## Draft Response to Public Comment

| Item | Source | Comment | Response |
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| 1 | 1 | Understandably, the reporting method used for measure sets is a limitation that was unavoidable given that our current payment design relies on EHR and claims data. Incentivizing quality by linking payment to claims and EHR data is only one method, while the self-reported outcomes, which come directly from the patient's experience, is often overlooked when assessing quality of care yet is critical to improving healthcare outcomes. | We agree with the noted limitations in the proposed measure set with respect to self-report outcomes (other than broad-based care experience). We will consider the opportunity to incorporate self-reported outcomes as the landscape evolves (e.g., ICHOM condition specific registries of patient reported outcomes). |
| 2 | 1 | The behavioral health measures recommended for inclusion in the core measure set are reflective of the standardized data collected through EHR and Claims reporting, while there is a heavy focus on services rendered, as reflected in 28, 31 and 31 on page 47. The inclusion of measures 29 and 30 reflect a shift from traditional fee-for-service payment design to a value-based design. Meaning that there is focus on the effectiveness of services as indicated by the remission of depressive symptoms. It will be important to explore the treatment provided that result in the remission of symptoms, as there is a growing awareness that dependence on medication leads to poor health outcomes. This finding is disproportionately associated most strongly within the Medicaid/Medicare population. | Thank you for the comment. It is not within the Quality Council's scope to undertake research of the sort recommended. However, we will make this recommendation publicly available for interested researchers to consider. |
| 3 | 1 | …we encourage SIM to continue to pursue the Reporting Measure Set, found on page 50, as it moves forward with the implementation of the planned innovations. Specifically, 10) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment and 11) Follow up after hospitalization for mental illness, 7 & 30 days. Although we recognize that referrals and follow up for treatment and community based support are aspects of care that were presented as standards of practice, we are encouraged by the inclusions of measures 10 and 11 within the Reporting Measure Set. Through monitoring, it is hoped that payment will be tied to referrals and follow-up in the future as an indicator of quality. | Thank you for the comment. |
| 4 | 1 | … we ask that SIM also consider including the PROMIS (Patient Reported Outcomes Measurement Information System) as a tool for measuring physical, mental, and social well-being. Specifically, as included by the Behavioral Health Design Group in an initial draft dated January 30, 2015, the 10-item Global Health Short Form. This would encourage providers to begin to include a more wellness oriented, and whole-person perspective when delivering care. | This instrument does not appear to result in NQF endorsed measures. As such, it would not be suitable for value-based payment. We will, however, share your comment with the Practice Transformation Task Force as this does appear to be a tool that could further our care delivery reforms. |

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| 5 | 1 | …it is an important step for SIM to propose that individuals who receive behavioral health services, either within a primary care setting or through a behavioral health provider, have the opportunity participate in the care experience survey, referenced beginning on page 57, and proposed to begin this year for baseline data collection. While, it is noteworthy they care experience will only be captured for individuals with private health plans. This is concerning because it is widely recognized that this is an area where individuals often report dissatisfaction that disrupts their overall engagement in care. It will be important that SIM continues to attend to this component of the proposed quality measures to ensure that payers factor the results of the care experience surveys into the payments calculations for future payment distribution cycles. | The administration of the PCMH CAHPS will be undertaken for participating commercial populations and will continue to be used for Medicaid beneficiaries as part of the DSS PCMH+ value-based payment program. The SIM PMO and DSS, respectively, will monitor the use of these measures for payment purposes and will review the benefits of doing so with stakeholders before recommending that these measures be continued. |

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| 6 | 2 | In our comments, we are taking an approach of offering a few general principles. We have taken the liberty to attach a grid that compares the SIM quality measure set to other existing sets of metrics. This grid is still a work-in-progress, but we are using it to keep the metrics organized. We have included a column that indicates the level of measurement for which each of the metrics has been validated (according their specifications as listed by NQF). We would suggest that the most important overarching principle for this process is that all metrics be used at the level for which they have been validated. For example, metrics validated at the health system level should not be used at the physician level. | The SIM PMO supports the general principle that measures should be used at the level for which they have been validated. However, we believe that there are circumstances under which exceptions are reasonable and appropriate as long as payers and providers recognize the potential limitations of such measures. In the case of the proposed core measure set, most of the recommended measures (based on the commenter's grid) appear to be appropriate for measuring the performance of an integrated delivery systems. Of the 12 exceptions, 5 are currently in use for measuring ACO performance as part of the Medicare Shared Savings Program (MSSP), another measure is very similar in specification to one of the 5 (NQF 1885) and presumably has similar characteristics. The PCMH CAHPS is intended for use with clinician/groups; however, the measure developer feels it is appropriate for measuring health system performance and it is comparable to the ACO CAHPS in use in MSSP.<br>Should this be a guiding principle?<br>Discuss remaining measures:<br>• Developmental screening<br>• Adolescent well visit<br>• BH screening (custom)<br>• Child and Adolescent MDD (suicide risk assessment)<br>• Unhealthy alcohol use |

