Quality Council
February 22, 2024

Call to Order and Roll Call

Agenda

Time	Topic
3:00 p.m.	Call to Order and Roll Call
3:05 p.m.	Approval of January 18, 2024 Meeting Minutes — Vote
3:10 p.m.	Review Revised 2024 Quality Council Goals and Measures
3:20 p.m.	Details on the CMMI AHEAD Model
3:40 p.m.	2024 Aligned Measure Set Annual Review
4:50 p.m.	Public Comment
4:55 p.m.	Meeting Wrap-Up and Next Steps
5:00 p.m.	Adjourn

Approval of January 18, 2024 Meeting Minutes—Vote

Review 2024 Quality Council Goals and Measures

Review 2024 Quality Council Goals and Measures

- During the January meeting, the Quality Council expressed interest in setting goals and associated measures for its work in 2024.
- Bailit Health presented example goals and the Quality Council offered feedback on the goals and suggested additional goals.
- The following slide presents a revised set of goals and measures based on the Quality Council's feedback.

2024 Goals (1 of 2)

Example 2024 Quality Council Goal	Example 2024 Quality Council Measure
1. Complete the annual measure set review for 2024	• Complete the annual review, with recommendations to OHS by June 2023. • Review patient-reported measures for potential addition to the 2025 Aligned Measure Set. • Remove low-value measures from the Aligned Measure Set.
2. Increase fidelity to the Aligned Measure Set across the five largest commercial insurers in Connecticut	• Adherence to the Aligned Measure Set among those insurers that reported for 2023 increases from 73% to 80% for 2025.
3. Report on 2022 Quality Benchmark performance at the state, insurer and Advanced Network level	• Review 2022 Quality Benchmark performance during a Quality Council meeting by April 2024. • Identify improvement opportunities in Quality Benchmark performance.

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2024 Goals (2 of 2)

Example 2024 Quality Council Goal	Example 2024 Quality Council Measure
4. Establish a Health Equity Subgroup to provide recommendations to the Quality Council and OHS for advancing health equity measurement activities	• Convene a Health Equity Subgroup in 2024 that submits draft recommendations to the Quality Council in June and final recommendations to the Quality Council and OHS by September.
5. Gain a better understanding of how provider groups are experiencing the Aligned Measure Set	• Survey provider groups in 2024 about their familiarity with the Aligned Measure Set and their efforts to drive improvement on the Aligned Measure Set measures. • Invite one or two provider groups to join a 2024 Quality Council meeting and share their experience with the Aligned Measure Set.

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Details on the CMMI AHEAD Model

CMMI AHEAD Model

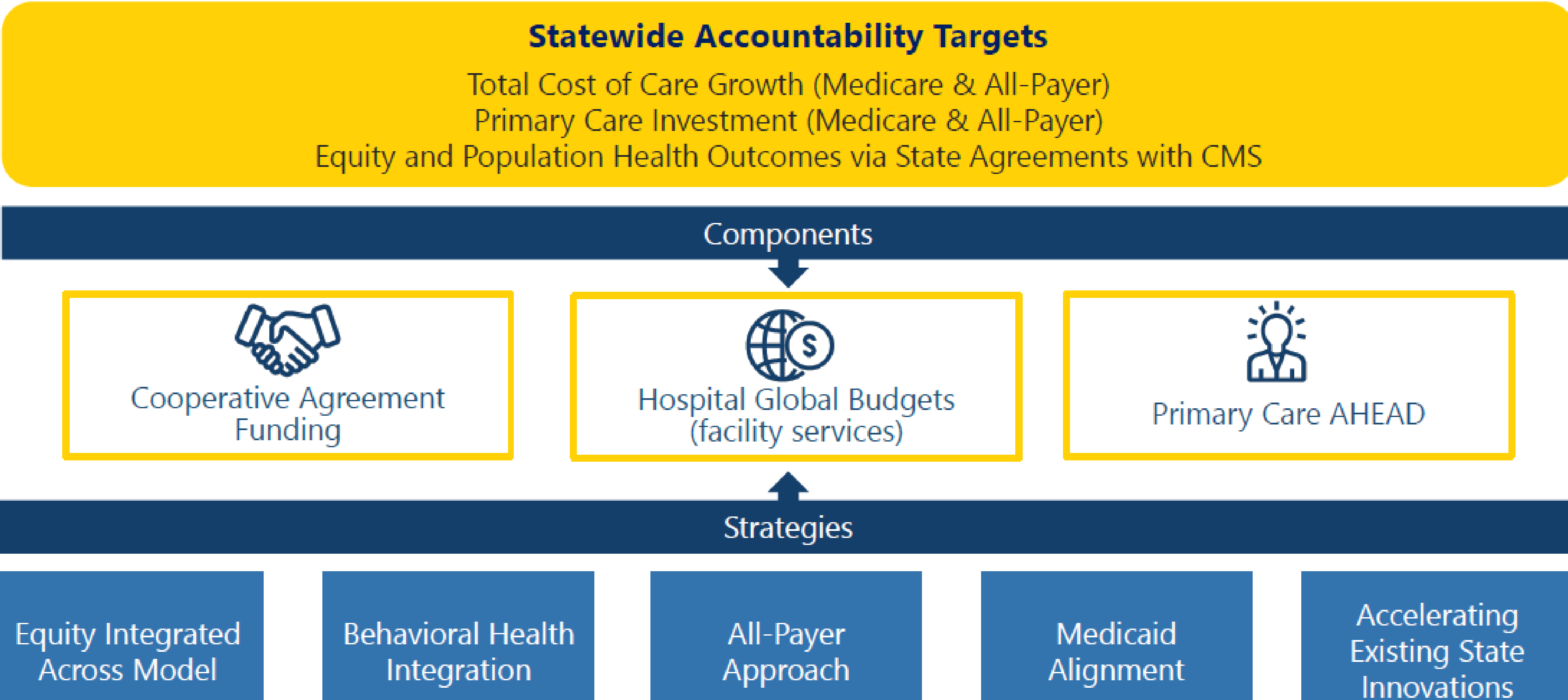
- Connecticut is planning to apply for the CMMI States Advancing Payer Health Equity Approaches and Development (AHEAD) Model.
- The following slides provide an overview on the AHEAD model, details on why Connecticut is a strong candidate for consideration and how Connecticut could participate from participating.
- Should Connecticut be selected to participate in the AHEAD model, OHS will likely engage the Quality Council in some of the quality-related model activities.

