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 3 through 5

Rhode Island Executive Office of Health and Human Services (EOHHS)
April 20, 2022

A full revision history can be found at the end of the manual, before Appendix A.

Contents

Purpose

Rhode Island Executive Office of Health and Human Services' (EOHHS) Health System Transformation Project (HSTP) is focused on the establishment and implementation of the Accountable Entity (AE) Program. The core strategic goal of the AE program is to transition the Medicaid payment system away from fee-for-service to alternative payment models. A fundamental element of the program, in the transition to alternative payment models, is to drive delivery system accountability to improve quality, member satisfaction, and health outcomes, while reducing total cost of care (TCOC).

The purpose of this document is to clearly outline guidelines for implementation of both the TCOC quality measures and pay-for-performance (P4P) methodology and the Outcome measures and incentive methodology for Performance Years (PY) 3 through 5 (for more information on methodology and targets from PY1 and PY2 please consult earlier versions of this document which can be found on the EOHHS website). 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
4	July 1, 2021-June 30, 2022	Jan 1, 2021-Dec 31, 2021	Jan 1, 2021-Dec 31, 2021
5	July 1, 2022-June 30, 2023	Jan 1, 2022-Dec 31, 2022	Jan 1, 2022-Dec 31, 2022

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.

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 will be reported annually for the full Quality Measures Performance Year.[2]

Measures are categorized in the following ways:

- **Incentive Use** status means that a measure must be included in the Overall Quality Score calculation, i.e., the measure will influence the distribution of any shared savings. The measure can be P4R, P4P or P4R/P4P.
- **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 reporting of or performance on the measure.

For QPY3, measures were impacted by EOHHS's methodology changes outlined in the May 8, 2020 EOHHS memo "Program Year 2 and 3 Modifications to HSTP/AE program as a result of COVID 19." For QPY3, EOHHS required that all QPY3 AE Common Measure Slate measures be reported. However, only a subset of these measures had to be used in the incentive methodology. The "QPY3 Reporting and Incentive Use" column in the table below indicates the measure's status in QPY3. For more information, see the "Calculation of the Overall Quality Score" section below.

For QPY4, measures marked as P4R or P4P are once again required for incentive use. Of note, EOHHS will track performance for the *Patient Engagement* measure internally for QPY4.

For QPY5, measures marked as P4R or P4P are required for incentive use.

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

[2] For QPY4, performance for Screening for Depression and Follow-up Plan need only be reported for July 1, 2021 – December 31, 2021.

Measures	Steward	Data Source[3]	Specifications	AE Common Measure Slate[4]		
				QPY3 Reporting and Incentive Use	QPY4 Reporting and Incentive Use	QPY5 Reporting and Incentive Use
HEDIS Measures						
Adult BMI Assessment	NCQA	Admin/ Clinical	Current HEDIS specifications: QPY3: HEDIS MY 2020 QPY4: HEDIS MY 2021 QPY5: HEDIS MY 2022	P4P/P4R		
Breast Cancer Screening	NCQA	Admin		P4P	P4P	P4P
Child and Adolescent Well-Care Visits (adolescent age stratifications only)[5]	NCQA	Admin		Reporting-only	Reporting-only	P4P
Child and Adolescent Well-Care Visits (2 components: 3-11 years and total)	NCQA	Admin			Reporting-only	Reporting-only
Controlling High Blood Pressure	NCQA	Admin/ Clinical		P4P/P4R	P4P	P4P
Eye Exam for Patients with Diabetes	NCQA	Admin/ Clinical		Reporting-only	P4P	P4P
Follow-up after Hospitalization for Mental Illness	NCQA	Admin		P4P – 7 or 30 days (the follow-up rate that is not P4P is reporting-only)	P4P – 7 days (30 days is reporting-only)	P4P – 7 days (30 days is reporting-only)
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Control (<8.0%)	NCQA	Admin/ Clinical		P4P/P4R	P4P	P4P
Lead Screening in Children	NCQA	Admin				P4R
Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents	NCQA	Admin/ Clinical		P4P/P4R	P4P	
Non-HEDIS Measures (Externally Developed)						
Developmental Screening in the First Three Years of Life	OHSU	Admin/ Clinical	QPY3: CTC-RI/OHIC (December 2018 version)[6] QPY4: CTC-RI/OHIC (December 2020 version)[7]	P4P/P4R	P4P	P4P

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

[4] Please refer to the May 21, 2021 version of the Implementation Manual for more information on the QPY1 and QPY2 measures.

[5] EOHHS initially included the HEDIS *Adolescent Well-Care Visits* measure in the AE Common Measure Slate beginning in QPY3. NCQA modified the measure for MY2020 (which overlaps with QPY3) to combine the previous *Adolescent Well-Care Visits* measure and the *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*, include members age 7-11 and only allow reporting using administrative data rather than administrative data or hybrid data. EOHHS adopted the adolescent age stratifications, i.e., 12-17 years and 18-21 years, of the new *Child and Adolescent Well-Care Visits* measure to align with the updated HEDIS measures and select a measure that was the closest replacement for the intended measure.

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

[7] http://www.ohic.ri.gov/documents/2021/April/Revised%20Measure%20Specifications%20Adult%20and%20Pedi%20CTC-OHIC%20December%202020%20clean.pdf

Measures	Steward	Data Source[3]	Specifications	AE Common Measure Slate[4]		
				QPY3 Reporting and Incentive Use	QPY4 Reporting and Incentive Use	QPY5 Reporting and Incentive Use
			QPY5: CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[8]			
Screening for Depression and Follow-up Plan	CMS	Admin/ Clinical	QPY3: CMS MIPS 2020[9] QPY4: CMS MIPS 2021, modified by EOHHS (April 8, 2021 version) QPY5: CMS MIPS 2022, modified by EOHHS (February 14, 2022 version – included as Appendix A)	P4P/P4R	P4P for July 1, 2021 – December 31, 2021[10]	P4P
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	Admin/ Clinical	QPY3: CMS MIPS 2020 QPY4: CMS MIPS 2021 QPY5: CMS MIPS 2022	P4P/P4R	Reporting- only	Reporting-only
Non-HEDIS Measures (EOHHS-developed)						
Social Determinants of Health Infrastructure Development	EOHHS	Admin/ Clinical	QPY3: EOHHS (August 6, 2020 version)	Reporting-only Yes		
Social Determinants of Health Screening	EOHHS	Admin/ Clinical	QPY3: EOHHS (August 6, 2020 version) QPY4: EOHHS (July 29, 2021 version) QPY5: EOHHS (February 14, 2022 version – included as Appendix B)	Reporting-only[11] Yes	P4P	P4P

[8] https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf

[9] https://qpp.cms.gov/mips/explore-measures/quality-measures?tab=qualityMeasures&py=2020

[10] EOHHS is only implementing this measure for half of QPY4 because of lack of consistent interpretation of "follow-up." .

[11] This measure was intended to be reporting-only for QPY3. However, due to a lack of clarity in previous iterations of the Implementation Manual, this measure was implemented as either reporting-only or P4R for QPY3.

Eligible Population for All Measures

Beginning in QPY3, all measures in the Common Measure Slate are calculated with Integrated Health Home (IHH) members attributed to the AE based on their primary care provider.

Beginning in QPY4, the eligible population should be calculated using the attribution methodology described in the "General Guidelines" section of the Implementation Manual.

Eligible Population for Non-HEDIS Measures

Beginning in QPY3, all non-HEDIS measures in the Common Measure Slate were 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 visit codes for determining an Active Patient:

1. Eligible CPT/HCPCS office visit codes: 99201-99205; 99212-99215; 99324-99337; 99341-99350; 99381–99387; 99391-99397; 99490; 99495-99496.
2. Eligible telephone visit, e-visit or virtual check-in codes:
    a. CPT/HCPCS/SNOMED codes: 98966-98968; 98969-98972; 99421-99423; 99441-99443; 99444; 11797002; 185317003; 314849005; 386472008; 386473003; 386479004.
    b. Any of the above CPT/HCPCS codes in 1 or 2.a. with the following POS codes: 02.
    c. Any of the above CPT/HCPCS codes in 1 or 2.a. with the following modifiers: 95; GT.

TCOC Quality P4P Methodology

This section describes the TCOC quality P4P methodology for QPY3-5. 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 Overall Quality Score Measures

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

QPY	Minimum # P4P/P4R Measures	Specific Measures Required for Overall Quality Score
3	3	P4P measures used in the QPY2 contracts
4	9	All AE Common Measure Slate measures except for *Child and Adolescent Well-Care Visits* (years 3-11, 12-21 and total), *Follow-up After Hospitalization for Mental Illness (30-day)* and *Tobacco Use: Screening and Cessation Intervention*, as these are reporting-only measures.
5	10	All AE Common Measure Slate measures except for *Child and Adolescent Well-Care Visits* (3-11 years and total), *Follow-up After Hospitalization for Mental Illness (30-day)* and *Tobacco Use: Screening and Cessation Intervention*, as these are reporting-only measures.

Calculation of the Overall Quality Score

For QPY3, EOHHS modified the Overall Quality Score methodology that was documented in previous versions of this Implementation Manual in effort to hold providers harmless for QPY3 quality performance due to the COVID-19 pandemic. MCOs were required to use their existing QPY2 measures and methodology (inclusive of measure targets and weights), except that:

1. for any measure designated as P4P in a QPY2 contract and for which an AE's QPY3 value is superior to the QPY2 value, MCOs were required to use the QPY3 rate instead of the QPY2 rate in the calculation of the Overall Quality Score, and
2. for *Social Determinants of Health Screening*, a QPY3 value could not be substituted for QPY2 since there were significant specification changes. *Social Determinants of Health Screening* was considered a reporting-only measure for QPY3.

MCOs were required to report measures that are listed as "reporting-only" in the "QPY3 Reporting and Incentive Use" column to EOHHS, but unless the measure is listed as P4P/P4R in the "QPY3 Reporting and Incentive Use" column, these measures were not included in the QPY3 Overall Quality Score calculation. See the September 21, 2021 version of the Implementation Manual for more information on which measures had to be included in the Overall Quality Score calculation.

For QPY4, EOHHS developed a standard Overall Quality Score methodology that is required for use by all AEs and MCOs.[12] 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 P4P 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-performance."
        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.

[12] For QPY1-QPY3, Thundermist was embedded within IHP. Effective July 1, 2021, Thundermist became a single-entity AE. For QPY4, IHP and Thundermist will be assessed using both the achievement targets and improvement target. IHP's QPY2 performance will serve as the baseline period against which to assess improvement for QPY4 for both IHP and Thundermist.

b. Improvement target:
    i. Improvement points will be awarded if QPY4 performance is 0.10 percentage points greater than baseline performance. AEs will not need to demonstrate a three-percentage point increase over baseline in QPY4, as the original QPY3 methodology specified.
        1. The value may be less than what would be required to demonstrate statistical significance in a given year.
    ii. QPY2 performance will be the basis of assessing improvement for QPY4, due to the negative impact of COVID-19 on QPY3 performance.
    iii. Improvement as defined by 1.b.i-ii will earn the AE a score of "1."

2. **Scoring *SDOH Screening***: This measure will be scored differently than the other Common Measure Slate measures for QPY4. Given that this measure changed significantly in QPY3, there is no QPY2 rate against which EOHHS can assess improvement in QPY4. Therefore, AEs will only be assessed based on achievement for this measure in QPY4, as described in 1.a above.

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 nine measures and divide the result by nine.[13] This resulting quotient is the "Overall Quality Score." The MCO shall multiply the annual savings generated by the AE by the Overall Quality Score, adjusted upwards as described below, to determine the shared savings to be distributed to the AE. The MCO shall multiply the annual losses accrued by the AE by value of the Overall Quality Score divided by four, as described below, and subtract this product from the total losses to determine the shared losses to be paid by the AE. **Appendix C: Example Overall Quality Score Calculation for QPY4** illustrates this calculation.

    a. Overall Quality Score Adjustment for Shared Savings Distribution**:** The overall quality multiplier shall be adjusted upwards by 0.10 for each AE contract, with a quality multiplier cap at one (1.0). This means, for example, that an AE earning 80% of the available points used to establish the quality multiplier would receive 90% of any earned shared savings.

    b. Overall Quality Score Adjustment for Shared Losses Mitigation: The overall quality multiplier shall be divided by four for each AE contract to mitigate shared losses.

MCOs and AEs may calculate AE Overall Quality Score performance using the "Overall Quality Score Determinations QPY4" Excel reporting template. A copy of the Excel reporting template can be obtained on EOHHS' SFTP site.[14]

[13] *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.
[14] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

For QPY5, EOHHS will use the same methodology as QPY4 with a few modifications. The list below summarizes the methodological changes from QPY4. The text that follows includes a more detailed explanation of the QPY5 Overall Quality Score Methodology.

- Improvement points will be awarded if QPY5 performance is three percentage points greater than baseline performance.
- AEs can earn improvement target points for *SDOH Screening*.
- AEs cannot earn improvement target points for *Lead Screening in Children* or *Screening for Depression and Follow-up Plan* due to lack of adequate baseline data.
- Baseline rates for assessing improvement for all other QPY5 measures will vary by measure

The required QPY5 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 P4P measure, 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-performance."
        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.
        iii. AEs will receive one point for reporting performance on *Lead Screening in Children*.

    b. <u>Improvement target:</u>
        i. Improvement points will be awarded if QPY5 performance is three percentage points greater than baseline performance.
            1. AEs cannot earn improvement target points for *Lead Screening in Children* or *Screening for Depression and Follow-up Plan*.
        ii. The baseline year for assessing improvement will vary by measure.
            1. QPY2 (i.e., 2019) will serve as the baseline year for the following measures: *Developmental Screening in the First Three Years of Life*, *HbA1c Control for Patients with Diabetes: HbA1c Control <8.0%*.
            2. QPY3 will serve as the baseline year for the following measures: *Breast Cancer Screening*, *Child and Adolescent Well-Care Visits (Adolescent Age Ranges*

Only), *Controlling High Blood Pressure*, *Eye Exam for Patients with Diabetes, Follow-up After Hospitalization for Mental Illness (7 Days)*, *SDOH Screening*.

3. The baseline rate for Thundermist will be based on the 33rd percentile across all FQHC-based AEs in the baseline year, as outlined in the table below.

