Quality Council
June 15, 2023

OHS
CONNECTICUT
Office *of* Health Strategy

Agenda

Time	Topic
4:00 p.m.	Call to Order and Roll Call
4:05 p.m.	Public Comment
4:10 p.m.	Approval of May 18, 2023 Meeting Minutes — Vote
4:15 p.m.	2023 Insurer Fidelity Assessment
4:45 p.m.	Finalize 2024 Aligned Measure Set Recommendations
5:15 p.m.	Discuss Implementation Guidance for Aligned Measure Set
5:50 p.m.	Wrap-up and Next Steps
6:00 p.m.	Adjourn

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Call to Order and Roll Call

Public Comment

Approval of May 18, 2023 Meeting Minutes—Vote

2023 Insurer Fidelity Assessment

Reminder about Quality Council Insurer Survey

- The purpose of the OHS Quality Council Insurer Survey is to capture the measures in use by payers in value-based contracts with Advanced Networks.*
- The 2023 survey captured:
  - **Measures in use** in contracts effective beginning on or after January 1, 2023
  - Whether the measures had **Pay-for-Performance or Pay-for-Reporting** status in contracts
  - **Number of contracts** in which measures were used
  - Payer **stratification** of measures by race, ethnicity and/or language
  - Measures with **modified specifications** and **homegrown measures**

***Advanced Networks** are defined by OHS as large provider entities that are or could be engaged in a total cost of care contract with one or more payers.

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Insurer 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, resource use measures).

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

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Important Notes about Insurer Fidelity Scores

- 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 an annual basis and contracts are multi-year.
  - OHS does not expect insurers and Advanced Networks to make changes in contract measures mid-contract.
- Insurers may be using **similar measures** as those in the Aligned Measure Set, but with different specifications or stewards.
  - For example, an insurer would not get credit towards their fidelity score for using *HbA1c Control (<8.0%)* (not in the Aligned Measure Set) rather than *HbA1c Poor Control (>9.0%)* (in the Aligned Measure Set).

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Insurer Fidelity Scores (2 of 4)

Connecticut Fidelity Scores						
Year	Commercial	Aetna	Anthem	Cigna	ConnectiCare	UnitedHealthcare
2022	46%	40%	40%	88%	86%	51%
2023	**73%**	**81%**	**69%**	**77%**	**67%**	**56%**

Insurer Fidelity Scores (4 of 4)

- Phase 1 Quality Benchmark Measure Use:
  - ***Asthma Medication Ratio***: Four out of five commercial insurers are using this measure in 2023 contracts.
  - ***Controlling High Blood Pressure***: Four out of five commercial insurers are using this measure in 2023 contracts.
  - ***HbA1c Poor Control (>9.0%)*****:** Four out of five commercial insurers are using this measure in 2023 contracts.

Finalize 2024 Aligned Measure Set Recommendations

Follow-up Tasks from the May 18th Meeting

- During the May 18th meeting, the Quality Council recommended retaining *Follow-up After Emergency Department Visit for Mental Illness* in the Core Set for the Medicaid population but did not come to consensus on placement for the commercial population.
- OHS will request denominator data from commercial insurers that indicated they are using the measure in the 2023 Insurer Survey so that the Quality Council can make a more informed recommendation next year regarding the measure's status.

Summary of Annual Review Recommendations

- During the March, April and May meetings, the Quality Council reviewed each of the measures in the 2023 Aligned Measure Set, as well as additional candidate measures for possible addition.
- The Quality Council recommended **elevating one measure** from the Menu Set to the Core Set:
  1. *Social Determinants of Health Screening*
- The Quality Council recommended **adding two new measures** to the Menu Set:
  1. *Maternity Care: Postpartum Follow-up and Care Coordination*
  2. *Use of Opioids at High Dosage*

Consider Size of the Measure Set

- The Quality Council's recommended 2024 Aligned Measure Set contains **28 measures** (not including the two Medicaid-only measures).
- Are there any measures that the Quality Council recommends removing from the 2024 Aligned Measure Set?
  - Please keep in mind that the aim of the Aligned Measure Set is to (a) reduce administrative burden on providers associated with operating under many quality measures and (b) focus provider quality improvement efforts on prioritized state healthcare improvement opportunities.