Model Purpose & Goals

- AHEAD is a state total cost of care model that seeks to drive state and regional health care transformation and multi-payer alignment, with the goal of improving the total health of a state population and lowering costs.
- A participating state is to use its authority to assume responsibility for managing health care quality and costs across all payers. States are also to assume responsibility for ensuring providers in their state deliver high-quality care, improve population health, offer greater care coordination, and advance health equity by supporting underserved patients.
- CMS' goal is to collaborate with states to **improve population health**; **advance health equity** by reducing disparities in health outcomes; and **curb health care cost growth**.

Model At-A-Glance (1 of 3)

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.



Source: CMS Presentation from September 18, 2023 AHEAD Model Overview Webinar

Model At-A-Glance (2 of 3)

Improve Population Health

Advance Health Equity

- Medicare FFS Primary Care Investment Target
- All-Payer Primary Care Investment Target
- Statewide Quality and Equity Targets (Medicare FFS and All-Payer)

Curb Health Care Cost Growth

- Medicare FFS Total Cost of Care Targets
- All-Payer Cost Growth Targets

- All-Payer and Medicare FFS **primary care investment targets** will be set by measuring primary care expenditures for beneficiaries residing in the state as a percentage of state TCOC for those beneficiaries.
  - The Medicare FFS primary care investment targets will be set by CMS. CMS anticipates each state's target will be between 6-7% of Medicare TCOC.
  - States will have flexibility to set all-payer targets, subject to CMS approval.
- States set **all-payer cost growth targets** which include Medicare FFS, Medicare Advantage, Medicaid, commercial, state employee health plans, and Marketplace-qualified health plans.
- The model will include quality measures across these components: **statewide quality measures, primary care measures, and hospital quality programs**.

Model At-A-Glance (3 of 3)

- There are three Model components to assist states in meeting accountability targets.
  - **Cooperative Agreement Funding**: Funding provided by CMS to support initial investments for states to begin planning activities during the Model's pre-implementation period and the initial performance years of the model.
  - **Hospital Global Budgets**: Provide hospitals with a pre-determined, fixed annual budget for a specific patient population or program to encourage hospitals to eliminate avoidable hospitalizations and improve care coordination between hospitals, primary care providers, and specialists. Increased investments in primary care under the Model can be offset over time by statewide savings generated by hospital global budgets.
  - **Primary Care AHEAD**: Eligible primary care practices can participate in Primary Care AHEAD, the primary care program component of the model. Primary Care AHEAD will align with ongoing Medicaid transformation efforts within each participating state and aims to increase Medicare investment in primary care.