Measure Name	Thundermist QPY5 Baseline Rate
Breast Cancer Screening	53.4%
Child and Adolescent Well-Care Visits (*Adolescent Age Ranges Only*)	29.8%
Controlling High Blood Pressure	55.2%
Developmental Screening in the First Three Years of Life	60.7%
Eye Exam for Patients with Diabetes	52.3%
Follow-up After Hospitalization for Mental Illness (7 Days)	50.8%
HbA1c Control for Patients with Diabetes: HbA1c Control <8.0%	58.9%
Lead Screening in Children	N/A – reporting only
Screening for Depression and Follow-up Plan	N/A – no improvement target in QPY5
SDOH Screening	18.2%

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

2. **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 ten. This resulting quotient is the "Overall Quality Score." The MCO shall multiply the annual savings generated by the AE by the Overall Quality Score, adjusted upwards as described below, to determine the shared savings to be distributed to the AE. The MCO shall multiply the annual losses accrued by the AE by value of the Overall Quality Score divided by four, as described below, and subtract this product from the total losses to determine the shared losses to be paid by the AE. **Appendix D: Example Overall Quality Score Calculation for QPY5** illustrates this calculation.

   a. Overall Quality Score Adjustment for Shared Savings Distribution**:** The overall quality multiplier shall be adjusted upwards by 0.10 for each AE contract, with a quality multiplier cap at one (1.0). This means, for example, that an AE earning 80% of the available points used to establish the quality multiplier would receive 90% of any earned shared savings.

   b. Overall Quality Score Adjustment for Shared Losses Mitigation: The overall quality multiplier shall be divided by four for each AE contract to mitigate shared losses.

MCOs and AEs may calculate AE Overall Quality Score performance using the "Overall Quality Score Determinations QPY5" Excel reporting template. A copy of the Excel reporting template can be obtained on the EOHHS' SFTP site.[15]

[15] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

TCOC Quality Benchmarks

For QPY3, negotiated AE and MCO QPY2 benchmarks were used to evaluate AE performance and inform the negotiated formula for distribution of shared savings.

For QPY4, EOHHS employed a combination of internal and external sources to set achievement targets. EOHHS set targets for QPY4 using AE QPY2 data,[16] national and New England Medicaid (HMO) data from NCQA Quality Compass 2020 (CY 2019) and national and Rhode Island state FY 2019 data from CMS' 2019 Child and Adult Health Care Quality Measures report in advance of QPY4. If there was a significant drop in the number of AEs meeting the target when moving from one target source to another, EOHHS selected the easier-to-meet target.

EOHHS utilized AE QPY2 data to ensure the following guiding principles were met for the threshold target: 1) the threshold target should be below the current Rhode Island Medicaid plan-weighted average; the threshold target should be, if possible, roughly two percentile distributions lower than the current Rhode Island Medicaid plan-weighted average; and 3) the threshold target should never be below the Medicaid national 50th percentile. EOHHS also utilized the following guiding principles for the high-performance target: 1) the high-performance target should be attainable for at least some AEs; 2) the high-performance target should not exceed a value that represents a reasonable understanding of "high performance"; and 3) the high-performance target should ideally never be below the current performance of every single AE.

EOHHS utilized 2020 data from AEs and MCOs that were able to provide these data to calculate the average difference between 2019 and 2020 rates. It then calculated an "adjuster" for each measure, i.e., half the difference between 2019 and 2020 performance, based on the expectation that 2021 performance will be better than 2020.

The achievement targets for QPY4 are as follows:

Measure Name	Threshold Target[17]	Source	High-Performance Target[18]	Source
Breast Cancer Screening	55.8	NCQA National Medicaid 67th percentile	63.2	NCQA National Medicaid 90th percentile
Comprehensive Diabetes Care: Eye Exam	51.8	NCQA National Medicaid 67th percentile	60.8	NCQA New England Medicaid 67th percentile
Comprehensive Diabetes Care: HbA1c Control <8.0%	49.3	NCQA National Medicaid 50th percentile	58.7	NCQA New England Medicaid 90th percentile
Controlling High Blood Pressure	53.8	NCQA National Medicaid 50th percentile	64.2	NCQA New England Medicaid 75th percentile

[16] QPY2 data were submitted by MCOs by October 31, 2020. For ease of MCO reporting, MCOs had to submit data with the IHH population included.
[17] All targets were modified to account for the impact of COVID-19 on performance using an "adjuster."
[18] See above footnote.

Measure Name	Threshold Target[17]	Source	High-Performance Target[18]	Source
Developmental Screening in the First Three Years of Life	53.2	CMS National 75th percentile	65.0	CMS RI average
Follow-up After Hospitalization for Mental Illness (7-day)	42.5	NCQA National Medicaid 67th percentile	62.2	NCQA National Medicaid 90th percentile
Screening for Depression and Follow-up Plan[19]	6.6	Lowest 2019 AE-reported performance	24.8	Conservative follow-up rate from Providence Community Health Center
Social Determinants of Health (SDOH) Screen	25.0	N/A	50.0	N/A
Weight Assessment and Counseling for Children and Adolescents – Composite Score	62.9	NCQA National Medicaid 50th percentile	67.9	NCQA National Medicaid 67th percentile

For QPY5, EOHHS employed a combination of internal and external data sources to set achievement targets for QPY5. EOHHS set targets for QPY5 using (1) AE data, as reported by MCOs, from QPY2-QPY3,(2) AE data, as reported by AEs, from QPY3-QPY4, (3) national and New England Medicaid (HMO) data from NCQA Quality Compass 2020 (CY 2019 or CY 2018 data), (4) national and Rhode Island state data from CMS' 2019 Child and Adult Health Care Quality Measures report and (5) Rhode Island practice-reported data for October 1, 2018 – September 30, 2019 from the OHIC PCMH Measures Survey.

EOHHS used the same guiding principles used for QPY4 to ensure the targets are both attainable and sufficiently ambitious as to motivate quality improvement. It solicited input from the AE/MCO Work Group prior to finalizing the targets.

The achievement targets for QPY5 are as follows:

Measure Name	Threshold Target	Source	High-Performance Target	Source
Breast Cancer Screening	55.1%	National Medicaid 33rd percentile	69.2%	National Medicaid 90th percentile
Child and Adolescent Well-Care Visits (*Adolescent Age Ranges Only*)	34.2%	New England Medicaid 25th percentile	56.5%	New England Medicaid 90th percentile

[19] Given how low the threshold target is for this measure, EOHHS did not further modify the target by applying the "adjuster" as it did for the other measures.

Measure Name	Threshold Target	Source	High-Performance Target	Source
Controlling High Blood Pressure	58.2%	National Medicaid 33rd percentile	67.6%	National Medicaid 75th percentile
Developmental Screening in the First Three Years of Life	63.0%	Rhode Island 25th percentile	79.0%	Rhode Island 50th percentile
Eye Exam for Patients with Diabetes	54.6%	National Medicaid 33rd percentile	64.5%	National Medicaid 75th percentile
Follow-up After Hospitalization for Mental Illness (7-day)	49.7%	National Medicaid 75th percentile	64.9%	National Medicaid 90th percentile
HbA1c Control for Patients with Diabetes: HbA1c Control <8.0%	47.7%	National Medicaid 33rd percentile	60.8%	National Medicaid 90th percentile
Lead Screening in Children	N/A – reporting only for QPY5			
Screening for Depression and Follow-up Plan	45.0%	2021 preliminary AE-reported data	75.0%	2021 preliminary AE-reported data
Social Determinants of Health (SDOH) Screen	42.4%	2020 Rhode Island AE 10th percentile (excluding low outliers)	59.2%	2020 Rhode Island AE 50th percentile (excluding low outliers)

Race, Ethnicity, Language and Disability Status (RELD) Measure

For QPY4 and QPY5, AEs and MCOs may earn up to 5% of AEIP funds based on submission of performance rates for four AE Common Measure Slate measures stratified by race, ethnicity, language, and disability status: (1) *Eye Exam for Patients with Diabetes*, (2) *HbA1c Control for Patients with Diabetes: HbA1c Control <8.0%*, (3) *Controlling High Blood Pressure* and (4) *Developmental Screening in the First Three Years of Life*. AEs must report stratified performance to EOHHS and MCOs using the measure specifications included in **Appendix E** by August 31 of the year following the measurement year (e.g., AEs must report CY 2021 performance by August 31, 2022). AEs must use the reporting template titled "RELD Measure QPY4 Reporting Template 2022 4-20." A copy of this Excel reporting template can be obtained through EOHHS' SFTP site.[20]

Data Collection and Reporting Responsibilities

Beginning in QPY3, MCOs are responsible for reporting performance on all AE Common Measure Slate measures to EOHHS by October 31 the year following the measurement year (e.g., MCOs must report CY 2021 performance by October 31, 2022). All Administrative measures must be generated and reported by the MCO. AEs and MCOs must work together to establish clinical data exchange capabilities as

[20] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

described in the "Electronic Clinical Data Exchange" section below for Administrative/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.

Beginning in **QPY4**, MCOs are responsible for reporting performance using the QPY3 methodology and through electronic clinical data exchange. EOHHS will assess systematic variation between the rates generated using the two methodologies to confirm the accuracy of electronic clinical data exchange (see the "Electronic Clinical Data Exchange" section below for more information).

For **QPY5**, EOHHS intends to have MCOs report performance through electronic clinical data exchange only, pending the results of the systematic variation analysis in winter 2022/2023. If there is significant variation in performance calculated using the QPY3 methodology and clinical data exchange, EOHHS will continue to have MCOs report performance using both methodologies. More information on the data collection and reporting responsibilities will be provided in winter 2022/2023.

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 offered incentive funding for AEs and MCOs during QPY2 for efforts to move towards electronic clinical data exchange (ECDE) for the Common Measure Slate for QPY3. AEs and MCOs chose two methods of electronic exchange: (1) individual practices within the AE submit data to an MCO and (2) individual practices within the AE submit data to IMAT, which then submits data to an MCO.

For either option above, AEs had to 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. If AEs were unable to electronically exchange clinical data for practices representing 75% or more of its MCO-specific attributed lives, MCOs must have received approval for an action plan and timeline for clinical data exchange readiness in 2019.

MCOs were required to submit an Operational Plan and Data Validation Plan to be eligible for QPY2 incentive funding. MCOs are required to submit **Implementation Status Reports** on an ongoing basis, which should detail the status of ECDE 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 "MCO Electronic Clinical Data Implementation Status Report Template." A copy of this document can be obtained on EOHHS' SFTP site.[21]
- Timing:
    - MCOs were required to submit several Implementation Status Reports in 2020 and 2021. MCOs are required to submit one more Report to EOHHS by March 15, 2022.

[21] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

In April 2021, CMS approved EOHHS' request to extend the PY2 deadline for establishing ECDE from July 30, 2021 to September 30, 2021. Any AE that wanted to take advantage of the extended deadline was required to submit a Project Plan modification request and a workplan detailing how they plan to meet the new deadline by June 1, 2021.

In fall/winter 2021-2022, IMAT participated in NCQA's Data Aggregator Validation (DAV) program, which "validates organizations that collect, aggregate and transform data from original data sources on behalf of vendors and health care organizations."[22] IMAT conducted primary source verification for all EHR "clusters" (i.e., all EHR platforms for a certain care setting, such as Epic's outpatient EHR interface) that were ready by fall 2021. EHR "clusters" that receive DAV certification for the State's Quality Reporting System (QRS) in early 2022 meet HEDIS audit standards for 2021. Therefore, MCOs may use data from the QRS for these "clusters" for reporting 2021 HEDIS measure performance to NCQA and 2021 AE Common Measure Slate measure performance to EOHHS. MCOs will need to conduct medical record reviews to obtain and validate clinical data for any non-certified EHR "clusters." After receiving initial certification, existing "clusters" must receive re-certification and IMAT may add additional EHR "clusters" on an annual basis.

Finally, AEs and MCOs should **verify the accuracy of data reported using ECDE**. EOHHS is conducting this verification process to ensure that data submitted via ECDE are comparable with data submitted using the QPY1 – QPY3 method. As a reminder, the DAV program ensures that data are not modified after AEs submit data to the QRS. To verify the accuracy of ECDE, AEs had to verify the integrity of a test submission of QPY2 clinical measure data with IMAT and UnitedHealthcare.[23] Further, MCOs will need to report and assess any variation in reporting QPY4 performance using ECDE and the QPY1 - QPY3 reporting method.

- Timing:
    - AEs submitted QPY2 clinical measure data to IMAT and UnitedHealthcare (per MCO clinical data exchange operational plans previously submitted to EOHHS) for testing purposes by October 1, 2021.[24]
    - IMAT and UnitedHealthcare verified the integrity of the test exchange of QPY2 clinical measure data from October 1, 2021 by November 1, 2021.
    - MCOs shall calculate and report AE performance on the Common Measure Slate for the QPY4 measures using (a) ECDE and (b) the QPY1 – QPY3 method by October 31, 2022.
    - EOHHS shall analyze any systematic variation in performance between QPY4 data using (a) ECDE and (b) the QPY1 - QPY3 method using data submitted by MCOs by November 30, 2022. MCOs will provide two rates for each measure to EOHHS for QPY4 AE performance on the Common Measure Slate. The first rate will include data from the file MCOs share with AEs, which includes administrative and supplemental data, inclusive of ECDE. The second rate will include data from the file AEs share with MCOs,

[22] See https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/data-aggregator-validation/ for more information.
[23] Some AE practice sites have elected to electronically send clinical data directly to UnitedHealthcare rather than sending data to MCOs via IMAT. No AE practice sites are taking this approach with Neighborhood Health Plan. As a result, Neighborhood Health Plan did not need to verify the integrity of a test submission.
[24] AEs had to have fully validated their data and be in production by September 30, 2021 in order to submit QPY2 data at this time.

which includes data from the first rate along with additional numerator hits found in AE EMRs. The difference between the two rates will identify data that are currently not being captured through either MCO claims feeds or ECDE. Of note, this assessment will allow AEs and MCOs to verify whether performance measures calculated following ECDE (and after undergoing several rounds of data validation conducted by AEs, MCOs and IMAT) have comparable results to those generated using the QPY1 - QPY3 reporting method. The assessment will be performed in parallel to the data validation performed by AEs, MCOs and IMAT as outlined in the AE-MCO clinical data exchange Evaluation Plans.

Outcome Measures and Incentive Methodology

The Medicaid Infrastructure Incentive Program (MIIP) runs through Program Years 1 through 6 (January 2018-June 2024) 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 performance on three quality outcome metrics.

Outcome Measures

The table below depicts the Outcome Measures Slate, required measure specifications 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[25]		
				OPY3	OPY4	OPY5
HEDIS Measures						
All-Cause Readmissions	CMS, modified by EOHHS	Admin	OPY3: EOHHS[26]	Other*		
Plan All-Cause Readmissions	NCQA	Admin	OPY4: HEDIS MY 2021 OPY5: HEDIS MY 2022		P4P[27]	P4P
Non-HEDIS Measures: Externally Developed						
Emergency Department (ED) Utilization for Individuals Experiencing Mental Illness	Oregon Health Authority	Admin	OPY3-4: EOHHS, adapted from OHA 2019[28] (April 8, 2021 version) OPY5: EOHHS, adapted from OHS 2020-2021[29] (March 1, 2022 version – included as Appendix F)	Other*	P4P	P4P
Non-HEDIS Measures (EOHHS-developed)						
Potentially Avoidable ED Visits[30]	NYU, modified by EOHHS	Admin	OPY3-4: EOHHS (April 8, 2021 version) OPY5: EOHHS (February 24, 2022 version – included as Appendix G)	Other*	P4P	P4P

*Payment was made for acceptable performance improvement plan submission and completion of a required presentation and question and answer exchange with EOHHS (see Calculation of the Outcome Measure Performance Area Milestones below).

