Rhode Island Accountable Entity Program

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

Implementation Manual

Requirements for Program Years 8 and 9

Rhode Island Executive Office of Health and Human Services (EOHHS)
January 29, 2026

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

Contents

Purpose

The Rhode Island Executive Office of Health and Human Services (EOHHS) is focused on the successful operation of the Accountable Entity (AE) Program. The core strategic goal in the establishment of the AE program was to transition the Medicaid payment system away from fee-for-service to alternative payment models. With alternative payment models, EOHHS seeks to drive delivery system accountability to improve quality, member satisfaction, and health outcomes, while reducing the rate growth in total cost of care (TCOC).

The purpose of this document is to clearly outline guidelines for the TCOC quality measures and associated pay-for-performance (P4P) methodology for Performance Years (PY) 8 and 9 (for more information on methodology and targets from PY1 through PY7 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 (PY)
1	July 1, 2018-June 30, 2019	Jan 1, 2018-Dec 31, 2018
2	July 1, 2019-June 30, 2020	Jan 1, 2019-Dec 31, 2019
3	July 1, 2020-June 30, 2021	Jan 1, 2020-Dec 31, 2020
4	July 1, 2021-June 30, 2022	Jan 1, 2021-Dec 31, 2021
5	July 1, 2022-June 30, 2023	Jan 1, 2022-Dec 31, 2022
6	July 1, 2023-June 30, 2024	Jan 1, 2023-Dec 31, 2023
7	July 1, 2024-June 30, 2025	Jan 1, 2024-Dec 31, 2024
8	July 1, 2025-June 30, 2026	Jan 1, 2025-Dec 31, 2025
9	July 1, 2026-June 30, 2027	Jan 1, 2026-Dec 31, 2026

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 and AE obligation for any shared losses (when applicable).

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 (or losses, as applicable). The measure can be P4R or 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 (or obligation for losses, as appropriate).
- **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 PY8 and PY9, measures marked as P4R or P4P are required for incentive use.

Measures data sources are categorized in the following ways:

- **Administrative ("Admin")** measures that use claims, encounters, and/or other administrative data sources.
- **Clinical** measures that use medical record data, such as electronic health records, paper medical records, or clinical registries.
- **Electronic Clinical Data Exchange (ECDE)** measures use NCQA's Electronic Clinical Data Systems (ECDS) reporting standard, which encourages the use and sharing of electronic clinical data among plans and health care providers.

[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]	
				PY8 Reporting and Incentive Use	PY9 Reporting and Incentive Use
HEDIS Measures					
Breast Cancer Screening (Ages 52-74)	NCQA	ECDE	Current HEDIS specifications: PY8: HEDIS MY 2025 PY9: HEDIS MY 2026	P4P	P4P
Breast Cancer Screening (Ages 42-51)	NCQA	ECDE		Reporting-Only	Reporting-Only
Breast Cancer Screening (Total, Ages 42-74)	NCQA	ECDE[4]		Reporting-Only	Reporting-Only
Child and Adolescent Well-Care Visits (Total)	NCQA	Admin		P4P	P4P
Chlamydia Screening in Women (Total)	NCQA	Admin		P4P	P4P
Colorectal Cancer Screening	NCQA	ECDE[5]		Reporting-only	Reporting-only
Controlling High Blood Pressure	NCQA	Admin/ Clinical		P4P	P4P
Eye Exam for Patients with Diabetes	NCQA	Admin/ Clinical		Reporting-only	Reporting-only
Follow-up After Hospitalization for Mental Illness	NCQA	Admin		Reporting-only – 7 days	Reporting-only – 7 days
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	NCQA	Admin/ Clinical		P4P	P4P
Immunizations for Adolescents (Combo 2)	NCQA	Admin/ Clinical		Reporting-only	Reporting-only
Kidney Health Evaluation for Patients with Diabetes	NCQA	Admin/ Clinical		Reporting-only	Reporting-only
Lead Screening in Children	NCQA	Admin		P4P	P4P
Non-HEDIS Measures (Externally Developed)					
Developmental Screening in the First Three Years of Life	OHSU	Admin/ Clinical	PY8-PY9: CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[6]	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. Please refer to the April 20, 2022 version for more information on the QPY3 measures, to the September 12, 2022 version for information on the QPY4 measures, to the February 2, 2024 version for information on the QPY5 and QPY6 measures, and to the January 9, 2025 version for information on the PY7 measures.

