CONNECTICUT QUALITY BENCHMARK INITIATIVE

Implementation Manual

Version 2.0

June 26, 2023

Version History

Version Number	Release Date	Summary of Changes
1.0	October 5, 2022	
1.1	November 2, 2022	• Updated specifications for Asthma Medication Ratio to request commercial performance in two age bands (ages 5 to 18 and ages 19 to 64) rather than one age band (ages 5 to 64).
2.0	June 26, 2023	• Removed Medical Professional Services (ID 105) from the list of Advanced Networks to be reported on. • Added Wellcare to the list of insurance carriers required to report Quality Benchmark data. • Clarified that OHS will not publicly report insurer and Advanced Network performance for measures that do not meet a minimum denominator size. • Clarified that for clinical data measures, insurers may calculate performance using a sample rather than the full population, but carriers should not submit performance for clinical data measures calculated using only administrative data. • Updated specifications to reflect that insurance carriers should use NCQA-HEDIS® MY 2022 specifications for calendar year 2022 performance. • Added a new Appendix B with instructions for how the Department of Social Services (DSS) will submit Quality Benchmark data.

Table of Contents

I. Overview

On January 22, 2020, Governor Lamont signed Executive Order No. 5 directing the establishment of Quality Benchmarks and directing the Office of Health Strategy (OHS) to develop annual Quality Benchmarks for Calendar Year (CY) 2022-2025. In 2021, OHS selected seven Quality Benchmark measures and Benchmark values for phased implementation, per the recommendation of the OHS Quality Council, its key advisory body on quality measurement.[1] During the 2022 legislative session, §§217-223 of Public Act 22-118 codified Executive Order No. 5's provisions into law. It also created new reporting requirements for the Quality Benchmarks, including requiring that OHS collect and report on payer and provider entity performance on the Quality Benchmarks. This manual contains the technical and operational steps for collecting and reporting on the Quality Benchmarks.

OHS Contact Information: For questions about this manual or the data submission template, please contact Hanna Nagy at Hanna.Nagy@ct.gov.

Attachment 1. Quality Benchmark Performance Submission Template
https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Quality-Benchmark-Implementation-Manual

Definition of Key Terms

Advanced Network: 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. This term is equivalent to "provider entities" referenced in Public Act 22-118.

Health Care Effectiveness Data and Information Set (HEDIS®): Standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). These measures are designed to allow consumers and purchasers to compare plans against national or regional benchmarks.

Healthcare Cost Growth Benchmark ("Benchmark"): The targeted annual per person growth rate for Connecticut's total healthcare spending, expressed as the percentage growth from the prior year's per spending. The benchmark is set on a calendar year basis (i.e., benchmarks for each calendar year).

[1] Connecticut Office of Health Strategy. "Connecticut Quality Benchmarks." Accessed May 15, 2023 from https://portal.ct.gov/-/media/OHS/Quality-Council/Quality-Benchmarks/Quality-Benchmarks-Report-May-2022.pdf.

Insurance Carriers (Carriers): Private health insurance companies that offer one or more of the following: commercial insurance, benefit administration for self-insured employers, and Medicare Advantage.

Market: The highest levels of categorization of the health insurance market. For example, Medicare and Medicare MCO are collectively referred to as the "Medicare Market." Medicaid Fee-for-Service is referred to as the "Medicaid Market." Individual, self-insured, small and large group, and student health insurance markets are collectively referred to as the "Commercial Market."

Measurement Year (MY): The measurement year is the calendar year for which Quality Benchmark performance is collected and reported.

National Committee for Quality Assurance (NCQA): A private organization that works to improve health care quality through the administration of evidence-based standards, measures, programs and accreditation.

Net Cost of Private Health Insurance (NCPHI): The costs to Connecticut residents associated with the administration of private health insurance (including Medicare Advantage). It is defined as the difference between premiums earned and benefits incurred, and includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs, net additions or subtractions from reserves, rate credits and dividends, premium taxes and profits or losses.

Payer: A term used to refer collectively to both insurers and public programs that pay health care providers for health care services.

Quality Benchmarks: Annual measures and target values that all public and private payers, providers, and the State must work to achieve to improve healthcare quality in the State beginning on January 1, 2022 as per Executive Order No. 5 and Public Act 22-118. They are intended to ensure the maintenance and improvement of healthcare quality as the State in parallel implements the cost growth benchmark and the primary care spending target.