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| 7 | 2 | In general, we are supportive of the use of metrics from the CHIPRA core measure set as well as those included in CAHPS. However, these metrics are often more appropriate for epidemiological surveillance purposes and not specifically designed for payment models. As a general principle, to be used for a payment model, metrics should have absolute targets of success available. For example, metrics for vaccination rates typically do have absolute targets whereas a metric like avoiding the emergency department for patients with asthma lacks an absolute target. For the latter, there may be some non-preventable reasons why patients will need to use the ED and we do not really know how to identify the "right percentage". This type of issue can make payment models unfair. | This is a principle that has been followed with very few exceptions in the Core measure set. In the case of ED visits, the Council ultimately recommended against a pure measure of visit volume (with limitations of the sort noted in your comment) in favor of measures that balance population risk with observed frequency. This is the approach taken in a new measure of ED use that NCQA is currently piloting. Should this be a guiding principle? |
| 7 | 2 | We believe that no metrics should be used for payment purposes until they have been used as reporting measures for at least two years. This principle is important because it allows sufficient opportunity for field testing and for understanding how the metric works in a specific environment. | The purpose of the Quality Council report is to recommend measures for use in value-based payment. It is not within the current scope of the Quality Council to establish recommendations regarding the use of the measures (e.g., attribution, weighting). Recommendations regarding use of measures may be considered in the future.<br>Payers vary with respect to the experience they have with individual measures and, as such, we defer to payers as to extent that a measure should be field tested or "reporting only" before implementing as a payment measure. |

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| 8 | 2 | We are not supportive of metrics based upon electronic-EHR data at this time. Given the statewide challenges to date with Meaningful Use, we believe that infrastructures and analytic capacities are not yet robust enough to take that step. …we look forward to a time when it will be possible to reliably capture the appropriate information. We would suggest that you consider pilot testing the ability to capture information from electronic health records, and we would be happy to work with you to determine the infrastructure and systems that would be required. | We share your concern about the challenges associated with reliable and valid reporting of EHR-sourced quality measures. The Quality Council has recommended EHR-sourced measures with the expectation that the State, payers and providers will begin taking steps to produce these measures and that they will be adopted when minimum standards for reliability, validity and verifiability have been met. Payers may differ as to the stringency with which they apply such standards before seeking to negotiate the inclusion of EHR-sourced measures into value-based payment contracts. Note, some payers including CMS have implemented EHR-sourced measures using generally accepted NCQA methods for calculating hybrid measures, which rely on sampling and can be subject to verification. The Council recommendations do not preclude this approach, although we recognize that this presents a greater resource burden on both payers and providers.<br>Finally, the State intends to pilot methods to support the efficient collection of EHR-sourced measures using federal SIM funds. The Quality Council recommendations provide an important point of reference as to which measures the State should prioritize for testing. |
| 9 | 2 | We would suggest that you consider convening a coordinated stakeholder group that could perform a detailed peer review assessment of each of the metrics on this list and assess the appropriateness of those metrics for payment models. This group would follow the industry model to ensure the list is properly curated. Such a process could encompass a full literature review and the solicitation of comments from quality experts in other states to learn from their experiences using some of these metrics for payment models. | While we recognize the value of a more rigorous approach to recommending measures for multi-payer alignment, the proposed approach is currently beyond the resources of the SIM Program Management Office. The Program Management Office will consider opportunities to strengthen our methods in future review cycles. |

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| 10 | 3 | To support the adoption of a balanced Measure set, commenter recommends that only endorsed performance measures be included in the Core Measure Set of the value-based program. | This is one of the Council's guiding principles and it is one that has been followed with very few exceptions in the Core measure set. A few exceptions to this principle were made when the importance of the measure and potential benefits were viewed as outweighing the preference for endorsement. |
| 11 | 3 | 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 modes. (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 the 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. | We agree with this comment. We specifically sought to align our selection of EHR sourced measures with those identified for Meaningful Use and PQRS. These federal measure sets are light on measures of prenatal care and pediatrics, so exceptions we made exceptions for development screening and prenatal/post-partum care. In addition, we included a second depression remission measure because the business process to produce this measure will be similar to the one that is included on PQRS and because this measure was endorsed by the Core Quality Measure Collaborative, which has substantial physician participation. |
| 12 | 3 | …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 … 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. | The purpose of the Quality Council report is to recommend measures for use in value-based payment. It is not within the current scope of the Quality Council to establish recommendations or policies and procedures regarding the use of the measures (e.g., attribution, weighting). Recommendations regarding use of measures may be considered in the future. |

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| 13 | 3 | 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 add to a validated survey instrument, the survey instrument must be validated again. …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… 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 SIM PMO is working with Yale University, one of the two research teams that supports the development and testing of the CAHPS for the Agency for Healthcare Research and Policy, in support of our efforts to enable the use of CAHPS for value-based payment.<br>Note that the CAHPS is comprised of more than 35 questions, which yield a small number of performance measures corresponding to a small number of care experience domains. The addition of several new BH questions to the PCMH CAHPS does not invalidate the other measures that are derived from the core PCMH CAHPS question sets. That said, Yale does intend to examine the data obtained in the baseline survey in order to determine the suitability of each CAHPS component measure for use in value-based payment. For example, it may be that there is insufficient opportunity for improvement to warrant the inclusion of one of the CAHPS measures in a commercial value-based payment scorecard. The characteristics of the BH items will also be examined, prior to recommending their use in reporting. Of particular interest is determining whether base rate responses to these items are sufficient. So at this time, we intend to maintain the recommendation that the PCMH CAHPS be included in value-based payment, without yet specifying the measure domains to which that recommendation applies. We will include a clarifying comment in the report.<br>Finally, the Care Experience Design Group conferred with Yale regarding the Cultural Competence Item Set and determined that it is not suitable for use in value-based payment due to weaknesses in the statistics properties of the resulting measures. |

