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 5 through 6

Rhode Island Executive Office of Health and Human Services (EOHHS)
March 1, 2023

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) 5 through 6 (for more information on methodology and targets from PY1 through PY4 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
6	July 1, 2023-June 30, 2024	Jan 1, 2023-Dec 31, 2023	Jan 1, 2023-Dec 31, 2023

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.

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 QP5through QPY6, 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

Measures	Steward	Data Source[2]	Specifications	AE Common Measure Slate[3]	
				QPY5 Reporting and Incentive Use	QPY6 Reporting and Incentive Use
HEDIS Measures					
Breast Cancer Screening	NCQA	Admin	Current HEDIS specifications: QPY5: HEDIS MY 2022 QPY6: HEDIS MY 2023	P4P	P4P
Child and Adolescent Well-Care Visits (Total)	NCQA	Admin		Reporting-only	P4P
Child and Adolescent Well-Care Visits (12-21 years)	NCQA	Admin		P4P	
Child and Adolescent Well-Care Visits (3-11 years)	NCQA	Admin		Reporting-only	
Chlamydia Screening in Women (Total)	NCQA	Admin			Reporting-only
Controlling High Blood Pressure	NCQA	Admin/ Clinical		P4P	P4P
Eye Exam for Patients with Diabetes	NCQA	Admin/ Clinical		P4P	P4P
Follow-up after Hospitalization for Mental Illness	NCQA	Admin		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	P4P
Lead Screening in Children	NCQA	Admin		P4R	P4P
Non-HEDIS Measures (Externally Developed)					
Developmental Screening in the First Three Years of Life	OHSU	Admin/ Clinical	QPY5-QPY6: CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[4]	P4P	P4P
Screening for Depression and Follow-up Plan	CMS	Admin/ Clinical	QPY5: CMS MIPS 2022, modified by EOHHS (February 14, 2022 version – included in Quality Measure Specifications Manual[5]) QPY6: CMS MIPS 2023, modified by EOHHS (January 26, 2023 version – included in Quality Measure Specifications Manual[6])	P4P	P4P
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	Admin/ Clinical	QPY5: CMS MIPS 2022 QPY6: CMS MIPS 2023	Reporting-only	Reporting-only

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

[3] Please refer to the May 21, 2021 version of the Implementation Manual for more information on the QPY1 and QPY2 measures. to the April 20, 2022 version for more information on the QPY3 measures and to the September 12, 2022 version for more information on the QPY4 measures.

[4] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html

[5] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

[6] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

Measures	Steward	Data Source[2]	Specifications	AE Common Measure Slate[3]	
				QPY5 Reporting and Incentive Use	QPY6 Reporting and Incentive Use
Non-HEDIS Measures (EOHHS-developed)					
Patient Engagement with an AE Primary Care Provider	RI EOHHS	Admin	QPY6: EOHHS (May 23, 2022 version – included in Quality Measure Specifications Manual[7])		Reporting-only
Social Determinants of Health Screening	RI EOHHS	Admin/ Clinical	QPY5-QPY6: EOHHS (August 3, 2022 version – included in Quality Measure Specifications Manual[8])	P4P	P4P

[7] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[8] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

Eligible Population for All Measures

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. 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

All non-HEDIS measures in the Common Measure Slate are defined to only include Active Patients in their denominator (with the exception of *Patient Engagement with an AE Primary Care Provider*). 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 QPY5-6. 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
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.
6	10	All AE Common Measure Slate measures except for *Chlamydia Screening in Women (Total)*, *Follow-up After Hospitalization for Mental Illness (30-day)*, *Patient Engagement with an AE Primary Care Provider* and *Tobacco Use: Screening and Cessation Intervention*, as these are reporting-only measures.

Calculation of the Overall Quality Score

- **For QPY5**, EOHHS developed a standard Overall Quality Score methodology that is required for use by all AEs and MCOs.

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 A: 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.[9]

For QPY6, EOHHS will use the same methodology as QPY5 with a few modifications.

