Connecticut Quality Benchmarks

Connecticut Office of Health Strategy

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Table of Contents

I. Executive Summary 3
II. Background 4
III. Quality Benchmarks 4
A. Quality Council 4
B. Process for Establishing Quality Benchmarks 5
Quality Benchmark Measures 5
Quality Benchmark Values 7
C. Methodology for Collecting Data for and Measuring Performance on the Quality Benchmarks 11
D. Process for Reviewing and Updating Quality Benchmarks 12
IV. Next Steps 14
V. Appendices 15
Appendix A: Quality Council Members as of December 31, 2021 15

I. Executive Summary

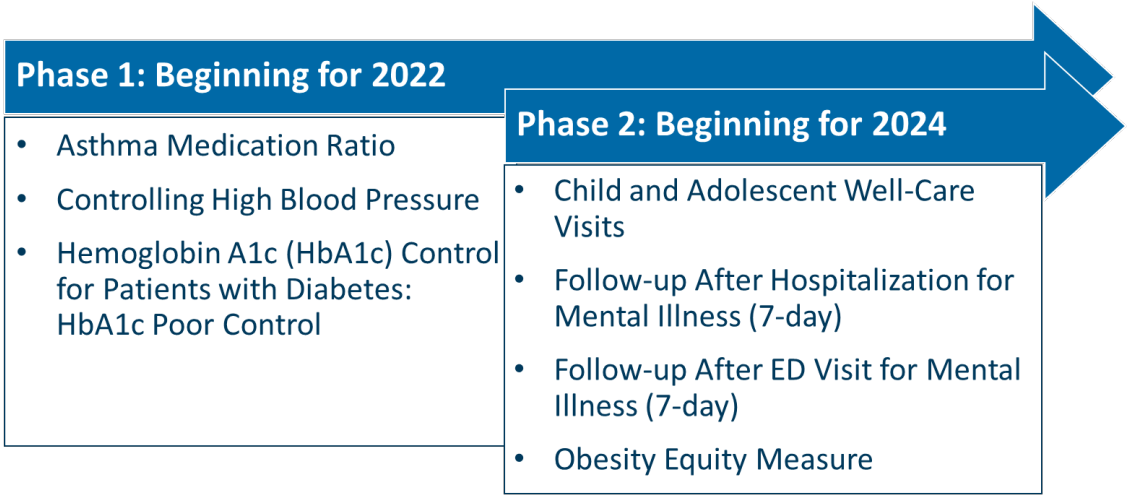
On January 22, 2020, Governor Lamont signed Executive Order No. 5 directing the establishment of a statewide healthcare Cost Growth Benchmark, a Primary Care Spend Target and Quality Benchmarks. Executive Order No. 5 directs the Office of Health Strategy (OHS) to develop annual Cost Growth Benchmarks and Primary Care Spend Targets for calendar years (CY) 2021-2025 and Quality Benchmarks for CY 2022-2025.

The Quality Benchmarks are annual measures and target values that all public and private payers, providers, and the State must work to achieve to improve healthcare quality in the State beginning on January 1, 2022.

OHS launched its work on the Quality Benchmarks in summer 2021. Throughout the process, OHS was supported by the Quality Council, its key advisory body on quality measurement. OHS charged the Quality Council with recommending measures and values for the Quality Benchmarks and the best methods for collecting data and evaluating performance. OHS also consulted the Department of Social Services (DSS) and its Transparency Council to ensure alignment with activities specified by Executive Order No. 6.

OHS has adopted the Quality Council's recommendations for a phased implementation of seven Quality Benchmark measures. OHS also adopted the Quality Council's recommended specific Benchmark values for the commercial, Medicaid and Medicare Advantage markets for six measures and one statewide Benchmark value for the remaining measure. **Figure 1** below identifies the Quality Benchmarks for 2022-2025.

Figure 1: 2022-2025 Quality Benchmarks



OHS will continue to refine the parameters for program implementation on an annual basis in consultation with the Quality Council, while maintaining as much consistency as possible.

II. Background

Governor Lamont signed Executive Order No. 5 on January 22, 2020 to establish a statewide healthcare Cost Growth Benchmark, Primary Care Spend Target and Quality Benchmarks.[1] The Executive Order directs the Office of Health Strategy (OHS) to develop annual Cost Growth Benchmarks and Primary Care Spend Targets for calendar years (CY) 2021-2025 and Quality Benchmarks for CY 2022-2025. Executive Order No. 5 also has several additional, related initiatives, including:

- monitoring and reporting annually on healthcare spending growth across public and private payers, and
- monitoring accountable care organizations and the adoption of alternative payment models.

