EOHHS Medicaid Managed Care 2021-2022 Procurement: Policy Report

August 2021

RHODE ISLAND

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RI Medicaid Overview – Current MCOs

88% - or 296K members – are in one of three managed care organizations. MCOs are responsible for cost, quality and access for their populations. MCOs receive a monthly payment from the state for each member that they take care of. Members can select their own MCO when they become eligible and change once a year.

Neighborhood Health Plan OF RHODE ISLAND™

- ~185K members as of June 2021
- Includes all children in the DCYF-Child Welfare population
- Also includes joint Medicaid / Medicare product called Integrity aka MMP (~13K)

UnitedHealthcare®

- ~96K members as of June 2021
- Includes child and family, single adults and adult disabled population
- Separately operates RIte Smiles dental program (~127K members)

TUFTS Health Plan

- ~16K members as of June 2021
- Includes child and family, single adults and adult disabled population
- New entrant into the RI Medicaid program in 2016

RI Medicaid – Current AE and HSTP

RI Medicaid is a leader in the development of Accountable Entities (AEs) through our Health System Transformation Project (HSTP).

Health System Transformation Project

- Section 1115 waiver grants authority
- Brought $230M into the RI system

Supports the establishment of Accountable Entities

Value-Based Payment Model	Demonstration of Core Capacities	Investment in Infrastructure
• Total cost of care → AEs and MCOs gain if they reduce costs year over year • Quality measurement embedded within the payment model	• AEs must demonstrate that they meet basic requirements – network of providers, IT infrastructure, approach to population health, governance, etc. • EOHHS certifies AEs annually	• AEs earn incentive funds by meeting program milestones and improving on metrics • EOHHS invests in additional enabling infrastructure and technical assistance

MCO Procurement Executive Summary

Through a deliberative assessment and discovery process we have determined an MCO Procurement and Contract Changes are necessary to advance RI's current Managed Care Program in accordance with EOHHS values of choice, race equity and community engagement.

The Assessment and Discovery Process:

- Interviewed internal and external staff across agencies, AEs, MCOs, provider agencies, advocacy organizations, members
- Issued a Request for Information (RFI) and summarized comments from 19 organizations – MCOs, providers, & community organizations
- Issued a member survey that yielded over 2,300 responses
- Held member focus group to supplement survey responses
- Convened internal, cross-agency staff work groups- focused on policy decisions

MCO procurement and contract changes will yield a benefit for RI's Medicaid program in four main areas:

1. Empowering members to make informed choices about their health plans and care
2. Improved care and service coordination and management
3. Increased investment in population health, focus on social determinants of health and *actual* focus on race equity
4. Improved budget predictability and increased payments for improved outcomes

MCO Procurement – What We Heard through the Discovery Process

We conducted interviews with state agencies, current MCOs, potential bidders, providers, Medicaid members and community-based organizations and conducted a formal RFI. Stakeholders identified the following procurement goals:

Implement changes to the member/ MCO enrollment process

Focus more on race equity and ensuring MCOs meet health outcome targets with specific breakdowns by race and ethnicity

Improve inter-agency coordination, especially for children with special needs and children involved with DCYF or the justice system

Improve integration of behavioral health services, especially for children, within primary care

Better continuity of care for transitionary members (like those moving from FFS to managed care or between acute and community-based settings)

Clarify roles and responsibilities between AEs and MCOs, including appropriate support for AEs by MCOs

Use targeted risk mitigation instead of risk corridors

MCO Procurement – RFI Feedback

EOHHS has carefully reviewed the RFI responses received and identified the following key highlights and areas of consensus among respondents:

Key Area	Highlights and Areas of Consensus
Care and Service Coordination	• Deliver care management and service coordination in accordance with the consumer's choice and preferences. The most recommended approach is to pair the member with the provider who has an established relationship to the patient in order to optimize engagement and successful outcomes. • Establish appropriate parameters to further support transparent and timely data sharing among and between EOHHS, MCOs and providers. All stakeholders should use the data flow to inform, support and track individual member, system, and programmatic performance to achieve EOHHS policy goals for the managed care program.
Behavioral Health	• Implement systemic improvements at the state, MCO, AE, and provider levels to achieve an integrated system of whole-person care that addresses physical and behavioral health needs for children and adults. Providers should be well-versed in evidence-based care models including trauma-informed care, adverse childhood experiences, principles of recovery and empowerment, health literacy, and harm reduction. In addition, a service continuum assessment should address early identification, prevention and care transitions.
Social Determinants of Health (SDoH)/Population Health/Health Equity	• Support alignment of quality, operational, and financial incentives across MCOs, AEs and other providers, including community-based organizations. Support should build on current EOHHS and RI Department of Health's Health System Transformation Program (HSTP), Rhode to Equity, Health Enterprise Zones (HEZs), Care Transformation Collaborative Rhode Island (CTC-RI) and Community Resource Platform, and other strategies. • Consider requirements for MCOs to have a health equity plan developed with member input to address internal and external anti-racism, implicit and unconscious bias training, staffing, quality, and financial incentives to reflect Black, Indigenous, and Persons of Color experiences.
Value-Based Payments and APMs	• Discourage exclusivity arrangements between AEs and MCOs. However, most respondents supported flexibility in value-based purchasing arrangements between MCOs, AEs and other providers to achieve the required outcomes while meeting providers where they are and advancing to more sophisticated arrangements over time.
Member Enrollment	• Contract with an independent enrollment broker for unbiased member outreach and education to facilitate active member choice among all available options. Outreach and education should be tailored to RI enrollees' cultural, linguistic, and literacy levels. Most respondents suggested requiring enrollees to select a primary care provider (PCP) at the point of managed care enrollment. • Maintain members in their MCO for physical and behavioral health services when a non-dual member qualifies for long-term services and supports (LTSS) with additional requirements for coordination and communication to ensure continuity of care and coverage to ensure whole-person centered care.
MCO Financing and Comprehensive Risk	• Continue actuarially sound rate setting. Respondents note this is a key to the successful transfer of financial risk to MCOs. MCOs with demonstrated financial stability and experience should be well positioned to assume risk with additional mechanisms to recognize membership allocation and incentives for improved quality and member outcomes.
Other	• Respondents highly encouraged continued telehealth flexibilities, especially for meeting behavioral and SDoH needs of members.

Member Survey: 2,280 Total Responses

Medicaid Managed Care members received a hard copy invitation to complete the survey, as well as an email with the online survey link. The survey was available in 11 languages in addition to English.

535

Paper Surveys Submitted

EOHHS received 535 survey responses in hard copy mail or email attachment format.