II. Quality Benchmark Measures and Values

This section includes the Quality Benchmark measures and values and provides an overview of OHS' process for establishing, reviewing and updating the measures and values.

A. Process for Establishing Quality Benchmarks

Executive Order No. 5 tasked OHS' Quality Council with providing recommendations on the Quality Benchmark measures and values. The Quality Council consists of healthcare providers, health insurers, patient advocates, consumer representatives, state agencies and other experts from across the Connecticut healthcare sector.[2] The Quality Council developed its recommendations for the Quality Benchmarks over the course of six meetings from June 2021 to December 2021. For a full description of the Quality Council's process for reviewing and recommending measures for the Quality Benchmark program, please see OHS' Connecticut Quality Benchmarks Report.

Quality Benchmark Measures

The Quality Council recommended seven measures for the Quality Benchmarks. OHS accepted the Quality Council's recommendations and decided to implement the measures in a phased approach to reduce reporting burden. Phase 1 measures became effective on January 1, 2022. Phase 2 measures will become effective on January 1, 2024. **Table 1** below includes the 2022-2025 Quality Benchmark measures.

Table 1. 2022-2025 Quality Benchmark Measures

Quality Benchmark Measure	Steward[3]	Description
Phase 1 Measures (2022-2025)		
Asthma Medication Ratio (Ages 5-18 and Ages 19-64)	NCQA	Percentage of patients (ages 5–18 and 19-64 years of age) who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year
Controlling High Blood Pressure	NCQA	Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement year
Hemoglobin A1c (HbA1c) Control for Patients with	NCQA	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

[2] A list of Quality Council members is available at: https://portal.ct.gov/OHS/Pages/Quality-Council/Members.
[3] CT OHS: Connecticut Office of Health Strategy
BRFSS: Behavioral Risk Factor Surveillance System
NCQA: National Committee for Quality Assurance

Diabetes: HbA1c Poor Control		
Phase 2 Measures (2024-2025)		
Child and Adolescent Well-Care Visits	NCQA	Percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a primary care provider or an OB/GYN practitioner during the measurement year
Follow-up After Emergency Department (ED) Visit for Mental Illness (7-day)	NCQA	Percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit
Follow-up After Hospitalization Visit for Mental Illness (7-day)	NCQA	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge
Obesity Equity Measure	CT OHS (using data from BRFSS)	A ratio of statewide obesity rates for the Black, non-Hispanic population and the White, non-Hispanic population

Quality Benchmark Values

After recommending Quality Benchmark measures, the Quality Council considered Benchmark values for each measure. The Quality Council recommended setting separate Benchmark values for each market, i.e., the commercial, Medicaid, and Medicare Advantage markets. This approach acknowledges that the baseline performance for each measure varies by market. To recommend Quality Benchmark values, the Council considered Connecticut's market-specific performance in 2019 and selected 2025 Benchmark values after considering market-specific national and New England performance. For each measure, the Quality Council strived to select 2025 Benchmark values that:

1. motivated meaningful quality improvement;
2. could reasonably be attained by 2025 and
3. are equally ambitious for each market (i.e., the difference in the baseline rate and the 2025 Benchmark value for each measure should be similar across markets).

The Quality Council also developed recommendations for interim annual Benchmark values for 2022, 2023 and 2024 for the Phase 1 Quality Benchmark measures. The Quality Council recommended setting the 2022 Benchmark value at the 2019 baseline rate and the Quality Council recommended setting 2023 and 2024 Benchmark values that reflected equal annual performance improvement.

For a full description of the Quality Council's process for recommending Quality Benchmark values for the Quality Benchmark program, please see OHS' Connecticut Quality Benchmarks Report.

OHS accepted the Quality Council's recommendations for Quality Benchmark values for all measures. **Table 2, Table 3,** and **Table 4** include the Benchmark values for the commercial, Medicaid, Medicare Advantage markets, respectively. **Table 5** includes the statewide Benchmark values for the *Obesity Equity Measure*.

