

Quality Council

October 21, 2021

Call to Order

Public Comment

Agenda

<u>Time</u>	<u>Topic</u>
4:00 p.m.	Call to Order
4:05 p.m.	Public Comment
4:15 p.m.	Approval of August 19, 2021 Meeting Minutes
4:20 p.m.	Discussion of OHS' Proposed Revisions to the Quality Benchmarks
4:40 p.m.	Resume Discussion of Quality Benchmark Values
4:55 p.m.	Break
5:00 p.m.	Continue Discussion of Quality Benchmark Values
5:15 p.m.	Begin Discussion on Data Collection and Performance Evaluation
5:30 p.m.	Health Equity Measure Follow-up
5:40 p.m.	Presentation on Executive Order No. 6
5:55 p.m.	Wrap-up & Next Steps
6:00 p.m.	Adjourn

Approval of August 19, 2021 Meeting Minutes

Discussion of OHS' Proposed Revisions to the Quality Benchmarks

Recap of the August 19, 2021 Meeting

- The Quality Council recommended ten measures for the Quality Benchmarks for assessment at the state level.
 1. Substance Use Disorder in the Past Year
 2. Drug Overdose Deaths Involving Any Opioids per 100,000 Resident Population per Year
 3. High School Students Who Actually Attempted Suicide
 4. Follow-Up After Hospitalization for Mental Illness (7-Day)
 5. Follow-Up After Emergency Department Visit for Mental Illness (7-Day)
 6. Weight Classification by Body Mass Index (BMI)
 7. Obesity Equity Measure – Weight Classification by BMI, Stratified by Race/Ethnicity
 8. Percentage of Eligibles that Received Preventive Dental Services
 9. Percentage of Adults who Visited the Dentist/Dental Clinic In the Past Year
 10. Dental Equity Measure – Percentage of Adults who Visited the Dentist or Dental Clinic within the Past Year, Stratified by Race/Ethnicity

OHS' Proposed Modifications – Rationale

- OHS is proposing several modifications to the Council's recommendations for the following reasons:
 1. OHS sees **Advanced Networks (ANs)** as **critical for improving cost and quality** and believes that public reporting of *healthcare* measures will motivate meaningful action to drive improvement.
 2. OHS wants to **align the Quality Benchmarks with state health priorities**, which includes addressing chronic conditions, improving behavioral health treatment, and reducing childhood obesity.
 3. OHS hopes to **create alignment in statewide quality efforts** (i.e., the Core Measure Set, DSS' PCMH+ Measure Set and DSS' quality transparency strategy outlined in Executive Order No. 6).

OHS' Proposed Modifications – Considerations

- OHS considered several factors when evaluating which measures from the Quality Council's list of recommended measures to retain and which additional measures to propose, including:
 1. Does the measure address a state health priority?
 2. Is the measure in the Core Measure Set?
 3. Is the measure in use in payer-provider contracts?
 4. Can the measure be reported by AN and payer?
 5. Does the measure have opportunity for improvement?
 6. Was the measure recommended by the Quality Council?

OHS' Proposed Modifications – Measures

- OHS is proposing a phased adoption of seven measures for the Quality Benchmarks to allow for reporting by AN and insurance carrier and to reduce payer/provider reporting burden.

Phase 1: Beginning for 2022

- Asthma Medication Ratio
- Child and Adolescent Well-Care Visits
- Controlling High Blood Pressure
- Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control

Phase 2: Beginning for 2024

- Follow-up After ED Visit for Mental Illness (7-day)
- Follow-up After Hospitalization for Mental Illness (7-day)
- Obesity Equity Measure

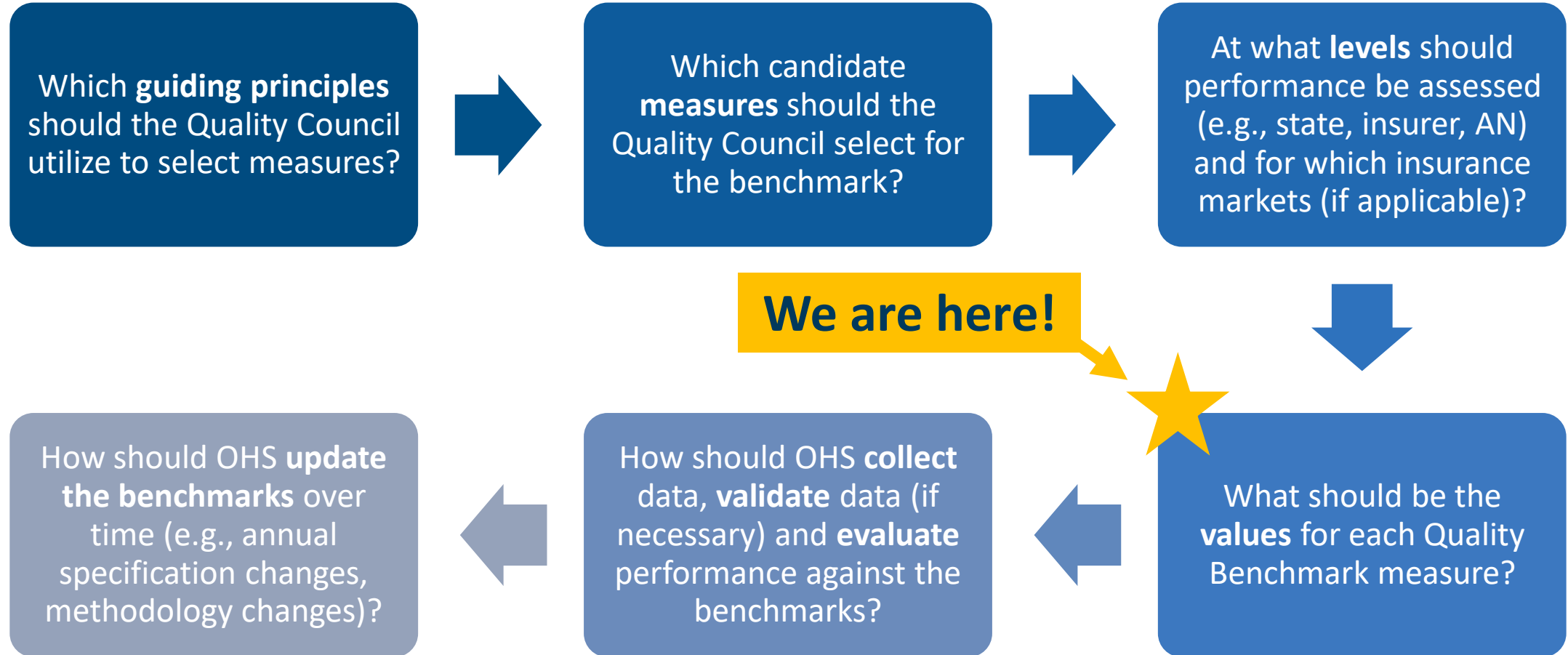
OHS' Proposed Modifications – Data Collection Methodology and Reporting

- Both phases would rely on payer reporting.
 - Insurance carriers would be requested to report performance by AN (for each AN with which they contract) and by line of business (i.e., commercial, Medicare).
 - DSS would also report performance by AN and for Medicaid overall.
- OHS aims to leverage Connie, the statewide health information exchange, to report performance for all ANs in future years.*
- OHS anticipates reporting performance for all measures (except the *Obesity Equity Measure*) at the AN, insurance carrier, insurance market and state levels.

*The timing of Phase 2 depends on when ANs have successfully connected to [Connie](#). Per CGS Sec. 17b-59d, each healthcare provider with an electronic health record system must apply to begin the process of connecting to and participating in Connie by May 3, 2023.

Resume Discussion of Quality Benchmark Values

Roadmap of Quality Benchmark Questions to Consider



Overview

- During today's meeting, the Quality Council will review current and historical performance for commercial insurance carriers in the state. It will use national or New England commercial performance to set Quality Benchmark values for the commercial market.
- OHS is working with DSS to identify a process for setting Quality Benchmark values for the Medicaid market to ensure it aligns with Executive Order No. 6. The Quality Council will discussion Quality Benchmark values for Medicaid during the November meeting.
- The Quality Council will not set benchmarks or collect performance for the Medicare market given a) the market's small population size relative to the commercial and Medicaid markets b) challenges associated with obtaining clinical data for the Medicare fee-for-service population.

Asthma Medication Ratio

Description	Steward	Measure Type	Data Source	Population
Percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	NCQA	Process	Claims	Adult and Pediatric

- CT performance

2019	78
2018	81
2017	79

A higher rate indicates better performance

CT performance is a weighted average of four commercial plans' performance.

- National performance (2019)

Nat'l 25 th	76
Nat'l 50 th	79
Nat'l 75 th	83
Nat'l 90 th	84

Child and Adolescent Well-Care Visits

Description	Steward	Measure Type	Data Source	Population
Percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner	NCQA	Process	Claims	Pediatric and Adolescent

- This is a newer HEDIS measure and therefore there are no baseline data to assess current performance.
- OHS can collect and report performance for this measure beginning in 2022, and can set a benchmark value in winter 2023 / spring 2024 once data are available.

Controlling High Blood Pressure

Description	Steward	Measure Type	Data Source	Population
Percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90 mm Hg)	NCQA	Outcome	Claims and Clinical Data	Adult

- CT performance

2019	61
2018	61
2017	51

**A higher rate
indicates better
performance**

CT performance is a weighted average of four commercial plans' performance.

- New England performance (2019)

NE 25 th	53
NE 50 th	63
NE 75 th	69
NE 90 th	73

Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control (>9.0%)

Description	Steward	Measure Type	Data Source	Population
Percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was >9.0%	NCQA	Outcome	Claims and Clinical Data	Adult

- CT performance

2019	27
2018	26
2017	36

A lower rate indicates better performance

CT performance is a weighted average of four commercial plans' performance.

