Meeting of the Quality Council

Meeting Date	Meeting Time	Location
November 18, 2021	4:00 pm – 6:00 pm	Webinar/Zoom

Participant Name and Attendance

Quality Council		
Rohit Bhalla	Karin Haberlin	Marlene St. Juste
Elizabeth Courtney	Danyal Ibrahim (representing Syed Hussain)	Daniel Tobin
Monique Crawford	Paul Kidwell	Alison Vail
Sandra Czunas	Joe Quaranta	Orlando Velazco
Stephanie De Abreu	Laura Quigley	Steve Wolfson
Tiffany Donelson	Brad Richards	Rob Zavoski
Lisa Freeman	Andy Selinger (Chair)	
Others Present		
Michael Bailit, Bailit Health	Hanna Nagy, OHS	Jeannina Thompson, OHS
Deepti Kanneganti, Bailit Health	Kelly Sinko, OHS	
Members Absent:		
Susannah Bernheim	Michael Jefferson	Doug Nichols / Jeffrey Langsam
Amy Gagliardi	Nikolas Karloutsos	Kyisha Velazquez

Meeting Information is located at: https://portal.ct.gov/OHS/SIM-Work-Groups/Quality-Council/Meeting-Materials

	Agenda	Responsible Person(s)
1.	**Welcome and Introductions**	**Hanna Nagy**
	Hanna Nagy called the meeting to order at 4:05pm.	
2.	**Public Comment**	**Hanna Nagy**
	Hanna Nagy welcomed public comment. None was offered.	
3.	**Approval of October 21, 2021 Meeting Minutes**	**Hanna Nagy**
	Rob Zavoski motioned to approve minutes of the Quality Council's October 21st meeting. Orlando Velazco seconded the motion. No one objected to or abstained from approving the meeting minutes. The motion passed.	
4.	**Follow-up from the October 21, 2021 Meeting**	**Michael Bailit**
	Michael Bailit summarized Executive Order No. 5, which directs the Quality Council to assist the Office of Health Strategy (OHS) in the development of a set of Quality Benchmarks. Michael provided a recap of the Quality Council's recommended changes to OHS' proposed phased implementation of Quality Benchmarks from the last meeting. He then shared OHS' proposed responses to the Council's feedback: 1. Move *Child and Adolescent Well-Care Visits* to Phase 2 given that 2022 performance data (the most recent year for which performance data will be available that hopefully will not be heavily impacted by COVID-19) will not be available until winter 2023. a. There were no comments in opposition to this proposal. b. **Recommendation**: Move *Child and Adolescent Well-Care Visits* to Phase 2. 2. Remove *Asthma Medication Ratio* from the Quality Benchmarks because it could disincentivize providers from writing prescriptions for multiple inhalers for different care settings, which is an undesired adverse consequence. a. Joe Quaranta agreed that this measure is flawed but noted that there are no alternate asthma measures that the Council could consider. He said this measure incentivizes providers to issue controlling inhalers, which is a good outcome. b. Tiffany Donelson expressed concern about having no asthma-focused measures because of the disparities in asthma rates in Connecticut. c. Steve Wolfson agreed with Joe and Tiffany and advocated for retaining the measure. d. Rohit Bhalla noted that this is one of the few measures focused on chronic conditions in children. e. Lisa Freeman requested and received confirmation that there are no strong alternate asthma measures that the Council could consider. She then supported retaining the measure because the measure aims to improve care for children with asthma. f. Dan Tobin advocating for removing the measure because of its identified flaws. He expressed his disappointment in the lack of drug overdose measures. Dan shared that there were 1,374 accidental overdose deaths in CT last year, which was the highest rate to date. He advocated for include an opioid or drug overdose measure in the Quality Benchmarks. g. Rob Zavoski explained that this measure tries to assess whether patients are receiving appropriate preventive care for asthma by identifying 1) which patients are not receiving a preventive inhaler and 2) which patients are only prescribed rescue inhalers. h. Monique Crawford noted that UnitedHealthcare is currently tracking performance for this measure.	

i. Danyal Ibrahim asked whether the Council considered a measure from AHRQ focused on avoidable hospitalizations for conditions that could be addressed in an ambulatory setting, such as asthma. Michael indicated that the Council is considering Quality Benchmarks that come from the Core Measure Set. The Core Measure Set does not include the AHRQ avoidable hospitalization measure.
j. **Next Steps**: OHS will reconsider *Asthma Medication Ratio* and consider inclusion of a potential drug overdose measure.

