STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
June 17, 2015

Meeting Location: CT Behavioral Health Partnership, 500 Enterprise Drive, Rocky Hill

Members Present: Rohit Bhalla; Aileen Broderick; Mehul Dalal; Deb Dauser Forrest; Steve Frayne; Daniela Giordano; Karin Haberlin; Robert Hockmuth; Elizabeth Krause; Kathy Lavorgna; Arlene Murphy; Robert Nardino; Donna O'Shea; Jean Rexford; Sheryll Roberson (for Todd Varricchio); Andrew Selinger; Steve Wolfson

Members Absent: Mark DeFrancesco; Amy Gagliardi; Kathleen Harding; Kathy Lavorgna; Steve Levine; Donna O'Shea; Meryl Price; Rebecca Santiago; Thomas Woodruff; Robert Zavoski

Call to order
The meeting was called to order at 6:11 p.m. Steve Wolfson served as meeting chair.

Public Comment
There was no public comment

Review and approval of minutes
Approval of minutes was postponed.

Conflict of Interest Protocol
Earlier that day, the Quality Council Executive Team met with Howard Rifkin of the Lieutenant Governor's office regarding the Conflict of Interest Protocol. The intent of the protocol is to ensure there are safeguards in place. The Healthcare Innovation Steering Committee took up the protocol at its last meeting and, while deciding further discussion was needed to determine whether the work groups should fall under the entire State Code of Ethics, requested that the protocol be put into place. There may be a new document to sign based on further Steering Committee discussions.

Robert Nardino asked for an example of something that would constitute a conflict. Dr. Schaefer said that because the work groups are advisory, there are few situations that would pose a clear conflict. One example would be voting on an allocation of monetary recourses when representing an entity that is funded through those resources. However, Dr. Schaefer noted that the Steering Committee is more likely to encounter that example than the other work groups.

Members requested time to review the document before signing it. Deb Dauser Forrest asked what would constitute a conflict for the payer representatives. Dr. Wolfson said that there would only be a conflict if the issue did not impact all of the payers equally.

Steve Frayne asked what would happen if a work group member did not sign the protocol. Dr. Schaefer said the likely outcome would be that the member could not serve. Mr. Frayne expressed concern about the work needed to get the protocol in place for a five week time frame, especially if the Steering Committee decided to make changes. He asked why they would not wait until July to put it into place. He said he will need to bring the protocol to legal counsel and get an opinion which

would require time and an expense. Dr. Schaefer noted that this issue had not been raised as a consideration but would share it with Mr. Rifkin.

Updates
Dr. Schaefer reviewed the work completed to date (see meeting presentation here). Arlene Murphy requested a statement be included that stresses the importance of including an HIV measure. Dr. Schaefer said they will work with the Department of Public Health offline to determine what work is required to incorporate an HIV measure.

Readmission Measures
The Council reviewed NQF #1789 (a CMS measure) and NQF# 1768 (an NCQA measure). Dr. Schaefer noted there has been an effort by NQF to harmonize these measures but that it may not be possible based on the way the measures are constructed. Andrew Selinger asked how #1789 was risk adjusted. It is adjusted based on age, gender, and co-morbidities. Dr. Wolfson asked why #1768 did not apply to Medicaid. Dr. Schaefer said that it could apply but that it had not been implemented. Dr. Forrest asked how the lack of risk standardization for Medicaid impacted the assessment of ACO performance, particularly if an ACO had more commercial patients. Dr. Schaefer said that comparisons are done apples to apples (i.e., commercial to commercial), so Medicaid patients would not impact the commercial comparison nor would commercial impact the Medicaid performance comparison.

The Council discussed the inclusion of self-funded plans in the All Payer Claims Database. Dr. Schaefer said that it is not ready for implementation in 2016. Steve Frayne asked about the impact of using different measures to measure the same thing (e.g., readmission). Dr. Schaefer said they could engage CMMI technical assistance on how to do that. He noted that some states are working to create a panel-wide report. They could aim for high, rather than perfect, alignment.

Dr. Wolfson noted they were looking at either risk standardizing for Medicaid for the NCQA measure or adding behavioral health to the CMS measure. He asked which would be more difficult. Dr. Schaefer did not know. Dr. Schaefer also proposed considering the availability of appropriate national benchmark data. PMO does not know the price of stewarding risk standardization. Dr. Forrest expressed concerns about not having risk standardization for Medicaid.

The Council discussed the existing measure in use for Medicaid for readmissions. Medicaid uses a Medicaid Medical Directors Learning Network readmission measure that is not risk standardized for payment. Dr. Schaefer noted that Medicaid Medical Director Robert Zavoski strongly recommended using the NCQA measure. Dr. Schaefer noted that the Council could endorse the measure and figure out a way to finance the risk standardization with another state. Mr. Frayne noted that Medicaid uses their current readmission measure differently from how Medicare uses theirs. Medicaid uses aggregate performance for the whole Medicaid population.