[25] Please refer to the May 21, 2021 version of the Implementation Manual for more information on the OPY1 and OPY2 measures.

[26] When EOHHS first developed the measures and methodology for OPY3 in 2019-2020, it intended to use a modified version of the CMS specifications for *All-Cause Readmissions* as MCOs initially did not know if they could calculate and report performance using the HEDIS measure. MCOs, however, confirmed they could calculate performance using the HEDIS specifications in 2021. Therefore, EOHHS provided AEs with their performance on the HEDIS measure, as reported by MCOs, for OPY3 in summer 2021.

[27] Thundermist and IHP will not be held accountable for performance for this measure for QPY4. Thundermist became a single-entity AE effective July 1, 2021, and therefore EOHHS did not have baseline data for the newly attributed IHP and Thundermist populations in order to set AE-specific targets for the measure.

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

[29] https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2020-2021-specs-(Disparity)-20201222.pdf

[30] In previous communications, this measure has been referred to as *Ambulatory Care-Sensitive ED Visits*.

Eligible Population for Outcome Measures

Beginning in OPY3, all Outcome measures are calculated with IHH members attributed to the AE based on their primary care provider.

Beginning in OPY4, the eligible population should be calculated using the attribution methodology described in the "General Guidelines" section of the Implementation Manual.

Outcome Measure Incentive Methodology

AEs must 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
3	0	
4	3	All Outcome Measure Slate measures
5	3	All Outcome Measure Slate measures

Calculation of the Outcome Measure Performance Area Milestones

For OPY3, AEs earned a percentage of the AEIP based on the submission of an acceptable description and self-evaluation of implemented plans to improve performance on each of the three outcome measures and completion of a presentation and question-and-answer exchange with EOHHS or its designee.

Action	Deadline	AE Incentive Pool Allocation
Submission of Outcome performance improvement reports	12/31/2020	Up to 15%
Interview with EOHHS to discuss Outcome performance improvement efforts	2/15/2021	Up to 20%

EOHHS sent memos to each AE on April 9, 2021 titled "OPY3 Performance Improvement Plan Scoring and Feedback" that conveyed how the AE performance on the two actions described above and the total earned AEIP funds. AEs had an opportunity to achieve any unearned AEIP funds for OPY3 if they submitted a narrative of future steps to address the shortcomings outlined for each measure and demonstrated that AE staff will participate in an approved formal training. See the September 21, 2021 version of the Implementation Manual for more information.

For OPY4, 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 0%, 25%, 50%, 75% or 100% of incentive funds for achievement of successive AE-specific graduated targets for each Outcome measure. AEs must meet or exceed each graduated target in order to receive the eligible percentage of incentive funds (e.g., an AE must meet or exceed the 50% graduated target to receive 50% of incentive funds associated with that measure).

2. **Measure Weights:** 45% of the AE Incentive Pool allocation and 45% 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).

Weighting for BVCHC, Coastal, Integra, PCHC and Prospect

Outcome Measure	OPY4 Weight
Plan All-Cause Readmissions	15%
Emergency Department Utilization for Individuals Experiencing Mental Illness	20%
Potentially Avoidable ED Visits	10%

Weighting for IHP and Thundermist

Outcome Measure	OPY4 Weight
Emergency Department Utilization for Individuals Experiencing Mental Illness	27%
Potentially Avoidable ED Visits	18%

For OPY5, AEs will earn a percentage of the AEIP based on the annual performance on Outcome metrics. The Outcome metric score methodology for OPY5 is the same as OPY4, except for the measure weights. The OPY5 measure weights are as follows:

Weighting for all AEs

Outcome Measure	OPY5 Weight
Plan All-Cause Readmissions	20%
Emergency Department Utilization for Individuals Experiencing Mental Illness	12.5%
Potentially Avoidable ED Visits	12.5%

Outcome Measure Targets

For OPY3, EOHHS required submission of performance improvement plans for each of the three Outcome measures.

For OPY4, EOHHS employed historical AE performance for January 1, 2019 – December 30, 2019 to set the AE-specific graduated achievement targets. EOHHS relied on MCO-calculated data for *Plan All-Cause Readmission* and on EOHHS-calculated data for *Emergency Department Utilization for Individuals Experiencing Mental Illness* and *Potentially Avoidable ED Visits*. For all measures, targets were calculated for an AE's total population across all MCOs, which is also how final performance will be calculated.

For ***Plan All-Cause Readmission***, AEs with a 2019 observed-to-expected ratio of less than 1.0300 must maintain an observed-to-expected ratio of less than 1.0300 for OPY4. AEs with a 2019 observed-to-expected ratio of greater than 1.0300 must have an observed-to-expected ratio in OPY4 that is equal to or lower than 0.03 less than its 2019 ratio. The 2019 observed-to-expected ratios and AE-specific graduated targets for OPY4 can be found in the table below.

AE	2019 Observed-to-Expected Ratio	OPY4 Graduated Targets for *Plan All-Cause Readmission* (Observed-to-Expected Ratio)			
		25%	50%	75%	100%
BVCHC	0.9491	N/A	N/A	N/A	< 1.0300
Coastal	1.0063	N/A	N/A	N/A	< 1.0300
Integra	1.1224	1.1149	1.1074	1.0999	1.0924
PCHC	1.1697	1.1622	1.1547	1.1472	1.1397
Prospect	0.9965	N/A	N/A	N/A	< 1.0300

For ***ED Utilization for Individuals with Mental Illness*** and ***Potentially Avoidable ED Visits***, EOHHS identified what each AE needs to achieve in OPY4 to demonstrate a "statistically significantly decline" (i.e., improvement) in utilization rates from 2019, determined using a one-tailed test with a power of 0.8 and p value of 0.05. The 2019 rates and AE-specific graduated targets for each measure for OPY4 can be found in the tables below.

AE	2019 Rate	OPY4 Graduated Targets for *ED Utilization for Individuals Experiencing Mental Illness* (Visits per 1,000 Member Months)			
		25%	50%	75%	100%
BVCHC	90.6	89.1	87.5	86.0	84.5
Coastal	59.3	58.2	57.1	56.0	54.9
IHP	87.8	87.1	86.4	85.7	85.0
Integra	81.8	81.2	80.5	79.8	79.1
PCHC	108.1	107.3	106.5	105.7	104.9
Prospect	82.8	82.0	81.1	80.2	79.3
Thundermist	92.4	91.6	90.8	89.9	89.1

AE	2019 Rate	OPY4 Graduated Targets for *Potentially Avoidable ED Visits*			
		25%	50%	75%	100%
BVCHC	46.64%	46.24%	45.83%	45.42%	45.02%
Coastal	40.56%	40.09%	39.62%	39.15%	38.68%
IHP	42.09%	41.84%	41.59%	41.34%	41.09%
Integra	42.06%	41.84%	41.63%	41.42%	41.21%
PCHC	43.58%	43.39%	43.20%	43.02%	42.83%
Prospect	45.73%	45.40%	45.06%	44.73%	44.40%
Thundermist	42.62%	42.35%	42.08%	41.80%	41.53%

For OPY5, EOHHS employed historical AE performance for CY 2019 and CY 2020 to set the AE/MCO dyad-specific graduated achievement targets for *Plan All-Cause Readmission* and historical AE performance for CY 2019 to set the AE/MCO dyad-specific graduated achievement targets for *ED Utilization for Individuals with Mental Illness* and *Potentially Avoidable ED Visits*. In OPY5, targets are specific to an individual AE/MCO *dyad*, rather than to an AE. As described further below, MCOs are responsible for both quarterly and annual reporting on all three outcome measures in OPY5. Therefore, EOHHS used MCO-calculated data by AE/MCO dyad for all outcome measures to set targets for OPY5. EOHHS solicited input from the AE/MCO Work Group prior to finalizing targets.

For ***Plan All-Cause Readmission***, EOHHS used the higher of the 2019 and 2020 observed-to-expected ratio for each AE/MCO dyad to set graduated targets for OPY5. AEs with a baseline observed-to-expected ratio of less than 1.0300 must maintain an observed-to-expected ratio of less than 1.0300 for OPY5. AEs with a baseline observed-to-expected ratio of greater than 1.0300 must have an observed-to-expected ratio in OPY5 that is equal to or lower than 0.03 less than its baseline ratio. The baseline observed-to-expected ratios and AE-specific graduated targets for OPY5 can be found in the table below. This use of the higher of two ratios was for one time only, in recognition of disruptions in care coordination during 2021 due to the effects of the COVID-19 pandemic and volatility in AE performance during 2019 and 2020.

AE/MCO Dyad	Baseline Year	Baseline Observed-to-Expected Ratio	OPY5 Graduated Targets for *Plan All-Cause Readmission* (Observed-to-Expected Ratio)			
			25%	50%	75%	100%
BVCHC/NHP	2020	1.1278	1.1203	1.1128	1.1053	1.0978
Coastal/NHP	2019	1.1650	1.1575	1.1500	1.1425	1.1350
IHP/NHP	2020	1.2901	1.2826	1.2751	1.2676	1.2601
Integra/NHP	2019	1.2499	1.2424	1.2349	1.2274	1.2199
PCHC/NHP	2020	1.1662	1.1587	1.1512	1.1437	1.1362
Prospect/NHP	2020	1.3336	1.3261	1.3186	1.3111	1.3036
Thundermist/NHP	2019	1.2094	1.2019	1.1944	1.1869	1.1794
Coastal/United	2019	0.8014	<1.0300			
IHP/United	2019	1.2256	1.2181	1.2106	1.2031	1.1956
Integra/ United	2020	1.0525	1.0469	1.0413	1.0356	1.0300
PCHC/ United	2020	1.5371	1.5296	1.5221	1.5146	1.5071
Prospect/ United	2019	1.1721	1.1646	1.1571	1.1496	1.1421
Thundermist/ United	2019	1.1898	1.1823	1.1748	1.1673	1.1598

For ***ED Utilization for Individuals with Mental Illness*** and ***Potentially Avoidable ED Visits***, EOHHS identified what each AE/MCO dyad needs to achieve in OPY5 to demonstrate a "statistically significantly decline" (i.e., improvement) in utilization rates from 2019, determined using a one-tailed test with a power of 0.8 and p value of 0.05. Coastal's baseline rate for *ED Utilization for Individuals with Mental Illness* is low compared to other AE/MCO dyads. Therefore, its OPY5 target is to maintain its baseline performance, with an allowance for change due to random variation. The 2019 rates and AE-specific graduated targets for each measure for OPY5 can be found in the tables below.

AE	2019 Rate	OPY5 Graduated Targets for *ED Utilization for Individuals Experiencing Mental Illness* (Visits per 1,000 Member Months)				
		0%	25%	50%	75%	100%
BVCHC/NHP	98	98	96	95	93	91
Coastal/NHP	73	80				
IHP/ NHP	108	108	107	106	105	104
Integra/NHP	114	114	113	112	111	110
PCHC/NHP	127	127	126	125	124	122
Prospect/NHP	90	90	88	87	86	85
Thundermist/NHP	118	118	117	116	115	114

AE	2019 Rate	OPY5 Graduated Targets for *ED Utilization for Individuals Experiencing Mental Illness* (Visits per 1,000 Member Months)				
		0%	25%	50%	75%	100%
Coastal/United		86				
IHP/United	98	98	97	95	94	92
Integra/ United	84	84	83	81	80	79
PCHC/ United	126	126	124	123	121	119
Prospect/ United	109	109	107	105	104	102
Thundermist/ United	96	96	94	93	91	89

AE	2019 Rate	OPY5 Graduated Targets for *Potentially Avoidable ED Visits*				
		0%	25%	50%	75%	100%
BVCHC/NHP	45.7%	45.7%	45.3%	44.9%	44.5%	44.1%
Coastal/NHP	39.6%	39.6%	39.0%	38.4%	37.8%	37.2%
IHP/NHP	40.9%	40.9%	40.6%	40.3%	40.0%	39.7%
Integra/NHP	41.5%	41.5%	41.2%	41.0%	40.7%	40.5%
PCHC/NHP	43.3%	43.3%	43.1%	42.8%	42.6%	42.4%
Prospect/NHP	44.6%	44.6%	44.1%	43.7%	43.3%	42.8%
Thundermist/NHP	41.7%	41.7%	41.4%	41.1%	40.8%	40.5%
Coastal/United	37.5%	37.5%	36.8%	36.2%	35.5%	34.8%
IHP/United	40.1%	40.1%	39.7%	39.2%	38.8%	38.4%
Integra/ United	38.5%	38.5%	38.2%	37.9%	37.7%	37.4%
PCHC/ United	39.3%	39.3%	39.0%	38.7%	38.4%	38.1%
Prospect/ United	39.6%	39.6%	39.2%	38.8%	38.4%	38.0%
Thundermist/ United	38.9%	38.9%	38.4%	38.0%	37.5%	37.0%

Outcome Measures Data Collection Responsibilities

For OPY3, EOHHS generated AE Outcome measure performance rates for *Emergency Department Utilization for Individuals Experiencing Mental Illness* and *Potentially Avoidable ED Visits* for each AE while MCOs generated performance rates for *All-Cause Readmission*. Performance on these Outcome measures, however, did not affect payment, which was instead based on AEs submission of Outcome performance improvement reports by December 31, 2020 and participation in an interview by February 15, 2021. MCOs and EOHHS both contributed data toward quarterly performance reports to assist in AE improvement.

For OPY4, EOHHS shall calculate annual AE Outcome measure performance, across MCOs, for *ED Utilization for Individuals Experiencing Mental Illness* and *Potentially Avoidable ED Visits*. For this final annual calculation, it will calculate numerator and denominator performance using only the claims from the MCO with which the member is enrolled in December of the measurement year (e.g., for CY 2021 reporting, use claims from the MCO with which the member is enrolled in December 2021). Final calculation of OPY performance will be calculated using 180 days of claims runout. EOHHS will upload data on final performance on the two ED-related measures to the EOHHS SFTP site by July 15 the year following the measurement year (e.g., EOHHS will report CY 2021 performance by July 15, 2022). MCOs will calculate AE-specific performance for the *Plan All-Cause Readmission* measure and report performance in the spreadsheets with data for the ED-related measures to the EOHHS SFTP site by

August 1 the year following the measurement year (e.g., MCOs will report CY 2021 performance by August 1, 2022). MCOs will then share reports on all three outcome measures with the AEs. EOHHS shall calculate aggregate performance across the MCOs and share that data in memos to AEs and MCOs.

