Rhode Island Accountable Entity Program

Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities:

Implementation Manual

Requirements for Program Years 1 through 3

Rhode Island Executive Office of Health and Human Services
December 13, 2019

Revision History

Version	Date	Revisions
1.0	4/26/19	Initial version of implementation manual
1.1	7/17/19	Updated to include SDOH measure specifications, added TCOC P4P methodology, revised TCOC reporting requirements, revised information on clinical data exchange, revised TCOC measure reporting timeline, added outcome measures methodology and reporting requirements, revised outcome measures timeline, and other smaller edits
1.2	8/1/19	Updated to remove embedded documents except where indicated (instead included as appendices), added in information about the calculation of the Weight Assessment and Counseling for Children and Adolescents composite measure, refined the SDOH Infrastructure Development specifications, merged TCOC and Outcome timelines into a

		single chronological timeline, added instructions on the submission of the Operational and Data Validation Plans, extended the due date for the requirement for AEs and MCOs to meet to discuss OPY2 processes to reduce avoidable IP admissions and ED visits, and other smaller edits
1.3	10/10/19	Updated to change Screening for Clinical Depression and Follow-up Plan to P4R for QPY3, remove the reporting-only Patient Engagement measure for QPY3, add language noting the intent of EOHHS to share MCO-submitted clinical data exchange reports with the AEs, remove reference to the overall quality score applying to shared losses, revise the timing and benchmark sources for the QPY3 TCOC Quality Benchmarks, revise the specifications allowed for use in OPY1 and OPY2, update the OPY3 Outcome Measure Targets to change Coastal's target for Potentially Avoidable ED Visits and add All-Cause Readmissions targets, add outcome measure weights, add Appendix C "Example Overall Quality Score Calculation for QPY3", add Appendix F "All-Cause Readmissions", and other smaller edits
1.4	12/11/19	Revised timeline for MCO calculation of baseline QPY2 performance on the Common Measure Slate using clinical data, timeline for EOHHS to provide final quality targets for QPY3, updated requirement for OPY2 to clarify documentation must be provided on inpatient admissions instead of avoidable inpatient admissions, removed EOHHS re-assessment of OPY3 benchmarks based on OPY2 data, changed timeline for EOHHS re-assessment of the OPY3 benchmark for ED Utilization Among Members with Mental Illness, clarified the CPT codes under "Eligible Population for Non-HEDIS Measures" are used to define Active Patient, clarified that performance above or equal to the high achievement target will result in full credit under the TCOC methodology, clarified that both QPY1 and QPY2 data will inform the final TCOC QPY3 targets

Contents

Purpose

A fundamental element of the EOHHS Accountable Entity (AE) program, and specifically the transition to alternative payment models, is a focus on quality of care processes and outcomes.

The purpose of this document is to clearly outline guidelines for implementation of both the Total Cost of Care (TCOC) quality measures and P4P methodology and the Outcome measures and incentive methodology for Performance Years 1 through 3. The contents of this document supersede all prior communications on these topics.

	Program Year	TCOC Quality Measures Performance Year (QPY)	Outcome Measures Performance Year (OPY)
1	July 1, 2018-June 30, 2019	Jan 1, 2018-Dec 31, 2018	July 1, 2018-June 30, 2019
2	July 1, 2019-June 30, 2020	Jan 1, 2019-Dec 31, 2019	July 1, 2019-June 30, 2020
3	July 1, 2020-June 30, 2021	Jan 1, 2020-Dec 31, 2020	Jan 1, 2020-Dec 31, 2020

TCOC Quality Measures and P4P Methodology

AE Quality Measures

In accordance with 42 CFR §438.6(c)(2)(ii)(B)[1], AE quality performance must be measured and reported to EOHHS using the Medicaid Comprehensive AE Common Measure Slate. These measures shall be used to inform the distribution of any shared savings. For QPY1 and QPY2, AEs and MCOs may agree to include up to 4 additional optional menu measures. For QPY3, AEs and MCOs must use only the AE Common Measure Slate measures to inform the distribution of any shared savings.

The following table depicts the AE Common Measure Slate, required measure specifications, and whether the measure is pay-for-reporting (P4R), pay-for-performance (P4P), or reporting-only by quality performance year. EOHHS expects that performance on each Common Measure Slate measure be reported annually for the full Quality Measures Performance Year.

Measures are categorized in the following ways:

- **P4R** status means that whether or not an AE reports the measure will influence the distribution of any shared savings.
- **P4P** status indicates that an AE's performance on the measure will influence the distribution of any shared savings.
- **P4R/P4P** indicates the measure may be utilized as either pay-for-reporting or pay-for-performance at the discretion of each contracting AE and MCO dyad.
- **Reporting-only** indicates that measure performance must be reported to EOHHS for EOHHS' monitoring purposes, but that there are no shared savings distribution consequences for submission of performance on the measure.

[1] https://www.ecfr.gov/cgi-bin/text-idx?SID=85dc983b09de39869ece9ee0d34d0a09&mc=true&node=se42.4.438_16&rgn=div8

Measures[2]	Steward	Data Source[3]	Specifications	AE Common Measure Slate		
				QPY1	QPY2	QPY3
HEDIS Measures						
Adult BMI Assessment	NCQA	Admin/Clinical	Current HEDIS specifications: QPY1: HEDIS 2019 QPY2: HEDIS 2020 QPY3: HEDIS 2020* *A work group of AE and MCO participants shall convene once HEDIS 2021 specifications are released to approve adoption of HEDIS 2021 specifications for use in QPY3.	P4R	P4P/P4R	
Adolescent Well-Care Visits	NCQA	Admin/Clinical				P4P
Breast Cancer Screening	NCQA	Admin		P4R	P4P	P4P
Comp. Diabetes Care: Eye Exam	NCQA	Admin/Clinical				P4P
Comp. Diabetes Care: HbA1c Control (<8.0%)	NCQA	Admin/Clinical		P4R	P4P/P4R	P4P
Controlling High Blood Pressure	NCQA	Admin/Clinical		P4R	P4P/P4R	P4P
Follow-up after Hospitalization for Mental Illness	NCQA	Admin		P4R – 7 or 30 days	P4P – 7 or 30 days	P4P – 7 days
Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents	NCQA	Admin/Clinical		P4R	P4P/P4R	P4P
Non-HEDIS Measures (Externally Developed)						
Developmental Screening in the 1st Three Years of Life	OHSU	Admin/Clinical	QPY1-3: CTC-RI/OHIC (December 2018 version)[4]	P4R	P4P/P4R	P4P
Screening for Clinical Depression and Follow-up Plan	CMS	Admin/Clinical	QPY1: CMS MIPS 2018[5] Depression QPY2: CMS MIPS 2019[6] Tobacco QPY2: CMS MIPS 2018[7] QPY3: CMS MIPS 2020	P4R	P4P/P4R	P4R[8]
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	Admin/Clinical		P4R	P4P/P4R	Reporting-only
Non-HEDIS Measures (EOHHS-developed)						
Social Determinants of Health Screening	EOHHS	Admin/Clinical	QPY1-2: EOHHS February 15, 2018 version[9] QPY3: EOHHS a July 8, 2019 version – included as Appendix A	P4R	P4R	Reporting-only
Social Determinants of Health Infrastructure Development	EOHHS	Admin/Clinical	QPY3: EOHHS (July 23, 2019 version – included as Appendix B)			P4P

[2] Attachments L1 for Program Years 1 and 2 included Self-Assessment/Rating of Health Status as developed by EOHHS. This measure is no longer part of the AE Common Measure Slate for QPY1-3. EOHHS communicated its decision to drop this measure from Program Year 2 in its 4/30/19 amended Attachment L1.

[3] "Admin/Clinical" indicates that the measure requires use of both administrative and clinical data.