312

Web Link Surveys Submitted

312 members completed their survey by clicking the website link/QR code provided by EOHHS via social media or other channels

1,433

Surveys Taken Via Email Link

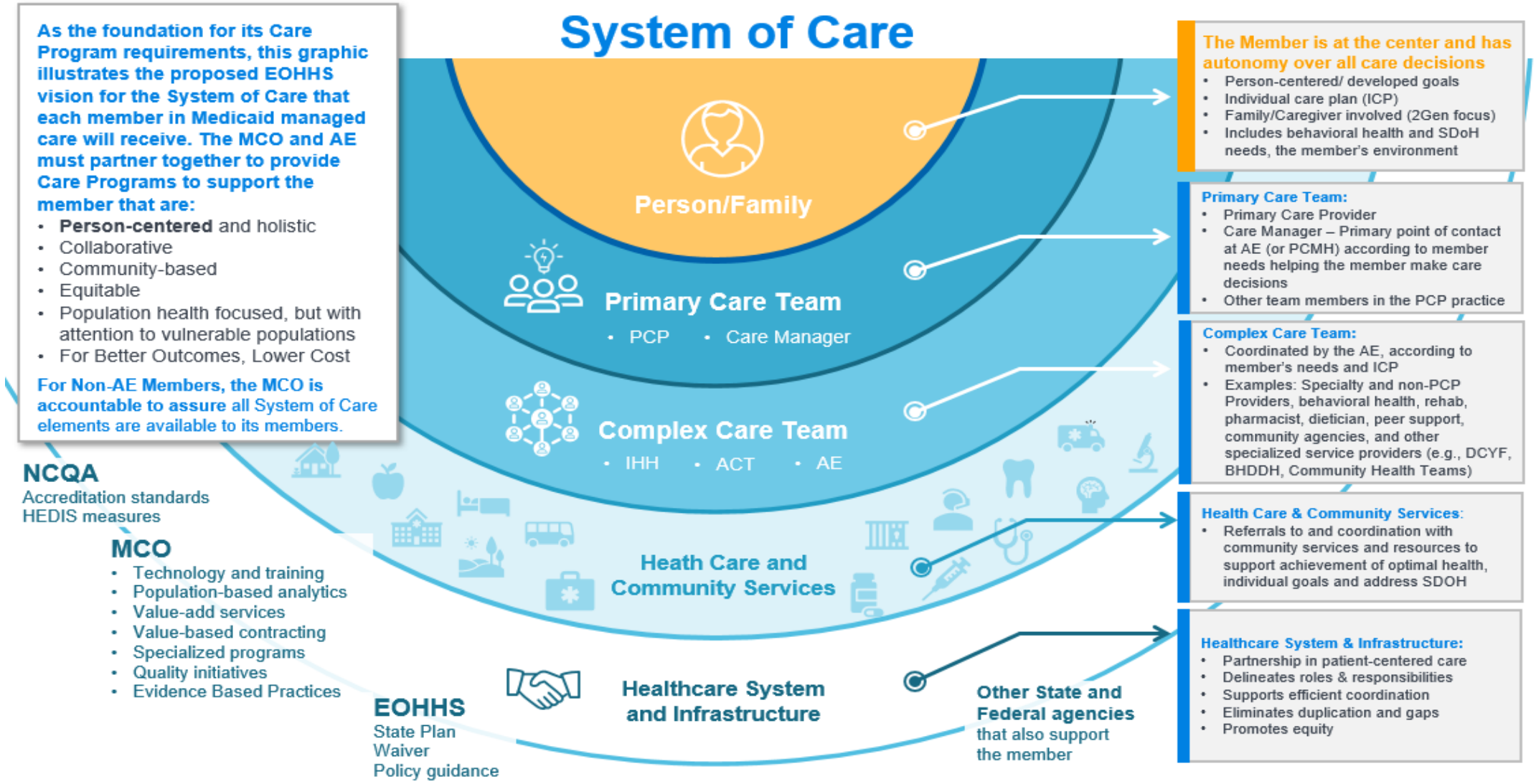
The majority of survey respondents took the survey via a link emailed to the head of household by EOHHS.

25

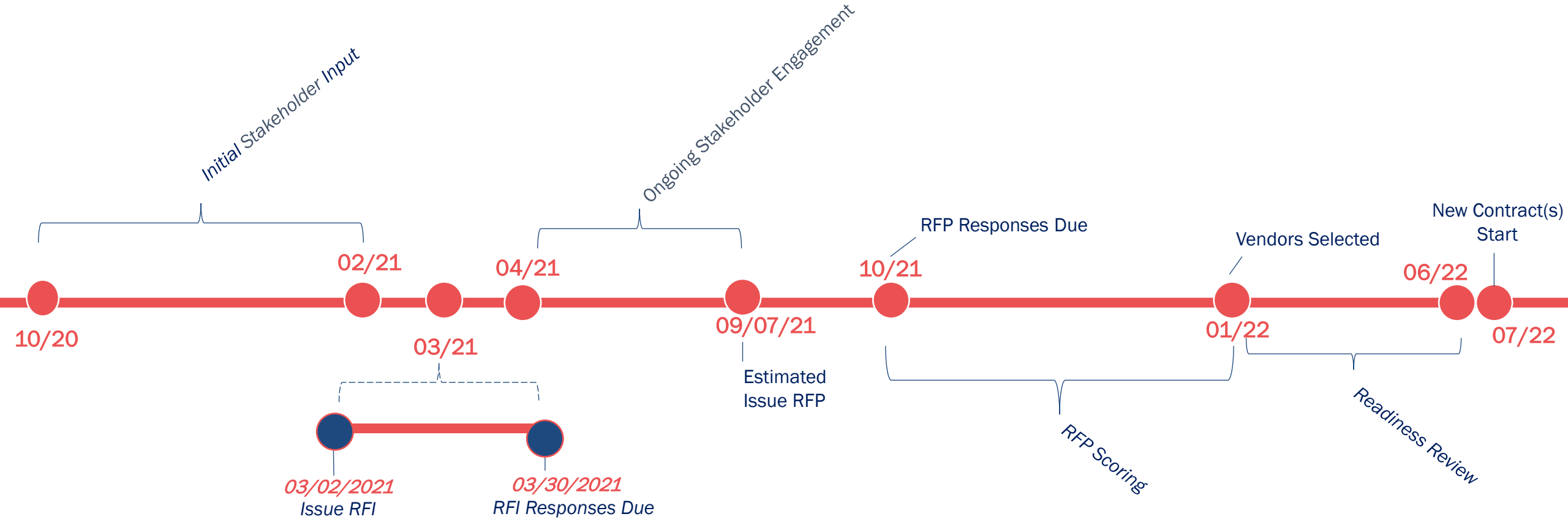
Foreign Language Surveys

25 survey responses were submitted in a language other than English.

MCO role considered within broader healthcare system



Anticipated Timeline for the Procurement *(Updated 7/2021)*



This timeline is tentative and subject to change.

Four Priority Areas Identified for Change

EOHHS will use a competitive procurement process to identify and offer contracts to high performing MCOs to address four areas: Member Centricity, Care Coordination, Health Equity and Financing Supporting Quality, Access and Budget Predictability.

Data and Quality Performance

Member Centric

Empowering the member to make informed decisions, especially in choosing a Health Plan

Improved Care Coordination and Management

Creating infrastructure that treats the whole person and reduces duplication and fragmentation of care and services

Health Equity and Social Determinants of Health

Promoting social services to offer Medicaid members a benefit package that supports person-centered healthcare

Financing that supports Quality, Access & Budget Predictability

Achieving greater budget predictability and use of funds to support movement toward paying for value and outcomes