- *Lead Screening in Children* is a P4P measure and therefore AEs can earn points for the measure by demonstrating achievement or improvement, as defined by EOHHS.
- The baseline year for assessing improvement for all measures will be QPY4 (2021).

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

- EOHHS will not recognize improvement if QPY6 (2023) performance is statistically significantly below QPY3 (2020) performance. A statistically significant decline is defined using a p-value of less than 0.1. EOHHS uses the following formulas to calculate statistical significance in Excel:

$$p - value = 1 - NORMDIST(ABS(Z))$$

$$Z = \frac{(\hat{p}_1 - \hat{p}_2) - 0}{\sqrt{p(1-p)(\frac{1}{n_1} + \frac{1}{n_2})}}$$

  - $\hat{p}_1 = 2022\ rate$
  - $\hat{p}_2 = 2020\ rate$
  - $p = \frac{Y_1 + Y_2}{n_1 + n_2}$
  - $Y_1 = 2022\ numerator$
  - $Y_2 = 2020\ numerator$
  - $n_1 = 2022\ denominator$
  - $n_2 = 2020\ denominator$

Appendix B: Example Overall Quality Score Calculation for QPY6 illustrates how to calculate the Overall Quality Score for QPY6 based on each AE's achievement and improvement points. MCOs and AEs may calculate AE Overall Quality Score performance using the "Overall Quality Score Determinations QPY6" Excel reporting template. A copy of the Excel reporting template can be obtained on the EOHHS' SFTP site.[10]

TCOC Quality Benchmarks

For QPY5, EOHHS employed a combination of internal and external data sources to set achievement targets. 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 guiding principles to ensure the achievement targets were both attainable and sufficiently ambitious as to motivate quality improvement. EOHHS utilized the following guiding principles for the threshold target: (1) the threshold target should be below the current Rhode Island Medicaid plan-weighted average; (2) 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.

Finally, EOHHS solicited input from the AE/MCO Work Group prior to finalizing the targets.

The achievement targets for QPY5 are as follows:

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

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
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)

For QPY6, EOHHS employed a combination of internal and external data sources to set achievement targets. EOHHS set targets for QPY6 by January 2023 using (1) AE data, as reported by MCOs, from QPY4 (2021), (2) national and New England Medicaid (HMO) data from NCQA Quality Compass 2022 (CY 2021 data) and (3) national and Rhode Island state data from CMS' 2021 Child and Adult Health Care Quality Measures report.

EOHHS also used guiding principles to ensure the achievement targets were both attainable and sufficiently ambitious as to motivate quality improvement. EOHHS modified the guiding principles slightly from QPY5. EOHHS utilized the following guiding principles for the threshold target: (1) the threshold target should be below the current Rhode Island Medicaid plan-weighted average; (2) 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 three 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.

Finally, EOHHS adjusted targets for two measures where MCOs will no longer be able to use AE self-report as an eligible data source (see the "Data Collection and Reporting Responsibilities" section of the Implementation Manual). EOHHS lowered the targets using the average difference between (1) AE performance including all data sources except for AE self-report and (2) AE performance including all data sources across all AEs, weighted based on each AE's measure denominator.[11]

The achievement targets for QPY6 are as follows:

Measure Name	Threshold Target	Source	High-Performance Target	Source
Breast Cancer Screening	51%	National 50th percentile	61%	National 90th percentile
Child and Adolescent Well-Care Visits (*Total*)	49%	National 50th percentile	57%	National 75th percentile
Controlling High Blood Pressure	61%	New England 50th percentile	69%	New England 67th percentile
Developmental Screening in the First Three Years of Life	52%	CMS 75th percentile (adjusted)	61%	CMS 90th percentile (adjusted)
Eye Exam for Patients with Diabetes	52%	New England 50th percentile (adjusted)	58%	New England 75th percentile (adjusted)
Follow-up After Hospitalization for Mental Illness (7-day)	48%	New England 50th percentile	59%	New England 75th percentile
HbA1c Control for Patients with Diabetes: HbA1c Control <8.0%	50%	National 50th percentile	58%	National 90th percentile
Lead Screening in Children	64%	National 50th percentile	80%	National 90th percentile
Screening for Depression and Follow-up Plan	45%	QPY5 target	75%	QPY5 target
Social Determinants of Health (SDOH) Screen	42%	QPY5 target	59%	QPY5 target

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

For QPY5 and QPY6, 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,

[11] Please refer to the January 17, 2023 AE/MCO Quality Work Group meeting materials for more information on rationale behind this methodology.

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 use the measure specifications included in the Quality Measure Specifications Manual[12] to report stratified performance for QPY5 and QPY6 to EOHHS and MCOs by August 31 of the year following the measurement year (e.g., AEs must report CY 2022 performance by August 31, 2023). AEs must use the reporting template for the appropriate year to report performance, which can be obtained through EOHHS' SFTP site.[13]

Data Collection and Reporting Responsibilities

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 2023 performance by October 31, 2024). MCOs must generate accurate quality measure rates that capture performance for the entire AE population. All Administrative measures must be generated and reported by the MCO. AEs and MCOs must work together to establish clinical data exchange capabilities as described in the "Electronic Clinical Data Exchange" section below for 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) for select practices, measures and years.

For **QPY5**, MCOs are responsible for reporting performance using administrative data, chart review, clinical data that are obtained through electronic data feeds (e.g., from KIDSNET, CurrentCare, MCO-managed registries), electronic clinical data exchange (ECDE) and AE self-report.

Beginning in **QPY6**, EOHHS will start to phase out use of AE self-report and MCO chart review data (including historical chart review) for measures that require clinical data. MCOs therefore will be responsible for reporting performance using administrative data, clinical data that are obtained through electronic data feeds (e.g., from KIDSNET, CurrentCare, MCO-managed registries) and ECDE only. The table below summarizes which data sources MCOs are able to use for reporting performance by performance year.

Data Source	Data Sources MCOs Can Use by Performance Year	
	QPY5 (2022)	QPY6+ (2023+)
Administrative data (e.g., claims)	Yes	Yes
MCO chart review	Yes	Yes/No*
Clinical data obtained through electronic data feeds (e.g., from KIDSNET, CurrentCare, MCO-managed registries)	Yes	Yes
ECDE	Yes	Yes
AE self-report	Yes	Yes/No*

**This data source can be used only for specific measures with specific practice types based on the performance year. See below for more information.*

[12] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

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

EOHHS will introduce the phasing out of AE self-report and chart review data on a measure-by-measure specific basis over three years. The table below identifies for which measures MCOs are **not** allowed to use AE self-report or chart review data (except for certain practice types describe below) by performance year. MCOs can use all relevant QPY5 data sources for reporting performance on measures not referenced in the table below.

Performance Year	Measures for which MCOs Cannot Use AE Self-report or MCO Chart Review Data
QPY6 (2023)	*Eye Exam for Patients with Diabetes* and *Developmental Screening in the First Three Years of Life*
QPY7 (2024)	All measures for QPY6 as well as *Controlling High Blood Pressure*, *HbA1c Control for Patients with Diabetes* and *Tobacco Use: Screening and Cessation Intervention* (reporting only)
QPY8 (2025)	All measures for QPY6 and QPY7 as well as *Screening for Depression and Follow-up Plan* and *SDOH Screening*

This phasing out of AE self-report and chart review data will be applicable for *all* primary care practices in non-network-based AEs (i.e., BVCHC, Coastal, PCHC and Thundermist) and for those primary care practices in network-based AEs (i.e., IHP, Integra and Prospect) that have at least 1,000 attributed patients across MCOs, as identified using MCO data as of July 2022. Practice sites will be identified using practice TINs.. All other practices (i.e., primary care practices with fewer than the 1,000 attributed patients threshold of AE patients within network-based AEs and specialty care practices) can continue to use self-report and chart review data. AEs are encouraged to participate in additional measure validation opportunities to ensure that data are being transmitted properly via electronic clinical data exchange. The table below summarizes the practices for which AE self-report and chart review data will be phased out.