[4] http://www.ohic.ri.gov/documents/Revised-Measure-Specifications-Adult-and-Pedi-CTC-OHIC-Dec-2018-FINAL.pdf

[5] https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2018#measures

[6] https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2019#measures

[7] Tobacco Use: Screening and Cessation Intervention had substantive changes in the CMS MIPS 2019 version.

[8] EOHHS has decided to make Screening for Clinical Depression and Follow-up Plan P4R in QPY3 so it can better understand the impact on performance of the significant changes in the 2019 technical specifications.

[9] http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/AE/Final%20Documents/SDOH%20Guidance%20Document%202018-02-15.pdf

Measures[2]	Steward	Data Source[3]	Specifications	AE Common Measure Slate		
				QPY1	QPY2	QPY3
Optional Measure Slates (for QPY1 and QPY2 EOHHS permits selection of up to 4 optional measures)[10]						
OHIC Aligned Measure Set Menu			QPY1: OHIC 2018[11] QPY2: OHIC 2019[12]	P4R/P4P	P4R/P4P	
CMS Medicaid Adult Core Set			QPY1: CMS 2018[13] QPY2: CMS 2019[14]	P4R/P4P	P4R/P4P	
CMS Medicaid Child Core Set			QPY1: CMS 2018[15] QPY2: CMS 2019[16]	P4R/P4P	P4R/P4P	

[10] Optional Admin measures must be pay-for-performance in QPY1. Optional Admin/Clinical or Clinical-only measures may be pay-for-performance or pay-for-reporting in QPY1.

[11] http://www.ohic.ri.gov/documents/Crosswalk%20of%20RI%20Aligned%20Measure%20Sets%202017%2011-2.xlsx

[12] http://www.ohic.ri.gov/documents/Crosswalk-of-RI-Aligned-Measure-Sets--For-2019-2018-10-13.xlsx

[13] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-adult-core-set.pdf

[14] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf

[15] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2018-child-core-set.pdf

[16] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf

Eligible Population for Non-HEDIS Measures

For QPY1 and QPY2, all non-HEDIS measures in the Common Measure Slate use the eligible population as defined in the measure's specification.

Beginning in QPY3, all non-HEDIS measures in the Common Measure Slate are defined to only include Active Patients in their denominator. Active Patients are individuals seen by a primary care clinician associated with the AE anytime within the last 12 months. For the purpose of these measures "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel.

The following are the eligible CPT/HCPCS office visit codes for determining an Active Patient: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381–99387; 99391-99397; 99490; 99495-99496.

TCOC Quality P4P Methodology

This section describes the TCOC quality P4P methodology for QPY1-3. Medicaid AEs are eligible to share in earned savings based on a quality multiplier (the "Overall Quality Score"). Overall Quality Scores shall be generated for each AE based on the methodology defined below. The Overall Quality Score will be used as a multiplier to determine the percentage of the Shared Savings Pool the AE and MCO are eligible to receive. The Overall Quality Score shall function as a multiplier, and the TCOC quality P4P methodology does not include a gate; as such, any quality points earned must be associated with a share of the Shared Savings Pool.

Selection of P4P Measures

The table below outlines the required measures for the Overall Quality Score calculation, by year.

QPY	Minimum # P4P Measures	Specific Measures Required P4P
1	0	Any Optional Measure Slate measure using Admin data must be P4P
2	3	Breast Cancer Screening Follow-up after Hospitalization for Mental Illness (7 day or 30-day measure component)[17] One additional measure of choice from the AE Common Measure Slate or the Optional Measure Slates
3	9	All AE Common Measure Slate measures except for Screening for Clinical Depression and Follow-up PlanSDOH Screening and Tobacco Use: Screening and Cessation Intervention, as these are either P4R or reporting-only measures.

Calculation of the Overall Quality Score

For QPYs 1 and 2, MCOs and AEs may use any EOHHS-approved methodology for calculating the Overall Quality Score. EOHHS approved these methodologies as part of its overall approval of TCOC contracts.

[17] Note that while all measure subcomponents must be reported, an individual measure subcomponent may be selected as pay for performance.

EOHHS, has, however, provided a recommended methodology for MCO and AE use.[18] Even with this flexibility, EOHHS specifies the following stipulations:

- ***P4R Measures:*** EOHHS requires that any pay-for-reporting measures receive a pass/fail score (either 100% or 0%); there shall be no partial credit for reporting measures. The following conditions must be met to receive a passing score: 1) reporting of required data for the measure is timely and in accordance with MCO-defined formats; and 2) the process and methodology for calculating measure performance in accordance with the MCO-defined formats has been adequately demonstrated.
- **For QPY1**, All the Medicaid AE Common Measure Slate measures must be included in the calculation of the Overall Quality Score.
- **For QPY2**, all measures must be included in the Overall Quality Score, with a weight greater than 0% for each measure. The measure weight assigned to each measure is negotiable and shall be agreed upon by the MCO and AE. The Overall Quality Score must be a sum of the measure-specific quality score times the measure weight for each measure.

For QPY3, EOHHS developed a standard Overall Quality Score methodology that is required for use by all AEs and MCOs. The required TCOC Overall Quality Score methodology is as follows:

1. **Target Structure:** The Overall Quality Score recognizes AEs that either attain a high-achievement target or demonstrate a required level of improvement over prior performance. MCOs will assess AE performance on each Common Measure Slate P4P measure for both achievement and improvement. For each Common Measure Slate measure except SDOH Screening, AEs will be awarded whichever score yields the most performance points. The maximum earnable score for each measure will be "1", and each measure will be weighted equally.
    a. <u>Achievement targets:</u>
        i. EOHHS will establish two achievement targets: "threshold" and "high."
        ii. Achievement points will be scored on a sliding scale for performance between the threshold and high values.
            1. If performance is below or equal to the threshold-performance target: 0 achievement points
            2. If performance is between the threshold-performance and the high-performance target, achievement points earned (between 0 and 1) will be determined based on the following formula:
                (Performance Score – Threshold Performance) / (High-Performance Target – Threshold Performance)
            3. If performance is equal to or above the high-performance target: 1 achievement point
    b. <u>Improvement target:</u>
        i. The improvement target will be a fixed number of percentage points, with three percentage points as the default value.
            1. The value may vary from three percentage points if deemed appropriate by EOHHS.

[18] See "Rhode Island Medicaid Accountable Entity Program, Attachment L 1 Accountability Entity Total Cost of Care Requirements – Program Year Two Requirements" December 11, 2018.

2. The value may be less than what would be required to demonstrate statistical significance in a given year.

ii. Improvement will not be recognized by the MCO if the rate is statistically significantly below the rate of two calendar years prior[19].

iii. Improvement as defined by 1.b.i and 1.b.ii will earn the AE a score of "1."

2. **Scoring SDOH Screening, SDOH Infrastructure Development, and Screening for Clinical Depression and Follow-up Plan**: These three measures will be scored differently than the other Common Measure Slate measures for QPY3. There will be neither an achievement nor improvement assessment for these measures. Instead, these three measures will be treated as follows:
   - SDOH Screening: Reporting-only measure with no Overall Quality Score Implications for QPY3.
   - SDOH Infrastructure Development**:** AEs will have the opportunity to earn a score of "1" if the percentage of attributed patients whose primary care clinician's EHR contains a defined field that indicates whether a social determinants of health screen was completed equals or exceeds 50%. If the AE does not report the measure, or if the resulting measure performance is less than 50% , it will earn a score of "0."
   - Screening for Clinic Depression and Follow-Up Plan: AEs will have the opportunity to earn a score of "1" if they report performance on the measure. If the AE does not report the measure, it will earn a score of "0."
3. **Overall Quality Score Calculation:** Each MCO will sum the points earned across all measures for which the AE has an adequate denominator size (please see the section "Adequate Denominator Sizes" for the definition of adequate denominator size) and divide that sum by the number of measures for which there is an adequate denominator size. For example, if an AE has an adequate denominator size for all AE Common Measure Slate measures, then the MCO would sum the scores for each of the ten measures and divide the result by 10[20]. This resulting quotient is the "Overall Quality Score." The MCO shall multiply the annual savings generated by the AE by the Overall Quality Score to determine the shared savings to be distributed to the AE. **Appendix C: Example Overall Quality Score Calculation for QPY3** illustrates this calculation.
   a. **Percentage of Quality Measures Needed to Achieve Full Shared Savings:** EOHHS will define this parameter once QPY1 AE performance data and NCQA HEDIS benchmarks for CY2018 are available. It anticipates doing so and making any necessary changes to step 3 by November 30, 2019. In setting this parameter, EOHHS' general principle is that AEs should be allowed to achieve the full share of shared savings without having to earn the maximum possible points, i.e., through hitting the high achievement or improvement targets for all ten measures.

