eCQM Final Report and Recommendations

Summary of Comments

The following is a collection of input received from the Health IT Advisory Council and the public for the eCQM Design Group's *Final Report and Recommendations.* The Design Group deliberated and identified several governance, operations and general recommendations for a statewide quality measurement system. Council members were asked to provide their feedback to the Final Report and Recommendations for the May 18th statewide Health IT Advisory Council meeting.

As of May 8th, the Health IT Program Management Office (HIT PMO) received input from 22 out of the 29 Council members with a total of six (6) written comments in which five (5) were from council members and one (1) was a public member.

- 18 Council members **Agreed** with the eCQM Recommendations
- 03 Council members had **no additional comments** to the eCQM Recommendations
- 01 Council member provided feedback without statement of agreement/disagreement

Summary of Council Members Comments

- This document is good.

  One suggestion: In order to truly measure value to the consumer, it is important to have full cost transparency for the consumer, so he/she can assess value to him/herself. That includes the all-in cost of healthcare to the consumer: premium plus all other patient responsibilities.

  I understand that this concept is embedded in the document's thinking, now, but for my own part, I would like to see this called out a bit more. Perhaps some language could be added somewhere, perhaps on the table at p. 22 where patient cost transparency is being discussed. (Though the language below is a little long to fit there), along the following lines:

  Measuring quality is an important part of the true assessment of value to the consumer, but value assessment also requires taking into account all the financial costs that the consumer must personally bear. The only measure that matters is all-in cost to the consumer. For this reason, the patient costs calculation must include premiums, but also must include all of the other financial patient responsibilities, such as co-pays, deductibles, co-insurance, and any other costs borne by the consumer.

  Thanks for the opportunity to review. This looks very good.

- I'm sorry to take so long getting back to you about the final eCQM report and recommendations. I am not the most fluent in these matters and it takes some time for me to work through it. With that caveat, I can say that I'm impressed with the committee's work and

the resulting product. So far as I can tell, I agree with the recommendations and have no specific comments otherwise.

- Footnote 2 on Page 9 mentions a meeting on April 17 with DSS to get feedback on the work of the design group. I feel it is important to incorporate that feedback or somehow acknowledge it in this final report.

- 1. The work done by the eCQM Design Group is to be commended. In a short period of time, the Design Group was able to put together a reasonable set of requirements for a statewide eCQM solution. The requirements appear to be well-informed by the needs of various stakeholders. Also, it appears as though the Design Group looked at eCQM initiatives by other states. If this has not already been done, we would suggest that during the RFP development process, we collect and examine relevant documents (e.g., RFPs, requirements, project plans, contracts, lessons learned ... etc.) from other states.

  2. We would like to echo the comments made by Matthew Katz during the last HIT meeting that the Council should strongly consider prioritizing the eCQM requirements. The scope of the requirements is very ambitious. Any information system that can meet all of these requirements will be complex, costly, challenging to develop, and challenging to administer. Focusing on a minimal set of requirements for a first phase will prevent the project from languishing and increase the likelihood that appropriate funding can be secured.

  3. We would like to echo the comments made by Lisa Stump during the last HIT meeting that the Enterprise Master Person Index is very important to the success of an eCQM, as well other endeavors within the broader purview of Health Information Exchange. If there are any interface, interoperability, or data governance concerns with an EMPI, they should be addressed proactively and as soon as possible.

  4. In the long run, we would recommend alignment of Quality Measurement Systems in use by State Medicaid Agencies, including DSS, DDS, DMHAS, DCF, DOA, and possibly OEC. Adoption of nationally accepted standard tools, such as the CMS-promoted Personal Experience Survey (PEX) used in "Money Follows the Person," would provide a standards-based approach and comparative data across multiple supported populations.

  5. We should caution the Council that DDS is in the beginning stages of significantly modernizing its information systems. The modernization effort will unfold over many years. One consequence of this modernization is that interfaces to our systems may need to change significantly over time. Another consequence is that DDS IT resources will be strained significantly during the next few years. There is a real need to communicate to **consumers** the value of the current work that is happening at the Advisory Council and in the SIM office.

- Please see the following comments regarding language in the report.

1. On page 3, the Design Group recommends that ***"an additional statewide quality measurement system oversight group be formed"*** to take next steps to implement the following statewide quality measurement value proposition.
   Comment: We question the need for the creation of an additional oversight group.