[4] NCQA transitioned to exclusively using the Electronic Clinical Data Systems (ECDS) reporting standard for this measure beginning in MY23. RI EOHHS has adopted this practice to align with NCQA. For more information, see: https://www.ncqa.org/blog/transition-to-ecds-reporting-breast-cancer-screening/

[5] NCQA transitioned to exclusively using the ECDS reporting standard for this measure beginning in MY24. RI EOHHS had adopted this practice to align with NCQA. For more information, see: https://www.ncqa.org/blog/improving-quality-measurement-for-colorectal-cancer-screening/

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

Measures	Steward	Data Source[2]	Specifications	AE Common Measure Slate[3]	
				PY8 Reporting and Incentive Use	PY9 Reporting and Incentive Use
Screening for Depression and Follow-up Plan	CMS	Admin/ Clinical	PY8-PY9: CMS MIPS (see Quality Measure Specifications Manual[7] for guidance on defining "follow-up")	P4P	Reporting Only
Non-HEDIS Measures (EOHHS-developed)					
Patient Engagement with an AE Primary Care Provider	RI EOHHS	Admin	PY8-PY9: EOHHS (January 29, 2026 version – included in Quality Measure Specifications Manual[8])	Reporting-only	Reporting-only
Social Determinants of Health Screening	RI EOHHS	Admin/ Clinical	PY8-PY9: EOHHS (January 29, 2026 version – included in Quality Measure Specifications Manual[9])	P4P	P4P
Race, Ethnicity, and Language (REL) Data Completeness	RI EOHHS	Clinical	PY8: EOHHS (January 29, 2026 version – included in Quality Measure Specifications Manual[10]) PY9: EOHHS (January 29, 2026 version – included in Quality Measure Specifications Manual[11])	P4P	P4P
Race, Ethnicity, Language and Disability Status (RELD) Stratification	RI EOHHS	Clinical	PY8: EOHHS (January 29, 2026 version – included in Quality Measure Specifications Manual[12]) PY9: EOHHS (January 29, 2026 version – included in Quality Measure Specifications Manual[13])	Reporting-only	Reporting-only
Screening for Depression and Follow-up Plan Data Completeness[14]	RI EOHHS	ECDE	PY9: EOHHS (January 29, 2026 version – included in Quality Measure Specifications Manual[15])	NA	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.
[9] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[10] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[11] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[12] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[13] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[14] This measure will be calculated by EOHHS' QRS-vendor using data on continuity of care documents (CCDs) submitted by AEs.
[15] 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: 99202-99205; 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; 98970-98972; 99421-99423; 99441-99443; 98016; 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; 10.
    c. Any of the above CPT/HCPCS codes in 1 or 2.a. with the following modifiers: 93; 95; GT.

TCOC Quality P4P Methodology

This section describes the TCOC quality P4P methodology for PY8-9. 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. 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 or a reduction to the share of Shared Losses (as applicable).

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
8	9	All AE Common Measure Slate measures except for *Breast Cancer Screening (Ages 42-51), Breast Cancer Screening (Total, Ages 42-74), Colorectal Cancer Screening, Developmental Screening in the First Three Years of Life, Eye Exam for Patients with Diabetes, Follow-up After Hospitalization for Mental Illness (7-Day), Immunizations for Adolescents (Combo 2), Kidney Health Evaluation for Patients with Diabetes, Patient Engagement with an AE PCP* and *RELD Stratification,* as these are reporting-only measures.

QPY	Minimum # P4P/P4R Measures	Specific Measures Required for Overall Quality Score
9	10	All AE Common Measure Slate measures except for *Breast Cancer Screening (Ages 42-51), Breast Cancer Screening (Total, Ages 42-74), Colorectal Cancer Screening, Developmental Screening in the First Three Years of Life, Eye Exam for Patients with Diabetes, Follow-up After Hospitalization for Mental Illness (7-Day), Immunizations for Adolescents (Combo 2), Kidney Health Evaluation for Patients with Diabetes, Patient Engagement with an AE PCP, Screening for Depression and Follow-up Plan,* and *RELD Stratification,* as these are reporting-only measures.

