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Quality Council
March 20, 2025

Call to Order and Roll Call

Agenda

Time	Topic
3:00 p.m.	Call to Order, Roll Call, and Agenda Review
3:05 p.m.	Approval of February 20, 2025 Meeting Minutes — Vote
3:10 p.m.	*Health Equity Measure* Update
3:20 p.m.	Aligned Measure Set Use in 2025 Payer Contracts
3:30 p.m.	Continue Process of Setting 2026-2030 Quality Benchmarks
4:50 p.m.	Public Comment
4:55 p.m.	Next Steps and Adjournment

Approval of February 20, 2025 Meeting Minutes – Vote

Health Equity Measure Update

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***Health Equity Measure* Update** (1 of 2)

- As a reminder, the *Health Equity Measure* calls for stratification by race, ethnicity, and language for five measures in the Aligned Measure Set. The five measures are:
  - *Child and Adolescent Well-Care Visits*
  - *Controlling High Blood Pressure*
  - *Glycemic Status Poor Control (>9.0%)*
  - *Prenatal and Postpartum Care*
  - *Screening for Depression and Follow-Up Plan*
- The Quality Council recently recommended replacing *Screening for Depression and Follow-Up Plan* in the 2026 Aligned Measure Set with *Depression Screening and Follow-Up for Adolescents and Adults*.
  - On the following slide, we will consider options for modifying the *Health Equity Measure* for 2026.

Health Equity Measure **Update** (2 of 2)

1. Drop *Screening for Depression and Follow-Up Plan* from the measure and **only require stratification of the other four measures** for 2026.

   Note: This would mean no behavioral health measure is required for stratification.

2. **Require stratification of *Depression Screening and Follow-Up for Adolescents and Adults*** instead of *Screening for Depression and Follow-Up Plan* for 2026.

   Note: Requiring stratification of a measure that is brand new to the Measure Set could create a barrier to adoption of the *Health Equity Measure*.

3. **Require stratification of one of the other behavioral health measures** in the Aligned Measure Set instead of *Screening for Depression and Follow-Up Plan* for 2026:

   a) Unhealthy Alcohol Use Screening and Follow-Up (also new to the 2026 Measure Set)

   b) Follow-Up After Emergency Department Visit for Mental Illness (7-day)

Aligned Measure Set Use in 2025 Payer Contracts

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Aligned Measure Set Use in 2025 Payer Contracts

- During our last meeting, we reviewed commercial insurer fidelity scores for 2025. A Council member requested a summary of the extent to which each measure was being used.
  - Another member requested the analysis indicate which measures are claims-based and which are HEDIS measures.
- We will review this analysis on the following slides.

Core Set Use in 2025 Payer Contracts

Core Measure Name	# of Payers Using in 2025 (n=6)	Steward	Data Source
Child and Adolescent Well-Care Visits	6	NCQA	Claims
Controlling High Blood Pressure	5	NCQA	EHR
Follow-Up After Emergency Department Visit for Mental Illness (7-day)	2	NCQA	Claims
Glycemic Status Assessment for Patients with Diabetes: Poor Control (>9.0%)	4	NCQA	EHR
Plan All-Cause Readmission	2	NCQA	Claims
Prenatal & Postpartum Care	3	NCQA	Claims
Race, Ethnicity, and Language Data Completeness	0	CT OHS	EHR

Menu Set Use in 2025 Payer Contracts

Menu Measure Name	# of Payers Using in 2025 (n=6)	Steward	Data Source
~~Asthma Medication Ratio~~**	3	NCQA	Claims
Breast Cancer Screening	6	NCQA	Claims
Cervical Cancer Screening	5	NCQA	Claims
Chlamydia Screening	5	NCQA	Claims
Colorectal Cancer Screening	4	NCQA	EHR
Developmental Screening in the First Three Years of Life	2	OHSU	EHR
~~Follow-Up After Hospitalization for Mental Illness (7-day)~~**	1	NCQA	Claims
Health Equity Measure	2	CT OHS	EHR
Immunizations for Adolescents (Combo 2)	3	NCQA	Claims
Kidney Health Evaluation for Patients with Diabetes	4	NCQA	EHR
~~PCMH CAHPS~~	1	AHRQ	Survey
~~Screening for Depression and Follow-Up Plan~~**	2	CMS	EHR
~~Social Determinants of Health Screening~~**	1	CT OHS	Survey
Statin Therapy for Patients with Diabetes	2	NCQA	Claims
~~Transitions of Care~~	0	NCQA	EHR
Well-Child Visits in the First 30 Months of Life	6	NCQA	Claims

