



**November 3, 2017**

## **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 section 10(d)(3) of OHIC Regulation 2. This interpretive guidance will be updated periodically as Aligned Measure Sets are reviewed.

Nothing that follows is to supersede existing regulatory requirements codified in OHIC Regulation 2 Section 10(d)(3).

### **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. The changes made during the first Annual Review Meeting on November 4, 2016 shall be effective for contracts with primary care providers, relevant specialists, hospitals, and Integrated Systems of Care and a Health Insurer which incorporate quality measures into the payment terms of the contract and which are entered into after July 1, 2017, or expire after July 1, 2017, or which would expire after July 1, 2017 but for the amendment or renewal of the contract (whether the renewal is effective pursuant to the terms of a previously executed contract, or otherwise). The next annual review will be convened by August 1, 2017; changes from that meeting will be effective for insurer contracts with performance periods beginning on or after January 1, 2018. Future changes to the Aligned Measure Sets will be developed via a similar Annual Review Committee process convened by August 1, and completed on or after October 1, effective for insurer contracts with performance periods beginning on or after the 1<sup>st</sup> of January following the Annual Review Meeting(s).

### **Applicable Contracts**

OHIC has developed Aligned Measures Sets for Accountable Care Organization (otherwise known as Integrated Systems of Care) contracts, hospital contracts, primary care provider contracts, professional maternity care provider contracts, and 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 Section 10(d)(3). Section 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 section 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 sections 3(h) and 3(q), respectively.<sup>1</sup>

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.

---

<sup>1</sup> Section IV. 2 A. 1 of the Commissioner's 2016-17 Alternative Payment Methodology Plan requires that contracts which transfer financial risk to medical service providers or ACOs shall include as part of the reimbursement model requirements that link performance on quality measures to reimbursement levels.



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).

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 Section 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
- developing and implementing pharmacy system alerts to trigger a pharmacist/prescriber consult on various medication topics

## **Performance Measurement**

With the exception of hospital contracts, 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 section 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 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, Hospital, Primary Care, Maternity, and 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, 14 federal and national measure sets (including CPC+, MIPS, Core Quality Measures), and five additional state 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 blue columns to the left (Columns B – K) include basic information about the measure.
- The purple column (Column O) includes links to the measure specifications.
- The next set of dark blue columns (Columns AU – AZ) provide a score of how well measures are aligned. The columns to the right of the “Calculation” section provide detailed information about the measure sets in which each measure is included. The RI-specific measure sets are included in columns BA – BF; the remaining federal, national, and state measure sets are included in columns BG – BY.

The Buying Value Measure Selection Tool has some additional features that may not be of use for the group. Within the “Crosswalk of SIM Measure Sets” tab, the following capabilities have been hidden for simplicity:

- The orange columns (Columns L – N) are a place where you can document information about who recommended the measure, why the measure was included, etc.
- The green columns (Columns P – AJ) are a way to score measures against selection criteria.

There are two additional tabs that have been hidden, the “Instructions” tab and the “Measure Crosswalk” tab. These tabs provide additional resources for organizations want to commence the development of an aligned measure set.

Health insurers should use the measure specifications maintained by the measure steward. 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 Regulation 2 Section 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.