Key Stakeholder Roles

States

- Establish model governance
- Set all-payer cost growth targets
- Increase primary care investment
- Implement statewide health equity plan
- Design Medicaid hospital global budgets and primary care transformation
- Facilitate multi-payer alignment and can engage State Employee Health Plans and Marketplace Plans

Hospitals

- Can participate in hospital global budgets, transform care, and improve population health
- Pursue opportunities for quality improvement (e.g., CMS hospital quality programs and other metrics) and identify other efficiencies
- Create hospital health equity plans to reduce disparities in care and outcomes within the hospital and community

Primary Care Practices

- Can participate in Medicaid transformation efforts and Primary Care AHEAD for Medicare FFS
- Meet care transformation requirements for person-centered care
- Pursue opportunities for quality improvement and improved care coordination

Payers

- Contribute to the All-Payer Cost Growth Target and All-Payer Primary Care Investment Targets
- Participate as an aligned payer in hospital global budgets and primary care transformation

Source: CMS Presentation from September 18, 2023 AHEAD Model Overview Webinar

Hospital Global Budgets – Value Proposition

- The AHEAD Model aims to rebalance health care spending across the system, shifting utilization from acute care settings to primary care and community-based settings.

Initial investment to support transformation in early years of the model

Opportunity to earn upside dollars for improving health equity and quality while contributing to population health in their community

Increased financial stability and predictability

Potential use of waivers to support care delivery transformation

Ability to share in savings from reduced potentially avoidable utilization and more efficient care delivery

Opportunity to participate in system learning opportunities when moving to a population-based payment

Source: CMS Presentation from September 18, 2023 AHEAD Model Overview Webinar

Hospital Global Budgets

- Hospital global budgets are the primary mechanism for achieving all-payer and Medicare FFS TCOC targets, improving hospital quality, and helping to curb cost growth. Each participating payer provides a global budget, determined prospectively, to the participating hospital for facility services.
  - Medicare FFS: States with statewide rate setting or hospital global budget authority and experience in value-based care can develop their own hospital global budget methodology. States without these authorities will use a CMS-designed methodology.
  - Medicaid: States will be required to implement an aligned Medicaid hospital global budget payment by Performance Year 1. The state Medicaid agency will be responsible for developing its Medicaid-specific hospital global budget methodology with alignment principles outlined by CMS.
  - Commercial: Participation is voluntary; however, states must recruit at least one payer to participate in hospital global budgets by Performance Year 2. States will develop a methodology with high-level alignment principles outlined by CMS. Commercial payers include state employee health plans, Basic Health Plans, Qualified Health Plans, and Medicare Advantage plans (including Dual Eligible Special Needs Plans).

Hospital Participation in Global Budgets

- States must have participation from hospitals representing a minimum of 10% of Medicare FFS volume in the state in Year 1, and 30% of Medicare FFS volume by Year 4.
- CMMI does not require states to have formal commitment from hospitals at the time of state application to CMMI.

Quality and Population Health Strategy

- The AHEAD model quality strategy includes three sets of quality measures, each with a health equity focus:
  1. Statewide measures: States will be held accountable for performance and improvement on a set of at least six population-level measures.
  2. Primary care measures: Participant Primary Care Practices will be accountable for performance on a set of five measures.
  3. Hospital quality programs: PPS hospitals participating in hospital global budgets in AHEAD will continue to report through national hospital quality programs. CAH hospitals will include an upside-only quality adjustment based on scoring in a CAH specific quality program.

PPS = Prospective Payment Systems

CAH = Critical Access Hospitals

Statewide Health Equity Plan

- States will develop a Statewide Health Equity Plan (HEP) to define and guide Model activities. States will use a guiding template provided by CMS to:
  - identify health disparities and population health focus areas;
  - set measurable goals to reduce disparities and improve population health, including optimizing performance on population health and quality measures and primary care investment targets;
  - identify evidence-based strategies to advance toward those goals;
  - inform plans for allocating resources (e.g., Cooperative Agreement award funding) to support progress toward goals, and
  - develop processes to involve a wide range of stakeholders in State HEP implementation.

Application & Implementation Timeline

		2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034
Model Year			MY1	MY2	MY3	MY4	MY5	MY6	MY7	MY8	MY9	MY10	MY11
1st NOFO Period	Cohort 1	NOFO	Pre- Implementation (18 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8	PY9
	Cohort 2	NOFO	Pre-Implementation (30 mos)			PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8
2nd NOFO Period	Cohort 3		NOFO	Pre-Implementation (24 mos)		PY1	PY2	PY3	PY4	PY5	PY6	PY7	PY8

Source: CMS AHEAD Model Website

- CMI created three cohorts to accommodate variation in readiness among participating states and providers. The first cohort pre-implementation period is scheduled to begin in summer 2024 with a performance period scheduled to begin as soon as January 2026.
- The Model is scheduled to operate for a total of 11 years, from 2024 through 2034.

Connecticut is a Strong Candidate

Connecticut is well-positioned to apply for the AHEAD Model:

- Existing statewide cost growth target, quality benchmarks and primary care spend target, with a mechanism for annually measuring performance against all three targets.
- Commitment to primary care transformation through DSS' PCMH program and through OSC programs.
- Commitment to, and activities in place, to advance health equity, e.g., *Health Equity* and SDOH measure development through the Connecticut Aligned Measure Set.