Calculation of the Overall Quality Score

For PY8, EOHHS developed a standard Overall Quality Score methodology that was required for use by all AEs and MCOs.[16]

The required PY8 TCOC Overall Quality Score Methodology was as follows:

1. **Target Structure:** The Overall Quality Score recognized AEs that either attain a high-achievement target or demonstrate a required level of improvement over prior performance. MCOs assessed AE performance on each Common Measure Slate P4P measure for both achievement and improvement. For each Common Measure Slate P4P measure, AEs were awarded whichever score yielded the most performance points. The maximum earnable score for each measure was "1", and each measure was weighted equally.
    a. <u>Achievement targets:</u>
        i. EOHHS established two achievement targets: "threshold" and "high-performance."
        ii. Achievement points were scored on a sliding scale for performance between the threshold and high values.
            1. If performance was below or equal to the threshold-performance target: 0 achievement points.
            2. If performance was between the threshold-performance and the high-performance target, achievement points earned (between 0 and 1) were determined based on the following formula:
                (Performance Score – Threshold Performance) / (High-Performance Target – Threshold Performance)
            3. If performance was equal to or above the high-performance target: 1 achievement point.
        iii. For *REL Data Completeness*, AEs received 0.33 points for meeting the target for each variable (race, ethnicity, and language).
    b. <u>Improvement target:</u>

[16] For PY1-PY7, RIPCPC was embedded within Integra. Effective July 1, 2025, RIPCPC became a single-entity AE. For PY8, Integra and RIPCPC will be assessed using both achievement targets and improvement targets. Integra's performance will exclude RIPCPC. For PY8 P4P measures, the MCOs will provide updated PY6 baselines for RIPCPC and Integra.

i. Improvement points were awarded if PY8 performance was three percentage points greater than baseline performance.
    1. AEs did not earn improvement target points for *Chlamydia Screening in Women* or *REL Data Completeness*.
ii. The baseline year for assessing improvement for all measures was PY6 (2023).
iii. EOHHS did not recognize improvement if PY8 (2025) performance was statistically significantly below PY5 (2022) performance. A statistically significant decline was defined using a p-value of less than 0.1. EOHHS used the following formulas to calculate statistical significance in Excel:

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

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

1. $\hat{p}_1 = 2025\ rate$
2. $\hat{p}_2 = 2022\ rate$
3. $p = \frac{Y_1 + Y_2}{n_1 + n_2}$
4. $Y_1 = 2025\ numerator$
5. $Y_2 = 2022\ numerator$
6. $n_1 = 2025\ denominator$
7. $n_2 = 2022\ denominator$

2. Overall Quality Score Calculation: Each MCO summed the points earned across all measures for which the AE had an adequate denominator size (please see the section "Adequate Denominator Sizes" for the definition of adequate denominator size) and divided that sum by the number of measures for which there was an adequate denominator size. For example, if an AE had an adequate denominator size for all AE Common Measure Slate measures, then the MCO summed the scores for each of the ten measures and divided the result by ten. This resulting quotient was the "Overall Quality Score." The MCO multiplied the annual savings generated by the AE by the Overall Quality Score, adjusted upwards as described below, to determine the shared savings that were distributed to the AE. The MCO multiplied the annual losses accrued by the AE by value of the Overall Quality Score divided by four, as described below, and subtracted this product from the total losses to determine the shared losses that were paid by the AE. **Appendix A: Example Overall Quality Score Calculation for PY8** illustrates this calculation.

a. Overall Quality Score Adjustment for Shared Savings Distribution**:** The overall quality multiplier was adjusted upwards by 0.10 for each AE contract, with a quality multiplier cap at one (1.0). This meant, for example, that an AE that earned 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 was divided by four for each AE contract to mitigate shared losses.