- National performance (2019)

Nat'l 25 th	36
Nat'l 50 th	30
Nat'l 75 th	25
Nat'l 90 th	21

Follow-Up After Emergency Department Visit for Mental Illness (7-Day)

Description	Steward	Measure Type	Data Source	Population
Percentage of ED visits for members 6+ with a principal diagnosis of mental illness or intentional self-harm diagnoses who had a follow-up visit for mental illness within 7 days of the ED visit	NCQA	Process	Claims	Adult and Pediatric

- CT performance

2019	60
2018	63
2017	63

**A higher rate
indicates better
performance**

CT performance is a weighted average of four commercial plans' performance.

- New England performance (2019)

NE 25 th	56
NE 50 th	62
NE 75 th	71
NE 90 th	73

Follow-Up After Hospitalization for Mental Illness (7-Day)

Description	Steward	Measure Type	Data Source	Population
Percentage of discharges for members 6+ who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses who had a follow-up visit with a mental health provider within 7 days after discharge	NCQA	Process	Claims	Adult and Pediatric

- CT performance

2019	56
2018	54
2017	55

A higher rate indicates better performance

CT performance is a weighted average of four commercial plans' performance.

- New England performance (2019)

NE 25 th	47
NE 50 th	53
NE 75 th	59
NE 90 th	64

Obesity Equity Measure – Weight Classification by BMI, Stratified by Race/Ethnicity

Description	Steward	Measure Type	Data Source	Population
Difference in the obesity rate of the majoritized (i.e., White, non-Hispanic) and minoritized (i.e., Black, non-Hispanic) race/ethnicity populations	BRFSS	Other	Survey	Adult

- CT performance

2019	17
2018	10
2017	10
2016	15
2015	13

- National performance (2019)

Nat'l White , non-Hispanic, and Black , non-Hispanic difference	10
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A lower rate indicates better performance

Interim Quality Benchmark Values

- As we mentioned at the last meeting, **it is unlikely that there will be notable improvement towards the Benchmark values in 2022** because the Benchmarks are being finalized a few months before the start of the measurement year.
 - Therefore, we have kept the 2022 Benchmark value in the following slides at the same value as the baseline rate.

Interim Quality Benchmark Values (Cont'd)

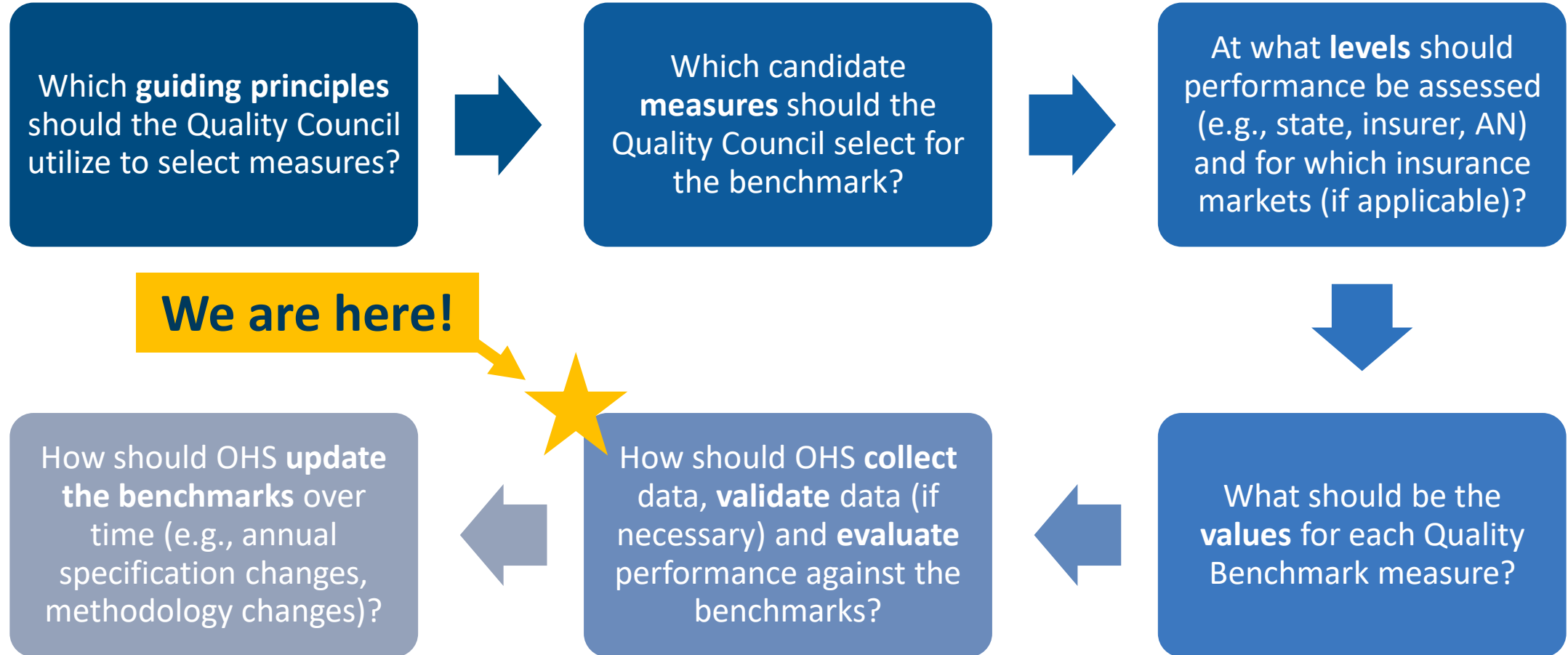
- **For measures with data that are published annually:** Should each interim benchmark value be 1/3rd of the distance between the baseline rate and the 2025 value, or should there be a gradual ramp-up over time?
 - **Gradual Ramp-up:** Each year, the Benchmark value can grow using a CAGR, which is based on the baseline rate, the 2025 Benchmark value and the number of years over which performance can change.

$$\text{Compound Annual Growth Rate (CAGR)} = \frac{\text{Final Rate}}{\text{Baseline Rate}}^{\frac{1}{3}} - 1 = \frac{80\%}{50\%}^{\frac{1}{3}} - 1 = 16.95\%$$

	Baseline Rate	2022	2023	2024	2025
Equal Annual Values	50%	50%	60%	70%	80%
Ramp-up Values	50%	50%	58%	68%	80%

Begin Discussion on Data Collection and Performance Evaluation

Roadmap of Quality Benchmark Questions to Consider



Proposed Data Collection Methodology

- The table below summarizes our proposed approach to Quality Benchmark data collection by data source.

Measure(s)	Data Source	Proposed Annual Reporting Date	Proposed Data Collection Timeline
<u>Claims-based measures:</u> <ul style="list-style-type: none">• Asthma Medication Ratio• Child and Adolescent Well-Care Visits• Follow-Up After Emergency Department Visit for Mental Illness (7-Day)• Follow-Up After Hospitalization for Mental Illness (7-Day)	<ul style="list-style-type: none">• Insurance carrier reporting by AN and line of business (i.e., commercial, Medicare)• DSS reporting by AN and for Medicaid	Insurance carriers and DSS submit data to OHS by August 31 the year following the MY	OHS validates and uses data from insurance carriers and DSS to aggregate performance by AN, payer, market and state by December 31 the year following the MY

AN: Advanced Network
HIE: Health Information Exchange

DSS: Department of Social Services
MY: Measurement Year

Proposed Data Collection Methodology (Cont'd)

Measure(s)	Data Source	Proposed Annual Reporting Date	Proposed Data Collection Timeline
<u>Clinical data-based measures:</u> <ul style="list-style-type: none"> Controlling High Blood Pressure Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control 	<u>Beginning in 2022:</u> <ul style="list-style-type: none"> Same methodology for claims-based measures 	<u>Beginning in 2022:</u> <ul style="list-style-type: none"> Same reporting date as claims-based measures 	<ul style="list-style-type: none"> OHS validates and uses data from insurance carriers, DSS and/or Connie to aggregate performance by AN, payer, market and state by December 31 the year following the MY
	<u>Beginning in or after 2023:</u> <ul style="list-style-type: none"> Insurance carrier reporting by line of business (i.e., commercial, Medicare) DSS reporting for Medicaid Connie, the statewide HIE, for AN data 	<u>Beginning in or after 2023:</u> <ul style="list-style-type: none"> Insurance carriers and DSS submit payer data to OHS by August 31 the year following the MY OHS obtains AN data from Connie by August 31 the year following the MY 	

