OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

January 31, 2024

For ***contracts subject to amendment or renewal beginning on or after January 1, 2024.***

**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)(3). 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)(4) 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 and maintains 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, 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)(3). §4.10(D)(3) 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)(4)(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)(17), 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 or until performance data are published) in provider contracts. Monitoring Measures (i.e., measures that meet OHIC's "topped out "definition (provided below) and that OHIC has chosen to move out of the Aligned Measure Set due to high performance) 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 defined below).

It is unacceptable, however, for an insurer to utilize a Core Measure in 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 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).

**Topped-Out Measures:** Insurers may delay implementation of the topped-out criteria until measurement year (MY) 2025 given the suppression of certain measures' performance in MY 2020 and because of OHIC's updates to this guidance in January 2024.

OHIC defines "topped-out measures" as follows: [1]

- For measures where percentile benchmarks can be calculated (e.g., HEDIS measures): Performance is 80 percent (rounded) or higher (20 percent or lower for measures where lower performance is better) and performance is above the 90th percentile and has been above the 90th percentile for three or more consecutive years.
- For measures where percentile benchmarks cannot be calculated: Performance is 90 percent (rounded) or higher (10 percent or lower for measures where lower performance is better) and (if national performance is available) performance has been above the national average for three or more consecutive years.
- For hospital-acquired infection (HAI) measures and CMS readmission measures (READM-30-HWR and READM-30 IPF): Performance has been "better than" the CMS national benchmark for three or more consecutive years.[1]

OHIC utilizes this definition of "topped out" in two distinct ways:

1. For the purposes of the Annual Review process, OHIC will bring to the Measure Alignment Work Group's attention measures that meet its "topped out" definition at the market level. The Work Group will assess performance for "topped-out" measures and determine whether to recommend that measures be retained or moved to the Monitoring Set. OHIC will make the final determination whether to move a measure to the Monitoring Set.
2. For the purposes of measure use in contracts, 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".
    a. For the Accountable Care Organization Measure Set, a maximum of 2 topped out measures.
    b. For the Acute Care Hospital Measure Set, a maximum of 1 topped out measures.
    c. For the Behavioral Health Hospital Measure Set, a maximum of 1 topped out measure.
    d. 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)(3) 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)(3) 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 five Rhode Island Aligned Measure Sets (ACO, Acute Care Hospital, Behavioral Health Hospital, Primary Care, 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 five 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 – S) provide status in each of the OHIC Aligned Measure Sets for 2024.

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.

Specifications for OHIC's homegrown measures can be found in the Appendix (*Race, Ethnicity and Language [REL] Data Completeness* in Appendix C and *Social Determinants of Health (SDOH) Screening* for use with outpatient behavioral health providers in Appendix D). Should an insurer wish to use a *Health Equity (Race, Ethnicity and Language (REL)) Measure* found in the ACO, Acute Care, and Primary Care 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).

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 and maintained by OHIC. 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)(3). 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.

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**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 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.

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**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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**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 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:**

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

## Background

OHIC's Aligned Measure Sets include two *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 (for most up-to-date EOHHS specifications 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*
  - *Child and Adolescent Well-Care Visits (Total)*
  - *Eye Exam for Patients with Diabetes*
  - *Glycemic Status Assessment for Patients with Diabetes: Glycemic Status, 8.0%*
- ***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.<br><br>***For race***: Providers should use the following race categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2024:<br>• White<br>• Black<br>• American Indian/Alaska Native<br>• Asian<br>• Native Hawaiian and Other Pacific Islander |

| | |
|---|---|
| | • Some Other Race<br>• Two or More Races<br>• Declined<br>• Unknown<br><br>***For ethnicity***: Providers should use the following ethnicity categories proposed by NCQA for reporting stratified performance on select HEDIS measures for 2024:<br>• Hispanic/Latino<br>• Not Hispanic/Latino<br>• Declined<br>• Unknown<br><br>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.<br><br>***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]<br>• English (en)<br>• Spanish (es)<br>• Portuguese (pt)<br>• Other<br>• Unknown<br><br>***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) Measures*:<br>• CMS' 2023 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[3] for:<br>  ○ *Child and Adolescent Well-Care Visits (Total)*<br>• CMS 2023 eCQM specifications for Eligible Professionals / Eligible Clinicians[4], which are designed for reporting by provider organizations for:<br>  ○ *Controlling High Blood Pressure*<br>  ○ *Eye Exam for Patients with Diabetes* |

[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.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html.
[4] See: https://ecqi.healthit.gov/ep-ec?qt-tabs_ep=1&globalyearfilter=2024.

| | |
|---|---|
| | ○ *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%)<br>• CMS' Hospital Inpatient Readmission Measures for 2023[5]<br>○ *Hospital-Wide Readmit* |
| **Sample Reporting Template** | REL Measure Reporting Template |

[5] See: https://qualitynet.cms.gov/inpatient/measures/readmission/methodology.

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Crosswalk of Race/Ethnicity Reporting Categories

## Crosswalk of Race/Ethnicity Categories

| National Committee for Quality Assurance (NCQA) Categories[6] | Office of Management and Budget (OMB) Categories[7] | Health Resources & Services Administration (HRSA) Uniform Data System (UDS) Categories[8] |
|---|---|---|
| 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.

[6] Source: NCQA's Race and Ethnicity Stratification For Auditors: Measurement Year 2023 Resource Guide. https://www.ncqa.org/wp-content/uploads/Auditor-Resource-Guide_V2-Final.pdf.
[7] 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.
[8] 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.

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## Appendix C: Race, Ethnicity and Language (REL) Data Completeness

| Overview | |
|---|---|
| **Measure Name** | Rate of Race Data Completeness – ACO/AE |
| **Steward** | Massachusetts EOHHS (Modified by the Rhode Island Office of the Health Insurance Commissioner) |
| **NQF Number** | N/A |
| **Data Sources** | Numerator source: ACO/AE Denominator<br>source: Payer |

| Population Health Impact |
|---|
| Complete, beneficiary-reported race data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality. |

| Measure Summary | |
|---|---|
| **Description** | The percentage of ACO/AE attributed members with self-reported race data that was collected by an ACO/AE in the measurement year. |
| **Numerator** | ACO/AE attributed members with self-reported race data that was collected by an ACO/AE during the measurement year |
| **Denominator** | ACO/AE attributed members in the measurement year |

| Eligible Population | |
|---|---|
| **Age** | ACO/AE attributed members 0 to 64 years of age as of December 31 of the measurement year |
| **Continuous Enrollment** | The measurement year |
| **Allowable Gap** | No more than one gap in enrollment of up to 45 days during the measurement year |
| **Anchor Date** | December 1st of the measurement year |
| **Event/Diagnosis** | None |

| Definitions |
|---|

| | |
|---|---|
| **Complete Race Data** | Complete race data is defined as:<br>At least one (1) valid race value (valid race values are listed in Attachment 1).<br>o If value is "UNK" it will not count toward the numerator.<br>o If value is "ASKU," it will count toward the numerator.<br>o If value is "DONTKNOW," it will count toward the numerator.<br>o Each value must be self-reported. |

| | |
|---|---|
| **Data Collection** | Race data may be collected:<br>• over the phone, electronically (e.g., a patient portal), in person, by mail, etc.;<br>• from an acute hospital;<br>• must include one or more values in Attachment 1 |
| **Measurement Year** | Measurement Years correspond to Calendar Years |
| **Rate of Race Data Completeness** | (Numerator Population / Eligible Population) * 100 |
| **Self-Reported Data** | Race data must be self-reported. Race data that derived using an imputation methodology must not be included. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).<br>Self-reported race data that has been rolled-up or transformed for reporting purposes may be included. For example, if an ACO/AE's data systems include races that are included in HHS' data collection standards and an individual self-reports their race as "Samoan", then the ACO/AE can report the value of "Native Hawaiian or Other Pacific Islander" since the value of Samoan is not a valid value in Attachment 1. |

| **Administrative Specification** | |
|---|---|
| **Denominator** | The eligible population |

| | |
|---|---|
| **Numerator** | For members in the denominator, identify those with complete race data, defined as: At least one (1) valid race value (valid race values are listed in Attachment 1).<br>o If value is "UNK," it will not count toward the numerator.<br>o If value is "ASKU," it will count toward the numerator.<br>o If value is "DONTKNOW," it will count toward the numerator.<br>o Each value must be self-reported. |
| **Exclusions** | If value is UTC, the member is excluded from the denominator. |

| **Additional Measure Information** | |
|---|---|
| **Completeness Calculations** | Completeness is calculated for each individual ACO/AE. |