[19] For Weight Assessment and Counseling for Children and Adolescents, statistical significance is determined using the average of numerators across component scores.

[20] Weight Assessment and Counseling for Children and Adolescents is assessed as one measure. The measure is a composite, created by averaging the scores of the three individual measure components 1) BMI percentile, 2) counseling for nutrition, and 3) counseling for physical activity.

MCOs and AEs may calculate AE Overall Quality Score performance using Overall Quality Score Determinations Excel model (current version: 9/12/19). The Overall Quality Score Determinations Excel model can be obtained by emailing Rebekah LaFontant, Rebekah.LaFontant@ohhs.ri.gov.

TCOC Quality Benchmarks

For QPY1 and QY2 benchmarks shall be negotiated by each AE and MCO dyad. These benchmarks may be employed to evaluate AE performance on Common Measure Slate measures and optional measures to inform the negotiated formula for distribution of shared savings.

For QPY3, EOHHS will employ a combination of internal and external sources to set achievement targets. EOHHS will:

a. set interim targets for Quality Performance Year 3 using Quality Performance Year 1 data (in conjunction with the other sources listed below) in advance of Quality Performance Year 3, and
b. set final Quality Performance Year 3 targets using Quality Performance Years 1 and 2 data (in conjunction with the other sources listed below) once they become available.

AE Quality Performance Year 1 and 2 data will be used to ensure the following guiding principles are met: 1) the high achievement target should be attainable for at least some AEs; 2) the high achievement target should not exceed a value that represents a reasonable understanding of "high performance"; and 3) the high achievement target should not be below the current performance of every single AE.

EOHHS will also consider the following benchmark sources:

a. <u>HEDIS measures</u>
    i. NCQA's Quality Compass benchmarks will be used whenever possible, for QPY3, HEDIS 2019 (CY2018) will be used. The benchmark (e.g., 75th percentile for Medicaid managed care) used to set achievement targets will vary by measure based on EOHHS assessment of past MCO or AE performance.
b. <u>Non-HEDIS measures</u>
    ii. Alternative sources to NCQA's Quality Compass will be used for non-HEDIS measures as available for the measure.
    iii. For QPY3, EOHHS will use OHIC-gathered Rhode Island PCMH 10/18-9/19 performance measure data for benchmarking purposes. These data are collected annually by OHIC from primary care practices seeking OHIC PCMH designation (171 practices submitted in 2018). OHIC data can be stratified to identify Medicaid-focused practices (i.e., self-reported to have >50% of patients covered by Medicaid or be uninsured), although the absolute number of such practices has historically been low.

Should benchmark data be unavailable for a given measure, EOHHS will convene a meeting of AEs, MCOs, and clinicians to review the measure and determine appropriate benchmarks.
As MCOs and AEs begin transitioning in QPY3 to using electronic clinical data exchange for generation of those Common Measure Slate measures requiring clinical data, EOHHS anticipates that MCOs will use different data collection techniques with different AEs (see "Data Collection and Reporting

Responsibilities", immediately below). EOHHS will assess the impact of different data collection techniques on AE performance on Common Measure Slate measure results. Should different data collection techniques appear to have substantive systemic effects on AE performance on some or all of those measures requiring clinical data, EOHHS will modify benchmarks for affected AEs using its best judgement.

Data Collection and Reporting Responsibilities

For QPY1 and QPY2, MCOs are responsible for reporting performance on all AE Common Measure Slate measures to EOHHS as well as any measures selected as pay-for-performance from the optional measure sets (i.e., the SIM Menu Measure Set and CMS Medicaid Child and Adult Core Sets). All Admin measures must be generated and reported by the MCO. AEs must provide the necessary data to the MCO to generate any Admin/Clinical measures. The MCO and AE shall agree upon the manner and format for demonstrating that appropriate measurement processes and methodologies are in place. For Admin/Clinical measures, this includes: defining the clinical population and data sources, extracting data elements from the EHR, and reviewing data quality for accuracy and validity of measure scores. For the SDOH Screening measure, AEs must demonstrate that processes are in place to administer the screening tool, and that data collection processes are aligned across the AE.

For QPY3, MCOs are responsible for reporting performance on all AE Common Measure Slate measures to EOHHS. All Admin measures must be generated and reported by the MCO. AEs and MCOs must work together to establish clinical data exchange capabilities as described in the "Electronic Clinical Data Exchange" section below for Admin/Clinical measures. Practices have varying capabilities for clinical data exchange so EOHHS will allow for AEs to exchange data via self-report (manual spreadsheet/file), but only if an AE lacks the capability for clinical data exchange as described below.

Electronic Clinical Data Exchange

EOHHS wishes to promote the capabilities of AEs to transmit clinical data to contracted MCOs. To assist in achieving that end, EOHHS has offered incentive funding for AEs and MCOs during QPY2 for efforts to move towards electronic clinical data exchange for the Common Measure Slate for QPY3.

EOHHS defines electronic exchange to be inclusive of any of the following methods:

1. aggregated AE-level file submitted to an MCO;
2. aggregated AE-level file submitted to the State's vendor, IMAT, which then submits data to an MCO;
3. individual practices within the AE submit data to an MCO, and
4. individual practices within the AE submit data to IMAT, which then submits data to an MCO.

For any of the options above, AEs must be able to submit data for those primary care practices together representing at least 75% of the AE's MCO-specific attributed lives for the exchange to be used for MCO generation of Common Measure Slate measures.

Should an AE be unable to electronically exchange clinical data for practices representing 75% or more of its MCO-specific attributed lives, AEs may submit data to MCOs in the following ways:

1. AEs gather documentation for all AE-attributed members meeting the denominator definition using an MCO-provided list (as is being done for PY1); or

2. AEs gather documentation for AE-attributed members meeting the denominator definition using an MCO-provided list for just those practices unable to electronically exchange data, and use electronic clinical data exchange using any of the four options listed above for the other practices.

There could be a circumstance in which an MCO does not have sufficient clinical data exchange capacity for one or more AEs. In those circumstances, MCOs must: 1) submit to EOHHS and receive approval of an action plan and timeline for clinical data exchange readiness by November 1, 2019; and 2) follow one of the methodologies identified for AEs without sufficient data exchange capacity for QPY3.

To be eligible for the QPY2 incentive funding, MCOs must submit to EOHHS 1) an Operational Plan, 2) Data Validation Plan, and 3) four Implementation Status Reports, as described further below. EOHHS will share the MCO-submitted clinical data exchange data validation plans, operational plans, and implementation status reports with AEs to promote transparency and best practice sharing.

The **Operational Plan** should describe the operational steps the MCO will take a) with each AE to obtain electronic clinical data needed to generate each Common Measure Slate measure requiring clinical data, and b) to calculate admin/clinical measures with the data obtained from the AEs.