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Benefits of AHEAD to Connecticut

- **Extensive funding for the state to aid implementation** and to help advance the state's priorities and ongoing efforts related to affordability, primary care transformation, and health equity and align these efforts across payers.
- **Medicare participation** in multi-payer hospital and primary care payment models.
- **Stable and predictable funding for hospitals** using hospital global budgets, potential savings generated from reductions in avoidable utilization, and gains in care delivery efficiency. Hospitals can also use benefit enhancements available under the Model to support care redesign.
- **Increased investments for primary care practices**, for which Connecticut residents will benefit from strengthened primary care, including whole-person care and improved supports and connections to community resources to address unmet health-related social needs.

2024 Aligned Measure Set Annual Review

Overview of the Connecticut Aligned Measure Set

The Connecticut Aligned Measure Set

- The Aligned Measure Set is a group of measures from which OHS requests insurers select measures for use in value-based contracts.
- The Aligned Measure Set was first established in 2016 (as the "Core Measure Set") as part of the State Innovation Model (SIM) Program.
- The overarching aim of the Aligned Measure Set is to promote alignment of quality measures in use by commercial insurers and Medicaid to assess and reward the quality of services delivered under value-based payment arrangements with Advanced Networks.*

*Advanced Networks are provider organizations or contractually affiliated provider organizations that either (a) hold a value-based contract with a payer or (b) are able to hold a value-based contract by virtue of having a sufficient number of primary care providers.

The Connecticut Aligned Measure Set (Cont'd)

- The Aligned Measure Set contains Core Measures and Menu Measures.
  - Measures used in value-based contracts should be limited to Core and Menu measures.

Connecticut Aligned Measure Set

Core Measures

- *Measures that OHS asks insurers to use in all value-based contracts with Advanced Networks*

Menu Measures

- *Measures that are optional for use in value-based contracts*

2024 Aligned Measure Set

1. **Child and Adolescent Well-Care Visits**
2. **Controlling High Blood Pressure**
3. **Follow-Up After Emergency Department Visit for Mental Illness (7-Day)**
4. **Glycemic Status Assessment for Patients with Diabetes (>9.0%)**
5. **Health Equity Measure**
6. **Plan All-Cause Readmission**
7. **Prenatal and Postpartum Care**
8. **Social Determinants of Health Screening**
9. Asthma Medication Ratio
10. Behavioral Health Screening*
11. Breast Cancer Screening
12. Cervical Cancer Screening
13. Chlamydia Screening in Women
14. Colorectal Cancer Screening
15. Concurrent Use of Opioid and Benzodiazepines
16. Developmental Screening in the First Three Years of Life
17. Eye Exam for Patients with Diabetes
18. Follow-Up After Hospitalization for Mental Illness (7-Day)
19. Immunizations for Adolescents (Combo 2)
20. Kidney Health Evaluation for Patients with Diabetes
21. Maternity Care: Postpartum Follow-up and Care Coordination
22. Metabolic Monitoring for Children and Adolescents on Antipsychotics*
23. PCMH CAHPS Survey
24. Screening for Depression and Follow-Up Plan
25. Substance Use Assessment in Primary Care
26. Transitions of Care
27. Use of Opioids at High Dosage
28. Use of Pharmacotherapy for Opioid Use Disorder
29. Well-Child Visits in the First 30 Months of Life

*Medicaid-only measure
Core Measures are in bold

Measure Selection Criteria

Measure Selection Criteria

- The Quality Council has defined three sets of measure selection criteria to guide its work in recommending measures to OHS for measure set inclusion.
  - **Criteria to apply to individual measures** are meant to assess the merits of individual measures. They ensure that each measure has sufficient merit for inclusion.
  - **Criteria to apply to Core Measures** are meant to guide the Quality Council in choosing which measures warrant special focus in Connecticut (i.e., should be used by all insurers in all value-based contracts).
  - **Criteria to evaluate the measure set as a whole** are meant to more holistically assess whether the Aligned Measure Set is representative and balanced, and meets policy objectives identified by the Quality Council.

Criteria to Apply to Individual Measures (1 of 2)

1. 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, economic status, and other important demographic and cultural characteristics.
2. Represents an opportunity for improvement in quality of care, inclusive of outcomes and of population health.
3. Accessible with minimal burden to the clinical mission, and:
   a. draws upon established data acquisition and analysis systems;
   b. is efficient and practicable with respect to what is required of payers, providers, and consumers, and
   c. makes use of improvements in data access and quality as technology evolves and become more refined over time.
4. Evidence demonstrates that the structure, process, or outcome being measured correlates with improved patient health.

