



Rhode Island Medicaid Managed Care Program (Aggregate Report)

Annual External Quality Review Technical Report Reporting Year 2019

**Prepared on behalf of:
The state of Rhode Island
Executive Office of Health and Human Services**

April 30, 2021



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Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

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I. EXECUTIVE SUMMARY

Introduction

The Centers for Medicare and Medicaid Services (CMS) require that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). In order to comply with these requirements, the State of Rhode Island Executive Office of Health and Human Services (EOHHS) contracted with Island Peer Review Organization (IPRO) to assess and report the impact of its Medicaid program on the quality, timeliness, and accessibility of health services. Specifically, this report provides IPRO's independent evaluation of the services provided by MCOs participating in the Rhode Island Medicaid managed care program.

Rhode Island Medicaid Managed Care Program

Rlte Care, Rhode Island's Medicaid managed care program for children, families, and pregnant women, began enrollment in August 1994. Rlte Care operates as a component of the State's Global Consumer Choice Compact Waiver Section 1115(a) demonstration project, which was approved through December 31, 2019¹.

It is important to note that the provision of health care services to each of the applicable eligibility groups (Core Rlte Care, Rlte Care for Children with Special Health Care Needs (CSHCN), Rlte Care for Children in Substitute Care², Rhody Health Partners (RHP), Rhody Health Options (RHO)³, and Rhody Health Expansion (RHE)) is evaluated in this report. RHP is a managed care option for Medicaid-eligible adults with disabilities, while RHO members include those that are dual-eligible for Medicaid and Medicare. The RHE population includes Medicaid-eligible adults, ages nineteen (19) to sixty-four (64) years, who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible for mandatory coverage under the state plan. As members of the Health Plans, each of these populations were included in all measure calculations, where applicable. For comparative purposes, results for 2016 and 2017 are displayed when available and appropriate. The framework for this assessment is based on the guidelines established by the CMS EQR protocols, as well as state requirements.

Scope of External Quality Review Activities

In addition to the individual, MCO-specific Technical Reports that detail IPRO's independent evaluation of the services provided by each of the three (3) MCOs (Neighborhood Health Plan of Rhode Island, Inc. (Neighborhood), UnitedHealthcare Community Plan of Rhode Island (UHCP-RI), and Tufts Public Health Plan (Tufts)⁴), EOHHS requested that IPRO prepare an aggregate report that evaluates the performance of the State's Medicaid managed care program overall. Specifically, this report provides IPRO's independent evaluation of the combined services provided by the Medicaid MCOs in Rhode Island for reporting year 2019, and compares and contrasts the individual performance of the MCOs.

This EQR technical report focuses on the federally mandated EQR activities and one optional EQR activity that were conducted for reporting year 2019. It should be noted that validation of provider network adequacy,

¹ In December 2018, the renewal request submitted by EOHHS was approved by CMS, resulting in an extension of the State's Global Consumer Choice Compact Waiver Section 1115(a) through December 31, 2023.

² Neighborhood is the only Health Plan that serves the Children in Substitute Care population.

³ Neighborhood is the only Health Plan that serves the Rhody Health Options population.

⁴ Tufts began enrollment in the Medicaid product line in 2017; therefore, data for many of the elements contained in this report were unavailable for Reporting Year 2018.

though currently a standard in *Title 42 Code of Federal Regulations (CFR) Section (§) 438.358 Activities related to external quality review (b)(1)(iv)*, was not part of the *CMS External Quality Review (EQR) PROTOCOLS*⁵ published in October 2019 and therefore not required for the 2019 EQR. As set forth in *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)* EQR activities are:

- (i) **Validation of Performance Improvement Projects (Protocol 1)** – This activity validates that MCO performance improvement projects (PIPs) were designed, conducted and reported in a methodologically sound manner, allowing for real improvements in care and services. (Note: Rhode Island refers to PIPs as Quality Improvement Projects (QIPs) and the term QIP will be used in the remainder of this report.)
- (ii) **Validation of Performance Measures (Protocol 2)** – This activity assesses the accuracy of MCO reported performance measures and determines the extent to which the performance measures follow state specifications and reporting requirements.
- (iii) **Compliance Monitoring (Protocol 3)** – This activity determines MCO compliance with its contract and with state and federal regulations.
- (iv) **Validation of Network Adequacy (Protocol 4)** – This activity assesses MCO adherence to state standards for time and distance for specific provider types, as well as the MCO’s ability to provide timely care. (CMS has not published an official protocol for this activity.)
- (v) **CMS Optional Protocol 6. Administration or Validation of Quality of Care Surveys** – Each MCO contracted with a National Committee for Quality Assurance (NCQA)-certified survey vendor to administer the 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the adult and child Medicaid populations to measure consumer satisfaction.

CMS defines validation in Title 42 CFR § 438.320 Definitions as “the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.”