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| 14 | 3 | 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 NQF Perinatal and Reproductive Health Project 2015-2016 includes this measure. It is under review and possible revision at this time. … 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. | Discuss disposition of 1517 |
| 15 | 3 | 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. … 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, … strongly discourages the use of race and ethnicity as part of a value-based payment system.<br>However, … 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. … 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. | Discuss…should the health equity measurement methods be explicitly referred to as a "development" activity given that there are currently no methods yet specified or tested? |

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| 17 | 3 | 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, … urges thoughtfulness and patience. Healthcare providers are allocating resources at a pace and a price unrivaled in recent history. …urge 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. | Thank you for this comment. The Council recognizes the importance of choosing aligned and nationally recognized measures, while also allowing for innovation in critical areas such as health equity. The Council also recognizes the importance of avoiding unnecessary additional resource burden on providers and, in fact, is undertaking this effort in part to reduce the problem of having too numerous and too varied measures in use by payers today. |
| 18 | 3 | …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. | We acknowledge the significance of the challenges that exist with respect to BH access. Although some of these challenges are beyond the control of providers, we believe that there are solutions that providers can pursue that can substantially reduce the barriers to access that are predominant in the system today. The inclusion of these measures will reward providers that succeed in implementing such solutions. Note that SIM funding for technical assistance is available through CCIP to support integrated behavioral health care. |
| 19 | 3 | …recommends that reporting mechanisms be addressed prior to implementation. 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. | The purpose of the Quality Council report is to recommend measures for use in value-based payment. It is not within the current scope of the Quality Council to establish recommendations or regarding the use of the measures (e.g., attribution, weighting). We would encourage payers and providers to define these expectations when negotiating value-based payment contracts. |

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| 20 | 3 | … 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 File," in the American Journal of Medical Quality, and Kao's article, "Driven to Care: Aligning External Motivators with Intrinsic Motivation," in Health Services Research. | Assuming that this comment relates to the EHR-sourced measures, the State intends to pilot methods to support the efficient collection of EHR-sourced measures using federal SIM funds. Minimizing the burden that such methods impose on providers will be a key design consideration. |
| 21 | 4 | Health Equity – Addressing current disparities. Currently, there are 7 Equity-related measures in the Core Measure Set. There are two recent publications that portray health disparities in Connecticut. Re-examining the following and reconsidering its inclusion into the Measure Set will go far to address these prominent disparities that are present – 1. Racial, Ethnic Disparities Common in Connecticut Hospital Readmissions http://csms.org/2015/02/05/racial-ethnic-disparities-common-in-ct-hospital-readmissions/ 2. Despite Efforts, Black Women Deliver More Preterm Births http://c-hit.org/2016/02/23/despite-efforts-black-women-deliver-more-preterm-births/ | Thank you for this comment. Plan all-cause readmission is already designated as a health equity priority measure. Discuss disposition of 1517 |

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| 22 | 4 | Health Equity – Uniformity in capturing Race, Ethnicity, Language & Status (RELS) data. Of the 7 Equity-related measures in the Core Measure Set – 1 is sourced from PCMH-CAHPS, 2 are sourced from Claims data and 3 are derived from EHR sources. It is unclear how Race, Ethnicity, Language & Status (RELS) data is acquired, assessed and inserted into the Measure Sets. While there are several approaches: geocoding by race & ethnicity (e.g., CENSUS), deduction by 'last name', and cross-tabulation of external database (e.g., birth records) – it would be more beneficial to undertake a more precise manner of gathering RELS data.<br>I would like to suggest to promote a more systematic and uniform process of capturing RELS data across the SIM implementation using predefined guidelines and categorizations. CT-SIM plans to deploy community health workers, implement population health management and leverage 'cultural competency' of its participatory organizations to achieve its goals. But, this may be difficult to achieve without a standardized manner of addressing RELS data and tracking the outcomes during the various phases of value-based care. A minimum standard REL data-set can traverse across the various participatory systems within CCIP and PCMH, to assure uniformity and make interoperability across various entities more harmonious. It would be beneficial to encourage patients in their self-reporting of their RELS data. This could be achieved via healthcare literacy programs, cooperation of Community Health Workers and Provider staff that are closer to the patients. | We concur with the recommendation that trusted providers be the primary means of encouraging the self-reporting of RELS data. Although the collection of structured demographic data including race/ethnicity is a requirement of Meaningful Use Stages 1 and 2 (50% and 80% respectively) we also believe that technical assistance can play a role. Accordingly, the collection of RELS data using the 900+ CDC categories is a prominent feature of the Health Equity Improvement Standard of the Community and Clinical Integration Program (CCIP) and the associated technical assistance strategy. |

