# MEDICARE-MEDICAID
# CAPITATED FINANCIAL ALIGNMENT MODEL
# QUALITY WITHHOLD TECHNICAL NOTES (DY 2 – 4): RHODE ISLAND-SPECIFIC MEASURES

Effective as of January 1, 2018; Issued August 15, 2018

**Attachment D**
**Rhode Island Quality Withhold Measure Technical Notes: Demonstration Years 2 through 4**

## Introduction

The measures in this attachment are quality withhold measures for the Medicare-Medicaid Plan (MMP) in the Rhode Island Integrated Care Initiative (ICI) for Demonstration Years (DY) 2 through 4. These state-specific measures directly supplement the Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 2 through 5, which can be found at the following address: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/Downloads/QualityWithholdGuidanceDY2-503142018.pdf.

DY 2 through 4 in the Rhode Island ICI Demonstration are defined as follows:

| Year | Dates Covered |
|---|---|
| DY 2 | January 1, 2018 – December 31, 2018 |
| DY 3 | January 1, 2019 – December 31, 2019 |
| DY 4 | January 1, 2020 – December 31, 2020 |

The state-specific measures within this attachment apply to all demonstration years listed above; however, CMS and the State may elect to adjust the analyses and/or benchmarks for DY 3 and 4. Stakeholders will have the opportunity to comment on any changes prior to finalization.

### *Variation from the CMS Core Quality Withhold Technical Notes*

Because of the six month continuous enrollment requirement and sampling timeframe associated with CAHPS, the Rhode Island MMP was unable to report CMS core quality withhold measures CW3 and CW5 for DY 1. As a result, these measures will be included as part of the withhold analysis for DY 2 for the Rhode Island MMP. The details and benchmarks for these measures are provided in the CMS Core Quality Withhold Technical Notes for DY 1, and also reiterated on pages 7 through 8 of this document.

### *Applicability of the Gap Closure Target to the State-Specific Quality Withhold Measures*

The gap closure target methodology as described in the CMS Core Quality Withhold Technical Notes for DY 2 through 5 **will** apply to the state-specific measures contained in this attachment, unless otherwise noted in the measure descriptions below.

## Rhode Island-Specific Measures: Demonstration Years 2 through 4

### Measure: RIW7 – Care for Older Adults – Medication Review

| | |
|---|---|
| Description: | Percent of members 66 years and older who received at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year and the presence of a medication list in the medical record |
| Measure Steward/ Data Source: | NCQA/HEDIS (the MMP should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year) |
| HEDIS Label: | Care for Older Adults (COA) – Medication Review |

| | |
|---|---|
| NQF #: | 0553 |
| Benchmarks: | DY 2: 79%<br>DY 3: 80%<br>DY 4: 81% |
| Notes: | This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate. |

**Measure: RIW8 – Care for Older Adults – Functional Status Assessment**

| | |
|---|---|
| Description: | Percent of members 66 years and older who received at least one functional status assessment during the measurement year |
| Measure Steward/ Data Source: | NCQA/HEDIS (the MMP should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year) |
| HEDIS Label: | Care for Older Adults (COA) – Functional Status Assessment |
| NQF #: | N/A |
| Benchmarks: | DY 2: 67%<br>DY 3: 68%<br>DY 4: 69% |
| Notes: | This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate. |

**Measure: RIW9 – Care for Older Adults – Pain Assessment**

| | |
|---|---|
| Description: | Percent of members 66 years and older who received at least one pain assessment during the measurement year |
| Measure Steward/ Data Source: | NCQA/HEDIS (the MMP should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year) |
| HEDIS Label: | Care for Older Adults (COA) – Pain Assessment |
| NQF #: | N/A |
| Benchmarks: | DY 2: 62%<br>DY 3: 63%<br>DY 4: 64% |
| Notes: | This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate. |

**Measure: RIW10 – Care for Older Adults – Advance Care Planning**

| | |
|---|---|
| Description: | Percent of members 66 years and older who had advance care planning during the measurement year |
| Measure Steward/ Data Source: | NCQA/HEDIS (the MMP should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year) |
| HEDIS Label: | Care for Older Adults (COA) – Advance Care Planning |
| NQF #: | N/A |
| Benchmarks: | DY 2: 40%<br>DY 3: 45%<br>DY 4: 50% |
| Notes: | This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate. |