MCOs and AEs calculated AE Overall Quality Score performance using the "Overall Quality Score Determinations PY8" Excel reporting template. A copy of the Excel reporting template can be obtained on the EOHHS' SFTP site.[17]

For PY9, EOHHS will use the same methodology as PY8 with a few modifications.[18]

- The baseline year for assessing improvement for all measures will be PY7 (2024) and EOHHS will not recognize improvement in PY9 (2026) if performance is statistically significantly below PY6 (2023) performance.

Appendix B: Example Overall Quality Score Calculation for PY9 illustrates how to calculate the Overall Quality Score for PY9 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 PY9" Excel reporting template. A copy of the Excel reporting template can be obtained on the EOHHS' SFTP site.[19]

TCOC Quality Benchmarks

For PY8, EOHHS employed a combination of internal and external data sources to set achievement targets. EOHHS set targets for PY8 in January 2025 using (1) AE data, as reported by MCOs, from PY6 (2023), (2) AE REL completeness data, as reported by AEs, from PY5 (2022) and PY6 (2023), (3) national and New England Medicaid (HMO) data from NCQA Quality Compass 2024 (CY 2023 data) and (4) national and Rhode Island state data from CMS' 2023 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 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.

The achievement targets for PY8 are as follows:

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

[18] For PY1-PY7, RIPCPC was embedded within Integra. Effective July 1, 2025, RIPCPC became a single-entity AE. For PY9, Integra and RIPCPC will be assessed using both achievement targets and improvement targets. Integra's performance will exclude RIPCPC. For PY9 P4P measures, the MCOs will provide updated PY7 baselines for RIPCPC and Integra.

[19] 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	60%	National 75th percentile	66%	New England 67th percentile
Child and Adolescent Well-Care Visits (Total)	55%	National 67th percentile	64%	New England 50th percentile
Chlamydia Screening in Women (Total)	56%	National 50th percentile	66%	New England 67th percentile
Controlling High Blood Pressure	68%	New England 50th percentile	75%	New England 90th percentile
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	52%	National 25th percentile	62%	New England 67th percentile
Lead Screening in Children	69%	National 67th percentile	80%	National 90th percentile
Race Data Completeness	69%	Review of 2023 AE data completeness	83%	Review of 2023 AE data completeness
Ethnicity Data Completeness	80%	Review of 2023 AE data completeness	94%	Review of 2023 AE data completeness
Language Data Completeness	79%	Review of 2022 AE data completeness	93%	Review of 2022 AE data completeness
Screening for Depression and Follow-up Plan	50%	Review of 2023 AE performance	65%	Review of 2023 AE performance
Social Determinants of Health (SDOH) Screen	42%	PY5, PY6, and PY7 Targets	59%	PY5, PY6, and PY7 Targets

For PY9, EOHHS employed combination of internal and external data sources to set achievement targets. EOHHS set targets for PY9 using (1) AE data, as reported by MCOs, from PY7 (2024), (2) AE REL data completeness data, as reported by AEs, from PY7 (2024), (3) national and New England Medicaid (HMO) data from NCQA Quality Compass 2025 (CY 2024 data) and (4) national and Rhode Island state data from CMS' 2023 Child and Adult Health Care Quality Measures report. EOHHS used the same guiding principles to set targets as used in PY8.

The achievement targets for PY9 are as follows:

Measure Name	Threshold Target	Source	High-Performance Target	Source
Breast Cancer Screening (Ages 52-74)	56%	National 50th Percentile	66%	New England 50th Percentile
Child and Adolescent Well-Care Visits (Total)	55%	National 50th Percentile	61%	National 75th Percentile