The Quality Benchmarks are annual measures and target values that all public and private payers, providers, and the State must work to achieve to improve healthcare quality in the State beginning on January 1, 2022. They are meant to ensure the maintenance and improvement of healthcare quality as the State implements the cost growth benchmark and the primary care spending target. Executive Order No. 5 indicates that the Quality Benchmarks may include clinical quality, utilization, and safety measures.

Connecticut is the second state to establish statewide quality benchmarks and Delaware was the first. Delaware developed its measures and benchmarks in 2019; it had eight benchmarks from 2019-2021 and has 12 benchmarks for 2022-2024.[2]

III. Quality Benchmarks

This section details the process for establishing the Quality Benchmark measures and values, collecting data for and measuring performance on the Quality Benchmarks and annually reviewing and updating the Quality Benchmarks.

A. Quality Council

Executive Order No. 5 tasked OHS' Quality Council with providing recommendations on the Quality Benchmark measures and values. The Quality Council consists of healthcare providers, health insurers, patient advocates, consumer representatives, state agencies and other experts from across the healthcare sector in Connecticut. **Appendix A** provides a list of the Quality Council members.

The Quality Council first updated OHS' Core Measure Set, a standard set of quality measures recommended for use in contracts between payers and provider, over the course of seven

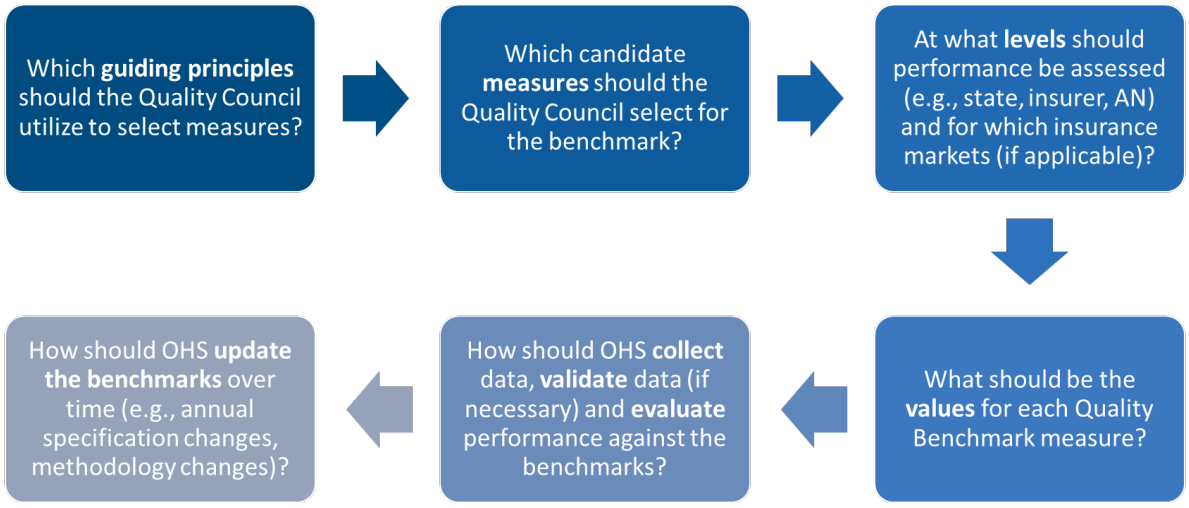
[1] Office of the Governor. "State of Connecticut by His Excellency Ned Lamont Executive Order No. 5." January 22, 2020. Accessed January 4, 2022 from https://portal.ct.gov/-/media/Office-of-the-Governor/Executive-Orders/Lamont-Executive-Orders/Executive-Order-No-5.pdf.
[2] Delaware Health and Social Services. "Quality Benchmarks Newly Proposed Measures." April 2021. Accessed November 24, 2021 from https://dhss.delaware.gov/dhcc/files/benchmarkproposedqlty04092021.pdf.

meetings from December 2020 to June 2021.[3] The Quality Council developed its recommendations for the Quality Benchmarks over the course of six meetings from June 2021 to December 2021.[4] This staggered review allowed the Council to refer to the Core Measure Set when developing its recommendations for the Quality Benchmarks. OHS provided opportunity for public comment at all meetings.