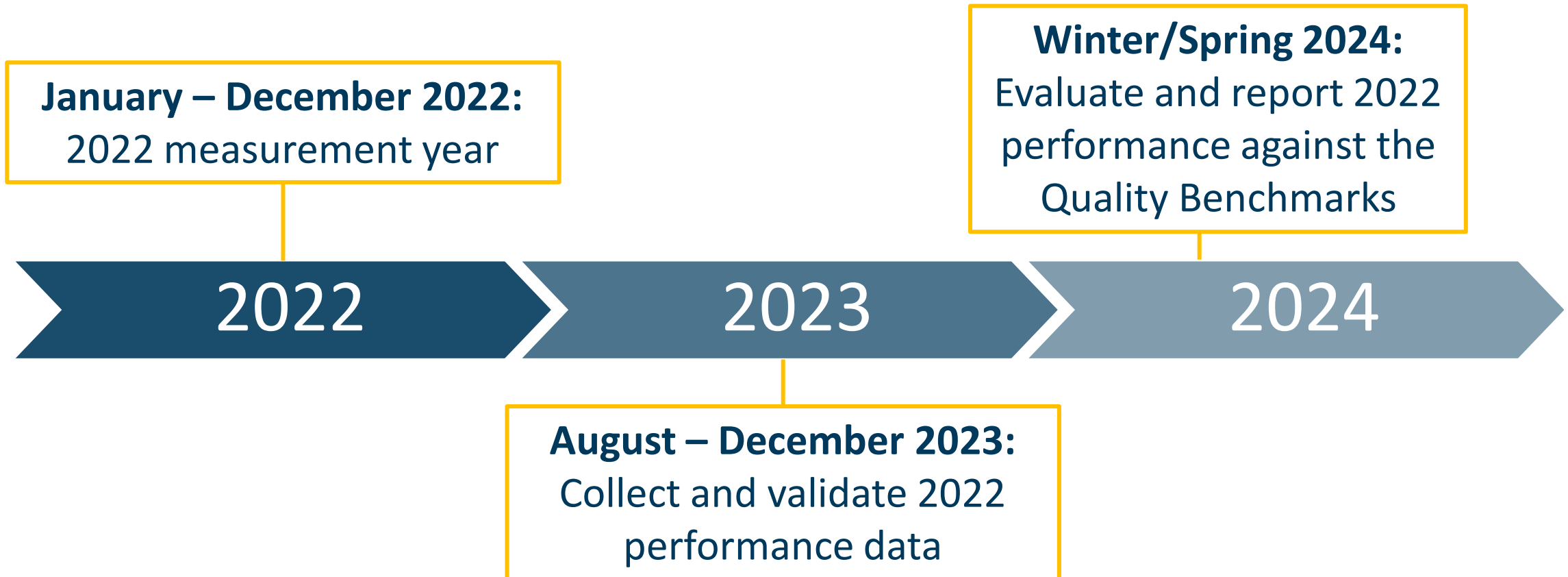
Proposed Data Collection Methodology (Cont'd)

Measure(s)	Data Source	Proposed Annual Reporting Date	Proposed Data Collection Timeline
Obesity Equity Measure – Weight Classification by BMI, Stratified by Race/Ethnicity	Centers for Disease Control and Prevention (CDC) – Behavioral Risk Factor Surveillance System (BRFSS) for state-level data	CDC releases data by August of the year following the MY	OHS validates and uses data from the CDC, insurance carriers, DSS and/or Connie to aggregate performance by AN, payer, market and/or state by December 31 the year following the MY

Proposed Data Evaluation Methodology

- By December 31 of the year after the measurement year, OHS should have collected and validated data for all of the Quality Benchmarks.
- We propose that OHS evaluate and report performance against the Quality Benchmark values in the winter/spring two years following the measurement year to align with Cost Growth Benchmark reporting.

Proposed Timeline for the 2022 Measurement Year



Health Equity Measure Follow-Up

Health Equity Measure Follow-Up

- OHS solicited feedback from the Quality Council on the draft specifications for the *Health Equity Measure*. It received feedback from three Council members.
 - Two members supported the specifications and only had minor grammatical edits.
 - One insurer member requested a longer timeframe to collect valid, reliable and robust race, ethnicity and language (REL) data. OHS understands this concern but notes:
 - the *Health Equity Measure* uses REL data from Advanced Networks (ANs), not insurers, and
 - the Core Measure Set is constructed as a menu from which insurers should pick measures. Insurers and ANs could choose the *Health Equity Measure* (1) with ANs that have more complete REL data or (2) could implement the measure as reporting only until ANs strengthen their REL data.

Executive Order 6: Medicaid and CHIP Transparency Work

Oct 21, 2021

Executive Order 6: DSS Advisory Board

In the January 2020, **Governor Lamont** in coordination with **Commissioner Gifford** issued an Executive Order (EO No. 6) that authorized **Commissioner Gifford** to establish an Advisory Board to support the Department of Social Services (DSS) in identifying ongoing areas of focus for improving quality, controlling cost growth, and developing a public facing data dashboard of HUSKY Health information. A major objective is to help DSS build on the considerable information that it has been sharing with the legislature, enhance transparency of its operations, promote health equity, and engage stakeholders in determining which data points are of greatest interest and value to decisions around future direction for our program. Please see the column at right for additional detail from the EO.

1. *The Commissioner of Social Services, consistent with the Commissioner's statutory authority, shall, in coordination with OHS, develop a public transparency strategy for Medicaid cost and quality reporting across all groups covered under Connecticut Medicaid by December 2020 and report on said strategy to the Governor by January 31, 2021.*
2. *The Commissioner shall convene an Advisory Board for Transparency on Medicaid Cost and Quality (Advisory Board) to provide advice and input on the content, metrics and goals for such reporting.*
3. *The Advisory Board shall, at the invitation of the Commissioner of Social Services, include the Executive Director of the Office of Health Strategy, the Commissioners of Public Health, Mental Health and Addiction Services, Children and Families, and Developmental Services, the Secretary of the Office of Policy and Management, one or more members served by Connecticut HUSKY Health, representatives of Medicaid-enrolled providers, and experts in quality measurement and reporting.*
4. *Such public reporting of measures of cost and quality shall enable a) examination of performance over time, both specific to the Connecticut Medicaid program, and in comparison to other state Medicaid programs; b) strategic interventions on behalf of Medicaid members; and c) continuous quality improvement.*
5. *Such public reporting shall form the basis of future initiatives to develop and implement payment and care delivery strategies aimed at improving outcomes and reducing health disparities.*
6. *The Commissioner shall continue to monitor efforts to establish transparency and the adoption of Medicaid cost and quality reporting pursuant to this order, and make recommendations for legislation or other initiatives to fulfill the purposes of this order.*

The full text of EO No. 6 is available here:

<https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-6.pdf>

Board Meetings and Final Report

Meetings:

1. January 12, 2021[^]
2. February 23, 2021[^]
3. March 30, 2021[^]
4. April 27, 2021 **
5. May 25, 2021 **
6. June 29, 2021 **

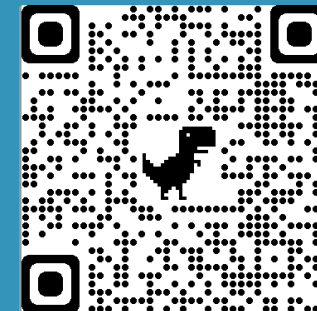
Final report:

1. July 2021

[^] Link to videos on ct.gov

<https://portal.ct.gov/DSS/Common-Elements/Advisory-Board-for-Transparency-on-Medicaid-Cost-and-Quality/Meetings>

**QR Code to CT DSS YouTube



The Board's Statement of Intent focuses on improving health through increasing data transparency

That the Board focus upon using data, both to tell the story of Connecticut HUSKY Health (Medicaid and Children's Health Insurance Programs) and to drive continuous improvement through increased awareness and literacy; identification of discontinuity, gaps, disparities and under-performance on measures, in support of informing development and implementation of additional care delivery, value-based payment and social determinant initiatives.

This transparency work coincides with current efforts to improve outcomes for HUSKY Health members through care delivery and value-based payment reforms including the maternity bundle, Substance Use Disorder waiver, and the PCMH+ initiative.

Executive Summary of Recommendations of the Board

1. Use an equity lens to inform selection, depiction, analysis and application of Medicaid and CHIP data.
2. Develop and implement a public dashboard of key indicators and related data, which will evolve and expand over time with increasing interoperability and capacity for additional data points.
3. Continue to convene the Board ongoing, for purposes of advising the Department on measure selection, analysis, updates and successive stages of the implementation and use of the public dashboard.

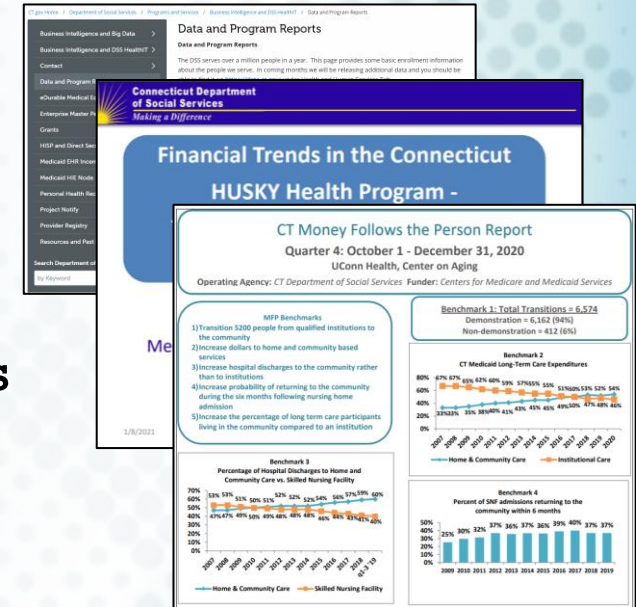
Initial phases of work for the Board

1 DSS initiated the work of the Board with an overview of quality and financial measures¹ that are currently used to assess performance in HUSKY Health.



2 Further, for illustrative purposes, DSS reviewed a number of existing, publicly available sources of data, including:

- A sample of the Medicaid and CHIP eligibility reports² that are posted on the state Open Data Portal
- The most recent annual financial trends report³ to the Medical Assistance Program Oversight Council
- Money Follows the Person (MFP) quarterly dashboard,⁴ which is produced by the UConn Center on Aging
- Several examples of Medicaid dashboards from other states



1 <https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Communications/HUSKY-Health-Overview-of-Quality-and-Cost-Trends-Presentation-121020.pdf>

2 <https://portal.ct.gov/DSS/ITS/DSS-HealthIT/Business-Intelligence-and-DSS-HealthIT/Data-and-Program-Reports>

3 https://www.cga.ct.gov/ph/med/related/20190106_Council_Meetings_&_Presentations/20210108/HUSKY_Financial_Trends_January_2021_.pdf

4 <https://health.uconn.edu/aging/wp-content/uploads/sites/102/2021/02/MFP-Q4-2020-report.pdf>

The Board identified a set of overarching goals for its work

Goals

- 1 Identification of a **core set of currently available, equity-informed quality and cost data** points that will be reported out publicly on a routine basis
- 2 Identification of **means of measuring program impact** on population health, social determinants of health and other areas that need further time to implement
- 3 **Benchmarking our performance** on the core measure set, and also aspirational measures as that becomes feasible, over time and against performance of other states
- 4 **Visualization of data** in accessible, plain language electronic dashboard format that enables:
 - a broad view of measures, for purposes of program accountability and continuous quality assessment/improvement;
 - drill down capacity for purposes of routinizing access to raw, deidentified data;
 - scheduled refreshes of the data; and
 - push alerts to cue interested parties to updates

The Board established three work groups: Principles, Quality, Financial

The Board determined that its tasks could usefully be assigned to three distinct work groups, described below. Please see subsequent slides for an overview of the work of each.

1

Principles, focused on developing guidance for data presentation, use, and evaluation across the data life cycle

Participants: Grace Damio, Karen Siegel, Kate McEvoy, Brad Richards, Susan Smith

2

Quality measures, focused on developing a framework for quality measures to be displayed and identifying upstream and downstream health indicators to be utilized

Participants: Grace Damio, Susannah Bernheim, Karen Siegel, Ann Spenard, Susan Smith, Ben Oldfied, James Cardon, Bonni Hopkins, Brad Richards

3

Financial measures, focused on the identification of existing high level financial benchmarks and future opportunities to link quality and cost

Participants: Kelly Sinko, Susan Smith, Mike Gilbert, Judy Dowd, Sue Eccleston, Bonni Hopkins, Mag Moreli, Chima Ndumele

Specific goals over five phases

Group	Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Quality Measures	High Level Currently Accessible Data	High Level External Data to DSS and Capturing New Internal Data	Interactive and Integrative	Ongoing Evaluation	Development and Expansion
Financial Measures	High Level Benchmarks	Strategic/Investment Oriented Metrics	Interactive Financial Data “Mart”	-	-
Principles	Use Principles as Litmus Test For Each Successive Phase				
Visualization	Development of Dashboard(s) and Related Products	Launching of Filterable Dashboards	Ongoing Dashboard Refinement and Expansion of Presented Data	-	-

Goals by Phase for Quality Subgroup

- **Phase 1 – High Level Currently Accessible Data**
 - Add and use current quality metrics available from DSS with drill down and disaggregation
 - Include Meta Data – Dictionary + Notation of data source(s) for each measure
- **Phase 2 – High Level External Data to DSS and Capturing New Internal Data**
 - Data from outside DSS (e.g. Department of Public Health, Department of Corrections)
 - Cataloging data from outside DSS
 - New DSS measure capture (patient reported outcomes and clinic records extraction)
- **Phase 3 – Interactive and Integrative**
 - Develop interactive drill down capacity to include quality measures that are stratified and categorized by services and program area (HUSKY A, B, C and D) and associated enrollment metrics
 - Integrate quality data directly with financial data such PMPM by service category and HUSKY components
- **Phase 4 – Ongoing Evaluation**
 - Ongoing review of new measures being captured for integration (Substance Use Disorder waiver)
 - Streamlining of processes for collection, processing, and display data
 - Review and reevaluation of existing data/integration on dashboard
- **Phase 5 – Development**
 - Development/Implementation of new measures

Data Categories for Quality Subgroup

Categories



Population Health: Well-Being + Primary Prevention



Clinical Quality:

- Primary Care
- Acute Disease
- Chronic Disease



Social Determinants of Health



Enrollment, Access + Churn









Special Populations



Managing Costs

Outcome, process, and member experience indicators for Quality subgroup

		Outcome Measures	Process Measures	Member Experience, Satisfaction, and Reported Outcomes
		Comparison with other States		
     	Population Health: Well-Being + Primary Prevention	Indicators of Connecticut population and Medicaid and CHIP population wellbeing and primary prevention (e.g. Life expectancy at birth, DM prevalence, Tobacco use, Deaths due substance use, 3 rd Grade Reading level and K readiness, Racial wealth gap, Screening for diabetes, Wellness visits, Children's Screenings/Developmental Assessments, Falls screening, parental mental illness and parental SUD (Substance Use Disorder), CAHPS, Culturally/Linguistically Competent Care)		
	Clinical Quality: <ul style="list-style-type: none"> Primary Care Acute Disease Chronic Disease 	Indicators of Connecticut Medicaid and CHIP individuals disease incidence, prevalence, and prevention (e.g. Medicaid and CHIP Scorecard (CMS), Office of Health Strategy Core Measures, HEDIS measures, ED utilization for chronic disease (DM, asthma, COPD, ESRD, overdose, SPMI), patient reported wellbeing, physical, and mental health measures)		
	Social Determinants of Health	Indicators of Connecticut Medicaid and CHIP individuals access to and addressing of the social determinants of health (e.g. REL Data completeness, Access to Transportation, NEMT metrics, Primary Language, % members receiving SNAP and TANF)		
	Enrollment, Access + Churn	Indicators of Connecticut Medicaid and CHIP access to providers and enrollment in the programs (e.g. Number total members in A, B, C, D by quarter/SFY Number disenrolled by A, B, C, D by quarter/SFY, % of individuals with an identified PCP, Number of PCPs and specialists enrolled as providers)		
	Special Populations	Indicators of Connecticut Medicaid and CHIP special groups and populations health and wellbeing e.g. Money Follows the Person (MFP), CHESS, Waivers, Maternal Health)		
	Managing Costs	Indicators of Connecticut Medicaid and CHIP ability to manage costs as it pertains to quality (e.g. Over and under utilization of health care services, Timeliness of payments to providers)		

Key Demographic + Geographic Disaggregation

DSS Next Steps for Transparency Work

- 1 Launching Transparency Dashboard in fall of 2021 with currently available data
- 2 Convening the Transparency Advisory Council
- 3 Developing ongoing plans and processes to carry forward the parallel transparency phases

Relationship between E06 and E05

Overview of the Measure Sets

DSS PCMH+ Measure Set (effective 1/1/2021)

- Consists of 27 measures:
 - 8 scoring
 - 7 challenge
 - 12 reporting only
- Of the 15 scoring and challenge measures, 4 are utilization-focused, a focus area not included in the Core Measure Set:
 - Avoidable ED Visits, Avoidable Hospitalizations, Ambulatory Care, Readmissions within 7 and 30 Days
- <https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/Attachment-no-1--PCMH-Quality-Measures-Set-eff-112021.pdf>

2022 OHS Core Measure Set

- Consists of a menu of 26 measures
 - *2 measures are Medicaid-focused:*
Behavioral Health Screening, Metabolic Monitoring for Children and Adolescents on Antipsychotics
- <https://portal.ct.gov/OHS/Pages/Quality-Council/Core-Measure-Set>

Between the two measure sets, there are 34 unique, distinct measures.

Alignment between the Measure Sets

- 64% (seven measures) of the eleven scoring and challenge measures in the DSS PCMH+ Measure Set (*excluding* utilization measures) are also in the 2022 Core Measure Set.

	# of Overlapping Measures	Measure Names
PCMH+ Scoring Measures	2	<ul style="list-style-type: none"> • Child and Adolescent Well-Care Visits • Developmental Screening in the First Three Years of Life
PCMH+ Challenge Measures	5	<ul style="list-style-type: none"> • Behavioral Health Screening • Follow-Up After Emergency Department Visit for Mental Illness • Follow-Up After Hospitalization for Mental Illness • Metabolic Monitoring for Children and Adolescents on Antipsychotics • Prenatal & Postpartum Care

Non-Aligned Measures in the PCMH+ Measure Set

- The remaining 36% (four measures) of the PCMH+ Measure Set consists of measures that are not found in the Core Measure Set.
 - Two were supported by the Quality Council, but not adopted for 2022.

Supported by the Quality Council

Measure	Quality Council Recommendation
Antidepressant Medication Management	<ul style="list-style-type: none"> • Adopt <i>Follow-up After ED Visit for Mental Illness</i> and <i>Follow-up After Hospitalization Visit for Mental Illness</i> first. • Revisit inclusion for 2023.
Person-Centered Primary Care Measure	<ul style="list-style-type: none"> • Conduct a pilot of this measure before revisiting inclusion for 2023.

Not Supported by the Quality Council

Measure	Quality Council Recommendation
Avoidance of Antibiotic Treatment in Adults and Children with Acute Bronchitis	<ul style="list-style-type: none"> • Expressed interest in overuse measures but didn't think this was a good measure. • Re-considering overuse measures for 2023.
Comprehensive Diabetes Care: HbA1c Testing	<ul style="list-style-type: none"> • Removed because NCQA retired the measure for MY 2022. • Recommended <i>Comprehensive Diabetes Care: HbA1c Poor Control</i> instead.