Area for Change: Member Centricity

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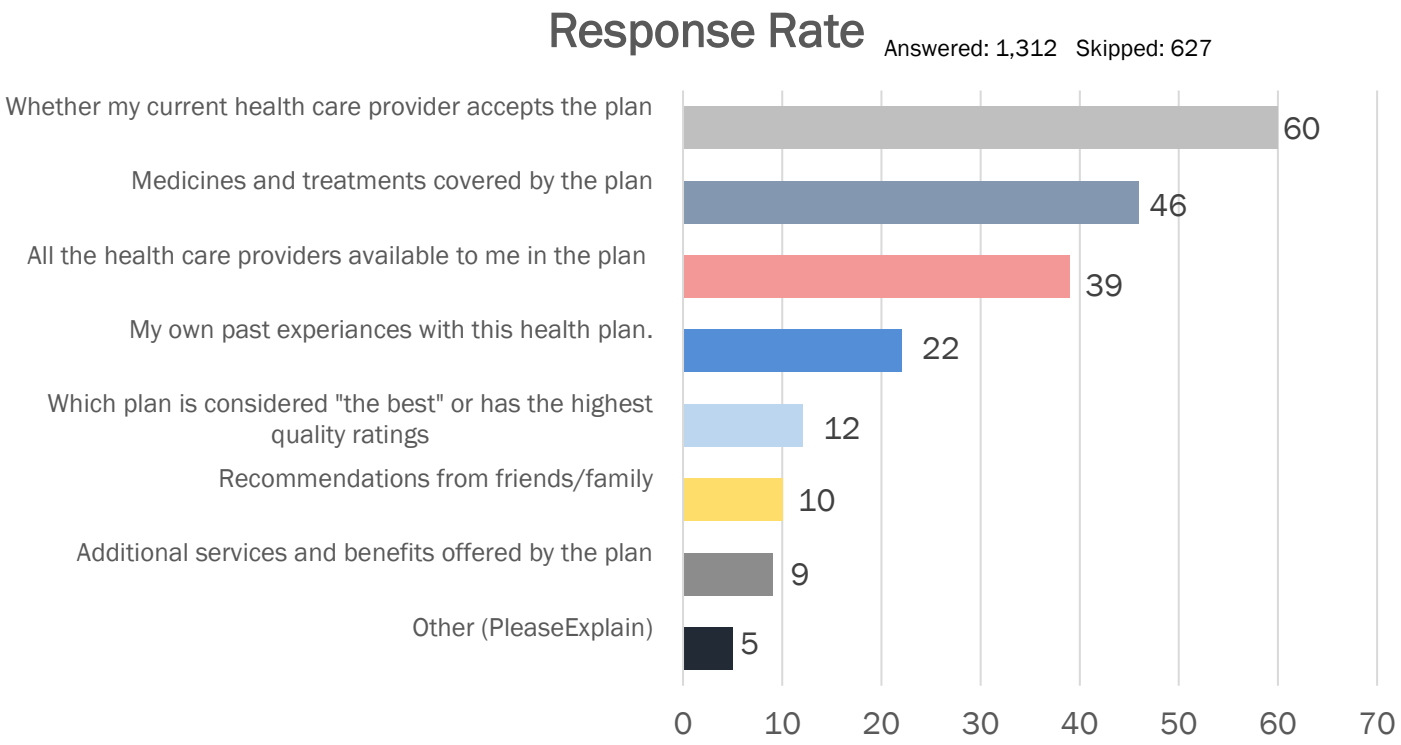
Member Choice – Current State

New Medicaid members and members transitioning into managed care from FFS currently lack the information and autonomy to make an informed choice about their MCO.

- No option for MCO competition or choice for children and families in DCYF custody.
- Absence of complete education around member options. For some members, language barriers make the educational resources inaccessible.
- Lack of standardization and resources to facilitate member transition from FFS to managed care.
- Lack of transparency and education regarding AE assignment related to MCO selection.
- Further strengthen its beneficiary support system required by federal regulation (42 CFR §438.71).

Top Reasons for Health Plan Choice: Current Provider, Medicines/Treatments, Other Providers in Network*

Member Survey Question: What was most important to you when choosing your current health plan? (Choose one or more response)

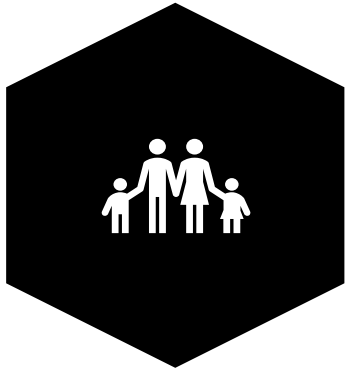


- Supports **member choice based on relationship with provider.**
- Identifies **providers as the key to member engagement and trust.**
- Supports care and service coordination at the provider level, according to member preference.

**As of June 10, 2021. Based preliminary results of responses to the Member Survey.*

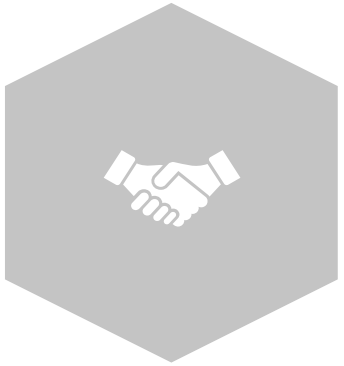
Changes to Improve Member Choice

Creating infrastructure that is member-centric and empowers members to make affirmative choices regarding their healthcare and fosters a health delivery system which further considers members needs and preferences.



Member and Family Centric Values

- Will allow DCYF families to **choose among all MCOs** for their children.
- **Members will be empowered** to make an active selection of their MCO/PCP with **attention to cultural and language preferences and SDOH needs**.
- EOHHS will provide **increased member education** during initial & yearly open enrollment period.



Improved Coordination and Continuity of Care

- Will **maintain those eligible for LTSS services in managed care for acute & behavioral health care needs.**
- Will require MCOs to establish additional policy and procedural requirements to **ensure continuity of care** during transitions.

Knowledge Building

- Will use a beneficiary support system to provide **un-biased, member-centric** educational materials that **complies with federal requirements.**
- Continues support for **member choice** with **increased transparency** of MCO performance during selections.

Enhanced Plan Performance

- MCOs will be required to provide transparent information about **access and coverage policies, networks, and performance.**
- Will set additional requirements for MCO **member engagement in policy and planning.**
- **Quality and payment incentives** will be focused on the delivery of **whole-person and family-centered care.**

Area for Change: Care Coordination and Management

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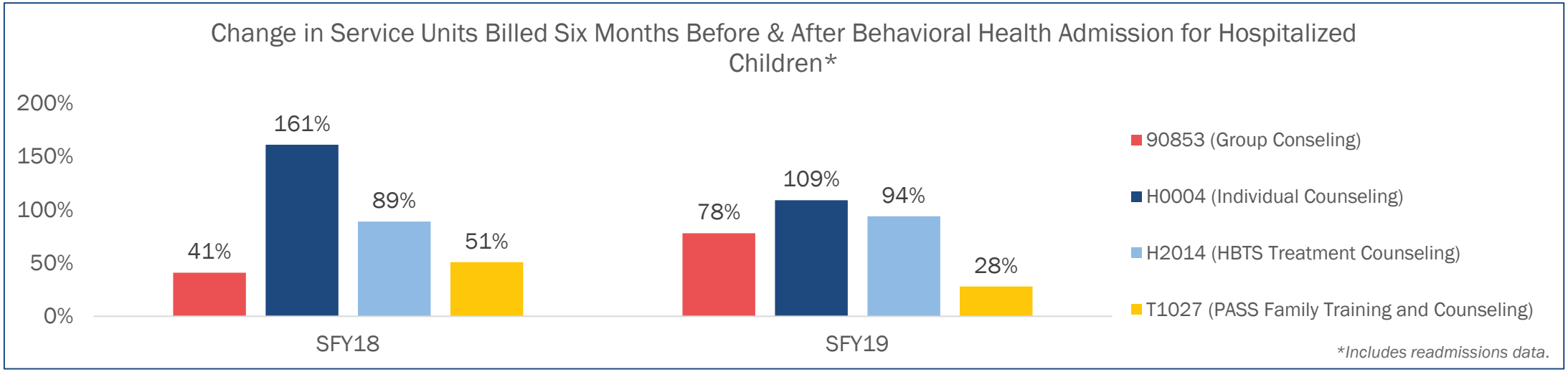
Care and Service Coordination – Current State

Care and service coordination for members is fragmented, inefficient, duplicative and the roles and responsibilities of the MCOs and AEs are ambiguous.

