OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

September 29th, 2020

For ***contracts subject to amendment or renewal beginning on or after January 1st, 2021.***

Updated Guidance on Use of Aligned Measure Sets

The Office of the Health Insurance Commissioner (OHIC) is issuing guidance related to the implementation of Aligned Measure Sets required under 230-RICR-20-30-4.10(D)(5). This interpretive guidance will be updated periodically as Aligned Measure Sets are reviewed.

Nothing that follows is to supersede existing regulatory requirements codified in §4.10(D)(6) related to quality programs for hospital contracts.

Timelines

The Commissioner will convene a Quality Measure Alignment Committee by August 1 each year. The Committee will determine whether changes need to be made to existing Aligned Measure Sets. Changes to the Aligned Measure Sets shall be effective for insurer contracts with performance periods beginning on or after the 1st of January following the Annual Review Meeting(s).

Should a stakeholder wish to bring forth a measure for consideration during the annual review of the Aligned Measure Sets, they should submit a request by following the guidelines in Appendix A.

Applicable Contracts

OHIC has developed Aligned Measures Sets for Accountable Care Organization (otherwise known as Integrated Systems of Care) contracts, hospital contracts (including both acute care and behavioral health hospitals), primary care provider contracts, maternity care provider contracts, and outpatient behavioral health care provider contracts. The Commissioner may develop Aligned Measure Sets for other types of provider contracts, including for specific episodes of care, in the future.

Only contracts that incorporate quality measures into the terms of payment must comply with the measure alignment provisions of§4.10(D)(5). §4.10(D)(5) does not mandate an insurer to develop and implement a quality performance incentive and /or disincentive provision within any provider contract that otherwise would not include such terms. The exceptions are hospital contracts, which pursuant to §4.10(D)(6)(d) must include a quality incentive program that complies with OHIC rules, and Global Capitation Contracts and Risk Sharing Contracts, as defined in §§4.3(A)(8) and 4.3(A)(21), respectively.

Applicable provider contracts which incorporate quality measures into the terms of payment shall include all Core Measures that are appropriate to the contract. Any further application of quality measures into the terms of payment beyond the Core Measures shall be limited to Menu Measures designated as such on the Aligned Measure Set corresponding to the appropriate type of provider contract.

Measures contained within the Primary Care Aligned Measure Set shall be contractually applied by an insurer as appropriate given a primary care practice's specialty. Specifically, insurers should apply those measures with a denominator definition that includes persons under age 18 with pediatric practices. Insurers should apply those measures with a denominator definition that includes persons age 18 and older with adult medicine and family medicine practices. Insurers may also use measures with a denominator definition that includes persons under age 18 with family medicine practices at the insurer's discretion. Similarly, insurers may also use measures with a denominator definition that includes persons over age 18 with pediatric practices at the insurer's discretion.

OHIC acknowledges that in certain circumstances, it may not be appropriate for a Core Measure to be applied. Acceptable scenarios for the exclusion of Core Measures include:

- the measure is not applicable for the patient population (e.g., adult population measures in a contract with a pediatric provider), and
- the denominator size is inadequate (as described in further detail in the Performance Measurement section).

It is unacceptable, however, for an insurer to utilize a Core Measure into the terms of payment with a de minimis weight attached to the measure, such that performance on the Core Measure lacks meaningful financial implication for the provider.

It is also unacceptable for an insurer to utilize a Core Measure as a "reporting-only" measure, i.e., the provider is rewarded for reporting rather than performance, *except* when the measure's specifications have changed such that national benchmarks are non-comparable and therefore may not be utilized in a given year to assess performance. Under such circumstances, the insurer must obtain written authorization to use the Core Measure on a reporting-only basis.

Similarly, there may be limited circumstances in which a measure that is not on the menu list may be used in a contract. Acceptable circumstances for inclusion of a non-menu measure include:

- the insurer and provider are contracting for a pilot program with a unique patient population and/or clinical focus (e.g., substance-using pregnant women).

Beyond the circumstances listed above, non-inclusion of core measures, or inclusion of non-menu measures in a contract subject to §4.10(D)(5) must be approved by OHIC.

Should an insurer wish to introduce a contractual quality incentive that is tied not to a quality measure, but instead to documentation of implementation of a new or revised care process, these Aligned Measure Set requirements shall not prohibit the insurer from doing so. Examples of such care processes include:

- improving hospitalist workflows to facilitate more efficient and collaborative discharge planning, and
- developing and implementing pharmacy system alerts to trigger a pharmacist/prescriber consult on various medication topics.