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| 24 | 4 | Health Equity - Inclusion for Social & Behavioral data into EHR<br>There is ample evidence that addressing social and behavioral determinants of health can bring achievement in health equity. Linkages between these determinants and disparities are important to identify conditions and contribute to the diagnosis and treatments. Recently, the Institute Of Medicine (IOM) released recommendations to incorporate measures of Social and Behavioral determinants of health into EHRs. It provides standard measures with clinical usefulness and is conducive to the clinical workflow. This approach of including Social and Behavioral data provides several opportunities and benefits for value-based care:<br>1. It can permit greater precision in diagnoses and improve treatment<br>2. This approach can facilitate more effective shared decision making<br>3. The measures can help clinicians to identify risk factors<br>4. The information can prompt the clinical team to refer a patient to a public health department or a community agency to address problems<br>5. Information on social and behavioral factors can expand health systems' capacity to tailor services to their population's needs<br>6. Use of these measures can broaden the patient context available to researchers for EHRs, which would store standard measures of social conditions and behavioral risk alongside clinical data I would like to suggest that the above approach be considered for a Reporting Measure set and it can also supplement the operations in Community health settings and Population Health management. | Thank you for these comments and your reference to the work conducted by the IOM entitled Capturing Social and Behavioral Domains and Measures in Electronic Health Records: Phase 2. The measures identified in this report do not appear to be specified for quality measurement or performance measurement purposes and, as such, may not have immediate implications for the work of the Council.<br>We have, however, shared this report with our care delivery transformation staff and will examine the extent to which these proposed measures have been adopted in the latest EHR certification requirements. New EHR capabilities related to social and behavioral health determinants can be leveraged in support of our Community and Clinical Integration Program standards and technical assistance activities. These capabilities are already reflected in our CCIP Standard 2 related to the collection of race/ethnic data. |
| 25 | 5 | I commend the Committee and SIM Steering Committee for including Item 6: "Oral Evaluation, Dental Services (Medicaid only) in the "Reporting Only" Measure Set', NQF 2517. This procedure is completed in the dental home, but increasing awareness and referral to the dental home by the health homes is critical to maintain or improve the health of the children. It had been listed on your report for Medicaid only. As this is the only place we can receive quality data at this time, it is most appropriate. In the future, when this data is more available from the commercial payers, it should be expanded to all children. | We will revisit this measure when oral health data is more readily available to commercial health plans for reporting. |

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| 26 | 5 | It is imperative that an oral health measurement be included that measures actions taken in the health home. In the past, I supported along with some of the members of the Quality Control and Steering Committee, the inclusion of Item 12: "Oral Health: Primary Caries Prevention," NQF formerly-endorsed 1419. The measure tracks the extent to which the PCMP or clinic applies fluoride varnish as part of the EPSDT examinations and the increase from year to year. I recommend that this measurement be moved from Developmental to the Core Measure Set, as it can is being tracked for Medicaid patients and by commercial insurers. …there are more Medicaid practitioners trained and applying that training in practice within the state. It will be a short time before the data on Code 99188 will be available from commercial insurers to continue the tracking in for all. | Discuss disposition of 1419 |
| 27 | 6 | … as a Medicare Accountable Care Organization, we use the CAHPS surveys that required of participants in the Medicare Shared Savings program, which is not one and the same as the PCMH-CAHPS version. There is additional cost and inefficiency in managing the distribution of different surveys to patients for different programs; [we do] not intend to use the PCMH CAHPS tool even if it does move forward w/PCMH renewal. | The recommended use of PCMH CAHPS will not necessarily introduce new inefficiencies since the PCMH CAHPS is targeting a different non-overlapping population. Moreover, in order to minimize inefficiency and cost, the State is preparing to undertake a single payer agnostic administration on behalf of commercial payers and their accountable Advanced Network providers. Rather than sampling by each payer/Advanced Network at a statistically sufficient sampling rate, the CAHPS vendor will pull a single sample proportionate to each payer's representation on the Advanced Network's panel. We intend to use SIM funds to cover the cost of the first three administration cycles and then assess the value of the use of PCMH CAHPS for this purpose. At that time, we will also discuss the extent to which the ongoing costs of the survey should be borne by payers, providers or the State. |
| 28 | 6 | Annual monitoring for persistent medications: This has become a standard metric for patients >65 but less prevalent for the younger population | Research in progress |

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| 29 | 6 | Cervical cancer screening: PCPs are typically frustrated by this metric in that most gynecological care is performed by the gynecologist. | We acknowledge that gynecologists perform most of these screenings; however, this is also one of the most important preventive screening activities for which PCPs have some responsibility as the lead practitioner and coordinator of care. Moreover, this expectation is analogous to breast cancer screening, which is also frequently ordered by the gynecologist.<br>In addition, patients who rely exclusively on their gynecologist for primary care likely will not be attributed to a PCP under a value-based payment arrangement. |
| 30 | 6 | Chlamydia screening: This is a very controversial measure for PCP for two key reasons: similar to the cervical cancer screening, the chlamydia screenings are being performed outside the primary care office. Secondly, the HEDIS definition makes this measure difficult to track. There are nuances around how they define an eligible population (i.e., use of birth control as an indication that the patient is sexually active) that raise concern about documentation and whether the patient will provide a truthful response. | Discuss with Council |
| 31 | 6 | Adolescent female immunizations for HPV: This metric went to our Clinical Council for consideration in 2015 and was unanimously voted down. Concerns include minimum age and parental influence | Discuss with Council |
| 32 | 6 | Weight assessment and counseling for nutrition and physical activity for children and adolescents: This would be much better accepted if there was reimbursement for nutritional consults and follow-up visits. Difficult to document in a manner that can be easily exported for reporting. If it was a billable service, the CPT code could be used to track activity. | We acknowledge the commenter's interest in fee for service reimbursement for these activities. However, scope of coverage is beyond the purview of the Quality Council. We believe that documentation procedures can be put into place that parallel those for *NQF 0421 Preventative care and screening: BMI screening and follow up*, which most providers have established to support participation in the Medicare Shared Savings Program (MSSP). |