Measure Name	Threshold Target	Source	High-Performance Target	Source
Chlamydia Screening in Women (Total)	56%	National 50th Percentile	66%	New England 67th Percentile
Controlling High Blood Pressure	68%	New England 50th Percentile	75%	New England 67th Percentile
Glycemic Status Assessment for Patients with Diabetes (<8.0%)[20]	55%	National 25th Percentile	66%	New England 67th Percentile
Lead Screening in Children[21]	70%	PY7 AE 25th Percentile (admin)	79%	PY7 AE 75th Percentile (admin)
Race Data Completeness	69%	PY8 Threshold Target	83%	PY8 High-Performance Target
Ethnicity Data Completeness	80%	PY8 Threshold Target	94%	PY8 High-Performance Target
Language Data Completeness	79%	PY8 Threshold Target	93%	PY8 High-Performance Target
Screening for Depression and Follow-up Plan Data Completeness	See table below for AE-specific values	80% of the AE's PY7 *Screening for Depression and Follow-up Plan* performance rate (with AE self-report data)	See table below for AE-specific values	100% of the AE's PY7 *Screening for Depression and Follow-up Plan* performance rate (with AE self-report data)
SDOH Screening	42%	PY5-PY8 Threshold Target	59%	PY5-PY8 High-Performance Target

The PY9 targets for Screening for Depression and Follow-up Plan Data Completeness are as follows:

AE Name	MCO Name	Threshold Target	High-Performance Target
Astrana	**NHP**	45%	57%
	UHC	46%	58%
BVCHC	**NHP**	62%	78%
	UHC	NA	NA

[20] EOHHS will make a five-percentage-point adjustment to AE performance for *Glycemic Status Assessment for Patients with Diabetes (<8.0%)* to account for differences in performance with and without AE self-reported data.
[21] EOHHS used CY 2024 administrative rates for *Lead Screening in Children* submitted by MCOs to EOHHS because NCQA is transitioning to ECDS-only reporting in MY 2026 for this measure.

IHP	**NHP**	53%	66%
	UHC	52%	65%
Integra[22]	**NHP**	51%	64%
	UHC	49%	62%
PCHC	**NHP**	55%	69%
	UHC	55%	69%
RIPCPC	**NHP**	36%	45%
	UHC	42%	53%
Thundermist	**NHP**	22%	28%
	UHC	26%	33%

Race, Ethnicity, Language and Disability Status (RELD) and REL (REL) Data Completeness Measures

AEs use the measure specifications included in the Quality Measure Specifications Manual[23] to report stratified performance for PY8 and PY9 to EOHHS (for their full population combined across both MCOs) and to MCOs (for each MCO's population) by August 31 of the year following the measurement year (e.g., AEs must report CY 2025 performance by August 31, 2026). AEs must use the reporting template for the appropriate year to report performance, which can be obtained through EOHHS' SFTP site.[24]

Data Collection and Reporting Responsibilities

MCOs are responsible for reporting performance on all AE Common Measure Slate measures (with the exception of *REL Data Completeness* and *Screening for Depression and Follow-Up Plan Data Completeness*) to EOHHS by October 31 of the year following the measurement year (in MCOs must report CY 2025 performance by October 30, 2026). 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.

Beginning in **PY6**, EOHHS started 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 are responsible for reporting performance for such measures using administrative data, clinical data that are obtained through third-party electronic data feeds (e.g., from KIDSNET, CurrentCare, MCO-managed registries) and direct AE ECDE only. The table below summarizes which data sources MCOs are able to use for reporting performance.

[22] Integra's target for this measure was based on PY7 performance without RIPCPC, which was provided by the MCOs to EOHHS.

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

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

Data Source	MCOs May Use?
Administrative data (e.g., claims)	Yes
MCO chart review	Yes/No*
Clinical data obtained through electronic data feeds (e.g., from KIDSNET, CurrentCare, MCO-managed registries)	Yes
ECDE	Yes
AE self-report	Yes/No*

**Chart review and AE self-report can be used only for specific measures and practice types as determined by the performance year (see tables below).*

EOHHS is phasing out AE self-report and chart review data on a measure-by-measure-specific basis. 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 described below) by performance year. MCOs can use all relevant data sources for reporting performance on measures not referenced in the table below.

Measure Name	PY6 (2023)	PY7 (2024)	PY8 (2025)	PY9 (2026)
Controlling High Blood Pressure			✓	✓
Developmental Screening in the First Three Years of Life	✓	✓	✓	✓
Eye Exam for Patients with Diabetes	✓	✓	✓	✓
Glycemic Status Assessment for Patients with Diabetes[25]				✓
Screening for Depression and Follow-up Plan				✓

Practices Subject to Phase-Out of AE Self-Report

The phase-out of AE self-report and chart review data does not apply equally across all practices. EOHHS uses two rules to determine applicability: (1) a 1,000 attributed lives threshold, applied to individual practices, and (2) the "75 percent rule", applied at the AE level.