B. Process for Establishing Quality Benchmarks

The Quality Council considered six key questions when developing recommendations for Quality Benchmark measures and values. **Figure 2** summarizes the Quality Council's process.

Figure 2: Quality Council Process for Developing Recommendations for the 2022-2025 Quality Benchmarks



Quality Benchmark Measures

The Quality Council recommended adopting two types of measures for the Quality Benchmarks – *health status* measures and *healthcare* measures. *Health status* measures quantify certain population-level characteristics of Connecticut residents, inclusive of prevalence (e.g., statewide obesity rate, opioid-related overdose deaths) and are assessed at the state level. *Healthcare* measures quantify performance on healthcare processes or outcomes and can be assessed at the state, market, payer and Advanced Network (AN) levels (e.g., Core Measure Set measures).[5] OHS indicated its preference for prioritizing healthcare measures, as it sees ANs as critical agents for improving quality. OHS believes that public reporting of healthcare measures at the AN and payer levels will motivate meaningful action to drive improvement.

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[3] Connecticut Office of Health Strategy. "Quality Council 2022 Core Measure Set." September 7, 2021. Accessed November 24, 2021 from https://portal.ct.gov/OHS/Pages/Quality-Council/Core-Measure-Set.

[4] There was no September 2021 Quality Council meeting.

[5] Advanced networks are entities that are or could be engaged in a total cost of care contract with one or more payers.

The Quality Council then established a set of guiding principles to inform selection of Quality Benchmark measures. OHS expanded upon the first and fourth guiding principles to align with the agency's priorities. The final guiding principles are outlined below.

1. Addresses the most significant health needs of Connecticut residents and aligns with state health priorities, including the most prevalent chronic conditions (i.e., asthma, diabetes, hypertension), behavioral health treatment and childhood obesity.
2. Represents an opportunity to promote health equity, evaluated by performing an assessment of data and literature to identify disparities by race, ethnicity, language, disability status, and other important demographic and cultural characteristics.
3. Represents an opportunity for improvement in quality of care or the health status of the population.
4. Draws from the Core Measure Set whenever possible and aligns with statewide quality measurement activities (i.e., the Department of Social Services' (DSS) quality transparency strategy, as outlined in Executive Order No. 6, and PCMH+ Measure Set).[6]
5. Associated performance data are produced annually and are published no later than two years after the end of the performance period.
6. Prioritizes measures that are not receiving attention.

The Quality Council recommended seven measures for the Quality Benchmarks. OHS accepted the Quality Council's recommendations and decided to implement the measures in a phased approach to reduce reporting burden for ANs and payers. Phase 1 measures became effective on January 1, 2022. Phase 2 measures will become effective on January 1, 2024. **Table 1** below includes the 2022-2025 Quality Benchmark measures.

Table 1: 2022-2025 Quality Benchmark Measures

Quality Benchmark Measure	Steward[7]	Description	Levels of Measurement
Phase 1 Measures			
Asthma Medication Ratio	NCQA	Percentage of patients 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 during the measurement year	State, Market, Payer, Advanced Network

[6] CT Department of Social Services. "PCMH+ Wave 3 Quality Measure Set (Effective January 1, 2021)." July 16, 2020. Accessed January 4, 2022 from 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.

[7] CT OHS: Connecticut Office of Health Strategy
BRFSS: Behavioral Risk Factor Surveillance System
NCQA: National Committee for Quality Assurance

Quality Benchmark Measure	Steward[7]	Description	Levels of Measurement
Controlling High Blood Pressure	NCQA	Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement year	State, Market, Payer, Advanced Network
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control	NCQA	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	State, Market, Payer, Advanced Network
Phase 2 Measures			
Child and Adolescent Well-Care Visits	NCQA	Percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a primary care provider or an OB/GYN practitioner during the measurement year	State, Market, Payer, Advanced Network
Follow-up After Emergency Department (ED) Visit for Mental Illness (7-day)	NCQA	Percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit	State, Market, Payer, Advanced Network
Follow-up After Hospitalization Visit for Mental Illness (7-day)	NCQA	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge	State, Market, Payer, Advanced Network
Obesity Equity Measure	CT OHS (using data from BRFSS)	A ratio of statewide obesity rates for the Black, non-Hispanic population and the White, non-Hispanic population	State