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| 33 | 6 | Developmental screening in first 3 years in life: Needs to be clearly defined – what instrument/tool is acceptable, how is this tracked, is there clear billing guidance? Health plans often have very different policies on this and sometimes the codes that they recommend are contrary to guidance from the AAP. | We believe that the specification for this measure is sufficient and that the issues can be addressed during implementation. We will raise with participating payers in the Quality Council the importance of aligning as much as possible payer specific billing guidance across payers and with the CMS specifications.<br>Please note the federal specifications for this measure contained in the CMS document entitled: Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2016 Reporting, June 2016.<br>The numerators identify children who were screened for risk of developmental, behavioral, and social delays using a standardized tool. During the development of the measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (socioeconomic development or autism, respectively), rather than a full, general assessment of developmental delays. |
| 34 | 6 | Behavioral health screening: Similar to developmental screening, the instrument/tool and billing codes must be clear and standardized across payors. | This measure is only recommended for Medicaid, which has specified the instrument/tool and billing codes as part of its PCMH+ program. |
| 35 | 6 | Asthma medication ratio: This will be a tough sell. In my experience, providers are agreeable to being held accountable for what they prescribe; but are extremely hesitant to be evaluated on whether the patient adheres to the prescribed regimen. | This measure is no longer included in the recommended core measure set. |

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| 36 | 6 | Diabetes A1c control (>9%): This is a standard metric across commercial and Medicare plans, both MSSP and Medicare Advantage. However, it is critical that the health plans be able to supplement claims data with the lab values they might receive from providers' charts. Reporting from the EHR sounds easy but it's actually very complicated to pull the data and transfer it to the receiving party in a standardized electronic manner. I would suspect that small practices will have a difficult time with this. | We acknowledge the importance of these concerns related to data completeness and feasibility. Accordingly, this measure is not recommended as a claims-based measure.<br>The State intends to pilot methods to support the efficient collection of EHR-sourced measures using a combination of state and federal SIM funds. We are not asking payers to adopt the EHR source measures until an acceptable data collection methodology is in place. |
| 37 | 6 | Diabetes eye exam: See A1c control above … Same concerns. This is one of the more controversial measures: patients don't want to go to an eye doctor, ophthalmologists don't send reports, significant staff time and expense to tracking down results. | See above. Several states have developed methods for EHR sourced clinical quality measure reporting using person-centered methods that compile results across multiple un-affiliated providers involved in a patient's care. This use case will be considered in the development of our CQM production solution. |
| 38 | 6 | Use of imaging studies for low back pain: This is popular among commercial plans but frustrating to PCPs who are not typically the ones ordering the imaging. Our providers think the onus for evaluating the appropriateness should be placed on the health plan or radiologist. | We acknowledge this concern, however, PCPs have the ability to develop referral relationships with subspecialty providers who practice in accordance with accepted standards of practice and provide high value care. |
| 39 | 6 | Avoidance of antibiotic treatment in adults w/acute bronchitis: Another popular commercial metric that is difficult to truly evaluate based on claims data. There are other considerations that might influence whether an antibiotic is prescribed and those nuances can't be captured in claims. | Discuss with Council |
| 40 | 6 | Appropriate treatment for children w/URI: See [previous]. Claims do not tell the whole story. | Discuss with Council |
| 41 | 6 | Follow-up care for children prescribed ADHD medication: We have this as an internal metric now but we did get a lot of pushback from PCPs who were not writing the ADHD scripts (ADHD specialists, psychiatrists, etc.) The concern is that if a child is seeing a specialist for their medications/counseling, there is no incremental value to coming in for a PCP visit (additional copay). We had to change our metric accordingly. | Research in progress |

