CONNECTICUT

Quality Council
December 19, 2024

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 November 21, 2024 Meeting Minutes — Vote
3:10 p.m.	Continue Annual Review of the Aligned Measure Set
4:50 p.m.	Public Comment
4:55 p.m.	Meeting Wrap-Up and Next Steps
5:00 p.m.	Adjournment

Approval of November 21, 2024 Meeting Minutes – Vote

Continue Annual Review of the Aligned Measure Set

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Reminder: The 2025 Aligned Measure Set

Core Set

1. Child and Adolescent Well-Care Visits
2. Controlling High Blood Pressure
3. Follow-Up After ED Visit for Mental Illness (7-Day)
4. Glycemic Status Assessment for Patients with Diabetes (>9.0%)
5. Plan All-Cause Readmission
6. Prenatal and Postpartum Care
7. Race, Ethnicity, and Language Data Completeness

Menu Set

1. Asthma Medication Ratio
2. Breast Cancer Screening
3. Cervical Cancer Screening
4. Chlamydia Screening in Women
5. Colorectal Cancer Screening

Menu Set (continued)

6. Developmental Screening in the First Three Years of Life
7. Follow-Up After Hospitalization for Mental Illness (7-Day)
8. Health Equity Measure
9. Immunizations for Adolescents (Combo 2)
10. Kidney Health Evaluation for Patients with Diabetes
11. Patient Centered Medical Home (PCMH) CAHPS Survey
12. Screening for Depression and Follow-Up Plan
13. Social Determinants of Health Screening
14. Statin Therapy for Patients with Diabetes
15. Transitions of Care
16. Well-Child Visits in the First 30 Months of Life

October and November 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 and November 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 and potentially replacing it in the Core Set with a different behavioral health measure.

4. The Council recommended **removing** *Asthma Medication Ratio* **from the Menu Set** for 2026 and researching alternative asthma measures for potential addition to the Set.

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 and November Meetings Recap (3 of 4)

6. The Council recommended **retaining the following eight 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*

October and November Meetings Recap (4 of 4)

- Finally, while discussing *Immunizations for Adolescents* during our last meeting, a member of the public noted that payer-reported immunization rates are lower than what rates appear to be when using CT WiZ.
  - Quality Council staff suggested that insurers access and use CT WiZ to supplement their immunization data, as is common practice in Rhode Island (using its own state version of CT WiZ). Council members expressed support for such action.
  - Since our last meeting, Council staff have learned that **Connecticut law does not authorize payers to directly access CT WiZ**.

Reminder: Measure Considerations

We will review the following types of data for each measure:

1. **Changes to the measure specifications** and use in existing measure sets, including as a Quality Benchmark.
2. **Measure use** in contracts by CT payers (identified via insurer survey)
3. **Evidence of health inequities**. Sources include:
   - 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
4. **Opportunity for improvement**
   - Commercial: We calculated weighted average **MY 2023** plan HEDIS performance from NCQA's Quality Compass relative to national commercial benchmarks.
   - Medicaid: MY 2023 DSS performance is not yet available. We compared **MY 2022** DSS HEDIS performance to NCQA's national Medicaid benchmarks.

Review Key

- As a reminder, 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

- As we review each measure, please consider whether you recommend…
  - retaining the measure;
  - changing the measure's status (e.g., Core to Menu), or
  - removing the measure from the Aligned Measure Set altogether.

PCMH CAHPS (Menu) (1 of 2)

Measure Steward: Agency for Healthcare Research and Quality
Data Source: Survey
National Measure Sets of Interest: None

Equity Analysis

- A national study of racial/ethnic differences in experiences with primary care in PCMH settings among Veterans found that Black, Hispanic, and Asian/Pacific Islander populations reported worse experiences than Whites with access, comprehensiveness, communication, and office staff helpfulness/courtesy (Jones et al., 2016).

Status/Measure Specification Changes	Insurer Measure Use (2025)	Commercial Performance (2023)	Medicaid Performance (2022)
No Changes to PCMH Item Set 3.0	1 payer	NA	NA

PCMH CAHPS (Menu) (2 of 2)

- During our last meeting, a member proposed include patient experience surveys without specifying an instrument. We agreed to revisit this proposal today.

Pros of the proposed approach	Cons of proposed approach
• Would lessen the need for provider organizations to conduct / pay for multiple surveys • Would allow provider organizations to continue using whichever survey they are accustomed to using • Payers have been unwilling to fund their own surveys, so this provides another mechanism for incorporating patient experience	• Payers would lack a basis for comparing performance across Advanced Networks, or against a benchmark • Relies upon each Advance Network survey vendor for a valid survey administration process

How do members recommend proceeding re: patient experience survey(s) in the 2026 Aligned Measure Set?