While the *CMS External Quality Review (EQR) PROTOCOLS* published in October 2019 stated that an Information Systems Capabilities Assessment (ISCA) is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the NCQA Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit™ may be substituted for an ISCA. Findings from IPRO’s review of the MCO’s HEDIS Final Audit Reports (FARs) are in the **Validation of Performance Measures** section of this report.

High-level summaries of validation results for these EQR activities and performance outcomes related to **quality**, **timeliness** and **access** are in the **Findings** section that immediately follows.

Findings

Validation of Quality Improvement Projects

IPRO’s validation of the MCOs 2019 QIPs confirmed the State’s compliance with the standards of *Title 42 CFR § 438.330(a)(1)*. The results of the validation activity determined that the MCOs were generally compliant with the standards of *Title 42 CFR § 438.330(d)(2)*. QIP summaries and detailed validation results are in **Section IV** of this report.

⁵ [Medicaid.Gov Website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf](https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf)

Between 2018 and 2019, each MCO conducted in two (2) to six (6) QIPs. The contractually mandated QIPs comprised multi-faceted intervention strategies that targeted providers and member populations, as well as system-level changes to the MCOs' processes. Results of the 2018-2019 quality improvement activities were mixed across projects and the MCOs; some performance measures demonstrated improvement, while others demonstrated declines in performance. The MCOs presented the results of the two (2) to six (6) QIPs to EOHHHS in December 2019. Summaries of the QIPs can be found in the **Performance Measure Validation** section in the MCO-level EQR technical reports.

Validation of Performance Measures

IPRO's validation of the MCOs' performance measures confirmed the State's compliance with the standards of *Title 42 CFR § 438.330(a)(1)*. The results of the validation activity determined that the each MCO was compliant with the standards of *Title 42 CFR § 438.330(c)(2)*.

Information Systems Capabilities Assessment

The 2020 HEDIS FARs for measurement year (MY) 2019 produced by the MCOs' HEDIS Compliance Auditors indicated that the all MCOs met all IS requirement to successfully report HEDIS data to EOHHHS and to NCQA.

HEDIS

The assessment of MCO performance on HEDIS® 2019 is based on comparisons to the *Quality Compass*® 2019 national Medicaid benchmarks and percentiles. Statewide rates were calculated by totaling the numerators and denominators for Neighborhood and UHCP-RI, as Tufts was unable to report sufficient data for HEDIS® 2018.

For the HEDIS® *Effectiveness of Care* domain, which assesses preventive care and care for chronic conditions, all Health Plans performed similarly across the measures. All Health Plans achieved the 2019 *Quality Compass*® Medicaid Mean for the following measures: *Follow-Up after Hospitalization for Mental Illness—30 Days*, *Follow-Up After Hospitalization for Mental Illness—7 Days*, and *Childhood Immunization Status—Combination 10*, *Childhood Immunization Status—Combination 3*, *Chlamydia Screening (16-24 Years)*, *Medication Management for People with Asthma 75% (5-64 Years)*. UHC and Neighborhood achieved the 90th percentile benchmark for the following measures: *Childhood Immunization - Combo 10*, *Follow-Up After Hospitalization for Mental Illness—30 Days* and *Follow-Up After Hospitalization for Mental Illness—7 Days*. Neighborhood also achieved the 90th percentile benchmark for the *Childhood Immunization Status—Combination 3* measure and the *Cervical Cancer Screening* measures. Tufts achieved the 90th percentile benchmark for the *Medication Management for People with Asthma 75% (5-64 Years) measure*.

The HEDIS® *Access and Availability* domain evaluates the proportions of members who access PCPs, ambulatory services, and preventive care, as well as timely perinatal care. All three plans achieved the 2019 *Quality Compass*® Mean benchmark for the *Timeliness of Postpartum Care* measure. Neighborhood achieved the 75th Medicaid mean for all *Child Access to PCPs* age ranges, all *Adults Access to Ambulatory/ Preventative Care* measures and the *Timeliness of Prenatal Care* measure.

For the HEDIS® *Use of Services* domain, rates for Neighborhood and UHC exceeded the 2019 *Quality Compass*® national Medicaid mean. Additionally, both plans benchmarked at the *Quality Compass*® 90th percentile for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure, while both plans benchmarked in the 75th percentile for the *Adolescent Well-Care Visits* measure and the *Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life* measure.

Performance Goal Program

For the 2019 Performance Goal Program, there was one (1) state-specified measure and nineteen (19) HEDIS® measures, resulting in a total of twenty (20) PGP measures. Regarding the state-specified measure, Neighborhood exceeded the Contract goal qualifying for a partial incentive award for the one (1) measure. UHCP-RI also exceeded the Contract goals qualifying for partial incentive awards this state-specified measure.

