Meeting of the Quality Council

Meeting Date	Meeting Time	Location
March 17, 2022	4:00 pm – 5:30 pm	Webinar/Zoom

Participant Name and Attendance

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

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**	**Andy Selinger, Chair**
	Andy Selinger called the meeting to order at 4:03pm.	
2.	**Public Comment**	**Hanna Nagy, OHS**
	Hanna Nagy welcomed public comment. Dashni Sathasivam from Health Equity Solutions offered public comment. Dashni asked if the Council had considered NCQA accreditation for advanced practices and insurance carriers, specifically the multicultural health care distinction and health equity accreditation. Kelly Sinko said that OHS would follow-up with Dashni with a written response to her comment. Michael Bailit noted the Quality Council's presently assigned scope was a) recommending quality measures for an aligned set to be used in payer/Advanced Network contracts, and b) recommending Quality Benchmark measures and values, as well as strategies to attain the latter. **Next Steps**: Dashni Sathasivam will share the public comment in writing and OHS will share a written response with both Dashni and the Quality Council.	
3.	**Approval of February 17, 2022 Meeting Minutes**	**Andy Selinger, Chair**
	Michael Jefferson motioned to approve the meeting minutes. Elizabeth Courtney seconded the motion. No one objected to or abstained from approving the meeting minutes. The motion passed.	
4.	**Follow-up Actions from February Meeting**	**Michael Bailit, Bailit Health**
	Michael Bailit shared two updates from the February meeting. First, Michael reminded the Quality Council that during the February meeting, the group discussed how to prioritize strategies that payers, providers and agencies could implement to achieve the Quality Benchmarks. Michael shared that OHS and Bailit Health were working on a draft strategy implementation plan to bring to the Council during a future meeting. Second, Michael said that the Quality Council Insurer Survey was still underway and that OHS would share the results with the Quality Council later in the spring.	
5.	**Discuss Adoption of a "True" Core Measure Set**	**Michael Bailit, Bailit Health**
	Michael introduced the concept of a "true" Core Measure Set and how it differed from the Quality Council's current Core Measure Set. Michael explained that adopting a "true" Core Measure Set would mean that would be a subset of quality measures that payers would use in all of their value-based Advanced Network contracts. Michael shared that there were two New England states with "true" Core Measure Sets. Michael said Rhode Island had regulation to require that commercial insurers use Core Measures since 2017 and the state's Medicaid program had always voluntarily aligned. Michael said that in Massachusetts, Medicaid and commercial insurers had voluntarily adopted an	

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aligned measure set since 2019. Michael reported the sizes of the Rhode Island and Massachusetts' core and menu measure sets.

- Andy Selinger asked to what extent Connecticut insurers were out of alignment with the current Core Measure Set. Michael said OHS would share alignment information when they present the results of the Quality Council Insurer Survey in the spring, but noted that it appeared that there was opportunity for improvement. Andy said he could not think of a more important strategy for achieving alignment than adopting a "true" Core Measure Set.
- Danyal Ibrahim asked whether, under a "true" Core Measure Set scenario, there was an opportunity for insurers and providers to negotiate Menu Measures. Michael confirmed such an opportunity existed, explaining that the "true" core measures would automatically be in all contracts, and insurers and providers would negotiate what Menu Measures they might add, if any.
- Susannah Bernheim asked whether the Quality Council had the authority to insist that insurers use Core Measures. Michael said that the Quality Council did not have such authority, adding that Connecticut's best reference was Massachusetts, where there was not a statutory or regulatory requirement to use the Core Measures, but the insurers made a voluntary commitment and measure set fidelity was high. Susannah asked whether the goal was to achieve alignment for all 26 measures, but with priority on the Core Measures. Michael said the goal was to achieve alignment on the Core Measures, because it was unlikely that a contract would contain 26 measures.
- Sandra Czunas asked about Massachusetts's methodology for selecting Core Measure. Michael said that Massachusetts selected measures for the entire measure set using one set of criteria and then selected the Core Measures from the measure set using a narrower set of criteria.
- Lisa Freeman asked why insurers would oppose adopting a "true" Core Measure Set. Michael said that his experience was that insurers, particularly those that operated in multiple states, liked to develop a common set of measures to use in every state and that adding measures from Core Measure Sets created additional administrative work for them. Stephanie De Abreu added that UnitedHealthcare appreciated alignment but said that creating a "true" Core Measure Set would take away some of United's discretion to select measures tailored to specific providers. Michael said that this was an argument for choosing a smaller number of Core Measures.