Screening for Depression and Follow-Up Plan (Menu) (1 of 4)

Measure Steward: Centers for Medicare & Medicaid Services
Data Source: Claims/Clinical Data
National Measure Sets of Interest: CMS Medicaid Child Core Set (Ages 12-17); CMS Medicaid Adult Core Set (Age 18+); CMS eCQMs; CMS MIPS; Core Quality Measures Collaborative Core Set; CMS AHEAD Model

Equity Analysis

- In CT, the percentage of adults who ever reported being told by a health professional that they have a depressive disorder is highest for White (19.9%) adults, followed by Multiracial (17.6%), Hispanic (17.7%), Black (11.7%) and Asian (8.5%) adults (America's Health Rankings, 2022).

Status/Measure Specification Changes	Insurer Measure Use (2025)	Commercial Performance (2023)	Medicaid Performance (2022)
No changes	2 payers	NA	NA

Screening for Depression and Follow-Up Plan (Menu)(2 of 4)

- When finalizing the 2024 Aligned Measure Set, the Quality Council recommended permitting the use of NCQA's ***Depression Screening and Follow-Up for Adolescents and Adults*** instead of this measure from CMS after one payer indicated that it was planning to move to using the NCQA measure. OHS accepted that recommendation.
- During our last Quality Council meeting, a provider expressed concern with permitting use of the NCQA measure because the measure uses LOINC codes; LOINC codes are not a part of claims submissions and therefore, the NCQA measure necessitates submission of supplemental data.

Screening for Depression and Follow-Up Plan (Menu) (3 of 4)

Measure Comparison

Measure | Steward	Description
Screening for Depression and Follow-Up Plan | CMS	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of or up to two days after the date of the qualifying encounter.
Depression Screening and Follow-Up for Adolescents and Adults | NCQA	The percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care within 30 days.

Screening for Depression and Follow-Up Plan (Menu)(4 of 4)

- For 2026, does the Quality Council recommend…

    1. Only permitting use of CMS' *Screening for Depression and Follow-Up Plan* and **not** NCQA's *Depression Screening and Follow-Up for Adolescents and Adults*?

    2. **Replacing** CMS' *Screening for Depression and Follow-Up Plan* in the Menu Set with NCQA's *Depression Screening and Follow-Up for Adolescents and Adults*?

    3. Continuing to permit use of either measure, and, if so, should the NCQA measure be formally included in the Menu Set?

Social Determinants of Health Screening (Menu) (1 of 5)

Measure Steward: CT Office of Health Strategy
Data Source: Survey
National Measure Sets of Interest: None

Equity Analysis

- Social risk factors contribute to health inequities.

Status/Measure Specification Changes	Insurer Measure Use (2025)	Commercial Performance (2023)	Medicaid Performance (2022)
No changes	1 payer*	NA	NA

Social Determinants of Health Screening (Menu) (2 of 5)

- During our last annual review, the Quality Council moved this measure from Core to Menu due to a lack of clarity in how to document that a screening was performed for patients that screen negative across domains.

- The Quality Council could consider replacing this homegrown measure with one of the similar measures that have been developed by national stewards (NCQA and CMS), as these measures specify the codes to use when documenting that a screening was performed.

Social Determinants of Health Screening (Menu) (3 of 5)

Social Need Screening and Intervention (NCQA)

- **Description**: The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
  - The measure specifications provide **LOINC codes** that can be used for both the screenings and for positive findings, depending on which eligible screening instrument is used.
  - The Quality Council considered this measure previously but did not adopt it because the measure requires use of electronic claims or EHR data only.

Social Determinants of Health Screening (Menu) (4 of 5)

Screening for Social Drivers of Health (CMS)

- **Description**: The percentage of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
  - Unlike the NCQA measure, this measure does not require the use of specific instruments and does not include the rate of positive screens.
  - The measure specifications indicate that **HCPCS Code M1207** should be used to indicate that a patient was screened.