Quality Benchmark Values

After recommending Quality Benchmark measures, the Quality Council considered Benchmark values for each measure. The Quality Council recommended setting separate Benchmark values for each market, i.e., the commercial, Medicaid, and Medicare Advantage markets.[8] This

[8] The Quality Council expressed interest in setting Benchmark values for the Medicare fee-for-service (FFS) market as well. It ultimately recommended benchmarks only for the Medicare Advantage market because OHS could not obtain data for the Medicare FFS market at the AN and payer levels. The Quality

approach acknowledges that the baseline performance for each measure varies by market. To recommend Quality Benchmark values, the Council considered Connecticut's market-specific performance in 2019 and selected 2025 Benchmark values after considering market-specific national and New England performance. For each measure, the Quality Council strived to select 2025 Benchmark values that:

1. motivated meaningful quality improvement;
2. could reasonably be attained by 2025 and
3. are equally ambitious for each market (i.e., the difference in the baseline rate and the 2025 Benchmark value for each measure should be similar across markets).

The Quality Council also developed recommendations for interim annual Benchmark values for 2022, 2023 and 2024 for the Phase 1 Quality Benchmark measures. First, the Quality Council recommended setting the 2022 Benchmark value at the 2019 baseline rate. The Quality Council and OHS acknowledged that they were setting 2022 Benchmark values just prior to the start of the performance year. They did not think it was reasonable to expect notable improvement towards the 2025 Benchmark value without advance notice. Second, the Quality Council recommended setting 2023 and 2024 Benchmark values that reflect equal annual performance improvement.

OHS solicited feedback from DSS and its Transparency Council, which provides feedback and recommendations to DSS on its quality measurement strategy. OHS presented the Quality Council's recommendations during the November and December Transparency Council meetings. The Transparency Council agreed with the Quality Council's recommendations. Of note, the Transparency Council did provide measure-specific recommendations for the Quality Council to consider when it conducts its 2022 annual review of the Core Measure Set.[9]

Tables 2, **3** and **4** summarize the Quality Council's recommended Benchmark values for the commercial, Medicaid, Medicare Advantage markets, respectively. Table 5 summarizes the recommended statewide Benchmark values for the *Obesity Equity Measure*. OHS accepted the Quality Council's recommended Benchmark values for all measures.

Council recommended adopting two measures for the Medicare Advantage market that it believed payers are using in contracts with ANs: *Controlling High Blood Pressure* and *Hemoglobin A1c (HbA1c) Control: HbA1c Poor Control*.

[9] The Transparency Council recommended including oral health measures and additional health equity measures (e.g., measures that assess completeness of patient race, ethnicity, language and/or disability status data).

Table 2: Commercial Quality Benchmark Values

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement[10]
Phase 1 Measures					
Asthma Medication Ratio (Ages 5 – 18)	79%	81%	83%	86% Between the national commercial 50th and 75th percentiles	Overall: 7% Annual: 2%
Asthma Medication Ratio (Ages 19 – 64)	78%	80%	82%	85% National commercial 90th percentile	Overall: 7% Annual: 2%
Controlling High Blood Pressure	61%	63%	65%	68% Between the New England commercial 50th and 75th percentiles	Overall: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c Poor Control[11]	27%	26%	25%	23% Between the national commercial 75th and 90th percentiles	Overall: 4% Annual: 1%
Phase 2 Measures					
Child and Adolescent Well-Care Visits	TBD[12]	TBD	TBD	TBD	TBD
Follow-up After ED Visit for Mental Illness (7-day)	60%	N/A	N/A	75% Between the New England commercial 75th and 90th percentiles	Overall: 15%
Follow-up After Hospitalization Visit for Mental Illness (7-day)	56%	N/A	N/A	63% Between the New England commercial 75th and 90th percentiles	Overall: 7%

[10] Annual percentage point improvement values may not be even due to rounding.
[11] A lower rate indicated better performance.
[12] The Quality Council will set a Benchmark value for this measure in winter / spring 2023 once 2022 baseline data are available. The Council recommended against setting a Benchmark value based on 2020 data given the impact of COVID-19 on performance.