EOHHS will also provide AEs and MCOs with data to assist in improvement on *ED Utilization for Individuals Experiencing Mental Illness* and *Potentially Avoidable ED Visits*. MCOs shall continue to provide AEs with data to assist in improvement on *Plan All-Cause* Readmission. EOHHS and MCOs shall provide quarterly reports on performance using three months of claims runout for a rolling 12-month period. EOHHS shall also include a subtotal for performance for the prior measurement period and current measurement period. EOHHS will use the "AEIP Quarterly Outcome Metrics" Excel template for OPY4. A copy of the Excel template can be obtained on EOHHS' SFTP site.[31] Similar to the annual reports, EOHHS will upload a quarterly report to the EOHHS SFTP site with data on the two ED-related measures; MCOs will download this report, add data for *Plan All-Cause Readmission*, and upload the complete report to the EOHHS SFTP site; and EOHHS will share the complete quarterly report with AEs and MCOs.[32] MCOs shall also provide patient lists to the AEs, as requested by AEs.

For OPY5, MCOs are responsible for both quarterly and annual reporting on all three outcome measures. MCOs shall send quarterly performance reports with 90 days of claims runout to both AEs and EOHHS, as well as final annual reports with 180 days of claims runout. MCOs shall report data for a rolling 12-month period and for year-to-date performance for *Plan All-Cause Readmission* and data for a rolling 12-month period for *ED Utilization for Individuals Experiencing Mental Illness* and *Potentially Avoidable ED Visits*. MCOs shall report performance using the "AEIP Quarterly Outcome Metrics" Excel template for OPY5 and upload the report to the EOHHS SFTP site according to the reporting calendar below. A copy of the Excel template can be obtained on the EOHHS' SFTP site.[33] MCOs shall also provide patient lists to the AEs, as requested by AEs.

The reporting periods and reporting date for each of the quarterly reports for OPY4 and OPY5 are indicated in the tables below.

OPY4 Reporting Schedule		
Reporting Period (Rolling 12-month)	**Reporting Period (Year-to-Date)**	**Reporting Date**
April 1, 2020 – March 31, 2021	January 1, 2021 – March 31, 2021	August 16, 2021
July 1, 2020 – June 30, 2021	January 1, 2021 – June 30, 2021	November 15, 2021
October 1, 2020 – September 30, 2021	January 1, 2021 – September 30, 2021	February 15, 2022
January 1, 2021 – December 31, 2021	January 1, 2021 – December 31, 2021	May 13, 2022

OPY5 Reporting Schedule		
Reporting Period (Rolling 12-month)	**Reporting Period (Year-to-Date)**	**Reporting Date**
April 1, 2021 – March 31, 2022	January 1, 2022 – March 31, 2022	August 15, 2022
July 1, 2021 – June 30, 2022	January 1, 2022 – June 30, 2022	November 15, 2022

[31] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).
[32] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).
[33] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

OPY5 Reporting Schedule		
Reporting Period (Rolling 12-month)	**Reporting Period (Year-to-Date)**	**Reporting Date**
October 1, 2021 – September 30, 2022	January 1, 2022 – September 30, 2022	February 15, 2023
January 1, 2022 – December 31, 2022	January 1, 2022 – December 31, 2022	May 13, 2023

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.

Patient Attribution to AEs

Beginning in PY4, for purposes of evaluating annual Quality and Outcome measure performance, each member will be attributed to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, the member will not be attributed to any AE for measurement purposes. EOHHS and MCOs shall use the December Population Extract files submitted by the MCOs to identify the members attributed to each AE for Quality and Outcome measure performance calculations. Note that the December Population Extract files will determine attribution using the AE TIN rosters that are in place as of December.

For purposes of evaluating quarterly Outcome measure performance, each member will be attributed to a single AE, based on the AE to which the member is attributed in the last month of each quarter, i.e., March, June, September, and December of the performance year. If a member is not enrolled in the last month of each quarter, the member will not be attributed to any AE for measurement purposes for that quarterly report. EOHHS and MCOs shall use the Population Extract files submitted by the MCOs for each of these months (March, June, September, and December) to identify the members attributed to each AE for quarterly Outcome measure performance calculations. Note that the Population Extract files will determine attribution using the AE TIN rosters that are in place as of the month for which the file is reporting attribution (i.e., March, June, September, and December).

Provider Attribution to AEs

Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[34]

Grid on Provider Attribution and TIN Roster

The following table shows the AE TIN rosters that should be used when calculating attribution for different purposes.

Attribution Purpose	TIN Roster
Monthly Population Extract File	The TIN roster for each AE should reflect the TINs participating in the AE during the month for which the Population Extract File is produced, to the best knowledge of the MCO at the time the Population Extract file is produced. Once an AE reports the addition or removal of a TIN to/from AE participation, the TIN roster used for the next Population Extract File produced following the AE's report should reflect the change.

[34] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.

Attribution Purpose	TIN Roster
Attribution to set annual Incentive Fund Pool	Generally, the Incentive Fund Pool is set for a Program Year based on attribution in the Population Extract File from April of the year preceding the start of the Program Year in July. It should therefore reflect the TINs participating in each AE during the month of that Population Extract File. EOHHS may request an additional Population Extract File to account for, e.g., the expectation that a new AE will join the program in July (but would not be reflected in the regular April or May Population Extract files, due to not being an AE at that time), or similar anticipated changes.
Attribution to produce quarterly reports on Outcome Measures	The Population Extract File from the final month of the quarter should be used for quarterly Outcome Measures. As described above, those monthly Population Extract Files should reflect the TINs participating in the AE during that month, to the best knowledge of the MCO.
Attribution to produce annual reports on Quality and Outcome Measures	The Population Extract File from the final month – December – of the Performance Year should be used for annual Quality and Outcome measure reporting. As described above, the December Population Extract Files should reflect the TINs participating in the AE during that month, to the best knowledge of the MCO.
Attribution to produce Historical Base Data to set TCOC targets	The TIN rosters for Historical Base Data should be the rosters that are current as of March of the year preceding the start of the Program Year for which the MCO prepares the Historical Base Data. For example, if the MCO prepares Historical Base Data for Program Year 5 (SFY23) in March 2022, the TIN roster should be current as of March 2022.
Attribution to produce quarterly and annual TCOC reports	The same TIN rosters should be used to produce Historical Base Data and TCOC quarterly and annual reports. In the example above, the quarterly and annual reports for Program Year 5 will all use the March 2022 TIN rosters.

Changes to Specifications

EOHHS shall annually convene AEs and MCOs to review whether annual measure specification changes made by a measure steward (e.g., NCQA) 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 published HEDIS changes for both HEDIS MY 2020 and HEDIS MY 2021. NCQA did so to transition from its prior 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 asked AEs and MCOs to review HEDIS changes and non-HEDIS changes for Quality and Outcome Performance Years 3 and 4. AEs and MCOs finalized changes for Quality and Outcome Performance Year 4 after NCQA releases its Technical Specifications Update for MY 2021 in May 2021.

Following the 2022 annual review, EOHHS will ask AEs and MCOs to review HEDIS changes (released on or about August 1, 2022) and non-HEDIS changes for Quality and Outcome Performance Year 6. AEs and

MCOs will finalize changes for Quality and Outcome Performance Year 6 after NCQA releases its Technical Specifications Update for MY 2023 on March 31, 2023.

Adequate Denominator Sizes

There must be an adequate denominator size at the AE and MCO dyad level for a P4P measure to be included in the TCOC Quality measure performance calculations. Consistent with NCQA guidelines per the HEDIS® MY 2020 – MY 2023 Volume 2: Technical Update, minimum denominator sizes are defined as follows:

Measure Type	Measures	Minimum Denominator Size
Quality Measures	• AE Common Measure Slate	30 members
Risk-Adjusted Utilization Measures	• Plan All-Cause Readmissions	150 acute inpatient and observation stay discharges
Non-Risk-Adjusted Utilization Measures	• Emergency Department Utilization for Individuals Experiencing Mental Illness • Potentially Avoidable ED Visits	360 member months

TCOC Quality and Outcome Measures Reporting Timeline

The table below indicates regular reporting activity responsibilities of EOHHS and AEs specific to the TCOC Quality Measures and Outcome Measures Slate. MCOs should refer to the "MCO Core Contract Reporting Calendar" on EOHHS' SFTP site for their reporting activity responsibilities.[35]

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: 1) approve adoption of updated measure specifications for use in OPY5 and QPY5[36], 2) discuss any changes to the measures or methodology for OPY6 and QPY6 and 3) tentatively approve adoption of updated measure specifications for use in OPY6 and QPY6[37]	EOHHS	OPY5/QPY5 and OPY6/QPY6	3/2022 – 7/2022
Outcomes	Outcome performance reporting	Fourth quarterly report of Outcome measure performance for OPY5 for the January 1, 2021 to December 31, 2021 reporting period due to: • AEs and MCOs for *ED Utilization for Individuals Experiencing Mental Illness* and *Potentially Avoidable ED Visits* from EOHHS • AEs and EOHHS for *Plan All-Cause Readmission* from MCOs Reporting of patient lists, as requested by the AEs, due to AEs from MCOs	MCOs/EOHHS	OPY4	5/16/2022
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of final performance on the Outcome measures to the AEs	EOHHS	OPY4	8/16/2022

[35] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).
[36] HEDIS MY 2022 technical specifications update will become available in March 2022. CMS MIPS 2022 specifications will become available in winter 2022.
[37] HEDIS MY 2023 specifications will become available August 1, 2022.

Topic	Category	Task	Responsible Party	PY	Deadline
Outcomes	RELD Measure reporting	Reporting of stratified AE performance on the RELD Measure to EOHHS and MCOs	AEs	QPY4	8/31/2022
Outcomes/TCOC	Updates to measure specifications and measure and methodology changes	Ad hoc convening of AE/MCO participants to review any relevant modifications to OPY6 and QPY6 measures from: 1) the 2022 annual review of the OHIC Aligned Measure Sets, and 2) NCQA's updated specifications for MY 2023, 3) NCQA's 2021 Quality Compass Medicaid data (released September 2022).	EOHHS	OPY6/QPY6	10/2022 – 11/2022
TCOC	Overall Quality Score methodology	Finalize OPY6 and QPY5 measure slate	EOHHS	OPY6/QPY6	11/30/2022
TCOC	Clinical data exchange	Analysis of any systematic variation in performance between QPY4 data using (1) ECDE and (b) the QPY1 – QPY3 method using data submitted by MCOs	EOHHS	QPY4	11/30/2022
TCOC	Overall Quality Score and Outcome measure scoring methodology	Solicit input from AEs and MCOs on the methodology for setting targets for QPY6 and OPY6	EOHHS	OPY6/QPY6	12/2/2022
TCOC	Overall Quality Score and Outcome measure scoring methodology	Calculation of threshold, high-achievement and improvement targets for QPY6 and OPY6 using QPY1-4 and other available data	EOHHS	OPY6/QPY6	1/31/2023
TCOC	Overall Quality Score and Outcome measure scoring methodology	Update "Overall Quality Score Determinations" Excel reporting template for QPY6 and "AEIP Quarterly Outcome Metrics" for OPY6	EOHHS	OPY6/QPY6	1/31/2023
TCOC	Overall Quality Score methodology	Update the AE Common Measure Slate table with links to updated specifications for *Developmental Screening in the First Three Years of Life*, *Screening for Depression and Follow-up Plan* and *Tobacco Use: Screening and Cessation Intervention*	EOHHS	QPY6	1/31/2023

Topic	Category	Task	Responsible Party	PY	Deadline
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of final performance on the Outcome measures to the AEs	EOHHS	OPY5	8/16/2023
Outcomes	RELD Measure reporting	Reporting of stratified AE performance on the RELD Measure to EOHHS and MCOs	AEs	QPY5	8/31/2023

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 D "Example Overall Quality Score Calculation for QPY3," add Appendix G "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 *Emergency Department Utilization for Individuals Experiencing 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, changed CDE requirements from 90% to 75% of attributed lives and other smaller edits.
1.5	3/13/20	Revised the methodology used to set interim QPY3 targets to reflect methodology stated in the 11/26/19 memo, added language on the level of quality performance needed to achieve full shared savings distribution as stated in the 11/26/19 memo, updated clinical data exchange deadlines based on changes to deliverables, updating timing for reporting on the AE

Version	Date	Revisions
		Common Measure Slate, clarified timing of Outcome quarterly reports and other smaller edits.
1.6	5/13/20	Revised QPY2, QPY3, and OPY3 sections to reflect the May 8, 2020 EOHHS memorandum "Program Year 2 and 3 Modifications to HSTP/AE program as a result of COVID 19."
2.1	10/7/20	Updated to include QPY4 and OPY4 methodology (including Appendix E "Example Overall Quality Score Calculation for QPY4"), revised electronic clinical data exchange timelines (which are delayed due to COVID-19), incorporated decisions recommended during the 2020 AE and MCO Work Group discussions, included specifications for non-HEDIS measures (i.e., *Screening for Clinical Depression and Follow-up Plan* and *Emergency Department Utilization for Individuals with Mental Illness*), revised specifications for non-HEDIS measures to incorporate telehealth (i.e., *SDOH Screening*, *SDOH Infrastructure Development* and *Screening for Clinical Depression and Follow-up Plan*), added the SQL code utilized by EOHHS to calculate the Outcome measures and other smaller edits
2.2	1/21/2021	Updated to include minor clarifications necessary as a result of public comment, embed a revised version of the "Overall Quality Score Determinations" Excel reporting template, include new QPY4 targets and a revised QPY4 methodology, clarify attribution requirements for Quality and Outcome measures, revise the requirements for interim Outcome measure reporting, embed the "AEIP Quarterly Outcome Metrics" template, specify how EOHHS is calculating performance for *Emergency Department Utilization for Mental Illness*, include revised SQL code utilized by EOHHS to calculate performance for two Outcome measures and other smaller edits.
2.3	5/21/2021	Updated to: • move *Child and Adolescent Well-Care Visits* (adolescent age stratifications only) to reporting-only status for QPY4, • clarify that the 30-day rate for *Follow-up after Hospitalization for Mental Illness* is for reporting-only for QPY3 and QPY4, • confirm that PY4 will use specifications from HEDIS MY 2021 and CMS MIPS 2021 for select measures, • update the specifications for *Developmental Screening in the First Three Years of Life* for QPY4, • indicate that *Screening for Clinical Depression and Follow-up Plan* is a P4P measure for QPY4 for July 1, 2021 – December 31, 2021 only, • revise the specifications for *Tobacco Use: Screening and Cessation Intervention* to use CMS MIPS 2020 in QPY3 and CMS MIPS 2021 in QPY4, • clarify that the specifications for *SDOH Infrastructure Development* only apply for QPY3, • remove the Optional Measure Slates for QPY1 and QPY2, • change the EOHHS contact from Rebekah LaFontant to Charles Estabrook,