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| 42 | 6 | Adolescent on antipsychotics: Not sure what custom measure means but if it applies to PCPs, I can imagine that the pushback would be even more significant if the PCP is not writing the antipsychotic prescription. | Research in progress, question to DSS |
| 43 | 6 | Depression remission at 12 months: We reported on this for the 1st time in 2015 and the results taught us an important lesson about how this is calculated. The denominator ends up being very small so you either do really well or terrible. This is the result of the appropriateness of doing another depression screening to document the PHQ score when the patient has already been diagnosed as depressed. It is counterintuitive to do follow-up "screenings" based on a confirmed diagnosis. | Research in progress, question out to Pro Health |
| 44 | 6 | Suicide risk assessment; Unhealthy alcohol use: Similar to developmental screening, the instrument/tool and billing codes must be clear and standardized across payors. | The NQF website provides high level information regarding measures 1365 (suicide risk assessment) and access to the detailed specification that has been proposed for the annual update.<br>Discuss whether the PMO should move Unhealthy Alcohol Use to the development site where this non-endorsed NQF measure can be compared with NQF endorsed alternatives including 2152, 1661, 1663, and 2597. |
| 45 | 6 | With respect to the reporting measures, these are not commonly seen in payor arrangements. The two exceptions would be:<br>- % PCPs that meet Meaningful Use<br>- Well-child visits in ages 3-6<br>It would be very difficult to get consensus on the other preventive, acute/chronic, and behavioral health measures unless they were limited to specific specialties (i.e. cardiology, behavioral health providers). PCP buy-in is unlikely. | This concern will be addressed in the revised Quality Council report, which will indicate that the reporting measures are for public scorecard reporting, rather than payer/provider specific reporting under value-based payment arrangements. This will avoid undue reporting burden on the public and private payers and it will enable further development and review of the final reporting set prior to the implementation of the SIM public scorecard. |
| 46 | 6 | The development measures, with the exception of the unplanned admissions, are also non-standard. Almost all are based on claims and the ones that are based on EHR would be subject to a lot of scrutiny given their clinical focus. I'm not sure you'd find a group willing to report patient names for these acute and chronic conditions. Diabetic foot exams would be fine. | We acknowledge that the measures on the development set present an array of challenges that need to be addressed in order for any of these measures to be recommended for the core measure set. |

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| 47 | 6 | Overall, even with just the 33 core measures, it will be a lot for providers to absorb, especially if they are new to the value-based environment and have limited infrastructure to be able to identify and manage so much at once. Most of the commercial plans limit the # of metrics to 10-20. MSSP has 33 metrics and our providers firmly believe that is too many at one time. Consistency with the standard metrics is the key to engaging providers; raising the bar too high too quickly will cause providers to feel the "ask" is impossible and disengage altogether. | We acknowledge the burden that so many measures entail and will take this under consideration as we finalize the recommended core measure set. The Council had as a reference that at least one commercial payer with the largest portfolio of SSP arrangements routinely includes more than 25 measures. |
| 48 | 7 | I am pleased to see that of the 5 measures our CT school based health center teams are testing in a national quality initiative for SBHC-specific National Performance Measures, all 5 measures are included in your listing. We are testing: annual well child exams, annual depression screening for youth 12 yrs or greater, annual chlamydia screening for sexually-active youth, annual risk assessment, and annual BMI assessment and nutrition/physical activity counseling in students 3-20 years of age. These were selected through a yearlong Rand Delphi process drawn from several nationally recognized measure sets. The challenge in reporting on some of these measures is how they were entered into the EHR. For example, a depression screen is regularly conducted during a risk assessment, but the results may not be entered as a separate result in the record, so extracting it as a separate measure is difficult. Moving forward, the data required in the measures sets will need to be entered in accordance with the desired report. | Thank you for your comment. We are also pleased with the alignment and acknowledge the challenges associated with depression screening, risk assessment, and symptom measurement (PHQ-9). |
| 49 | 8 | I would recommend that item 6 from the 'Reporting Measure Set' under 'Prevention': 'Oral Evaluation, Dental Services (Medicaid only)' be moved to the 'Core Measure Set'.<br>Dental caries is the most common childhood disease. Both caries and periodontal disease, chronic conditions, are very common in adults. They are significantly more common that a number of the other diseases in the 'Prevention' section of the 'Core Measure Set'.<br>Dental diseases are serious, causing missed school, work and a great deal of pain. While there is no comprehensive collection of the data, a number of deaths from complications of these infections have been reported. | Oral health coverage is not uniform in commercial pediatric populations. As such, reported performance for an Advanced Network or FQHC may reflect variations in coverage within the attributed population rather than the effectiveness of the practice in ensuring the use of routine preventative oral evaluation. In addition, oral health coverage is often separate from medical coverage and thus not available to commercial payers. For these reasons, we do not feel that this measure is an appropriate payment measure for commercial pediatric populations. |