Of the nineteen (19) HEDIS® measures included in the 2019 Performance Goal Program, UHCP-RI met the *Quality Compass*® benchmark for an incentive award for twelve (12) out of nineteen (19) measures, with three (3) benchmarking at the 90th percentile and nine (9) benchmarking at the 75th percentile. For the State-specified measure, UHCP-RI exceeded the contract goal and qualified for a partial incentive award for the measure. Neighborhood met a *Quality Compass*® benchmark to qualify for an incentive award for fifteen (15) measures, with eleven (11) benchmarking in the 90th percentile (full incentive award) and four (4) benchmarking in the 75th percentile (partial incentive award).

Review of Compliance with Medicaid and CHIP Managed Care Regulations

I PRO's review of the results of most current accreditation review confirmed the State's compliance with evaluating MCO adherence to the standards in *Title 42 CFR Part 438 Subpart D* and *Title 42 CFR § 438.330*. All MCOs were compliant with these standards.

The three (3) MCOs were compliant with the standards of *Title 42 CFR Part 438 Subpart D* and *Title 42 CFR § 438.330*.

Validation of Network Adequacy

I PRO's evaluation of each MCO's network evaluation reports confirmed the State's compliance with the requirements of *Title 42 CFR § 438.68 Network adequacy standard (a) and (b)*.

In the absence of a CMS protocol for *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(iv)*, I PRO assessed MCO compliance with the State's time and distance standards.

GeoAccess software was used to evaluate the adequacy of the Health Plans' provider networks. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed. Each Health Plan developed access criteria that complies with the state's July 2019 *Medicaid Managed Care Services Contract* based on Health Plan-specific criteria. Neighborhood, UHCP-RI and Tufts exceeded their respective access standards for all provider types reported.

Administration or Validation of Quality of Care Surveys

I PRO's review of the CAHPS report produced the MCOs' certified CAHPS vendor, confirmed that the surveys was conducted in alignment with CMS EQR *Protocol 6. Administration or Validation of Quality of Care Studies*.

Performance on the adult CAHPS® survey varied across measures and Health Plans. Rates for five (5) of the nine (9) reported measures were above the *Quality Compass 2019* national Medicaid mean for both UHCP-RI and Neighborhood. For the adult CAHPS survey, Neighborhood reported one (1) measure that achieved the *Quality Compass 2019* national Medicaid 90th percentile and five (5) measures that benchmarked in the 75th percentile. Two measures ranked below the 75th percentile. For UHCP-RI, all nine (9) of the adult CAHPS measures reported exceeded the *Quality Compass 2019* national Medicaid mean. Additionally, five (5) measures achieved the *Quality Compass 2019* national Medicaid 90th percentile and three (3) benchmarked at or above the 2019 national Medicaid 75th percentile. One measure ranked below the 2019 national Medicaid 75th percentile for 2019.

In 2019, Neighborhood conducted the child CAHPS® survey for the Chronic Conditions population while UHCP-RI conducted the survey for the General population. Rates for four (4) of the eight (8) reported measures were above the *Quality Compass 2019* national Medicaid mean for both UHCP-RI and Neighborhood. Regarding Neighborhood's child CAHPS® survey results, there were six (6) reported rates. The Health Plan reported four (4) measures in each of the *Quality Compass 2019* national Medicaid 90th percentile bands and two in the *Quality Compass 2019* national Medicaid 75th percentile bands. UHCP-RI's rates for all eight (8) Child CAHPS measures were reported as meeting the *Quality Compass 2019* national Medicaid mean. Overall, six (6) measures achieved the *Quality Compass 2019* national Medicaid 90th percentile. Two measures ranked below the 75th percentile.

Conclusion

I PRO's external quality review concludes that the Rhode Island Medicaid managed care program and its participating MCOs have had an overall positive impact on the accessibility, timeliness, and quality of services for Medicaid recipients. This is supported by Neighborhood and UHCP-RI receiving "Excellent" accreditation statuses from the NCQA for 2019, as well as the Health Plans' four and a half (4.5) out of five (5) ratings. Overall strengths continue to be women's health and perinatal care, childhood immunizations, diabetes care, and follow-up care for members post-discharge from psychiatric care.

Recommendations

Recommendations to the Rhode Island Executive Office of Health & Human Services

Per Title 42 CFR § 438.364 External quality review results (a)(4), this report is required to include a description of how EOHHS can target the goals and the objectives outlined in its quality strategy to better support improvement in the quality of, timeliness of, and access to health care services furnished to Rhode Island Medicaid managed care enrollees.

The EOHHS quality strategy aligns with CMS's requirements and provides a framework for MCOs to follow while aiming to achieve improvements in the quality of, timeliness of and access to care. In addition to conducting the required EQR activities, EOHHS's quality strategy includes state- and MCO-level activities that expand upon the tracking, monitoring and reporting of performance as it relates to the Medicaid service delivery system.

