OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

October 11, 2022

For ***contracts subject to amendment or renewal beginning on or after January 1, 2023.***

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. Insurers are not required to use Developmental Measures (i.e., measures considered in need of further refinement and/or testing before use in contracts) or On Deck Measures (i.e., measures that OHIC plans to include in the Aligned Measure Sets in the two to three years following endorsement to give payers and providers time to prepare for reporting) in provider contracts. Monitoring Measures (i.e., measures that OHIC has moved out of the Aligned Measure Set due to high performance, defined as performance above the 90th percentile and an absolute rate for commercial and Medicaid of 80% [rounded] or higher for HEDIS measures and three or more consecutive years of performance above the national average for non-HEDIS measures) should not be used in contracts.

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.

Measures contained within the Behavioral Health Hospital Measure Set shall be contractually applied to behavioral health hospitals and hospitals participating in CMS' IPFQR program, including general acute care facilities. Insurers contracts with general acute care facilities participating in the CMS' IPFQR program shall be subject to both the Behavioral Health Hospital Measure Set and the Acute Care Hospital Measure Set. When a measure appears in both the Behavioral Health Hospital and Acute Care Hospital Measure Sets, insurers are only required to use the measure once in their contracts with hospitals participating in the CMS' IPFQR program.

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),
- the denominator size is inadequate (as described in further detail in the Performance Measurement section), and
- the provider's performance on the measure is "topped out" (as described in further detail below).

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. The one exception for contracts subject to amendment or renewal beginning on or after January 1, 2023 is *30-Day All-Cause Unplanned Readmission Following Psychiatric Hospitalization*, for which OHIC will allow one year of de minimis weighting due to data reporting delays.

It is also unacceptable for an insurer to utilize a Core or Menu 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 from OHIC to use the Core or Menu 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).

OHIC has developed limits specific to four of the Aligned Measure Sets for the number of measures for which insurers may reward maintenance of prior year performance in provider contracts when the measure is "topped out". For HEDIS measures, a measure is "topped out" when the provider's absolute performance rate is 90 percent or higher and/or the provider's performance is above the national 90th percentile. For non-HEDIS measures when national percentiles cannot be calculated, a measure is "topped out" when the provider's performance is above the national average for three or more consecutive years.

- For the Accountable Care Organization Measure Set, a maximum of 2 topped out measures.
- For the Acute Care Hospital Measure Set, a maximum of 1 topped out measures.

- For the Behavioral Health Hospital Measure Set, a maximum of 1 topped out measure.
- For the Outpatient Behavioral Health Measure Set, a maximum of 0 topped out measure.

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.

Should an insurer wish to use a *Health Equity (Race, Ethnicity and Language (REL)) Measure* found in the ACO, Acute Care, Primary Care, and Maternity Measure Sets, refer to Appendix B for stratification parameters and a proposed reporting template. General guidelines and reporting template draw from the EOHHS Accountable Entity quality program (see: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents).

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 2022.

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.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF 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, acute care hospital, behavioral health hospital, maternity or outpatient behavioral health;
    b. whether the measure is to be proposed as Developmental (i.e., measures in need of further refinement and/or testing before use in contracts, as is being done currently with SDOH screening), On Deck (i.e., measures that OHIC should include in the Aligned Measure Sets in the two to three years following endorsement to give payers and providers time to prepare for reporting), Menu or Core, and
    c. the rationale for adoption of the measure in commercial provider 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 May to schedule a date to present the measure to the Work Group.

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

OHIC Aligned Measure Sets Measure Submission Template

Please complete the following document and email it to Cory King (cory.king@ohic.ri.gov) 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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STATE OF RHODE ISLAND

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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HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

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 for the intended use	
12. Utilizes a HEDIS measure when multiple options exist	

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

OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Appendix B: Health Equity (Race, Ethnicity, and Language (REL) Measure

Background

OHIC's Aligned Measure Sets include three *Health Equity Measures* that stratify measure performance by REL. OHIC prioritized stratification of measures that have evidence of disparities in performance by REL in Rhode Island and that are required to be stratified for reporting to the National Committee for Quality Assurance (NCQA). The *Health Equity (REL) Measures* will initially focus on stratifying performance by race, ethnicity, and language to encourage providers to collect REL data and use REL data to stratify measure performance. OHIC aims to include *Health Equity (REL) Measures* focused on reducing disparities in performance in the future once provider organizations have more robust and more experience with REL data.

These guidelines for *Health Equity (REL) Measure* implementation are a modified version of RI EOHHS' guidelines. RI EOHHS first adopted an RELD Measure for its Accountable Entity (AE) program for 2022 (see: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents).