Practice Type	Subject to Phasing Out of AE Self-report and Chart Review Data?
Primary care practice in non-network-based AEs (i.e., BVCHC, Coastal, PCHC and Thundermist)	Yes
Primary care practice in network-based AEs (i.e., IHP, Integra and Prospect) that have at least 1,000 attributed patients across MCOs	Yes
Primary care practice in network-based AEs (i.e., IHP, Integra and Prospect) with fewer than 1,000 attributed patients across MCOs	No
Specialty care practices in any AE	No

Once a practice is identified to have at least 1,000 attributed patients across MCOs, it will be subject to the AE self-report phase-out requirement even if its attributed patient count subsequently drops below 1,000 during the performance year. EOHHS will utilize the following process to identify which practices will be subject to the AE self-report phase-out requirement for the following measurement year.

- By September 30 of the year prior to the measurement year, EOHHS will re-run its analysis to identify which practices meet the threshold.

- AEs and/or MCOs can request a re-evaluation of which practices newly meet the 1,000 attributed patients threshold on an ad hoc basis if there is a significant change that could impact the number of attributed patients (e.g., a practice acquisition or merger).

EOHHS will assess systematic variation between the rates generated using the QPY5 data sources and the rates generated without AE self-reported or chart review data to see if the two rates are comparable. Therefore, MCOs will be responsible for reporting QPY6 performance in two ways: (1) using administrative data, clinical data that are obtained through electronic data feeds and ECDE only (which EOHHS will use for incentive purposes) and (1) using the QPY5 data sources (which EOHHS will use for analysis purposes only). EOHHS will provide more information on how it will assess systematic variation between these two rates in fall 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 in 2019 for efforts to move towards electronic clinical data exchange (ECDE) for the Common Measure Slate.[14] 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 through flat files or CCDs, 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. MCOs were required to submit Implementation Status Reports that detailed the status of ECDE efforts with *each* AE.

IMAT participates in NCQA's Data Aggregator Validation (DAV) program on an annual basis beginning in 2021, which "validates organizations that collect, aggregate and transform data from original data sources on behalf of vendors and health care organizations."[15] DAV certification ensures that data are not modified after AEs submit data to the QRS. IMAT conducts primary source verification, with the help of MCOs, for all EHR "clusters" (i.e., all EHR platforms for a certain care setting, such as Epic's outpatient EHR interface) that are ready for DAV certification. EHR "clusters" that receive DAV certification for the State's Quality Reporting System (QRS) in the spring meet HEDIS audit standards for the prior performance year (e.g., DAV certification in spring 2023 means the EHR "cluster" meets HEDIS audit standards for performance year 2022). Therefore, MCOs may use DAV-certified data from the QRS for these "clusters" for reporting HEDIS measure performance to NCQA and AE Common Measure Slate measure performance to EOHHS without conducting any additional audits. MCOs will need to conduct PSV for clinical data from any non-DAV-certified EHR "clusters."

Finally, EOHHS, AEs and MCOs should **verify the accuracy of data reported using ECDE**.[16] EOHHS is conducting this verification process to ensure that data submitted via ECDE are comparable with the

[14] In April 2021, CMS approved EOHHS' request to extend the deadline for establishing ECDE from July 30, 2021 to September 30, 2021.

[15] See https://www.ncqa.org/programs/data-and-information-technology/hit-and-data-certification/hedis-compliance-audit-certification/data-aggregator-validation/ for more information.

[16] AEs and MCOs conducted several activities prior to QPY4 to verify the accuracy of ECDE data. 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. AEs had to have fully validated their data

traditional reporting method in use in QPY5 and earlier. On an annual basis, MCOs shall report the percentage of gaps closed using ECDE data only at the plan level and at the AE level. This 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.

and be in production by September 30, 2021 in order to submit QPY2 data at that time. IMAT and UnitedHealthcare verified the integrity of the test exchange of QPY2 clinical measure data from October 1, 2021 by November 1, 2021.