I PRO recommends the following to EOHHS:

- EOHHS should establish appointment availability thresholds for Medicaid Managed Care program to hold the MCOs accountable for increasing the number of timely appointments available to members.
- Identify opportunities to support the expansion of telehealth capabilities and member access to telehealth services across the state.

Recommendations to the MCOs

Recommendations provided in this report apply to Neighborhood, Tufts and UHCP-RI, and as such, may be opportunities for improvement that EOHHS may wish to address. More specific data and recommendations are provided for each MCO in its individual EQR Technical Report.

To improve the provision of care and services to members, overall recommendations made apply to the following areas:

Quality of Care:

- NCQA Accreditation Survey:

- *Getting Better*
- Member Satisfaction:
 - Child CAHPS® *Rating of Personal Doctor*
 - Children with Chronic Conditions CAHPS® *Getting Care Quickly*
 - Children with Chronic Conditions CAHPS® *Getting Needed Care*
 - Children with Chronic Conditions CAHPS® *Rating of All Health Care*
- HEDIS® Effectiveness of Care domain:
 - HEDIS® *Medication Management for People with Asthma 75% (5-64 Years)*
- Performance Goal Program Results:
 - HEDIS® *Lead Screening in Children*
 - HEDIS® *Breast Cancer Screening*
 - HEDIS® *Follow-Up After Hospitalization for Mental Illness—7 Days*
 - HEDIS® *Antidepressant Medication Management—Effective Acute Phase Treatment*
 - HEDIS® *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

Accessibility and Timeliness of Care:

- Access and Availability Survey results:
 - Routine appointment availability
 - Urgent appointment availability
- HEDIS® Access and Availability domain:
 - HEDIS® *Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)*
 - HEDIS® *Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)*
 - HEDIS® *Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)*
 - HEDIS® *Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)*
 - HEDIS® *Adults' Access to Preventive/Ambulatory Health Services (65+ Years)*
- Performance Goal Program Results:
 - HEDIS® *Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)*
 - HEDIS® *Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)*
 - HEDIS® *Initiation of Alcohol and Other Drug Dependence Treatment*

I. Background

Purpose of This Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with an MCO provide for an annual external, independent review of the quality outcomes, timeliness of and access to the services included in the contract between the state agency and the MCO. *Title 42 Code of Federal Regulations (CFR) Section (S) 438.350 External quality review (a) through (f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCOs. States are required to contract with an EQRO to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities and that the information provided to the EQRO be obtained through methods consistent with the protocols established by CMS. Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as “the degree to which an MCO, PIHP⁶, PAHP⁷, or PCCM⁸ entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that is consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement.”

Title 42 CFR § 438.364 External review results (a) through (d) requires that the annual EQR be summarized in a detailed technical report that aggregates, analyzes and evaluates information on the quality, timeliness and access to health care services that MCOs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCOs regarding health care quality, timeliness and access, as well as make recommendations for improvement.

To comply with *Title 42 CFR § 438.364 External review results (a) through (d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, EOHHS contracted with IPRO to assess and report the impact of its Medicaid managed care program and each of the participating MCO on the accessibility, timeliness, and quality of services. Specifically, this report provides IPRO’s independent evaluation of the services provided by UHCP-RI in 2019. For comparative purposes, results for 2017 and 2018 are also displayed when available and appropriate. The framework for IPRO’s assessment is based on the guidelines and protocols established by CMS, as well as State requirements.

Rhode Island Executive Office of Health and Human Services

2019 State Medicaid Quality Strategy

For over 25 years, Rhode Island has utilized managed care as a strategy for improving access, service integration, quality and outcomes for Medicaid beneficiaries while effectively managing costs. To achieve its goals for improving the quality and cost-effectiveness of Medicaid services for beneficiaries, the contracted Managed Care Entities (MCEs) program have the following responsibilities:

- Ensuring a robust network beyond safety-net providers and inclusive of specialty providers,
- increasing appropriate preventive care and services, and
- assuring access to care and services consistent with the state Medicaid managed care contract standards, including for children with special health care needs.

⁶ Prepaid Inpatient Health Plan

⁷ Prepaid Ambulatory Health Plan

⁸ Primary Care Case Management

Guiding Principles, Goals and Objectives

Rhode Island's Medicaid managed care program is dedicated to improving the health outcomes of the State's diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well-being, independence and quality of life. A working group was established to present innovative recommendations to modernize the State's Medicaid program and increase efficiency. The four guiding principles established by the Working Group are:

- pay for value, not volume,
- coordinate physical, behavioral, and long-term health care,
- rebalance the delivery system away from high-cost settings, and
- promote efficiency, transparency and flexibility.

