STATE OF CONNECTICUT
State Innovation Model
Quality Council

Conference Call Summary
June 29, 2015

Members Present: Rohit Bhalla; Aileen Broderick; Deb Dauser Forrest; Steve Frayne; Daniela Giordano; Karin Haberlin; Elizabeth Krause; Steve Levine; Arlene Murphy; Robert Nardino; Donna O'Shea; Jean Rexford; Andrew Selinger; Todd Varricchio; Steve Wolfson; Thomas Woodruff; Robert Zavoski

Members Absent: Mehul Dalal; Mark DeFrancesco; Amy Gagliardi; Kathleen Harding; Robert Hockmuth; Kathy Lavorgna; Meryl Price; Rebecca Santiago

Other Participants: Deb Amato; Sandra Czunas; Anthony Dias; Faina Dookh; Monica Farina; Kathy Henchey; Jane McNichol; Johnny Mei; Mark Schaefer

1. Call to order
The meeting was called to order at 6:07 p.m. Steve Wolfson served as meeting chairman.

2. Public Comment
There was no public comment.

3. Review and approval of minutes
Members said they had not had an opportunity to review the minutes prior to the call. Mark Schaefer invited members to send any comments they had to the Program Management Office. The comments will be addressed and revised minutes will be sent for review and action at the next meeting.

4. Implementation Road Map
Dr. Schaefer provided an overview of the implementation road map. It is anticipated there will be two meetings scheduled in July to conduct the level 3 culling process. The Attorney General's office is currently involved in negotiations with NCQA for a contract to support the level 3 culling. The goal is to have a common measure set to report on at the August 13 Healthcare Innovation Steering Committee meeting. After that meeting, there will be a public comment period where the public could weigh in on the proposed set. During that time, the health plans will conduct in depth reviews of the proposed set. Certain measures may be deemed as either essential or optional.

Todd Varricchio said he would like the opportunity to discuss feasibility, usability, accuracy, and reliability as part of the review process. Donna O'Shea said she preferred the term "highly recommended" to "essential." She said "essential" would be tough to sell, especially in a tight time frame. Dr. Schaefer said he thought "essential" was an improvement over "mandatory" but appreciated the comment. Aileen Broderick agreed with Dr. O'Shea. There were no objections. She also said the Council should propose a timeline that includes items for roll out in 2017 and 2018.

Dr. Schaefer asked Council members to think about what adoption would look like over time. They could allow the process to unfold naturally, taking existing contracts into account, or they could encourage more rapid synchrony. The PMO negotiated an extension on its contract with the Chartis Group that will allow them to assist in developing the road map. The road map will take several months to formulate.

5. Care coordination and patient safety measures

Dr. Schaefer reviewed the base rate calculation (see presentation here). The PMO proposed eliminating measures that lack base rate sufficiency across payers. For measures where there were sufficient base rates for one payer type but not others, the measure could be implemented for that payer type only, but the charge of the Quality Council is to find ways to align across payers. Base rate sufficiency means that, at the ACO level, the measure is statistically valid to show trend from period to period. Measures with insufficient base rates cannot accurately depict performance over time.

Arlene Murphy expressed concern about eliminating measures during the call without sufficient time to review them. She noted that some of the measures may be in use by other states and that she would like additional information before removing them from the list. Dr. Wolfson proposed that the executive team review the base rate data prior to the next meeting to bring a recommendation to the full council.

Ms. Broderick said that if a measure did not have sufficient base rates, it seemed a logical next step to eliminate them. Mr. Varricchio said that eliminating a particular measure would not mean that the area covered by the measure could not be picked up elsewhere. There are broader based measures available that can be drilled down to diagnosis. Dr. O'Shea said that if a measure did not result in meaningful data, it would be a waste of time to further deliberate on it. Dr. Wolfson proposed reviewing the final proposed measure set to determine whether gaps exist and then finding composite measures that would capture the data.

Daniela Giordano asked whether the plan was to have base rates for every measure on the list. Dr. Schaefer said that there are certain conditions where prevalence would not be an issue, such as diabetes. Asthma measures can have sufficiency if they are not cut by age (e.g., adults 18-39 and 40-64). Preventive care measures (wellness visits, screenings) would also have sufficient base rates. Other areas may have base rate issues. With developmental screenings, if there are 1000 children attributed to an ACO, it is not about how many of them were developmentally screened, but rather, how many of those 1000 children are between the ages of 0 and 3. If the number is low, then statistically, it would not be reliably measured.