Performance Measurement

With the exception of hospital contracts and core measures, to the extent noted above, at this time OHIC does not mandate or otherwise articulate specific terms around how financial consequences are tied to quality measures (e.g., based on performance or on reporting only) in provider contracts subject to the provisions of §4.10(D)(5) or dictate the financial terms of these arrangements. Moreover, insurers are granted discretion to set minimum denominator sizes for measures to have financial consequences in individual provider contracts, including for Core Measures, to ensure statistically valid measurements. To the extent that any Core Measure does not meet minimum denominator size, the insurer may elect to not include the measure when applying a performance incentive and/or disincentive provision in the contract. OHIC retains the right to request and review an insurer's minimum denominator size policies.

Regarding Use of Specifications

OHIC has developed a document titled 'Crosswalk of RI Aligned Measure Sets.' The document is a crosswalk of the six Rhode Island Aligned Measure Sets (ACO, Acute Care Hospital, Behavioral Health Hospital, Primary Care, Maternity, and Outpatient Behavioral Health). The crosswalk includes a few

notable features including information about the measures, links to specifications for each measure, and measure alignment across the six RI Aligned Measure Sets.

The crosswalk has been developed in Excel. It is an adapted version of the Buying Value Measure Selection Tool. The tool has a number of features that have been developed to help assist states, employers, consumer organizations and providers in aligning measure sets. Below is a quick orientation to what information is included in the "Crosswalk of SIM Measure Sets" tab:

- The navy columns to the left (Columns B – K) include basic information about the measure.
- The green column (Column L) includes a designation of whether the measure is facility-based or professional-based.
- The orange column (Columns M) contains special notes about particular measures.
- The purple column (Column N) includes links to the measure specifications.
- The blue columns (Columns O – U) provide status in each of the OHIC Aligned Measure Sets for 2020.

Health insurers should use the measure specifications included in Column N. Insurers should not modify specifications unless OHIC is consulted and able to provide guidance to all insurers implementing the measures.

Insurers may elect to operationalize measures using claims and/or provider reported clinical data. If a practice or ACO is submitting aggregate practice data and an insurer does not provide any information on which patients are to be included in the practice's or ACO's denominator, then insurers should use the clinical data specifications developed by CTC-RI. Insurers have the authority to validate provider-generated measures.

An insurer may petition the Commissioner to modify or waive one or more of the requirements of §4.10(D)(5). Any request to modify or waive one or more of the requirements must articulate a clear rationale supporting the waiver request and must demonstrate how the insurer's request will advance the quality, accessibility, and/or affordability of health care services in Rhode Island.

Appendix A: OHIC Aligned Measure Sets, Submission of Measures for Consideration

1. Prepare a cover letter that explains:
    a. for which measure set(s) the measure is being proposed, e.g., ACO, primary care, hospital, behavioral health or maternity;
    b. whether the measure is to be proposed as developmental (i.e., for refinement and/or testing, as is being done currently with SDOH screening) or for the menu or core sets, and
    c. the rationale for adoption of the measure in commercial and Medicaid contracts.
2. Document the measure's specifications and provide other key information using the "OHIC Aligned Measure Sets Measure Submission Template":
    a. the measure steward;
    b. validation testing, and
    c. how the proposed measure matches the Measurement Alignment Work Group's selection criteria.
3. Communicate with OHIC in June to schedule a date to present the measure to the Work Group.

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OHIC Aligned Measure Sets Measure Submission Template

Please complete the following document to submit a measure for consideration by the OHIC Measure Alignment Work Group. The work group meets annually during the summer and will consider your submitted measure during its next annual review process.

Please provide your contact information so we can contact you should we have any questions regarding your submission:

Name:

Organization:

Email:

Telephone Number:

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Measure Specification

Measure Name:
Steward:
NQF #:

Description

Eligible Population

Product lines	
Stratification	
Ages	
Continuous enrollment	
Allowable gap	
Anchor date	
Lookback period	
Benefit	
Event/diagnosis	
Exclusions	

Specifications

Data Source	
Denominator	
Numerator	

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Additional Information

Please describe how the measure meets the following OHIC Measure Alignment Work Group criteria for measure selection:

Criterion	Measure Alignment with the Criterion
1. Evidence-based and scientifically acceptable	
2. Has a relevant benchmark	
3. Not greatly influenced by patient case mix	
4. Consistent with the goals of the program	
5. Useable and relevant	
6. Feasible to collect	
7. Aligned with other measure sets	
8. Promotes increased value	
9. Present an opportunity for quality improvement	
10. Transformative potential	
11. Sufficient denominator size	

If the measure is homegrown, please describe steps taken to validate the measure: