To: Quality Council
From: Vicki Veltri, Kelly Sinko and Hanna Nagy
Date: October 14, 2021
Re: Quality Benchmark Recommendations

The Quality Council finalized its recommended list of measures for the Quality Benchmarks during the August meeting. OHS has since reviewed the Council's recommendations and identified several proposed revisions that aim to align the Benchmarks with the intention of Executive Order No. 5 and Connecticut's statewide health priorities. This memo serves to provide additional context for OHS' proposed revisions to the Quality Council's recommended slate of Quality Benchmarks. OHS looks forward to discussing OHS' perspective further during the October 21st Quality Council meeting.

Rationale

During the August 19th Quality Council meeting, the Quality Council recommended eight measures that can be applied at the state level and two measures that can be applied at the state, market, insurance carrier and Advanced Network (AN) levels. OHS is proposing a new direction with the Quality Benchmarks. There are three primary motivations for this change:

1. **OHS sees large providers, i.e., ANs, as critical for improving cost and quality**. We believe that public reporting of AN Quality Benchmark performance on an annual basis will motivate meaningful action to drive improvement. We see the Quality Benchmarks as a complementary strategy to the Cost Growth Benchmark and Primary Care Spend Target identified in Executive Order No. 5. As a result, OHS is interested in selecting Quality Benchmarks that measure *healthcare* and which ANs can realistically impact and be held accountable. We believe it will be much more difficult for ANs to identify and execute strategies to improve performance on *health status* measures before 2025.
2. **OHS wants the Quality Benchmarks to align with state health priorities** identified during the Quality Council's review of the Core Measure Set. The top three state health priorities are chronic conditions (notably, asthma, diabetes and hypertension), behavioral health treatment and childhood obesity. The Quality Council's recommended measures do not address the first or third priorities.
3. **OHS hopes to create alignment across statewide quality measurement activities**. We wish to select Benchmark measures from the Core Measure Set, as well as measures that are part of the Department of Social Services' (DSS) quality transparency strategy, as outlined in Executive Order No. 6. The majority of the state-level Benchmark measures proposed by the Quality Council are currently not part of either initiative.

OHS' Recommendations

OHS is proposing a phased introduction of Quality Benchmarks over the next five years as data collection and reporting functionalities improve. This includes two waves of Benchmark measures:

1. **Measures to report beginning for 2022:** Collect and report performance for four measures by AN, insurance carrier, insurance market and state. Insurance carriers would be requested to report their performance for their commercial and Medicare lines of business and for each AN with which they contract. DSS would report performance for Medicaid and for each AN with which it contracts.

    a. ***Asthma Medication Ratio***: This measure addresses a state health priority, is in the Core Measure Set and is a claims-based measure that can more easily be reported by AN, insurance carrier and market. There is opportunity for improvement, as current performance is 78%, which is between the national 25th and 50th percentiles.[1] Finally, it is a reporting-only measure in the DSS PCMH+ Measure Set. Of note, this measure was newly added to the Core Measure Set for 2022. Therefore, we do not have information on whether the measure is currently in use by insurance carriers.[2]

    b. ***Child and Adolescent Well-Care Visits***: This is the only pediatric measure that also can impact a state health priority (i.e., childhood obesity), albeit indirectly. It is in the Core Measure Set and is a claims-based measure that can be reported by AN, insurance carrier and market. It is a scoring measure in the DSS PCMH+ Measure Set. This is a newer HEDIS measure, so there are no data on current performance. Therefore, OHS will collect and report performance beginning for 2022, but will not set a benchmark for this measure until winter 2023/spring 2024 when it analyzes baseline data and when NCQA publishes comparison data. Similar to the previous measure, this measure was newly added to the Core Measure Set for 2022 so we do not have information on whether the measure is in use by insurance carriers.

    c. ***Controlling High Blood Pressure***: This measure addresses a state health priority, is in the Core Measure Set and is in use by all six surveyed insurance carriers. There is opportunity for improvement, as current performance is 61%, which is between the national 50th and 75th percentiles. This measure is included in DSS' transparency strategy developed in response to Executive Order No. 6.

    d. ***Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control***:[3] This measure addresses a state health priority, is in the Core Measure Set and is in use by three of six surveyed insurance carriers. There is opportunity for improvement, as current performance is 27% (a lower rate indicates better performance), which is between the national 75th and 90th percentiles. This

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[1] Assessment is using CY 2019 commercial data from NCQA's Quality Compass. It is a statewide weighted average of the four largest insurance carriers (i.e., Aetna, Anthem, Cigna and United) in Connecticut.

[2] OHS surveyed six insurance carriers (i.e., Aetna, Anthem, Cigna, ConnectiCare, Harvard Pilgrim and UnitedHealthcare) in winter 2020/2021 to identify which of the existing Core Measure Set measures they were using in contracts with ANs.

[3] This measure was formerly named *Comprehensive Diabetes Care: HbA1c Poor Control*.

measure is included in DSS' transparency strategy developed in response to Executive Order No. 6.

2. **Measures to report beginning for 2024:** Collect and report performance for the four previously mentioned measures, as well as three additional measures. OHS would use the same reporting methodology described previously, i.e., insurance carriers and DSS would be requested to report performance for each relevant line of business and for each AN with which they contract.

    a. ***Follow-up After Emergency Department Visit for Mental Illness (7-day)***: This measure addresses a state health priority (i.e., behavioral health treatment), is in the Core Measure Set and has been recommended by the Quality Council. There is opportunity for improvement, as current performance is 60% for the 7-day rate, which is between the national 75th and 90th percentiles. Finally, it is a challenge measure in the DSS PCMH+ Measure Set.

    b. ***Follow-up After Hospitalization for Mental Illness (7-day)***: This measure addresses a state health priority (i.e., behavioral health treatment), is in the Core Measure Set and has been recommended by the Quality Council. There is opportunity for improvement, as current performance is 56% for the 7-day rate, which is between the national 75th and 90th percentiles. Finally, it is a challenge measure in the DSS PCMH+ Measure Set.

    c. ***Obesity Equity Measure***: This measure addresses a state health priority and has been recommended by the Quality Council. There is opportunity for improvement, as current performance is 29% and there are known, stark inequities when assessing performance by race/ethnicity. Specifically, there is a 17-percentage point difference in performance for White, non-Hispanics compared to Black, non-Hispanics.[4] Further, people who are obese are more likely to have hypertension and diabetes, which are two additional state health priorities for which OHS is proposing measures for the Quality Benchmarks. Finally, Connecticut is working to improve collection of race/ethnicity data, per Substitute Senate Bill No. 1 / Public Act No. 21-35.[5]

3. **Future Directions:** OHS aims to leverage Connie, the statewide health information exchange (HIE), to report performance for all ANs in future years. Per Connecticut General Statutes (CGS) Sec. 17b-59d, each health care provider with an electronic health record system must apply to begin the process of connecting to and participating in Connie by May 3, 2023.[6] OHS anticipates that Connie will be a viable data source in or after 2024.

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[4] Assessment is using data from the Behavioral Risk Factor Surveillance System (BRFSS) for 2019.
[5] See: https://www.cga.ct.gov/2021/ACT/PA/PDF/2021PA-00035-R00SB-00001-PA.PDF.
[6] See: https://portal.ct.gov/OHS/HIT-Work-Groups/Health-Information-Alliance.

Next Steps

OHS greatly appreciates the time and effort the Quality Council has put into developing its recommended Quality Benchmarks and for considering OHS' proposed revisions to the slate of measures. We look forward to discussing this proposal further on October 21st.