Criteria to Apply to Individual Measures (2 of 2)

5. Addresses the most significant health needs of Connecticut residents, with attention to areas of special priority, beginning with:
   a. behavioral health
   b. health equity
   c. patient safety, and
   d. care experience.
6. Measures and methods are valid and reliable at the data element and performance score level.
7. Useable, relevant and has a sufficient denominator size.

Criteria to Apply to Core Measures

1. Includes Quality Benchmark measures unless there is a compelling reason not to do so.
2. Includes one Core Measure from each of the broad measure categories, minimally including behavioral health.
3. Includes at least one health equity measure.
4. Outcomes-oriented.
5. Crucial from a public health perspective.

Criteria to Apply to the Measure Set as a Whole

1. Includes topics and measures for which there are opportunities to promote health equity by race, ethnicity, language and/or disability status.
2. Broadly addresses population health.
3. Prioritizes health outcomes, including measures sourced from clinical and patient-reported data.
4. Taken as a whole, high performance on the proposed measure set should significantly advance the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered (STEEEP) care.
5. Balances comprehensiveness and breadth with the need for parsimony to enable effective quality improvement.
6. Representative of the array of services provided, and the diversity of patients served, by the program.

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Overview of the Annual Review Process

Data Sources for Six Considerations (1 of 5)

1. **Have there been any major changes to the measure specifications?**
   - We reviewed any changes to the measure specifications by each measure's "steward" in 2023 and those newly proposed by NCQA in 2024.
2. **What is the measure's status in the national measure sets of interest?**
   - We identified whether the measure is currently in any of the following 7 measure sets that were previously indicated to be of interest to the Quality Council:
     - CMS Electronic Clinical Quality Measures (eCQMs) *(2023)*
     - CMS Medicaid Child Core Set *(2023 and 2024 Updates)*
     - CMS Medicaid Adult Core Set *(2023 and 2024 Updates)*
     - CMS Merit-based Incentive Payment System (MIPS) *(2023)*
     - CMS Medicare Shared Savings Program ACO and Next Generation ACO *(2023)*
     - NQF Core Quality Measures Collaborative Core Sets *(2021)*
     - NCQA HEDIS *(2024)*

Data Sources for Six Considerations (2 of 5)

3. **Is the measure currently utilized by Connecticut payers?**
   - We identified whether the measure is in use by payers (5 insurance carriers in their commercial contracts, DSS PCMH+ Measure Set and OSC) in 2024 using data from the 2024 Quality Council Insurer Survey.

4. **Is there evidence of health disparities related to the measure?**
   - Bailit Health conducted an equity review for each measure. We primarily used the following sources to identify inequities in measure performance or related health outcome by race/ethnicity, disability status, language, socioeconomic status, and education:
     - America's Health Rankings
     - AHRQ Quality and Disparities Reports
     - Healthy Connecticut 2025 State Health Assessment
     - Health Disparities in Connecticut (CT Health Foundation)
     - Literature review to identify any additional disparities

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Data Sources for Six Considerations (3 of 5)

5. **Is there opportunity for improvement?**
   - We assessed Connecticut's opportunity for improvement on the Aligned Measure Set measures for the commercial and Medicaid markets.
     - **Commercial:** We calculated weighted average plan performance from NCQA's Quality Compass for HEDIS measures. We compared commercial performance on HEDIS measures to NCQA's national benchmarks.
     - **Medicaid:** We used Medicaid performance provided by DSS. We compared Medicaid performance on HEDIS measures to NCQA's national benchmarks.

Data Sources for Six Considerations (4 of 5)

5. Is there opportunity for improvement (cont'd)?

- We use the following color scheme to indicate how Connecticut commercial and Medicaid performance on HEDIS measures compares to NCQA's national benchmarks:

Commercial and Medicaid Performance Key:				
<25th percentile	Between 25th and 50th percentiles	Between 50th and 75th percentiles	Between 75th and 90th percentiles	≥90th percentile

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Data Sources for Six Considerations (5 of 5)

6. **Did stakeholders submit feedback on the measure?**
   - We compiled the feedback OHS received from stakeholders in response to its request for feedback on the Aligned Measure Set in December 2023 and January 2024.
   - New measures that were submitted for consideration will be raised topically (i.e., at the same time as related measures already in the Measure Set).

Review of Individual Measures

Questions to Consider

- As you review each measure, please consider:
  1. how the measure performs against the just-reviewed six considerations;
  2. whether the measure meets the adopted selection criteria,
  3. whether you recommend retaining, removing, or replacing the measure in the Aligned Measure Set, and
  4. whether you recommend changing the measure's status (e.g., elevating to Core or moving from Core to Menu).
- Please also consider whether any of the measures are "low value" measures, in keeping with our 2024 Quality Council goal on this topic.