Wrap-up & Next Steps

Meeting Wrap-Up & Next Steps



- Discuss strategies to generate action to meet Quality Benchmarks
- Discuss Core Measure Set follow-up items (e.g., measure set gaps, uptake of the Core Measure Set, work plan for 2022)



- Continue discussion of Core Measure Set follow-up items (e.g., measure set gaps, uptake of the Core Measure Set, work plan for 2022)

Appendix

The Board provided recommendations on several key decision points

Audience	A focus on the general public (including, but not specifically targeted to, policymakers, consumers and researchers)
Transparency Vehicle/Platform	Electronic Dashboard/Web Platform with visualized data and repository for other reports/data sets
Data Stratification and Access	Key indicators (e.g. geography, race/ethnicity, disability), with drill down/other capacity to permit researchers to download raw deidentified data
Comparison	Across states/regions/nation, payors, providers, time (some comparisons will not be feasible)

Identify measures in all categories that are equity sensitive and highlight those in specific public facing display

Transparency Work Oversight

Recommend the ongoing engagement of the Transparency Board as a Transparency Advisory Council that will perform the following functions:

1. Create a Charter that is agreed upon between DSS and the Advisory Members that will help delineate the role of the Advisory Council in overseeing:
 - a. Measure curation
 - b. Measure portrayal
 - c. Measure benchmarking
 - d. Dashboard utility and ease of use
 - e. Timeline for transparency work

The Board's Principles of Data Use and Oversight

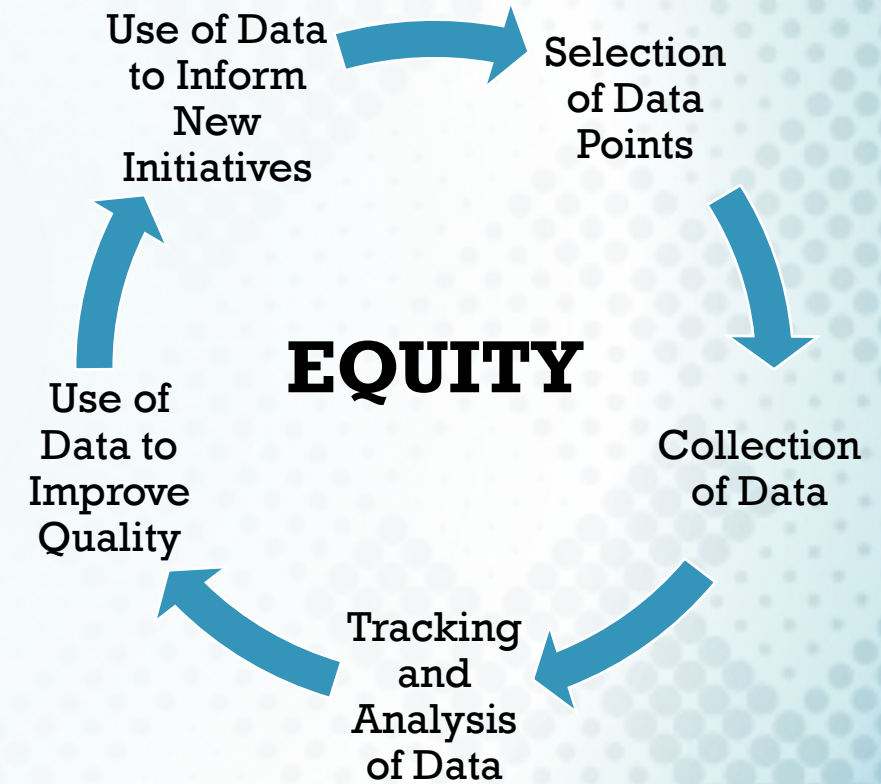
Statement of Intent

The data that is featured in the HUSKY Health data dashboard should be 1) used to illuminate the experiences and outcomes of Medicaid members, with an emphasis on achieving equity for all served; 2) member informed; 3) selected with a lens that safeguards against reinforcing preconceptions and stereotypes; and 4) presented in a clear and comprehensible manner and in formats that accommodate access by all who wish to use it.

For this purpose, the term equity means that everyone has a fair and just opportunity to attain their optimal health and socioeconomic status regardless of race, ethnicity, disability, gender identity, or sexual orientation.

Further, the Transparency Board wishes to ensure that the Department of Social Services applies these principles across the lifecycle of the data that DSS collects and manages

Equity framework



The Board's Principles of Data Use and Oversight

- The process through which DSS selects, reviews, sunsets and replaces data points and measures for purposes of quality improvement must be equity-informed, person-centered, member-informed, inclusive and transparent.
- Whenever possible, data points should be standardized across the enterprise to reduce the reporting burden on HUSKY Health members and providers.
- Selection, use, and publication of data points and measures should safeguard the privacy, dignity and health equity of HUSKY Health members.
- Within the above parameters and where feasible, data points and measures should, in support of health equity, routinely be disaggregated and publicly reported by race, ethnicity, age, and other demographic factors.
- When data is adjusted to account for age, risk, or other factors, both adjusted and unadjusted measures will be reported.
- Selection and use of measures should anticipate and mitigate unintended consequences including, but not limited to:
 - inherent bias of data analysis tools (e.g. algorithms);
 - perpetuation or exacerbation of health disparities and inequities;
 - under-service of members; and/or
 - adverse impact on providers that serve a high incidence of HUSKY Health members.
- To avoid misperception, stigma, and perpetuation of health disparities, DSS should always use best efforts to identify and report out on a baseline or reference group, and to provide contextual detail in reporting out disparities.

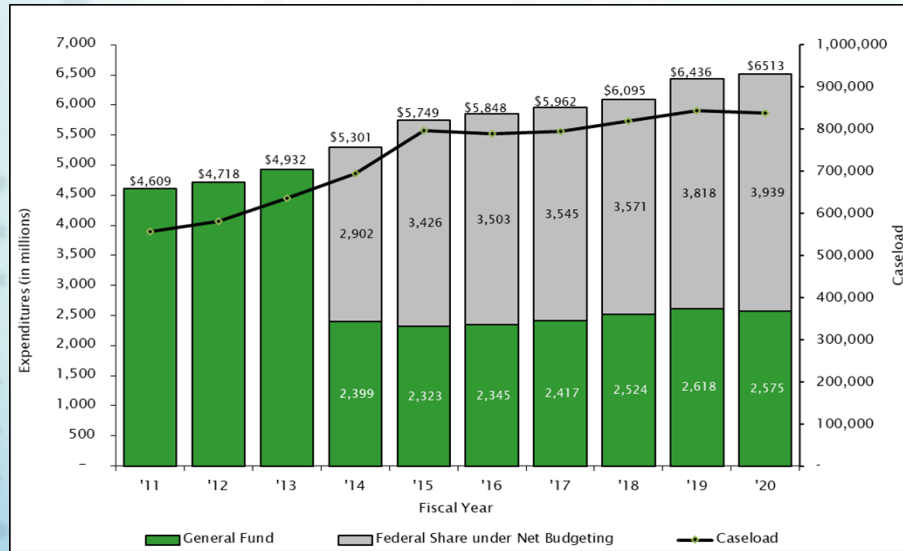
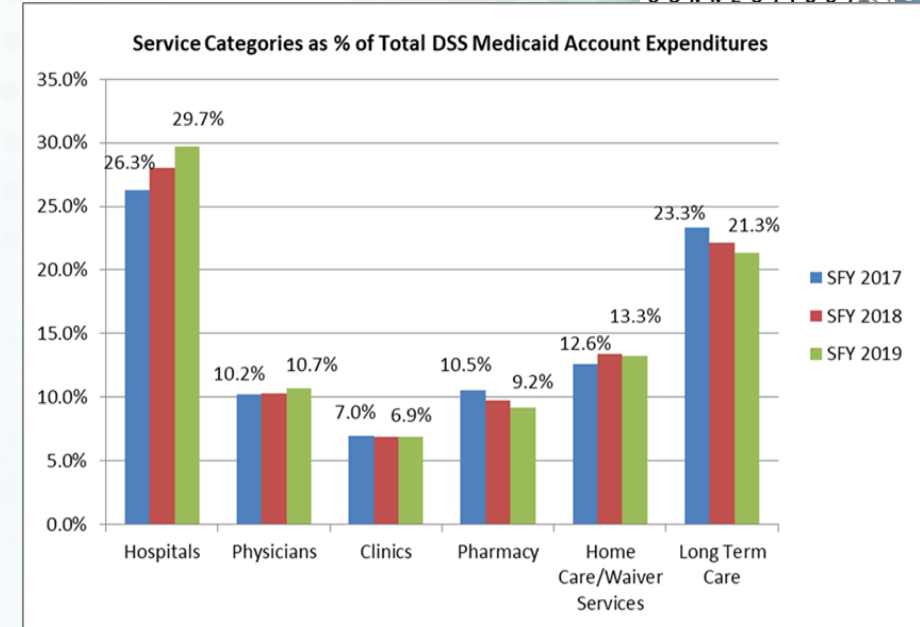
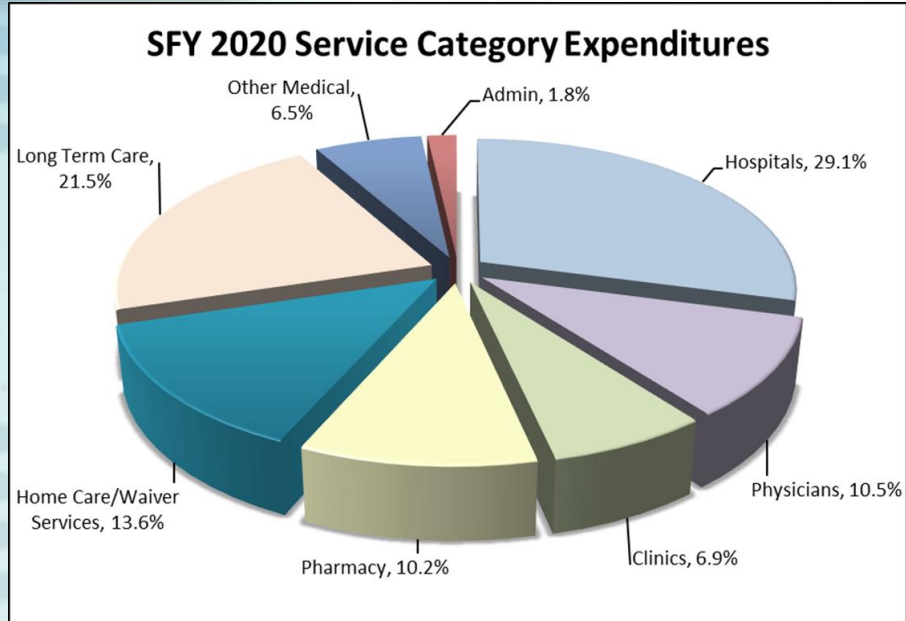
DETAIL: Goals by phase for Financial subgroup