Table 2. Commercial Quality Benchmark Values

Quality Benchmark Measure	2022 Value	2023 Value	2024 Value	2025 Value and Benchmark Range as of 2019	Percentage Point Improvement[4]
Phase 1 Measures					
Asthma Medication Ratio (Ages 5 – 18)	79%	81%	83%	86% Between the national commercial 50th and 75th percentiles	Three-year: 7% Annual: 2%
Asthma Medication Ratio (Ages 19 – 64)	78%	80%	82%	85% National commercial 90th percentile	Three-year: 7% Annual: 2%
Controlling High Blood Pressure	61%	63%	65%	68% Between the New England commercial 50th and 75th percentiles	Three-year: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c Poor Control[5]	27%	26%	25%	23% Between the national commercial 75th and 90th percentiles	Three-year: 4% Annual: 1%
Phase 2 Measures					
Child and Adolescent Well-Care Visits	TBD[6]	TBD	TBD	TBD	TBD
Follow-up After ED Visit for Mental Illness (7-day)	60%	N/A	N/A	75% Between the New England commercial 75th and 90th percentiles	Three-year: 15%
Follow-up After Hospitalization Visit for Mental Illness (7-day)	56%	N/A	N/A	63% Between the New England commercial 75th and 90th percentiles	Three-year : 7%

[4] Annual percentage point improvement values may not be even due to rounding.
[5] A lower rate indicated better performance.
[6] The Quality Council will set a Benchmark value for this measure in winter / spring 2023 once 2021 baseline data are available. The Council recommended against setting a Benchmark value based on 2020 data given the impact of COVID-19 on performance.

Table 3. Medicaid Quality Benchmark Values

Quality Benchmark Measure	2022 Value	2023 Value	2024 Value	2025 Value Benchmark Range as of 2019	Percentage Point Improvement[7]
Phase 1 Measures					
Asthma Medication Ratio (Ages 5 – 18)	66%	68%	70%	73% Between the national Medicaid 50th and 75th percentiles	Three-year: 7% Annual: 2%
Asthma Medication Ratio (Ages 19 – 64)	63%	65%	67%	70% Between the national Medicaid 75th and 90th percentiles	Three-year: 7% Annual: 2%
Controlling High Blood Pressure	61%	63%	65%	68% National Medicaid 75th percentile	Three-year: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c Poor Control[8]	37%	36%	35%	33% National Medicaid 75th percentile	Three-year: 4% Annual: 1%
Phase 2 Measures					
Child and Adolescent Well-Care Visits[9]	TBD	TBD	TBD	TBD	TBD
Follow-up After ED Visit for Mental Illness (7-day)	50%	N/A	N/A	65% National Medicaid 90th percentile	Three-year: 15%
Follow-up After Hospitalization Visit for Mental Illness (7-day)	48%	N/A	N/A	55% New England Medicaid 90th percentile	Three-year: 7%

[7] Annual percentage point improvement values may not be even due to rounding.
[8] A lower rate indicates better performance.
[9] The Quality Council will set a Benchmark value for this measure in 2023 once 2022 baseline data are available. The Council recommended against setting a Benchmark value based on 2020 data given the impact of COVID-19 on performance.

Table 4. Medicare Advantage Quality Benchmark Values

Quality Benchmark Measure	2022 Value	2023 Value	2024 Value	2025 Value and Benchmark Range as of 2019	Percentage Point Improvement[10]
Phase 1 Measures					
Controlling High Blood Pressure	73%	75%	77%	80% National Medicare Advantage 75th percentile	Three-year: 7% Annual: 2%
HbA1c Control for Patients with Diabetes: HbA1c Poor Control[11]	20%	18%	16%	15% National Medicare Advantage 75th percentile	Three-year: 5% Annual: 2%

Table 5. Statewide Quality Benchmark Values

Quality Benchmark Measure	2022 Value	2023 Value	2024 Value	2025 Value and Benchmark Range as of 2019	Improvement
Phase 2 Measures					
Obesity Equity Measure[12]	1.65	N/A	N/A	1.33 National rate	Three-year: 0.32

B. Process for Reviewing and Updating Quality Benchmark Measures and Values

OHS staff will review measure specifications in September of the measurement year to determine if there have been any major specification changes. For NCQA measures, OHS will review measure specifications (released by August 1 of the year preceding the measurement year) to determine whether there has been a substantive change. OHS will solicit feedback from the Quality Council before deciding if the NCQA specification changes are substantive.[13] During the measurement year, OHS will consult NCQA's measure trending determinations (released in the summer of each measurement year) to confirm the Quality Council's assessment whether any changes were substantive (i.e., caused a "break in trending"). For the Obesity Equity Measure, OHS will review changes in the BRFSS survey questions, the method of distribution, the population receiving the