Mr. Varricchio said it was one thing to review something statewide and another to hold an ACO accountable. Volume is required for the measure to be statistically sound. They should avoid a situation where a provider wins or loses based on luck. Dr. O'Shea said that as a nationwide payer, they work with many different sized ACOs. Connecticut has very small ACO groups compared to other states. That makes getting to sufficient base rates a challenge. Something may be statistically valid in Wisconsin but not in Connecticut based on the structures in place in each state. Dr. Schaefer said that Vermont has only three ACOs, which may help them in getting to base rate sufficiency. Connecticut has between 15 and 20. Vermont has one or two dominant payers while Connecticut has a larger number of payers. That makes the test significantly more difficult in Connecticut.

Dr. Schaefer asked whether the Council could elect not to consider base rates in finalizing their measure set. The payers could then implement only those measures they determined had sufficient base rates for a given provider. He noted that Maine drops any measure for a given provider and contract year where the base rates are low. Rohit Bhalla said that taking base rates out of consideration for measure selection would put Connecticut out of sync with what is being done nationally. Dr. Schaefer said that he had conducted interviews with other states and was not certain he could get additional information in a timely fashion. To do so would require additional lead time and would further delay the level 3 culling process.

Ms. Broderick asked whether they would have enough time to complete the Level 3 review. Dr. Schaefer said August may not be realistic. He said they should potentially target September and see what they can do about scheduling meetings over the summer. Dr. O'Shea said the closer they get to the fourth quarter, the less likely they will be able to implement anything by 2016. Mr. Varricchio said they were pushing the limit now. Dr. Schaefer said they were targeting August to give time for a public comment period and to try to stand up some measures by 2016. He said that if the council felt they needed ample time for deliberations, then they were looking at September or October for Steering Committee review. He noted that the NCQA composite measure is only risk standardized for Medicare and would take a year to fully stand up. The proposal is to test out the measure and determine whether the results are promising enough to propose adoption in 2017 or 2018.

Dr. Schaefer reviewed base rates for the remaining measures and noted that the disposition on them could be tabled until the Level 3 review. He asked the payers for feedback on the NCQA relative resource use measures.

Robert Zavoski noted that the post admission follow up measure is a home grown one, stewarded by the Department of Social Services. He noted that with the ICD-10 transition, it required a great deal of updating. Even for reporting only, it would take a great deal of work to move forward with it. He recommended against including this measure in the provisional set as other plans do not use the measure and DSS may not be able to maintain it. The group agreed not to recommend the measure.

Dr. Schaefer asked Dr. Zavoski if there are measures that the Care Management Committee of the Council on Medical Assistance Program Oversight was proposing for the Medicaid Quality Improvement and Shared Savings Program. Dr. Zavoski said that there is a webinar scheduled to walk through the Quality Council measures and that committee members have been asked to submit other measures they feel are important. That may require some development. Mr. Varricchio asked how the Council would be able to vote on a provisional set if there are still measures that will be added. Dr. Schaefer said that the Care Management Committee measures may be used by Medicaid only and not commercial, such as antipsychotic medication in pediatrics. Dr. Zavoski said he did not foresee the addition of measures that would impact the commercial plans and noted that any proposed measures would likely be reflective of the unique characteristics of the Medicaid program, particularly with regard to under-service. As a public entity, he said, they need to follow through with their established vetting process and provide an opportunity for their stakeholders to weigh in. Dr. Schaefer said that process argues in favor of a September presentation to the Steering Committee, which would allow an opportunity to review any Medicaid proposed measures. Dr. Zavoski said there is a great deal of overlap between the Quality Council list and the Medicaid list.

6. Meeting schedule/next steps

There are two meeting dates proposed: July 15 and July 30th. Dr. Schaefer said he was not optimistic they could convene a quorum in August, but this will be explored. Members said they could participate on July 15 but not July 30. Dr. Schaefer said the PMO will retain the July 15 date as a face to face with the option to call in. They would also seek additional dates for August and early September. The PMO would update the one page summary and the Quality Measure Consensus Review spreadsheet with the latest information, but also still have a PowerPoint to work from during the meetings.

The meeting adjourned at 7:37 p.m.