- **Phase 1 – High Level Benchmarks**
 - Propose use of current “standard” financial metrics as reported annually and monthly to the Medical Assistance Program Advisory Committee (MAPOC)
- **Phase 2 – Strategic/Investment Oriented Metrics**
 - Linking strategic objectives and investments to desired financial changes or quality outcomes
 - Integrate quality data directly with financial data such PMPM by service category and HUSKY components
 - For example, linkage between primary care or other investments and network access and/or enhanced health outcomes. Alternatively, specialty care access and linkage to downstream associated costs.
 - Review alignment with other standards such as overall state health care cost benchmarking work, other health economic indicators, and other available state comparisons
- **Phase 3 – Interactive Financial Data “Mart”**
 - Develop interactive financial drill down capacity to include financial detail by category of service (COS) and program area (HUSKY A, B, C and D), associated enrollment metrics, and PMPM by service category and HUSKY component

DETAIL: Phase 1 measures for Financial subgroup

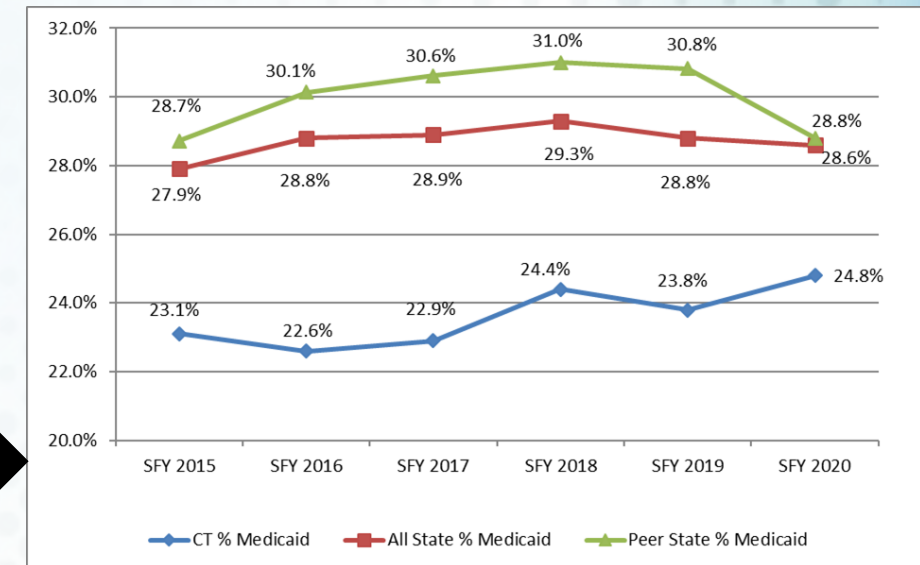
- Phase 1 – High Level Benchmarks
- Building off existing financial metrics, propose the following annual measures:
 - Category of service breakdown
 - Per member per month cost trends (overall and by program)
 - State share of Medicaid expenses
 - Medicaid share of the total CT state budget
 - Administrative expense ratio (unadjusted and adjusted)
- Propose the following quarterly measures:
 - Per member per month overall and by program (A,C, D)
 - Expenditures overall and by program
 - Enrollment overall and by program

Key Visualizations for Financial subgroup (1/3)



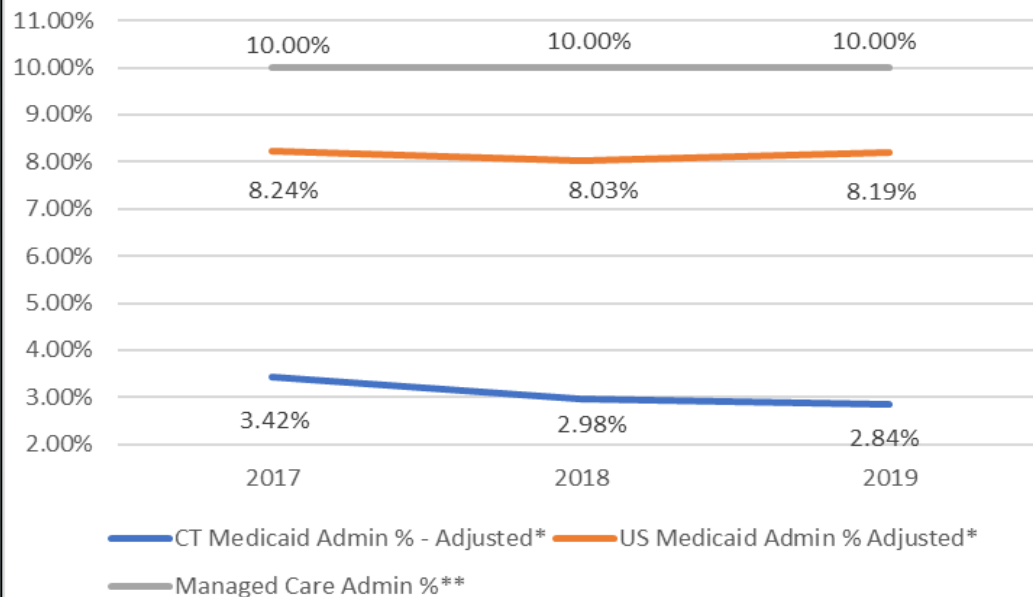
State Share Cost Stability

Medicaid as Share of Total State Budget

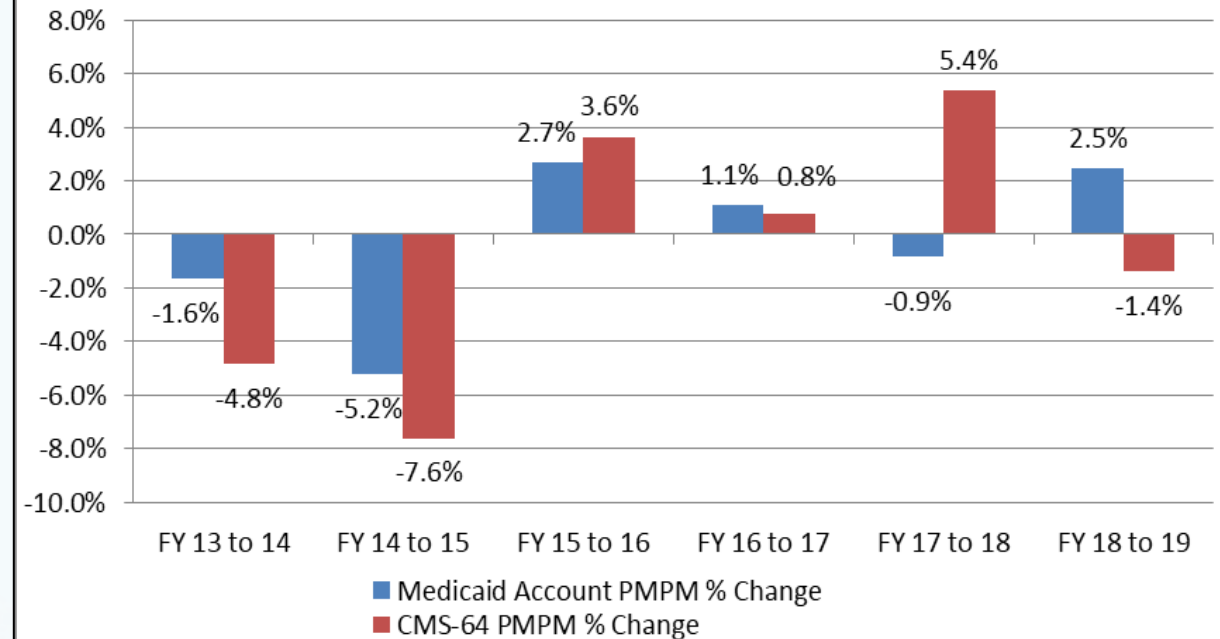


Key Visualizations for Financial subgroup (2/3)

