Connecticut Aligned Measure Set
2024 Measures and Implementation Guidance
July 25, 2023

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[1] select measures for use in their value-based contracts. 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' 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 2024 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** displays Core and Menu measures by domain (e.g., prevention, behavioral health, care coordination) in the 2024 Aligned Measure Set.

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

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*[2]
5. *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9.0%)*
6. *Plan All-Cause Readmission*

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[1] "Advanced Network" is OHS' 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.

[2] The *Health Equity Measure* stratifies performance for five measures by race, ethnicity and language (REL). The *Health Equity Measure* is intended to reward Advanced Networks for reporting the measures stratified by REL to incentivize REL data capture and completeness.

7. *Prenatal and Postpartum Care*
8. *Social Determinants of Health Screening*

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 Medication Ratio*
2. *Behavioral Health Screening*[3]
3. *Breast Cancer Screening*[4]
4. *Cervical Cancer Screening*
5. *Chlamydia Screening in Women*
6. *Colorectal Cancer Screening*
7. *Concurrent Use of Opioids and Benzodiazepines*
8. *Developmental Screening in the First Three Years of Life*
9. *Eye Exam for Patients with Diabetes*
10. *Follow-up After Hospitalization for Mental Illness (7-Day)*
11. *Immunization for Adolescents (Combo 2)*
12. *Kidney Health Evaluation for Patients with Kidney Disease*
13. *Maternity Care: Postpartum Follow-up and Care Coordination*
14. *Metabolic Monitoring for Children and Adolescents on Antipsychotics*[5]
15. *CAHPS Patient Centered Medical Home (PCMH) Item Set*
16. *Screening for Depression and Follow-up Plan*[6]
17. *Substance Use Assessment in Primary Care*
18. *Transitions of Care*[7]
19. *Use of Opioids at High Dosage*
20. *Use of Pharmacotherapy for Opioid Use Disorder*
21. *Well-Child Visits in the First 30 Months of Life*

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 1/1/24 as contracts are renewed.
b. Department of Social Services (DSS) timeframe. DSS should align with the Connecticut Aligned Measure Set, where feasible.

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[3] *Behavioral Health Screening* is applicable for Medicaid only and is not intended to be used in any commercial payer contracts.
[4] NCQA allows organizations to expand the denominator age range for *Breast Cancer Screening* to 40-74 years of age. The available benchmarks for this measure, however, are commonly for the 50-74 years of age range.
[5] *Metabolic Monitoring for Children and Adolescents on Antipsychotics* is applicable for Medicaid only and is not intended to be used in any commercial payer contracts.
[6] NCQA's *Depression Screening and Follow-up for Adolescents and Adults* may be used in lieu of CMS' *Screening for Depression and Follow-up Plan* for the purposes of aligning with the Aligned Measure Set.
[7] *Transitions of Care* is specified as a Medicare-only measure and can be used in commercial and Medicaid contracts; however, NCQA prohibits public reporting of performance if the measure is utilized with commercial and Medicaid populations.

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 Spring/Summer 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 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 Connecticut public and private payers;
4. the most recent state performance and opportunities for improvement in performance for measures based on benchmark comparison, and
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), 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.

Adequate Denominators

Advanced Networks and payers should not use measures in contracts if denominators are too small to report a reliable measurement.[8,9] Minimum denominator sizes to achieve reliable measurement may differ based on the measure type.[10] 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.

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.

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[8] 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. OHS staff will update this language, as necessary, to reflect any modifications to NQF's definition of reliability of the measure score.

[9] For further guidance on how to calculate reliability, please see RAND Health's publication, "The Reliability of Provider Profiling: A Tutorial"(2009). Available at: https://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR653.pdf (Accessed May 1, 2023).

[10] 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 May 1, 2023).

Appendix A. 2024 Aligned Measure Set

#	Measure Name	NQF	Steward	Source
Core Measure Set (8)				
Care Coordination (1)				
1	**Plan All-cause Readmission**	1768	NCQA	Claims
Acute & Chronic Care (2)				
2	**Controlling High Blood Pressure**	0018	NCQA	EHR
3	**Hemoglobin A1c Control for Patients with Diabetes: HbA1c Poor Control (>9%)**	0059	NCQA	EHR
Prevention (2)				
4	**Child and Adolescent Well-care Visits**	NA	NCQA	Claims
5	**Prenatal and Postpartum Care**	1517	NCQA	EHR
Behavioral Health (1)				
6	**Follow-up After Emergency Department Visit for Mental Illness (7-Day)**	3489	NCQA	Claims
Health Equity (1)				
7	**Health Equity Measure**[11]	NA	CT OHS	EHR
Social Determinants of Health (1)				
8	**Social Determinants of Health Screening**[12]	NA	CT OHS	Survey
Menu Measure Set (21)				
Consumer Engagement (1)				
1	**PCMH CAHPS Survey**	0005	NCQA	Survey
Care Coordination (1)				
2	**Transitions of Care**[13]	NA	NCQA	EHR
Prevention (10)				
3	**Breast Cancer Screening**[14]	2372	NCQA	Claims
4	**Cervical Cancer Screening**	0032	NCQA	Claims
5	**Chlamydia Screening in Women**	0033	NCQA	Claims
6	**Colorectal Cancer Screening**	0034	NCQA	EHR

[11] This measure was previously titled the *Race, Ethnicity and Language (REL) Stratification Measure*. Specifications for this measure can be found here: https://portal.ct.gov/OHS/Pages/Quality-Council/2024-Aligned-Measure-Set

[12] Specifications for this measure can be found here: https://portal.ct.gov/OHS/Pages/Quality-Council/2024-Aligned-Measure-Set

[13] This measure is specified as a Medicare-only measure and can be used in commercial and Medicaid contracts; however, NCQA prohibits public reporting of performance if the measure is utilized with commercial and Medicaid populations.

[14] NCQA allows organizations to expand the denominator age range to 40-74 years of age. The available benchmarks for this measure, however, are commonly for the 50-74 years of age range.

#	Measure Name	NQF	Steward	Source
7	**Developmental Screening in the First Three Years of Life**	1448	OHSU	EHR
8	**Immunizations for Adolescents (Combo 2)**	1407	NCQA	Claims
9	**Maternity Care: Postpartum Follow-up and Care Coordination**	NA	AMA-PCPI	EHR
10	**Well-Child Visits in the First 30 Months of Life**	1392	NCQA	Claims
11	**Screening for Depression and Follow-up Plan**	0418	CMS	EHR
12	**Behavioral Health Screening (Medicaid only)**[15]	NA	CT DSS	Claims
Acute & Chronic Care (3)				
13	**Asthma Medication Ratio**	1800	NCQA	Claims
14	**Eye Exam for Patients with Diabetes**	0055	NCQA	EHR
15	**Kidney Health Evaluation for Patients with Diabetes**	NA	NCQA	EHR
Behavioral Health (6)				
16	**Concurrent Use of Opioids and Benzodiazepines**	3389	PQA	Claims
17	**Follow-up Care for Children Prescribed ADHD Medication**	0108	NCQA	Claims
18	**Metabolic Monitoring for Children and Adolescents on Antipsychotics (Medicaid only)**[16]	2800	NCQA	Claims
19	**Substance Use Assessment in Primary Care**	NA	IEHP	Claims
20	**Use of Opioids at High Dosage**	NA	NCQA	Claims
21	**Use of Pharmacotherapy for Opioid Use Disorder**	3400	CMS	Claims

[15] This measure is applicable for Medicaid only and is not intended to be used in any commercial payer contracts.

[16] This measure is applicable for Medicaid only and is not intended to be used in any commercial payer contracts.