- Responsibilities and expectations of MCOs and AEs are not well defined in the current contract.
- MCOs are contractually required to coordinate care, but AEs are also incentivized to do so but only for their attributed members, resulting in duplication for AE members and care gaps for non-AE members.
- Care coordination for transitions (e.g. hospital to home) are particularly challenging for the MCOs to coordinate and for EOHHS to monitor.
- There is no standardized approach or formal arrangements to support connections to social services and community-based organizations (CBOs).
- Data collection, reporting and monitoring of both the MCOs and AE's is limited to meet the needs of implementing a member-centric approach to care and service coordination across preventative, primary, and acute care.
- AE's have potential, and desire, as evidenced by the RFI responses, to increase the amount of care management activities that occur at the provider level but need significant changes to the current financing and operational policy.

RI Medicaid – Example of Current Challenge

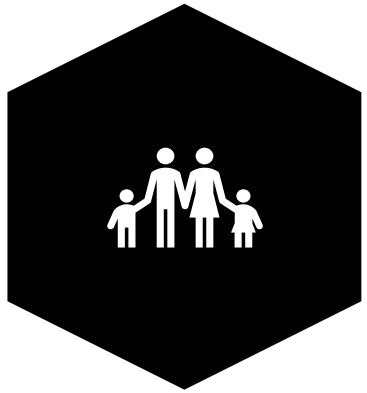
Further engagement with members, families and providers through person-centered planning is lacking and contributes to acute episodes and poor care transitions and readmissions.



- Data suggests beneficiaries are not getting the quantity and frequency of services that they need until an inpatient stay occurs.
- Screening for behavioral health symptoms and intervention to address behavioral health needs could prevent hospitalizations and other acute events from being the entry point into the behavioral health continuum of care, keeping care weighted towards the least restrictive end of the spectrum.

Policy Decisions to Improve Care and Service Coordination

Creating infrastructure that is member-centric and reduces duplication and fragmentation of care and services.



Member and Family Centric Focus

- Care management requirements will be **person-centered and will occur at the provider level according to the members preferences.**
- Care management requirements will focus beyond the traditional medical model and will **incorporate whole-person care principles, including SDOH.**

Reduced Duplication between AE/MCO

- Will set **clear expectations for delegation to AEs** and outline new roles and responsibilities for MCOs and AEs certification.
- Will require MCOs to ensure a **centralized care plan** that includes all care team members, including the member, with required timely updates.
- Will set requirements for **identification of single points of contact** for communication.

Flexible and Supportive Models

- MCO must actively **support AEs to grow their capabilities** by providing technical assistance.
- MCOs and AEs must develop **standardized data sharing protocols.**
- MCOs will be required to **advance alternative payment methodologies (APMs)** to support population-health improvements and provider innovation

Sustainable Funding Support

- As described through contract language**, MCOs will financially support care management delegation** through payments to AEs or other lead coordination entities for care coordination.
- Will **support HSTP investments and AE sustainability** through MCO APM requirements as described in the contract.

Area for Change: Health Equity

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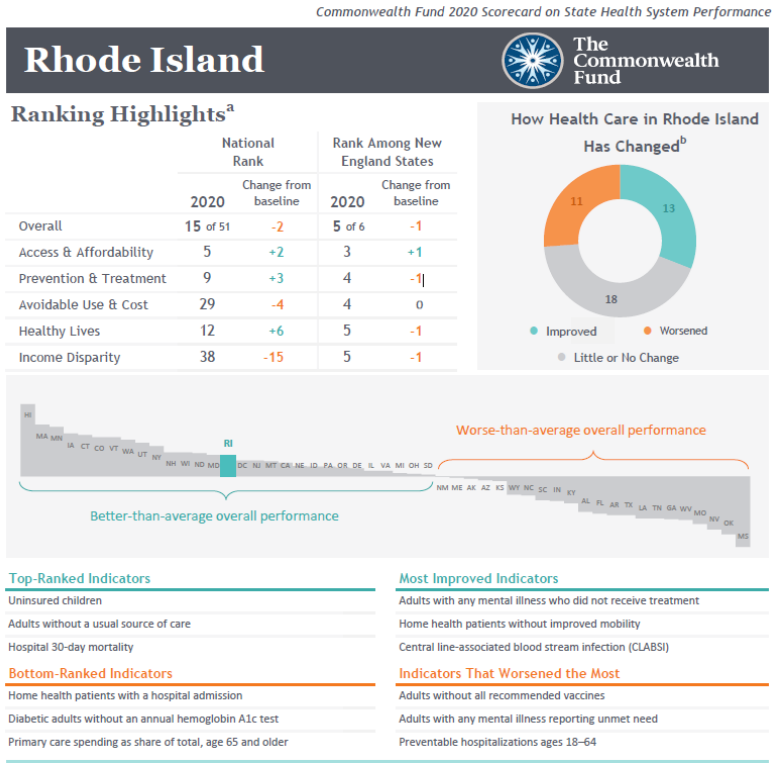
Health Equity– Current State

Health equity is currently not a primary driver for decision-making, thereby impacting health outcomes for the RI Medicaid population.

- MCOs are not currently required to have Multi-Cultural Health Care Distinction from NCQA.
- Aggregate outcomes data currently collected does not include data necessary to show health disparities based on race, ethnicity, and/or language (REL). Imputation of race and ethnicity data suggested.
- REL data collection is lacking from the MCOs. MCOs do not leverage the AE to get additional demographics to enable targeting disparities.
- MCOs are not currently required to develop and submit a health equity plan to EOHHS.
- MCOs and AEs do not have the incentive or flexibility to develop contractual arrangements or relationships that target disparities or other SDOH.

Addressing Health Equity- Example of Current Challenge

While RI's overall performance remains strong, especially on insurance access, there are signs of worsening indicators, particularly regarding race and income disparities that primarily effect the Medicaid population.



