CONNECTICUT
Health Strategy

Quality Council
Meeting Minutes
March 20, 2025 | 3:00 – 5:00 p.m. EDT
https://us02web.zoom.us/j/84750861796

ATTENDANCE:

By Electronic Device:

Stephanie De Abreu
Sandra Czunas
Petrina Davis
Amy Gagliardi
David Krol
David Perry
Joe Quaranta, Co-Chair
Andy Selinger
Marlene St. Juste
Larry Magras (for Jody Terranova)
Dan Tobin
Alison Vail
Steve Wolfson

Absent:

Rohit Bhalla
Ellen Carter, Co-Chair
Elizabeth Courtney
Lisa Freeman
Alix Pose
Phil Roland/Doug Nichols
Setu Vora

Other Participants:

Alex Reger, OHS
Lisa P. Sementilli, OHS
Michael Bailit, Bailit Health
Matt Reynolds, Bailit Health

WELCOME AND CALL TO ORDER

Joe Quaranta called the meeting to order at 3:02pm and welcomed everyone to the March meeting. Matt Reynolds conducted a roll call. There was a quorum present. Joe reviewed the agenda for the meeting.

APPROVAL OF FEBRUARY 20, 2025, MINUTES

Steve Wolfson motioned to approve the February meeting minutes. David Krol seconded the motion. There was no opposition nor any abstentions. The minutes were approved.

***Health Equity Measure* UPDATE**

Matt Reynolds noted that one of the five measures required for stratification in OHS' *Health Equity Measure* is *Screening for Depression and Follow-Up Plan*, which the Council recently recommended for removal from the Aligned Measure Set for 2026. Matt asked the Council how members wished to modify the *Health Equity Measure* for 2026, noting that OHS recommended dropping *Screening for Depression and Follow-Up Plan* from the measure and only requiring stratification of the other four measures.

- A Council member wondered how easy it would be to stratify *Follow-Up After Emergency Department Visit for Mental Illness*. Matt asked the payers and providers on the call to weigh in; none responded.
- A provider representative voiced support for OHS' recommendation. No other members offered comment.
- **Recommendation**: Drop *Screening for Depression and Follow-Up Plan* from the *Health Equity Measure* and only require stratification of the other four measures for 2026.

Aligned Measure Set Use in 2025 Payer Contracts

Matt Reynolds shared the extent to which payers and providers were using claims-based vs non-claims-based and HEDIS vs non-HEDIS measures in 2025 contracts. Matt summarized that claims-based

measures were used by an average of 3.7 payers while non-claims-based measures were used by an average of 2.3 payers, and that HEDIS measures were used by an average of 3.6 payers while non-HEDIS measures were being used by an average of 1.3 payers. Matt asked members for their reactions to these findings.

- A provider representative said that claims-based HEDIS measures are easiest for providers. They added that EHR-based measures are more challenging, especially for Advanced Networks using multiple EHR vendors, as practices often must pay to have reports developed by the EHR vendors.

Continue the Process of Setting 2026-2030 Quality Benchmarks

Michael Bailit reminded members of the statutory requirements for the Quality Benchmarks, as well as the measures being used for the 2022-2025 Quality Benchmarks. Michael then reviewed OHS' proposed edits to the criteria for selecting Quality Benchmarks and asked members if they had any further edits to the criteria.

- A provider representative questioned the need for a criterion to consider measures that are not receiving attention from national entities. No members disagreed. The criterion will be removed.
- Alex Reger asked about aligning the Quality Benchmarks with quality measures the state will use for AHEAD. Michael suggested the group instead consider the domains outlined for AHEAD, given CMMI's stated flexibility to incorporate measures from state aligned measure sets so long as they fit within AHEAD domains. Michael noted that the AHEAD domains included behavioral health, chronic conditions, healthcare quality and utilization, population health, and prevention and wellness.
    - A provider representative expressed hesitation in aligning with a program in such an early stage and noted that they thought the AHEAD domains were so broad that taking them into consideration did not seem particularly meaningful.
    - Another provider representative said they had not been enthused by AHEAD's lack of interest in pediatric populations, but thought it was fine to make the AHEAD domains a consideration.
    - Elisa Neira from OHS said her team could provide more information to the Council about AHEAD during a future meeting.
    - Michael summarized that the Council would consider the AHEAD domains as a practice, without making it a Quality Benchmark selection criterion.