Version	Date	Revisions
		• specify that for QPY4, Thundermist will be a new AE and clarify that IHP's QPY2 performance will be used to assess improvement for QPY4 for IHP and Thundermist, • confirm that QPY2 will be the basis of assessing improvement for QPY4, • remove the language that says EOHHS will revisit selection of the baseline year in the first half of QPY4, • revise the example Overall Quality Score calculation for QPY4 to include nine measures in the denominator, • update the "Overall Quality Score Determinations" Excel reporting template for QPY4, include the final threshold and high-performance targets and methodology for QPY4, • include information about the required *RELD Measure* for QPY4, • specify that MCOs shall submit another Electronic Clinical Data Implementation Status Report by July 1, 2021, • include information about the deadline extension for establishing ECDE and the timeline for submitting a Project Plan modification, • revise the timeline and methodology to verify the accuracy of data reported using ECDE, • specify that IHP and Thundermist will not be held accountable for *Plan All-Cause Readmission* for OPY4, • indicate that AEs may earn incentive funds for achievement of graduated targets for each Outcome measure for OPY4, • include the final graduated achievement targets and methodology for OPY4 for all AEs, • clarify how EOHHS is calculating OPY4 performance, update the timeline for calculating and reporting *Plan All-Cause Readmission* performance for OPY4, • indicate that the Outcome quarterly progress reports shall newly be provided by EOHHS for *ED Utilization for Individuals Experiencing Mental Illness* and *Potentially Avoidable ED Visits* for OPY4, • update the TCOC Quality and Outcome Measures Reporting Timeline to remove 2020 tasks, make EOHHS the responsible party for Outcome performance reporting for *ED Utilization for Individuals Experiencing Mental Illness* and *Potentially Avoidable ED Visits* from 5/14/2021 onwards, and include new deadlines to solicit input from AEs and MCOs on PY5 targets; • update measure specifications for *Screening for Clinical Depression and Follow-up Plan* in Appendix A, • update measure specifications in the Appendix to include patient and provider attribution to AE information, • include an example of ICD-10 Z codes in use by at least one AE to capture SDOH screening results electronically in the measure specifications for *SDOH Screening*, • update the example Overall Quality Score Calculation in Appendix E,

Version	Date	Revisions
		• update the reporting date for the electronic clinical data exchange Implementation Status Report in Appendix F and • remove Appendix J.
3.1	9/21/21	Updated to: • remove detailed information about PY1 and PY2, • direct individuals to EOHHS' SFTP site to obtain any relevant templates or relevant files, list Michelle Lizotte as the point of contact for any SFTP-related questions, and remove embedded files, • update language to note that EOHHS is tracking performance for the *Patient Engagement* measure internally in QPY4, • include QPY5 measures that are required for incentive use, • include language on additional considerations EOHHS will make in fall 2021 regarding the QPY5 measure slate, • update the name of the *Screening for Depression and Follow-up Plan* measure to align with changes made by the measure steward, • italicize measure names, • include the TCOC quality P4P methodology for QPY5, • revise the minimum number of P4P measures in QPY4 from 10 to nine and update the list of reporting-only measures, • include the data sources and approach for setting TCOC quality benchmarks for QPY5, • provide more information about the *RELD Measure* for QPY4 and QPY5, • update the data collection and reporting responsibilities section to indicate that the QPY3 and QPY4 methodology will apply to QPY5 as well, • streamline historical information on ECDE, • include a new Implementation Status Report due March 15, 2022, • include additional language on IMAT's participation in the Data Aggregator Validation program and how this relates to EOHHS' steps to verify the accuracy of data reported using ECDE, • clarify which specifications EOHHS used for *All-Cause Readmissions* for OPY3 and which specifications EOHHS will use for OPY4, • include OPY5 measures that are required for incentive use, • update the OPY3 methodology to include information on how AEs can achieve any unearned AEIP funds, • update the OPY4 methodology to specify that targets were set for *ED Utilization for Individuals with Mental Illness* and *Potentially Avoidable ED Visits* using a p value of 0.05, • include the methodology for OPY5, • include the data sources and approach for setting Outcome measure targets for OPY5, • update the data collection responsibilities for OPY4, • update the data collection responsibilities section to indicate that EOHHS expects to use MCO-calculated data for all measures in OPY5,

Version	Date	Revisions
		• update the reporting schedule to include the reporting date and reporting period for OPY4 and OPY5, • revise the general guidelines section to clarify which TIN roster to use for when calculating attribution for different purposes, • specify that the adequate denominator sizes for risk-adjusted utilization measures, i.e., *Plan All-Cause Readmission*, is 150, • update the TCOC Quality and Outcome Measures Reporting Timeline to remove historical reporting deadlines, remove reporting deadlines for MCOs and refer MCOs to the "MCO Core Contract Reporting Calendar" on the EOHHS SFTP site, include the date for AE reporting of stratified performance on the RELD Measure for QPY4, and include timelines associated with QPY5 and OPY5, • update Appendix A to include language to clarify how to identify a positive depression screen if a practice has an EMR that can only capture a "yes/no" assessment of whether a patient has depression, include information on what constitutes a positive depression screen, and include guidance on how to define "follow-up" for the *Screening for Depression and Follow-up Plan* measure, • update Appendix C "SDOH Screening Measure Specifications" to clarify that an integrated interface that makes the SDOH screening accessible from within a practice EHR meets the documentation requirements, • remove the "Reporting" column from Appendix D "Example Overall Quality Score Calculation for QPY4," • include a new Appendix E "Example Overall Quality Score Calculation for QPY5," • include a new Appendix G "Race, Ethnicity, Language and Disability Status (RELD) Measure," • remove old Appendix G "All-Cause Readmissions."
3.2	3/3/2022	Updated to: • remove the methodology for PY1 and PY2 and direct readers to earlier versions of the Implementation Manual for more information, • removed detailed methodology for PY5, • include the final measures and measure specifications for QPY5, • include the final achievement and improvement targets for QPY5, • include information on how to access the "Overall Quality Score Determinations QPY5" Excel reporting template, • update information on the "RELD Measure Reporting Template," • include information on which EHR "clusters" received DAV certification as of February 2022, • update the name of the OPY4-OPY5 readmission measure to *Plan All-Cause Readmission*, • include the final measures and measure specifications for OPY5, • include the final targets for OPY5, • include the final outcome measure data collection responsibilities for OPY5,

Version	Date	Revisions
		• clarified that the minimum denominator size for *Plan All-Cause Readmission* is 150 acute inpatient and observation stay discharges, • update the specifications for *Screening for Depression and Follow-up Plan* in Appendix A, • remove Appendix B, Appendix D and relabel remaining Appendices accordingly, • update the specifications for *SDOH Screening* in new Appendix B, • update the example Overall Quality Score calculation for QPY5 in new Appendix D, • update the measure names and specifications for *RELD Measure* in new Appendix E, • update the specifications for *ED Utilization for Individuals with Mental Illness* in new Appendix F and • update the specifications for *Potentially Avoidable ED Visits* in new Appendix G.
3.3	3/9/2022	Updated to: • include the correct OPY5 targets for *Plan All-Cause Readmission*.
3.4	4/20/2022	Updated to: • update the codes to identify patient encounters for the denominator of *Screening for Depression and Follow-up Plan* in Appendix A, • include revised Z codes for *SDOH Screening* in Appendix B and • update the *RELD Measure* reporting template.

Appendix A: Screening for Depression and Follow-up Plan

Screening for Depression and Follow-up Plan
Steward: Centers for Medicare and Medicaid Services Merit-based Incentive Payment System 2022, Modified by Rhode Island Executive Office of Health and Human Services
As of April 20, 2022

SUMMARY OF CHANGES FOR 2022 (PERFORMANCE YEAR 5)

- Updated the codes to identify patient encounters for the denominator to align with the CMS MIPS 2022 specifications.
- Updated the definition of eligible follow-up plans and the guidance to define "follow-up" to include "referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen."
- Added F32.A to the denominator exclusions.

Description

Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter.

Definitions

Screening	Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
Standardized Depression Screening Tool	A normalized and validated depression screening tool developed for the patient population in which it is being utilized. An age-appropriate, standardized, and validated depression screening tool must be used for numerator compliance. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. Examples of screenings tools include but are not limited to those provided in the three rows below.
Adolescent Screening Tools (12-17 Years)	Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), and PRIME MD-PHQ-2.
Adult Screening Tools (18 Years and Older)	Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale or Depression in Dementia (CSDD), PRIME MD-PHQ-2, Hamilton Rating Scale for Depression (HAM-D), Quick Inventory of Depressive Symptomatology

	Self-Report (QID-SR), Computerized Adaptive Testing Depression Inventory (CAT-DI), and Computerized Adaptive Diagnostic Screener (CAD-MDD).
Perinatal Screening Tools	Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, Patient Health Questionnaire 9 (PHQ-9), Beck Depression Inventory, Beck Depression Inventory–II, Center for Epidemiologic Studies Depression Scale, and Zung Self-rating Depression Scale.
Positive Depression Screen	The definition of a positive depression screen varies based on the standardized depression screening tool. See the "Positive Depression Screen Crosswalk" section below for more information on what constitutes a positive depression screen for each tool. Practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.
Follow-up Plan	Documented follow-up for a positive depression screening ***must*** include one or more of the following: • Referral to a referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen • Pharmacological interventions • Other interventions or follow-up for the diagnosis or treatment of depression Please refer to the "Guidance to Define "Follow-up"" section below for more information on what is an eligible follow-up plan.

Eligible Population

Product lines	Medicaid
Stratification	None
Ages	Ages 12 and older
Continuous enrollment	Enrolled in the MCO for 11 out of 12 months during the measurement year.
Anchor date	December 31 of the measurement year.
Lookback period	12 months
Event/diagnosis	Patient has at least one eligible encounter during the measurement

	period. See the "Denominator" section below for a list of eligible encounters.
Exclusions	Patients who have had a diagnosis for depression or a diagnosis of bipolar disorder prior to the eligible encounter.
Exceptions	• Patient refuses to participate • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status • Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (e.g., certain court appointed cases or delirium)

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[38]

Administrative Specification[39]

Denominator	The eligible population 1. Patients aged ≥12 years on date of encounter AND 2. Patient encounter during the performance period: a. Eligible CPT/HCPCS office visit codes: 59400, 59510, 59610, 59618, 90791–90792, 90832, 90834, 90837,

[38] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.

[39] Modified from: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/CQM-Measures/2020_Measure_134_MIPSCQM.pdf.

	92625, 96105, 96110, 96112, 96116, 96125, 96136, 96138, 96156, 96158, 97161–97163, 97165–97167, 99078, 99202–99205, 99212–99215, 99304–99310, 99315–99316, 99318, 99324–99328, 99334–99337, 99339–99340, 99401–99403, 99483–99484, 99492–99493, 99384–99387, 99394–99397, G0101, G0402, G0438–G0439, G0444 b. Eligible telephone visit, e-visit or virtual check-in codes: i. CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ii. Any of the above CPT/HCPCS codes in 1 or 2.a. with the following POS codes: 02 iii. Any of the above CPT/HCPCS codes in 2 or 2.a. with the following modifiers: 95, GT AND NOT 3. Documentation stating the patient has had a diagnosis of depression or has had a diagnosis of bipolar disorder: G9717 AND NOT 4. Not Eligible for Depression Screening or Follow-Up Plan (Denominator Exclusion) – a. Patients who have been diagnosed with depression - F01.51, F32.A, F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.89, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9, F34.1, F34.81, F34.89, F43.21, F43.23, F53.0, F53.1, O90.6, O99.340, O99.341, O99.342, O99.343, O99.345 b. Patients who have been diagnosed with bipolar disorder - F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9 AND NOT 5. Patients with a Documented Reason for not Screening for Depression (Denominator Exception) – One or more of the following conditions are documented during the encounter during the measurement period: a. Patient refuses to participate b. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status c. Situations where the patient's cognitive capacity, functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the eligible encounter 1. Performance Met: Screening for depression is documented as being positive AND a follow-up plan is documented (G8431) OR 2. Performance Met: Screening for depression is documented as negative, a follow-up plan is not required (G8510) OR 3. Denominator Exception: Screening for depression not completed, documented reason (G8433) OR 4. Performance Not Met: Depression screening not documented, reason not given (G8432) OR 5. Performance Not Met: Screening for depression documented as positive, follow-up plan not documented, reason not given (G8511) **Note**: See "Positive Depression Screen Crosswalk" section below for more information on what constitutes a positive depression screen for the purpose of this measure. Practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.

Clinical Specification[40]

Denominator	The eligible population
Numerator	Patients screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the eligible encounter **Note**: See "Positive Depression Screen Crosswalk" section below for more information on what constitutes a positive depression screen for the purpose of this measure. Practices can use a "yes/no"

[40] Modified from: https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Web-Interface-Measures/2020_Measure_PREV12_CMSWebInterface_v4.1.pdf.

	assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.

Positive Depression Screen

The list of standardized depression screening tools included in the measure specifications differ in what they are evaluating. For example, some tools are designed to detect different levels of severity of depression (e.g., the PHQ-9), whereas others do not.

EOHHS has adopted a score of 10+ as an indication of a positive score for the PHQ-9. This is commonly accepted as the cut-point for moderate depression and is identified as a positive depression score by NCQA in its "Depression Screening and Follow-up for Adolescents and Adults" measure.[41] The table below identifies the definition of a positive screen for the other screening tools included in the measure specifications, which is usually the score used to identify moderate depression. The table also indicates if a tool has multiple cut points for a positive score or does not have a clear definition of a positive screen.

As a reminder, practices can use a "yes/no" assessment of whether a patient has depression to identify a positive depression screen ***only if*** the practice EMR is unable to capture data on the numerical score from the screen but can record a summary "yes/no" finding in a structured field. If the EMR can only capture a "yes/no" assessment for individual questions and not for the screen overall, practices must manually calculate the numerical score to identify whether the patient has depression and record the finding in the medical record for assessment of numerator compliance. If the practice does not calculate the overall assessment for whether a patient has a positive depression screen, the patient is considered numerator non-compliant.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
Patient Health Questionnaire for	Adolescent (12-17 years)	A score of 10+ (could be indicative of moderate depression)[42,43]

[41] National Committee for Quality Assurance (NCQA). "Proposed Changes to Existing Measures for HEDIS MY 2020: Depression Screening and Follow-up Measures." https://www.ncqa.org/wp-content/uploads/2020/02/20200212_18_Depression_Measures.pdf. Accessed April 26, 2021.