Child and Adolescent Well-Care Visits* (Core)

Measure Steward: National Committee for Quality Assurance **Data Source:** Claims **National Measure Sets of Interest:** CMS Medicaid Child Core Set			
Equity Analysis			
• CT DSS reported that in 2021, Child and Adolescent Well-Care visits was among the measures with the lowest/worst rates for Black/African American Non-Hispanic Medicaid members (63.6%) (DSS MAPOC Presentation, 2023).			
Status/Measure Specification Changes	**Insurer Measure Use (2024)**	**Commercial Performance (2022)**	**Medicaid Performance (2022)**
• Minor changes for MY 2024 • Minor proposed change for MY 2025 (removing telehealth visits)	Yes (5 insurers; DSS)	79% (above National 90th percentile)	64% (above National 90th percentile)

* Phase 2 Quality Benchmark measure

Controlling High Blood Pressure* (Core)

<table>
<tr><td colspan="4">Measure Steward: National Committee for Quality Assurance
Data Source: Claims/Clinical Data
National Measure Sets of Interest: CMS Medicaid Adult Core Set; CMS eCQMs; CMS MIPS; Core Quality Measures Collaborative Core Set</td></tr>
<tr><td colspan="4">Equity Analysis</td></tr>
<tr><td colspan="4">• In CT, about 42% of non-Hispanic Black individuals are estimated to have been diagnosed with high blood pressure, compared to 33.4% of non-Hispanic white individuals (BRFSS, 2021).</td></tr>
<tr><td>Status/Measure Specification Changes</td><td>Insurer Measure Use (2024)</td><td>Commercial Performance (2022)</td><td>Medicaid Performance (2022)</td></tr>
<tr><td>• Minor changes for MY 2024
• Major proposed changes for MY 2025 (see next slide)</td><td>Yes (4 insurers)</td><td>66% (between National 50th and 75th percentiles)</td><td>62% (between National 50th and 75th percentiles)</td></tr>
</table>

* Phase 1 Quality Benchmark measure

Controlling High Blood Pressure* (Core)

- NCQA has proposed that this measure be phased-out and be replaced by a new blood pressure control measure: *Blood Pressure Control for Patients with Hypertension.*
- NCQA's long-term goal is to include only *Blood Pressure Control for Patients with Hypertension* in HEDIS but NCQA has not released a timeline for the transition (i.e., *Controlling High Blood Pressure* will still be a 2025 HEDIS measure but will eventually be removed from HEDIS).

* Phase 1 Quality Benchmark measure

Controlling High Blood Pressure* (Core)

- The proposed new measure, *Blood Pressure Control for Patients with Hypertension,* is an improvement on the existing *Controlling High Blood Pressure* HEDIS measure, which uses the hybrid reporting method (including medical record review) and focuses on blood pressure <140/90 mm Hg.
- The proposed measure has three key modifications:

  1. The measure uses the ECDS reporting method.
  2. The denominator includes a pharmacy data method.
  3. The numerator includes two rates: Blood Pressure <140/90 mm Hg, Blood Pressure <13080 mm Hg.

* Phase 1 Quality Benchmark measure

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

<table>
<tr><td colspan="4">Measure Steward: National Committee for Quality Assurance
Data Source: Claims
National Measure Sets of Interest: CMS Medicaid Child Core Set; CMS Medicaid Adult Core Set; Core Quality Measures Collaborative Core Set</td></tr>
<tr><th colspan="4">Equity Analysis</th></tr>
<tr><td colspan="4">• A national study of follow-up after mental health ED discharge found that the odds of follow-up were lower for Black adults compared to White adults (odds ratio = 0.83 for 7-day rate) (Croake et al., 2017).</td></tr>
<tr><th>Status/Measure Specification Changes</th><th>Insurer Measure Use (2024)</th><th>Commercial Performance (2022)</th><th>Medicaid Performance (2022)</th></tr>
<tr><td>• Minor Changes for MY 2024
• Major Proposed Changes for MY 2025 (see next slide)</td><td>Yes (1 insurer; DSS)</td><td>63% (above National 90th percentile)</td><td>48% (between National 50th and 75th percentiles)</td></tr>
</table>

* Phase 2 Quality Benchmark measure

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

- NCQA has proposed the following revisions to this measure's numerator and denominator for MY 2025:
  - **Denominator revisions:**
    - Diagnosis Position Criteria: Allow any diagnosis position for intentional self-harm diagnoses, and maintain the principal position requirement for all other mental health diagnoses.
    - Additional Diagnosis Codes: Include the phobia diagnoses, anxiety diagnoses, intentional self-harm X-chapter codes and the R45.851 suicidal ideation code in the denominator diagnosis code lists.

