



August 3, 2016

Mark Schaefer, PhD
Director
SIM Program Management Office
Office of the Healthcare Advocate
ATTN: Healthcare Innovation
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Dear Dr. Schaefer:

On behalf of the Connecticut Hospital Association and its members, I am writing to provide comments on the *Connecticut State Innovation Model (SIM) Report of the Quality Council on A Multi-Payer Quality Measure Set for Improving Connecticut's Healthcare Quality*.

In previously submitted comments dated January 20, 2015 and September 25, 2015, CHA outlined its position on the prior proposed measure sets. CHA recommended:

- Starting with a small, initial set of well-established measures that can be expanded over time;
- Excluding those measures that are custom, still being developed, or currently under review or revision; and
- Developing a phased-in approach to allow participants to gain expertise, implement technical components, and adapt their work flows accordingly.

CHA is pleased to submit additional comments on the full report. CHA commends the Quality Council on the substantive report developed by an expert consensus of stakeholders, and notes that the model aligns with the national shift in healthcare to provide higher-quality and lower-cost care. CHA also supports the Council in its decision to group the proposed measures into Core, Development, and Reporting Measure Sets.

As the Council notes in the report, measuring care is complex and involves factors related to structure, process, and outcomes, as well as determining the correct source of reliable data. CHA fundamentally supports the use of reliable, accurate, and care setting-appropriate measures that have been field-tested, evaluated for validity, and for which actionable data can be provided back to participants in a timely manner. Of critical importance is the need for balancing the collection of meaningful performance data with the burden reporting requirements place on providers. The measures that are included in the final Core Measure Set should reflect current clinical work flow and should not require providers to redesign patient care delivery in an effort to meet reporting requirements. To support the adoption of a balanced Measure Set, CHA recommends that only endorsed performance measures be included in the Core Measure Set of the value-based program.

With regard to the proposed measures to be derived from the Electronic Health Record (EHR), only measures that are currently included in the Meaningful Use, Physician Quality Reporting System (PQRS), or similar program should be included for consideration. Because this area is in flux, with changing payment models (e.g., the Merit-based Incentive Payment System and the Advanced Alternative Payment Models), relying on current measures will assist the Council in limiting the use of non-validated, custom measures and assure a yield of reliable data. Aligning measures will benefit the Council by establishing flexibility, especially by endorsing what is currently allowed at the federal level and taking into consideration that providers may not yet have fully implemented an EHR. Furthermore, if performance measures are aligned with current federal programs, that allows for benchmarking, validation of processes, and alignment with the time frame for implementation of an EHR. For all measures, CHA recommends that consideration be given to situations in which a value-based arrangement could result in duplicative penalties. Policies and procedures should be developed that outline how duplicative penalties will be prevented.

Finally, utilizing aligned measures would have the added benefit of statewide, regional, and national comparison studies and benchmarking. In response to the Quality Council's request for comments on specific measures (e.g., Patient-Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers and Systems (CAHPS), Prenatal and Postpartum Care Measures, and Race/Ethnic Stratification Measures), CHA respectfully submits the following comments:

The Council is considering the inclusion of a survey instrument for measuring care experience (PCMH CAHPS) that has been modified with additional questions to assess behavioral health access and coordination. Once additional measures are added to a validated survey instrument, the survey instrument must be validated again. CHA recommends that only a validated survey instrument be included in the Core Measure Set. If the PCMH CAHPS survey is modified with additional questions, it should be considered for inclusion in either the Development or Reporting Measure Set for a defined period of time (e.g., one year) and its efficacy as a valid survey instrument should be evaluated. As an alternative, CHA suggests the Council review for consideration the Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set (NQF 1904), which is a modified CAHPS instrument.

The Council is interested in comments on the merits of including the Prenatal and Postpartum Measure (NQF 1517) as part of an ACO shared savings program model. CHA notes that the NQF Perinatal and Reproductive Health Project 2015-2016 includes this measure. It is under review and possible revision at this time. CHA recommends either eliminating this measure from the Core Measure Set or moving it to the Development or Reporting Measure Set until the review is complete.

The Council has also requested comments on the measures that have been designated as high priority for Race/Ethnic Stratification and will be included in value-based payment scorecards. CHA recommends that only measures designed, endorsed, and validated be included in the value-based payment program, reporting, or scorecard development. EHR and claims-based data remain limited as reliable sources of health equity data. Coded claims data may not accurately reflect race and ethnicity as reported by the patient and, therefore, CHA strongly discourages the use of race and ethnicity as part of a value-based payment system.

However, CHA concurs that measures of health equity should be included as part of the program and suggests they be included in the Development or Reporting Measure Set. Until validity can be determined, however, they should not be included in the Core Measure Set. CHA recommends that the Department develop a sampling methodology in advance of reporting and data collection and test it for reliability and validity in advance of scorecard development or inclusion in the payment program.

With regard to the Council's comment that the payers will be encouraged to use the final Core Measure Set as a reference when negotiating contracts, CHA urges thoughtfulness and patience. Healthcare providers are allocating resources at a pace and a price unrivaled in recent history. The March, 2016 edition of *Health Affairs* reported that "each year U.S. physician practices in four common specialties spend, on average, 785 hours per physician and \$15.4 billion dealing with the reporting of quality measures." This represents time spent away from the patient. CHA urges the Council to be cognizant of the many demands on providers that have been mandated by regulators and accrediting bodies, including the adoption and implementation of EHR systems. Choosing aligned and nationally recognized measures of performance will accelerate positive changes to Connecticut's healthcare delivery system and assure great chance of long-term and sustainable success.

Several other areas are important to note:

First, the lack of available providers to care for or see behavioral health patients in a timely manner makes meeting Measures 27, 29, and 30 difficult. Mandating compliance with a measure when the system is fundamentally broken is not the way to fix the system. We recognize that there are no data available to establish a baseline for improvement, but putting the onus on the providers is not an acceptable method to establish that baseline.

Second, prior to implementation, CHA recommends that reporting mechanisms be addressed. The ability to get the data back at the provider level, so that a provider will be able to see his or her performance and compare it to peers, is a strong driver for providers.

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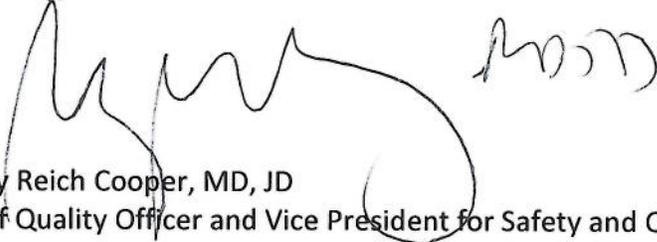
Page 4

Finally, CHA recommends a strategy that does not place the entire burden of reporting costs on providers and allows providers to receive and have access to routine, timely, and actionable data that compares their performance to others. This recommendation is supported by literature including Herzer and Pronovost's article, "Motivating Physicians to Improve Quality: Light the Intrinsic Fire," in the *American Journal of Medical Quality*, and Kao's article, "Driven to Care: Aligning External Motivators with Intrinsic Motivation," in *Health Services Research*.

CHA extends its gratitude to the members of the Quality Council for their commitment to improvement and innovation, and we look forward to the final report.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'Mary Reich Cooper', with a large, stylized flourish extending from the end of the name.

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