**Attachment 1.** Race: Accepted Values

| | Description | Valid Values | Notes |
|---|---|---|---|
| **Race** | American Indian/Alaska Native | 1002-5 | |
| | Asian | 2028-9 | |
| | Black/African American | 2054-5 | |
| | Native Hawaiian or other Pacific Islander | 2076-8 | |
| | White | 2106-3 | |
| | Other Race | OTH | |
| | Choose not to answer | ASKU | Member was asked to provide their race, and the member actively selected or indicated that they "choose not to answer." |
| | Don't know | DONTKNOW | Member was asked to provide their race, and the member actively selected or indicated that they did not know their race. |
| | Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g., clinical condition that alters consciousness) | UTC | Unable to collect this information on member due to lack of clinical capacity of member to respond. |
| | Unknown | UNK | The race of the member is unknown since either:<br><br>(a) the member was not asked to provide their race, or<br><br>(b) the member was asked to provide their race, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be assigned the value of ASKU instead of UNK. |

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| Overview | |
|---|---|
| **Measure Name** | Rate of Hispanic or Latino Ethnicity Data Completeness – ACO/AE |
| **Steward** | Massachusetts EOHHS (Modified by the Rhode Island Office of the Health Insurance Commissioner) |
| **NQF Number** | N/A |
| **Data Sources** | Numerator source: ACO/AE Denominator<br>source: Payer |

| Population Health Impact |
|---|
| Complete, beneficiary-reported ethnicity data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality. |

| Measure Summary | |
|---|---|
| **Description** | The percentage of ACO/AE attributed members with self-reported Hispanic or Latino ethnicity data that was collected by an ACO/AE in the measurement year. |
| **Numerator** | ACO/AE attributed members with self-reported Hispanic or Latino ethnicity data that was collected by an ACO/AE during the measurement year |
| **Denominator** | ACO/AE attributed members in the measurement year |

| Eligible Population | |
|---|---|
| **Age** | ACO/AE attributed members 0 to 64 years of age as of December 31 of the measurement year |
| **Continuous Enrollment** | The measurement year |
| **Allowable Gap** | No more than one gap in enrollment of up to 45 days during the measurement year |
| **Anchor Date** | December 1st of the measurement year |
| **Event/Diagnosis** | None |

| Definitions | |
|---|---|
| **Complete Hispanic or Latino Ethnicity Data** | Complete Hispanic ethnicity data is defined as:<br>One (1) valid Hispanic or Latino ethnicity value (valid Hispanic or Latino ethnicity values are listed in Attachment 2).<br>o If value is "UNK," it will not count toward the numerator. |

| | |
|---|---|
| | ○ If value is "ASKU it will count toward the numerator.<br>○ If value is "DONTKNOW" it will count toward the numerator.<br>○ Each value must be self-reported. |
| **Data Collection** | Hispanic or Latino ethnicity data may be collected<br>• over the phone, electronically (e.g., a patient portal), in person, by mail, etc.<br>• from an acute hospital;<br>• must include one value in Attachment 2 |
| **Measurement Year** | Measurement Years correspond to Calendar Years |
| **Rate of Hispanic or Latino Ethnicity Data Completeness** | (Numerator Population / Eligible Population) * 100 |
| **Self-Reported Data** | Hispanic or Latino ethnicity data must be self-reported. Hispanic or Latino ethnicity data that is a result of an imputation methodology must not be included. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy).<br>Self-reported Hispanic or Latino ethnicity data that has been rolled-up or transformed for reporting purposes may be included. For example, if an ACO/AE's data systems include ethnicities that are included in HHS' data collection standards (i.e., Mexican; Puerto Rican; Cuban; Another Hispanic, Latino/a, or Spanish origin) and an individual self-reports their ethnicity as "Puerto Rican", then the ACO/AE can report the value of "Hispanic or Latino" since the value of Puerto Rican is not a valid value in Attachment 2. |