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| 50 | 9 | I am writing to ask you about the SIM quality measures, asking to move the oral health measures from the Development Set (page 8) and the Reporting Only set (page 9) to the Core Measure Set.<br>…prevention is the way to go. It's cheaper (so important in this state), less painful for the patient and it is easy. | With respect to Oral Evaluation, Dental Services (Medicaid only, NQF 2517), please see response to question #49. For 1419 discuss |
| 51 | 10 | I am concerned that the voluntary nature of payers aligning with the measures, coupled with the number of core measures, leaves room for self-selection that may exclude some of the core equity measures in the set. While I applaud the inclusion of language on page 60 that encourages payers with race/ethnicity data to include a focus on health equity in the VBP contracts, it seemingly contradicts the strong language to move forward with inclusion of the equity specific measures as noted on page 8. I have a preference for the language on page 8 and would encourage that if the phrasing remains as is in both sections, that the draft go a step further and encourage payers to begin to collect this data in a uniform, inclusive, non-discriminating, and reportable manner going forward. | We do not recommend relying on payers to collect race/ethnic information because we believe consumers are more likely to self-report when requested by their providers. Consumers often have a trusting relationship with their providers and providers are in a position to explain the reason that such information can enable them to provide better care. |
| 52 | 10 | There is a missing measure. On the SIM PMO Consumer Advisory Board website, there are slides posted from a webinar on July 28th (the July 27th slides are not accessible using the web link). The Health Equity Design Group Recommended Measures Summary slide (slide 10) includes Diabetes mellitus HbA1c screening as an equity measure. However, in the draft report, this is not recorded as an equity measure in any chart listing in the measure set (charts located on pages 7, 47, and 59). I am not sure if this is an oversight but argue that given the disparate impact of diabetes on racial and ethnic populations and the importance of screening populations with risk factors to prevent complications (and often full conversion to type 2 diabetes), this measure should be included as an equity measure. | The final recommendation of the Health Equity Design Group discussed in the Quality Council meeting of August 12, 2015 did not include HbA1c testing as a recommended claims based measure. However, given the challenges associated with implementing the EHR-sourced measure HbA1c measure, we have added HbA1c testing as a recommended claims-sourced health equity measure. |

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| 53 | 10 | There are additional measures in the provisional core set that should be included as equity measures because of the disparate impact on racial and ethnic populations. They are as follows:<br>o Breast cancer screening<br>o Cervical cancer screening<br>o Chlamydia screening in women | We acknowledge the commenters concern about the important quality performance areas for which health equity measures have not been recommended. There are currently no NQF endorsed measures or methods specific to health equity. Accordingly, we are covering new ground in proposing to include such measures on Connecticut's core measure set. We believe that it is appropriate to develop and test our methods on a small number of measures, before considering whether and to what extent the scope of recommended health equity measures should be broadened. |
| 54 | 10 | … I have concerns about the number of core measures. However, beyond this concern, it is troubling that the initial set of measures – the claims-based measures – only contain three measures identified as equity measures by the HEDG.* Thought of differently, only three out of seventeen measures (17%) relate to closing health equity gaps. The HEDG group put forth eight total recommendations and while several relay on electronic health record (EHR) data, I am concerned that focusing on closing the health equity gaps in quality and outcomes is tied to a challenging process to build this level of technological capability. | See above. |

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| 55 | 10 | There is an overall concern with creating a tiered system of quality. The voluntary nature of aligning the measure set will improve the quality of care for some and not for others. High quality care with optimal outcomes for disparately impacted populations, regardless of carrier, should be widely available. Ideally, all payers should be convinced that this is the right way to proceed and the state should mandate this in any way possible. | We strongly agree with the importance of promoting alignment across all payers and populations. However, we do not believe that non-alignment will create a tiered system of quality. The primary disadvantage to a lack of alignment on payment measures is the inefficiency it creates for providers and the corresponding drag it creates on providers' efforts to improve care for patient panels. Finally, SIM is premised on the notion of voluntary participation. We intend to promote alignment to the greatest extent possible. However, state legislative authority is limited because more than half of the commercially insured population is in an ERISA exempt plan. |
| 56 | 10 | This section outlines a few "technical" issues with the document that may or may not be directly tied to health equity.<br>• In the core measure set, it is unclear which two measures are recommended for Medicaid only.<br>• In the final version of the document, it would be helpful to repeat the chart headings on each page for ease of following what category the measures are for (equity vs MQISSP).<br>• Acronyms not appearing in the acronym list on page 3 but appearing on the core measure chart: OHSU (core measure#10); CMMC (core measure#11); AMA/PCPI (core measure #14,31,32); MNCM (core measure#29 & 30) | Thank you for these comments. We will address these issues in the final document. |

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| 57 | 11 | This measure (Developmental screening in the first three years of life, NQF 1448) is included as an electronic health record measure when it is easily assessed using claims from Medicaid and commercial insurance plans. Both types of payers reimburse child health providers for developmental screening on the same day as a well child exam. The CPT code is 96110, and Medicaid in CT requires the addition of a U code modifier to signify whether or not the screening yielded any concerns.<br>Developmental screening with a formal, validated tool in the first three years of life is an EPSDT approved service. The American Academy of Pediatrics endorses developmental screening at the 9, 18 and 30 month well child exams. NCQA medical home standard #3 includes developmental screening with a formal tool for practices that serve pediatric patients. Medicaid in CT approved payment in 2006, and commercial insurers followed. The measure is also a PCMH performance measure. Rates of screening for PCMH practices in 2014 reached 37% of children 3 and younger.<br>It is important that this measure be considered claims based to ensure that it is included in the initial implementation of quality measures. | We appreciate the interest in maximizing the ease and efficiency of reporting on recommended measures. In this case, we have concerns about recommending the measure as a claims-based measure, without knowing whether the policies and procedures are in place to ensure reliable and valid reporting. Please note the federal guidance (reproduced in italics below) regarding reliance on claims vs EHR excerpted from the CMS document entitled:<br>Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) Technical Specifications and Resource Manual for Federal Fiscal Year 2016 Reporting, June 2016.<br><br>Acknowledging that there are circumstances under which claims-based reporting may be acceptable, we will asterisk the reference to EHR as source in the final recommendation and incorporate the reference below.<br><br>*Guidance for Reporting:*<br>• *This measure includes three age-specific indicators assessing whether children are screened by their first, second or third birthdays. Four rates, one for each age group and a combined rate, are to be calculated and reported.*<br>• *The code 96110 has been shown to have questionable validity in states that do not have policies clarifying the standardized tools meeting the criterion stated in the specification (see Section C). The measure steward recommends that such policies be in place if a state uses the administrative data component of the specifications. It is recommended (although not required) that states assess the accuracy of their claims/encounter data compared to medical charts. For example, a state could do a chart review on a sample of records where the CPT code was used to* |