Table 3: Medicaid Quality Benchmark Values

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement[13]
Phase 1 Measures					
Asthma Medication Ratio (Ages 5 – 18)	66%	68%	70%	73% Between the national Medicaid 50th and 75th percentiles	Overall: 7% Annual: 2%
Asthma Medication Ratio (Ages 19 – 64)	63%	65%	67%	70% Between the national Medicaid 75th and 90th percentiles	Overall: 7% Annual: 2%
Controlling High Blood Pressure	61%	63%	65%	68% National Medicaid 75th percentile	Overall: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c Poor Control[14]	37%	36%	35%	33% National Medicaid 75th percentile	Overall: 4% Annual: 1%
Phase 2 Measures					
Child and Adolescent Well-Care Visits[15]	TBD	TBD	TBD	TBD	TBD
Follow-up After ED Visit for Mental Illness (7-day)	50%	N/A	N/A	65% National Medicaid 90th percentile	Overall: 15%
Follow-up After Hospitalization Visit for Mental Illness (7-day)	48%	N/A	N/A	55% New England Medicaid 90th percentile	Overall: 7%

[13] Annual percentage point improvement values may not be even due to rounding.
[14] A lower rate indicates better performance.
[15] The Quality Council will set a Benchmark value for this measure in winter / spring 2023 once 2022 baseline data are available. The Council recommended against setting a Benchmark value based on 2020 data given the impact of COVID-19 on performance.

Table 4: Medicare Advantage Quality Benchmark Values

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement[16]
Phase 1 Measures					
Controlling High Blood Pressure	73%	75%	77%	80% National Medicare Advantage 75th percentile	Overall: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c Poor Control[17]	20%	18%	16%	15% National Medicare Advantage 75th percentile	Overall: 5% Annual: 2%

Table 5: Statewide Quality Benchmark Values

Quality Benchmark Measure	2022 Value / Baseline Rate	2023 Value	2024 Value	2025 Value and Source	Percentage Point Improvement[18]
Phase 2 Measures					
Obesity Equity Measure[19]	1.65	N/A	N/A	1.33 National rate	Overall: 0.32

OHS accepted all of the aforementioned Quality Council recommendations regarding Quality Benchmarks, including the measures and values.

C. Methodology for Collecting Data for and Measuring Performance on the Quality Benchmarks

The Quality Council considered and agreed with OHS' approach to collecting and measuring performance for the Quality Benchmarks. For all measures that will be assessed at the AN and payer level[20], OHS will request measure-specific performance from payers for each AN with which they contract, including:

1. insurance carriers that report data for the Cost Growth Benchmark for the commercial (i.e., the fully-insured, self-insured and student markets) and Medicare Advantage markets (excluding dual eligibles) and
2. DSS for the Medicaid market (excluding dual eligibles).

[16] Annual percentage point improvement values may not be even due to rounding.
[17] A lower rate indicated better performance.
[18] Annual percentage point improvement values may not be even due to rounding.
[19] A rate of 1 indicates that the statewide obesity rates for both populations are identical.
[20] This includes: *Asthma Medication Ratio*, *Child and Adolescent Well-Care Visits*, *Controlling High Blood Pressure*, *Follow-up After ED Visit for Mental Illness (7-Day)*, *Follow-up After Hospitalization for Mental Illness (7-Day)* and *HbA1c Control for Patients with Diabetes: HbA1c Poor Control*.

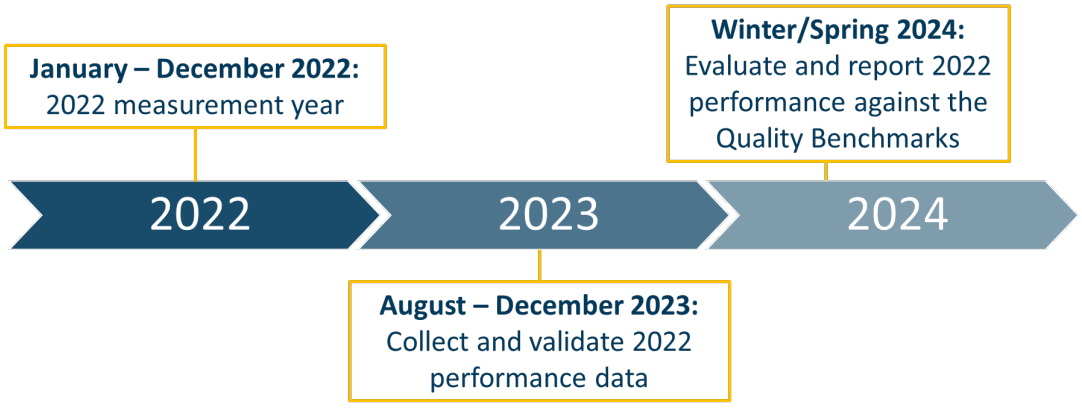
OHS will request payers submit performance data using the most recent measure specifications for the given measurement year, which OHS will post on an annual basis. The population measured for the Quality Benchmarks will differ slightly from the population measured for the Cost Growth Benchmark and Primary Care Spend Target, as the latter are limited to Connecticut residents only.