Adjusted Medicaid Administrative Expense %



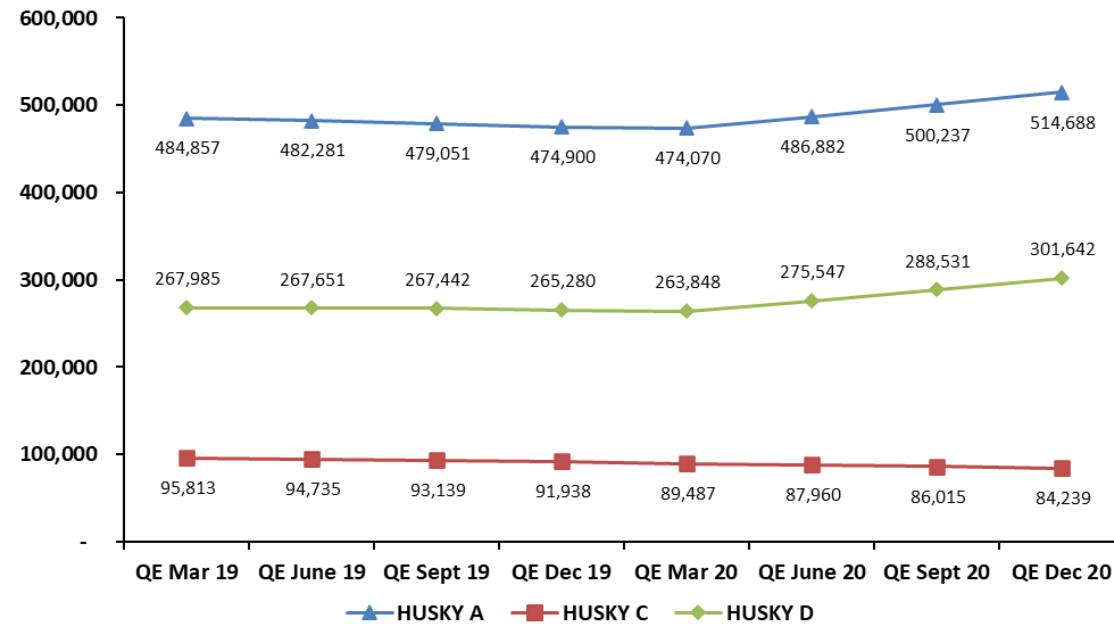
Medicaid Account and CMS-64 PMPM Percent Change Comparison



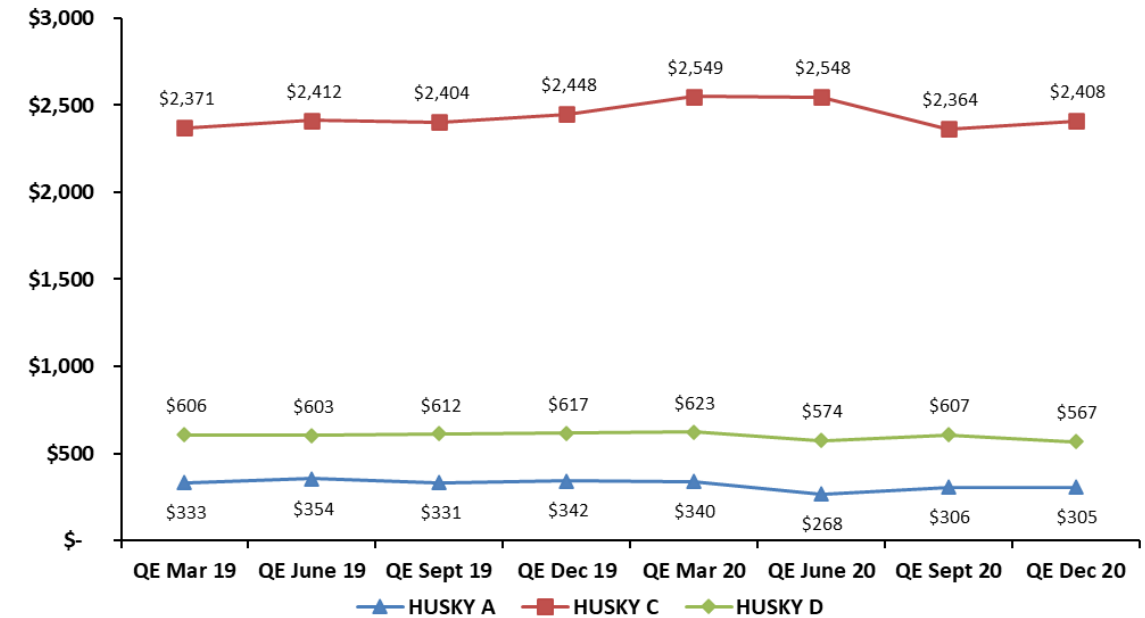
Key visualizations for Financial subgroup (3/3)



Average Quarterly Enrollment by Program



Average Quarterly PMPM by Program



Dashboard and Visualization



**Key Data Points And Story
Visualization Mock Up**



Key Milestones

Key Data Points And Story Website Mock-Up

CT Department of Social Services
Medicaid/HUSKY Health Transparency + Quality

Connecticut Department
of Social Services

EQUITY LENS



The data that is featured in the HUSKY Health dashboard seeks to illuminate the experiences and outcomes of Medicaid members, with an emphasis on achieving equity for all served. For this purpose, the term **equity** means that everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, gender identity, sexual orientation, or socioeconomic status.

PROMOTING A HEALTHIER CONNECTICUT



Population
Health



Enrollment,
Access + Churn



Clinical
Quality



Social Determinants
of Health



Special
Populations



Managing Costs

OTHER DATA + RESOURCES



[Other DSS Data + Reports](#)
[Medicaid.Gov CT Profile](#)
[CT COVID 19 Data](#)
[CT Open Data Portal](#)

[CT Data Plan](#)
[CT Data Collaborative](#)
[Census Data](#)
[American Community Survey Data](#)

QUESTIONS + COMMENTS



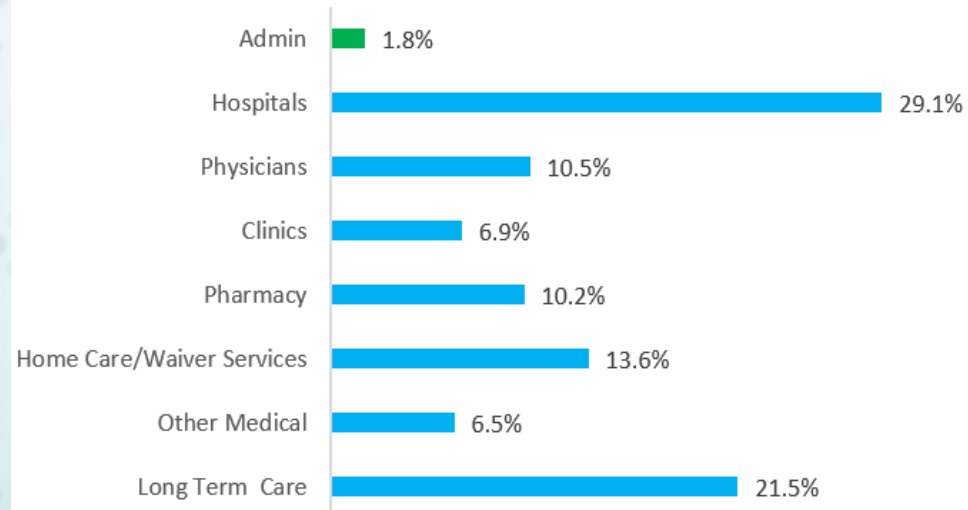
Key Data Points And Story

Dashboard Mock-Up

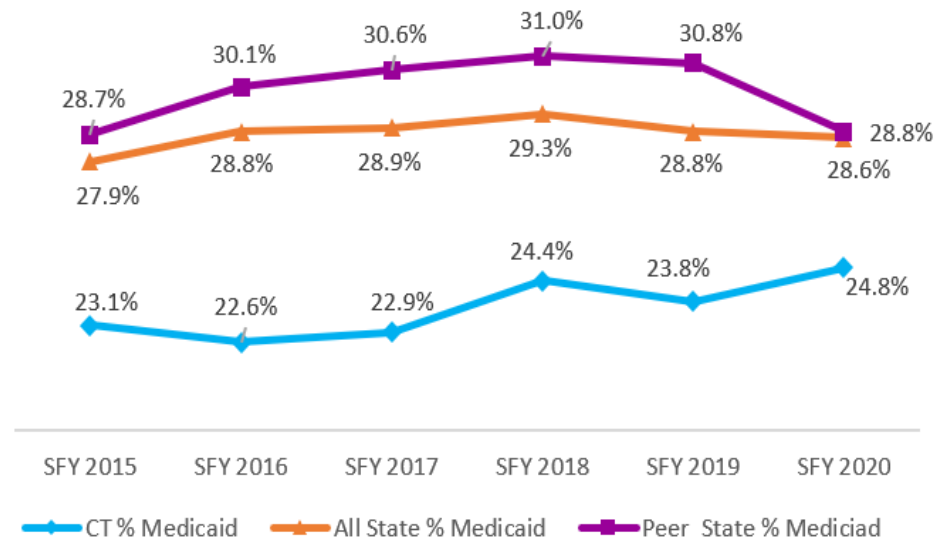
PROMOTING A HEALTHIER CONNECTICUT



SFY 2020 Service Category Expenditures



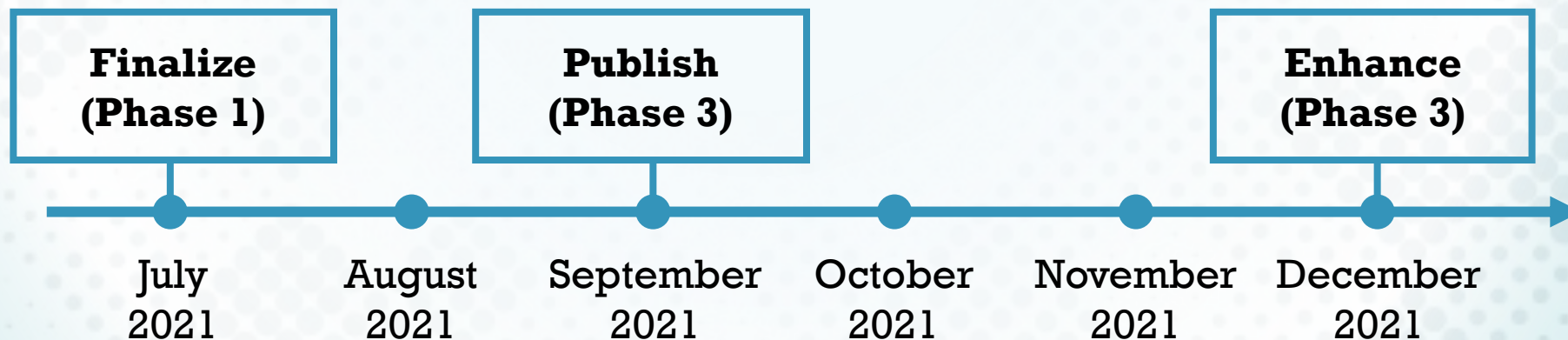
Medicaid as Share of Total State Budget





Key Phases

The development of the dashboard(s) and related products (e.g., infographic, data narrative, etc.) will need to be an iterative, multipronged process. The availability and format of data, and the number and complexity of the dashboard(s) will dictate how quickly products can be turned around. Also, the type of dashboard (i.e., static v. interactive) will significantly impact that timeframe. Other challenges to roll-out will include intervening priorities and availability of resources from other DSS Divisions and State agencies.