[42] This tool is sometimes referred to as the Patient Health Questionnaire Modified for Teens (PHQ-9M). American Academy of Child & Adolescent Psychiatry. "Scoring the PHQ-9 Modified for Teens." https://www.aacap.org/App_Themes/AACAP/docs/member_resources/toolbox_for_clinical_practice_and_outcomes/symptoms/GLAD-PC_PHQ-9.pdf. Accessed April 20, 2021.

[43] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
Adolescents (PHQ-A)		
Beck Depression Inventory-Primary Care Version (BDI-PC)	Adolescent (12-17 years)	A score of 8+ (could be indicative of moderate depression)[44]
Beck Depression Inventory (BDI or BDI-II)	Adult (18 years and older), Perinatal	A score of 20+ (could be indicative of moderate depression)[45,46]
Computerized Adaptive Diagnostic Screener (CAD-MDD)	Adult (18 years and older)	No clear cutoff for a positive score, as the tool is adaptive and does not have all patients answer the same questions[47]
Computerized Adaptive Testing Depression Inventory (CAT-DI)	Adult (18 years and older)	A score of 66+ (could be indicative of moderate symptoms of depression)[48]
Center for Epidemiologic Studies Depression Scale (CES-D)	Adolescent (12-17 years), Adult (18 years and older), Perinatal	A score of 17+ (could be indicative of clinical depression)[49,50,51]
Cornell Scale for Depression in Dementia (CSDD)	Adult (18 years and older)	A score of 6+ (could be indicative of presence of depressive symptoms)[52,53,54]
Depression Scale (DEPS)	Adult (18 years and older)	A score of 9+ (could be indicative of any level of depression)[55]
Duke Anxiety Depression Scale (DADS)	Adult (18 years and older)	A score of 5+ (could be indicative of

[44] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[45] The National Child Traumatic Stress Network. "Beck Depression Inventory-Second Edition." https://www.nctsn.org/measures/beck-depression-inventory-second-edition. Accessed April 26, 2021.
[46] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[47] Graham, A.K., Minc, A., Staab, E., Beiser, D.G., Gibbons, R.D., Laiteerapong, N. (2019). "Validation of the Computerized Adaptive Test for Mental Health in Primary Care." *Annals of Family Medicine*, 17(1): 23-30. https://www.annfammed.org/content/annalsfm/17/1/23.full.pdf. Accessed April 20, 2021.
[48] Ibid.
[49] American Psychological Association. (2011). "Center for Epidemiological Studies-Depression." https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/depression-scale. Accessed April 20, 2021.
[50] Boyd, J.H., Weissman, M.M., Thompson, W.G., Myers, J.K. (1982). "Screening for Depression in a Community Sample: Understanding the Discrepancies between Depression Symptom and Diagnostic Scales. *Archives of General Psychiatry*, 39(10)L 1195-1200. https://doi.org/10.1001/archpsyc.1982.04290100059010.
[51] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[52] Alexopoulos, G.S. (2002). "The Cornell Scale for Depression in Dementia: Administration and Scoring Guidelines." *Cornell Institute of Geriatric Psychiatry*. http://www.scalesandmeasures.net/files/files/The%20Cornell%20Scale%20for%20Depression%20in%20Dementia.pdf. Accessed April 26, 2021.
[53] Bienenfeld, D and Stinson, K.N. (December 23, 2018). "Screening Tests for Depression." Medscape. https://emedicine.medscape.com/article/1859039-overview#a1. Accessed April 20, 2021.
[54] Edelstein, B.A., Drozdick, L.W., Ciliberti, C.M. (2010). "Assessment of Depression and Bereavement in Older Adults" in *Handbook of Assessment in Clinical Gerontology*. https://www.sciencedirect.com/science/article/pii/B9780123749611100016. Accessed April 29, 2021.
[55] Poutanen, O., Koivisto, A.M., Kaaria, S., Salokangas, K.R. (2010). "The Validity of the Depression Scale (DEPS) to Assess the Severity of Depression in Primary Care Patients." *Family Practice*, 27(5): 527-534. https://academic.oup.com/fampra/article/27/5/527/717051. Accessed April 20, 2021.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
		anxiety and/or depression symptoms)[56]
Edinburgh Postnatal Depression Scale	Perinatal	A score of 10+ (could be indicative of possible depression)[57,58]
Geriatric Depression Scale (GDS)	Adult (18 years and older)	A score of 10+ (for the 30-item survey) [could be indicative of mild depression][59,60] A score of 5+ (for the 15-item survey) [could be indicative of depression][61,62] A score of 2+ (for the 5-item scale) [could be indicative of depression][63]
Hamilton Rating Scale for Depression (HAM-D)	Adult (18 years and older)	A score of 20+ (could be indicative of moderately severe depression)[64]
Quick Inventory of Depressive Symptomatology Self-Report (QID-SR)	Adult (18 years and older)	A score of 11+ (could be indicative of moderate depression)[65]
Mood Feeling Questionnaire (MFQ)	Adolescent (12-17 years)	A score of 8+[66] or 11+[67] on the short questionnaire for children (could be indicative of major depression)
Patient Health Questionnaire (PHQ-9)	Adolescent (12-17 years), Adult (18 years and	A score of 10+ (could be indicative of moderate depression)[68,69]

[56] Duke University Medical Center. (2016). "Duke Anxiety-Depression Scale." https://fmch.duke.edu/sites/cfm.duke.edu/files/cfm/Research/HealthMeasures/DukeAD.pdf. Accessed April 20, 2021.
[57] University of California San Francisco School of Medicine Fresno. "Edinburgh Postnatal Depression Scale." https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf. Accessed April 20, 2021.
[58] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[59] Yesavage, J.A., Brink, T.L., Rose, T.L., Lum, O., Huang, V., Adey, M., Leirer, V.O. (1983). "Development and Validation of a Geriatric Depression Screening Scale: A Preliminary Report." *Journal of Psychiatric Research*, 17:37-49. https://img.medscape.com/pi/emed/ckb/psychiatry/285911-1335297-1859039-1859094.pdf. Accessed April 26, 2021.
[60] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[61] Anderson, J.E., Michalak, E.E., Lam, R.W. (2002). "Depression in Primary Care: Tools for Screening, Diagnosis and Measuring Response to Treatment." British Columbia Medical Journal, 44(8): 415-419. https://bcmj.org/articles/depression-primary-care-tools-screening-diagnosis-and-measuring-response-treatment. Accessed April 20, 2021.
[62] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[63] Bienenfeld and Stinson.
[64] Bienenfeld and Stinson.
[65] IDS-QIDS. (2021). "Interpretation: Inventory of Depressive Symptomatology (IDS) and Quick Inventory of Depressive Symptomatology (QIDS)." http://ids-qids.org/interpretation.html. Accessed April 26, 2021.
[66] Seattle Children's Hospital. "Short Mood and Feelings Questionnaire." https://www.seattlechildrens.org/globalassets/documents/healthcare-professionals/pal/ratings/smfq-rating-scale.pdf. Accessed April 29, 2021.
[67] University of Washington. "Moods and Feelings Questionnaire." https://depts.washington.edu/uwhatc/PDF/TF-%20CBT/pages/3%20Assessment/Standardized%20Measures/Moods%20and%20Feelings%20Questionnaire%202.08.pdf. Accessed April 28, 2021.
[68] This definition was developed by the AE/MCO Work Group.
[69] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.

Tool Name	Intended Population Use	Definition of a Positive Depression Screen
	older), Perinatal	
Pediatric Symptom Checklist (PSC-17)	Adolescent (12-17 years)	The following scores could be indicative of psychological impairment (not solely focused on depression) and suggests the need for further evaluation: A score of 28+ for ages 6-16 A score of 24+ for ages 4-5 A score of 30+ for the PSC-Y for ages 11+[70]
Postpartum Depression Screening Scale	Perinatal	A score of 80+ (indicates that a woman has a high probability of depression)[71]
PRIME MD-PHQ-2	Adolescent (12-17 years), Adult (18 years and older)	A score of 3+ (could be indicative of having depression symptoms, but developer recommends administration of a PHQ-9, GAD-7 or other screening tool to determine whether a mental health condition is present)[72,73]
Zung Self-rating Depression Scale	Perinatal	A score of 60+ (could be indicative of moderate depression)[74]

Guidance to Define "Follow-up"

This section identifies what does and does not classify as an eligible "follow-up plan" for the Screening for Depression and Follow-up Plan measure. It does not provide any clinical guidance on the diagnosis or treatment of depression. For more guidance on that topic, consider referring to sources such as the American Psychological Association[75] and the Institute for Clinical Systems Improvement.[76]

According to the measure specifications, "Documented follow-up for a positive depression screening **must** include one or more of the following:

[70] Bright Futures. "Instructions for Using Pediatric Symptom Checklist." https://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf. Accessed April 20, 2021.
[71] Mancini, F., Carlson, C., Albers, L. (2007). "Use of the Postpartum Depression Screening Scale in a Collaborative Obstetric Practice." *Journal of Midwifery & Women's Health*, 52(5): 429-434. https://www.medscape.com/viewarticle/563220. Accessed April 20, 2021.
[72] Pfizer. "Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures." https://www.phqscreeners.com/images/sites/g/files/g10016261/f/201412/instructions.pdf. Accessed April 20, 2021.
[73] NCQA, Proposed Changes to Existing Measures for HEDIS MY 2020.
[74] Bienenfeld and Stinson.
[75] American Psychological Association. "Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts." https://www.apa.org/depression-guideline. Accessed April 26, 2021.
[76] Trangle, M., Gursky, J., Haight, R., Hardwig, J., Hinnenkamp, T., Kessler, D., Mack, N. and Myszkowski, M. (2016). "Health Care Guideline: Adult Depression in Primary Care." *Institute for Clinical Systems Improvement*. https://www.icsi.org/wp-content/uploads/2019/01/Depr.pdf. Accessed April 2, 2021.

- Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression"

Please note that additional evaluation or assessment for depression and suicide risk assessment are no longer considered eligible follow-up activities according to CMS as of 2021. The measure assesses the most recent depression screen completed during the eligible encounter or within 14 days prior to the encounter. Therefore, an additional screen performed during the eligible encounter would serve as the most recent screen that, if positive, should have additional follow-up. Should a patient screen positive for depression, a clinician should opt to complete a suicide risk assessment when appropriate and based on individual patient characteristics. A suicide risk assessment no longer qualifies as a follow-up plan for the purposes of this measure as the patient could potentially harm themselves, which would be considered an urgent or emergent situation, i.e., an eligible exception outlined in the measure specifications.[77]

Each action that is classified as an eligible "follow-up plan" component is defined further below. Please note that follow-up planning must be provided by a licensed provider or by an ancillary provider working under the general supervision of the licensed provider. The documented follow-up plan must be related to a positive depression screen. For example, "Patient referred for psychiatric evaluation due to positive depression screening."[78]

Referral to a provider for additional evaluation and assessment to formulate a plan for a positive depression screen. This can include, but is not limited to, referral to a psychiatrist, psychologist, social worker, mental health counselor, and/or to a mental health service such as family or group therapy, support group or depression management program.

This can also include a warm hand-off to a behavioral health clinician embedded within the practice.[79]

The referral to a practitioner or program for further evaluation for depression must be made on the date of the eligible encounter for it to be an eligible follow-up action. The patient, however, can make a follow-up appointment with the practitioner or program on a subsequent date.

Pharmacologic interventions. This can include a prescription for antidepressants, including tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs) and atypical antidepressants (e.g.,

[77] [Email from CMS Practice Improvement and Measures Management Support (PIMMS) Team]. (May 3, 2021).
[78] Oregon Health Authority. (2014). "Depression Screening and Follow-Up Plan Guidance Document." https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/Depression-Screening-Guidance-Document.pdf. Accessed April 14, 2021.
[79] Savoy, M. and O'Gurek, D. (2016). "Screening Your Adult Patients for Depression." *Fam Pract Manag,* 23(2): 16-20. https://www.aafp.org/fpm/2016/0300/p16.html. Accessed April 13, 2021.

bupropion, mirtazapine, nefazodone, trazodone, etc.)). It can also include a prescription for other medications, such as antipsychotics, for the treatment of depression as advised by the practitioner.[80,81,82]

The prescription must be written on the date of the eligible encounter for it to be an eligible follow-up action. The prescription, however, can be filled by the patient on a subsequent date.

Treatment for depression is often indicated during pregnancy and/or lactation. Review and discussion of the risks of untreated versus treated depression is advised. Consideration of each patient's prior disease and treatment history, along with the risk profiles for individual pharmacologic agents, is important when selecting pharmacologic therapy with the greatest likelihood of treatment effect. There may be some instances in which a patient refuses pharmacologic intervention due to the risks associated with antidepressants, even when the provider advises starting treatment.[83]

Other interventions or follow-up for the diagnosis or treatment of depression. This can include behavioral health evaluation,[84] psychotherapy or additional treatment options.

Examples of psychotherapy can include cognitive behavioral therapy (CBT), interpersonal therapy (IPT), dialectical behavior therapy, psychodynamic therapy, psychoanalysis, supportive therapy and more.[85]

Additional treatment options can include enrolling the patient in a collaborative care model to treat and manage depression,[86] acupuncture, or St. John's wort.[87]

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[80] Mulder, R., Hamilton, A., Irwin, L., Boyce, P., Morris, G., Porter, R.J., Malhi, G.S. (October 16, 2018). "Treating Depression with Adjustive Antipsychotics." *Bipolar Disorders*, 20(52), 17-24. https://doi.org/10.1111/bdi.12701.

[81] While not an eligible follow-up activity for the purposes of this measure, a provider could consider having a registered nurse (RN) or pharmacist follow-up with (1) the patient in three to five weeks to assess the effectiveness and side effects of the medication and (2) the prescribing provider to discuss titration of the medication.
[Email from J. Gates]. (April 26, 2021).

[82] If necessary and deemed appropriate, a provider should consider a follow-up assessment with a pharmacist or trained nurse specialist on medication adherence for depression. Such follow-up is typically conducted after an individual has been on a prescription for some time, i.e., would occur on a date other than the eligible encounter, and therefore would not be considered an eligible follow-up activity.
U.S. Preventive Services Task Force. (2016). "Depression in Adults: Screening."
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening#fullrecommendationstart. Accessed April 13, 2021.

[83] Ibid.

[84] Behavioral health evaluation is an eligible follow-up activity if it is performed by a provider other than the provider that conducted the initial positive screen because it would be classified as a "referral to a practitioner or program for further evaluation for depression." It is also an eligible follow-up activity if behavioral health evaluation is used as an intervention to treat depression.
[Email from CMS PIMMS Team]. (May 3, 2021).