OHS will request data by August 31st of the year following the measurement year. It will validate data and aggregate performance by AN, payer, market and state by December 31st of the year following the measurement year. OHS will periodically update its list of ANs for the measurement year. In the long term, OHS aims to use Connecticut's Health Information Exchange (Connie) to obtain AN performance data.[21]

For the *Obesity Equity Measure*, OHS will obtain state-level obesity data for the White, non-Hispanic population and Black, non-Hispanic population from the Centers for Disease Control and Prevention Prevalence and Trends Tool by August of the year following the measurement year. It will use the data to calculate the *Obesity Equity Measure* by December 31st of the year following the measurement year.[22]

OHS will evaluate and report AN and payer performance against the Quality Benchmarks in late winter / early spring two years following the measurement year to align with Cost Growth Benchmark reporting. **Figure 3** below depicts the data collection, evaluation and reporting cycle for measurement year 2022.

Figure 3: Data Collection, Evaluation and Reporting Cycle for Measurement Year 2022



D. Process for Reviewing and Updating Quality Benchmarks

Finally, the Quality Council considered and agreed with OHS' approach for annually reviewing changes to the Quality Benchmark measure specifications.

[21] Connie. Accessed January 4, 2022 from https://conniect.org/.
[22] Centers for Disease Control and Prevention. "BRFSS Prevalence and Trends Data." Accessed January 4, 2022 from https://www.cdc.gov/brfss/brfssprevalence/index.html.

1. OHS staff will review measure specifications in September of the measurement year.
    a. For NCQA measures, OHS will review measure specifications (released by August 1 of the year preceding the measurement year) and measure trending determinations (released in the summer of each measurement year).
    b. For the Obesity Equity Measure, OHS will review the BRFSS survey questions, the method of distribution, the population receiving the survey, or any other difference that might affect the comparison.

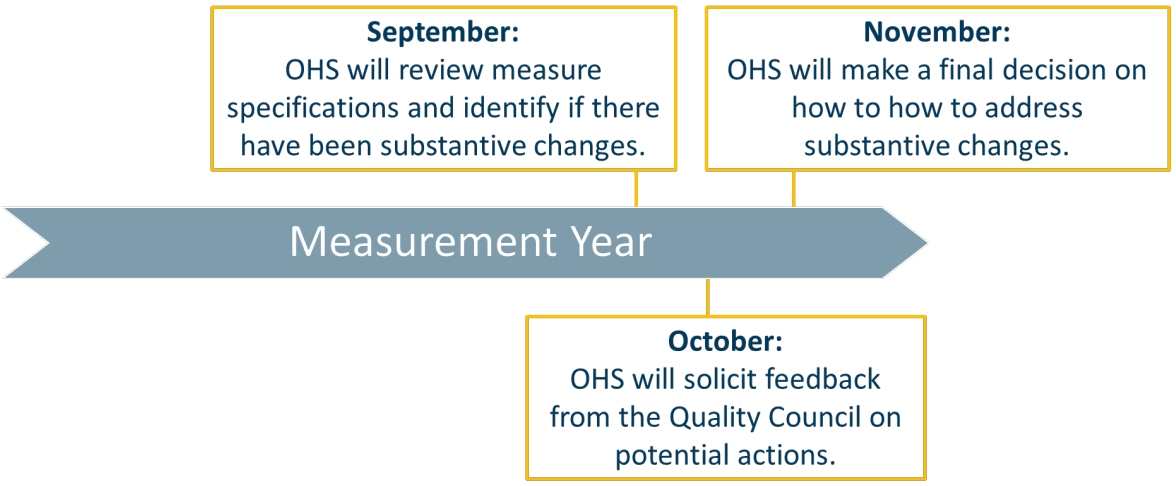
2. OHS staff will identify if there have been any major changes to measure specifications in September of the measurement year.
    a. If there are no major changes, no further action will be needed.
    b. If there are substantive changes, move to Step 3.
        i. For NCQA measures: A substantive change is when NCQA indicates that there should be a "break in trending."
        ii. For the Obesity Equity Measure: A substantive change is one that does not allow performance to be compared to prior years. OHS will solicit feedback from the Quality Council before deciding if the change is substantive.[23]
3. If the change is considered substantive, OHS will solicit feedback from the Quality Council in October of the measurement year on the following options:
    a. Remove the Quality Benchmark measure for the affected and future measurement years and discuss including an alternate measure instead.
    b. Reset the Quality Benchmark value for the affected and future measurement years (using the same methodology in place to develop the initial values).
    c. Maintain the original Quality Benchmark measure and value and re-evaluate after the next measurement period.