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[17]	
				OPY5	OPY6
HEDIS Measures					
Plan All-Cause Readmissions	NCQA	Admin	OPY5: HEDIS MY 2022 OPY6: HEDIS MY 2023	P4P	P4P
Non-HEDIS Measures: Externally Developed					
Emergency Department (ED) Utilization for Individuals Experiencing Mental Illness	Oregon Health Authority	Admin	OPY5-6: EOHHS, adapted from OHS 2020-2021[18] (August 3, 2022 version – included in Quality Measure Specifications Manual[19])	P4P	P4P
Non-HEDIS Measures (EOHHS-developed)					
Potentially Avoidable ED Visits	NYU, modified by EOHHS	Admin	OPY5-6: EOHHS (August 3, 2022 version –included in Quality Measure Specifications Manual[20])	P4P	P4P

[17] Please refer to the May 21, 2021 version of the Implementation Manual for more information on the OPY1 and OPY2 measures, to the April 20, 2022 version for more information on the OPY3 measures and to the September 12, 2022 version for more information on the OPY4 measures.

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

[19] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

[20] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

Eligible Population for Outcome Measures

All Outcome measures are calculated with IHH members attributed to the AE based on their primary care provider. 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
5	3	All Outcome Measure Slate measures
6	3	All Outcome Measure Slate measures

Calculation of the Outcome Measure Performance Area Milestones

For OPY5, 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 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%

For OPY6, AEs will earn a percentage of the AEIP based on the annual performance on Outcome metrics. The Outcome metric score methodology for OPY6 is the same as OPY5, except for the measure weights. The OPY6 measure weights are as follows:

Weighting for all AEs

Outcome Measure	OPY6 Weight
Plan All-Cause Readmissions	15%
Emergency Department Utilization for Individuals Experiencing Mental Illness	15%
Potentially Avoidable ED Visits	15%

Outcome Measure Targets

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
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%

For OPY6, EOHHS employed historical AE performance for CY 2019, CY 2020 and CY 2021, calculated by MCOs, to set AE-specific graduated achievement targets. EOHHS calculated targets for all measures based on an AE's total population across all MCOs, which is also how final performance will be

calculated. EOHHS also developed a methodology that allows high-performing AEs to receive incentives for maintaining high performance rather than demonstrating statistically significant improvement.

For ***Plan All-Cause Readmission***, 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 OPY6. AEs with a baseline observed-to-expected ratio of greater than 1.0300 must have an observed-to-expected ratio in OPY6 that is equal to or lower than 0.03 less than its baseline ratio. All targets and AE performance for OPY6 will be rounded to the ten-thousandths decimal place. The baseline observed-to-expected ratios and AE-specific graduated targets for OPY6 can be found in the table below.

AE	2019-2021 Baseline Observed-to-Expected Ratio	OPY6 (2023) Graduated Targets for *Plan All-Cause Readmission* (Observed-to-Expected Ratio)			
		25%	50%	75%	100%
BVCHC	1.0644	1.0569	1.0494	1.0419	1.0344
Coastal	0.8789	N/A	N/A	N/A	<1.0300
IHP	1.2111	1.2036	1.1961	1.1886	1.1811
Integra	1.1022	1.0947	1.0872	1.0797	1.0722
PCHC	1.2256	1.2181	1.2106	1.2031	1.1956
Prospect	1.1107	1.1032	1.0957	1.0882	1.0807
Thundermist	1.0820	1.0745	1.0670	1.0595	1.0520

For ***ED Utilization for Individuals with Mental Illness*** and ***Potentially Avoidable ED Visits***, AEs with baseline rate that is 80 percent or less of the value of the overall rate across AEs will be asked to maintain high performance, i.e., their baseline rate +/- statistically significant change. EOHHS identified what each AE needs to achieve in OPY6 to demonstrate a "statistically significantly decline" (i.e., improvement) in utilization rates from baseline, determined using a one-tailed test with a power of 0.8 and p value of 0.05. All targets and AE performance for OPY6 will be rounded to the tenth decimal place. The baseline rates and AE-specific graduated targets for each measure for OPY6 can be found in the tables below.

