CONNECTICUT
Health Strategy

Connecticut Aligned Measure Set
2026 Measures and Implementation Guidance

I. Introduction

The Connecticut Aligned Measure Set is a group of measures from which the Office of Health Strategy (OHS) requests insurers and Advanced Networks select measures for use in their value-based contracts. Advanced Network is OHS's term for an organized group of clinicians that come together for the purposes of contracting, or are an established billing unit 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.

The Connecticut Aligned Measure Set was first established in 2016 (as the Core Measure Set) as part of the CMS grant-funded State Innovation Model (SIM) Program. In 2020, OHS's Quality Council (originally formed as a part of the SIM program) was reconstituted and granted responsibility for maintaining the Aligned Measure Set.

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. The Aligned Measure Set serves to reduce the administrative burden on providers associated with operating under multiple, non-aligned contractual measure sets and to focus provider quality improvement efforts on prioritized state healthcare improvement opportunities.

This document puts forth guidance for 2026 implementation of the Connecticut Aligned Measure Set as recommended by the Quality Council and endorsed by OHS.

II. Connecticut Aligned Measure Set

For payers that voluntarily choose to adopt the measures, payers and Advanced Networks will select measures for use in their contracts from two categories of measures – the Core Set and the Menu Set. Additional details on the measures included in the Connecticut Aligned Measure Set can be found in the associated Measure Specifications document. **APPENDIX A. 2026 ALIGNED MEASURE SET** displays Core and Menu measures by domain (e.g., prevention, behavioral health, care coordination) in the 2026 Aligned Measure Set.

The Core Set includes measures that payers and Advanced Networks are expected to always use in their value-based contracts.

1. Colorectal Cancer Screening
2. Controlling High Blood Pressure
3. Glycemic Status Assessment for Patients with Diabetes (>9.0%)
4. Immunization for Adolescents (Combo 2)
5. Prenatal and Postpartum Care
6. Race, Ethnicity, and Language Data Completeness

Of note: OHS does not expect payers to utilize the prenatal and postpartum care measure in contracts with Advanced Networks that do not include obstetric providers.

The **Menu Set** includes all other measures from which payers and Advanced Networks may choose to supplement the Core measures in their value-based contracts.

1. Asthma Emergency Department Visits
2. Breast Cancer Screening
3. Cervical Cancer Screening
4. Child and Adolescent Well-Care Visits
5. Childhood Immunization Status (Combo 10)
6. Chlamydia Screening

7. Depression Screening and Follow-Up for Adolescents and Adults
8. Developmental Screening in the First Three Years of Life
9. Follow-up After Emergency Department Visit for Mental Illness (7-Day)
10. Health Equity Measure
11. Kidney Health Evaluation for Patients with Diabetes
12. Plan All-Cause Readmission
13. Social Need Screening and Intervention
14. Statin Therapy for Patients with Diabetes
15. Timely Follow-Up After Acute Exacerbations of Chronic Conditions
16. Unhealthy Alcohol Use Screening and Follow-Up
17. Well-Child Visits in the First 30 Months of Life

Of note:

- NCQA expanded the denominator age range for breast cancer screening to 40-74 years of age for measurement year 2025. The expanded age range should not be used in contracts with benchmarks that were calculated based on the prior (50-74 years) age range.
- The Health Equity Measure stratifies performance for four measures by race, ethnicity and language (REL).

III. Implementation Guidance

a. Commercial implementation timeframe - Commercial insurers choosing to adopt the Connecticut Aligned Measure Set and that have not done so yet should do so for implementation beginning 1/1/26 as contracts are renewed.

b. Department of Social Services (DSS) timeframe - DSS should align with the Connecticut Aligned Measure Set, where feasible. DSS has included additional measures that are not found in the Connecticut Core or Menu Sets. The Quality Council has agreed that DSS's use of the following non-aligned measures should be permitted to meet Medicaid-specific program needs:

    1. Ambulatory- ED Visits

2. Annual Fluoride Treatment (ages 1-4)
3. Follow-Up Care for Children Prescribed ADHD Medication
4. Follow-Up After Hospitalization for Mental Illness (7-day)
5. Metabolic Monitoring for Children and Adolescents on Antipsychotics
6. Oral Evaluation, Dental Services
7. Potentially Preventable Emergency Department Visits
8. Potentially Preventable Hospital Admissions
9. Readmissions within 30 days – Physical and Behavioral Health

c. Annual review process and timeframe - The Quality Council will conduct an annual review of the Connecticut Aligned Measure Set and finalize any recommended modifications to the measure set during Winter and Spring each year for the next calendar year.

d. Automatic incorporation of annual measure set modifications - If language is not already included in contracts, payers and Advanced Networks are encouraged to have future contract language state that annual changes to the Connecticut Aligned Measure Set shall be automatically incorporated into contracts effective the next contract performance year.

e. Voluntary adoption in full and not in part - Those choosing to adopt the Connecticut Aligned Measure Set should adopt the set in its entirety, i.e., payers and Advanced Networks should not use any additional measures in contracts beyond those included in the Aligned Measure Set.

f. Meaningful financial implications - While OHS is not recommending specific monetary values for measures, insurers should consider thresholds that motivate performance on the measures.

IV. Annual Review Process

The Quality Council will conduct an annual review process to maintain the Connecticut Aligned Measure Set. OHS staff will prepare information on the following topics for review by the Taskforce:

1. substantive specification changes to the measures in the current Connecticut Aligned Measure Set
2. each measure's status in the national measure sets of interests
3. adoption of measures in value-based contracts by public and private payers
4. the most recent state performance and opportunities for improvement in performance for measures based on benchmark comparison
5. any stakeholder recommended changes to the Aligned Measure Set

V. Guiding Principles for Use of Aligned Measure Set in Contracts

While the focus of the Aligned Measure Set is on aligning contractual quality measures and not on the broader terms of value-based contracts, OHS has developed a set of guiding principles for those seeking to implement the Aligned Measure Set. These guiding principles apply to all Aligned Measure Set measure categories used in contracts.

Selection of Core and Menu Measures

For those Advanced Networks and payers that choose to adopt the Aligned Measure Set, the Core Set should be adopted in full as these measures represent high priority improvement areas for Connecticut as determined by the Quality Council and endorsed by OHS. The Menu Set allows Advanced Networks and payers to supplement the Core Set but OHS recommends that contracts limit use of Menu measures to allow providers to focus on a limited number of opportunities for improvement. OHS further recommends that Menu measures selected for contract use should target identified improvement opportunities specific to the contracted Advanced Network's patient population.

Reasonable Benchmarks

OHS recommends that Advanced Networks and payers negotiate contractual benchmarks that:

- are not below the most recently assessed Advanced Network performance
- are achievable by the Advanced Network (achievement benchmarks should not be so far above the most recent Advanced Network performance as to discourage improvement efforts)

- reflect a reasonable understanding of high performance

The quality incentive program should not be structured in a way that penalizes Advanced Networks for caring for populations with higher clinical and/or social risk.

Adequate Denominators

Advanced Networks and payers should not use measures in contracts if denominators are too small to report a reliable measurement. Minimum denominator sizes to achieve reliable measurement may differ based on the measure type.[1] To the extent that any Core Measure does not meet a minimum denominator size standard, the insurer may elect not to include the measure when applying a performance incentive and/or disincentive provision in the contract.

For this purpose, the NQF definition of reliability of the measure score is used: "Reliability of the measure score refers to the proportion of variation in the performance scores due to systematic differences across the measured entities (or signal) in relation to random error (or noise)."[2] OHS staff will update this language, as necessary, to reflect any modifications to NQF's definition of reliability of the measure score. RAND Health's publication, "The Reliability of Provider Profiling: A Tutorial" (2009) provides further guidance on how to calculate reliability.[3]

Total Number of Measures for Use in a Contract

OHS aims to align the use of quality measures across contracts and to reduce administrative burden on providers. In pursuit of those aims, the OHS recommends that payers and Advanced Networks limit the number of measures used in any given contract to 15 or fewer (this number excludes hospital measures). Contracting dyads should also consider overall measurement burden and prioritization of measures addressing subpopulations experiencing disparities.

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[1] Sequist, T, Schneider E, Li A, et al. Reliability of Medical Group and Physician Performance Measurement in the Primary Care Setting. *Medical Care* 2011; 49(2):126-131. Available at: https://journals.lww.com/lww-medicalcare/Abstract/2011/02000/Reliability_of_Medical_Group_and_Physician.4.aspx (Accessed June 6, 2025).

[2] https://www.qualityforum.org/Measuring_Performance/Improving_NQF_Process/Measure_Testing_Task_Force_Final_Report.aspx#:~:text=Reliability%20and%20Validity,-A%20quality%20measure&text=Reliability%20refers%20to%20the%20repeatability,in%20the%20same%20time%20period (Accessed June 6, 2025).

[3] https://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR653.pdf (Accessed June 6, 2025).

Appendix A. 2026 Aligned Measure Set

#	Measure Name	CBE #	Steward	Source
	Core Measure Set (6)			
	Acute & Chronic Care (2)			
1	Controlling High Blood Pressure	0018	NCQA	EHR
2	Glycemic Status Assessment for Patients with Diabetes (>9%)	0059	NCQA	EHR
	Health Equity (1)			
3	Race, Ethnicity and Language Data Completeness	NA	CT OHS	EHR
	Prevention (3)			
4	Colorectal Cancer Screening	0034	NCQA	EHR
5	Immunizations for Adolescents (Combo 2)	1407	NCQA	Claims
6	Prenatal and Postpartum Care	1517	NCQA	EHR

Of note: OHS does not expect payers to utilize the prenatal and postpartum care measure in contracts with Advanced Networks that do not include obstetric providers.

#	Measure Name	CBE #	Steward	Source
	Menu Measure Set (17)			
	Acute & Chronic Care (3)			
1	Asthma Emergency Department Visits	1381	Alabama Medicaid	Claims
2	Kidney Health Evaluation for Patients with Diabetes	NA	NCQA	EHR
3	Statin Therapy for Patients with Diabetes	NA	NCQA	Claims
	Behavioral Health (2)			
4	Follow-up After Emergency Department Visit for Mental Illness (7-Day)	3489	NCQA	Claims
5	Unhealthy Alcohol Use Screening and Follow-Up	NA	NCQA	EHR
	Care Coordination (2)			
6	Plan All-cause Readmission	1768	NCQA	Claims
7	Timely Follow-Up After Acute Exacerbations of Chronic Conditions	3455	IMPAQ	Claims
	Health Equity (1)			
8	Health Equity Measure	NA	CT OHS	EHR

#	Measure Name	CBE #	Steward	Source
	Prevention (8)			
9	Breast Cancer Screening	2372	NCQA	Claims
10	Cervical Cancer Screening	0032	NCQA	Claims
11	Child and Adolescent Well-care Visits	NA	NCQA	Claims
12	Childhood Immunization Status (Combo 10)	0038	NCQA	Claims
13	Chlamydia Screening	0033	NCQA	Claims
14	Depression Screening and Follow-Up for Adolescents and Adults	NA	NCQA	HER
15	Developmental Screening in the First Three Years of Life	1448	OHSU	HER
16	Well-Child Visits in the First 30 Months of Life	1392	NCQA	HER
	Social Determinants of Health (1)			
17	Social Need Screening and Intervention	NA	NCQA	EHR

Of note:

- The Health Equity Measure was previously titled the *Race, Ethnicity and Language (REL) Stratification Measure*.
- NCQA expanded the denominator age range for breast cancer screening to 40-74 years of age for measurement year 2025. The expanded age range should not be used in contracts with benchmarks that were calculated based on the prior (50-74 years) age range.
- CBE #: Consensus Based Entity Number (formerly NQF #)
- CMS: Centers for Medicare & Medicaid Services
- NCQA: National Committee for Quality Assurance
- OHSU: Oregon Health & Science University