4. OHS will decide, using feedback from the Quality Council, on how to address the substantive change by November of the measurement year.
    a. It will communicate the change to all measured ANs and payers.

Figure 4 below depicts the timeline for reviewing and updating Quality Benchmarks on an annual basis.

[23] OHS may assess whether the change is substantive by comparing the year-over-year trend in national median performance for the measurement year in which the substantive change occurred to prior measurement years. This assessment is not always reliable, however, if there are other major changes that are likely to impact measure performance (e.g., COVID-19, changes in insurance coverage).

Figure 4: Timeline for Reviewing and Updating Quality Benchmarks



IV. Next Steps

OHS will incorporate information on the Quality Benchmarks into the Cost Growth Benchmark and Primary Care Spend Target implementation manual prior to the data collection cycle for measurement year 2022.[24] It will outline the methodology for the Quality Benchmarks, including how OHS will collect and evaluate performance for each measure. Specifically, it will contain detailed specifications for payers to use when submitting data to OHS. The manual will also include information for how OHS will consolidate payer-reported data for reporting at the state, market, payer, and AN levels (as applicable by measure).

OHS extends its utmost gratitude to the members of the Quality Council for their dedicated service and thoughtful guidance. OHS is continuing to work with the Quality Council on an ongoing basis on the Quality Benchmarks. The Quality Council is developing recommendations on strategies to generate action to improve performance on the Quality Benchmarks in winter / spring 2022 and for implementation of these strategies during the remainder of 2022. OHS anticipates that the Quality Council will also review measure specifications, review performance prior to public reporting, discuss the implications and possible activities that can result from the findings and advise on strategies to generate action to improve performance.

[24] Connecticut Office of Health Strategy. "Guidance for Payers and Providers." Accessed January 4, 2022 from https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Implementation-Manual.

V. Appendices

Appendix A: Quality Council Members as of December 31, 2021

Susannah Bernheim, Yale New Haven Hospital

Rohit Bhalla, Stamford Health

Elizabeth Courtney, consumer advocate

Stephanie DeAbreu / Monique Crawford, UnitedHealthcare

Sandra Czunas, Office of the State Comptroller

Tiffany Donelson, Connecticut Health Foundation

Lisa Freeman, Connecticut Center for Patient Safety

Amy Gagliardi, Community Health Center, Inc.

Karin Haberlin, Department of Mental Health & Addiction Services

Syed Hussain / Danyal Ibrahim, Trinity Health of New England

Michael Jefferson, Anthem Blue Cross and Blue Shield

Nikolas Karloutsos, consumer advocate

Paul Kidwell, Connecticut Hospital Association

Jeffrey Langsam / Doug Nichols, Cigna

Joseph Quaranta, Community Medical Group

Laura Quigley, ConnectiCare

Brad Richards, Department of Social Services

Andrew Selinger (Chair), Quinnipiac

Marlene St. Juste, consumer advocate

Daniel Tobin, Yale

Alison Vail, Yale New Haven Health

Orlando Velazco, Department of Public Health

Kyisha Velazquez, KV Training and Consultation, LLC

Steve Wolfson, Cardiology Associates of New Haven PC

Robert Zavoski, First Choice Health

More information may be found at: https://portal.ct.gov/OHS/Pages/Quality-Council/Members