- The Operational Plan will be evaluated against specific criteria, as outlined in **Appendix D: EOHHS Evaluation Criteria: MCO Electronic Clinical Data Operational and Validation Plans**.
- The Operational Plan should be submitted following the instructions detailed in the sub bullets below:
    - MCOs should submit Operational Plans to EOHHS following the EOHHS Medicaid MCO Requirements for Reporting and Reporting Penalties Policy and Procedures for Managed Care Core Contact (embedded below) by November 1, 2019.
    - 
    - MCOs should create AE-specific project plans for the implementation of clinical data collection. Work plans must include: timelines, action items, MCO responsible parties, partners, and criteria for success in each of the topic areas identified in Appendix D.
- Because AEs differ in structure and because some MCOs are already receiving AE clinical data files, the plan should have AE-specific detail.
- The plan should extend through the production of PY2 (CY2019) Common Measure Slate calculations for measures requiring clinical data.
- Include dates and the names of responsible MCO and (as applicable) contractor staff.
- Timing:
    - EOHHS shall provide Operational Plan reporting instructions by September 9, 2019.
    - MCOs shall submit their Operational Plans to EOHHS by November 1, 2019.

The **Data Validation Plan** should describe how the MCO will have the completeness and accuracy of AE-reported clinical data externally validated, including audit procedures, and what steps will be taken when an AE's data fails the validation process.

- The Data Validation Plan will be evaluated against specific criteria, as outlined in **Appendix D: EOHHS Evaluation Criteria: MCO Electronic Clinical Data Operational and Validation Plans**.
- The Operational Plan should be submitted following the instructions detailed in the sub bullets below:
    - MCOs should submit Data Validation Plans to EOHHS following the EOHHS Medicaid MCO Requirements for Reporting and Reporting Penalties Policy and Procedures for Managed Care Core Contact (embedded below) by December 1, 2019.

    - MCOs should create AE-specific project plans for the implementation of data validation. Work plans must include: timelines, action items, MCO responsible parties, partners, and criteria for success in each of the topic areas identified in Appendix D.
- The MCO should use Minnesota Community Measurement (MNCM) or another vendor approved by the State for data validation. MCOs may choose to consider NCQA eMeasure certification vendors. Additional information on MNCM's data validation processes can be found here: https://mncm.org/services-solutions/mips-pqrs/#data-validation.
- EOHHS shall provide Data Validation Plan reporting instructions by September 9, 2019.
- MCOs shall submit their Data Validation Plans to EOHHS by December 1, 2019.

Implementation Status Reports should detail the status of clinical data exchange efforts with *each* AE, including progress made since the last status report towards transmitting clinical data necessary to generate the AE Common Measure Slate measures, application of data validation activities, and identification of major issues that need to be resolved.

- Implementation Status Reports should be submitted using the standard template, included as **Appendix E: MCO Electronic Clinical Data Implementation Status Report Template**.
- Timing:
    - MCOs shall submit their Implementation Status Reports to EOHHS by February 1, 2020, April 1, 2020, and June 1, 2020.

Outcome Measures and Incentive Methodology

The Medicaid Infrastructure Incentive Program (MIIP) runs through Program Years 1 through 4 (January 2018-June 2022) of the Accountable Entity program. Through the MIIP, AEs are eligible to receive funding from the Accountable Entity Incentive Pool (AEIP). One core determinant of funding eligibility is submission of and performance on a number of quality outcome metrics.

Outcome Measures

The table below depicts the Outcome Measures Slate, required measure specifications, and whether the measure is pay-for-reporting (P4R) or pay-for-performance (P4P) by Outcome Measure Performance Year. Performance on each measure must be assessed for the full Outcome Measures Performance Year.

Measures	Steward	Data Source	Specifications	Outcome Measures Slate		
				OPY1	OPY2	OPY3
HEDIS Measures						
Ambulatory Care: Emergency Department	NCQA	Admin	OPY1: HEDIS 2019 or MCO-defined specifications OPY2: HEDIS 2020 or MCO-defined specifications OPY3: EOHHS – included as Appendix F	P4R	P4R	
Inpatient Utilization—General Hospital/Acute Care	NCQA	Admin		P4R	P4R	
All-Cause Readmissions	NCQA	Admin		P4R	P4R	P4P
Non-HEDIS Measures: Externally Developed						
ED Utilization Among Members with Mental Illness	OHA	Admin	OPY3: OHA 2019[21]			P4P
Potentially Avoidable ED Visits (in previous communications, this measure has been referred to as "Ambulatory Care-Sensitive ED Visits")	NYU, modified by EOHHS	Admin	OPY2-3: EOHHS – included as Appendix G		P4R	P4P

[21] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2019-Disparity-Measures-ED-Utilization-Among-Members-Experiencing-Mental-Illness.pdf

Outcome Measure Incentive Methodology

AEs must also demonstrate performance on Outcome measures.

Section of P4P Measures

The table below outlines the required reporting on Outcome measures.

OPY	Minimum # P4P Measures	Specific Measures Required P4P
1	0	
2	0	
3	3	All Outcome Measure Slate measures

Calculation of the Outcome Measure Performance Area Milestones

For OPY 1: Performance is based on reporting of Outcome measures.

- MCOs must calculate performance on the Outcome measures for each AE on a quarterly basis.
- AEs must report to MCOs performance improvement plans specific to the outcome measures.
- The Outcome measures plan was due April 30, 2019.

For OPY2: Performance is based on reporting of Outcome measures.

- MCOs must calculate performance on the Outcome measures for each AE on an quarterly basis to EOHHS for each AE.
- AEs should provide MCOs with documentation of both continuing and new processes implemented in OPY2 to reduce a) inpatient admissions and b) avoidable ED visits. AEs and MCOs should meet to discuss these processes as well as performance on the OPY2 outcome metrics quarterly by October 31, 2019, January 31, 2020, April 30, 2020, and July 31, 2020.

For OPY3, AEs will earn a percentage of the AEIP based on the annual performance on Outcome metrics. The Outcome metric score methodology is as follows:

1. **Target Structure:** AEs must demonstrate attainment of an achievement target. For each measure an AE may earn either no credit or full credit.
2. **Measure Weights:** 35% of the AE Incentive Pool allocation and 35% of the MCO Incentive Management Pool allocation will be determined by Outcome measure performance. Weights to be applied to specific Outcome measures are provided in the table below. Should an AE not have an adequate denominator (as defined in "Adequate Denominator Sizes" below), the measure for which the denominator is too small will be dropped from the calculation and equal weight assigned to the remaining measure(s).

Outcome Measure	OPY3 Weight
All-Cause Readmissions	15%
ED Utilization Among Members with Mental Illness	15%
Potentially Avoidable ED Visits	5%

Outcome Measure Targets

For OPY1, at least 50% of the performance goals on Outcome measures shall be based on reporting. Specifics are up to the negotiations of AE and MCO dyads.

For OY2 EOHHS requires that outcome metrics be assessed on a pay-for-reporting basis.

For OPY3, the achievement targets are as follows:

Measure	Rationale	OPY3 Target
Potentially Avoidable ED Visits	-These targets were calculated individually by AE as the minimum value necessary for statistically significant performance improvement from each AE's 2018 rate.[22]	BVCHC: 40.04% Coastal: 23.96% IHP: 36.11% Integra: 36.72% PCHC: 39.22% Prospect: 39.69%
ED Utilization Among Members with Mental Illness (per 1,000-member months)	-AE performance was similar between 2016 and 2017 but dropped significantly between 2017 and 2018. This target value is approximately the midpoint of performance between the two years.	93 visits per 1000
All-Cause Readmissions	- EOHHS is employing an All-Cause Readmissions observed rate, with AE performance targets set so performance does not represent a statistically significantly increase (worse performance) than the AE's 2018 observed rate. [23]	BVCHC: 11.44% Coastal: 13.04% IHP: 15.30% Integra: 18.18% PCHC: 10.94% Prospect: 16.03%

Given the significant change in AE performance between 2017 and 2018, EOHHS shall re-evaluate the target for ED Utilization Among Members with Mental Illness once OPY2 performance data are available.

Outcome Measures Data Collection Responsibilities

MCOs are responsible for reporting performance for each AE on all AE Outcome measures to EOHHS for OPY1 and OPY2. EOHHS shall generate AE Outcome measure performance rates for each AE for OPY3. MCOs shall provide AEs with data necessary to help AEs perform well on the Outcome measures.