3. Move *Follow-up After Hospitalization for Mental Illness* from Phase 2 to Phase 1.
   a. Michael noted that this change is not necessary if OHS retains *Asthma Medication Ratio*. There was no additional comments from the Quality Council.
   b. **Next Steps**: OHS will consider moving *Follow-up After Hospitalization for Mental Illness* to Phase 1 if it removes *Asthma Medication Ratio* from the Quality Benchmarks.

Michael Bailit shared that OHS previously proposed excluding Medicare from the Quality Benchmarks given the market's small population size and challenges associated with obtaining clinical data-based measure for traditional (i.e., fee-for-service) Medicare. The Council, however, had recommended including Medicare population measures because of their medically complex needs. Michael shared OHS' new proposal to exclude benchmarks for the Medicare fee-for-service (FFS) market but include benchmarks for the Medicare Advantage market for *Controlling High Blood Pressure* and *Hemoglobin A1c Control: Poor Control*. Insurers are likely using these measures in Medicare Advantage contracts because CMS uses them for its Medicare Part C Star Ratings. He added that these are strong outcome-focused measures. The Council agreed with this proposal.

Recommendation: Include Quality Benchmarks for the Medicare Advantage market.

5.	**Continue Discussion of Quality Benchmark Values**	**Michael Bailit**

Michael Bailit reminded the Quality Council of the Benchmark values it recommended for the commercial market for four measures at the last meeting. Michael reviewed the last remaining measure for the commercial market:

- ***Follow-Up After Hospitalization for Mental Illness (7-Day)***:
  - Brad Richards noted that performance for this measure could increase significantly if providers use telehealth as a form of follow-up. He recommended a Benchmark value between 59 to 64 percent.
  - Lisa Freeman agreed with Brad and suggested a Benchmark value of 62 percent. She added that mental health treatment is often reimbursed at a rate lower than medical treatment and asked if this would impact performance rates. Joe Quaranta and Michael indicated that network adequacy does impact performance, but coverage benefits do not.
  - Joe Quaranta spoke in favor of setting higher Benchmark values for 2025. He recommended striving for a two-percentage point increase every year, which would result in a final Benchmark value between 68 to 70 percent by 2025. Lisa Freeman agreed with this approach.
  - Paul Kidwell confirmed that a follow-up visit with a mobile health clinic would be an eligible form of follow-up.
  - Rohit Bhalla proposed a target at the 75th percentile (i.e., 59 percent) because it is higher than current performance and is achievable in the next few years.
  - Rob Zavoski agreed with Brad's comment that telehealth can improve performance rates dramatically. He noted the importance of hospitals sharing information with providers to conduct follow-up.
  - Joe Quaranta and Brad Richards expressed their support for setting a Benchmark value at 64 percent.
  - **Recommendation**: Set a 2025 Benchmark value at 64 percent, which is the New England 90th percentile.

Michael Bailit summarized OHS' proposed approach for setting Benchmark values for the Medicaid market: the Quality Council will recommend Benchmark values for DSS' Transparency Council to review before providing a recommendation to OHS. The Council supported this approach.

- ***Child and Adolescent Well-Care Visits***: Michael shared that the Quality Council will revisit setting Benchmarks for this measure in winter 2023 when 2022 performance data are available.
  - **Next Steps**: Revisit setting a Benchmark value for this measure in winter 2023.
- ***Controlling High Blood Pressure***: Michael reminded the Council that it recommended a 2025 commercial Benchmark value of 65 percent. Commercial baseline performance is 61 percent, which is the same as Medicaid.
  - Dan Tobin noted that blood pressure readings can be highly variable depending on the care setting and technique. He noted that the Council should consider this when setting Benchmark values.
  - Joe Quaranta shared that this measure is heavily dependent on clinical data. He asked for more information about DSS' sampling methodology. Brad Richards explained that DSS uses a combination of claims and clinical data to calculate measure performance. Brad added that the specifications consider the lowest recorded blood pressure reading. Joe Quaranta confirmed that performance is based on a random sample of patients. Joe proposed a target of 73 percent.
  - Brad Richards proposed a target of somewhere between 65 and 68 percent.

- Dan Tobin noted that because of how data are captured, 73 percent was likely too high. He supported Brad's proposal.
- Rohit Bhalla spoke in favor of the national 75th percentile, which is 68 percent. Rohit commented that performance had not changed over the last three years. Rohit asked what principles the Council was using to set Benchmark values and questioned whether it would be better to achieve lower target values, or to strive for a higher target knowing that CT may not meet it.
  - Michael responded that the Council is striving to set Benchmark values that motivate improvement, but that are reasonably attainable by 2025. He added that if CT performance improves after being stagnant for three years, but doesn't meet the benchmark, that could be considered a success.
  - Joe Quaranta spoke in favor of setting a higher aspirational target that may motivate real change over a target that could more easily be met.
- Alison Vail indicated that 68 percent may be too hard to meet by 2025 and recommended setting a benchmark slightly lower.
- Marlene St. Juste, Andy Selinger and Steve Wolfson spoke in favor of the 75th percentile.
- Michael noted that the Council was recommending a Benchmark value for the commercial market that was lower than for Medicaid. Lisa Freeman, Andy Selinger and Steve Wolfson (via the chat) spoke in favor of setting the Benchmark for both markets at 68 percent.
- **Recommendation**: Set a 2025 Benchmark value for the commercial and Medicaid markets at 68 percent.