Commonwealth Fund 2020 Scorecard on State Health System Performance

Rhode Island — The Commonwealth Fund

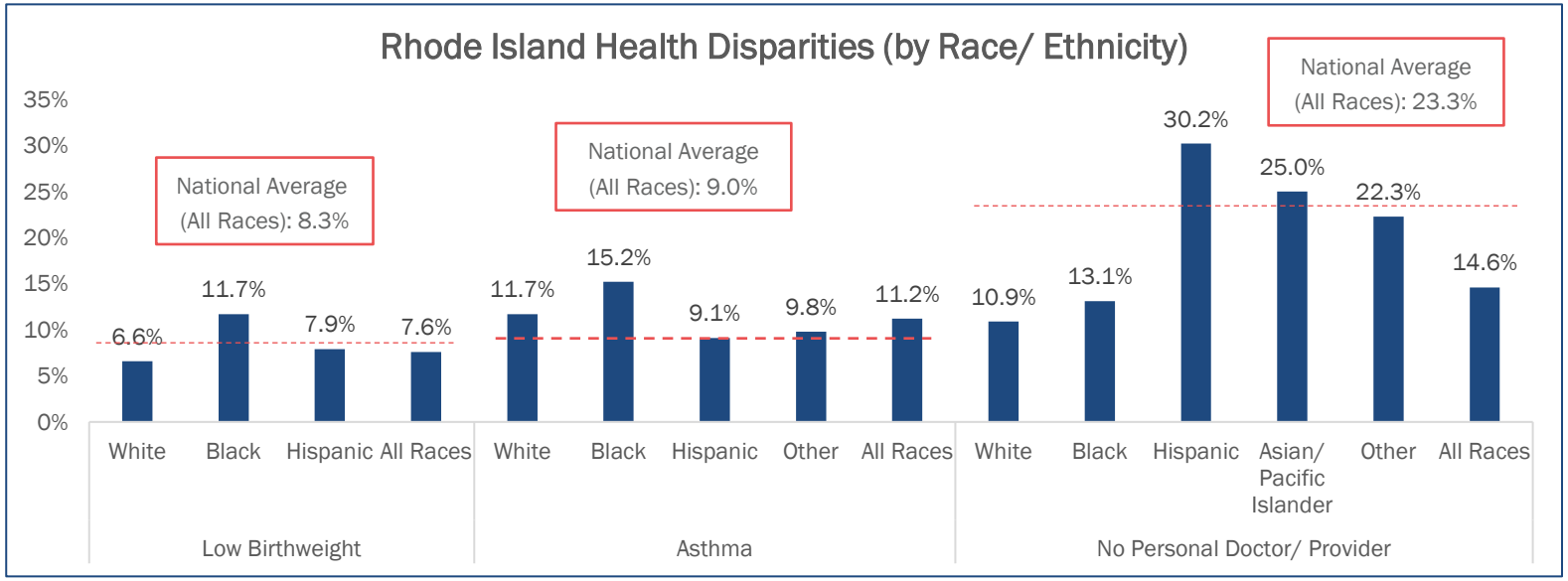
Ranking Highlights[a]

	National Rank		Rank Among New England States	
	2020	Change from baseline	2020	Change from baseline
Overall	15 of 51	-2	5 of 6	-1
Access & Affordability	5	+2	3	+1
Prevention & Treatment	9	+3	4	-1
Avoidable Use & Cost	29	-4	4	0
Healthy Lives	12	+6	5	-1
Income Disparity	38	-15	5	-1

How Health Care in Rhode Island Has Changed[b]

Top-Ranked Indicators	Most Improved Indicators
Uninsured children	Adults with any mental illness who did not receive treatment
Adults without a usual source of care	Home health patients without improved mobility
Hospital 30-day mortality	Central line-associated blood stream infection (CLABSI)
Bottom-Ranked Indicators	**Indicators That Worsened the Most**
Home health patients with a hospital admission	Adults without all recommended vaccines
Diabetic adults without an annual hemoglobin A1c test	Adults with any mental illness reporting unmet need
Primary care spending as share of total, age 65 and older	Preventable hospitalizations ages 18–64

- The Kaiser Family Foundation identifies low birth weight, adults with asthma, and self-reported not having a personal doctor/ health care provider as disparity indicators



2020 Scorecard on State Health System Performance | Commonwealth Fund

2019 Rhode Island: Disparities | Kaiser Family Foundation

Addressing Health Equity- Example of Current Challenge

Focusing REL data on prenatal and postpartum care will enable Rhode Island to direct improvement efforts in maternal and infant health which remains a key priority to advance quality of care and address disparities.

- Adequate **prenatal care decreased 10% in the past year** from 86.6% to 77.9% of live births (America's Health Rankings, 2020)
- **Low birthweight rates were highest in Black** (11.7%) **infants** when compared to Asian (9.3%) Hispanic (7.9%) and White (6.5%) infants (America's Health Rankings, 2020)
- Rhode Island's **Low-Risk Cesarean Delivery rate of 27.8% is higher than the National rate** of 25.9% (America's Health Rankings, 2020)

Addressing Health Equity – Data Collection

Procurement will allow for a phased approach that starts with MCOs capturing REL (race, ethnicity, and language) data and progressing toward specific target reductions in health inequities.

MCOs begin capturing REL data

AEs will report data to MCOs and the **MCOs will be responsible for collecting and reporting the data to EOHHS**

MCOs report to EOHHS

Contractual language **will specify requirements for MCOs to report results overall as well as stratified by AE**

MCOs incentivized to improve care for people of color by establishing target reductions in health inequities

Additional targets to decrease disparities among whites and non-whites (by percent reduction over baseline, without reducing overall rate)

Addressing Health Equity- Quality Data (I/II)

Bailit Health conducted an assessment to inform the selection of measures to stratify by REL (race, ethnicity, and language) data; The below align with the EOHHS quality strategy and these measures will be linked to MCO payment.

Bailit Health	
Measure	**Evidence of Disparities Assessment**
Breast Cancer Screening	• Rhode Island's age-adjusted breast cancer mortality is **48% higher** for African Americans than Whites from 2006-2010 (RIDOH, 2014) • Buying Value identified this to be a **"disparities-sensitive measure"** using NQF's 2017 Disparities Project Final Report (NQF, 2017)
Comprehensive Diabetes Care: Eye Exam Comprehensive Diabetes Care: HbA1c Control <8.0%)	• In Rhode Island, diabetes prevalence is **increasing mostly among Black non-Hispanic adults**. RI adults whose primary language is Spanish are diagnosed with diabetes **2x more often** than those whose first language is English (RIDOH, 2014) • In Rhode Island, diabetes is nearly **2x more common in lower income adults and adults with less education** (RIDOH, 2014) • In Rhode Island, **individuals with disabilities** are disproportionally represented among the diabetic population (roughly 18% of RIs have disabilities, but 42% of adult diabetes have disabilities) (RIDOH, 2014) • Buying Value identified this to be a **"disparities-sensitive measure"** using NQF's 2017 Disparities Project Final Report (NQF, 2017)
Controlling High Blood Pressure	• In Rhode Island, **33.0% of people have high blood pressure**. Rates are highest among multiracial individuals (53.0%), followed by Other (45.6%), Black (35.7%), White (34.3%), Hispanic (26.0%) and Asian (15.2%) (America's Health Rankings, 2020) • High Blood Pressure is **most common among individuals who are low income** (America's Health Rankings, 2020) • Buying Value identified this to be a **"disparities-sensitive measure"** using NQF's 2017 Disparities Project Final Report (NQF, 2017)
Follow-up After Hospitalization for Mental Illness	• People with developmental disability had a mean of 1.74 (SD 1.64) hospitalizations in 2005/06, compared with 1.32 (SD 0.82) hospitalizations for people without developmental disability (Lunsky et al, 2010) • Buying Value identified this to be a **"disparities-sensitive measure"** using NQF's 2017 Disparities Project Final Report (NQF, 2017)

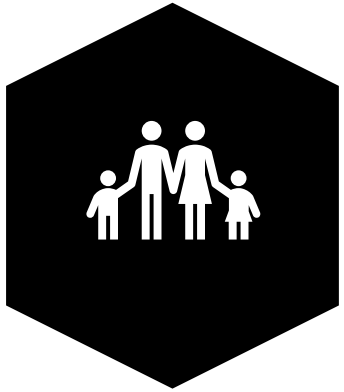
Addressing Health Equity- Quality Data (II/II)

Bailit Health conducted an assessment to inform the selection of measures to stratify by REL (race, ethnicity, and language) data. The measures below MCOs will be required to report on in the contract.