For OPY1, MCOs must submit quarterly performance on the Outcome measures as part of the "AE Incentive Pool (AEIP) Milestones Template" as provided by EOHHS.

For OPY2, EOHHS shall assume responsibility for calculating AE Outcome measure performance, across MCOs. Final calculation of OPY performance will be calculated using 180 days of claims runout. MCOs must provide AEs with data to assist in improvement on Outcome metrics. MCOs shall provide quarterly reports to the AEs on performance, by October 31, 2019, January 31, 2020, April 30, 2020, and July 31, 2020. MCOs shall also provide and patient lists to the AEs, as requested by AEs.

[22] Statistical significance is calculated using a one-tailed test by AE across MCOs using 0.8 power and p-value of 0.05. 2018 denominators were rounded to the nearest 5,000. Coastal's target does not represent a statistically significant decline. Given Coastal's low 2018 rate compared to other AEs, its 2020 target is based on maintenance of 2017 performance.

[23] Statistically significance is calculated using a one-tailed test by AE across MCOs using 0.8 power and a p-value of 0.05. 2018 denominators were rounded to the nearest 500. Since Coastal does not have statistically valid baseline data, its target is based on the average 2018 rate for other AEs, excluding Coastal.

For OPY3, EOHHS shall assume responsibility for calculating AE Outcome measure performance, across MCOs. Final calculation of OPY performance will be calculated using 180 days of claims runout. MCOs shall continue to provide AEs with data to assist in improvement on Outcome metrics. MCOs shall provide quarterly reports to the AEs on performance and patient lists to the AEs, both as requested by AEs.

General Guidelines

This section contains some general guidelines that are applicable to both the TCOC Quality Measures and P4P Methodology and the Outcome measures and Incentive Methodology.

Changes to Specifications

EOHHS shall annually convene AEs and MCOs to review whether annual measure specification changes are substantive. If changes are substantive, the work group will make recommendations to EOHHS on how to handle the measure during the year of the substantive change. If changes are not substantive, MCOs shall be granted flexibility to calculate the measure using the new or old specifications for the year in which the changes have been adopted.

In July 2020, NCQA will publish HEDIS changes for both HEDIS 2020 and HEDIS 2021. NCQA is doing so to transition from its current process of releasing measure specification changes during the performance year to its new process of releasing measure specification changes in advance of the performance year. During the 2020 annual review, EOHHS shall ask AEs and MCOs to review HEDIS changes for Quality and Outcome Performance Years 3 and 4.

During the annual review, EOHHS will also ask AEs and MCOs to review any changes to non-HEDIS specifications.

Adequate Denominator Sizes

There must be an adequate denominator size for a P4P measure to be included in the TCOC Quality or Outcome measure performance calculations. Consistent with NCQA guidelines per the HEDIS® 2020 Volume 2: Technical Update, minimum denominator sizes are defined as follows:

Measure Type	**Measures**	**Minimum Denominator Size**
Quality Measures	• AE Common Measure Slate • AE Optional Measure Slates	30
Utilization Measures	• Ambulatory Care: Emergency Department • Potentially Avoidable ED Visits • ED Utilization Among Members with Mental Illness • Inpatient Utilization—General Hospital/Acute Care • All-Cause Readmissions[24]	360 member months

[24] This measure is the observed rate.

TCOC Quality and Outcome Measures Reporting Timeline

The table below indicates regular reporting activity responsibilities of EOHHS, AEs, and MCOs specific to the TCOC Quality Measures and Outcome Measures Slate.

Topic	Category	Task	Responsible Party	PY	Deadline
Outcomes	Outcome performance reporting (for financial incentives)	Submission of performance improvement plans specific to the Outcome measures	AEs	OPY1	10/31/2018
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of performance on the Outcome measures to the AEs and EOHHS for a rolling 12 months of performance for OPY1	MCOs	OPY1	10/31/2018
Outcomes	Outcome performance reporting (for financial incentives)	Submission of performance improvement plans specific to the Outcome measures	AEs	OPY1	1/31/2019
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of performance on the Outcome measures to the AEs and EOHHS for a rolling 12 months of performance for OPY1	MCOs	OPY1	1/31/2019
Outcomes	Outcome performance reporting (for financial incentives)	Submission of performance improvement plans specific to the outcome measures	AEs	OPY1	4/30/2019
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of performance on the Outcome measures to the AEs and EOHHS for a rolling 12 months of performance for OPY1	MCOs	OPY1	4/30/2019
Outcomes	Outcome performance reporting (for financial incentives)	Submission of performance improvement plans specific to the Outcome measures	AEs	OPY1	7/31/2019
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of performance on the Outcome measures to the AEs and EOHHS for a rolling 12 months of performance for OPY1	MCOs	OPY1	7/31/2019

Topic	Category	Task	Responsible Party	PY	Deadline
TCOC	Clinical Data Exchange	Provision of Operational and Data Validation Plan reporting instructions to the MCOs	EOHHS	QPY2	9/9/2019
TCOC	Common Measure Slate Performance Reporting	Calculation and reporting of AE performance on the Common Measure Slate to determine the Overall Quality Score for the TCOC shared savings calculations	MCOs	QPY1	9/30/2019
Outcomes/TCOC	Public Comment on Updates for OPY3 and QPY3	Posting of the TCOC and Outcome measures and methodology PY3 materials for public comment	EOHHS	OPY3/QPY3	10/15/2019
Outcomes	Outcome performance reporting (for financial incentives)	AEs provide MCOs with documentation of both continuing and new processes implemented in OPY2 to reduce a) inpatient admissions and b) avoidable ED visits and AEs and MCOs should meet to discuss these processes as well as performance on the OPY2 outcome metrics	AEs/MCOs	OPY2	10/31/2019
Outcomes	Outcome performance reporting	Quarterly reporting of performance on the Outcome measures for a rolling 12 months of performance to AEs and patient lists as requested by the AEs for OPY2	MCOs	OPY2	10/31/2019
TCOC	Clinical Data Exchange	Submission of an Operational Plan separately addressing each contracted AE to EOHHS	MCOs	QPY2	11/1/2019
TCOC	Overall Quality Score Methodology	Establishment of interim threshold and high-achievement targets for QPY3 using QPY1 and other available data	EOHHS	QPY3	11/30/2019
TCOC	Overall Quality Score Methodology	Determination of the percentage of quality measures needed to achieve full shared savings and any associated methodological updates for QPY3	EOHHS	QPY3	11/30/2019
TCOC	Clinical Data Exchange	Submission of a Data Validation Plan with each contracted AE to EOHHS	MCOs	QPY2	12/1/2019
Outcomes	Outcome performance reporting (for financial incentives)	AEs provide MCOs with documentation of both continuing and new processes implemented in OPY2 to reduce a) inpatient admissions and b) avoidable ED visits and AEs and MCOs should meet to discuss these processes as well as performance on the OPY2 outcome metrics	AEs/MCOs	OPY2	1/31/2020

