TO: HANNA NAGY
OFFICE OF HEALTH STRATEGY
FROM: SUSAN J. HALPIN, EXECUTIVE DIRECTOR
CONNECTICUT ASSOCIATION OF HEALTH PLANS
DATE: DECEMBER 13, 2023

RE: QUALITY BENCHMARK PUBLIC HEARING

On behalf of the Connecticut Association of Health Plans (CTAHP), I'd like to express the industry's appreciation to the Office of Health Strategy (OHS) for soliciting stakeholder feedback related to the proposed voluntary Quality Benchmark Measures for Phase 2. CTAHP members share the agency's objective of using metrics to drive quality within the health care delivery system and have been at the forefront of such initiatives for some time. As such, it remains critical that OHS recognize the unique nature of various populations served and the associated services provided, incorporates flexibility in reflection of private market innovations, and does not create unnecessary friction between carriers and providers.

As we shared back in January, carriers appreciate that OHS would like all health plans and providers to use the same measure set. However, current quality metrics may already be locked in by contract for 3 years or more. If a carrier requires clinical data from a provider group to meet the agency's outline, it is likely to meet with resistance. Flexibility on implementation, such as providing that new measures are effective upon the renewal of the contract in the next two years, will alleviate provider discomfort regarding changes mid-way through contract terms. It's important to consider whether providers who are unable to meet the standard may be disadvantaged as a result.

Allowing recommended measures to be used at the "category" level (v. the individual level) would provide for necessary insurer and provider flexibility, thus ensuring the measures will be operational while still furthering the intent behind the measure's inclusion.

We ask that OHS give further consideration to a category level approach as follows:

Care Coordination
1. Plan All-cause Readmission

Acute & Chronic Care (pick 2)
1. Controlling High Blood Pressure
2. Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9%)
3. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8%)

Prevention (pick 2)
1. Child and Adolescent Well-care Visits
2. Prenatal and Postpartum Care
3. Breast cancer screening
4. Chlamydia screening

Behavioral Health (pick 1)
1. Follow-up after Emergency Department Visit for Mental Illness (7-Day)
2. Screening for Depression and Follow-Up Plan

Health Equity (pick 1)
1. Health Equity Measure
2. Health disparities - Submission to the insurer which disparity/disparities provider has identified for the improvement
3. Screening for Social Determinants of Health

We understand that using different metrics under a category might complicate the comparisons among providers in multiple health plans. We again respectfully request this as an exception for 2023 - 2024, then transition to standardized metrics in subsequent years guided by the Quality Council.

With respect to the proposed changes to the Phase 1 and the Phase 2 Quality Benchmarks, the carriers don't believe the low numbers associated with the follow-up measures will provide for meaningful results.

It's also important to note that for the proposed Child and Adolescent Well Care Visits, the 80% benchmark is at the national 90th percentile according to benchmarking data from NCQA Quality Compass. While aspirational goals are well-intentioned, it's also important to manage expectations. The same is true for the 7-Day Follow-Up after ED Visit

for Mental Illness and the 7-day Follow-Up After Hospitalization for Mental Illness proposed measures. Both are above the 90th percentile reporting by NCQA Quality Compass nationally.

Finally, as it relates to the obesity measure, there is not clear direction on the metric specifications, nor is this a current HEDIS metric, nor something carriers currently track. Determining obesity would require either supplemental clinical EMR information from the providers or very good reporting on ICD10 Z* diagnosis codes which doesn't usually occur today.

Determining race and ethnicity on all members is something carriers have been working towards, but it is not yet complete. It's also important to note that tracking of these measures is politically sensitive. National organizations have been working to assure that data of this nature is treated accordingly. Given the provider mandate included in Public Act 21-35, we respectfully suggest that collection of this data may be better accomplished through the Statewide Health Information Exchange or through direct reporting from the provider community as outlined below.

Public Act 21-35 requires certain health care providers to collect and include in their electronic health record (EHR) systems self-reported patient demographic data, including race, ethnicity, primary language, insurance status, and disability status. They must do so based upon OHS's implementation plan and using standard categories for race and ethnicity data. These provisions apply to health care providers with an EHR system capable of connecting to and participating in the Statewide Health Information Exchange."

We appreciate the opportunity to submit these collective industry comments. You may be hearing from individual members with more specific input, but we thought it important to provide a broad view of the challenges being experienced by the carriers. Thank you for your consideration.

CTAHP looks forward to continued collaboration.