AE	2019-2021 Baseline Rate	OPY6 (2023) Graduated Targets for *ED Utilization for Individuals Experiencing Mental Illness* (Visits per 1,000 Member Months)			
		25%	50%	75%	100%
BVCHC	75.0	74.4	73.7	73.1	72.4
Coastal	49.6	N/A	N/A	N/A	49.6 +/- 2.4
IHP	82.6	82.2	81.8	81.4	81.0
Integra	81.4	81.0	80.7	80.3	79.9
PCHC	98.9	98.5	98.1	97.6	97.2
Prospect	74.8	74.4	73.9	73.5	73.0
Thundermist	96.3	95.9	95.5	95.0	94.6

AE	2019-2021 Baseline Rate	OPY6 (2023) Graduated Targets for *Potentially Avoidable ED Visits*			
		25%	50%	75%	100%
BVCHC	41.2%	41.0%	40.7%	40.5%	40.2%
Coastal	35.0%	34.7%	34.5%	34.2%	33.9%
IHP	37.3%	37.2%	37.0%	36.9%	36.7%
Integra	37.1%	37.0%	36.9%	36.7%	36.6%
PCHC	38.6%	38.5%	38.4%	38.3%	38.2%
Prospect	39.0%	38.8%	38.7%	38.5%	38.3%
Thundermist	39.5%	39.4%	39.2%	39.1%	38.9%

Outcome Measures Data Collection Responsibilities

For OPY5 and OPY6, 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 the appropriate reporting year 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.[21] MCOs shall also provide patient lists to the AEs, as requested by AEs. EOHHS will share unblinded quarterly and annual outcome measure performance rates in memos to AEs and MCOs.

The reporting periods and reporting date for each of the quarterly and annual reports for OPY5 and OPY6 are indicated in the tables below.

MCO 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
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 15, 2023
January 1, 2022 – December 31, 2022 (with 180 days of claims runout)	January 1, 2022 – December 31, 2022 (with 180 days of claims runout)	August 1, 2023

MCO OPY6 Reporting Schedule		
Reporting Period (Rolling 12-month)	**Reporting Period (Year-to-Date)**	**Reporting Date**
April 1, 2022 – March 31, 2023	January 1, 2023 – March 31, 2023	August 14, 2023
July 1, 2022 – June 30, 2023	January 1, 2023 – June 30, 2023	November 15, 2023
October 1, 2022 – September 30, 2023	January 1, 2023 – September 30, 2023	February 15, 2024
January 1, 2023 – December 31, 2023	January 1, 2023 – December 31, 2023	May 15, 2024

[21] There are two separate templates for MCOs to report OPY5 performance – the "AEIP Quarterly Outcome Metrics" template to report quarterly performance and the "AEIP Annual Outcome Metrics" template to report annual performance. There is one template for MCOs to report quarterly and annual performance for OPY6. If you have any questions on how to access the EOHHS SFTP site, email Michelle Lizotte (Michelle.Lizotte@ohhs.ri.gov).

MCO OPY6 Reporting Schedule		
Reporting Period (Rolling 12-month)	**Reporting Period (Year-to-Date)**	**Reporting Date**
January 1, 2023 – December 31, 2023 (with 180 days of claims runout)	January 1, 2023 – December 31, 2023 (with 180 days of claims runout)	August 1, 2024

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.

Each MCO may decide whether to permit PCPs who contract with multiple TINs to be affiliated with multiple AEs through those different TINs.. If an MCO chooses to permit PCPs to be affiliated with multiple AEs, members will be attributed to an AE based on the affiliation of the TIN through which the member was assigned to that PCP (either through original MCO assignment or based on the TIN through which the PCP bills that member's visits).

For more information about which primary care providers are eligible for attribution to an AE, please refer to "Attachment M: Attribution Guidance."[22]

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

[22] https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

Attribution Purpose	TIN Roster
	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.
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.

EOHHS will ask AEs and MCOs to review HEDIS changes (released on or about August 1 the year prior to the measurement year) and non-HEDIS changes for Quality and Outcome Performance Year 6. AEs and MCOs will finalize changes for each Quality and Outcome Performance Year after NCQA releases its Technical Specifications Update for on or around March 31 of the measurement year.