* Phase 2 Quality Benchmark measure

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

- NCQA has proposed the following revisions to this measure's numerator and denominator for MY 2025:
  - **Numerator Revisions:**
    - Diagnosis Position Criteria at Follow-Up: Allow the mental health diagnosis in any diagnosis position on the follow-up claim for both measures, rather than in the principal position only.
    - Additional Follow-Up Services and Settings: Include psychiatric residential treatment, as well as peer support services and occupational therapy for a mental health diagnosis, as options for follow-up.

* Phase 2 Quality Benchmark measure

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

- NCQA found that these specifications had significant impacts on commercial and Medicare performance.
  - **Average denominator size increased by 67% and 94%** for Medicare Advantage and commercial product lines, respectively.
  - **Average performance increased between 17-19% and 6-7%** for Medicare Advantage and commercial product lines, respectively.

* Phase 2 Quality Benchmark measure

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

- During the January Quality Council Meeting, one member shared the following feedback about this measure:
  - The member said his practices were having trouble getting timely ED data to make *Follow-Up After Emergency Department Visit for Mental Illness* actionable. The member said this is a problem with the 7-day measure (i.e., the 30-day rate is more achievable).
  - The member also noted that some mental health data are being masked by payers.

* Phase 2 Quality Benchmark measure

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

- OHS also received the following feedback on this measure in response to its request for feedback on the Aligned Measure Set:
  - Yale New Haven Health and Nuvance Health recommended removing this measure from the Aligned Measure Set, with the rationale that…
    - 7-day follow-up is not always possible given the dearth of behavioral health providers in CT.
    - Providers have other mechanisms (e.g., post-ED engagement and calls) for their patients, especially those at highest risk.
    - This measure does not appear on the CMS Universal Measure set or does it feature prominently in payer programs.

* Phase 2 Quality Benchmark measure

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

- The Massachusetts Quality Measure Alignment Task Force recently reviewed this measure for its 2025 Aligned Measure Set and recommended removing the measure because…
  - Massachusetts 2022 performance exceeded the 90th percentile nationally for the commercial and Medicaid markets, and
  - the denominator size was only sufficient for Medicaid.

* Phase 2 Quality Benchmark measure

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

- Based on NCQA's proposed specification changes, the feedback OHS received about this measure, and the information Bailit Health shared about MA's experience with this measure, does the Quality Council recommend:
  - **Moving this measure from the Core Set to the Menu Set** until benchmark data are available using the new specifications; OR
  - **Removing this measure from the Aligned Measure Set entirely.**
    - If the Quality Council recommends removing the measure it may consider replacing it with another mental health follow-up measure (e.g., *Screening for Depression and Follow-up Plan*).

* Phase 2 Quality Benchmark measure

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Glycemic Status Assessment for Patients with Diabetes (>9.0%)* (Core)

Measure Steward: National Committee for Quality Assurance
Data Source: Claims/Clinical Data
National Measure Sets of Interest: CMS Medicaid Adult Core Set; CMS eCQMs; CMS MIPS; Core Quality Measures Collaborative Core Set

Equity Analysis

- In CT, Black and Hispanic residents are more than 2x more likely than White residents to have diabetes and have severe complications (CT Health Foundation, 2020).
- In CT, Black individuals account for 18% total diabetes deaths in CT, while the Black population makes up 12.9% of the total state population (Kaiser State Health Facts, 2021).

Status/Measure Specification Changes	Insurer Measure Use (2024)	Commercial Performance (2022)	Medicaid Performance (2022)**
• Major changes for MY 2024 • No proposed changes for MY 2025	Yes (3 insurers)	22%** (between National 75th and 90th percentiles)	35%** (between National 50th and 75th percentiles)

* Phase 1 Quality Benchmark measure ** Lower rate is better for this measure

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Glycemic Status Assessment for Patients with Diabetes (>9.0%)* (Core)

- NCQA revised the measure to:
  1. **Update the event/diagnosis criteria** to include members with at least two diagnoses of diabetes or who were dispensed at least one diabetes medication and have at least one diagnosis of diabetes.