Topic	Category	Task	Responsible Party	PY	Deadline
Outcomes	Outcome performance reporting	Quarterly reporting of performance on the Outcome measures for a rolling 12 months of performance to AEs and patient lists as requested by the AEs for OPY2/3[25]	MCOs	OPY2/3	1/31/2020
TCOC	Clinical Data Exchange	Submission of clinical data exchange Implementation Status Reports to EOHHS	MCOs	QPY2	2/1/2020
TCOC	Clinical Data Exchange	Submission of clinical data exchange Implementation Status Reports to EOHHS	MCOs	QPY2	4/1/2020
Outcomes	Outcome performance reporting (for financial incentives)	AEs provide MCOs with documentation of both continuing and new processes implemented in OPY2 to reduce a) inpatient admissions and b) avoidable ED visits and AEs and MCOs should meet to discuss these processes as well as performance on the OPY2 outcome metrics	AEs/MCOs	OPY2	4/30/2020
Outcomes	Outcome performance reporting	Quarterly reporting of performance on the Outcome measures for a rolling 12 months of performance to AEs and patient lists as requested by the AEs for OPY2/3[26]	MCOs	OPY2/3	4/30/2020
TCOC	Clinical Data Exchange	Submission of clinical data exchange Implementation Status Reports to EOHHS	MCOs	QPY2	6/1/2020
Outcomes	Outcome performance reporting (for financial incentives)	AEs provide MCOs with documentation of both continuing and new processes implemented in OPY2 to reduce a)inpatient admissions and b) avoidable ED visits and AEs and MCOs should meet to discuss these processes as well as performance on the OPY2 outcome metrics	AEs/MCOs	OPY2	7/31/2020
Outcomes	Outcome performance reporting	Quarterly reporting of performance on the Outcome measures for a rolling 12 months of performance to AEs and patient lists as requested by the AEs for OPY2/3[27]	MCOs	OPY2/3	7/31/2020

[25] One report will serve for both Outcome performance years due to the overlapping performance periods.
[26] One report will serve for both Outcome performance years due to the overlapping performance periods.
[27] One report will serve for both Outcome performance years due to the overlapping performance periods.

Topic	Category	Task	Responsible Party	PY	Deadline
Outcomes/TCOC	Updates to Measure Specifications and Measure and Methodology Changes	Annual convening of AE/MCO participants to discuss: 1) Approve adoption of updated measure specifications for use in OPY3, QPY3, OPY4, and QPY4. Of note, HEDIS is transitioning to a prospective release of updates. July 1, 2020 both HEDIS 2020 and HEDIS 2021 updates will be available.[28] 2) any changes to the measures or methodology for OPY4 and QPY4	EOHHS	OPY4/QPY4	7/31/2020
TCOC	Common Measure Slate Performance Reporting	Calculation and reporting of AE performance on the Common Measure Slate to determine the Overall Quality Score for the TCOC shared savings calculations	MCOs	QPY2	8/31/2020
Outcomes	Outcome performance reporting	Quarterly reporting of performance on the Outcome measures for a rolling 12 months of performance to AEs and patient lists as requested by the AEs for OPY3	MCOs	OPY3	10/31/2020
TCOC	Overall Quality Score Methodology	Calculation of baseline QPY2 performance on the Common Measure Slate to set achievement targets for QPY3 using clinical data exchange and report performance to EOHHS	MCOs	QPY2	11/30/2020
TCOC	Overall Quality Score Methodology	Establishment of final threshold, high-achievement and improvement targets for QPY3 using QPY1, QPY2 and other available data	EOHHS	QPY3	12/31/2020
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of performance on the Outcome measures to the AEs	EOHHS	OPY2	1/28/2021
Outcomes	Outcome measures methodology for OPY3	Re-evaluate the target for ED Utilization Among Members with Mental Illness using OPY2 data	EOHHS	OPY3	1/31/2021

[28] Following 2020, HEDIS updates will become available August 1 prior to the HEDIS measurement year.

Topic	Category	Task	Responsible Party	PY	Deadline
Outcomes	Outcome performance reporting	Quarterly reporting of performance on the Outcome measures for a rolling 12 months of performance to AEs and patient lists as requested by the AEs for OPY3	MCOs	OPY3	1/31/2021
TCOC	Overall Quality Score Methodology	Analysis of any systematic variation in performance between self-reported QPY2 data and QPY2 data calculated using the clinical data exchange; if there is a systematic difference, change threshold and high-achievement targets as appropriate for QPY3	EOHHS	QPY3	3/1/2021
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of performance on the Outcome measures to the AEs	EOHHS	OPY3	7/30/2021
TCOC	Common Measure Slate Performance Reporting	Calculation and reporting of AE performance on the Common Measure Slate to determine the Overall Quality Score for the TCOC shared savings calculations	MCOs	QPY3	8/31/2021

Appendix A: SDOH Screening Measure Specifications

Social Determinants of Health (SDOH) Screening
Steward: Rhode Island Executive Office of Health and Human Services
As of 7/8/2019

SUMMARY OF CHANGES FOR 2020 (PERFORMANCE YEAR 3)

- Clarified that the screening should be performed once per measurement year.
- Added the anchor date of December 31 for retrospective attribution for the eligible population.
- Added an event definition for primary care visit. A primary care visit is required for a member to be in the eligible population.
- Added members in hospice care as an acceptable exclusion.
- Added units of measurement, requiring that adolescents and adults each have an individual screen complete. For children 12 and under, one screen may be completed for all children 12 or under residing in the same household, so long as the results of the screen are documented in each child's medical record.
- Revised documentation requirements to clarify that the screening results must either be embedded in the EHR or a PDF of the screening results must be accessible in the EHR.
- Revised the domains required for screening to be: housing insecurity, food insecurity, transportation, interpersonal violence, and utilities assistance.

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[29]

The percentage of attributed patients who were screened for Social Determinants of Health using a screening tool once per measurement year, where the primary care clinician has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

Eligible Population

Note: *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

Product lines	Medicaid, Commercial
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.

[29] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 3/18/19.

Allowable gap	No break in coverage lasting more than 45 days.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Benefit	Medical
Event/diagnosis	• The patient has been seen by an AE/ACO-affiliated primary care clinician anytime within the last 12 months • For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel. • The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496
Exclusions	• Patients in hospice care (HEDIS Hospice Value Set) • Refused to participate

Electronic Data Specifications

The percentage of attributed patients who were screened for Social Determinants of Health using an EOHHS-approved screening tool, where the primary care practice has documentation of the completion of the screening, the date of the screen, and the results.

Denominator	The eligible population
Numerator	Individuals attributed to the primary care clinician who were screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR.
Unit of measurement	Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record.
Documentation requirements	All screenings must be documented in the attributed primary care clinician's patient health record, regardless of if the primary care clinician screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer or a community partner. The screening results must either be embedded in the EHR or a PDF of the screening results must be accessible in the EHR, i.e., the primary care clinician must not be required to leave the EHR to access a portal or other electronic location to view the screening results. Results for at least one question per required domain must be included for a screen to be considered numerator complaint.
Approved screening tools	For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the

	numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure.
Required domains	1. Housing insecurity; 2. Food insecurity; 3. Transportation; 4. Interpersonal violence; and 5. Utility assistance.

Appendix B: SDOH Infrastructure Development Measure Specifications

Social Determinants of Health (SDOH) Infrastructure Development
Steward: Rhode Island Executive Office of Health and Human Services
As of 7/23/19

SUMMARY OF CHANGES FOR 2020 (PERFORMANCE YEAR 3)

- This is a new measure for 2020 intended to assess Accountable Entities infrastructure development to be able to electronically report on the SDOH Screening measure for PY4 (2021).

Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[30]

The percentage of attributed patients whose primary care clinician's EHR contains a defined field that indicates whether a social determinants of health screen was completed.

Eligible Population

Note: *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

Product lines	Medicaid
Stratification	None
Ages	All ages
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Allowable gap	No break in coverage lasting more than 45 days.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Benefit	Medical
Event/diagnosis	• The patient has been seen by an AE-affiliated primary care clinician anytime within the last 12 months • For the purpose of this measure "primary care clinician" is any provider defined by the reporting managed care organization as a primary care clinician and holding a patient panel. • The following are the eligible CPT/HCPCS office visit codes for determining a primary care visit: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381 – 99387; 99391-99397; 99490; 99495-99496
Exclusions	N/A

[30] Definition from the CDC: www.cdc.gov/socialdeterminants/index.htm. Last accessed on 3/18/19.

Electronic Data Specifications

The percentage of attributed patients whose primary care clinician's EHR contains a defined field that indicates whether a social determinants of health screen was completed.