Social Determinants of Health Screening (Menu) (5 of 5)

Measure | Steward	Description
Social Determinants of Health Screening | OHS	The percentage of attributed patients who were screened for food insecurity, housing security, transportation needs, utility assistance needs, and interpersonal violence using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results.
Social Needs Screening and Intervention | NCQA	The percentage of members who were screened, using prespecified instruments, at least once during the measurement period for unmet food, housing and transportation needs, and received a corresponding intervention if they screened positive.
Screening for Social Drivers of Health | CMS	The percentage of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

- **Does the Quality Council wish to retain the current measure in the 2026 Aligned Measure Set or replace it with the NCQA and/or CMS measure(s)?**

Statin Therapy for Patients with Diabetes (Menu)

Measure Steward: National Committee for Quality Assurance
Data Source: Claims
National Measure Sets of Interest: Core Quality Measures Collaborative Core Set

Description

The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:
1. ***Received Statin Therapy***. Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. ***Statin Adherence 80%.*** Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

Status/Measure Specification Changes	Insurer Measure Use (2025)	Commercial Performance (2023)	Medicaid Performance (2022)
Minor changes	1 payer	**Received Therapy**: 64% **Adherence**: 76%	NA

Transitions of Care (Menu)

Measure Steward: National Committee for Quality Assurance
Data Source: Claims/Clinical Data
National Measure Sets of Interest: Core Quality Measures Collaborative Core Set

Equity Analysis

- A national study of patient-perceived gaps during care transition found that Black patients were less likely than other patient groups to report completing a post-discharge follow-up visit or to receive prescribed medical equipment (Jones et al., 2022).

Status/Measure Specification Changes	Insurer Measure Use (2025)	Commercial Performance (2023)*	Medicaid Performance (2022)*
Minor changes	0 payers	NA	NA

* Performance is not available because this measure is specified as a Medicare-only measure. When the Quality Council was considering adding this measure in 2022, NCQA confirmed that this measure can be used for other lines of business.

Well-Child Visits in the First 30 Months of Life (Menu)

Measure Steward: National Committee for Quality Assurance
Data Source: Claims
National Measure Sets of Interest: CMS Medicaid Child Core Set

Equity Analysis

- DSS reported that in 2022, *Well-Child Visits in the First 15 Months* performance rates were highest for White members (82.6%), followed by Hispanic (82.2%), Asian (81.0%) and Black (76.5%) members. Well-child visits for age 15-30 months rates were highest for White members (88.4%), followed by Asian (85.9%), Hispanic (85.4%) and Black (81.8%) members (2022 health equity data provided by DSS).

Status/Measure Specification Changes	Insurer Measure Use (2025)	Commercial Performance (2023)	Medicaid Performance (2022)
Removed telehealth visits from numerator	6 payers	**First 15 Months:** 91%	**First 15 Months:** 79%
		15-30 Months: 96%	**15-30 Months:** 83%

OSC Feedback on Core Measures (1 of 2)

- Before we move on to considering new measures for addition to the Aligned Measure Set, we committed during our last meeting to revisiting the Core Measures and the feedback that OSC provided during our November meeting.

- As a reminder, the two Core measures for which OSC shared feedback were *Glycemic Status Assessment for Patients with Diabetes (>9.0%)* and *Prenatal and Postpartum Care.*

OSC Feedback on Core Measures (2 of 2)

- *Glycemic Status Assessment for Patients with Diabetes (>9.0%):*
  - There are limited lab results in administrative claims, leading to the need for supplemental data feeds, which are burdensome.
- *Prenatal and Postpartum Care:*
  - Under global billing arrangements, coding for prenatal care is not always captured.
  - Not all provider groups have obstetricians, which poses challenges for the measure since primary care physicians often aren't aware of pregnancies in the first trimester.
  - Delivery triggers the measure, which is too late for it to be actionable by primary care physicians.
  - OSC recommended requiring obstetricians to include initial prenatal visit codes on all delivery claims.

What are your reactions to OSC's feedback?

New Measures for Consideration

- We will now consider new measures for addition to the Aligned Measure Set, including:
  - **alternative asthma measures** to replace *Asthma Medication Ratio* in the Menu Set;
  - **alternative behavioral health measures** to replace *Follow-Up After Emergency Department Visit for Mental Illness* and *Follow-Up After Hospitalization for Mental Illness* in the Core and/or Menu Sets;
  - **new HEDIS measures** for MY2025, and
  - measures **recommended for addition by the Health Equity Subgroup.**

Alternative Asthma Measures

Measure Name | Steward	Description
Optimal Asthma Control | Minnesota Community Measurement	Composite measure of the percentage of pediatric and adult patients (ages 5-50) whose asthma is well-controlled as demonstrated by one of three age-appropriate patient-reported outcome tools and not at risk for exacerbation.
Asthma Control: Minimal Important Difference Improvement | American Academy of Allergy, Asthma, and Immunology (AAAAI)	The percentage of patients aged 12 years and older whose asthma is not well-controlled as indicated by one of three age-appropriate patient-reported outcome tools and who demonstrated a minimal important difference improvement upon a subsequent office visit during the 12-month period.
Asthma Action Plan | AAAAI	Percentage of patients aged 5 years and older with a diagnosis of asthma who received a written asthma action plan at one or more visits during the measurement period.
Pharmacologic Therapy for Persistent Asthma | AAAAI	Percentage of patients aged 5 years and older with a diagnosis of persistent asthma who were prescribed long-term control medication.