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 2022 – 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.[23]

Topic	Category	Task	Responsible Party	PY	Deadline
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, Outcome measure scoring methodology and *RELD Measure* reporting	Update "Overall Quality Score Determinations" Excel reporting template for QPY6, the "AEIP Quarterly Outcome Metrics" for OPY6 and the "RELD Measure Reporting Template" for QPY5	EOHHS	OPY6/QPY6/ QPY5	1/31/2023
TCOC	Overall Quality Score methodology and *RELD Measure* reporting	Update the measure specifications for *Screening for Depression and Follow-up Plan* for QPY6 and for the *RELD Measure* for QPY5 and QPY6	EOHHS	QPY6/QPY5	1/31/2023
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of final performance on the Outcome measures to the AEs	EOHHS	OPY5	8/15/2023
Outcomes	*RELD Measure* reporting	Reporting of stratified AE performance on the RELD Measure to EOHHS and MCOs	AEs	QPY5	8/31/2023
TCOC	Overall Quality Score methodology	Notify AEs and MCOs of which practices are subject to the AE self-report phase-out requirement for QPY7	EOHHS	QPY7	9/30/2023
Outcomes	Outcome performance reporting (for financial incentives)	Reporting of final performance on the Outcome measures to the AEs	EOHHS	OPY6	8/15/2024
Outcomes	*RELD Measure* reporting	Reporting of stratified AE performance on the RELD Measure to EOHHS and MCOs	AEs	QPY6	8/30/2024

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

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,

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		• 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,

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		• 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,

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		• 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,

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		• 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.
s3.3	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.
4.1	8/3/2022	Updated to: • remove the methodology for PY3 and direct readers to earlier versions of the Implementation Manual for more information, • add information for PY6, • include the final measures, measure specifications and methodology for QPY6, • include the methodology for how EOHHS will set achievement and improvement targets for QPY6, • include information on how to access the "Overall Quality Score Determinations QPY6" Excel reporting template, • include information for how to access the QPY5 and QPY6 reporting templates for the *RELD Measure,* • include information on the updated reporting responsibilities for QPY6, • provide updated information related to ECDE, including the methodology for verifying the accuracy of data reported using ECDE, • include the final measures, measure specifications and methodology for OPY6, • include the methodology for how EOHHS will set achievement and improvement targets for OPY6, • include information on the updated reporting responsibilities for OPY6,

Version	Date	Revisions
		• provide the updated the "TCOC Quality and Outcome Measures Reporting Timeline," • relabel all appendices as needed and • add an example Overall Quality Score calculation for QPY6 in Appendix F.
4.2	1/30/2023	Updated to: • remove the methodology for PY4 and direct readers to earlier versions of the Implementation Manual for more information, • remove the measure specifications from the appendix, specify that measure specifications can be found in the Quality Measure Specifications Manual and relabel the existing appendices as appropriate, • update the final measures, measure specifications and methodology (including targets) for PY6, • include the formula used to calculate statistically significant decline used in the Overall Quality Score calculation for QPY6, • update information on which specifications to use for the *RELD Measure* for QPY5 and QPY6, • clarify use of historical MCO chart review data and MCO-managed registries for the AE self-report phase-out requirement beginning in QPY6, • update information on the threshold for primary care practices in network-based AEs that are subject to the AE self-report phase-out requirement, • clarify that practice transmission of either flat files or CCDs to IMAT qualifies as a form of ECDE, • update the timeline for reviewing measure specifications for each measurement year and • update the TCOC quality and outcome measures reporting timeline.

Appendix A: 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. The Excel reporting template can be obtained by through EOHHS' SFTP site.[24]

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**

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

Appendix B: Example Overall Quality Score Calculation for QPY6

Below is a high-level example of the calculation of the Overall Quality Score for QPY6. Further information on calculation of the individual score components will be provided in an updated "Overall Quality Score Determinations QPY6" Excel reporting template. The Excel reporting template can be obtained by through EOHHS' SFTP site.[25]

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 (*Total*)	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	0.75	1	1
Screening for Depression & Follow-up Plan	0.80	0	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**

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