[10] Annual percentage point improvement values may not be even due to rounding.
[11] A lower rate indicates better performance.
[12] A rate of 1 indicates that the statewide obesity rates for both populations are identical.
[13] OHS may assess whether the change is substantive by comparing the year-over-year trend in national median performance for the measurement year in which the substantive change occurred to prior measurement years. This assessment is not always reliable, however, if there are other major changes that are likely to impact measure performance (e.g., COVID-19, changes in insurance coverage).

survey, and any other difference that might affect the comparison. OHS will solicit feedback from the Quality Council before deciding if the BRFSS survey changes are substantive.

If the change is considered substantive, OHS will solicit feedback from the Quality Council in October of the measurement year on the following options:

1. Remove the Quality Benchmark measure for the affected and future measurement years and discuss including an alternate measure instead.
2. Reset the Quality Benchmark value for the affected and future measurement years (using the same methodology in place to develop the initial values).
3. Maintain the original Quality Benchmark measure and value and re-evaluate after the next measurement period.

OHS will decide, using feedback from the Quality Council, how to address the substantive change by November of the measurement year. It will communicate the change to all measured Advanced Networks and payers.

C. Public Reporting of Quality Benchmark Performance

This section contains details about how OHS will report performance on the Quality Benchmarks, including the levels at which performance will be reported and the reporting timeline.

Levels of Reporting

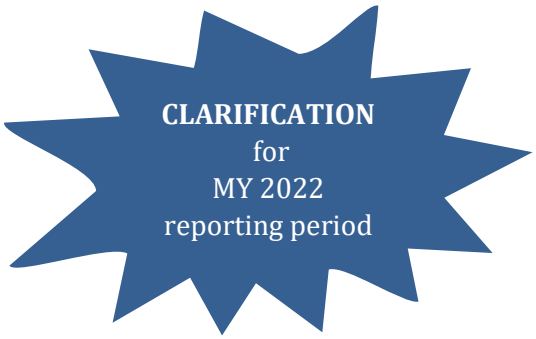
OHS will report performance on the Quality Benchmark Measures at three different levels:

1. **Market-level performance** for each measure for each market (commercial, Medicare Advantage, Medicaid)
2. **Insurer-level performance** for each measure across Advanced Networks for each market (commercial, Medicare Advantage, Medicaid)
3. **Advanced Network-level performance** for each measure across insurers for each market (commercial, Medicare Advantage, Medicaid)

This manual specifies OHS' request for commercial and Medicare Advantage performance on the Quality Benchmark Measures (**Appendix A**). OHS will obtain Medicaid performance on the Quality Benchmark Measures from the Connecticut Department of Social Services (DSS) (**Appendix B**).

OHS will compare performance at all three levels to the applicable Quality Benchmarks. When OHS has collected multiple years of data, it will publish year-over-year performance to display changes over time.

Minimum Denominator Size for Public Reporting: At the insurer and Advanced Network-levels, OHS will not report performance for measures with denominators less than 30, consistent with NCQA's minimum denominator size for its Effectiveness of Care measures.



Timeline for Measuring and Reporting Quality Benchmark Performance

OHS collected baseline MY 2021 data for the Phase 1 Quality Benchmarks in November 2022 and reported on statewide baseline performance by market in April 2023.

Beginning with MY 2022 data, OHS will follow a specific timeline to collect and report payer and Advanced Network performance, as required by Public Act 22-118:

- Not later than **August 15, 2023**, and annually thereafter, each payer shall submit Quality Benchmark performance data.
- Not later than **March 31, 2024**, and annually thereafter, OHS shall prepare and post a report concerning the Quality Benchmark performance data reported by payers and Advanced Networks.
- Not later than **May 1, 2024,** and annually thereafter, OHS shall identify, and notice within 30 days, each payer or Advanced Network that exceeded the Quality Benchmarks for the performance year.

- Not later than **June 30, 2024**, and annually thereafter, OHS shall hold an informational public hearing to compare the performance of payers and provider entities in the performance year to the Quality Benchmarks. Such hearing shall include an examination of:
    - the information reported by March 31st as outlined above;
    - any other matters that OHS deems relevant, including requiring participation from any payer or Advanced Network that failed to meet any of the Quality Benchmarks during the performance year.
- Not later than **October 15, 2024**, and annually thereafter, OHS shall prepare and submit a report to the General Assembly. The report shall:
    - describe healthcare quality trends in the state and the factors underlying such trends;
    - include the information reported by March 31st as outlined above;
    - disclose OHS' recommendations, if any, concerning strategies to improve the quality of the state's healthcare system, including, but not limited to, any recommended legislation concerning the state's health care system.