1. The 1,000 attributed lives threshold applies to practices in network-based AEs (i.e., Astrana Health, IHP, Integra, and RIPCPC). Once a practice reaches 1,000 attributed patients across MCOs, it becomes subject to the self-report phase-out, and it remains subject even if the count later falls below 1,000 during the performance year. Primary care practices in non-network-based AEs (i.e., BVCHC, PCHC and Thundermist) are subject to the phase-out, regardless of size. Primary care practices in network-based AEs with fewer than 1,000 attributed lives are exempt. EOHHS identifies which practices meet the 1,000 attributed lives threshold by re-running attribution analysis each September for the following measurement year. AEs or MCOs may request a re-evaluation if a significant change, such as a merger or acquisition, could materially alter attribution counts.

[25] For PY9, EOHHS will make a five-percentage-point adjustment to AE performance for *Glycemic Status Assessment for Patients with Diabetes (<8.0%)* to account for differences in performance with and without AE self-reported data.

2. The "75 percent rule" requires AEs to submit data electronically for primary care practices that together represent at least 75 percent of the AE's MCO-specific attribution lives. This ensures that electronic reporting is sufficiently representative of the AE's population. EOHHS waived the 75 percent requirement in 2025 during the transition to the State's new HIE vendor (discussed below), but is re-applying it in 2026, with plans to increase the threshold after that year.

The table below summarizes the practices for which AE self-report and chart review data are being phased out over PY8 and PY9.

	Subject to Phasing Out of AE Self-report and Chart Review Data?	
Practice Type	**PY8**	**PY9**
Primary care practice in non-network-based AEs (i.e., BVCHC, PCHC and Thundermist)	Yes	Yes
Primary care practice in network-based AEs (i.e., Astrana Health, IHP, Integra, and RIPCPC) that have at least 1,000 attributed patients across MCOs	Yes	NA
Primary care practice in network-based AEs (i.e., Astrana Health, IHP, Integra, and RIPCPC) with fewer than 1,000 attributed patients across MCOs	No	NA
Primary care practices in network-based AEs (i.e., Astrana Health, IHP, Integra, and RIPCPC) together representing at least 75% of the AE's MCO-specific attributed lives.	NA	Yes
Specialty care practices in any AE	No	No

Electronic Clinical Data Exchange

Historically, AEs and MCOs have had two options for electronic exchange: (1) individual practices within the AE submit data to an MCO and (2) individual practices within the AE submit data to IMAT to be included in the Quality Reporting System (QRS) through flat files or CCDs, which then submits data to an MCO.

Beginning in 2026, EOHHS will require AEs to submit data to the state's Health Information Exchange (HIE) rather than to IMAT. The transition period occurred in 2025, during which AEs continued submitting data to the QRS until directed by EOHHS to move to the HIE. In 2025, practices subject to the 1,000-patient threshold were still required to comply with the self-report phase-out, and practices that submitted data to IMAT in 2024 were required to continue doing so. However, the 75 percent requirement was waived for 2025. As of 2026, the 75 percent requirement is reinstated and now replaces the 1,000-patient threshold as the determining standard.

CRISP Shared Services (CCS) is EOHHS' new HIE vendor. CSS will undergo Data Aggregator Validation (DAV) Certification from the National Committee for Quality Assurance (NCQA) to create standard supplemental data feeds for use by MCOs and participating commercial health plans. Providers may also use this infrastructure to support Medicare ACO quality reporting. The HIE is expected to reduce

duplication and costs by enabling providers to maintain a single sustained EHR feed that can be used for multiple reporting purposes.

AEs and MCOs are expected to support EOHHS in verifying the accuracy of data reported using ECDE. On an annual basis, MCOs shall report the percentage of gaps closed using ECDE data, both at the plan level and at the AE level.