Bailit Health	
Measure	**Evidence of Disparities Assessment**
Developmental Screening in the First Three Years of Life	• Children with severe disabilities are at a **greater risk for receiving less than optimal health care** than children with less debilitating conditions (Sannicandro et al., 2017) • Children with developmental disabilities have the **most profound inequality** in their health care experiences (Prokup et al., 2017)
Screening for Clinical Depression and Follow-Up Plan	• In Rhode Island, **19.6% of adults are depressed.** Rates are highest among multiracial individuals (28.9%), followed by Whites (21.2%), Hispanics (17.1%), Other (14.4%) and Blacks (11.1%). Depression is most common among individuals who are low income (30.4%) and have a lower education level (23.5%) (America's Health Rankings, 2020) • Black and Asian adults were **less likely to be screened for depression** than white adults. Post-screening, Black adults, Latino males, and Asian adults were less likely to receive mental health care than their white counterparts (Hahm et al., 2015)
Social Determinants of Health Screen	• SDOH, by definition, indicate that "conditions in the environments where people are born, live, learn, work, play, worship and age… affect a wide **range of health, functioning and quality-of-life outcomes and risks.**" This can include: safe housing, transportation and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; polluted air and water; language and literacy skills and more (Healthy People 2030)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	• In Rhode Island, **35% of children** are considered overweight or obese. Hispanic children have the highest rates of overweight/obesity (45%), followed by non-Hispanic Black children (37%) (RI Kids Count, 2019). • Among youth aged 2-19 in 2015-2016, the prevalence of **obesity is higher among Black and Hispanic youth** compared to Whites and Asian youth for both girls and boys (CDC: https://www.cdc.gov/nchs/data/databriefs/db288.pdf).

Policy Decisions to Support Health Equity

Health equity must factor into plans' decision making and impacts health and social outcomes for members and creates opportunities for culturally competent care delivery.



Member and Family Specific Strategy

- **Health equity strategies must reflect specific member populations, languages spoken and socio-cultural dynamics.**
- When **MCOs solicits community feedback**, it must **ensure the respondents' demographic profile reflects that of their membership.**

Extensive Equity Lens

- As required by the contract, **MCO staff must include Black, Indigenous, and People of Color (BIPOC)** individuals in leadership positions.
- All staff (MCOs, AEs, Providers) must **complete regular anti-bias workshops as part of mandatory staff training.**
- Racial and cultural diversity is a critical element of network development. AS required by the contract, **MCOs must seek out contracts with BIPOC providers when possible.**

Equity as a Component of Value

- MCOs and AEs must set near and long-term goals to **incorporate health equity into their value-based arrangements.**
- Require MCOs have the flexibility to **prioritize the health equity outcomes** that are most **meaningful to their membership.**

Codifying Health Equity as a Priority

- MCOs must **have NCQA Multi-Cultural Distinction Certification.**
- Require **standardized SDOH tool** for providers and community-based organizations to **focus on state health equity priorities.**

Area for Change: Financing that supports Quality, Access & Budget Predictability

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Quality, Access and Budget Predictability – Current State

Medicaid financing relies on historical data, particularly encounter data, as the primary source for budget forecasting and to develop capitation rates, and risk sharing and reinsurance agreements. Quality payments not present in current contract. Current arrangement backstops MCO losses.

- Current contract lacks protections for the state against risk if an MCO fails to perform.
- Current MCOs are not fully incentivized to produce health outcomes.
- Unlike other states, Rhode Island's MCO contracts do not pay based on quality but only require that they report quality measures and contribute to AE total cost of care (TCOC) performance.
- The presence of a risk corridor likely keeps the MCOs focused on processes rather than outcomes.
- EOHHS can do more to encourage administrative spending so long as it contributes to quality improvement.

Quality and Access Strategy

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Quality Measures – Opportunities for Improvement

Current quality measurement design presents opportunities for improvement in the following areas:

Measure Selection

Large number of measures across many focus areas limits meaningful measurement necessary to drive high quality of care delivered to Medicaid members in areas that are critical gaps in care or costly.

Payment

Current MCO payment arrangement do not pay based on quality and backfill MCO losses regardless of quality outcomes.

Benchmarks

Benchmarks that are often either not being met or the benchmarks are not challenging enough which disincentivizes MCOs from improving quality of care and enables significant portions of the population to miss primary and preventative care benchmarks.

Alignment

Limited alignment between internal departments, across payors, and to state and federal priorities.

Quality Measures – Current State

Requiring too many measures involves large amounts of resources and may be counterproductive if it does not lead to meaningful insights and actionable clinical improvement efforts.

Of these 20 measures we identified:

- 6 benchmarks that are too low for meaningful outcomes
- 4 measures where Neighborhood and UHCP-RI exceeded the National 75th and 90th Percentiles
- Neighborhood did not meet the highest level of performance (90th percentile) in 9 measures
- UHCP-RI did not meet the highest level of performance (90th percentile) in 16 measures
- Recognizing Tufts only recently began reporting and lacks data in some areas, there are 13 measures that did not achieve the National 75th percentile

2019 HEDIS Rates per Aggregate EQR Report (MY18)			
Measure	Neighborhood	UHCP-RI	Tufts
Medication Management for People with Asthma 75% PDC (5-64 Years)	39.9%	46.2%	58.3%
Cervical Cancer Screening	74.2%	66.9%	40.2%
Chlamydia Screening in Women (16-24 Years)	69.8%	65.9%	58.7%
Childhood Immunization Status—Combination 3	78.7%	77.9%	N/A
Childhood Immunization Status—Combination 10	59.9%	59.4%	N/A
Comprehensive Diabetes Care—HbA1c Testing	90.4%	90.5%	89.8%
Follow-Up After Hospitalization for Mental Illness—30 Days	72.8%	73.9%	64.9%
Follow-Up After Hospitalization for Mental Illness—7 Days	54.3%	54.4%	44.8%
Children and Adolescents' Access to PCPs (12-24 Months)	97.9%	92.5%	86.7%
Children and Adolescents' Access to PCPs (25 Months-6 Years)	91.9%	86.8%	70.8%
Children and Adolescents' Access to PCPs (7-11 Years)	95.7%	93.2%	72.1%
Children and Adolescents' Access to PCPs (12-19 Years)	94.2%	89.9%	74.5%
Adults Access to Preventive/Ambulatory Health Services (20-44 Years)	81.4%	78.4%	60.2%
Adults Access to Preventive/Ambulatory Health Services (45-64 Years)	90.0%	87.0%	70.8%
Adults Access to Preventive/Ambulatory Health Services (65+Years)	95.8%	88.4%	N/A
Timeliness of Prenatal Care	96.1%	90.3%	79.7%
Timeliness of Postpartum Care	87.6%	71.5%	70.3%
Well-Child in First 15 mo (6+ Visits)	79.2%	74.2%	N/A
Well-Child in 3rd, 4th, 5th, and 6th Years of Life	79.0%	80.0%	48.1%
Adolescent Well-Care Visits	66.8%	67.4%	34.5%

Legend:
Red = Failed to meet 90th percentile
Blue= Failed to meet 75th percentile

Quality Measure Targets – Current State

Review of current MCO performance demonstrates they currently perform well in most measures against National Benchmarks at the 75th and 90th percentiles. Such benchmarks, however, are often too low and even seemingly high scores leave many Medicaid recipients with critical gaps in care and miss those with greatest health disparities.