RI Medicaid also developed the Accountable Entity (AE) program as a core part of its managed care quality strategy which are Rhode Island's version of an accountable care organization. AEs represent interdisciplinary partnership among providers in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services. The AE initiative focuses on achieving the following goals⁹:

1. Transition Medicaid from fee for service to value-based purchasing at the provider level
2. Focus on Total Cost of Care (TCOC)
3. Create population-based accountability for an attributed population
4. Build interdisciplinary care capacity that extends beyond traditional health care providers
5. Deploy new forms of organization to create shared incentives across a common enterprise, and
6. Apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs.

Improvement and Interventions

Rhode Island's ongoing and expanded interventions for Medicaid managed care quality and performance improvement include:

- **Ongoing requirements for MCEs to be nationally accredited:** RI Medicaid MCOs will continue to be required to obtain and maintain NCQA accreditation and to promptly share its accreditation review results and notify the State of any changes in its accreditation status.
- **Tracking participation in APMs related to value-based purchasing (pay for value not volume)**
Medicaid MCOs will be required to submit reports on a quarterly basis that demonstrate their performance in moving towards value-based payment models, including:
 - Alternate Payment Methodology (APM) Data Report
 - Value Based Payment Report and
 - Accountable Entity-specific reports.
 - **Pay for Performance Incentives for MCEs and AEs:** RI Medicaid intends create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.

⁹ RI Medicaid Accountable Entity Roadmap
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Acc_Entitites/AERoadmap041117v6.pdf

- **Statewide collaboratives and workgroups that focus on quality of care:** RI Medicaid works with MCEs and the EQRO to collect, analyze, compare and share quality and other performance data across plans and programs to support ongoing accountability and performance improvement.
- **Soliciting member feedback through a variety of forums and mechanisms:** empowering members in their care: RI Medicaid will require, compare, and share member experience data to support ongoing managed care accountability and performance improvement

Refer to **Appendix 1** of this report for the full Rhode Island State Medicaid Quality Strategy.

Rhode Island Medicaid Managed Care Program

The State’s initial Medicaid and CHIP managed care program, Rite Care, began in 1994. The Rite Care program covered children, families, and pregnant women, and began enrollment in August 1994 as a Section 1115 demonstration. Since 1994, the Rhode Island has expanded the Medicaid managed care program. **Table 1** displays the timeline for Rhode Island’s Managed Care Program additions.

Table 1: Rhode Island Medicaid Managed Care Program Additions

Year	Managed Care Program Additions
1994	Rite Care, SCHIP
2000	Children in Substitute Care, Rite Share
2003	Children with Special Needs, Rite Smiles
2008	Rhody Health Partners
2014	Medicaid Expansion , Behavioral Health carved in to managed care
2015	Accountable Entities Pilot
2016	Medicare-Medicaid Plan (MMP)
2018	MCO-Certified Accountable Entities APMs

Rite Care operates as a component of the State’s Global Consumer Choice Compact Waiver Section 1115(a) demonstration project, which was approved through December 31, 2019¹⁰. As is typical for Section 1115 waivers, CMS defined “Special Terms and Conditions” (STCs) for the demonstration. The STCs addressing quality assurance and improvement were as follows:

RI Medicaid contracts with three (3) MCOs: Neighborhood Health Plan of Rhode Island (Neighborhood); United Healthcare Community Plan of Rhode Island (UHC-RI), and Tufts Health Public Plan (Tufts); and one (1) managed dental health plan: United Healthcare Dental (UHC-Dental).

Contracted MCOs enroll members into the following lines of business: Rite Care Core (children and families); Rite Care Substitute Care (children in substitute care); Rite Care CSHCN (children with special healthcare needs); Rhody Health Expansion (low income adults without children); Rhody Health Partners (aged, blind, disabled adults). The contracted dental plan enrolls members into the Rite Smiles program.

Refer to **Appendix 4** of this report for a description of the State’s approach to quality and evaluation for the Rite Care and Rhody Health programs.

¹⁰ In December 2018, the renewal request submitted by EOHS was approved by CMS, resulting in an extension of the State’s Global Consumer Choice Compact Waiver Section 1115(a) through December 31, 2023.

II. MCO Information

The three (3) MCOs varied in the proportion of the statewide Medicaid population served. According to Medicaid enrollment data for the period ending on December 31, 2019, thirty percent (63%) of the overall Medicaid population was enrolled in Neighborhood, a total of 160,572 members. UHCP-RI's Medicaid enrollment accounted for approximately thirty-three percent (33%) of total Medicaid membership, with 83,515 members, while 8,973 members were enrolled in Tufts counting for approximately four percent (4%) of total Medicaid membership, with a total of 253,060 members (refer to Table 4a on page 14).

Corporate Profiles

The Rhode Island Medicaid managed care program was comprised of three (3) MCOs in 2019:

Neighborhood Health Plan of Rhode Island, Inc. (Neighborhood) is a local, not-for-profit health maintenance organization (HMO) that served Commercial and Medicaid populations. For Medicaid, Neighborhood served the following eligibility groups: Core Rite Care, Rite Care for Children with Special Health Care Needs, Rite Care for Children in Substitute Care, Rhody Health Partners, Rhody Health Options, and Rhody Health Expansion.

UnitedHealthcare Community Plan of Rhode Island (UHCP-RI) is a for-profit Health Plan that served Commercial, Medicare, and Medicaid populations. For Medicaid, UHCP-RI served the following eligibility groups: Core Rite Care, Rite Care for Children with Special Health Care Needs, Rhody Health Partners, and Rhody Health Expansion.

Tufts Public Health Plan (Tufts) is a not-for-profit HMO that served the Medicaid populations. Tufts served the following eligibility groups: Core Rite Care, Rite Care for Children with Special Health Care Needs, Rhody Health Partners, and Rhody Health Expansion.

Table 2 presents detailed information for each of the three (3) Health Plans.

Table 2: 2019 MCO Corporate Profiles

	Neighborhood	UHCP-RI	Tufts
Type of Organization	HMO	HMO	HMO
Tax Status	Not-for-profit	For-profit	Not-for-profit
Model Type	Network	Mixed	Network
Year Operational	1994	1979	1979
Year Operational (Medicaid)	1994	1994	2017
Product Line(s)	Medicaid	Commercial, Medicare, Medicaid	Private (Commercial)
Total Medicaid Enrollment	160,572	83,515	8,973
NCQA Accreditation Status	Yes	Yes	Yes
NCQA Medicaid Health Plan Rating	4.5	4.5	5.0

N/A: Not available

¹ Tufts did not report sufficient data to be eligible for NCQA Accreditation or a Health Plan rating in 2018.

Enrollment

Table 3 presents MCO Medicaid enrollment, as well as the percentage of the statewide Medicaid managed care population enrolled in each MCO. Neighborhood's Medicaid managed care membership comprised the majority

of statewide enrollment in 2019 (63%), with UHCP-RI's membership accounting for thirty-three percent (33%), and Tuft's enrollment accounting for four percent (4%).

Table 3: Statewide Medicaid Managed Care Enrollment by Health Plan—2019

MCO	Medicaid Managed Care Enrollment	% of Statewide Total
Neighborhood	160,572	63%
UHCP-RI	83,515	33%
Tufts	8,973	4%
Statewide Total	253,060	100%

Table 4 provides additional detail: enrollment by Medicaid eligibility group for the three (3) MCOs. Core Rite Care members comprised the majority of enrollment for all three plans.

Table 4: Medicaid Enrollment by Eligibility Group—December 31, 2019

Eligibility Group	Neighborhood		UHCP-RI		Tufts		Statewide	
	n	%	N	%	N	%	n	%
Core Rite Care	93,611	58%	47,975	57%	4,520	50%	146,106	58%
Children with Special Health Care Needs (CSHCN) ¹	5,119	3%	1,845	2%	69	1%	7,033	3%
Children in Substitute Care ²	2,616	2%					2,616	1%
Extended Family Planning (EFP) ³	1,265	1%	417	0%	53	1%	1,735	1%
Rhody Health Partners (RHP) ⁴	7,446	5%	6,536	8%	566	6%	14,548	6%
Rhody Health Options (RHO) ⁵	13,875	9%					13,875	5%
Rhody Health Expansion (RHE) ⁶	36,640	23%	26,742	32%	3,765	42%	67,147	27%
Total Medicaid Enrollment	160,572	100%	83,515	100%	8,973	100%	253,060	100%

¹ Children with Special Health Care Needs (CSHCN) were enrolled in Rite Care on a voluntary basis, effective 01/29/2003, because only one Health Plan was willing to enroll this population. As of 10/01/2008, managed care enrollment became mandatory for all Rite Care-eligible CSHCN who do not have another primary health insurance coverage. All of the state's current Medicaid-participating Health Plans serve CSHCN.

² Children in Substitute Care are enrolled on a voluntary basis. Neighborhood is the only Health Plan that serves this population.

³ The EFP population includes women who lose Medicaid coverage at 60 days postpartum who do not have access to creditable health insurance.

⁴ Appendix 1 of this report describes the eligibility criteria for Rhody Health Partners.

⁵ Rhody Health Options serves individuals who are dual-eligible for Medicaid and Medicare. Neighborhood is the only Health Plan that serves this population.

⁶ Rhody Health Expansion serves Medicaid-eligible adults ages 19-64 who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible or enrolled for mandatory coverage.

MCO Quality Improvement Programs

The overall strengths of the MCOs' Quality Improvement Programs include the involvement of a variety of staff and departments, resources, and committees across all levels of the organizations. Full descriptions of each Health Plan's Quality Improvement Program can be found in Section XI of the Health Plan-specific Annual EQR Technical Reports. In addition, the Quality Improvement Activity (QIA) Form template is included in Appendix 2 of the Health Plan-specific reports, as well as **Appendix 2** of this Aggregate EQR Technical Report.