Denominator	The eligible population
Numerator	Individuals attributed whose primary care clinician's EHR contains a defined field that indicates whether a social determinants of health screen was completed as of 12/31/20.
Unit of measurement	N/A
Documentation requirements	N/A
Approved screening tools	N/A
Required domains	N/A

Appendix C: Example Overall Quality Score Calculation for QPY3

Below is a high-level example of the calculation of the Overall Quality Score for QPY3. Further information on calculation of the individual score components can be found in the Overall Quality Score Determinations Excel model. The Overall Quality Score Determinations Excel model can be obtained by emailing Rebekah LaFontant, Rebekah.LaFontant@ohhs.ri.gov.

Cells in grey indicate the target type is not applicable for a given measure in QPY3.

Measure	Score by Target Type			Final Measure Score (highest performance across target types)
	Achievement (0-1)	Improvement (0 or 1)	Reporting (0 or 1)	
Adolescent Well-Care Visit	1	0		1
Breast Cancer Screening	1	1		1
Comprehensive Diabetes Care: Eye Exam	0.65	0		0.65
Comprehensive Diabetes Care: HbA1c Control <8.0%	0	1		1
Controlling High Blood Pressure	0.70	1		1
Developmental Screening in the First Three Years of Life	0	0		0
Follow-up After Hospitalization for Mental Illness (7-day)	0.45	1		1
Weight Assessment and Counseling for Children and Adolescents - Composite Score	0.30	0		0.30
Screening for Clinical Depression & Follow-up Plan			0	0
Social Determinants of Health Infrastructure Development	1			1
Overall Quality Score (sum of final measure scores divided by number of measures)				=6.95/10 = **0.695**

Appendix D: EOHHS Evaluation Criteria: MCO Electronic Clinical Data Operational and Validation Plans

Overview

MCOs must submit and update an Operational Plan and a Data Validation Plan to address how they will collect electronically transmitted clinical data from each AE and how they will calculate and ensure integrity of both clinical data and measure calculations for three classes of measures: a) standard HEDIS measures; b) non-standard, externally developed HEDIS-like quality measures; and c) the EOHHS-defined SDOH screening measure.

Where applicable, MCOs may use certified vendors (NCQA and/or eCQM) to meet these requirements. However, the intention is to ensure valid and reliable population-level data collection (in contrast to sampling used by NCQA for health plan accreditation). For required measures which are not currently supported by any certified external vendor, MCOs must describe their approach to meeting the data collection and validation requirements. (Where noted below with an asterisk (*), requirements can be met data through the RI Quality Reporting System administered by IMAT Solutions.)

I. Operational Plan Requirements

Develop a project plan with timelines (through December 2020), action items, MCO responsible parties, partners, and success criteria to include how the MCO will achieve (at a minimum) each of the following:

1) Collection of Clinical Data from Each AE

a) *Establish a HIPAA-compliant methodology for Secure Data Exchange of PHI.
b) *Provide to the AE:
    i) Denominator identification: patients included in each measure, as well as any known clinical results (e.g., provider, test, result, date);
    ii) The MCO's preferred file format for data submission, if existing data exchange is not available; and
    iii) A format and timeline for the AE to provide a detailed description of the data source including any data transformations that occur to get the output file and a Code Book for data elements that are non-standard.
c) Establish a mechanism to:
    i) Conduct case identification, reconciliation, and dispute resolution, assessing the reasonableness of the number of patients included in a specific measure, benchmarking against data from prior measurement periods and/or local and national rates;
    ii) Recognize file receipt;
    iii) Ensure that any homegrown codes used within the AE's EMR(s) to identify clinical results are fully understood by both the MCO and the AE. See 1) b) iii) above.
    iv) Establish expectations that the AE will prescreen data for data quality before sending it to the MCO;
    v) Report data quality issues identified; and
    vi) Reconcile any disputes between the AE and MCO regarding data collected.

II. Data Validation Plan

Develop a project plan with timelines (through December 2020), action items, MCO responsible parties, partners, and success criteria to include how the MCO will achieve (at a minimum) each of the following:

1) Assessment and Data Profiling of AE Files for Quality

a) *Develop an automated approach to assess data quality for conformance with the following:
   i) Variable length and type (e.g., numeric or text)
   ii) Expected values:
      (1) Range, mean and median for numeric or date fields (e.g., age)
      (2) Expected values for categorical variables (e.g., gender)
      (3) Expected values for text fields, particularly if used in file or record merging
         (a) Develop a plan for issues with extra spaces, leading 0s, case-sensitivity, spelling errors, etc.
      (4) Expected Patterns (e.g., telephone numbers, zip codes)
   iii) Uniformity of units within a field (e.g., weight in kilos or pounds, not both)
   iv) Required fields (e.g., health plan ID may be required for merging files)
   v) Unique fields (e.g., only one table entry for each health plan ID)
   vi) Cross-field validity (e.g., discharge date must be after admission date, men who aren't transgender aren't eligible for cervical cancer screenings)
   vii) Duplicate records
   viii) Relational integrity with other tables, as appropriate
   ix) Missing fields within records or records with excessively missing data

2) Reconciliation of Issues Identified by the Initial File Review

a) *Report results of data profiling to the AE to include unexpected, incorrect, and inconsistent data.
b) Reach agreement with the AE about how to fix or remove the anomalies discovered.
c) *After completion of corrections, repeat the data profiling exercise to confirm corrections are complete.
d) Document changes to achieve a final clean file.

3) **Incorporation of External Data Validation and Audit Process to Ensure Data Accuracy**

a) Ensure the data validation and audit plan achieves the same or better accuracy as that employed by Minnesota Community Measurement (MNCM).
   i) The MCO should use MNCM or another vendor approved by the State.

4) Management of the Merging of AE and MCO Data

a) *Address identity management across organizations.
   i) Ensure patient matching between MCO and AE files is complete and correct.
   ii) Develop a mechanism to reconcile:
      (1) Unmatched or ambiguously matched patient data
      (2) Duplicate patients, particularly if there are differing clinical measure results

5) Calculation of Final Clinical Measure Rates

a) Address data validity of calculated values.

i) Develop a process for conducting the same level of data validity testing on MCO input files used to calculate measure rates as the MCO is performing with AE files, i.e., # 1 immediately above.
ii) Develop a process to ensure that calculated variables are accurate and reasonable.
iii) Develop a process to reconcile AE clinical results when the MCO has an existing result from another source, consistent with measure specifications (e.g., HbA1c in MCO lab file feed vs. point of care result reported by AE).
iv) Conduct data validation steps on the final MCO output file to ensure reasonableness of all calculated rates.

Appendix E: MCO Electronic Clinical Data Implementation Status Report Template

The template below should be used by MCOs for submission of electronic clinical data exchange Implementation Status Reports.

Reports should be sent to EOHHS following the EOHHS Medicaid MCO Requirements for Reporting and Reporting Penalties Policy and Procedures for Managed Care Core Contact (embedded below) by the following dates: February 1, 2020, April 1, 2020, and June 1, 2020.

Report Information

MCO:

Report Submitter:

Reporting Period:

Operational Considerations

Please describe the status of your clinical data collection efforts with each contracted AE. All responses should include a description of the following activity, with associated timelines for each:

1. the planned data exchange methodology;
2. the status of process planning to exchange data (if not already initiated);
3. the plan for test data transmission and measure calculation activity;
4. identification of data transmission issues, and
5. proposed next steps to resolve data transmission issues.

BVCHC:

Coastal:

IHP:

Integra:

PCHC:

Prospect:

If you previously received any feedback from EOHHS on your Operational Plan, please describe steps taken to address EOHHS' feedback:

Data Validation

Please describe the status of your data validation activities with each contracted AE. Narrative descriptions should touch on the following activity, with associated timelines for each:

1. assessment and data profiling of AE files for quality;
2. reconciliation of issues identified by the initial file review;
3. incorporation of external data validation and audit processes to ensure data accuracy;
4. management of the merging of AE and MCO data, and
5. calculation of valid clinical measure rates.