| **Administrative Specification** | |
|---|---|
| **Denominator** | The eligible population |
| **Numerator** | For members in the denominator, identify those with complete Hispanic or Latino ethnicity data, defined as:<br>One (1) valid Hispanic or Latino ethnicity value (valid Hispanic or Latino ethnicity values are listed in Attachment 2).<br>○ If value is "UNK," it will not count toward the numerator.<br>○ If value is "ASKU," it will count toward the numerator.<br>○ If value is "DONTKNOW," it will count toward the numerator. |

| | |
|---|---|
| | ○ Each value must be self-reported. |
| **Exclusions** | If value is UTC, the member is excluded from the denominator. |

| **Additional Measure Information** | |
|---|---|
| **Completeness Calculations** | Completeness is calculated for each individual ACO/AE. |

**Attachment 2**. Hispanic Ethnicity: Accepted Values

| | Description | Valid Values | Notes |
|---|---|---|---|
| **Hispanic or Latino Ethnicity** | Hispanic or Latino | 2135-2 | |
| | Not Hispanic or Latino | 2186-5 | |
| | Choose not to answer | ASKU | Member was asked to provide their ethnicity, and the member actively selected or indicated that they "choose not to answer". |
| | Don't know | DONTKNOW | Member was asked to provide their ethnicity, and the member actively selected or indicated that they did not know not know their ethnicity. |
| | Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g., clinical condition that alters consciousness). | UTC | Unable to collect this information on member due to lack of clinical capacity of member to respond |
| | Unknown | UNK | The ethnicity of the member is unknown since either:<br><br>(a) the member was not asked to provide their ethnicity, or<br><br>(b) the member was asked to provide their ethnicity, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should be |

| | | | |
|---|---|---|---|
| | | | assigned the value of ASKU instead of UNK. |

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| Overview | |
|---|---|
| **Measure Name** | Rate of English Proficiency Data Completeness – ACO/AE |
| **Steward** | Massachusetts EOHHS (Modified by the Rhode Island Office of the Health Insurance Commissioner) |
| **NQF Number** | N/A |
| **Data Sources** | Numerator source: ACO/AE Denominator<br>source: Payer |

| Population Health Impact |
|---|
| Complete, beneficiary-reported English proficiency data are critically important for identifying, analyzing, and addressing disparities in health and health care access and quality. |

| Measure Summary | |
|---|---|
| **Description** | The percentage of ACO/AE attributed members with self-reported English Proficiency data that was collected by an ACO/AE in the measurement year. |
| **Numerator** | ACO/AE attributed members with self-reported English Proficiency data that was collected by an ACO/AE in the measurement year |
| **Denominator** | ACO/AE attributed members in the measurement year |

| Eligible Population | |
|---|---|
| **Age** | ACO/AE attributed members 0 to 64 years of age as of December 31 of the measurement year |
| **Continuous Enrollment** | The measurement year |
| **Allowable Gap** | No more than one gap in enrollment of up to 45 days during the measurement year |
| **Anchor Date** | December 1st of the measurement year |
| **Event/Diagnosis** | None |

| Definitions | |
|---|---|
| **Complete English Proficiency Data** | Complete English Proficiency data is defined as:<br>One (1) valid English Proficiency Value (valid English Proficiency values are listed in Attachment 3).<br>o If value is "UNK," it will <u>not</u> count toward the numerator.<br>o If value is "ASKU," it will count toward the numerator. |

| | |
|---|---|
| | ○ If value is "DONTKNOW," it will count toward the numerator.<br>○ Each value must be self-reported. |
| **Data Collection** | English Proficiency data may be collected<br>• over the phone, electronically (e.g., a patient portal), in person, by mail, etc.<br>• from an acute hospital;<br>• must include one value in Attachment 3. |
| **Measurement Year** | Measurement Years correspond to Calendar Years |
| **Rate of English Proficiency Data Completeness** | (Numerator Population / Eligible Population) * 100 |
| **Self-Reported data** | English Proficiency data must be self-reported. For the purposes of this measure specification, data is considered to be self-reported if it has been provided by either: (a) the individual, or (b) a person who can act on the individual's behalf (e.g., parent, spouse, authorized representative, guardian, conservator, holder of power of attorney, or health-care proxy). |

| **Administrative Specification** | |
|---|---|
| **Denominator** | The eligible population. |
| **Numerator** | For members in the denominator, identify those with complete English Proficiency data, defined as:<br>One (1) valid English Proficiency value (valid English Proficiency values are listed in Attachment 3).<br>○ If value is "UNK," it will <u>not</u> count toward the numerator.<br>○ If value is "ASKU," it will count toward the numerator.<br>○ If value is "DONTKNOW," it will count toward the numerator.<br>○ Each value must be self-reported. |
| **Exclusions** | If value is UTC, the member is excluded from the denominator. |
| **Additional Measure Information** | |
| **Completeness Calculations** | Completeness is calculated for:<br>each individual ACO/AE. |

**Attachment 3**. English Proficiency: Accepted Values

| | Description | Valid Values | Notes |
|---|---|---|---|
| **English proficiency** | Very well | VERWELL | |
| | Well | WELL | |
| | Not well | NOTWELL | |
| | Not at all | NOTALL | |
| | Choose not to Answer | ASKU | Member was asked to provide their English Proficiency, and the member actively selected or indicated that they "choose not to answer." |
| | Don't know | DONTKNOW | Member was asked to provide their English proficiency, and the member actively selected or indicated that they did not know their English proficiency. |
| | Unable to collect this information on member due to lack of clinical capacity of member to respond (e.g., clinical condition that alters consciousness) | UTC | Unable to collect this information on member due to lack of clinical capacity of member to respond. |
| | Unknown | UNK | The English Proficiency of the member is unknown since either:<br><br>(a) the member was not asked to provide their English Proficiency, or<br><br>(b) the member was asked to provide their English Proficiency, and a response was not given. Note that a member actively selecting or indicating the response "choose not to answer" is a valid response, and should |

| | | | |
|---|---|---|---|
| | | | be assigned the value of ASKU instead of UNK. |

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# Appendix D: Social Determinants of Health (SDOH) Screening – Outpatient Behavioral Health Measure Specifications

**Steward: Rhode Island Executive Office of Health and Human Services, modified by the Rhode Island Office of the Health Insurance Commissioner for use in outpatient behavioral health settings**
**As of August 24, 2023**

**SUMMARY OF CHANGES FOR 2024**

- None (new measure for 2024).

## Description

Social Determinants of Health are the "conditions in the places where people live, learn, work, and play [that] affect a wide range of health risks and outcomes."[9]

The percentage of patients seen by an outpatient behavioral health provider who were screened for Social Determinants of Health in an outpatient behavioral health setting using a screening tool once per measurement year, where the outpatient behavioral health provider has documented the completion of the screening and the results. Please note that for organizations participating in the Medicaid Accountable Entity (AE) program, the screening tool must be approved by EOHHS to count as meeting numerator requirements.

## Eligible Population

***Note:*** *Patients in hospice care or who refuse to participate are excluded from the eligible population. Additional details on exclusions can be found below.*

| | |
|---|---|
| **Product lines** | Medicaid, Commercial |
| **Stratification** | None |
| **Ages** | All ages |
| **Continuous enrollment** | Enrolled in the MCO for 11 out of 12 months during the measurement year. |
| **Allowable gap** | No break in coverage lasting more than 30 days. |
| **Anchor date** | December 31 of the measurement year. |
| **Lookback period** | 12 months |
| **Benefit** | Medical |
| **Event/diagnosis** | • The patient has been seen by an outpatient behavioral health provider anytime within the last 12 months<br>• For the purpose of this measure "outpatient behavioral health provider" is any provider defined by the reporting managed care organization as a behavioral health clinician, including therapists, psychiatrists, psychologists, counselors, and other professionals specializing in mental health and behavioral health services.<br>• Follow the below to determine an outpatient behavioral health visit: |