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| | | | *determine whether the developmental screening occurred and whether the tools used met the criteria for a standardized developmental screening. To facilitate CMS's understanding of the data reported for this measure, states should use the "Additional Notes on Measure" field to document whether a medical chart review was conducted to validate the use of the 96110 CPT code for this measure.*<br>• *States may calculate this measure using either the administrative specification (which depends on the 96110 CPT code) or the hybrid specification (which does not rely solely on this code).*<br>• *Only those tools cited in the specifications for this measure meet the criteria for the numerator. During the development of the measure, it was determined that the ASQ:SE and M-CHAT screening tools were too specific because they screen for a domain-specific condition (socioeconomic development or autism, respectively), rather than a full, general assessment of developmental delays. States should use the "Deviations from Measure Specifications" field to document any deviations from the specifications for this measure.* |

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| 58 | 12 | …believes that inclusion in the collection of all health data including payer data is as important to the health of our communities as is access to language, diagnostic tests and treatment. The language of this report alludes to the collection of more granular data but provides no specifics on what communities will be included.<br>We are requesting that this language be changed to include all communities living in Connecticut without regard for their size. While we understand that data analysis may not be possible for all groups in building a foundation for data collection we must assure that no one is excluded. | The Quality Council did not deliberate on the question of granularity of race/ethnic data collection by providers and thus the report is not prescriptive on this point. The collection of such data is in the purview of the Practice Transformation Task Force and the language in their CCIP final draft report and standards is substantially more prescriptive with respect to the expectation that Advanced Networks and FQHCs collect additional race and ethnicity categories for its patient population that a ) Draw from the recognized "Race & Ethnicity—CDC'' code system in the PHIN Vocabulary Access and Distribution System (VADS)) or a comparable alternative; b) Have the capacity to be aggregated to the broader OMB categories; and c) Be representative of the population it serves, validated by (a) data (e.g., census tract data, surveys of the population) and; (b) input from community and consumer members if the network is implementing fewer than the 900+ available categories.<br>The SIM PMO does not intend to promote more granular race/ethnic data collection for the purpose of value-based payment health equity measures primarily because base rate limitations would not allow the adoption of more granular measures by payers. The SIM PMO does intend to raise the question of race/ethnic stratified reporting for the purpose of the public scorecard, and this could potentially be more granular than the current OMB categories. Separate strategies will be required for claims and EHR-sourced measures. |

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| 59 | 13 | I respectfully request that the oral health measures be moved from the Development and Reporting Only sets to the Core Measure Set. The links between good oral health and good general health have become clear and undisputed. The connections include such diseases/conditions as endocarditis, cardiovascular disease, premature and low birth weight pregnancies, and many more. | With respect to Oral Evaluation, Dental Services (Medicaid only, NQF 2517), please see response to question #49. Discuss disposition of 1419 |

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| 60 | 14 | Prenatal and Postpartum Care (NQF 1517)<br>Maintaining health during and after pregnancy is an important way for women to prevent complications that can adversely affect their health and the health of their baby. Early prenatal care is essential to helping a woman monitor her pregnancy and control existing conditions like high blood pressure and diabetes. Healthy diet education, counseling, vitamin supplements, identification of maternal risk factors, and health promotion must occur in early pregnancy to have an optimal effect on the mother's and baby's health. Postpartum care assesses a woman's physical and mental well-being after delivery and provides breast-feeding support, nutrition counseling for mother and baby, and family planning guidance.<br>The merits of this measure as part of an ACO shared savings program model include:<br>- Cost savings realized through prenatal care given early and continually in the course of pregnancy to deter high risk pregnancies that result in very preterm, preterm, very low, and low birth weight babies. These birth outcomes adversely affect women of color the most, with non-Hispanic Blacks experiencing highest rates of very preterm and preterm, and very low and low birth rate babies, followed by Hispanic women.<br>- Postpartum care detects health problems of the mother and/or baby at an early stage, encourages breastfeeding, and provides families with support for a good start. -Postpartum care such as educational visits to a pediatrician is essential to improving maternal-infant parenting skills.<br>- Family planning guidance contributes to the health of both mother and baby by providing time for appropriate development. A woman's ability to use contraceptives and determine whether and when to have another child also enhances her education and employment chances. In turn, this improves her income, family stability, mental health and happiness, and the well-being of her other children.<br>… appreciates consideration of this important measure to the Core Set of quality metrics. Including this measure will ensure the health and well-being of mother and child. It will also help to avoid complications associated with preterm and low birth weight babies, some of which may be lifelong developmental and physical disabilities requiring long term support services. | Discuss disposition of 1517 |

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