BVCHC:

Coastal:

IHP:

Integra:

PCHC:

Prospect:

If you previously received any feedback from EOHHS on your Data Validation Plan, please describe steps taken to address EOHHS' feedback:

Appendix F: All-Cause Readmissions

All-Cause Readmissions
EOHHS

Description

For members 18 to 64 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. Data are reported in the following categories:

1. Count of Index Hospital Stays (IHS) (denominator).
2. Count of Observed 30-Day Readmissions (numerator).
3.

Note: References to definitions and value sets default to those used by NCQA for 2020/

Definitions

HIS	Index hospital stay. An acute inpatient or observation stay with a discharge on or between January 1 and December 1 of the measurement year, as identified in the denominator.
Index Admission Date	The IHS admission date.
Index Discharge Date	The IHS discharge date. The index discharge date must occur on or between January 1 and December 1 of the measurement year.
Index Readmission Stay	An acute inpatient or observation stay for any diagnosis with an admission date within 30 days of a previous Index Discharge Date.
Index Readmission Date	The admission date associated with the Index Readmission Stay.
Planned hospital stay	A hospital stay is considered planned if it meets criteria as described in step 3 (required exclusions) of the *numerator*.
Plan population	Members who meet all of the following criteria: • 18 and older as of January 1 of the measurement year. • Continuously enrolled for at least 395 days, with no more than one gap in enrollment of up to 45 days during the 395-day period, between January 1 of the year prior to the measurement year and December 1 of the measurement year. Assign members to the product and product line at the start of this defined continuous enrollment period.
Outlier	Medicaid members in the eligible population with four or more index hospital stays between January 1 and December 1 of the measurement year.
Nonoutlier	Members in the plan population who are not considered outliers.
Classification period	365 days prior to and including an Index Discharge Date.

Eligible Population

Product line	Medicaid
Stratification	
Ages	*For Medicaid,* ages 18–64 as of the Index Discharge Date.
Continuous enrollment	365 days prior to the Index Discharge Date through 30 days after the Index Discharge Date.
Allowable gap	No more than one gap in enrollment of up to 45 days during the 365 days prior to the Index Discharge Date and no gap during the 30 days following the Index Discharge Date.
Anchor date	Index Discharge Date.
Benefit	Medical.
Event/diagnosis	An acute inpatient or observation stay discharge on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not members. Include all acute inpatient or observation stay discharges for nonoutlier members who had one or more discharges on or between January 1 and December 1 of the measurement year. Follow the steps below to identify acute inpatient and observation stays.

Administrative Specification

Denominator	The eligible population.
Step 1	Identify all acute inpatient and observation stay discharges on or between January 1 and December 1 of the measurement year. To identify acute inpatient and observation stay discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays. The measure includes acute discharges from any type of facility (including behavioral healthcare facilities).
Step 2	*Direct transfers:* For discharges with one or more direct transfers, use the last discharge. Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found inNCQA's *Guidelines for Risk Adjusted Utilization Measures.* Exclude the hospital stay if the direct transfer's discharge date occurs after December 1 of the measurement year.
Step 3	Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.
Step 4	Exclude hospital stays for the following reasons: • The member died during the stay. • Female members with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim. • A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 5 Calculate continuous enrollment.

Step 6 Remove hospital stays for outlier members and report these members as outliers in Table ACR-1/2/3.
Note: *Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outlier members.*

Step 7 Add the denominators from each contracted plan rate to obtain the Accountable Entity's denominator.

Numerator At least one acute readmission for any diagnosis within 30 days of the Index Discharge Date.

Step 1 Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement year. To identify acute inpatient and observation admissions:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set) and observation stays (Observation Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

Step 2 *Direct transfers:* For discharges with one or more direct transfers, use the last discharge. Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation or between observation and acute inpatient using the definition found in the NCQA's *Guidelines for Risk Adjusted Utilization Measures.*

Step 3 Exclude acute hospitalizations with any of the following criteria on the discharge claim:

- Female members with a principal diagnosis of pregnancy (Pregnancy Value Set).
- A principal diagnosis for a condition originating in the perinatal period (Perinatal Conditions Value Set).
- Planned admissions using any of the following:
  - A principal diagnosis of maintenance chemotherapy (Chemotherapy Encounter Value Set).
  - A principal diagnosis of rehabilitation (Rehabilitation Value Set).
  - An organ transplant (Kidney Transplant Value Set, Bone Marrow Transplant Value Set, Organ Transplant Other Than Kidney Value Set, Introduction of Autologous Pancreatic Cells Value Set).
  - A potentially planned procedure (Potentially Planned Procedures Value Set) without a principal acute diagnosis (Acute Condition Value Set).

Note: *For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step.*

Step 4 For each IHS identified in the denominator, determine if any of the acute inpatient and observation stays identified in the numerator have an admission date within 30 days after the Index Discharge Date.
Note: *Count each acute hospitalization only once toward the numerator, for the last denominator event.*

If a single numerator event meets criteria for multiple denominator events, only count the last denominator event. For example, consider the following events:

- *Acute Inpatient Stay 1: May 1–10.*
- *Acute Inpatient Stay 2: May 15–25 (principal diagnosis of maintenance chemotherapy).*
- *Acute Inpatient Stay 3: May 30–June 5.*

All three acute inpatient stays are included as denominator events. Stay 2 is excluded from the numerator because it is a planned hospitalization. Stay 3 is within 30 days of Stay 1 and Stay 2. Count Stay 3 as a numerator event only towards the last denominator event (Stay 2, May 15–25).

Step 5 Add the numerators from each contracted plan rate to obtain the Accountable Entity's denominator.

Reporting: **Number of Members in Plan Population**

Step 1 Determine the member's age as of January 1 of the measurement year.

Step 2 Report the count of members in the plan population for each age group and the overall total. Enter these values in reporting Tables ACR-1/2/3.

Reporting: **Number of Outliers**

Step 1 Determine the member's age as of January 1 of the measurement year.

Step 2 Report the count of outlier members for each age group and the overall total. Enter these values in reporting Tables ACR-1/2/3.

Calculated: **Outlier Rate**

The number of outlier members divided by the number of members in the plan population, displayed as a permillage (multiplied by 1,000), for each age group and the overall totals calculated by IDSS.

Reporting: **Denominator**

Count the number of IHS among nonoutlier members for each age group and enter these values into the reporting table under Count of Index Stays.

Reporting: **Numerator**

Count the number of observed IHS among nonoutlier members with a readmission within 30 days of discharge for each age group and enter these values into the reporting tables under Count of Observed 30-Day Readmissions.

Calculated: **Observed Readmission Rate**

The Count of Observed 30-Day Readmissions divided by the Count of Index Stays calculated by IDSS.

- *Supplemental data may not be used for this measure.*

Table ACR-1/2/3: Population and Outlier Rate

Age	Members in Population	Outlier Members	Outlier Rate
18-44			
45-54			
55-64			
65-74			
75-84			
85+			
18-64 Total			

Table ACR-A-1/2/3: All-Cause Readmissions Rates Among Nonoutlier Members by Age

Age	Count of Index Stays	Count of Observed 30-Day Readmissions	Observed Readmission Rate
18-44			
45-54			
55-64			
65-74			
75-84			
85+			
18-64 Total			
65+ Total			

Appendix G: Potentially Avoidable ED Visits

Potentially Avoidable ED Visits
NYU, modified by EOHHS

Numerator: any visit during the measurement period for a non-emergent ED diagnosis (using the ICD-9 or ICD-10 codes supplied by NYU), this is calculated by combining the probabilities of the first 2 severity categories (non-emergent and a current emergency that could have been avoided by regular preventative visits) and if the combined probability is greater than 50%.

Denominator: all ED visits in the measurement period.

Additional Information on the NYU methodology, including a list of ICD-9/10 codes can be found here: https://wagner.nyu.edu/faculty/billings/nyued-background.

- Validation of an Algorithm for Categorizing the Severity of Hospital Emergency Department Visits: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3881233/.