- ***Hemoglobin A1c Control for Patients with Diabetes: HbA1c >9%***: Michael noted that a lower rate indicates better performance for this measure. Michael reminded the Council that it recommended a 2025 commercial Benchmark value of 65 percent, which is between the national 75th and 90th percentile. Commercial baseline performance is 61 percent.
  - Brad Richards recommended a Benchmark value of 33 percent, which is the national 75th percentile.
  - Joe Quaranta indicated that providers can improve measure performance just by documenting HbA1c rates because the numerator includes patients with no documented HbA1c rate. He said this was cause for setting a more aspirational target.
  - Lisa Freeman expressed interest in setting a more aspirational target because Medicaid's rate is much higher than the commercial rate (which was 27 percent in 2019). Michael noted that it is common for Medicaid to have a worse rate than commercial.
  - Rob Zavoski indicated that DSS aspires to have a performance rate that is better than commercial wherever possible. He agreed with Brad's proposal to set the Benchmark value at the 75th percentile.
  - Paul Kidwell also agreed with the 75th percentile and noted that that the distance between current performance and the Benchmark value for the commercial and Medicaid markets are relatively similar (i.e., three to four percentage points).
  - **Recommendation**: Set a 2025 Medicaid Benchmark value of 33 percent.
- ***Follow-up After Hospitalization for Mental Illness (7-Day)***: Michael shared that the Council recommended a 2025 commercial Benchmark value of 71 performance, which is the New England 75th percentile. Commercial baseline performance is 60 percent.
  - Andy Selinger noted that this is a challenging metric for the Medicaid population. He advocated for setting a Benchmark value at the national 90th percentile, which is 65 percent.
  - Brad Richards suggested using 60 percent, which is between the national 75th and 90th percentiles.
  - Joe Quaranta advocated for a Benchmark value closer to the 90th percentile. He pointed out that the denominator for this measure is relatively small and therefore specific interventions can have a big impact on performance.
  - Marlene St. Juste, Steve Wolfson, and Karin Haberlin agreed with the 90th percentile recommendation.
  - Paul Kidwell shared that while he thought the 90th percentile was important to achieve, it will be challenging for Medicaid to meet after COVID-19. Steve Wolfson asked if this was due to lack of resources. Paul noted that despite having resources focused on ensuring patients have follow-up visits, it is hard for patients to have a regular source of care.
  - Rob Zavoski noted that this is a national crisis and a problem that Connecticut has struggled with for decades. He spoke in favor of the national 90th percentile.
  - **Recommendation**: Set a 2025 Medicaid Benchmark value of 65 percent.
- ***Follow-up After ED Visit for Mental Illness (7-Day)***: Michael reminded the Council that it recently recommended a 2025 commercial Benchmark value of 64 percent, which is the New England 90th percentile. Commercial baseline performance is 56 percent.
  - Brad Richards recommended the New England 90th percentile, which is 55 percent. Steve Wolfson and Marlene St. Juste agreed with Brad.

- Joe Quaranta asked the Council if it wanted to consider a benchmark that pushes Medicaid to align with the commercial market. He noted that Connecticut may not meet the target, but it would be a valuable message to show that the Council is striving to create parity in performance between the markets.
- Rohit Bhalla spoke in favor of the 75th percentile, which is 54 percent.
- Lisa Freeman noted that mental illness is an important to address and advocated for a high target. She spoke in favor of aligning the Benchmark value with the commercial market.
- Paul Kidwell and Andy Selinger supported the 90th percentile.
- **Recommendation**: Set a 2025 Medicaid Benchmark value of 55 percent.

Michael shared that OHS is in the process of establishing benchmark data for the Medicare Advantage market. The Council will revisit this topic at the next meeting.

Michael noted that the Obesity Equity Measure will have one statewide Benchmark value for 2025. This measure considers the difference in performance between the majoritized (i.e., White, non-Hispanic) and minoritized (i.e., Black, non-Hispanic) race/ethnicity populations. He indicated that the difference ideally should be 0.