Recommended 2024 Aligned Measure Set

1. **Child and Adolescent Well-Care Visits**
2. **Controlling High Blood Pressure**
3. **Follow-Up After Emergency Department Visit for Mental Illness (7-Day)**
4. **Health Equity Measure**
5. **Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9%)**
6. **Plan All-Cause Readmission**
7. **Prenatal and Postpartum Care**
8. **Social Determinants of Health Screening** *[elevated to the Core for 2024]*
9. Asthma Medication Ratio
10. Behavioral Health Screening*
11. Breast Cancer Screening
12. Cervical Cancer Screening
13. Chlamydia Screening in Women
14. Colorectal Cancer Screening
15. Concurrent Use of Opioid and Benzodiazepines
16. Developmental Screening in the First Three Years of Life
17. Eye Exam for Patients with Diabetes
18. Follow-Up Care for Children Prescribed ADHD Medication
19. Follow-Up After Hospitalization for Mental Illness (7-Day)
20. Immunizations for Adolescents (Combo 2)
21. Kidney Health Evaluation for Patients with Diabetes
22. Maternity Care: Postpartum Follow-up and Care Coordination *[NEW for 2024]*
23. Metabolic Monitoring for Children and Adolescents*
24. PCMH CAHPS Survey
25. Screening for Depression and Follow-Up
26. Substance Use Assessment in Primary Care
27. Transitions of Care
28. Use of Opioids at High Dosage *[NEW for 2024]*
29. Use of Pharmacotherapy for Opioid Use Disorder
30. Well-Child Visits in the First 30 Months of Life

*Medicaid-only measure
Core Measures are in bold

Consider Size of the Measure Set (Cont'd)

- The table below compares the size of the Quality Council's recommended 2024 Aligned Measure Set to the size of the 2023 Rhode Island and Massachusetts Measure Sets.

	CT 2023 Aligned Measure Set*	**CT 2024 Aligned Measure Set*** *(as recommended by the Quality Council)*	**RI 2023 ACO Measure Set**	**MA 2023 ACO Measure Set**
# Core Measures	7	8	9	6
# Menu Measures	19	20	11	22
TOTAL Measures (Core and Menu)	26	28	20	28

*Excludes Connecticut's two Medicaid-only measures.

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Consider Size of the Measure Set (Cont'd)

- When considering whether to recommend removing any measures from the Aligned Measure Set, the Quality Council could consider:
  1. Measures with **limited opportunity for improvement**
     - Bailit Health reviewed performance on the Aligned Measure Set measures and did not find any measures that were so high-performing as to warrant raising for the Quality Council's consideration.
  2. Measures that are **not currently in use** by payers
  3. How the Measure Set performs against the Quality Council's **"Criteria to Apply to the Measure Set as a Whole"**

Measures Not in Use in 2023 Contracts

- There were six measures (all Menu Measures) that were not in use by any insurance carriers in 2023 contracts, according to the 2023 Quality Council Insurer Survey:

1. *Developmental Screening in the First Three Years of Life*
2. *Follow-up After Hospitalization for Mental Illness (7-Day)**
3. *Follow-up Care for Children Prescribed ADHD Medication*
4. *Transitions of Care***
5. *Use of Pharmacotherapy for Opioid Use Disorder****

**Follow-up After Hospitalization for Mental Illness (7-Day)* is a Phase 2 Quality Benchmark Measure.
***Transitions of Care* was added to the 2023 Aligned Measure Set.
***No payers reported using *Use of Pharmacotherapy for Opioid Use Disorder* in the 2022 Insurer Survey.

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Criteria to Apply to the Measure Set as a Whole

1. Includes topics and measures for which there are opportunities to promote health equity by race, ethnicity, language and/or disability status.
2. Broadly address population health.
3. Prioritizes health outcomes, including measures sourced from clinical and patient-reported data.
4. Taken as a whole, high performance on the proposed measure set should significantly advance the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered (STEEEP) care.
5. Balances comprehensiveness and breadth with the need for parsimony to enable effective quality improvement.
6. Representative of the array of services provided, and the diversity of patients served, by the program.

Discuss Implementation Guidance for Aligned Measure Set

Implementation Guidance Overview (1 of 2)

- During the March 16th meeting, the Quality Council recommended that OHS publish a document with guidance for how payers and Advanced Networks should implement the Aligned Measure Set in contracts.
- OHS and Bailit Health are working on the implementation guidance, including guidance for (a) selection of Core and Menu measures, (b) reasonable benchmarks, (c) adequate denominators, and (d) total number of measures for use in a contract.