Dashboard and Visualization Phases

- Phase 1 – Development of Dashboard(s) and Related Products
- Phase 2 – Launching of Filterable Dashboards
- Phase 3 – Ongoing Dashboard Refinement and Expansion of Presented Data

Dashboard and Visualization Phases

Phase 1

Development of Dashboard(s) and Related Products

- Finalize Available Data to DSS for Initial Launch
- Create Meta-Data and Data Dictionary

During Phase 1, the launching of an initial static dashboard will begin

Phase 2

Launching of Filterable Dashboards

- Finalize Identification of Data to Launch for Interactive Dash
- Launch First Batch of Interactive Dash Data
- Launch Second Batch of Interactive Dash Data
- Launch Third Batch of Interactive Dash Data

During Phase 2, the launching (or broadening) of filterable dashboards will begin.

Phase 3

Ongoing Dashboard Refinement and Expansion of Presented Data

- Maintenance and Refinement of Data, user experience and user interface
- Expansion of Data Breadth and Menu

Phase 3 represents ongoing refinement of the dashboard and, as available, the expansion of presented data. Analysis of DSS Data Requests will occur to inform expansion of the public facing data.

Meetings of the Board

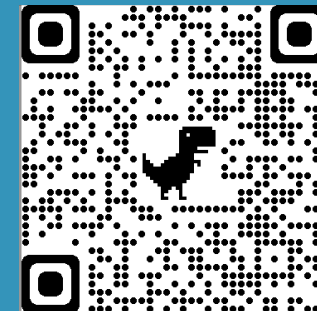
Meetings:

1. January 12, 2021[^]
2. February 23, 2021[^]
3. March 30, 2021[^]
4. April 27, 2021 **
5. May 25, 2021 **
6. June 29, 2021 **

[^] Link to videos on ct.gov

<https://portal.ct.gov/DSS/Common-Elements/Advisory-Board-for-Transparency-on-Medicaid-Cost-and-Quality/Meetings>

**QR Code to CT DSS YouTube



Transparency Board Quality Subgroup



Population
on Health:
Well-Being
and Primary
Prevention

Key Demographic + Geographic Disaggregation

Outcome Measures		Process Measures	Member Experience, Satisfaction, and Reported Outcomes
Comparison with other States			
Phase 1: Prevalence rates of acute and chronic diseases (DM, HTN, Asthma, COPD, CAD, mental health disorders, dental decay, obesity, cancer, substance use disorder) child, adolescent, adult, and parental Infant mortality Maternal mortality rate Preterm birth rate Breast Feeding (WIC/DSS)	Deaths Due to Suicide, Drug or Alcohol Overdose, Poisoning, Alcohol Related Liver Disease Tobacco Use	Phase 1: Screening for diabetes Wellness visits Screenings/Developmental Assessments Rate of positive screens for depression Falls screening (elders) ACE (Adverse Childhood Events)	Phase 1: CAHPS
Phase 2: Incarceration rates Released home from incarceration Food insecurity Children whose parents lack secure employment Vaccination rates adult/children Life Expectancy at Birth K Readiness (SDE) End of Third Grade Reading Level (SDE) Overall homelessness prevalence (CT Coalition to End Homelessness) Lead screening	Contraceptive Care--All Women (CCW) Racial Wealth Gap EITC and CTC tax filings Life Years Lost Years of Potential Life gained Nutrition Security High School Graduation Rate Parental Mental Health and Substance Use Disorder	Phase 2: Chronic Absenteeism follow-up or referral (SDE) ACEs (individual ACEs) Health Risk Score (e.g., HCC, ACG) Timely Referral or follow-up after positive screening	Phase 2: Culturally/Linguistically Competent Care Self-reported Health Status Self-reported Mental Health Status Perceived well-being - Cantril's Ladder (current, five years)

Data currently available to DSS

Transparency Board Quality Subgroup



Clinical Quality:

- Primary Care
- Acute Disease
- Chronic Disease

+ Includes medical and behavioral health measures
* Some measures as part of the measure set are currently measured by CT DSS and some are not


Key Demographic + Geographic Disaggregation

Outcome Measures	Process Measures	Member Experience, Satisfaction, and Reported Outcomes
Comparison with other States		
Phase 1: Medicaid and CHIP Scorecard (CMS) ⁺ OHS Core Measures ⁺⁺ HEDIS ⁺⁺ ED utilization for chronic disease (DM, asthma, COPD, ESRD, overdose, BH/SPMI, oral health) Inpatient utilization for chronic diseases (DM, COPD, ESRD, overdose, SPMI) Mortality rates for chronic behavioral health and medical diseases Follow-up after ED visits (dental, medical, and behavioral health) Prevalence rates of chronic diseases (DM, HTN, Asthma, COPD, CAD, SPMI, dental decay) Children receiving fluoride varnish	Phase 1: Medicaid and CHIP Scorecard (CMS) ⁺ OHS Core Measures ⁺⁺ HEDIS ⁺⁺ Depression screening % of individuals on opioids and BZD # of prescriptions per member Preventive and Diagnostic dental services Dental health utilization rate Rate of dental decay	Phase 1: CAHPS
Phase 2: OHS Core Measures ⁺⁺ HEDIS ⁺⁺ Avoidable ED utilization (children/adults) Avoidable inpatient utilization (children/adults) Unplanned readmission rates	Phase 2: OHS Core Measures ⁺⁺ HEDIS ⁺⁺ % with depression receiving evidence based treatment after diagnosis	Phase 2: Wellbeing, physical, mental health measures Person centered primary care measure (PCPM) Predict – bias in hospitalization (Yale) Language Access (translation services) Provider experience

Data currently available to DSS

Transparency Board Quality Subgroup



		Outcome Measures	Process Measures	Member Experience, Satisfaction, and Reported Outcomes
		Comparison with other States		
 <p>Social Determinants of Health (Individual Level)</p>	Key Demographic + Geographic Disaggregation	Phase 1: REL Data completeness Access to Transportation NEMT Primary Language	Phase 1: % receiving SNAP and TANF	Phase 1: -----
		Phase 2: Financial security Educational attainment Primary language Literacy levels Safe housing/neighborhood Access to food Physical Activity	Phase 2: NCQA SDoH screening SDoH Assessment + Referral (individual level)	Phase 2: Experience of racism, discrimination, and violence

Data currently available to DSS

Transparency Board Quality Subgroup



Enrollment,
Access + Churn

Key Demographic + Geographic Disaggregation	Outcome Measures	Process Measures	Member Experience, Satisfaction, and Reported Outcomes
	Comparison with other States		
	<p>Phase 1:</p> <ul style="list-style-type: none"> Number total members in A, B, C, D by quarter/SFY Number disenrolled by A, B, C, D by quarter/SFY % of individuals with an identified PCP Number of PCPs enrolled as providers Number of specialists enrolled as providers Number of mental health providers enrolled Number of dental health providers enrolled Number of adults and children with a dental visit in past year Number of adults and children with a primary care visit in the past year Number of adults and children with a behavioral health care visit in the past year 	<p>Phase 1:</p> <p>-----</p>	<p>Phase 1:</p> <p>-----</p>
	<p>Phase 2:</p> <ul style="list-style-type: none"> Disenrollment by reason by quarter and year and by HUSKY A, B, C, D Disenrollment and reenrollment within 90 days by HUSKY A, B, C, D 	<p>Phase 2:</p> <p>-----</p>	<p>Phase 2:</p> <p>Focus groups/survey on access to care</p>

Data currently available to DSS

Transparency Board Quality Subgroup



Special
Populations

Key Demographic + Geographic Disaggregation	Outcome Measures	Process Measures	Member Experience + Satisfaction Measures
	Comparison with other States		
	Phase 1: Money Follows the Person (MFP) CHESS Waivers	Phase 1: Money Follows the Person (MFP) CHESS Waivers	Phase 1: Money Follows the Person (MFP) satisfaction data and stories
	Phase 2: Carceral Perinatal (maternity, newborn, post-partum, dental care, birth control after delivery) Pediatric Special Health Needs Child welfare involved population	Phase 2: Carceral Perinatal (maternity, dental, newborn, post-partum) Pediatric Special Health Needs Child welfare involved population	Phase 2: CHESS

Data currently available to DSS

Transparency Board Quality Subgroup



Managing Costs

Key Demographic + Geographic Disaggregation

Outcome Measures	Process Measures	Member Experience + Satisfaction Measures
Comparison with other States		
<u>Phase 1:</u> -----	<u>Phase 1:</u> -----	<u>Phase 1:</u> -----
<u>Phase 2:</u> Efficiency – relationship between strategic aims around quality, efficiency, cost/benefit analyses, ROI, and spending	<u>Phase 2:</u> Timeliness of payments Over and under utilization of health care services	<u>Phase 2:</u> Focus groups/surveys on health related costs and care impact for members for non-covered services