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

| | |
|---|---|
| | ○ The following are the eligible CPT/HCPCS office visit codes for determining an outpatient behavioral health visit: 98960 – 98962, 99078, 99201-99205, 99211-99215, 99241-99245, 99341-99350, 99381-99387, 99391-99397, 99401-99404, 99411-99412, 99483, 99492-99494, 99510<br>○ The following are the eligible telephone visit, e-visit or virtual check-in codes for determining an outpatient behavioral health visit:<br>▪ CPT/HCPCS/SNOMED codes: 77406008, 84251009, 185463005, 185464004, 185465003, 281036007, 391233009, 391237005, 391239008, 391242002, 391257009, 391257009, 391261003, 439740005, 3391000175108, 444971000124105<br>▪ Any of the above CPT/HCPCS office visit codes for determining an outpatient behavioral health visit with the following POS codes: 02<br>▪ Any of the above CPT/HCPCS office visit codes for determining an outpatient behavioral health visit with the following modifiers: 95, GT |
| **Exclusions** | • Patients in hospice care (see Code List below)<br>• Refused to participate |

## Electronic Data Specifications

The percentage of patients who were screened for Social Determinants of Health in an outpatient behavioral health setting using an EOHHS-approved screening tool, where the outpatient behavioral health provider has documentation of the completion of the screening, the date of the screen, and the results.

| | |
|---|---|
| **Denominator** | The eligible population |
| **Numerator – Option 1** | Individuals who were seen by an outpatient behavioral health provider and were screened for Social Determinants of Health once per measurement year and for whom results are in the outpatient behavioral health provider's EHR.<br><br>Notes:<br>• Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with an outpatient behavioral health provider that triggered inclusion in the denominator.<br>• Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria. |

| | |
|---|---|
| **Numerator – Option 2** | Individuals who were seen by an outpatient behavioral health provider who were screened for Social Determinants of Health once per measurement year and for whom results are electronically documented using ICD-10 Z codes in the outpatient behavioral health provider's EHR.<br><br>Notes:<br>• Screens may be rendered asynchronously, i.e., at a time and through a modality other than a visit with an outpatient behavioral health provider that triggered inclusion in the denominator.<br>• Screens rendered during a telephone visit, e-visit or virtual check-in meet numerator criteria.<br><br>Identify screening using the following ICD-10 Z codes:<br>• Z04.89<br>  ○ Definition: Encounter for examination and observations for other specified reasons<br>  ○ Meaning: SDOH screening completed<br>• Z53.8<br>  ○ Definition: Procedure and treatment not carried out for other reasons<br>  ○ Meaning: SDOH screening offered, but patient refused/declined to complete screen |
| **Unit of measurement** | Screens should be performed at the individual patient level for adults and adolescents. Screens may be performed at the individual patient level or the household level for all children 12 and under residing in one household, so long as the screening is documented in each child's medical record. |
| **Documentation requirements** | All screenings must be documented in the outpatient behavioral health provider's patient health record, regardless of if the outpatient behavioral health provider screened the individual (or household, as applicable) or if the screen was performed by anyone else, including: another provider, the insurer or a community partner.<br><br>The screening results must a) be embedded in the EHR, b) be accessible in the EHR as a PDF of the screening results, or c) be accessible from within the EHR without requiring the outpatient behavioral health provider to leave the EHR to access another electronic location to search for the patient's record and locate and view the screening results. An integrated EHR interface with Unite Us that allows providers to view a patient's screening results meets the documentation requirements.<br><br>Results for at least one question per required domain must be included for a screen to be considered numerator complaint. |

| | |
|---|---|
| **Approved screening tools** | For those participating in the AE program, all screening tools must be approved by EOHHS prior to the reporting period to be counted in the numerator. Screens performed with tools not approved by EOHHS shall not be included in the numerator of this measure. |
| **Required domains** | 1. Housing insecurity;<br>2. Food insecurity;<br>3. Transportation;<br>4. Interpersonal violence; and<br>5. Utility assistance.<br><br>Note: If outpatient behavioral health providers are conducting the screen during a telephone visit, e-visit or virtual check-in or independent of a visit, they may use their discretion whether to ask questions related to interpersonal violence. The interpersonal violence domain must, however, be included for screens administered during in-person visits. |

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## Code List

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

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

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