2. On page 4,***"Explore and recommend mechanisms for financial sustainability once the system is built and functional"***
   Comment: We concur wholeheartedly. If sustainability cannot be reasonably assured, we recommend not launching this initiative until such time that the resources to fund and sustain are secured. The current economic climate suggests a fiscally prudent approach.

3. On page 5, **"*The work of the Electronic Clinical Quality Measures Design Group (Design Group) is ultimately governed by Connecticut state legislation"***
   Comment: P.A. 17-66 does not mention nor reference eCQMs. This technological solution was an attempt to solve for SIM. Market demand and willingness to support this service will be critical to its success.

4. On page 5, **"*Promoting the reuse of enterprise health IT assets, such as a Provider Directory, an Enterprise Master Person Index, Direct Secure Messaging, and Health Information Service Provider (HISP)"***
   Comment: P.A. 16-77 does omits any specific reference to eCQM in this reuse provision.

5. On page 7, ***"In response to the need for a more efficient reporting structure for quality measurement, the Connecticut Health IT Advisory Council chartered the formation of an eCQM Design Group on January 19, 2017, the purpose of which was to identify and recommend the objectives and requirements of a shared, statewide health IT-enabled clinical quality measurement system in the context of APMs"***
   Comment: This is work is directly solving for SIM and this should appropriately be referenced in this section.

6. On page 9, ***"Representation of the Department of Social Services (DSS) was invited at the beginning of the Design Group; however, DSS participation on the Design Group did not take place. A meeting was requested by DSS to be held on April 17, 2017 to give feedback on the work of the Design Group"***
   Comment: Met with Allan Hackney, Dr. Karen Bell, and Dave Fusco on 3/28/17 to review the eCQM report and comments were subsequently provided.

7. On page 11, ***"The system should not contain all data and information relative to care across the continuum on any given patient, but should be limited to data important to assess quality of care and contributing factors"***
   Comment: The intended meaning of this sentence is unclear.

8. On page 17, "***Should integrate with other components of Connecticut's health IT infrastructure, including the state's APCD"***
   Comment: Unsure why the APCD is referenced in this sentence as pg. 14 describes the APCD as being under development.

9. On page 18, ***"Together, these work products and the accompanying governance, operational, and general recommendations build a strong foundation for next steps toward a statewide quality measurement system. However, there is still much work to be done to realize how a statewide quality measurement system can support the vision of better care, smarter spending, better health, and better work life for providers. The Design Group recommends a Request for Proposal (RFP) to procure a vendor to meet the needs of all stakeholders for a statewide quality measurement system, and that an additional statewide quality measurement oversight group be formed to"***
   Comment: Meaning unclear. It might be beneficial to clarify clearly that this effort would not have any governance or oversight related to the Medicaid eCQMs process.

Public Comment

- How will it be possible to merge claims data from the APCD and the EHR data without identifying the APCD data as it becomes part of an identified EHR? State agencies have assured the Public Health Committee that even though a vendor receives identified insurance claims data for the APCD, only de-identified data would be released for study.

  However, it seems that the intention now is to override this provision by possibly using a Master Patient Index Number to merge the APCD and the EHR. But this data will not remain in a closed system that just attributes data. The data then will be released to auditors and studied by many people to make quality care assessments from studying all aspects of patient care, in order to know which provider provided what care to whom, as is called for in the report. Is this report saying that patient data can remain private (vs confidential) and un-identified?

  It is great that patients will be given the option to decide if they want their identified data to be seen by auditors for determining quality care. But in order for that to be possible, there needs to be a clear and specifically delineated pathway for the handling of identified data vs aggregated data in order to judge providers and their patients' care as per:

  Page 14 and Page 19 call for complete clinical data, "encounter" data and demographics of each patient and the care that was provided to them.

  Page 26 indicates that patients are to be linked with providers.

  Page 28 calls for individual and aggregate data to be used in reports.

  Page 20 calls for individual patients to be targeted for improvements in their treatments, meaning that there will always be three entities in any exam room, the provider, the patient and the state auditors reading the record.

  When a provider needs to justify or defend the "quality" of a treatment to a given patient, how will the patient remain unidentified in the deliberations with the oversight groups?