Analysis of Current Targets

- The benchmark of 75th or 90th National Percentile only demonstrates how a managed care plan is doing compared with the rest of the nation, as opposed to capturing the entire population and reporting on the percent of RI Medicaid members in compliance with a measure
- The methodology of random sampling with NCQA star ratings often fails to show the "full picture" such that even though it tends to be "directional," it fails to illustrate which members are missing services (MMS)

Example of measures where benchmarks are too low for meaningful outcomes		
Measure	2019 National 75th Percentile	2019 National 90th Percentile
Medication Management for People with Asthma 75% PDC (5-64 Years)	42.81	50
Chlamydia Screening in Women (16-24 Years)	66.29	71.58
Childhood Immunization Status — Combination 10	42.02	49.27
Timeliness of Postpartum Care	69.83	74.36
Well-Child in First 15 mo (6+ Visits)	69.83	73.24
Adolescent Well-Care Visits	62.77	68.14

This means a plan can perform in the 90th percentile even though ~27% of attributed infants are without a doctor's visit.

Quality Measure Targets – Recommended Changes

To facilitate improved quality of care, modifying the target methodology and setting rigorous targets beyond the national percentile benchmarks currently used by NCQA will motivate providers and MCOs to continue improvement.

- Full attributed population measurement instead of random sampling
- AEs measure their fully attributed population and that performance will roll up to the MCOs.
- Require a **percent improvement over baseline** (i.e., must improve by **10% over baseline**)
    - Require the same percent improvement for every measure, with full incentive payment given for maintaining or exceeding 90%
- Require targets to decrease disparities across REL within the measures overtime.
    - Five percent reduction over baseline without reducing overall rate.

Quality Measures – Recommended Changes

Concentrating quality performance and paying for quality improvement in the below key focus areas will move RI toward a more rigorous quality program consistent with 25 other states* and emphasizes populations important to RI and CMS.

- Chronic Disease Management
- Maternal/Infant Health
- Preventive Care for Children
- Preventive Care for Adults
- Behavioral Health

*Study can be found here: https://files.kff.org/attachment/Report-States-Focus-on-Quality-and-Outcomes-Amid-Waiver-Changes-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2018-and-2019

Quality Measures – Recommended Changes

Across the identified focus areas, these measures prioritize performance improvement while maintaining AE alignment where appropriate.

Quality Payment	Reporting Only - done by the MCOs but would not be part of the quality pay for performance program at initial contract implementation
• Asthma Medication Management (75% PDC) • Comprehensive Diabetes Care **Composite** (HbA1c<8.0%*, retinal exam**, medical attention for nephropathy) • Controlling High Blood Pressure** • Prenatal and Postpartum Care **Composite**: Timeliness of Prenatal Care and Postpartum Care • Breast Cancer Screening** • Cervical Cancer Screening • Adolescent Well-care Visits** • Well Child in 3rd, 4th, 5th and 6th year of life** OR combination measure that mirrors AE measure of Child & Adolescent Well-Care Visits (2 components: 3-11 years and total)** • Childhood Immunization Status—Combination 10 • Follow-Up After Hospitalization for Mental Illness— 7 Days**	• Weight Assessment & Counseling for Children and Adolescents – **Composite** Score • Developmental Screening in the First Three Years of Life (Non-HEDIS) • Screening for Clinical Depression and Follow-up Plan (Non-HEDIS) • Tobacco use: Screening and Cessation Intervention (Non-HEDIS) • SDOH Infrastructure Development (Non-HEDIS) • SDOH Screen (Non-HEDIS) • Ambulatory Care: Emergency Department • Inpatient Utilization—General Hospital/Acute Care

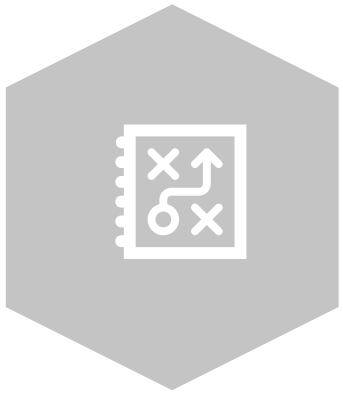
** KFF Study Available Here*
***Dual asterisk indicates alignment to current AE quality measures in PY4*

Changes to Support Quality and Access

Updated financial incentives will encourage MCOs to work toward more favorable outcomes and improve MCO performance.

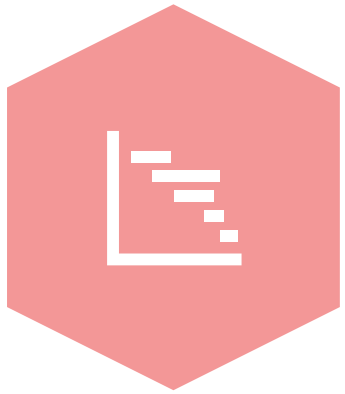
Goal of Paying for Outcomes

- **Quality withholds** focused on **core quality metrics** as defined by EOHHS, including targets to **reduce racial and ethnic disparities** and improve outcomes on key clinical and social health measures.
- Restructuring capitation withhold and other **financial incentives** will shift the MCOs focus from process to improving outcomes **on key clinical and social health measures**.



Deliberate Selection of Meaningful Outcomes and Community Investment

- **Quality incentive program** focused on **core quality metrics** as defined by EOHHS, **including targets to reduce racial and ethnic disparities**.
- Opportunity for MCOs to spend a portion of profits on initiatives to **support local communities.**
- Community reinvestment expenditures permitted to be included as an **adjustment to the minimum MLR**



Support Value Based Payments

- Creates a long-term goal with APM withhold included to incentive MCO adoption.
- MCOs maintain **flexibility** in negotiating arrangements **so requirements do not outpace the current infrastructure.**
- Previous APMs focused on AEs whereas new targets will encourage use of **additional APMs** with wider range of provider types

Role of Administrative Services

- EOHHS can **encourage** administrative spending focused on **activities that contribute to quality improvement**.
- Certain Quality Improvement Activities count toward the Medical Loss Ratio which will **encourage MCO innovation**.
- Actuarially sound rates should include **reasonable administrative loads** based on the requirements of the MCO contract and consideration of funding for delegated care management/ coordination entities.

Budget Predictability Strategy

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Data Collection – Opportunities for Improvement

The current collection and sharing of person-level eligibility and health service administration data between the MCO's, AE's, providers and EOHHS needs improvement.

Generating the Data

The lack of standardized assessments tools, especially in the areas of SDOH and health equity, hampers EOHHS's ability to generate meaningful data.

Unreported Data

Omitting data hinders EOHHS's ability to conduct surveillance and monitoring of the program and target care and service interventions and innovations to where resources are needed most.