Michael reviewed data from various sources on the prevalence of different health issues in Connecticut and asked members to identify, based on the data reviewed, what they believe are the most significant health needs of Connecticut residents. Michael also asked members if there were other health needs that were not captured in the data.

- A provider representative noted that data on causes of death weren't as relevant for identifying the primary health issues relevant for the pediatric population, adding that some pediatric care could help to prevent some of the issues identified in the data. A payer representative agreed.
- Another provider representative noted that immunizations, especially for children, should be something the Council considers. The first provider representative agreed, stating that *Childhood Immunization Status* would be a valuable measure to consider, especially with more and more parents refusing, questioning, or asking for alternative schedules for vaccines. Matt Reynolds noted that *Childhood Immunization Status* was not currently in the Aligned Measure Set, while *Immunizations for Adolescents* was.

- A Council member said that access to care (both primary care and specialist care) was currently a great challenge in Connecticut due to capacity limitations, leading to a lot of care being sought in emergency departments.

Michael asked members how many Quality Benchmarks they wished to set for 2026-2030.

- A patient advocate representative asked what other states had done. Michael noted that the only other state that had set Quality Benchmarks was Delaware, and he thought Delaware had fewer than the seven measures Connecticut had used for 2022-2025.
- A provider representative noted the importance of not just the number of metrics but also alignment of the metrics, as it is easier to have more metrics if they are aligned across payers. The provider suggested setting six Quality Benchmarks. Two other members agreed with the provider's proposal.
    - A representative for DSS agreed with the provider's recommendation as well, noting that when evaluating the Medicaid PCMH incentive program, DSS received feedback that 12 measures was far too many and ultimately settled on 5 adult measures, 5 pediatric measures, and 1 "challenge" measure.

Michael asked members whether the Quality Benchmarks should again include both measures of healthcare and health status.

- A payer representative said the trouble with health status measures was how the data are captured. Michael Bailit replied that health status measures mostly come from survey data gathered by the Department of Public Health or a federal agency.
- A provider representative asked who is held accountable (and how) health status measure performance. Michael observed that health status measures are influenced by factors that are sometimes beyond payer and provider influence.
- No members voiced support for the continued use of health status measures.

Michael noted that the Council would start by considering the measures it had recommended for inclusion in the 2026 Core Set. Michael shared that OHS would bring additional measures to consider during the next meeting to address a) vaccinations and b) access to primary care/primary care capacity, as requested by Council members earlier in the meeting.

Child and Adolescent Well-Care Visits

Matt Reynolds reviewed the measure definition and recent commercial and Medicaid performance for the measure. Matt noted that the measure relies on claims data and that all six payers reported using the measure in 2025. Matt asked if members were interested in the measure being a 2026-2030 Quality Benchmark measure.

- A provider representative observed that the measure covers a broad age range, adding that performance was much lower for adolescents and young adults.
    - Michael Bailit replied that the Quality Benchmark could target the adolescent population. A patient advocate representative expressed support for the idea.
- A representative for DSS said that for Medicaid, the lowest rates were for children around age 11.
- A provider representative noted that this is one of the only measures that all six payers use. He said it would be hard to improve performance on the measure, suggesting the State could focus instead on maintaining sustained excellence. The provider also noted the disparity between

commercial and Medicaid performance, adding that the Quality Benchmark could focus on Medicaid.
    - The representative for DSS said the problem for Medicaid was kids without an attributed primary care practitioner, as kids on Medicaid with an attributed PCP have well-care visits at comparable rates to kids insured in commercial plans.
    - A Council member noted that the social determinants of health contributed to the observed disparity between commercial and Medicaid performance. The member recommended consideration of a Quality Benchmark that addresses social determinants of health.
- Matt Reynolds observed that there was interest in developing a Quality Benchmark for this measure in some manner. Two Council members confirmed their support.

Controlling High Blood Pressure

Matt Reynolds reviewed the measure definition and recent commercial and Medicaid performance for the measure. Matt noted that the measure requires clinical data and that five of six payers reported using the measure in 2025. Matt added that the measure is a 2022-2025 Quality Benchmark measure and was among those suggested by CMMI for use in the AHEAD Model. Matt asked if members were interested in the measure being a 2026-2030 Quality Benchmark measure.