Do members wish to add any of these measures to the Aligned Measure Set for 2026?

Alternative Behavioral Health Measures (1 of 2)

- One HEDIS measure that it appears the Quality Council has not considered before, and which is included in the Core Quality Measures Collaborative's (CQMC) Behavioral Health Core Set, is:
  - ***Unhealthy Alcohol Use Screening and Follow-Up***: The percentage of members 18 years of age and older who were screened for unhealthy alcohol use using a standardized instrument and, if screened positive, received appropriate follow-up care within 60 days.

Alternative Behavioral Health Measures (2 of 2)

- In addition, CMS added a behavioral health measure to its Quality Payment Program for 2024 and beyond that may be of interest to the Quality Council:
  - ***Improvement or Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder***: The percentage of patients aged 18 years and older with a mental and/or substance use disorder who demonstrated improvement or maintenance of functioning based on results from the 12-item World Health Organization Disability Assessment Schedule or Sheehan Disability Scale 30 to 180 days after an index assessment.

Do members wish to add either of these measures for 2026?

New HEDIS Measures for MY 2025

- NCQA added three new HEDIS measures for MY 2025, all of which require use of electronic data only:
  1. ***Blood Pressure Control for Patients with Hypertension***: The percentage of members 18–85 years of age who had a diagnosis of hypertension and whose most recent blood pressure was <140/90 mm Hg during the measurement period.
  2. ***Documented Assessment After Mammogram***: The percentage of mammograms for members 40–74 years of age documented in the form of a breast imaging reporting and data system (BI-RADS) assessment within 14 days of the mammogram.
  3. ***Follow-Up After Abnormal Mammogram Assessment***: The percentage of inconclusive or high-risk BI-RADS assessments for members 40-74 years of age that received appropriate follow-up within 90 days of the assessment.

Do members wish to add any of these measures in the future?

Health Equity Subgroup Measure Recommendations

- As a reminder, OHS convened a Health Equity Subgroup this fall. The body met three times and provided recommendations to the Quality Council and OHS on how to advance health equity through the Aligned Measure Set.
  - In addition, to the Subgroup's recommended modifications to the existing equity measures in the Aligned Measure Set (which we have already discussed) the Subgroup recommended several measures for addition to the Set, the first of which is shown below.

Measure Name	Measure Steward	Description
Meaningful Access to Health Care Services for Persons Who Prefer a Language Other than English and Persons Who are Deaf or Hard of Hearing	Oregon Health Authority (OHA)	The percentage of member visits with interpreter need in which language access services were provided.

Health Equity Subgroup Measure Recommendations

- The Subgroup also recommended adding one of two similar measures; the Subgroup's preferred measure is below.

Measure Name	Measure Steward	Description
Achievement of External Standards for Health Equity	Massachusetts Executive Office of Health and Human Services (MA EOHHS)	This measure assesses progress towards and/or achievement of external standards related to health equity established by NCQA, The Joint Commission, and state-specific agencies, as applicable: 1. **Health Plans and Primary Care ACOs**: Progress towards/achievement of the NCQA Health Equity Accreditation 2. **All ACOs**: Achievement maintenance of state-specific ACO certification, if/where applicable. 3. **ACO's partnered hospitals**: Progress towards/achievement of The Joint Commission's Health Care Equity Certification Program

Health Equity Subgroup Measure Recommendations

- If Council members find the prior measure to be too burdensome, the Subgroup recommended adding the below measure instead.

Measure Name	Measure Steward	Description
Implementation of the National Culturally and Linguistically Appropriate Services (CLAS) Standards	Arizona Health Care Cost Containment System (AHCCCS)	Implementation shall include: 1. Completing an **organizational evaluation** of current practices and identifying a plan for implementing CLAS standards that are not yet in place. 2. Building and supporting a **culturally and linguistically diverse practice team**. **3. Offering language assistance services** to individuals who have limited English proficiency and/or other communication needs informed by the identified language needs of attributed members. 4. Designing, implementing, and improving programs that provide **culturally appropriate services** that meet the needs of attributed members.

Health Equity Subgroup Measure Recommendations

Do Council members wish to add any of the Subgroup's recommended measures to the Aligned Measure Set for 2026?

1. *Meaningful Access to Health Care Services for Persons Who Prefer a Language Other than English and Persons Who are Deaf or Hard of Hearing* (Oregon)
2. *Achievement of External Standards for Health Equity* (Massachusetts)
3. *Implementation of the National Culturally and Linguistically Appropriate Services Standards* (Arizona)

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, January 16th from 3-5 pm**.