D. Insurers Required to Submit and Advanced Networks upon Which Insurers Will Report

OHS will collect measure-specific performance from payers, including:

i. insurance carriers that report data for the Cost Growth Benchmark for the commercial (i.e., the fully-insured, self-insured and student markets) and Medicare Advantage markets (excluding dual eligibles) and
ii. DSS for the Medicaid market (excluding dual eligibles).

Table 6. Insurance Carriers Requested to Report Measure Performance by Market

Carrier	Commercial Fully and Self-Insured	Medicare Advantage
Aetna Health & Life	X	X
Anthem	X	X
Cigna	X	
ConnectiCare	X	X
UnitedHealthcare	X	X
Wellcare		X

Appendix A: Insurer Quality Benchmark Performance Data Specification

This carrier Quality Benchmark performance data specification provides technical details to assist insurers in reporting quality data to OHS.

A. Quality Benchmark Excel File Submission Instructions and Schedule

The Quality Benchmark data submission file layout for insurance carriers is included in this Appendix. Carriers will submit Quality Benchmark performance using the Excel template provided by OHS according to the schedule outlined in **Table A-1**. Carriers will submit Quality Benchmark data annually.

Table A-1. Insurance Carriers' Quality Benchmark Filing Schedule

Date	Files Due
August 15, 2023	MY 2022 Phase 1 Quality Benchmark Measures
August 15, 2024	MY 2023 Phase 1 Quality Benchmark Measures
August 15, 2025	MY 2024 Phase 1 & Phase 2 Quality Benchmark Measures
August 15, 2026	MY 2025 Phase 1 & Phase 2 Quality Benchmark Measures

After carriers submit their data according to the filing schedule, they must actively engage with OHS as it validates the data to ensure such data were submitted using the specifications outlined in this Implementation Manual. OHS will engage the carriers one-on-one to discuss the initial analysis of data, and once again to review final data before they are published. OHS also expects carriers to engage in data sharing with Advanced Networks whose performance will be publicly reported to describe and explain any discrepancies in performance with that assessed for use in value-based payment contracts.

B. General Guidance for Quality Benchmark Data Reporting

The performance data that insurers submit to OHS in response to this request should align with what is calculated for contractual purposes with Advanced Networks for all Quality Benchmark measures. If insurers did not include a Quality Benchmark in contracts with Advanced Networks for MY 2022, they need not report MY 2022 performance for the Quality Benchmark. Please note that two of the three Quality Benchmark measures (*Controlling High Blood Pressure* and *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control)* are Core measures in OHS' 2023 Aligned Measure Set, meaning that OHS requests insurers use these measures in all value-based Advanced Network contracts.

C. Quality Data Specifications

Eligible Population for All Measures: All Quality Benchmark measures should be calculated with members attributed to Advanced Networks during the measurement year, pursuant to all contracts between the insurer and an Advanced Network that include Quality Benchmark measures. Members can be attributed monthly, quarterly, annually, or at another frequency, so long as the attribution timing is consistent with the insurer contract.

Note: Unlike for the Healthcare Cost Growth Benchmark, for which performance measurement is limited to Connecticut residents, quality performance data may include all patients attributed to an Advanced Network, including those who reside outside of Connecticut.

Performance for Clinical Data Measures: For clinical data measures, insurers may calculate performance using a sample rather than the full population. Carriers should not submit performance for clinical data measures calculated using only administrative data. If a carrier submits an administrative-only rate for a clinical data measure, OHS will not use this rate when calculating performance at the state, market, insurer or Advanced Network levels.

D. Advanced Network Organization IDs

The following Advanced Networks are to be reported on using the identification number listed in **Table A-2** below. This list of Advanced Networks may be updated from time to time as the Advanced Network market changes.

Note: Unlike as for the Healthcare Cost Growth Benchmark, OHS is not requesting a separate category of quality performance data for members who are unattributed to an Advanced Network.

