MEDICARE-MEDICAID
CAPITATED FINANCIAL ALIGNMENT MODEL
QUALITY WITHHOLD TECHNICAL NOTES (DY 2 – 7):
RHODE ISLAND-SPECIFIC MEASURES

Effective as of January 1, 2018; Issued August 15, 2018;
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Attachment D
Rhode Island Quality Withhold Measure Technical Notes: Demonstration Years 2 through 7

<u>**Introduction**</u>

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 7. These state-specific measures directly supplement the [Medicare-Medicaid Capitated Financial Alignment Model CMS Core Quality Withhold Technical Notes for DY 2 through 9](#).

DY 2 through 7 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
DY 5	January 1, 2021 – December 31, 2021
DY 6	January 1, 2022 – December 31, 2022
DY 7	January 1, 2023 – December 31, 2023

Information about the applicable demonstration years for each state-specific measure, as well as benchmarks and other details, can be found in the measure descriptions below. Note that CMS and the State may elect to adjust the benchmarks or other details based on additional analysis or changes in specifications. Stakeholders will have the opportunity to comment on any substantive 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 were 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 9 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 9 **will** apply to the state-specific measures contained in this attachment, unless otherwise noted in the measure descriptions below.

<u>**Rhode Island-Specific Measures: Demonstration Years 2 through 7**</u>

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) |

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

Applicable Years: DY 2 through 7

Utilizes Gap Closure: Yes

Benchmarks: DY 2: 79%
                 DY 3: 80%
                 DY 4: 81%
                 DY 5: 86%
                 DY 6: 87%
                 DY 7: 88%

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

Applicable Years: DY 2 through 7

Utilizes Gap Closure: Yes

Benchmarks: DY 2: 67%
                 DY 3: 68%
                 DY 4: 69%
                 DY 5: 72%
                 DY 6: 73%
                 DY 7: 74%

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
Applicable Years:	DY 2 through 7
Utilizes Gap Closure:	Yes
Benchmarks:	DY 2: 62%
	DY 3: 63%
	DY 4: 64%
	DY 5: 90%
	DY 6: 91%
	DY 7: 92%
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
Applicable Years:	DY 2 through 5
Utilizes Gap Closure:	Yes
Benchmarks:	DY 2: 40%
	DY 3: 45%
	DY 4: 50%
	DY 5: 66%
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
Applicable Years:	DY 2 through 4
Utilizes Gap Closure:	No
Benchmark:	3.5%
Notes:	For quality withhold purposes, this measure is calculated as follows:

Denominator: Total number of long-stay nursing facility residents age 65 and older during the reporting period (Data Element A).

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).

Note that lower rates are better for 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
Applicable Years:	DY 2 through 7
Utilizes Gap Closure:	Yes
Benchmarks:	DY 2: 65% DY 3: 67% DY 4 through 7: 69%
Notes:	For quality withhold purposes, this measure is calculated as follows:

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).

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
Applicable Years:	DY 2 through 7
Utilizes Gap Closure:	Yes
Benchmark:	12%
Notes:	For quality withhold purposes, this measure is calculated as follows:

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).

Numerator: Total number of members readmitted to any hospital from the SNF within 30 days of admission (Data Element B).

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
Applicable Year:	DY 2
Utilizes Gap Closure:	Yes
Benchmark:	40%
Notes:	For quality withhold purposes, this measure is calculated as follows:

Denominator: Total number of members eligible for the Rhode to Home program (Data Element A) summed over four quarters.

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.

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 new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported:

- Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.
- Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.

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 Substance Use Disorder Treatment (IET)
NQF #:	0004
Applicable Years:	DY 2 through 7
Utilizes Gap Closure:	Yes
Benchmarks:	Initiation of SUD Treatment: 45% Engagement of SUD 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.
	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
Applicable Years:	DY 2 through 7
Utilizes Gap Closure:	No for DY 2 through 4; Yes for DY 5 through 7
Benchmark:	5%
Notes:	For quality withhold purposes, this measure is calculated as follows:

Denominator: Total number of long-stay nursing facility residents with a selected target assessment who meet the definition of high-risk (Data Element A).

Numerator: Total number of long-stay nursing facility residents with a selected target assessment who had Stage II-IV or unstageable pressure ulcers present (Data Element B).

Note that lower rates are better for 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
Applicable Years:	DY 2 through 4
Utilizes Gap Closure:	Yes
Benchmarks:	DY 2 and 3: 16% DY 4: 15%
Notes:	For quality withhold purposes, this measure is calculated as follows:

Denominator: Total number of long-stay nursing facility residents with a selected target assessment (Data Element A).

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).

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:

- In the last 6 months, how often did your health plan's customer service give you the information or help you needed?
- In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?
- 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
Applicable Year:	DY 2
Utilizes Gap Closure:	No
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.
	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:

- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?
- 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
Applicable Year:	DY 2
Utilizes Gap Closure:	No
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.

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.