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Quality Council
February 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 January 16, 2025 Meeting Minutes — Vote
3:10 p.m.	Complete Annual Review of the Aligned Measure Set
4:30 p.m.	Insurer Fidelity to the 2025 Aligned Measure Set
3:45 p.m.	2025 Quality Council Goals
4:00 p.m.	Begin Process of Setting 2026-2030 Quality Benchmarks
4:50 p.m.	Public Comment
4:55 p.m.	Next Steps and Adjournment

Approval of January 16, 2025 Meeting Minutes – Vote

Complete Annual Review of the Aligned Measure Set

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January Meeting Recap

During our January meeting…

- The Council discussed but did not reach consensus on which statin measure to include in the 2026 Aligned Measure Set.
- The Council recommended **replacing** *Transitions of Care* with *Timely Follow-Up After Acute Exacerbations of Chronic Conditions* in the **Menu Set** for 2026.
- The Council recommended **adding** *Unhealthy Alcohol Use Screening and Follow-Up* to the **Menu Set** for 2026.
- The Council requested additional information on alternative asthma measures.
- The Council expressed interest in Massachusetts Medicaid's *Achievement of External Standards for Health Equity* measure.

Statin Measure Decision

- Following the discussion of statin measures during our January meeting, OHS has decided to **retain** *Statin Therapy for Patients with Diabetes* in the **Menu Set** for 2026, for the following reasons:
  - The measure is already in the Aligned Measure Set and in use by more payers (two) than any of the other statin measures.
  - The measure assess both dispensing and patient adherence.
  - As a HEDIS measure, payers already report on the measure and benchmarks are available through NCQA.
  - Providers are assessed on the measure for Medicare Advantage, so retaining the measure supports multi-payer alignment.

Are members comfortable with this decision?

Alternative Asthma Measures (1 of 2)

- The Council reviewed four alternative asthma measures during our January meeting. The only measure in which members expressed interest was *Pharmacologic Therapy for Persistent Asthma.*
  - However, some providers expressed concern that the onus of proof that the medication had been prescribed was on the provider rather than the payer. OHS subsequently reached out to the measure steward to confirm that pharmacy claim data can't be used for the measure but has received no response.
- A member asked if there was a measure for asthma-related emergency department visits that the Council could consider instead.
  - OHS subsequently researched potential measures and, after consultation with the Co-Chairs, recommends a measure from Alabama's Medicaid Agency, which we will review on the following slide.

Alternative Asthma Measures (2 of 2)

Measure Name	Measure Steward	Description
Asthma Emergency Department Visits	Alabama Medicaid Agency	The percentage of patients ages 2-20 with asthma who have one or more visit to the emergency room for asthma during the measurement period.
Pharmacologic Therapy for Persistent Asthma	American Academy of Allergy, Asthma, and Immunology	The percentage of patients ages 5 years and older with a diagnosis of persistent asthma who were prescribed a long-term control medication.

Do members wish to add either measure to the 2026 Aligned Measure Set?

Achievement of External Standards for Health Equity (1 of 4)

- During our last meeting, we reviewed a measure developed by Massachusetts that assesses progress towards / achievement of external health equity standards, including:
  - The Joint Commission Health Care Equity Certification (for ACOs' partnered hospitals)
  - NCQA Health Equity Accreditation (for ACOs)
  - State-specific ACO certification
- One member noted FQHCs are accredited by the Joint Commission.
  - However, the requirements for FQHCs are different from the Health Care Equity Certification designed for hospitals, as explained on the following slide.

Achievement of External Standards for Health Equity (2 of 4)

- As part of The Joint Commission's **National Patient Safety Goals**, organizations (such as FQHCs) must 1) designate an individual to lead health equity activities, 2) screen for HRSNs, 3) stratify data to identify disparities, 4) develop a written action plan to improve health equity and 5) take necessary action, 6) inform stakeholders about progress annually.
- The Joint Commission's **Health Care Equity Certification is** a voluntary program for hospitals separate from accreditation that recognizes organizations that go beyond the basic accreditation requirements.