**Measure: RIW11 – LTC Nursing Facility Diversion**

| | |
|---|---|
| Description: | Percent of long-stay nursing facility residents with low care needs |
| Metric: | Measure RI4.9 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Rhode Island-Specific Reporting Requirements |
| Measure Steward/ Data Source: | State-defined measure |
| NQF #: | N/A |
| Benchmark: | 3.5% |
| Notes: | For quality withhold purposes, this measure is calculated as follows:<br><br>**Denominator**: Total number of long-stay nursing facility residents age 65 and older during the reporting period (Data Element A) summed over four quarters.<br><br>**Numerator**: Total number of long-stay nursing facility residents age 65 and older who meet the requirements for 'low-level care needs status' (Data Element B) summed over four quarters.<br><br>By summing denominators and numerators before calculating the rate, the final calculation is adjusted for volume.<br><br>Note that lower rates are better for this measure. The gap closure target methodology does not apply to this measure. |

**Measure: RIW12 – SNF Discharges to the Community**

| | |
|---|---|
| Description: | Percent of all new skilled nursing facility (SNF) admissions from a hospital who are discharged back to the community alive and remain out of a SNF for the next 30 days |

| | |
|---|---|
| Metric: | Measure RI4.5 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Rhode Island-Specific Reporting Requirements |
| Measure Steward/ Data Source: | State-defined measure |
| NQF #: | N/A |
| Benchmarks: | DY 2: 65%<br>DY 3: 67%<br>DY 4: 69% |
| Notes: | For quality withhold purposes, this measure is calculated as follows:<br><br>**Denominator**: Total number of members admitted to a SNF from an acute hospital during the prior 12 months who did not have a stay in a nursing facility in the 100 days prior to the SNF admission (Data Element A).<br><br>**Numerator**: Total number of members who were discharged back to the community alive from a SNF within 100 days of admission and remained out of any SNF for at least 30 days (Data Element B). |

**Measure: RIW13 – SNF Hospital Admissions**

| | |
|---|---|
| Description: | Percent of members in a SNF that are sent back to any hospital (excluding ER only visits) from the SNF within 30 days of admission |
| Metric: | Measure RI4.6 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Rhode Island-Specific Reporting Requirements |
| Measure Steward/ Data Source: | State-defined measure |
| NQF #: | N/A |
| Benchmark: | 12% |
| Notes: | For quality withhold purposes, this measure is calculated as follows:<br><br>**Denominator:** Total number of members admitted to a SNF from an acute hospital who had an MDS admission assessment during the prior 12 months (Data Element A) summed over four quarters.<br><br>**Numerator:** Total number of members readmitted to any hospital from the SNF within 30 days of admission (Data Element B) summed over four quarters.<br><br>By summing denominators and numerators before calculating the rate, the final calculation is adjusted for volume.<br><br>Note that lower rates are better for this measure. |

**Measure: RIW14 – Rhode to Home Eligibility**

| | |
|---|---|
| Description: | Percent of members eligible for the Rhode to Home program who are transitioned out of a nursing facility to the community |
| Metric: | Measure RI4.7 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Rhode Island-Specific Reporting Requirements |

| | |
|---|---|
| Measure Steward/ Data Source: | State-defined measure |
| NQF #: | N/A |
| Benchmark: | 40% |
| Notes: | This measure is applicable for DY 2 only. For quality withhold purposes, this measure is calculated as follows:<br><br>**Denominator:** Total number of members eligible for the Rhode to Home program (Data Element A) summed over four quarters.<br><br>**Numerator:** Of the members eligible for the Rhode to Home program, total number of members discharged from a nursing facility to the community (Data Element B) summed over four quarters.<br><br>By summing denominators and numerators before calculating the rate, the final calculation is adjusted for volume. |

**Measure: RIW15 – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment**

| | |
|---|---|
| Description: | Percent of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:<br>• Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis.<br>• Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit. |
| Measure Steward/ Data Source: | NCQA/HEDIS (the MMP should follow the version of the HEDIS Technical Specifications that is referenced in the HEDIS Reporting Requirements HPMS memorandum issued for the relevant reporting year) |
| HEDIS Label: | Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) |
| NQF #: | 0004 |
| Benchmarks: | Initiation of AOD Treatment: 45%<br>Engagement of AOD Treatment: 16% |
| Notes: | The MMP must meet or exceed the benchmark or gap closure target for both metrics in order to pass the measure as a whole.<br><br>This measure will be removed from the quality withhold analysis if the MMP has fewer than 1,000 enrollees as of July of the measurement year. It will also be removed if the MMP's HEDIS audit designation is "NA", which indicates that the denominator is too small (<30) to report a valid rate. |