Collecting the Data

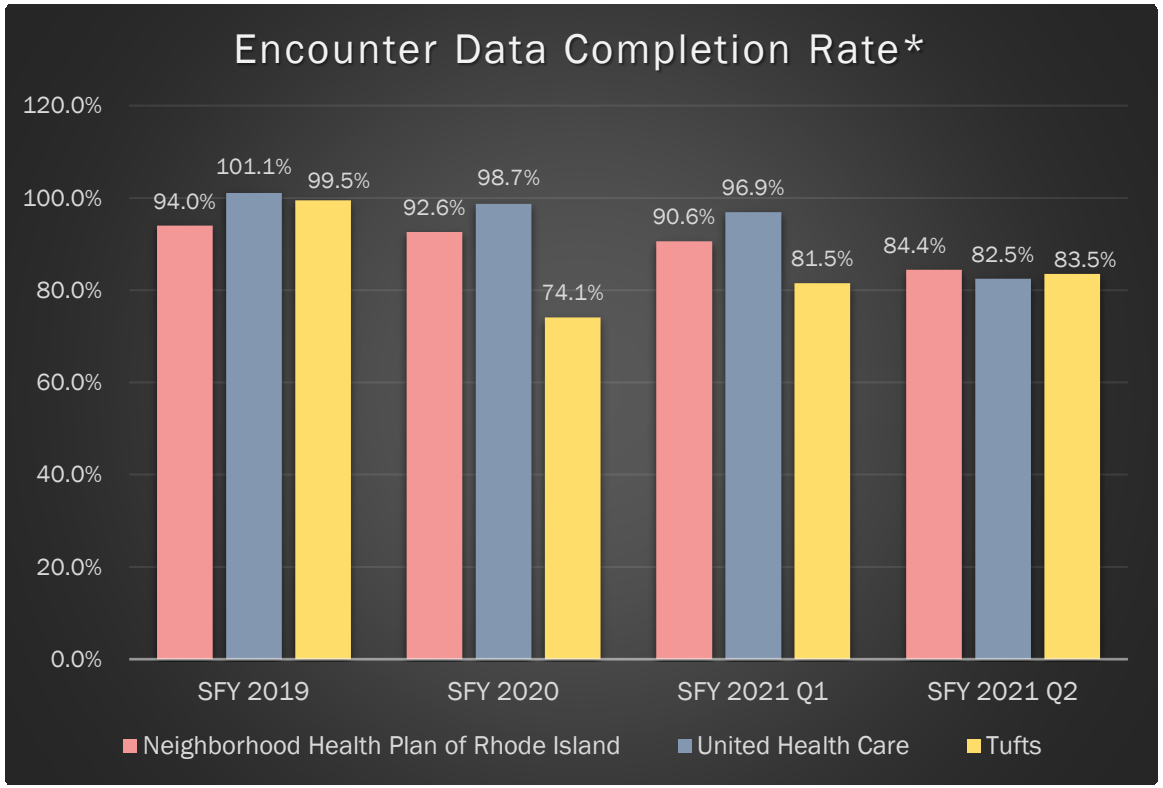
Current data collection efforts result in inaccurate and incomplete data which impedes the effective operation of the Medicaid managed care program. This includes race and ethnicity data.

Interpreting the Data

Unusable data makes it difficult to provide insight into the program, complete required statistical reports and to understand other program-related needs.

Addressing Encounter Data - Example of Current Challenge

Encounter data plays a critical role in RI's managed care plan rate setting process. Without accurate and complete encounter data submissions, it is difficult to accurately set MCO's capitation rates.



*The Encounter data completion rate is a composite percentage, based on the completion percentage of four service categories, inpatient hospital, outpatient hospital, retail pharmacy, and profession

- For SFY 2020 two of the three MCOs fell **five percent below** the encounter completeness threshold of 98 percent
- For SFY 2021 Q2 the average encounter completeness percentage is 83.5 percent among the three plans, **14.5 percent below the required threshold**.
- Incomplete encounter data effects EOHHS ability to comply with federal Transformed Medicaid Statistical Information System (T-MSIS) data submission guidelines.

Budget Predictability – New Risk Mitigation Techniques

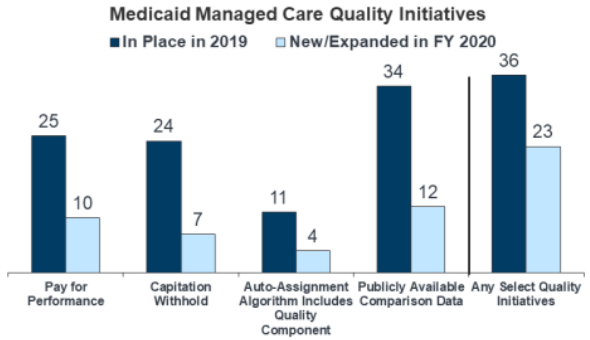
EOHHS will eliminate risk corridors, utilizing other risk mitigation techniques and shifting toward incentivizing and paying MCOs to improve quality and outcomes for members. This is consistent with other mature Medicaid managed care programs and will stop backstopping MCO losses while still protecting taxpayers from MCO excess profits.

Advantages of Eliminating Risk Corridors In Favor of Other Risk Mitigation Techniques

- Further incentivizes the MCOs to control costs and improve quality
- Reduces administrative complexity for EOHHS as cited by Auditor General findings and July 16, 2021 letter,
- Better aligns MCO and accountable entity incentives in shared risk arrangements
- Still permits the targeted use of risk mitigation techniques, including limited risk corridors, where needed (e.g., to address COVID-19 uncertainty)

Figure 11

States are implementing an array of quality initiatives within MCO contracts and linking these initiatives to a variety of performance measure focus areas.



Performance Measure Focus Areas for MCO Incentives	# states
Chronic Disease Management	31
Perinatal/Birth Outcome	26
Mental Health	24
Potentially Preventable Events	22
Substance Use Disorder	19
Value-Based Purchasing	17

NOTES: Medicaid Managed Care Quality initiatives: States with MCOs indicated if selected quality initiatives were in place in FY 2019, new or expanded in FY 2020. Performance Measure Focus Areas: States that employed a pay for performance bonus or penalty, a capitation withhold and/or an auto-assignment quality factor were asked to identify performance measure focus areas linked to these quality incentives.
SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

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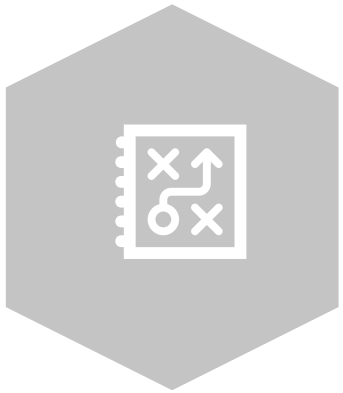
Measuring and incentivizing quality and outcomes have grown in tandem with MCO risk. **More than half of states with MCOs report using capitation withhold arrangements and/or pay for performance incentives.** **Without eliminating risk corridors, we cannot pay for quality.**

Changes to Support Budget Predictability

Focusing on minimum loss ratio (MLR) requirements rather than risk corridors as a financial control strategy to both eliminate reconciliation while protecting the state against overpaying MCOs through a more comprehensive risk mitigation strategy.

Risk Adjustments

- Risk adjustment was implemented in SFY 2020 to **account for variations in the acuity** of the attributed population among the MCOs
- Reallocates capitation revenue based on each MCO's covered population
- Add requirements on data quality, with liquidated damaged for failure to meet standards.



Reinsurance

- Require review of reinsurance contract and amendments which will **protect health plans** from insolvency due to unexpected or high-cost claims
- Set minimum reinsurance specifications for deductibles, maximum coverage, and covered services to **create greater stability** in capitation rates

Rate Amendments

- Process will allow for rate changes when **new information** becomes available
- Rate amendments can occur at any time and allow for **flexibility in timing**, if necessary, based on monitored financial performance
- Will allow for adjustments to account for changes **outside of the health plans' control**

Minimum MLR

- Implement a **Minimum MLR threshold of 86%**
- MLR calculation follows **CMS standard definition** (42 CFR 438.8)
- Ensures that a **minimum percent** of capitation payments are **used to pay for covered Medicaid services**