Achievement of External Standards for Health Equity (3 of 4)

NCQA's Health Equity Accreditation includes seven standards:

1. Organizational Readiness (e.g., staff diversity)
2. Demographic Data Collection (e.g., REL, SOGI)
3. Access and Availability of Language Services
4. Practitioner Network Cultural Responsiveness
5. Culturally and Linguistically Appropriate Services Programs
6. Reducing Health Care Disparities
7. Delegation of Health Equity Activities

Achievement of External Standards for Health Equity (4 of 4)

Given this information, do members recommend adding a measure to the 2026 Aligned Measure Set that assesses achievement of external standards for health equity?

And if so, should the measure:

1. Assess Advanced Network progress towards / achievement of **NCQA Health Equity Accreditation** only?
2. Assess Advanced Network progress towards / achievement of **NCQA Health Equity Accreditation** and **TJC National Patient Safety Goals**?
3. Assess Advanced Network progress towards / achievement of **TJC National Patient Safety Goals** only?

Insurer Fidelity to the 2025 Aligned Measure Set

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Reminders about Insurer Fidelity Scores

- Fidelity scores are calculated using insurer responses to OHS' Quality Council Insurer Survey.
  - The survey captured the measures in use by payers in value-based contracts with Advanced Networks* effective beginning on or after January 1, 2025.
- Insurer fidelity scores **reflect alignment** with the Aligned Measure Set, and **not performance** on the individual quality measures.
- Insurer fidelity scores will **likely never reach 100%** because the Aligned Measure Set is updated on annual basis and contracts are typically multi-year.
  - OHS does not expect insurers and Advanced Networks to make changes in contract measures mid-contract.

*An Advanced Network is an organized group of clinicians that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if it is not engaged in a total cost of care contract.

Insurer Aligned Measure Set Fidelity Score Methodology

- Using data from the Insurer Survey, OHS used the formula below to calculate each insurer's Aligned Measure Set fidelity score.
  - **Note**: The assessment only considered quality measures that would be considered for inclusion in the Aligned Measure Set (e.g., we excluded hospital-focused measures, prescription drug-focused measures, Medicare Advantage measures, and resource use measures).

$$\frac{Number\ of\ instances\ Aligned\ Measure\ Set\ measures\ were\ used\ by\ the\ insurer\ in\ contracts}{Sum\ of\ instances\ any\ measures\ (Aligned\ Measure\ Set\ measures\ or\ otherwise)\ were\ used\ by\ the\ insurer\ in\ contracts}$$

Insurer Core Measure Fidelity Score Methodology (1 of 2)

- OHS also calculated a Core Measure fidelity score to assess insurers' use of the Core Measures in the Aligned Measure Set.
- As a reminder, OHS asks insurers to use all Core Measures in *all* value-based contracts.

Insurer Core Measure Fidelity Score Methodology (2 of 2)

- OHS calculated Core Measure fidelity scores using the formula below to assess insurers' use of the Core Measures in the Aligned Measure Set.
  - **Note**: Given some Core Measures are only applicable to adults, if insurers engage in value-based contracts with the pediatric Advanced Network (CT Children's Care Network) their Core Measure fidelity score may slightly underrepresent their alignment.

$$\frac{Number\ of\ instances\ Core\ Measures\ were\ used\ by\ the\ insurer\ in\ contracts}{(Number\ of\ insurer's\ Advanced\ Network\ contracts * Number\ of\ Core\ Measures\ in\ the\ Aligned\ Measure\ Set\ (7))}$$

Insurer Fidelity Scores

- Alignment across the commercial market *decreased* slightly for the second year, from 70% in 2024 to 69% in 2025.
- Commercial-wide Core Measure fidelity, however, increased from 39% in 2024 to 58% in 2025.

Year	Commercial Market	Aetna	Anthem	Cigna	ConnectiCare	United Healthcare
Aligned Measure Set Fidelity Score						
2025	69%	74%	67%	71%	85%	47%
2024	70%	86%	67%	69%	89%	68%
2023	73%	81%	69%	77%	67%	56%
2022	46%	40%	40%	88%	86%	51%
Core Measure Fidelity Score						
2025	58%	19%	80%	29%	56%	14%
2024	39%	10%	47%	43%	35%	6%

Use of Aligned Measure Set Measures

- The table below shows the number of Aligned Measure Set measures and non-Aligned Measure Set measures insurers are using in Advanced Network contracts, as indicated in the 2025 Quality Council Insurer survey responses.
  - **Note**: This table does not reflect the number of contracts in which each measure is used (i.e., an insurer could be using a measure in only one contract, in some contracts or in all contracts).

Category	Aetna	Anthem	Cigna	ConnectiCare	United Healthcare
# of Core Measures in Use (higher is better, maximum = 7)	3	6	2	6	1
# of Menu Measures in Use (maximum = 16)	6	10	8	7	7
# of Non-Aligned Measure Set Measures in Use (lower is better)	5	10	4	3	9

2025 Quality Council Goals

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2025 Quality Council Goals (1 of 2)

- Based on the Council's 2024 goals and feedback from Council members during our January meeting, OHS has drafted the following Council goals for 2025:

Goal	Measure(s)
1. Complete the annual measure set review for 2025.	• Complete the annual review, with recommendations to OHS by March 2025. • Begin the practice of providing an assessment of potential provider administrative burden associated with quality measures as they are reviewed.
2. Increase fidelity to the Aligned Measure Set across the five largest commercial insurers.	• Meet with the five largest payers by the end of June to discuss how they might improve fidelity to the Aligned Measure Set. • Improve fidelity to the Aligned Measure Set for 69% in 2025 to 80% in 2026.

2025 Quality Council Goals (2 of 2)

Goal	Measure(s)

3. Gain a better understanding of how provider groups are experiencing the Aligned Measure Set.	• Survey provider groups by the May 31st, and present findings and recommended actions to the Quality Council by September 30th, regarding:
	  ○ their familiarity with the Aligned Measure Set;
	  ○ their efforts to drive improvement on the Aligned Measure Set measures;
	  ○ their readiness for moving to more electronic measurement and any ideas they may have for support that would facilitate their readiness, and
	  ○ the level of burden they experience related to quality measurement and any ideas thy may have for lessening the burden.
	• Invite one or two provider groups to join a 2025 Quality Council meeting and share their experience with the Aligned Measure Set by the end of September.

4. Support members' education and confidence related to quality measurement.	• Provide members with at least one opportunity to participate in a quality measurement educational session by June 30th.

What reactions do members have to these draft 2025 Quality Council goals?

Begin Process of Setting 2026 – 2030 Quality Benchmarks

Quality Benchmarks: 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.

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. [today]
2. Discuss the Quality Benchmarks **logic model**. [today]
3. Review **experience with and performance on** the Quality Benchmarks to date. [today]
4. Revisit the 2021 Quality Council **criteria for selecting measures** and adopt criteria for this year's process. [today]
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**.

Quality Benchmarks Logic Model

- Before we set new Quality Benchmarks for 2026-2030, it is important to ensure that we have a common understanding of the purpose that the Quality Benchmarks are intended to serve.
- That purpose is to ***ensure the improvement of healthcare quality and population health status in concert with slowed spending growth and redistribution of some spending to primary care***.
    - The Quality Benchmarks are target values for quality measures of high priority to the State that all public and private payers, providers, and the State should work to achieve.

Quality Benchmarks: Experience to Date (1 of 3)

- OHS is currently concluding its second year of Quality Benchmark analysis and reporting.
  - In 2024, OHS reported on 2022 performance. In March, OHS will report on 2023 performance.
  - Therefore, OHS has only reported on **Phase 1** measures to date (*Asthma Medication Ratio*, *Controlling High Blood Pressure*, and *HbA1c Poor Control (>9.0%)*).
- So far, Connecticut has performed well against the Quality Benchmarks at the market and insurer levels, with limited reporting challenges. Assessing Advanced Network-level performance, however, has proven difficult.