Michael proposed that the Quality Council use the Phase 1 Quality Benchmark measures as the "true" Core Measures in MY 2023. Michael asked whether the Quality Council supported the adoption of a true Core Measure Set and, if so, did the Quality Council agree with OHS' recommendation to use the Phase 1 Quality Benchmark as the Core Measures?

- Andy Selinger asked how long the three Phase 1 Quality Benchmark measures would be the Core Measures. Michael said they would be Core Measures for at least 2023, but ideally for longer than one year to create stability and consistency for payers and providers.
- Lisa Freeman said she supported adopting a "true" Core Measure Set but suggested adding measures focused on patient safety.
- Rohit Bhalla said he supported adopting a "true" Core Measure Set. Rohit asked whether *Asthma Medication Ratio* was a pediatric measure. Grace Flaherty shared that the measure included adults and children (ages 5-64).
- Amy Gagliardi said she supported the Core Measure set but suggested that the Quality Council discuss which measures to include in the Core Measure Set and potentially expanding beyond the three Quality Benchmark measures to address patient outcomes and health disparities.
- Danyal Ibrahim said he supported adopting a "true" Core Measure Set and said he liked the three Quality Benchmark Measures but challenged the Quality Council to adopt more Core Measures (perhaps six) across more domains (i.e., more than just chronic disease).
- Michael Bailit summarized that there seemed to be support for the idea of a "true" Core Measure Set and there seemed to be interest in adopting the Phase 1 Quality Benchmark measures as Core Measure but supplementing them with some number of additional measures from the larger Measure Set. Michael asked if anyone disagreed with that approach.
- Rohit Bhalla said he did not disagree with Michael's summary of the discussed approach but wondered whether starting with a larger number of Core Measures would make difficult universal adoption more difficult for payers.
- Stephanie De Abreu said the more Core Measures the Quality Council chose, the less likely all payers would be able to adopt all of the measures.
- Doug Nichols agreed with Stephanie and said that insurers were subject to several, multi-year existing contracts, meaning that even if insurers committed to alignment, it could take three years for fidelity rates to climb. Michael Bailit confirmed said this was consistent with Massachusetts' experience.
- Susannah Bernheim said she would support expanding the list of Core Measures beyond the Phase 1 Quality Benchmarks, perhaps including behavioral health measures.
- Michael suggested that the Quality Council complete the annual review process and then revisit the question of which Core Measures to select.
- Brad Richards agreed with Michael's suggestion.

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	Next Steps: The Quality Council expressed support for adopting a "true" Core Measure Set. The Quality Council will revisit which measures to adopt as "true" Core Measures after the annual review process is complete.	
6.	**Consider Candidate Measures to Fill Identified Gaps**	**Michael Bailit, Bailit Health**

Michael Bailit reminded the Quality Council members that they had previously identified priority gaps in the measure set across eight categories. Michael said that Bailit Health researched potential measures to fill the gaps and asked the Quality Council to keep in mind the Council's measure selection criteria as they considered each measure.

Care Coordination - Avoidable Hospitalizations

Michael said that Bailit Health could not identify appropriate measures related to avoidable hospitalizations, so they expanded their search to avoidable ED visits.

- *Potentially Avoidable Use of the Emergency Room* and *Avoidable ED Visits (per 1,000 Members)*
  - Andy said that *Potentially Avoidable Use of the Emergency Room* was easier to operationalize than *Avoidable ED Visits (per 1,000 Members)*. Michael Bailit clarified that both measures were claims-based and not exceptionally difficult to implement.
  - Lisa Freeman said that she did not think ED visits were comparable to hospitalizations and said she took issue with the avoidable ED visit measures because she thought it sent mixed signals to patients about their care.
  - Danyal Ibrahim suggested considering the AHRQ avoidable hospitalizations measures because they were connected to access and care coordination. Danyal said the ER measures could divert patients from the ER to urgent care sites. Michael Bailit and Grace Flaherty explained the AHRQ measure had not been recommended for consideration because of a) data availability and b) not enough observations for the measure to be reliable.
  - Susannah Bernheim said she agreed with Lisa's comment about not giving patients the impression that they should not go to the ED. Susannah questioned whether data availability would be an issue with the AHRQ avoidable hospitalization measures. Michael said he thought the events would occur quite infrequently in a commercial population.
  - Rohit Bhalla said he thought the ED measures were strongly influenced by sociodemographic variables.
  - Steven Wolfson said he was ambivalent about the ED measures but said they may have the added benefit that entities with high ED use would feel compelled to provide alternate sites for emergent but not urgent care that may have a favorable affect.
  - Danyal Ibrahim said he agreed with Steven and said, although he was sensitive to the messaging to the public, the measures were insurer and provider facing and would incentivize insurers and providers to reach out to vulnerable populations and set up alternative care sites.
  - Michael Bailit noted that there was already strong motivation on the part of the ANs operating under shared savings and shared risk contracts to reduce avoidable ED visits.
  - The Quality Council did not agree to recommend adoption of any of the three discussed potentially measures avoidable utilization measures.