~~Strikethrough~~ = recommended for removal in 2026
** = another measure recommended for replacement in 2026

Aligned Measure Set Use in 2025 Payer Contracts

- Of the measures in the 2025 Aligned Measure Set…
  - Claims-based measures were used by an average of **3.7** payers.
  - EHR and survey-based measures were used by an average of **2.3** payers.
  - HEDIS measures were used by an average of **3.6** payers.
  - Non-HEDIS measures were used by an average of **1.3** payers.

What reactions do members have to these findings?

Continue Process of Setting 2026–2030 Quality Benchmarks

Reminder: Statutory Requirements

- Connecticut General Statute (C.G.S.) § 19a-754g states that "**not later than July 1, 2025**, and every five years thereafter, the executive director shall **develop and adopt annual health care quality benchmarks for the succeeding five calendar years** for provider entities and payers."
- C.G.S § 19a-754g goes on to say that "the executive director shall consider (i) quality measures endorsed by nationally recognized organizations... and (ii) measures that:

  (I) concern health outcomes, overutilization, underutilization and patient safety,

  (II) meet standards of patient-centeredness and ensure consideration of differences in preferences and clinical characteristics within patient subpopulations, and

  (III) concern community health or population health."

Reminder: Current Quality Benchmarks

- OHS' current Quality Benchmarks expire after 2025. The 2021-2025 Quality Benchmarks are as follows:

Phase 1 (2022-2025)

- Asthma Medication Ratio
- Controlling High Blood Pressure
- Glycemic Status Assessment for Patients with Diabetes: HbA1c Poor Control (>9.0%)

Phase 2 (2024-2025)

- Child and Adolescent Well-Care Visits
- Follow-up After Hospitalization for Mental Illness (7-day)
- Follow-up After ED Visit for Mental Illness (7-day)
- Obesity Equity Measure

Setting 2026-2030 Quality Benchmarks: Process Overview

1. Review the **charge** outlined in statute and an **overview of the process** the Council will undertake.
2. Discuss the Quality Benchmarks **logic model**.
3. Review **experience with and performance on** the Quality Benchmarks to date.
4. Revisit the 2021 Quality Council **criteria for selecting measures** and adopt criteria for this year's process.
5. Determine the **number of Quality Benchmarks to set** and whether to again include measures of both **healthcare** and **health status**.
6. Consider **candidate measures**.
7. Determine whether to use a **phased approach** to implementation.
8. Review **recent performance and relevant benchmarks** for selected measures to inform **development of Quality Benchmark values**.

Criteria for Selecting Quality Benchmarks (1 of 2)

OHS has proposed edits (in red) to the Council's previous criteria based on member feedback during the February meeting.

1. Addresses the **most significant health needs of CT residents,** including but not limited to behavioral health, health equity, patient safety and patient care experience.
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.

Criteria for Selecting Quality Benchmarks (2 of 2)

4. **Draws from the Core Measure Set**, whenever possible.
5. Associated **performance data are produced annually** and are published no later than two years after the end of the performance period.
6. Considers measures that are **not receiving attention from national entities**.
7. Minimizes additional burden for payers and providers.

Do members have any more suggested edits to these criteria?

Most Significant Health Needs of Connecticut Residents (1 of 6)

- During our last meeting, a member asked how the Council was determining what are "the most significant health needs of Connecticut residents?"
- There is no definitive data source to answer this question. On the following slides, we review data from multiple sources to help the Council determine which health needs are of highest priority to inform the 2026-2030 Quality Benchmarks.
- Please take notes so that at the end we can decide which needs to prioritize.

Most Significant Health Needs of Connecticut Residents (2 of 6)

- According to the most recent data available from the CDC, the leading causes of death in Connecticut (based on an age-adjusted death rate per 100,000) are, in order:
  1. Heart disease
  2. Cancer
  3. Accidents
  4. Chronic lower respiratory diseases (such as COPD and asthma)
  5. Stroke
  6. Alzheimer's Disease
  7. Influenza/Pneumonia
  8. Diabetes

Source: CDC National Center for Health Statistics

Most Significant Health Needs of Connecticut Residents (3 of 6)

- Per CDC data cited in Connecticut's "Healthy Connecticut 2025 State Health Assessment," the top five causes of years of potential life lost before age 75 in Connecticut are:
  1. Accidents
  2. Cancer
  3. Heart Disease
  4. Suicide
  5. Perinatal deaths
- The State Health Assessment also notes that recent stalling (for women) and declining (for men) life expectancy trends are primarily due to **alcohol and drug-induced deaths**.

Source: Healthy Connecticut 2025 State Health Assessment

Most Significant Health Needs of Connecticut Residents (4 of 6)

- According to the latest Connecticut Behavioral Risk Factor Surveillance Survey (BRFSS) data, the only health indicator for which Connecticut prevalence exceeds the national median is **asthma** (10.6% in Connecticut vs 9.6% nationally).
- The United Health Foundation's America's Health Rankings assessed 49 factors that may have positively or negatively contributed to each state's ranking. CT is ranked #5.
  - Over 80% of the measured factors had a positive impact on CT's ranking.
  - Factors with a negative impact included **preventable hospitalizations, physical inactivity, and housing with lead risk.**

Sources: CT BRFSS and America's Health Rankings

Most Significant Health Needs of Connecticut Residents (5 of 6)

- Findings from DataHaven's 2024 Community Wellbeing Survey include:
  - 33% of respondents reported being told they have **high blood pressure**
  - 18% of respondents reported being told they have **asthma**, 72% of whom said they still have asthma
  - 13% of respondents said they didn't get needed medical care in the past 12 months while 28% postponed needed care in the past 12 months
    - 50% cited cost as a concern, while 44% said they could not get an appointment soon enough
  - 15% of respondents said they didn't get needed mental health treatment in the past 12 months
    - 38% cited cost as a concern, while 39% said they could not get an appointment soon enough
  - 18% of respondents screened positive for **depression** on the PHQ-2

Sources: DataHaven 2024 Community Wellbeing Survey

Most Significant Health Needs of Connecticut Residents (6 of 6)

- Finally, the Healthy Connecticut 2025 State Health Improvement Plan outlined the following as priority metrics that the State aimed to impact through the activities described in the Health Improvement Plan:
  - Obesity
  - Suicide
  - Drug overdose
  - Percent insured
  - Emergency room visits

Based on the data we have reviewed, what do members believe are the most significant health needs of Connecticut residents? Are there other needs that you believe were not captured in these data?

Additional Parameters for Selecting Quality Benchmarks

- For 2021-2025, the Quality Council selected seven Quality Benchmark measures. Six are measures of healthcare, while one is a health status measure.

How many Quality Benchmarks should the Quality Council set for 2026-2030?

- More measures allows more priorities to be addressed but also strains focus and bandwidth.

Should the Quality Council again include measures of both healthcare and health status?

- Should attention be on healthcare, public health, or both?

Begin Considering Candidate Measures

- Given our criterion to draw Quality Benchmarks from the Core Set whenever possible, we will start by considering the measures the Quality Council has recommended for inclusion in the 2026 Core Set.
- Based on input from members today on a) the most pressing health needs of Connecticut residents, b) interest in including measure(s) of health status, and c) the number of Quality Benchmarks to set, OHS will bring additional measures to consider next meeting if/as necessary.

Candidate Measures: 2026 Core Measures

Core Measure Name	Steward	Data Source
Child and Adolescent Well-Care Visits	NCQA	Claims
Controlling High Blood Pressure	NCQA	EHR
Glycemic Status Assessment for Patients with Diabetes: Poor Control (>9.0%)	NCQA	EHR
Plan All-Cause Readmission	NCQA	Claims
Prenatal & Postpartum Care	NCQA	Claims
Race, Ethnicity, and Language Data Completeness	CT OHS	EHR

We will review each measure individually on the slides that follow.

Candidate Measure: *Child and Adolescent Well-Care Visits*

- This measure assesses the percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year.
  - It is a **process** measure that relies on **claims** data.
  - The measure relates to **access**.
  - **Commercial** performance in 2023 was **81%**, above the national 90th percentile.
  - **Medicaid** performance in 2022 was **64%**, also above the national 90th percentile.
  - **All 6 payers** reported using the measure in 2025.

Are members interested in Child and Adolescent Well-Care Visits being a 2026-2030 Quality Benchmark measure?

Candidate Measure: *Controlling High Blood Pressure*

- This measure assesses the percentage of members 18-85 years of age with a diagnosis of hypertension whose blood pressure was adequately controlled during the measurement year.
  - It is an **outcome** measure that requires **clinical** data.
  - The measure relates to **cardiovascular health**.
  - The measure is a 2021-2025 Quality Benchmark measure. 2023 performance was **80% for Medicare Advantage** and **70% for both commercial and Medicaid**, meeting the benchmark for each market.
  - **5 of 6 payers** reported using the measure in 2025.
  - The measure is among those suggested by CMMI for use in **AHEAD**.

Are members interested in Controlling High Blood Pressure being a 2026-2030 Quality Benchmark measure?

Candidate Measure: *Glycemic Status Assessment*

- This measure assesses the percentage of members 18-75 years of age with diabetes whose most recent glycemic status was >9.0% during the measurement year (lower rates are better).
  - It is an **outcome** measure that requires **clinical** data.
  - The measure relates to **diabetes and cardiovascular health**.
  - The measure is a 2021-2025 Quality Benchmark measure. 2023 performance was **14% for Medicare Advantage, 23% for commercial, and 29% for Medicaid,** meeting the benchmark for each market.
  - **4 of 6 payers** reported using the measure in 2025.
  - The measure is among those suggested by CMMI for use in **AHEAD**.

Are members interested in Glycemic Status Assessment being a 2026-2030 Quality Benchmark measure?

Candidate Measure: *Plan All-Cause Readmission*

- For members 18 and older, this measure assesses the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days, as compared to the predicted probability of an acute readmission (lower rates are better).
  - It is an **outcome** measure that relies on **claims** data.
  - The measure relates to **potentially preventable hospitalizations**.
  - 2023 **commercial** performance was between the national 25th and 50th percentiles. 2022 **Medicaid** performance was below the national 25th.
  - **2 of 6 payers** reported using the measure in 2025.
  - The measure is among those suggested by CMMI for use in **AHEAD**.

Are members interested in Plan All-Cause Readmission being a 2026-2030 Quality Benchmark measure?

Candidate Measure: *Prenatal & Postpartum Care*

- This measure assesses the percentage of deliveries that had a prenatal care visit in the first trimester and the percentage that had a postpartum visit between 7 and 84 days after delivery.
  - It is a **process** measure that relies on **claims** data.
  - The measure relates to **maternal and perinatal health**.
  - 2023 **commercial** performance was **86%** for prenatal care and **89%** for postpartum care (both between 50th and 75th percentiles nationally).
  - 2022 **Medicaid** performance was **92%** for prenatal care (>90th percentile nationally) and **80%** for postpartum care (between 50th and 75th).
  - **3 of 6 payers** reported using the measure in 2025.
  - The measure is among those suggested by CMMI for use in **AHEAD**.

Are members interested in Prenatal & Postpartum Care being a 2026-2030 Quality Benchmark measure?

Candidate Measure: *REL Data Completeness*

- This measure assesses the percentage of members with self-reported race, ethnicity, and language data collected by an Advanced Network during the measurement year.
  - It is a **process** measure that requires **electronic** data.
  - The measure relates **health equity**.
  - Performance on this measure is currently **unknown**.
  - **0 of 6 payers** reported using the measure in 2025.

Are members interested in REL Data Completeness being a 2026-2030 Quality Benchmark measure?

Public Comment

Wrap-Up and Next Steps

Meeting Wrap-Up and Next Steps

- The Quality Council will meet next on **Thursday, April 17th from 3-5 pm**.