- Seven Council members expressed support for continued use of this measure as a Quality Benchmark.

Glycemic Status Assessment for Patients with Diabetes: Poor A1c Control (>9.0%)

Matt Reynolds reviewed the measure definition and recent commercial and Medicaid performance for the measure. Matt noted that the measure requires clinical data and that four of six payers reported using the measure in 2025. Matt added that the measure is a 2022-2025 Quality Benchmark measure and was among those suggested by CMMI for use in the AHEAD Model. Matt asked if members were interested in the measure being a 2026-2030 Quality Benchmark measure.

- Five Council members expressed support for the continued use of this measure as a Quality Benchmark.
- A provider representative suggested being aspirational and using the <8% rate for the Quality Benchmark. Three members agreed with this suggestion.
- Another provider representative voiced concern that the measure did not separate out newly diagnosed patients. However, the provider stated their preference for using the >9.0% rate.
- Michael Bailit observed that it would be inconsistent if the <8% measure was used as a Quality Benchmark and the >9% measure was in the Aligned Measure Set as Core Measure.
- Matt Reynolds summarized that the Council was interested in the measure being a Quality Benchmark for 2026-2030.

Plan All-Cause Readmission

Matt Reynolds reviewed the measure definition and recent commercial and Medicaid performance for the measure. Matt noted that the measure relies on claims data and that two of six payers reported using the measure in 2025. Matt added that the measure was among those suggested by CMMI for use in the AHEAD Model. Matt asked if members were interested in the measure being a 2026-2030 Quality Benchmark measure.

- A provider representative asked if other organizations had used an all-cause admissions measure instead of re-admissions, noting that re-admissions had received lots of attention but the measure impacts few patients, whereas many more patients are admitted (especially for Medicare) and admission rates receive little attention.
- A representative for DSS said they were not familiar with an all-cause admission measure, but knew of AHRQ admission rate measures for specific conditions. The DSS representative spoke to the problem with all-cause readmission measures being impacted by planned readmissions.
- Another provider representative noted that Connecticut performance was poor on readmissions relative to national benchmarks, measure limitations notwithstanding. The provider advocated for readmission measure use as a Quality Benchmark. Another Council member agreed, as did a payer representative who also, however, expressed unease with "all-cause" readmissions.
- The first provider representative said they would support the use of the readmission measure as a Quality Benchmark too.

Prenatal and Postpartum Care

Matt Reynolds reviewed the measure definition and recent commercial and Medicaid performance for the measure. Matt noted that the measure relies on claims data and that three of six payers reported using the measure in 2025. Matt added that the measure was among those suggested by CMMI for use in the AHEAD Model. Matt asked if members were interested in the measure being a 2026-2030 Quality Benchmark measure.

- A payer representative acknowledged the importance of the measure's purpose but said that primary care groups were challenged by this measure, and so the state employee plan moved this measure to "monitoring" status for primary care practice contracts.
- A patient advocate representative spoke to the racial disparity for perinatal health in Connecticut. They supported use of the measure as a Quality Benchmark.
- A public commenter from a health plan said that global billing makes capturing prenatal visits challenging.
- Another patient advocate representative recommended using both the prenatal and postpartum components of the measure as a Quality Benchmark.
- A representative for DSS supported using the measure as a Quality Benchmark, noting that DSS was using the measure for its new maternity bundled payment, which became effective on January 1st.
- A provider representative said that despite the challenges with implementing the measure, they felt the topic was too important to exclude for Quality Benchmark consideration.

REL Data Completeness

- This measure was not discussed due to lack of time.

A payer representative expressed a desire to consider pediatric measures in use in other national programs.

PUBLIC COMMENT

Alex Reger offered the opportunity for public comment. A member of the public said there was a focus nationally on "movement as medicine" and they encouraged a public health lens be applied by the Quality Council.

NEXT STEPS & MEETING ADJOURNMENT

Joe Quaranta shared that the next meeting would be held on April 17th from 3-5 pm. He expressed appreciation to Steve Wolfson for his years of engaged participation on the Quality Council, and his advocacy for improved population health. Others expressed their appreciation to Steve. The meeting adjourned at 4:57 pm.

UPCOMING MEETING:

April 17, 2025

Quality Council meeting materials:
https://portal.ct.gov/OHS/Pages/Quality-Council