[85] Parekh, R., Givon, L. (January 2019). "What Is Psychotherapy?" American Psychiatric Association.
https://www.psychiatry.org/patients-families/psychotherapy. Accessed April 26, 2021.

[86] Community Preventive Services Task Force. (2010). "Improving Mental Health and Addressing Mental Illness: Collaborative Care for the Management of Depressive Disorders."
https://www.thecommunityguide.org/sites/default/files/assets/Mental-Health-Collaborative-Care.pdf. Accessed April 14, 2021.

[87] Agency for Healthcare Research and Quality. (2015). "Nonpharmacological Versus Pharmacological Treatment for Adult Patients with Major Depressive Disorder." https://pubmed.ncbi.nlm.nih.gov/26764438/. Accessed April 14, 2021.

It can also include a follow-up assessment with a community health worker or medical assistant with a practice-approved checklist.[88]

Continuation of an existing treatment for a behavioral health condition other than depression that can also aid in the treatment of a newly diagnosed case of depression, as described above, is an eligible follow-up action.

For all of the above examples, referrals to or receipt of psychotherapy or other treatment options must be made on the date of the eligible encounter for it to be an eligible follow-up action. The patient, however, can make an appointment with the provider on a subsequent date.

Additional treatment options do **not** include those explicitly excluded in the measure specifications, i.e., additional evaluation or assessment for depression or suicide risk assessment, follow-up conducted by non-licensed provider that is not working under the supervision of a licensed provider, follow-up conducted on a day other than the eligible encounter.

There may be situations in which a patient has a positive screen for depression, but a provider on the basis of their clinical judgment does not implement one of the specified follow-up actions. This is why the target for this measure will never be 100%.

[88] While not an eligible follow-up activity for the purpose of this measure, any concerning findings from the checklist should result in a follow-up assessment by a RN or a visit with a provider within seven days. [Email from J. Gates]. (April 26, 2021).

Appendix B: SDOH Screening Measure Specifications

Social Determinants of Health (SDOH) Screening
Steward: Rhode Island Executive Office of Health and Human Services
As of April 20, 2022

SUMMARY OF CHANGES FOR 2022 (PERFORMANCE YEAR 5)

- Updated to add one SNOMED code to the list of code list to identify patients in hospice.
- Updated the ICD-10 Z codes to track completed SDOH screening electronically.

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."[89]

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.
Allowable gap	No break in coverage lasting more than 30 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.
	• Follow the below to determine a primary care visit:
	  ○ 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
	  ○ The following are the eligible telephone visit, e-visit or

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

	virtual check-in codes for determining a primary care visit: ▪ CPT/HCPCS/SNOMED codes: 98966-98968, 98969-98972, 99421-99423, 99441-99443, 99444, 11797002, 185317003, 314849005, 386472008, 386473003, 386479004 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following POS codes: 02 ▪ Any of the above CPT/HCPCS office visit codes for determining a primary care visit with the following modifiers: 95, GT
Exclusions	• Patients in hospice care (see Code List below) • Refused to participate

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[90]

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

[90] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.

	screened for Social Determinants of Health once per measurement year and for whom results are in the primary care clinician's EHR.
	
	Notes:
	• Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with a primary care clinician that triggered inclusion in the denominator.
	• Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria.
	
	AEs can, but not required to, use ICD-10 Z codes to track performance for this measure electronically. An example of two Z codes in use by at least one AE is provided below:
	• Z04.89
	  ○ Definition: Encounter for examination and observations for other specified reasons
	  ○ Meaning: SDOH screening completed
	• Z53.8
	  ○ Definition: Procedure and treatment not carried out for other reasons
	  ○ Meaning: SDOH screening offered, but patient refused/declined to complete screen

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 a) be embedded in the EHR, b) be accessible in the EHR as a PDF of the screening results, or c) be accessible from within the EHR without requiring the primary care clinician to leave the EHR to access another electronic location to search for the patient's record and locate and view the screening results. An integrated EHR interface with Unite Us that allows providers to view a patient's screening results meets the documentation requirements. 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. Note: If primary care clinicians are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits.

Code List

The following codes should be utilized to identify patients in hospice care:

Code System	Code
UBREV	0115
UBREV	0125
UBREV	0135
UBREV	0145
UBREV	0155
UBREV	0235
UBREV	0650
UBREV	0651
UBREV	0652
UBREV	0655
UBREV	0656
UBREV	0657
UBREV	0658
UBREV	0659
SNOMED CT US EDITION	170935008
SNOMED CT US EDITION	170936009
SNOMED CT US EDITION	183919006
SNOMED CT US EDITION	183920000
SNOMED CT US EDITION	183921001
SNOMED CT US EDITION	305336008
SNOMED CT US EDITION	305911006
SNOMED CT US EDITION	385763009
SNOMED CT US EDITION	385765002

Code System	Code
CPT	99377
CPT	99378
HCPCS	G0182
HCPCS	G9473
HCPCS	G9474
HCPCS	G9475
HCPCS	G9476
HCPCS	G9477
HCPCS	G9478
HCPCS	G9479
HCPCS	Q5003
HCPCS	Q5004
HCPCS	Q5005
HCPCS	Q5006
HCPCS	Q5007
HCPCS	Q5008
HCPCS	Q5010
HCPCS	S9126
HCPCS	T2042
HCPCS	T2043
HCPCS	T2044
HCPCS	T2045
HCPCS	T2046

Appendix C: Example Overall Quality Score Calculation for QPY4

Below is a high-level example of the calculation of the Overall Quality Score for QPY4. Further information on calculation of the individual score components can be found in the "Overall Quality Score Determinations QPY4" Excel reporting template. The Excel reporting template can be obtained by through EOHHS' SFTP site.[91]

Cells in grey indicate the target type is not applicable for a given measure in QPY4.

Measure	Score by Target Type		Final Measure Score (highest performance across target types)
	Achievement (0-1)	Improvement (0 or 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 Depression & Follow-up Plan	0.80	1	1
Social Determinants of Health Screening	1		1
Overall Quality Score (sum of final measure scores divided by number of measures)			=6.95/9 = **0.772**
Overall Quality Score Adjustment (upwards adjustment of 0.10 with a cap of 1) for Shared Savings Distribution			=0.772+0.1=**0.872**
Overall Quality Score Adjustment (Quality Score divided by 4) for Shared Losses Mitigation			=0.772/4=**0.193**

[91] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

Appendix D: Example Overall Quality Score Calculation for QPY5

Below is a high-level example of the calculation of the Overall Quality Score for QPY5. Further information on calculation of the individual score components will be provided in an updated "Overall Quality Score Determinations QPY5" Excel reporting template, which will be available in fall/winter 2021.

Measure	Score by Target Type		Final Measure Score (highest performance across target types)
	Achievement (0-1)	Improvement (0 or 1)	
Breast Cancer Screening	1	1	1
Child and Adolescent Well-Care Visits (*Adolescent Age Ranges Only*)	0.65	0	0.65
Controlling High Blood Pressure	0.70	1	1
Developmental Screening in the First Three Years of Life	0	0	0
Eye Exam for Patients with Diabetes	0.55	1	1
Follow-up After Hospitalization for Mental Illness (7-day)	0.45	1	1
HbA1c Control for Patients with Diabetes: HbA1c Control <8.0%	0.90	0	0.90
Lead Screening in Children	1		1
Screening for Depression & Follow-up Plan	0.80		0.80
Social Determinants of Health Screening	0.75	1	1
Overall Quality Score (sum of final measure scores divided by number of measures)			=8.35/10 **= 0.835**
Overall Quality Score Adjustment (upwards adjustment of 0.10 with a cap of 1) for Shared Savings Distribution			=0.835+0.1=**0.935**
Overall Quality Score Adjustment (Quality Score divided by 4) for Shared Losses Mitigation			=0.835/4=**0.209**

Appendix E: Race, Ethnicity, Language and Disability Status (RELD) Measure

Steward: Rhode Island Executive Office of Health and Human Services (EOHHS)
As of February 14, 2022

SUMMARY OF CHANGES FOR 2022

- Updated measure names to align with new NCQA HEDIS measure names.
- Updated the measure so that AEs report on the AE-specific population rather than their entire Medicaid population.

Background

Rhode Island EOHHS is adopting a RELD measure for its Accountable Entity (AE) program for 2022. EOHHS developed this measure in partnership with the AE/MCO Work Group, a stakeholder body of AE and Managed Care Organization (MCO) representatives, and the RELD Measure Work Group, a subgroup of the AE/MCO Work Group. EOHHS prioritized stratification of measures that have evidence of disparities in performance by RELD in Rhode Island and that are required to be stratified for reporting to the National Committee for Quality Assurance (NCQA) and to the Health Resources and Services Administration (HRSA) (for federally qualified health centers (FQHCs)).

The RELD Measure will initially focus on stratifying performance by race, ethnicity, language and disability status (RELD) for measures in the AE Common Measure Slate to encourage AEs to collect REL data (disability status data will come from MCOs) and use RELD data to stratify measure performance. EOHHS aims to include a RELD measure focused on reducing disparities in performance in the future once provider organizations have more robust and more experience with RELD data.

Description

The performance for each of the following measures, stratified by race, ethnicity, language and disability status (RELD):

- Measure #1: Eye Exam for Patients with Diabetes
- Measure #2: Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control <8.0%
- Measure #3: Controlling High Blood Pressure
- Measure #4: Developmental Screening in the First Three Years of Life

General Guidelines

Organizations Responsible and Data Source Used for Reporting Performance	AEs should use their own EHR-based clinical data, patient age and sex data and REL data, and disability status data obtained from MCOs, to report stratified performance for all measures.
Reporting Template and Deadline	AEs must use the reporting template titled "RELD Measure QPY4 Reporting Template 2022 4-20" to report performance to EOHHS by August 31 of the

	year following the measurement year (e.g., AEs must report CY 2021 performance by August 31, 2022). A copy of this Excel reporting template can be obtained through EOHHS' SFTP site.[92]
Overall Parameters for Stratification	AEs should report stratified performance: • for each race, ethnicity, language and disability status stratification category separately (e.g., within race, report measure performance separately for White, Black or African American, etc.; within ethnicity, report measure performance separately for Hispanic/Latino and non-Hispanic/Latino; within language, report measure performance separately for English, Spanish, etc.); • using patient self-reported data gathered by AEs rather than imputing a patient's REL, and • for the AE-specific Medicaid patient population served by the AE provider network meeting each measure's specifications, across health plans.
Data Completeness Threshold	There is no RELD data completeness threshold for reporting performance stratified by RELD. Organizations should report on all patients for whom they have RELD data.
Required RELD Reporting Categories	AE can use any framework to collect REL data but should report stratified performance to EOHHS using the following framework. ***For race***: Non-FQHC-based AEs should use the following race categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022: • White • Black • American Indian/Alaska Native • Asian • Native Hawaiian and Other Pacific Islander • Some Other Race • Two or More Races • Declined • Unknown FQHC-based AEs should use the following race categories in use by HRSA for Uniform Data System (UDS) reporting: • White • Black/African American • American Indian/Alaska Native • Asian • Native Hawaiian • Other Pacific Islander • More Than One Race • Unreported/Refused to Report

[92] If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

	For ethnicity: Non-FQHC-based AEs should use the following ethnicity categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2022: • Hispanic/Latino • Not Hispanic/Latino • Declined • Unknown FQHC-based AEs should use the following ethnicity categories in use by HRSA for UDS reporting: • Hispanic/Latino • Non-Hispanic/Latino • Unreported/Refused to Report Please refer to the "Crosswalk of Race/Ethnicity Reporting Categories" section to see how commonly used frameworks for collecting race and ethnicity data map onto the categories AE should use when reporting stratified performance to EOHHS. ***For language***: Use the following language categories. Health Level Seven Fast Healthcare Interoperability Resources (HL-7 FHIR) codes used in the US, when available, are included in parentheses.[93] If there is no US-based HL-7 FHIR code available, use the UK-based HL-7 FHIR code denoted with an asterisk (*).[94] • English (en) • Spanish (es) • Portuguese (pt) • Cape Verdean Creole (N/A – no HL-7 FHIR code available) • Haitian Creole (ht*) • Khmer (km*) • Lao (lo*) • Other • Unknown ***For disability status***: Use the following disability status categories: • Persons with Disabilities[95] • Persons without Disabilities

[93] A full list of HL-7 FHIR common language codes used in the US can be found here: https://www.hl7.org/fhir/valueset-languages.html#definition.

[94] A full list of HL-7 FHIR common language codes used in the UK can be found here: https://simplifier.net/guide/ukcoredevelopment/codesystemukcore-humanlanguage.

[95] EOHHS defines patients with disabilities as those who belong to the following enrollment categories: children with special healthcare needs (i.e., adoption subsidy, Katie Beckett, SSI <15 years of age, SSI >=15 years of age, substitute care*), substitute/Department of Children, Youth & Families (DCYF) foster care*, and Rhody Health Partners (i.e., intellectual disability (ID), severe and persistent mental illness (SPMI), other disabled ages 21-44, other disabled ages 45+). Categories denoted with an asterisk (*) have enrollment only in NHPRI.

	• Unknown Information on disability status will be included in the Monthly Member Report from NHPRI and the Monthly Enrollment File from United beginning in fall 2021. ***Note**: Each of the categories within each race, ethnicity, language, and disability status stratification are mutually exclusive. Therefore, the sum of all stratifications should equal the total population (e.g., the sum of all nine race stratifications should equal the total population).*
Measure Specifications	The REL Measure specifications can be accessed from the CMS eCQM specifications for Eligible Professionals / Eligible Clinicians for 2022 for Measure #1 – Measure #3.[96] These specifications are designed for reporting by provider organizations. ANs can simply run the specifications as provided by CMS, but stratify performance by race, ethnicity and language. For Measure #4, eCQM specifications are not available. Therefore, the REL Measure specifications are adapted from CMS' 2021 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP.[97]

[96] See: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1&globalyearfilter=2021.
[97] See: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html.

Measure #1: Eye Exam for Patients with Diabetes (CMS131v10)[98]

Measure #1 – Description

Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy in any part of the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.

Measure #1 – Denominator

Initial Population	Patients 18-75 years of age with diabetes with a visit during the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.
	• Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior
	  ○ OR advanced illness with one inpatient encounter during the measurement period or the year prior
	  ○ OR taking dementia medications during the measurement period or the year prior.
	• Exclude patients receiving palliative care during the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.
Rate 5	The denominator statement, stratified by disability status. Separately report the

[98] Source: CMS 2022 eCQM specifications for Diabetes: Eye Exam. https://ecqi.healthit.gov/ecqm/ep/2022/cms131v10.

	percentage of patients in the denominator statement for which the provider organization has complete disability status data.