NCQA Health Plan Accreditation and Plan Ratings

NCQA's Health Plan Accreditation program is considered the industry's gold standard for assuring and improving quality care and patient experience. It reflects a commitment to quality that yields tangible, bottom-line value. It also ensures essential consumer protections, including fair marketing, sound coverage decisions, access to care, and timely appeals. The accreditation process is a rigorous, comprehensive, and transparent evaluation process through which the quality of key systems and processes that define a health plan are assessed. Additionally, accreditation includes an evaluation of the actual results the health plan achieved on key dimensions of care, service, and efficacy. Specifically, NCQA reviews the health plan's quality management and improvement, utilization management, provider credentialing and re-credentialing, members' rights and responsibilities, standards for member connections, and HEDIS and CAHPS performance measures.

Although the on-site Accreditation Survey occurs once every three (3) years, star ratings are re-calculated annually by NCQA based on the most recent Accreditation Survey findings and the latest HEDIS and CAHPS results. The star rating performance levels are described in **Table 5**.

Table 5: NCQA Accreditation Survey Levels

Number of Stars	Accreditation Levels	Accreditation Requirement
★★★★	Excellent	Organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS results are in the highest range of national performance.
★★★	Commendable	Organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.
★★	Accredited	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take further action to achieve a higher accreditation status.
★	Provisional	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take significant action to achieve a higher accreditation status.
No stars	Denied	Organizations whose programs for service and clinical quality did not meet NCQA requirements during the Accreditation Survey.

Health plans are scored along the following five (5) dimensions using these star ratings (1-lowest; 4-highest)¹¹:

¹¹ www.ncqa.org

- **Access and Service:** An evaluation of Health Plan members’ access to needed care and good customer service. Are there enough primary care doctors and specialists to serve all plan members? Do members report problems getting needed care? How well does the Health Plan follow up on grievances?
- **Qualified Providers:** An evaluation of Health Plan efforts to ensure that each doctor is licensed and trained to practice medicine, and that Health Plan members are happy with their doctors. Does the Health Plan check whether physicians have had sanctions or lawsuits against them? How do members rate their personal doctor?
- **Staying Healthy:** An evaluation of Health Plan activities that help people maintain good health and avoid illness. Does the Health Plan give its doctors guidelines about how to provide appropriate preventive health services? Do members receive appropriate tests and screenings?
- **Getting Better:** An evaluation of Health Plan activities that help people recover from illness. How does the Health Plan evaluate new medical procedures, drugs, and devices to ensure that patients have access to the most up-to-date care? Do doctors in the Health Plan advise patients to quit smoking?
- **Living with Illness:** An evaluation of Health Plan activities that help people manage chronic illness. Does the Health Plan have programs in place to help patients manage chronic conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?

Table 6 presents the NCQA Accreditation findings for Neighborhood and UHCP-RI. Again, Tufts was not eligible for NCQA Accreditation for reporting year 2019.

Table 6: Accreditation Survey Findings—2019

Product Line	Access and Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Accreditation Outcome
Neighborhood	★★★★	★★★★	★★★★	★★	★★★	Excellent
UHCP-RI	★★★★	★★★★	★★★	★★	★★	Excellent

Table 7 presents the MCOs’ overall ratings, along with their performance in each of the three (3) categories. Tufts was unable to report sufficient data to be eligible for a Health Plan rating for Reporting Year 2019.

Table 7: NCQA Ratings by Category—2019

Product Line	Consumer Satisfaction	Prevention	Treatment	2019 Overall Rating
Neighborhood	3.5	4.5	4.0	4.5
UHCP-RI	3.5	4.5	4.0	4.5
Tufts ¹	4.0	4.5	4.5	5.0

¹Tufts was unable to report sufficient data to be eligible for a Health Plan rating for Reporting Year 2019

III. EQRO Evaluation Methodology

In order to assess the impact of the MCOs participation in the Medicaid managed care program on **access**, **timeliness**, and **quality**, IPRO reviewed pertinent information from a variety of sources, including State managed care standards, Health Plan contract requirements, Accreditation Survey findings, member satisfaction surveys, performance measures, and State monitoring reports.

Within each EQR activity section of this report activity, summaries of the objectives, technical methods of data collection, description of data obtained, data aggregation and analysis, and Findings are presented.

Section IV, **Section V**, and **Section VI** discuss UHCP-RI's results, or findings, from the required EQR activities (validation of QIPs, validation of performance measures, and review of compliance with Medicaid standards) and one optional EQR activity; while Section VII discuss UHCP-RI's strengths and recommendations related to the **quality** of, **timeliness** of and **access** to care. These three elements are defined as:

- A. **Quality** is the extent to which an MCO increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through health care services provided, which are consistent with current professional knowledge.
- B. **Access** is the timely use of personal health services to achieve the best possible health outcomes.¹²
- C. **Timeliness** is the extent to which care and services, are provided within the periods required by the Minnesota model contract with MCOs, federal regulations, and as recommended by professional organizations and other evidence-based guidelines.