Implementation Guidance Overview (2 of 2)

- Today we would like your feedback on the following items:

1. **Implementation Guidance**
   - Expectations for payer implementation of the Aligned Measure Set.
2. **Guiding Principles for Use of the Aligned Measure Set in Contracts**
   - Recommendations for how to use Aligned Measure Set measures in contracts.

Implementation Guidance (1 of 2)

Category	Description
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 1/1/24 as contracts are renewed.
Department of Social Services (DSS) timeframe	DSS should align with the Connecticut Aligned Measure Set, where feasible.
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 Spring/Summer each year for the next calendar year.

Implementation Guidance (2 of 2)

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

Guiding Principles (1 of 4)

Guiding Principle	Description
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.

Guiding Principles (2 of 4)

Guiding Principle	Description
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), and • reflect a reasonable understanding of high performance. Furthermore, 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.

Guiding Principles (3 of 4)

Guiding Principle	Description
Adequate Denominators	**Payers and Advanced Networks 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. To the extent that any Core Measure does not meet a minimum denominator size standard, the insurer may elect to not 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)." www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=87595.

Other resources on calculating reliability:

- RAND Health. The Reliability of Provider Profiling: A Tutorial". 2009. Available at: https://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR653.pdf
- 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

Guiding Principle (4 of 4)

Guiding Principle	Description
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 • prioritizing measures addressing subpopulations experiencing disparities.

Wrap-up & Next Steps

Meeting Wrap-Up & Next Steps

Update: The Quality Council will <u>not</u> be meeting in July or August.

Appendix

Aligned Measure Set
Measure Selection Criteria

Measure Selection Criteria

- The Quality Council has defined three sets of measure selection criteria to guide its work in recommending measures to OHS for measure set inclusion.
  - **Criteria to apply to individual measures** are meant to assess the merits of individual measures. They ensure that each measure has sufficient merit for inclusion.
  - **Criteria to apply to Core Measures** are meant to guide the Quality Council in choosing which measures warrant special focus in Connecticut (i.e., should be used by all insurers in all value-based contracts).
  - **Criteria to evaluate the measure set as a whole** are meant to more holistically assess whether the Aligned Measure Set is representative and balanced, and meets policy objectives identified by the Quality Council.

Criteria to Apply to Individual Measures

1. 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, economic status, and other important demographic and cultural characteristics.
2. Represents an opportunity for improvement in quality of care, inclusive of outcomes and of population health.
3. Accessible with minimal burden to the clinical mission, and:
   a. draws upon established data acquisition and analysis systems;
   b. is efficient and practicable with respect to what is required of payers, providers, and consumers, and
   c. makes use of improvements in data access and quality as technology evolves and become more refined over time.
4. Evidence demonstrates that the structure, process, or outcome being measured correlates with improved patient health.

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Criteria to Apply to Individual Measures (Cont'd)

5. Addresses the most significant health needs of Connecticut residents, with attention to areas of special priority, beginning with:
   a. behavioral health
   b. health equity
   c. patient safety, and
   d. care experience.
6. Measures and methods are valid and reliable at the data element and performance score level.
7. Useable, relevant and has a sufficient denominator size.

Criteria to Apply to Core Measures

1. Includes Quality Benchmark measures unless there is a compelling reason not to do so.
2. Includes one Core Measure from each of the broad measure categories, minimally including behavioral health.
3. Includes at least one health equity measure.
4. Outcomes-oriented.
5. Crucial from a public health perspective.

Criteria to Apply to the Measure Set as a Whole

1. Includes topics and measures for which there are opportunities to promote health equity by race, ethnicity, language and/or disability status.
2. Broadly address population health.
3. Prioritizes health outcomes, including measures sourced from clinical and patient-reported data.
4. Taken as a whole, high performance on the proposed measure set should significantly advance the delivery system toward the goals of safe, timely, effective, efficient, equitable, patient-centered (STEEEP) care.
5. Balances comprehensiveness and breadth with the need for parsimony to enable effective quality improvement.
6. Representative of the array of services provided, and the diversity of patients served, by the program.