Care Coordination – Follow-Up After Hospital Admissions

Michael said that Bailit Health could not identify any measures related to follow-up after hospital admissions. Michael said if they identified any measures in the future, they would bring them to the Quality Council for consideration.

- Andy Selinger said it was shocking that there were no measures for this category given the "Transitions in Care" CPT Code.
- Susannah Bernheim recommended considering *Timely Follow-Up After Acute Exacerbations of Chronic Conditions*.

Next Step: OHS and Bailit Health will consider *Timely Follow-Up After Acute Exacerbations of Chronic Conditions* and if it seems like a good fit, will bring it back to the Quality Council for consideration.

Care Coordination – Timely Referrals and Treatment

- *Care Coordination Quality Measures for Primary Care*
  - Michael said he did not think this survey was appropriate because it numbered 66 questions, with only one focused on timely referrals.
  - Steven Wolfson said he would encourage OHS and Bailit Health to keep looking for measures to fill this gap because care coordination is extremely important, and referrals are difficult.

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	◦ Michael noted that care coordination comes up in many states, but the best care coordination measures are patient surveys, which are difficult to implement. • *Closing the Referral Loop: Receipt of Specialist Report* ◦ Andy Selinger strongly supported this measure, noting he was in a training program for residents where there was a lack of return information on referrals that resulted in a lack of care coordination. ◦ Steven Wolfson said he had the opposite experience using Epic because primary care and specialists share a record. ◦ Lisa Freeman said she supported this measure, based on a personal experience of a diagnostic test not getting back to the referring surgeon. ◦ Daniel Tobin said he supported the measure because not all providers use Epic. Daniel said sending specialist reports should be a requirement. ◦ Marlene St. Juste said she supported the measure. ◦ Brad Richards asked how the measure was implemented. Grace shared the numerator and denominator data. **Next Steps**: Bailit Health will research how *Closing the Referral Loop* is implemented (data source, how the measure captures referrals, how the measure documents report receipt) and bring more information to the Quality Council at the next meeting so it can make a final decision about the measure. **Maternity Care** Michael shared that Bailit Health was working with an OB on the Massachusetts Quality Measure Alignment Taskforce to identify potential new maternity measures. When the OB identifies the measures Bailit Health will bring them back to the Quality Council for consideration. **Opioid Overdose Deaths** Michael shared that Bailit Health did not identify any measures to fill the opioid overdose death gap. Michael noted that opioid death rates are difficult to utilize for accountability at the AN level because of their infrequency. **Oral Health** Michael shared that NCQA recently introduced two oral health measures for public comment. • *Topical Fluoride for Children* ◦ Michael said the Quality Council could consider the DQA measure or wait until NCQA finalized the measure (which is essentially the DQA measure). ◦ Steve Wolfson said he hoped Bailit Health and OHS would continue looking for oral health measures because oral health was a key measure determining employability. Michael noted that health insurers do not cover dental services, which limits available measures. ◦ Lisa Freeman said she was under the impression that many urban water supplies have water added and that it was not advisable to do additional topical application. • *Oral Evaluation, Dental Services* ◦ Michael noted this was a Medicaid-only measure so perhaps not suited for the Quality Council's purposes. **Next Steps**: Bailit Health and OHS will investigate whether additional topical fluoride application is necessary and potentially harmful given that many urban water supplies contain fluoride, and will bring the information back to the Quality Council at the next meeting.
7.	**Adjourn** — **Andy Selinger, Chair**
	Steven Wolfson made a motion to adjourn the meeting. Lisa Freeman seconded the motion. There were no objections. The meeting adjourned at 5:24pm.

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