed rule. Please contact us at pab62@georgetown.edu or jca25@georgetown.edu if you have any questions or if we can be of further assistance.

Respectfully submitted,

Tricia Brooks
Research Professor
Center for Children and Families
McCourt School of Public Policy
Georgetown University

Joan Alker
Executive Director and Research Professor
Center for Children and Families
McCourt School of Public Policy
Georgetown University