Table A-2. Advanced Network Organizational Identification Number for Quality Benchmark Reporting

Advanced Network	Organizational Identification Number
Community Medical Group	101
Connecticut Children's Medical Center	102
Connecticut State Medical Society IPA	103
Integrated Care Partners	104
Northeast Medical Group	106
OptumCare Network of Connecticut	107
Prospect Connecticut Medical Foundation Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings)	108
Southern New England Health Care Organization (aka SOHO Health, Trinity Health of New England ACO, LLC)	109
Value Care Alliance	110

Advanced Network	Organizational Identification Number
ProHealth	111
Charter Oak Health Center	112
CIFC Greater Danbury Community Health Center	113
Community Health and Wellness Center of Greater Torrington	114
Community Health Center	115
Community Health Services	116
Cornell Scott Hill Health Center	117
Fair Haven Community Health Center	118
Family Centers	119
First Choice Community Health Centers	120
Generations Family Health Center	121
Norwalk Community Health Center	122
Optimus Health Care, Inc.	123
Southwest Community Health Center, Inc.	124
Stamford Medical Group	125
Starling Physicians	126
UConn Medical Group	127
United Community and Family Services	128
WestMed Medical Group	129
Wheeler Clinic	130
Yale Medicine	131

E. Quality Benchmark Reporting File Specifications

Carriers should submit one Excel File using the template provided by OHS that includes its commercial and Medicare Advantage quality performance data. This section describes the detailed information that carriers should submit within the following tabs in the Excel file:

- Contents
- References Tables
- Commercial – 2022
- Medicare Advantage – 2022
- Mandatory Questions
- Validation by Market
- Validation by Advanced Network

Contents Tab

This tab contains information regarding what the Excel file includes. Carriers do not need to submit information within this tab.

Reference Tables Tab

This tab includes reference tables of key codes outlined herein for ease of reference and descriptions of the Quality Benchmark measures. Carriers do not need to submit information within this tab.

Commercial – 2022 Tab

Insurance Carrier Commercial Performance Table

Insurance Carrier Org ID: The OHS-assigned organization ID for the carrier submitting the file, which is outlined in **Table A-3**.

Table A-3. Insurance carriers' Organizational Identification Number for TME Reporting

Insurer	Organizational ID
Aetna Health & Life	201
Anthem	202
Cigna	203
ConnectiCare	204
UnitedHealthcare	206
Wellcare	208

Performance Period Beginning and Ending Dates: The dates for the beginning and ending of the period represented by the reported data. OHS requests that payers submit data for the performance year **beginning January 1 and ending December 31** to remain consistent with the Healthcare Cost Growth Benchmark and the payer measurement period reporting to NCQA.

Note: OHS recognizes that some carriers may have Advanced Network contracts that do not align with the calendar year. Carriers with contracts that do not align with the calendar year should still submit performance but indicate performance period start and end dates in their data submission. If the performance period bridges the calendar year, carriers should use the contract period that ended in the calendar year being requested (e.g., the period ending in 2022 for MY 2022 performance).

Numerator and Denominator Data: Commercial numerator and denominator data at the insurance carrier level following the specifications for each Phase 1 Quality Benchmark Measure listed in **Table A-4**.

Table A-4. Phase 1 Quality Benchmark Measures and Technical Specifications

Quality Benchmark Measure	Steward	Data Source/Technical Specifications
Asthma Medication Ratio (Ages 5-18 and ages 19-64)	NCQA	Admin NCQA-HEDIS® MY 2022
Controlling High Blood Pressure	NCQA	Admin/Clinical Data

		NCQA-HEDIS® MY 2022
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control	NCQA	Admin/Clinical Data NCQA-HEDIS® MY 2022

Advanced Network Commercial Performance Table

Advanced Network Organization ID: The OHS Organization ID of the Advanced Network, as listed in **Table 8.**

Note: Unlike as for the Healthcare Cost Growth Benchmark, OHS is not requesting a separate category of quality performance data for members who are unattributed to an Advanced Network.

Numerator and Denominator Data: Commercial numerator and denominator data at the Advanced Network level following the specifications for each Phase 1 Quality Benchmark measure listed in **Table 10**.

Medicare Advantage – 2022 Tab

Insurance Carrier Medicare Advantage Performance Table

Insurance Carrier Org ID: The OHS-assigned organization ID for the carrier submitting the file, which is outlined in **Table A-5**.