Daniela Giordano asked whether they were considering using different measures for different payers. Dr. Schaefer said that measures appropriate for an older population could lead to a supplemental common measure set for Medicare Advantage. The Council is seeking alignment across commercial and Medicaid, recognizing that not all measures will be used by all payers.

The Council agreed to include NQF#1768 with the intent to introduce risk standardization for Medicaid.

Other care coordination and patient safety measures

Dr. Schaefer noted that they will not be able to make conclusive decisions as there is base rate information missing. Robert Hockmuth said that Cigna had few patients who entered skilled nursing facilities and that they did not have the volume required for statistical significance. Ms. Murphy asked what is reported at a granular level. Dr. Schaefer said the measures could be calculated based on certain conditions. He noted that with a composite, it is difficult to see where the improvement opportunities are. Ms. Krause said that she is generally in favor of using composites and having few measures rather than more. She asked whether including diabetes and asthma in composite measures loses something. Dr. Dalal said that asthma and diabetes are conditions with significant disparities and there is an advantage to being able to stratify. Dr. Selinger said they would need to be certain they could report out by disease and also noted the importance of rewarding impact on individual conditions like diabetes and asthma. Dr. Schaefer said that you couldn't improve on this composite measure without targeting diabetes and asthma.

NCQA just released an ambulatory care composite measure for Medicare. Dr. Schaefer noted it would not be reasonable to include the measure unless it was risk standardized for commercial and Medicaid, neither of which has happened. That would require the state to steward the measure. He suspected NCQA may handle the risk standardization down the line. Ms. Murphy expressed concern about using measures with incomplete information. She suggested considering other state's measures. Dr. Schaefer said he did not believe other states were using the measure.

Ms. Murphy said that Vermont is using hospital admissions for COPD and asthma. There was discussion about the challenges of using the measure, including low base rates. Dr. Schaefer noted that Maine retained measures with low base rates, but drop them on a provider by provider basis when base rates are not sufficient. Dr. Wolfson said there was concern among providers about being judged on performance based on few patients.

The Council discussed the ability to compare Connecticut's performance to that of other states. Dr. Schaefer said that concern applied to any of the measures as there is not national benchmark data. He noted there is a cost to stewarding risk standardization. He said that if payers are computing claims based measures, they could assign points based on their national data or use NCQA's benchmarking. It would be difficult for a plan without national benchmark data to do that. The Council made no decisions on the care coordination measures.

The Council discussed NQF# 1560, an NQCQ relative resource use measure that includes emergency department use for people with asthma. Ms. Broderick said the measure required a lot of effort to produce and many did not understand its use. Dr. Wolfson asked how a similar measure stewarded by Alabama was generated. Dr. Schaefer said he could seek additional information. It was noted that many factors can impact emergency department usage. Ms. Giordano said they hadn't figured out how social determinants play a role. She noted that many people use the emergency room inappropriately for primary care and that they could get to that issue. Dr. Dalal said the data supported that and that the issue was about the measures technical features. Dr. Schaefer said he was struck that there is no NQF endorsed measures regarding emergency department use. He said that suggests the presence of significant methodological challenges that makes them difficult to apply.

Mr. Frayne noted that hospitals cannot engage patients in ED use education and they are prohibited by federal law from turning patients away. He noted the measure centered on failures in the larger system. Ms. Giordano noted they are looking at primary care rather than hospital use. She asked

how they accounted for those without insurance. Dr. Schaefer said that geographic attribution can eventually get towards those who aren't attributed due to not using primary care.

The Council decided to continue the discussion at its next meeting due to a lack of time.

Level 3 Review
There is a tool available from Robert Wood Johnson Foundation (RWJF) that will help the Council cull the measures that pass Level 2 review. Dr. Schaefer proposed two new level 3 culling items: moving "national benchmarks" and including risk standardization. Council members agreed.

Meeting schedule/next steps
Dr. Schaefer reviewed next steps. The PMO is in the process of extending the contract with Chartis and they are being asked to work with the Council to formulate a path towards adoption. Chartis staff would meet with the payers to take the various issues into account. This would be when other payer representatives with expertise should be included in the process.

Dr. Schaefer said there is a need to move from aspirational to focusing on what is achievable and measureable within the proposed time frame. The Council will need to vote on a recommended set for Steering Committee, public, and health plan review and comment. Their vote would not necessarily be an endorsement of measures but, rather, an endorsement of moving forward with the process. Dr. Wolfson suggested scheduling an additional meeting before the July 16th Steering Committee. Dr. Schaefer said that he could verify whether there will be a Steering Committee meeting in early August and wrap things up by then. He will circle back with the Lieutenant Governor's office.

The meeting adjourned at 8:10 p.m.