STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
March 11, 2015

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

Members Present: Rohit Bhalla; Aileen Broderick; Mehul Dalal; Deb Dauser Forrest; Jessica DeFlumer-Trapp (for Karin Haberlin); Steve Frayne; Daniela Giordano; Elizabeth Krause; Arlene Murphy; Robert Nardino; Donna O'Shea; Todd Varricchio; Thomas Woodruff

Members Absent: Mark DeFrancesco; Amy Gagliardi; Kathleen Harding; Gigi Hunt; Kathy Lavorgna; Steve Levine; Meryl Price; Jean Rexford; Rebecca Santiago; Andrew Selinger; Steve Wolfson; Robert Zavoski

Other Participants: Deborah Amato; Sandra Czunas; Faina Dookh; Mark Schaefer

Call to order
The meeting was called to order at 6:09 p.m. Mehul Dalal chaired the meeting. Participants introduced themselves.

Public Comment
There was no public comment.

Steering Committee Presentation Review
Mark Schaefer provided an overview of the process for the Healthcare Innovation Steering Committee. He incorporated the Council's comments on the presentation for the March 12th Steering Committee meeting. The Council further reviewed the presentation in preparation for the next day's meeting (see presentation here). The Steering Committee will have the opportunity to provide input but will not yet approve the recommendations. Dr. Schaefer suggested the Council look at next steps.

The payer representatives discussed the difficulty in committing to a specific scorecard format. Donna O'Shea said they are dealing with SIM grants in multiple states. Todd Varricchio said they are looking to align but that using state-specific cards would require a significant investment. Daniela Giordano raised concerns about being able to compare data. Thomas Woodruff said that there could be one card but the items could be weighted in different ways. Aileen Broderick asked whether it was an appropriate time for the payers to bring the set to their senior leadership. Dr. Schaefer said more work was needed to complete and further refine the measure set, and suggested elevating the measure set at a later point in time. However, payers are welcome to bring the provisional measure set to their leadership if they feel it is necessary.

Dr. Dalal suggested explaining why there are no measures included for those over 65. Rohit Bhalla agreed as they set "maximizing alignment with Medicare" as a principle. Dr. Dalal said their payment environment is different and the payer (Medicare) is not at the table. The Council will consider over 65-specific measures separately. Ms. Giordano suggested the presentation make clear that the Care Management Committee discussions have not yet been included in the recommendation.

The Council discussed how the Health Information Technology Council's recommendations could affect the measure set. If the HIT Council suggests a measure could be staged, the Quality Council could stage its recommendation. Mr. Varricchio asked who would audit the results that came from electronic medical records (EMR) as those are generally self reported. Arlene Murphy said she was concerned about eliminating a measure outright rather than trying to address the feasibility of it. Dr. Schaefer said that they could ask about Medicare ACO audits. Deb Dauser Forrest said that Medicare does audit and a plan can be penalized under both commercial and Medicare Advantage.

Ms. Broderick said she is not permitted to provide the percentile measures reported in Quality Compass based on restrictions in their licensing agreement. Dr. Dalal said that the HEDIS State of Health Care Quality Report lists percentiles and suggests that 90-95% is best. Ms. Broderick said the report is not state specific and does not define the rate that gets to those percentiles. Steve Frayne said they should model against the rest of the country. If some entities are able to achieve higher performance, they should be able to determine why.

Elizabeth Krause asked if a measure has made it this far in the review process whether it was set or if it could come up in the third level review. Dr. Schaefer said that once input is solicited they may need to revisit certain issues. He stressed the importance of the public comment period.

Readmission, admission, and ED measures
Dr. Schaefer reviewed the list of readmission measures currently still under review. He said they discussed the NCQA readmission measure with Robert Saunders, who noted that the NCQA measures are only risk standardized for commercial populations. He suggested one option would be to steward risk standardization for Medicaid. Dr. Schaefer also discussed limitations of the Medicare SSP readmission measure, which lacks a BH admission component and national benchmark information. One option would be for CT SIM to adopt the measure and apply it to commercial and Medicaid and use a regression model to provide valid risk stratification. The downside is that this would not resolve the lack of national benchmark data. Dr. Schaefer reported a follow up discussion with CMMI to see what other SIM states are doing. None have adopted the Medicare SSP measure. One state has used the NCQA readmission measure for commercial and another for Medicaid.

CMMI is working on a behavioral health specific measure but Dr. Schaefer said he has not been able to find more information on it. They could work with Yale to incorporate behavioral health admission information. Dr. Dalal said the exclusion of behavioral health could be a pro as it may fall outside the control of primary care. Dr. Bhalla said that every hospital has a list of patients they care for on a frequent basis with underlying behavioral health conditions but there may not be resources or supports for those clients. He said that in New York between 60 to 70% of readmissions were for behavioral health. Mr. Frayne said that they should be careful when looking at national benchmarks. He noted that states the best readmission rates tend to have the worst mortality rates. Connecticut scores low on mortality but high on readmission. Dr. Schaefer said that the Medicare SSP readmission measure excludes most cancer admissions because of the fact that lower readmission rates can be correlated with higher mortality.

Oral health measures
This was not discussed due to a lack of time.

HIV measures
This was not discussed due to a lack of time.

Next Steps
The group briefly discussed key questions. Dr. Schaefer said that payment methods and weights may be the most difficult area to find consensus. Dr. Forrest said that she envisioned the scorecard as being simply data-based without including value based payment. Dr. Schaefer said there are other important questions that need to be answered including what the state will produce for the benefit of payers and providers and whether to include payer agnostic measures. Work will need to be done in order to set the stage for those discussions.

Dr. Schaefer noted that it was unlikely the Steering Committee would get through the entire Quality Council update presentation and could be completed at the Committee's April meeting. The updated presentation will be shared with the Council.

The meeting was adjourned at 8:08 p.m.