Table A-5. Insurance carriers' Organizational Identification Number for TME Reporting

Insurer	Organizational ID
Aetna Health & Life	201
Anthem	202
Cigna	203
ConnectiCare	204
UnitedHealthcare	206
Wellcare	208

Performance Period Beginning and Ending Dates: The dates for the beginning and ending of the period represented by the reported data. OHS requests that payers submit data for the performance year **beginning January 1 and ending December 31** to remain consistent with the Healthcare Cost Growth Benchmark and the payer measurement period reporting to NCQA.

Note: OHS recognizes that some carriers may have contracts that do not align with the calendar year. Carriers with contracts that do not align with the calendar year should still submit performance but indicate performance period start and end dates in their data submission. If the performance period bridges the calendar year, carriers should use the contract period that ended in the calendar year being requested (e.g., the period ending in 2022 for MY 2022 performance).

Numerator and Denominator Data: Medicare Advantage numerator and denominator data at the insurance carrier level following the specifications for each Phase 1 Quality Benchmark Measure listed in **Table 10** (with the exception of *Asthma Medication Ratio*, which is a commercial and Medicaid-only measure).

Advanced Network Medicare Advantage Performance Table

Advanced Network Organization ID: The OHS Organization ID of the Advanced Network, as listed in **Table 8.**

Note: Unlike as for the Healthcare Cost Growth Benchmark, OHS is not requesting a separate category of quality performance data for members who are unattributed to an Advanced Network.

Numerator and Denominator Data: Medicare Advantage numerator and denominator data at the Advanced Network level following the specifications for each Phase 1 Quality Benchmark measure listed in **Table 10** (with the exception of *Asthma Medication Ratio*, which is a commercial and Medicaid-only measure).

Mandatory Questions Tab

Insurers should answer questions about their data submission to ensure the submission is in alignment with the specifications outlined in this implementation manual.

Validation by Market Tab

This tab uses insurer-provided information from the Commercial and Medicare Advantage tabs to flag potentially aberrant rates and numerators/denominators. These summary tables are intended to help insurers validate their own data prior to submission to OHS.

Insurers are not required to input any data in this tab, but should review it prior to submitting to ensure the data are correct.

Validation by Advanced Network Tab

This tab uses insurer-provided information from the Commercial and Medicare Advantage tabs to flag potentially aberrant rates and numerators/denominators. These summary tables are intended to help insurers validate their own data prior to submission.

Insurers are not required to input any data in this tab but should review it prior to submitting to ensure the data are correct.

F. File Submission

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

Insurance Carrier Name_QualityBenchmarks_YYYY_Version.xls

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx

Below are examples of valid file names:

CARRIER A_QualityBenchmarks_2022_01.xlsx or CARRIER A_QualityBenchmarks_2022_1.xlsx or CARRIER A_QualityBenchmarks_2022.xlsx

Submitting Files to OHS

Electronic files are to be submitted through the State's secure file transfer (SFT) server at https://sft.ct.gov/ to OHS.

OHS will provide a contact form at https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Payer-Data-Portal for the carrier's contact(s) to fill out and email to OHS. This information is required:

- To facilitate user access to the State's SFT Web Client;
- To confirm the user is the authorized and designated contact for the carrier at registration;
- To facilitate securing and protecting confidential data;
- To enable OHS communicate with the contact about data error correction and validation, system or process changes and updates.

The contact should fill out the form and email it to OHS@ct.gov. OHS will acknowledge receipt of the filled form, credential and grant the contact/new user access to the State's network within two business days. Upon receiving the credentials to access the server, the authorized user will upload the required data files. The contact must alert OHS through email after uploading the file(s).

Appendix B: CT DSS Medicaid Quality Benchmark Performance Data Specification

This Quality Benchmark performance data specification provides technical details to assist the Department of Social Services (DSS) in reporting quality data to OHS.

A. Quality Benchmark Submission Instructions and Schedule

DSS will submit Quality Benchmark performance annually to OHS according to the schedule outlined in **Table B-1**. DSS will submit its Quality Benchmark data using its own Excel report format.