- Joe Quaranta shared that the difference in performance between the two populations had changed quite dramatically year-over-year. Michael agreed with Joe and noted that it could be due to the changes in the survey respondents and/or survey administration. Joe added that the average difference over the last five years was 13 percentage points.
- Andy Selinger noted that if Connecticut achieved a ten-percentage point difference in the past, it should be able to do so again. Brad Richards agreed with Andy.
- Steve Wolfson asked what resources are available to improve performance on this measure. He noted that obesity is highly impacted by limited access to healthy foods in predominantly non-White neighborhoods.
- Lisa Freeman shared that she was comfortable with a Benchmark value of ten percent if Connecticut had reached this value in the past and wondered if the State should strive for a Benchmark value of nine percent.
- Rob Zavoski noted that DSS had challenges associated with its race/ethnicity data in 2017 and 2018, which may explain the low difference in obesity rates between the White and Black population in those years. Karin Haberlin agreed with Rob.
- Brad Richards added there is high percentage of Medicaid members for which race/ethnicity data is "unknown."
- Marlene St. Juste supported a Benchmark value of ten.
- **Recommendation**: Set a 2025 statewide Benchmark value of ten percentage points.

Michael Bailit noted that the Quality Council needed to recommend interim Benchmarks values prior to 2025. He proposed that the 2022 Benchmark value be equal to baseline performance given that the Benchmarks were being set just before the start of the measurement year. The Council agreed with this proposal.
Recommendation: Set the 2022 Benchmark value for all measures and markets at the 2019 baseline rate.

Michael described two potential options for setting Benchmark values for 2023 and 2024. The first approach was to set equal annual Benchmark values for each year. The second approach was to use a compound annual growth rate so that performance must improve at a higher rate each year between 2023 and 2025.

- Steve Wolfson noted that the equal annual target approach was easier to understand. Andy Selinger agreed with Steve. Alison Vail and Lisa Freeman also agreed with Steve and noted that it will be harder to make big improvements in later years.
- Dan Tobin spoke in favor of using an annual growth rate to set interim Benchmark values because in theory, process changes should compound over time.
- **Next Steps**: OHS will consider the Council's feedback before proposing a methodology to set Benchmark values or 2023 and 2024.

6.	**Begin Discussion on Data Collection and Performance Evaluation**	**Deepti Kanneganti**

Deepti Kanneganti presented proposals for payer responsibility for reporting performance to OHS and the timeline for doing so for each benchmark measure (August 31st of the year after the measurement year). She distinguished claims-based and clinical data-based measures, noting that the approach would be the same for both in the short term. In the long term (2024, optimistically), OHS aims to use Connie, the statewide health information exchange, for clinical data-based measures. Finally, she explained that the CDC would be the source for the *Obesity Equity Measure*. For all measures, OHS would release performance simultaneously with the annual release of the Cost Growth Benchmark and Primary Care Spend Target performance results, which would be early 2024 for measurement year 2022. There were no objections to the proposal.
Recommendation: Adopt OHS' proposed methodology for reporting Quality Benchmark performance.

Deepti then introduced performance evaluation recommendations. OHS would report performance and Quality Benchmark achievement at the state, insurance market, payer and/or Advanced Network levels. Michael Bailit recommended that the

	evaluation methodology recognize improvement so that the payers and ANs are not penalized for improving performance but not attaining the benchmark aspirational values. Andy Selinger and Steve Wolfson supported the recommendation. **Recommendation**: Adopt OHS' proposed evaluation recommendations and include an assessment of payer and AN improvement.	
7.	**Begin Discussion on Updating Benchmarks Over Time**	**Deepti Kanneganti**
	Deepti Kanneganti noted that measure specifications do change sometimes, which may impact Quality Benchmark values. She then set forth a proposed method for assessing any measure specification changes by September the year after the measurement year, determining whether the changes are substantive by October the year after the measurement year, and then identifying what actions OHS could take to respond to the substantive changes by November the year after the measurement year. There were no objections to the proposal. **Recommendation**: Adopt OHS' proposed methodology for updating Benchmarks over time.	
8.	**Adjourn**	**Andy Selinger**
	Deepti Kanneganti explained that Council staff will provide a write-up of all Benchmark recommendations to date prior to the next Quality Council meeting. During that meeting, the Council will revisit the *Asthma Medication Ratio* measure and the proposal to add drug overdose-related Benchmark measures, continue its discussion of the Quality Benchmark values (including for the Medicare Advantage market), and discuss how to generate strategies to "move the needle" on the Benchmark measures. Steve Wolfson made a motion to adjourn the meeting. Andy Selinger seconded the motion. There were no objections. The meeting adjourned at 5:56pm.	