Measure #1 – Numerator

Numerator Statement	Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: • Diabetic with a diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period • Diabetic with no diagnosis of retinopathy in any part of the measurement period and a retinal or dilated eye exam by an eye care professional in the measurement period or the year prior to the measurement period
Numerator Exclusions	Not applicable
Guidance	Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included. The eye exam must be performed by an ophthalmologist or optometrist, or there must be evidence that fundus photography results were read by a system that provides an artificial intelligence (AI) interpretation.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.
Rate 5	The numerator statement, stratified by disability status.

Measure #2: Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control <8.0% (CMS122v10)[99]

Measure #2 – Description

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c <8.0% during the measurement year.

Measure #2 – Denominator

Initial Population	Patients 18-75 years of age with diabetes with a visit during the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.
	• Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior
	  ○ OR advanced illness with one inpatient encounter during the measurement period or the year prior
	  ○ OR taking dementia medications during the measurement period or the year prior.
	• Exclude patients receiving palliative care during the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.
Rate 5	The denominator statement, stratified by disability status. Separately report the percentage of patients in the denominator statement for which the provider organization has complete disability status data.

[99] Source: Modified from CMS 2022 eCQM specifications for Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%). https://ecqi.healthit.gov/ecqm/ep/2022/cms122v10.

Measure #2 – Numerator

Numerator Statement	Patients whose most recent HbA1c level (performed during the measurement period) is <8.0%.
Numerator Exclusions	Not applicable
Guidance	Patient is numerator compliant if most recent HbA1c level <8%. If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance. Only patients with a diagnosis of Type 1 or Type 2 diabetes should be included in the denominator of this measure; patients with a diagnosis of secondary diabetes due to another condition should not be included.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.
Rate 5	The numerator statement, stratified by disability status.

Measure #3: Controlling High Blood Pressure (CMS165v10)[100]

Measure #3 – Description

Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

Measure #3 – Denominator

Initial Population	Patients 18-85 years of age who had a visit and diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period. Services delivered via telehealth are eligible encounters.
Denominator Statement	Equals Initial Population

Denominator Exclusions	• Patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.
	• Exclude patients who are in hospice care for any part of the measurement period.
	• Exclude patients 66 and older who are living long term in an institution for more than 90 consecutive days during the measurement period.
	• Exclude patients 66 and older with an indication of frailty for any part of the measurement period who meet any of the following criteria:
	  ○ Advanced illness with two outpatient encounters during the measurement period or the year prior
	  ○ OR advanced illness with one inpatient encounter during the measurement period or the year prior
	  ○ OR taking dementia medications during the measurement period or the year prior.
	• Exclude patients 81 and older with an indication of frailty for any part of the measurement period.
	• Exclude patients receiving palliative care during the measurement period.

Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.

[100] Source: CMS 2022 eCQM specifications. https://ecqi.healthit.gov/ecqm/ep/2022/cms165v910.

Rate 4	The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.
Rate 5	The denominator statement, stratified by disability status. Separately report the percentage of patients in the denominator statement for which the provider organization has complete disability status data.

Measure #3 – Numerator

Numerator Statement	Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.
Numerator Exclusions	Not applicable
Guidance	In reference to the numerator element, only blood pressure readings performed by a clinician or a remote monitoring device are acceptable for numerator compliance with this measure. This includes blood pressures taken in person by a clinician and blood pressures measured remotely by electronic monitoring devices capable of transmitting the blood pressure data to the clinician. Blood pressure readings taken by a remote monitoring device and conveyed by the patient to the clinician are also acceptable. It is the clinician's responsibility and discretion to confirm the remote monitoring device used to obtain the blood pressure is considered acceptable and reliable and whether the blood pressure reading is considered accurate before documenting it in the patient's medical record. Do not include BP readings: • Taken during an acute inpatient stay or an ED visit. • Taken on the same day as a diagnostic test or diagnostic or therapeutic procedure that requires a change in diet or change in medication on or one day before the day of the test or procedure, with the exception of fasting blood tests. • Taken by the patient using a non-digital device such as a with a manual blood pressure cuff and a stethoscope. If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled." If there are multiple blood pressure readings on the same day, use the lowest systolic and the lowest diastolic reading as the most recent blood pressure reading.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.
Rate 5	The numerator statement, stratified by disability status.

Measure #4: Developmental Screening in the First Three Years of Life[101]

Measure #4 – Description

Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday

Measure #4 – Denominator

Initial Population	Patients 1-3 years of age during the measurement period
Denominator Statement	Equals Initial Population
Denominator Exclusions	None
Denominator Exceptions	None
Rate 1	The denominator statement.
Rate 2	The denominator statement, stratified by race. Separately report the percentage of patients in the denominator statement for which the provider organization has complete race data.
Rate 3	The denominator statement, stratified by ethnicity. Separately report the percentage of patients in the denominator statement for which the provider organization has complete ethnicity data.
Rate 4	The denominator statement, stratified by language. Separately report the percentage of patients in the denominator statement for which the provider organization has complete language data.
Rate 5	The denominator statement, stratified by disability status. Separately report the percentage of patients in the denominator statement for which the provider organization has complete disability status data.

Measure #4 – Numerator

Numerator Statement	Patients who had screening for risk of developmental, behavioral and social delays using a standardized, validated tool that was documented in the 12 months preceding or on their first, second and third birthday
Numerator Exclusions	Not applicable
Guidance	Documentation in the medical record must include all of the following: • A note indicating the date on which the test was performed, and • The standardized tool used (see below), and • Evidence of a screening result or screening score

[101] Source: CMS 2021 Medicaid Child Core Set specifications. https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf?t=1623809181.

	Tools must meet the following criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor (fine and gross), language, cognitive, and social-emotional. 2. Established Reliability: Reliability scores of approximately 0.70 or above. 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s). 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above. The following tools meet the above criteria and are included in the Bright Futures Recommendations for Preventive Care, which reference the updated January 2020 American Academy of Pediatrics (AAP) Statement.[102] • Ages and Stages Questionnaire - 3rd Edition (ASQ-3) • Parents' Evaluation of Developmental Status (PEDS) - Birth to age 8 • Parent's Evaluation of Developmental Status - Developmental Milestones (PEDS-DM) • Survey of Well-Being in Young Children (SWYC) Note: The 2020 AAP Statement describes the screening tool properties that may be useful for states to consider in designing their policies. Tools included in the 2006 Statement that meet the above criteria but were not listed in the 2020 Statement (as they often are not used by primary care providers in the context of routine well-child care) include the following:[103] • Battelle Developmental Inventory Screening Tool (BDI-ST) - Birth to 95 months • Bayley Infant Neuro-developmental Screen (BINS) - 3 months to age 2 • Brigance Screens-II - Birth to 90 months • Child Development Inventory (CDI) - 18 months to age 6 • Infant Development Inventory - Birth to 18 months The tools listed above are not specific recommendations for tools but are examples of tools cited in Bright Futures that meet the above criteria. Tools that do NOT meet the criteria: It is important to note that standardized tools specifically focused on one domain of development (e.g., child's socio-emotional

[102] Lipkin, Paul H., and Michelle M. Macias. "Promoting optimal development: identifying infants and young children with developmental disorders through developmental surveillance and screening." Pediatrics, vol. 145, no. 1, January 1, 2020. https://pediatrics.aappublications.org/content/145/1/e20193449.

[103] Bright Futures Steering Committee, and Medical Home Initiatives for Children With Special Needs Project Advisory Committee. "Identifying infants and young children with developmental disorders in the medical home: An algorithm for developmental surveillance and screening." Pediatrics, vol. 118, no.1, July 2006, pp. 405-420. https://pediatrics.aappublications.org/content/118/1/405.

	development [ASQ-SE] or autism [M-CHAT]) are not included in the list above as this measure is anchored to recommendations related to global developmental screening using tools that identify risk for developmental, behavioral, and social delays.
Rate 1	The numerator statement.
Rate 2	The numerator statement, stratified by race.
Rate 3	The numerator statement, stratified by ethnicity.
Rate 4	The numerator statement, stratified by language.
Rate 5	The numerator statement, stratified by disability status.

Crosswalk of Race/Ethnicity Reporting Categories

Crosswalk of Race/Ethnicity Categories

National Committee for Quality Assurance (NCQA) Categories[104]	Office of Management and Budget (OMB) Categories[105]	Health Resources & Services Administration (HRSA) Uniform Data System (UDS) Categories[106]
White	White	White
Black	Black or African American	Black/African American
American Indian/Alaska Native	American Indian or Alaska Native	American Indian/Alaska Native
Asian	Asian	Asian
Native Hawaiian and Other Pacific Islander	Native Hawaiian and Other Pacific Islander	Native Hawaiian
		Other Pacific Islander
Hispanic/Latino	Hispanic or Latino	Hispanic/Latino
Not Hispanic/Latino	Non-Hispanic or Latino	Non-Hispanic/Latino
Unknown	Unknown	Unreported/Refused to Report
Declined	Asked but No Answer	
Some Other Race	N/A	N/A
Two or More Races	N/A*	More than One Race

*OMB allows individuals to select more than one of the five race categories.

[104] Source: NCQA's Proposed Changes to Existing Measures for HEDIS MY 2022: Introduction of Race and Ethnicity Stratification Into Select HEDIS Measures. https://www.ncqa.org/wp-content/uploads/2021/02/02.-Health-Equity.pdf.

[105] Source: CMS' Inventory of Resources for Standardized Demographic and Language Data Collection. https://www.cms.gov/about-cms/agency-information/omh/downloads/data-collection-resources.pdf.

[106] Source: HRSA's Uniform Data System 2021 Health Center Data Reporting Requirements. https://data.hrsa.gov/tools/data-reporting/program-data/state/LA/table?tableName=7.

Appendix F: Emergency Department Utilization for Individuals Experiencing Mental Illness

Steward: Oregon Health Authority, December 22, 2020 Specifications, Adapted by Executive Office of Health and Human Services
As of March 1, 2022

SUMMARY OF CHANGES FOR 2022 (PERFORMANCE YEAR 5)

- Specified that the measure focuses on non-mental health and non-chemical dependency-related ED visits for individuals experiencing mental illness.
- Updated the Excel spreadsheet that refers to specific codes to calculate the numerator and denominator. See "Summary of Changes" tab for detailed information about code-specific changes.
- Removed the Oracle SQL code that EOHHS used to calculate the measure.

Description

Non-mental health and non-chemical dependency-related ED visits per 1,000 member months of adult members enrolled with an MCO and attributed to an AE who are identified as having experienced mental illness.

Eligible Population

Product lines	Medicaid
Ages	18 years or older as of December 31 of the measurement year
Continuous enrollment	None
Allowable gap	None
Anchor date	N/A
Lookback period	The measurement year and the two years preceding the measurement year (a rolling lookback period for total of 36 months)
Benefit	Medical
Event/diagnosis	Two or more visits with specific mental illness diagnoses. A 'visit' is defined as a unique member and date of service. See "Denominator" tab in Excel spreadsheet for eligible codes.
Exclusions	• Members in hospice care (see "Denominator Exclusions" tab in Excel spreadsheet for eligible codes)

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine

	attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[107]

Administrative Specifications

Denominator	The eligible population, reported in 1,000 member months[108]
Numerator	Number of emergency department visits from the denominator (members experiencing mental illness), during the enrollment span with the organization within the measurement year. Count each visit to an ED that does not result in an inpatient encounter once; count multiple ED visits on the same date of service as one visit.[109] EOHHS is calculating the measure using the revenue codes associated with visits to the ED. See the "Numerator Option 1" tab in the Excel spreadsheet for eligible codes.[110]
Numerator Exclusions[111]	• ED visits that result in an inpatient stay. • Mental health and chemical dependency services. See "Numerator Exclusions" tab in Excel spreadsheet for eligible codes.

[107] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.

[108] A member should be included in the measure due to a history of qualifying mental illness claims in the 36-month lookback period for the MCO with which they have coverage as of December 31st of the measurement year. Of note, if an MCO does not have 36 months of claims for the member, it should utilize all the claims it has for the member for up to 36 months for the lookback period (e.g., if an MCO only has 24 months of claims for a member, it should utilize all of the 24 months for the lookback period).

[109] When an outpatient, ED or observation visit and an inpatient stay are billed on separate claims, the visit results in an inpatient stay when the outpatient/ED/observation date of service occurs on the day prior to the admission date or any time during the admission (admission date through discharge date). An outpatient, ED or observation visit billed on the same claim as an inpatient stay is considered a visit that resulted in an inpatient stay.

[110] While EOHHS is using "Numerator Option 1" to calculate performance for this measure, MCOs could also calculate the measure using codes associated with procedures that are commonly performed in an ED with an ED place of service code. See the "Numerator Option 2" tab in the Excel spreadsheet for eligible codes.

[111] Apply exclusions at the claim line level. Keep all paid claim lines (i.e., unless the entire claim was denied, the paid lines pass through the algorithm and are picked up for this exclusion).

Excel Spreadsheet

ED Utilization for
Individuals Experien

Appendix G: Potentially Avoidable ED Visits

Potentially Avoidable ED Visits
Steward: New York University, Modified by Rhode Island Executive Office of Health and Human Services
As of February 24, 2022

SUMMARY OF CHANGES FOR 2022 (PERFORMANCE YEAR 5)

- Removed the Oracle SQL code that EOHHS used to calculate the measure.

Numerator

The total sum of the probabilities of 1) preventable/avoidable emergent ED visits, 2) non-emergent ED visits, and 3) emergent ED visits that could have been avoided by regular primary care, using the probabilities supplied by NYU for the primary diagnosis code (ICD-9/10) of each ED visit. Only visits from Medicaid members should be included. There are no age or continuous enrollment exclusions.

Denominator

All ED visits for Medicaid members in the measurement period. There are no age or continuous enrollment exclusions.

Calculated: Preventable ED Visit Rate

The total potentially avoidable ED visits (numerator) divided by all ED visits, stratified by MCO and AE.

Patient/Provider Attribution to AEs

Patient Attribution to AEs	Attribute each member to a single AE, based on the AE to which the member is attributed in December of the performance year. If a member is not enrolled in Medicaid in December, do not attribute the member to any AE for measurement purposes. Determine attribution using the AE TIN rosters that are in place as of December of the performance year.
Provider Attribution to AEs	Each primary care provider (PCP) bills under a Taxpayer Identification Number (TIN), typically the TIN of the entity that employs that PCP or through which the PCP contracts with public and/or private payers. Some PCPs may contract through more than one TIN. Each TIN is permitted to affiliate with at most one AE at any given time, and each PCP is permitted to affiliate with as most one AE at any given time. That is, even if a PCP contracts through more than one TIN and those TINs are affiliated with different AEs, the PCP may only be affiliated with one of the AEs. For more information about which primary care

	providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[112]

Additional Information

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/.

[112] https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Attachment%20M%20-%20PY4%20Attribution%20Guidance.pdf.