B-1. Insurance Carriers' Quality Benchmark Filing Schedule

Date	Files Due
August 15, 2023	MY 2022 Phase 1 Quality Benchmark Measures
August 15, 2024	MY 2023 Phase 1 Quality Benchmark Measures
August 15, 2025	MY 2024 Phase 1 & Phase 2 Quality Benchmark Measures
August 15, 2026	MY 2025 Phase 1 & Phase 2 Quality Benchmark Measures

After DSS submits its data according to the filing schedule, OHS will engage with DSS as it validates the data to ensure such data were submitted using the specifications outlined in this Implementation Manual. OHS will also engage with DSS to discuss the initial analysis of data, and once again to review final data before they are published.

B. Quality Data Specifications

DSS will report numerators, denominators, and performance rates by program (HUSKY A/B, HUSKY C, and HUSKY D) and statewide[14] for the Quality Benchmark measures. DSS should submit performance following the specifications for each Phase 1 Quality Benchmark Measure listed in **Table B-2** below. DSS will report numerators, denominators, and performance rates by Advanced Network for the Quality Benchmark measures that are in DSS' PCMH+ Wave 3 Quality Measure Set using the Advanced Network Organization IDs in **Table B-3** below. DSS data will exclude Medicare/Medicaid dual eligible members and Third Party Liability (TPL) policies from Quality Benchmark performance data.

B-2. Phase 1 Quality Benchmark Measures and Technical Specifications

Quality Benchmark Measure	Steward	Data Source/Technical Specifications

[14] The statewide rate for the hybrid measures will be a weighted average of HUSKY A/B, HUSKY C, and HUSKY D.

Asthma Medication Ratio (Ages 5-18 and ages 19-64)	NCQA	Admin NCQA-HEDIS® MY 2022
Controlling High Blood Pressure	NCQA	Admin/Clinical Data NCQA-HEDIS® MY 2022
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Poor Control	NCQA	Admin/Clinical Data NCQA-HEDIS® MY 2022

C. Advanced Network Organization IDs

DSS will report on Advanced Networks using the identification numbers listed in **Table B-3** below. This list of Advanced Networks may be updated from time to time as the Advanced Network market changes.

DSS will only report performance by Advanced Network for measures calculated using administrative data (i.e., not for hybrid measures). For the Phase 1 Quality Benchmark measures, DSS will only report performance by Advanced Network for *Asthma Medication Ratio* (ages 5-18 and ages 19-64).

Note: Unlike as for the Healthcare Cost Growth Benchmark, OHS is <u>not</u> requesting a separate category of quality performance data for members who are unattributed to an Advanced Network.

B-3. Advanced Network Organizational Identification Number for Quality Benchmark Reporting

Advanced Network	Organizational Identification Number
Community Medical Group	101
Connecticut Children's Medical Center	102
Connecticut State Medical Society IPA	103
Integrated Care Partners	104
Northeast Medical Group	106
OptumCare Network of Connecticut	107
Prospect Connecticut Medical Foundation Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings)	108
Southern New England Health Care Organization (aka SOHO Health, Trinity Health of New England ACO, LLC)	109
Value Care Alliance	110
ProHealth	111
Charter Oak Health Center	112
CIFC Greater Danbury Community Health Center	113
Community Health and Wellness Center of Greater Torrington	114
Community Health Center	115

Advanced Network	Organizational Identification Number
Community Health Services	116
Cornell Scott Hill Health Center	117
Fair Haven Community Health Center	118
Family Centers	119
First Choice Community Health Centers	120
Generations Family Health Center	121
Norwalk Community Health Center	122
Optimus Health Care, Inc.	123
Southwest Community Health Center, Inc.	124
Stamford Medical Group	125
Starling Physicians	126
UConn Medical Group	127
United Community and Family Services	128
WestMed Medical Group	129
Wheeler Clinic	130
Yale Medicine	131

Submitting Files to OHS

Electronic files are to be submitted through the State's secure file transfer (SFT) server at https://sft.ct.gov/ to OHS.

OHS will provide a form at https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Payer-Data-Portal for the carrier's contact(s) to fill out and email to OHS. This information is required:

- To facilitate user access to the State's SFT Web Client;
- To confirm the user is the authorized and designated contact for the carrier at registration;
- To facilitate securing and protecting confidential data;
- To enable OHS communicate with the contact about data error correction and validation, system or process changes and updates.

The contact should fill out the form and email it to OHS@ct.gov. OHS will acknowledge receipt of the filled form, credential and grant the contact/new user access to the State's network within two business days. Upon receiving the credentials to access the server, the authorized user will upload the required data files. The contact must alert OHS through email after uploading the file(s).