General Guidelines

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

Patient Attribution to AEs

EOHHS established beginning in PY4 that for purposes of evaluating annual Quality 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 measure performance calculations. Note that the December Population Extract files will determine attribution using the AE Taxpayer Identification Number (TIN) rosters that are in place as of December.

Provider Attribution to AEs

Each primary care provider (PCP) bills under a 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."[26]

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.
Attribution to produce annual reports on Quality Measures	The Population Extract File from the final month – December – of the Performance Year should be used for annual Quality 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.

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

Attribution Purpose	TIN Roster
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 9 (SFY27) in March 2026, the TIN roster should be current as of March 2026.
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 9 will all use the March 2026 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.

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 the next Quality Performance Year. 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 2026 Volume 2 Technical Specifications for Health Plans, the minimum denominator size for all quality measures in the AE Common Measure Slate is 30 members.

TCOC Quality Measures Reporting Timeline

The table below indicates regular reporting activity responsibilities of EOHHS and AEs specific to the TCOC Quality Measures Slate. MCOs should refer to the "MCO Core Contract Reporting Calendar" on EOHHS' SFTP site for their reporting activity responsibilities.[27]

Category	Task	Responsible Party	PY	Deadline
Overall Quality Score methodology	Notify AEs and MCOs of which practices are subject to the AE self-report phase-out requirement for PY9	EOHHS	PY9	10/31/2025
RELD Stratification and *REL Data Completeness* reporting	Reporting of AE performance on *RELD Stratification* and *REL Data Completeness* to EOHHS and MCOs	AEs	PY8	8/31/2026
Overall Quality Score methodology	Notify AEs and MCOs of which practices are subject to the AE self-report phase-out requirement for PY10	EOHHS	PY10	10/30/2026
RELD Stratification and *REL Data Completeness* reporting	Reporting of AE performance on *RELD Stratification* and *REL Data Completeness* to EOHHS and MCOs	AEs	PY9	8/31/2027

[27] 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,

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,

Version	Date	Revisions
		• update the data collection responsibilities section to indicate that EOHHS expects to use MCO-calculated data for all measures in OPY5, • 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*,

Version	Date	Revisions
		• 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, • 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.
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,

Version	Date	Revisions
		• include the methodology for how EOHHS will set achievement and improvement targets for OPY6, • include information on the updated reporting responsibilities for OPY6, • 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.
5.1	8/10/2023	Updated to: • add information for PY7, including measures, measure specifications and methodology for QPY7 and OPY7, • add the methodology for how EOHHS will set targets for QPY7 and OPY7, • add information on how to access Excel reporting templates for QPY7 and OPY7, • add information on the *RELD Measure* for PY7, • add information on the Outcome measure reporting timeline for OPY7, • provide an updated "TCOC Quality and Outcome Measures Reporting Timeline" and

Version	Date	Revisions
		• add an example Overall Quality Score Calculation for QPY7 in Appendix C.
5.2	9/29/2023	Updated to: • include final measures for QPY7 and OPY7, • update the example Overall Quality score Calculation in Appendix C
5.3	12/7/2023	Updated to: • note that EOHHS made adjustments to the weights for the two Outcome measures (*Plan-All Cause Readmissions* and *Potentially Avoidable ED Visits*) and the RELD measure, and • explain FQHC-based AEs remaining in shared savings only contracts will have up to 60% of the outcome measure incentive available to them.
5.4	1/31/2024	Updated to: • change PY5 and PY6 language in "TCOC Quality P4P Methodology" section from past to present tense, • update the final measures, measure specifications and methodology (including targets) for PY7, • clarify BCS and CCS are now ECDE-only, and • update the TCOC quality and outcome measures reporting timeline.
6.1	11/25/2024	Updated to: • remove the methodologies for PY5 and PY6 and direct readers to earlier versions of the Implementation Manual for more information, • add information for PY8, including final measure and measure specifications for PY8, • add the methodology for how EOHHS will set targets for PY8, and • add information on how to access Excel reporting templates for PY8, • provide an updated "TCOC Quality and Outcome Measures Reporting Timeline" and • add an example Overall Quality Score Calculation for QPY8 in Appendix C.
6.2	1/9/2025	Updated to: • update the targets for PY8, • update the timeline for the phase-out of AE self-report for *Glycemic Status Assessment for Patients with Diabetes (<8.0%),* and • updated ECDE requirements.
7.1	1/29/2026	Updated to: • remove the methodology for PY7 and direct readers to earlier versions of the Implementation Manual for more information, • remove details on Outcome measures and reporting which are no longer in place for PY8 or PY9, • add information for PY9, including final measures, measure specifications, and targets for PY9, • update measures phasing out of AE self-report for PY9, • add information on how to access Excel reporting templates for PY9,