**Measure: RIW16 – Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers**

| | |
|---|---|
| Description: | Percent of long-stay, high-risk nursing facility residents with Stage II-IV pressure ulcers |
| Metric: | Measure RI4.2 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Rhode Island-Specific Reporting Requirements |
| Measure Steward/ Data Source: | State-defined measure |
| NQF #: | 0679 |
| Benchmark: | 5% |
| Notes: | For quality withhold purposes, this measure is calculated as follows:<br><br>**Denominator:** Total number of long-stay nursing facility residents with a selected target assessment who meet the definition of high-risk (Data Element A).<br><br>**Numerator:** Total number of long-stay nursing facility residents with a selected target assessment who meet both of the following conditions: 1) there is a high risk for pressure ulcers and 2) Stage II-IV pressure ulcers are present (Data Element B).<br><br>Note that lower rates are better for this measure. The gap closure target methodology does not apply to this measure. |

**Measure: RIW17 – Long-Stay Nursing Facility Residents Who Received Antipsychotic Medications**

| | |
|---|---|
| Description: | Percent of long-stay nursing facility residents who received antipsychotic medications |
| Metric: | Measure RI4.10 of Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements: Rhode Island-Specific Reporting Requirements |
| Measure Steward/ Data Source: | State-defined measure |
| NQF #: | N/A |
| Benchmarks: | DY 2 and 3: 16%<br>DY 4: 15% |
| Notes: | For quality withhold purposes, this measure is calculated as follows:<br><br>**Denominator:** Total number of long-stay nursing facility residents with a selected target assessment (Data Element A) summed over four quarters.<br><br>**Numerator:** Total number of long-stay nursing facility residents with a selected target assessment where the following condition is true: antipsychotic medications received (Data Element B) summed over four quarters.<br><br>By summing denominators and numerators before calculating the rate, the final calculation is adjusted for volume.<br><br>Note that lower rates are better for this measure. |

**Additional CMS Core Measures for Rhode Island: Demonstration Year 2 Only**

**Measure: CW3 – Customer Service**

| | |
|---|---|
| Description: | Percent of the best possible score the plan earned on how easy it is for members to get information and help from the plan when needed:<br>• In the last 6 months, how often did your health plan's customer service give you the information or help you needed?<br>• In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?<br>• In the last 6 months, how often were the forms for your health plan easy to fill out? |
| Measure Steward/ Data Source: | AHRQ/CAHPS (Medicare CAHPS – Current Version) |
| NQF #: | 0006 |
| Benchmark: | 86% |
| Minimum Enrollment: | 600 |
| Continuous Enrollment Requirement: | Yes, 6 months |
| Notes: | The case-mix adjusted composite measure is used to assess how easy it was for the member to get information and help when needed. CAHPS measures are adjusted for self-reported physical and mental health status, age, education, proxy status, dual eligibility, low income subsidy eligibility, and language of survey. For a list of CAHPS case-mix coefficients, please see the Star Ratings Technical Notes at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.<br>The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100. The percentage of the best possible score each plan earned is an average of scores for the questions within the composite. |

**Measure: CW5 – Getting Appointments and Care Quickly**

| | |
|---|---|
| Description: | Percent of best possible score the plan earned on how quickly members get appointments and care:<br>• In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?<br>• In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?<br>• In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time? |
| Measure Steward/ Data Source: | AHRQ/CAHPS (Medicare CAHPS – Current Version) |
| NQF #: | 0006 |
| Benchmark: | 74% |
| Minimum Enrollment: | 600 |

| | |
|---|---|
| Continuous Enrollment Requirement: | Yes, 6 months |
| Notes: | This case-mix adjusted composite measure is used to assess how quickly the member was able to get appointments and care. CAHPS measures are adjusted for self-reported physical and mental health status, age, education, proxy status, dual eligibility, low income subsidy eligibility, and language of survey. For a list of CAHPS case-mix coefficients, please see the Star Ratings Technical Notes at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html.<br><br>The CAHPS score uses the mean of the distribution of responses converted to a scale from 0 to 100. The percentage of the best possible score each plan earned is an average of scores for the questions within the composite. |