Description

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

- ***ACO/Primary Care Health Equity (REL) Measure (Menu):***
  - *Controlling High Blood Pressure*
  - *Developmental Screening in the First Three Years of Life*
  - *Eye Exam for Patients with Diabetes*
  - *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (< 8.0%)*
- ***Maternity Care Health Equity (REL) Measure (Menu):***
  - *Behavioral Health Risk Assessment Screenings*
  - *Prenatal and Postpartum Care: Postpartum Care*
  - *Prenatal and Postpartum Care: Timeliness of Prenatal Care*
- ***Acute Care Hospital Health Equity (REL) Measure (On Deck):***
  - *Hospital-wide Readmit*

General Guidelines

Organizations Responsible and Data Source Used for Reporting Performance	Providers should use their own EHR-based clinical data, patient age and sex data and REL data to report stratified performance for all measures.
Data Completeness Threshold	There is no REL data completeness threshold for reporting performance stratified by REL. Organizations should report on all patients for whom they have REL data.
Required REL Reporting Categories	Providers can use any framework to *collect* REL data but should *report* stratified performance using the following framework. ***For race***: Providers should use the following race categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2023: • White • Black

	• American Indian/Alaska Native • Asian • Native Hawaiian and Other Pacific Islander • Some Other Race • Two or More Races • Declined • Unknown ***For ethnicity***: Providers should use the following ethnicity categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2023: • Hispanic/Latino • Not Hispanic/Latino • Declined • Unknown Please refer to the "Crosswalk of Race/Ethnicity Reporting Categories" section to see how commonly used frameworks for collecting race and ethnicity data map onto the categories providers should use when reporting stratified performance. ***For language***: Use at least the following language categories (providers can use additional languages if they prefer). Health Level Seven Fast Healthcare Interoperability Resources (HL-7 FHIR) codes used in the US, when available, are included in parentheses.[1] If there is no US-based HL-7 FHIR code available, use the UK-based HL-7 FHIR code denoted with an asterisk (*).[2] • English (en) • Spanish (es) • Portuguese (pt) • Other • Unknown ***Note****: Each of the categories within each race, ethnicity, and language status stratification are mutually exclusive. Therefore, the sum of all stratifications should equal the total population (e.g., the sum of all nine race stratifications should equal the total population).*

Measure Specifications	Providers can use the following sources to report performance for the *Health Equity* (*REL) Measure*:
	• the Agency for Healthcare Research and Quality[3] for:
	  ○ *Behavioral Health Risk Assessment*
	• CMS' 2023 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[4] for:
	  ○ *Developmental Screening in the First Three Years of Life*

[1] A full list of HL-7 FHIR common language codes used in the US can be found here: https://www.hl7.org/fhir/valueset-languages.html#definition.
[2] A full list of HL-7 FHIR common language codes used in the UK can be found here: https://simplifier.net/guide/ukcoredevelopment/codesystemukcore-humanlanguage.
[3] See: https://www.ahrq.gov/sites/default/files/wysiwyg/policymakers/chipra/factsheets/0085behavior.pdf.
[4] See: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html.

	• CMS 2023 eCQM specifications for Eligible Professionals / Eligible Clinicians[5], which are designed for reporting by provider organizations for:
	  ○ *Controlling High Blood Pressure*
	  ○ *Eye Exam for Patients with Diabetes*
	  ○ *Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (< 8.0%)* (adapted for reporting HbA1c Control (<8.0%) as the specifications are written for HbA1c Poor Control (>9.0%)
	• CMS' Hospital Inpatient Readmission Measures for 2023[6]
	  ○ *Hospital-Wide Readmit*
	• NCQA's HEDIS specifications for MY2023 (adapted for provider reporting using the Allowable Adjustments)[7] for:
	  ○ *Prenatal and Postpartum Care*

Sample Reporting Template	REL Measure Reporting Template

[5] See: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1&globalyearfilter=2023.
[6] See: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology.
[7] See: https://www.ncqa.org/hedis/measures/.

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STATE OF RHODE ISLAND

Crosswalk of Race/Ethnicity Reporting Categories

Crosswalk of Race/Ethnicity Categories

National Committee for Quality Assurance (NCQA) Categories[8]	Office of Management and Budget (OMB) Categories[9]	Health Resources & Services Administration (HRSA) Uniform Data System (UDS) Categories[10]
White	White	White
Black	Black or African American	Black/African American
American Indian/Alaska Native	American Indian or Alaska Native	American Indian/Alaska Native
Asian	Asian	Asian
Native Hawaiian and Other Pacific Islander	Native Hawaiian and Other Pacific Islander	Native Hawaiian
		Other Pacific Islander
Hispanic/Latino	Hispanic or Latino	Hispanic/Latino
Not Hispanic/Latino	Non-Hispanic or Latino	Non-Hispanic/Latino
Unknown	Unknown	Unreported/Refused to Report
Declined	Asked but No Answer	
Some Other Race	N/A	N/A
Two or More Races	N/A*	More than One Race

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

[8] Source: NCQA's Proposed Changes to Existing Measures for HEDIS MY 2022: Introduction of Race and Ethnicity Stratification Into Select HEDIS Measures. https://www.ncqa.org/wp-content/uploads/2021/02/02.-Health-Equity.pdf.
[9] Source: CMS' Inventory of Resources for Standardized Demographic and Language Data Collection. https://www.cms.gov/about-cms/agency-information/omh/downloads/data-collection-resources.pdf.
[10] Source: HRSA's Uniform Data System 2021 Health Center Data Reporting Requirements. https://data.hrsa.gov/tools/data-reporting/program-data/state/LA/table?tableName=7.