Quality Benchmarks: Experience to Date (2 of 3)

- Two of the Phase 1 Quality Benchmarks (*Controlling High Blood Pressure* and *HbA1c Poor Control (>9.0%)*) are **hybrid measures**, meaning they require the use of both claims and clinical data to calculate performance.
  - These two measures have been of high priority to the Council, as they assess interim **clinical outcomes** that have significant impact on morbidity and mortality.
  - However, there appears to be inconsistent and incomplete **clinical data exchange** between providers and payers, making it a challenge for OHS to assess Advanced Network performance for these measures.

Quality Benchmarks: Experience to Date (3 of 3)

- In addition, the insurer with the largest Medicare Advantage market share in Connecticut (UnitedHealthcare) has repeatedly **declined to submit** Advanced Network-level data for the Medicare Advantage market.
  - UnitedHealthcare has stated that isolating Connecticut-specific performance for its regional Medicare Advantage products is too onerous.
  - The omission of United's Medicare Advantage data further complicates OHS' ability to assess Advanced Network performance for the Medicare Advantage market, specifically, because of its large market share.

Experience to Date: Discussion

1. Do any payers or providers on the Council wish to provide additional context about your experience with the Quality Benchmarks?
2. What are the implications of our collective experience with the Quality Benchmarks on:
    - the new Quality Benchmarks we must set for 2026-2030?
    - strategies to meet the new Quality Benchmarks for 2026-2030?

Criteria for Selecting Quality Benchmarks (1 of 2)

Does the Council recommend any changes to the selection criteria it developed in 2021 (below and on the following slide)?

1. Addresses the **most significant health needs of CT residents**, with attention to the following areas of special priority: behavioral health, health equity, patient safety and 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. Prioritizes measures that are **not receiving attention from national entities**.

Public Comment

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Wrap-Up and Next Steps

Meeting Wrap-Up and Next Steps

- The Quality Council will meet next on **Thursday, March 20th from 3-5 pm**.

Appendix

October-December Meetings Recap (1 of 4)

1. The Council recommended **retaining the following six measures in the Core Set** for 2026:
   - *Child and Adolescent Well-Care Visits*
   - *Controlling High Blood Pressure*
   - *Glycemic Status Assessment for Patients with Diabetes (>9.0%)*
   - *Plan All-Cause Readmissions*
   - *Prenatal and Postpartum Care*
   - *Race, Ethnicity and Language Data Completeness*

2. For *Race, Ethnicity, and Language Data Completeness*, the Council agreed with the Health Equity Subgroup's recommendation to **modify the measure to require collection** according to OHS' recently released data standards.

October-December Meetings Recap (2 of 4)

3. The Council recommended **moving** *Follow-Up After Emergency Department Visit for Mental Illness (7-Day)* **from the Core Set to the Menu Set** for 2026.

4. The Council recommended **removing** *Asthma Medication Ratio* and *PCMH CAHPS* **from the Menu Set** for 2026.

5. The Council recommended **removing** *Follow-Up After Hospitalization for Mental Illness* **from the Menu Set** for 2026 and adding it to the list of measures that DSS may use to meet Medicaid-specific program needs.

October-December Meetings Recap (3 of 4)

6. The Council recommended **replacing** CMS' *Screening for Depression and Follow-Up Plan* in the 2026 **Menu Set** with NCQA's *Depression Screening and Follow-Up for Adolescents and Adults*.

7. The Council recommended **replacing** OHS' *Social Determinants of Health Screening* in the 2026 **Menu Set** with NCQA's *Social Needs Screening and Intervention*.

October-December Meetings Recap (4 of 4)

8. Finally, the Council recommended **retaining the following nine measures in the Menu Set** for 2026:

   - *Breast Cancer Screening*
   - *Cervical Cancer Screening*
   - *Chlamydia Screening*
   - *Colorectal Cancer Screening*
   - *Developmental Screening in the First Three Years of Life*
   - *Health Equity Measure*
   - *Immunizations for Adolescents*
   - *Kidney Health Evaluation for Patients with Diabetes*
   - *Well-Child Visits in the First 30 Months of Life*