STATE OF CONNECTICUT
State Innovation Model
Quality Council

Meeting Summary
May 6, 2015

Meeting Location: CT State Medical Society, 127 Washington Avenue, North Haven

Members Present: Rohit Bhalla; Mehul Dalal; Deb Dauser Forrest; Jessica DeFlumer-Trapp; Steve Frayne; Daniela Giordano; Robert Hockmuth; Elizabeth Krause; Arlene Murphy; Robert Nardino; Donna O'Shea; Jean Rexford; Andrew Selinger; Todd Varricchio; Steve Wolfson; Thomas Woodruff; Robert Zavoski

Members Absent: Aileen Broderick; Mark DeFrancesco; Amy Gagliardi; Kathleen Harding; Kathy Lavorgna; Steve Levine; Meryl Price; Rebecca Santiago

Other Participants: Sandra Czunas; Faina Dookh; Monica Farina; Jane McNichol; Minakshi Tikoo

Call to Order
The meeting was called to order at 6:14 p.m. Mehul Dalal served as the meeting chair. Participants introduced themselves.

Meaningful Use Measure – ACO 11
Minakshi Tikoo presented on meaningful use (see presentation here). Arlene Murphy asked how Connecticut's participation compared to other states. Dr. Tikoo said that Connecticut is in the middle – 80 percent of physicians are using electronic health records systems (EHR) but not all are participating in the EHR Incentive program. The measure is tracked at the individual level. Todd Varricchio asked whether a provider not scoring well on meaningful use would be problematic for the validity of other measures. Dr. Tikoo said that may be a reasonable assumption but there are other factors that need to be taken into account, such as the patient panel. Mr. Varricchio noted that if physicians are not using their EHR systems in a similar matter, it could cause noise in the data. Mark Schafer said that relates to the question of whether electronic clinical quality measures (eCQM) produced by an EHR are valid representations of what is happening in the system.

Dr. Tikoo spoke to ACO Measure 11. She asked what information the measure provides other than the fact a provider participated in the program. She asked the Council to think about what their use for the measure is in order to decide if it will be useful to them. Arlene Murphy asked why Medicare requires the measure for its shared savings program. Dr. Tikoo said she thought the rationale is that by having providers use certified technologies, they are more likely to adhere to the program guidelines and support surveillance and monitoring. She added that there may be providers who use their EHR systems better than those in the meaningful use program but don't receive incentive payments and thus would not be reflected in this measure.

Dr. Dalal asked about the life cycle of the program and what it will look like down the road. The program will be phased out in 2021. Providers can enroll in the program through 2016. Steve Frayne said that incentive payments will phase out but that providers could lose funds by not pursuing the program. Providers will have to demonstrate progression over time. Mr. Varricchio said he was not sure that ACO 11 was a quality measure. Dr. Schaefer said it was a structural

measure focusing on capabilities. Mr. Frayne said it was more than just structural change but demonstrating an ability to communicate across disparate parts of the system. Steve Wolfson said there were implementation issues. Providers who are not on the EPIC system cannot accept input and EPIC has no analytic capabilities. Hospitals are superimposing analytic capabilities on top of the EPIC system. He said the next levels will be much more difficult to achieve. Mr. Frayne said that it will be difficult for standalone practices to create the connections required under meaningful use and that it is a large undertaking for a smaller practice.

The Council discussed the numerator and denominator for the measure. Dr. Schaefer said that what Medicare is rewarding is a health system or enterprise having an increasingly greater percentage of practitioners in either the Medicare or Medicaid program. A practice would be in the denominator if it is a PCP and in the numerator if they are participating in the program and receiving payment. PCPs can only qualify for the Medicare or Medicaid program while hospitals can qualify for both. PCPs would need to pick the program based on which population was larger. Mr. Frayne said that most would qualify on the Medicare side. Dr. Schaefer said the question is whether the measure would work for commercial shared savings. He noted that adoption of the measure is different than commercial payers adopting their own meaningful use programs.

The Council also discussed which of the 64 eCQMs are required. There are nine core measures and the rest are optional. Dr. Tikoo said that not every EHR can generate all 64 measures. Rohit Bhalla said it would be helpful to know which nine are required. Jessica DeFlumer-Trapp said that the proof of solution would be important in the event that data cannot be indexed.

HIT Council Update

Dr. Schaefer reviewed the Health Information Technology Council membership, purpose, and work completed to date. The Council discussed the Zato proposal regarding the use of edge server technology to produce EHR-based measures. They have tested the proposed approach on multiple systems outside of health care and the method requires the least centralization of data. Other states have created a central data repository but there have been concerns raised about that approach. Dr. Schaefer noted that, to his knowledge, existing value-based payment measure sets do not cut data by provider or race and ethnicity.

Jean Rexford asked about de-identification of data. Dr. Schaefer said the Zato proposal interfaces with EHRs and pulls up specific data points to calculate performance. Mr. Frayne noted that the Stage 2 solution was more invasive than Stage 1 and that hospitals have concerns about access to patient records due to data sensitivity. Dr. Dalal said the Stage 2 solution seemed too good to be true and that there could be issues with data integrity. Dr. Schaefer said they would want to lead with a demonstration, working with one or two collaborators to get firsthand experience with standing up the solution.

Ms. Rexford asked why the All Payer Claims Database (APCD) was not performing this work. Dr. Schaefer said the APCD was not authorized to work on anything other than claims. There is value to the APCD but he did not predict it would become a central repository of EHR data. There are also issues with the APCD maintaining a complete data set due to certain plans being exempt from participation due to ERISA (such as self-funded plans). That requires discussion with payers and employers to demonstrate the value of including their data. Both Mr. Varricchio and Mr. Frayne expressed concerns with sharing data. Mr. Frayne said that unless state law mandates it, providers cannot just give out information.

Dr. Schaefer said that part of the Council's work is to identify barriers and potential solutions. The proposed solution will require substantial detail and complexity but it is what the state has put forward as the best option without going to a central data repository and absent a health information exchange. The Council may decide to look at only using claims-based measures. Ms. Murphy said that the technology seemed promising but that she did not want to abandon existing technology and investments. Dr. Schaefer said the process is not easy for any state. There are ways they can improvise interim solutions and begin to make progress. He said he was not optimistic they could implement a comprehensive and sophisticated solution by 2016.

Readmission Measures
This was not discussed due to a lack of time.

Provisional Measure Set: Claims vs. EHR
This was not discussed due to a lack of time.

Minutes
The minutes were not approved due to a lack of time.

Public Comment
There was no public comment.

Next Steps
Dr. Schaefer noted that the PMO is signing an agreement with NCQA to receive data. The PMO will propose additional meeting dates.

The meeting adjourned at 8:12 p.m.