Version	Date	Revisions
		• provide an updated “TCOC Quality Measures Reporting Timeline” and • add an example Overall Quality Score Calculation for PY9 in Appendix B.

Appendix A: Example Overall Quality Score Calculation for PY8

Below is a high-level example of the calculation of the Overall Quality Score for PY8. Further information on calculation of the individual score components will be provided in an updated "Overall Quality Score Determinations PY8" Excel reporting template. The Excel reporting template can be obtained through EOHHS' SFTP site.[28]

Measure	Score by Target Type		Final Measure Score (highest performance across target types)
	Achievement (0-1)	Improvement (0 or 1)	
Breast Cancer Screening	1.00	1.00	1.00
Child and Adolescent Well-Care Visits (*Total*)	0.65	0.00	0.65
Chlamydia Screening in Women	0.55	NA	0.55
Controlling High Blood Pressure	0.70	1.00	1.00
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	0.90	0.00	0.90
Lead Screening in Children	0.75	1.00	1.00
REL Data Completeness – Total	1.00	NA	1.00
REL Data Completeness – Rate #1 (Race)	*0.33*	NA	-
REL Data Completeness – Rate #2 (Ethnicity)	*0.33*	NA	-
REL Data Completeness – Rate #3 (Language)	*0.33*	NA	-
Screening for Depression & Follow-up Plan	0.80	0.00	0.80
Social Determinants of Health Screening	0.75	1.00	1.00
Overall Quality Score (sum of final measure scores divided by number of measures)			=7.90/9 = **0.718**
Overall Quality Score Adjustment (upwards adjustment of 0.10 with a cap of 1) for Shared Savings Distribution			=0.718+0.1 = **0.818**
Overall Quality Score Adjustment (Quality Score divided by 4) for Shared Losses Mitigation			=0.718/4 = **0.180**

[28] 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 PY9

Below is a high-level example of the calculation of the Overall Quality Score for PY9. Further information on calculation of the individual score components will be provided in an updated "Overall Quality Score Determinations PY9" Excel reporting template. The Excel reporting template can be obtained through EOHHS' SFTP site.[29]

Measure	Score by Target Type		Final Measure Score (highest performance across target types)
	Achievement (0-1)	Improvement (0 or 1)	
Breast Cancer Screening	1.00	1.00	1.00
Child and Adolescent Well-Care Visits (*Total*)	0.65	0.00	0.65
Chlamydia Screening in Women	0.55	NA	0.55
Controlling High Blood Pressure	0.70	1.00	1.00
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	0.90	0.00	0.90
Lead Screening in Children	0.75	1.00	1.00
REL Data Completeness – Total	1.00	NA	1.00
REL Data Completeness – Rate #1 (Race)	*0.33*	NA	-
REL Data Completeness – Rate #2 (Ethnicity)	*0.33*	NA	-
REL Data Completeness – Rate #3 (Language)	*0.33*	NA	-
Screening for Depression & Follow-up Plan Data Completeness	0.80	0.00	0.80
Social Determinants of Health Screening	0.75	1.00	1.00
Overall Quality Score (sum of final measure scores divided by number of measures)			=7.90/9 = **0.718**
Overall Quality Score Adjustment (upwards adjustment of 0.10 with a cap of 1) for Shared Savings Distribution			=0.718+0.1 = **0.818**
Overall Quality Score Adjustment (Quality Score divided by 4) for Shared Losses Mitigation			=0.718/4 = **0.180**

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