Method	Description
Previous event/diagnosis criteria	• At least two outpatient encounters, or one inpatient encounter with a diagnosis of diabetes, ***or*** • Dispensed at least one diabetes medication
Updated event/diagnosis criteria	• At least two diagnoses of diabetes on different dates of service (in any setting), ***or*** • Dispensed at least one diabetes medication and at least one diagnosis of diabetes (in any setting)

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Glycemic Status Assessment for Patients with Diabetes (>9.0%)* (Core)

- NCQA revised the measure to:

2. **Add glucose management indictor (GMI)** as an option to meet numerator criteria (alongside HbA1c) to reflect updated ADA guidelines and recognize those who manage diabetes with continuous glucose monitoring devices.
3. **Adopt a new measure name**: *NCQA changed the measure's name from HbA1c Control for Patients with Diabetes: HbA1c Poor Control to Glycemic Status Assessment for Patients with Diabetes.*

ADA = American Diabetes Association

OHS CONNECTICUT Office of Health Strategy

Glycemic Status Assessment for Patients with Diabetes (>9.0%)* (Core)

- When the Quality Council reviewed these specifications changes in 2023 (when they had just been proposed and were not yet finalized), it recommended retaining this measure in the Core Set for MY 2024.
- **Does the Quality Council recommend retaining this measure in the Core Set for MY 2025?**

Health Equity Measure (Core)

Measure Steward: CT Office of Health Strategy
Data Source: Claims/Clinical Data
National Measure Sets of Interest: None

Description

The performance for each of the following measures, stratified by race, ethnicity and language:*

1. Child and Adolescent Well-Care Visits
2. Comprehensive Diabetes Care: HbA1c Control
3. Controlling High Blood Pressure
4. Prenatal and Postpartum Care
5. Screening for Depression and Follow-Up Plan

Status/Measure Specification Changes	Insurer Measure Use (2024)	Commercial Performance (2022)	Medicaid Performance (2022)
None	Yes (1 insurer)	NA	NA

*OHS prioritized stratification of measures that have evidence of disparities in performance by REL in CT and that are required to be stratified for reporting to NCQA.

Plan All-Cause Readmission (Core)

Measure Steward: National Committee for Quality Assurance **Data Source:** Claims **National Measure Sets of Interest:** CMS Medicaid Adult Core Set; Core Quality Measures Collaborative Core Set
Equity Analysis
• In CT, non-Hispanic Black adults are more likely than their peers in other racial/ethnic groups to experience readmission within 30 days of discharge (25 per 1,000 population for Black adults, compared to 17, 14, and 4 per 1,000 population for White, Hispanic, and Asian adults) (CT State Health Assessment, 2020).

Status/Measure Specification Changes	Insurer Measure Use (2024)	Commercial Performance (2022)	Medicaid Performance (2022)
• Minor changes for MY 2024 • No proposed changes for MY 2025	Yes (1 insurer)	0.59* (between National 25th and 50th percentiles)	1.29* (below National 25th percentile)

*Ratio of Observed All-Cause Readmissions to Expected Readmissions (lower rate is better for this measure)

Prenatal & Postpartum Care (Core)

Measure Steward: National Committee for Quality Assurance **Data Source:** Claims/Clinical Data **National Measure Sets of Interest:** CMS Medicaid Child Core Set; CMS Medicaid Adult Core Set			
Equity Analysis			
• In CT, the percentage of pregnant women who receive early prenatal care is lower for Black (77.4%), Hispanic (79.1%) and Asian (83.5%) women than for White (88.3%) women (CT State Health Assessment, 2020).			
Status/Measure Specification Changes	**Insurer Measure Use (2024)**	**Commercial Performance (2022)**	**Medicaid Performance (2022)**
• Minor changes for MY 2024 • No proposed changes for MY 2025	Yes (2 insurers; DSS)	**Timeliness of Prenatal Care:** 90% (between National 50th and 75th percentiles)	**Timeliness of Prenatal Care:** 92% (above National 90th percentile)
		Postpartum Care: 87% (between National 50th and 75th percentiles)	**Postpartum Care**: 80% (between National 50th and 75th percentiles)

Social Determinants of Health Screening* (Core)

Measure Steward: CT Office of Health Strategy **Data Source:** Survey **National Measure Sets of Interest:** None			
Equity Analysis			
• *Negative Social Determinants of Health contribute to health inequities.*			
Status/Measure Specification Changes	**Insurer Measure Use (2024)**	**Commercial Performance (2022)**	**Medicaid Performance (2022)**
None	Yes (1 insurer)	NA	NA

*Screening for housing insecurity, food insecurity, transportation, interpersonal violence and utility assistance.

Core Measures in Use by Payers

Core Measure Name (2024 Aligned Measure Set)	Number of Insurers Using the Measure (2024 Contracts)
Child and Adolescent Well Care Visits	5 insurers
Controlling High Blood Pressure	4 insurers
Follow-up After Emergency Department Visit for Mental Illness (7-Day)	1 insurer
Glycemic Status Assessment for Patients with Diabetes (>9.0%)	3 insurers
Health Equity Measure	1 insurer
Plan All-Cause Readmission	1 insurer
Prenatal and Postpartum Care	2 insurer
Social Determinants of Health Screening	1 insurer

Public Comment

Wrap-up & Next Steps

Meeting Wrap-Up & Next Steps

- Continue 2024 Aligned Measure Set Annual Review