¹²Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to health care in America. Washington, DC: National Academy Press; 1993. <https://www.ncbi.nlm.nih.gov/books/NBK235882/>

IV. Validation of Performance Improvement Projects

This subpart of the report presents the results of the evaluation of the QIPs that were in progress in 2019.

Objectives

Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(i) mandates that the state or an EQRO must validate the PIPs that were underway during the preceding twelve (12) months. IPRO performed this activity for the 2019 QIPs. The QIP validation was conducted using an evaluation approach developed by IPRO and consistent with the CMS EQR *Protocol 1. Validation of Performance Improvement Projects*.

MCOs were required to conduct at least four (4) QIPs directed at the needs of the Medicaid-enrolled population, as well as the MCO-established Communities of Care programs¹³.

Technical Methods of Data Collection and Analysis

All QIPs were documented using NCQA's *Quality Improvement Activity (QIA) Form*. A copy of the *QIA Form* is in **Appendix 2** of this report.

The QIP assessments were conducted using an evaluation approach developed by IPRO and consistent with CMS EQR *Protocol 1. Validation of Performance Improvement Projects*. IPRO's assessment includes the following ten (10) elements:

- Review of the selected study topic(s) for relevance of focus and for relevance to the MCO's enrollment.
- Review of the study question(s) for clarity of statement.
- Review of the identified study population to ensure it is representative of the MCO's enrollment and generalizable to the MCO's total population.
- Review of selected study indicator(s), which should be objective, clear, unambiguous and meaningful to the focus of the QIP.
- Review of sampling methods (if sampling used) for validity and proper technique.
- Review of the data collection procedures to ensure complete and accurate data were collected.
- Review of the data analysis and interpretation of study results.
- Assessment of the improvement strategies for appropriateness.
- Assessment of the likelihood that reported improvement is "real" improvement.
- Assessment of whether the MCO achieved sustained improvement.

Upon IPRO's review of the 2019 QIP QIA Forms completed by the MCOs and provided to IPRO by EOHHS, a determination was made as to the overall credibility of the results of each QIP, with assignment of one of three categories:

- There are no validation findings that indicate that the credibility is at risk for the QIP results.
- The validation findings generally indicate that the credibility for the QIP results is not at risk; however, results should be interpreted with some caution. Processes that put the Findings at risk are enumerated.

¹³ The State's *Medicaid Managed Care Services Contract* (July 2018) requires that all Health Plans establish and maintain a Communities of Care program designed to decrease non-emergent and avoidable emergency department (ED) utilization through service coordination, defined member responsibilities, and associated incentives and rewards.

- There were one or more validation findings that indicate a bias in the QIP results. The concerns that put the conclusion at risk are enumerated.

Description of Data Obtained

Information obtained throughout the reporting period included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, and final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Findings

Neighborhood

Neighborhood conducted the following QIPs in 2019:

- QIP 1 – *Children’s and Adolescents’ Access to Primary Care Practitioners*
- QIP 2 – *Developmental Screening in the 1st, 2nd, 3rd Years of Life*
- QIP3 – *Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication*
- QIP 4 – *Lead Screening in Children*
- QIP 5 – *Improve Performance for Care for Older Adults*
- QIP 6 – *Increase the Percentage of Transitions from the Nursing Home to the Community*

Neighborhood’s QIP validation results are presented in **Table 9**.

Table 9: 2019 QIP Validation Findings

Validation Element	QIP 1	QIP 2	QIP 3	QIP 4	QIP 5	QIP 6
Selected Topic	Met	Met	Met	Met	Met	Met
Study Question	Met	Met	Met	Met	Met	Met
Indicators	Met	Met	Met	Met	Met	Met
Population	Met	Met	Met	Met	Met	Met
Sampling Methods	Met	Met	Met	Met	Met	Met
Data collection Procedures	Met	Met	Met	Met	Met	Met
Interpretation of Study Results	Met	Met	Met	Met	Met	Met
Improvement Strategies	Met	Met	Met	Met	Met	Met

Tufts

Tufts conducted the following QIPs in 2019:

- QIP 1 – *Timely and Accurate Reporting*
- QIP 2 – *Member Experience and Retention*

Tufts’ QIP validation results are presented in **Table 8**.

Table 8: 2019 Tufts QIP Validation Findings

Validation Element	QIP 1	QIP 2
Selected Topic	Not Met	Met
Study Question	Not Met	Met
Indicators	Not Met	Met
Population	Not Applicable	Met
Sampling Methods	Not Applicable	Met
Data collection Procedures	Not Met	Met
Interpretation of Study Results	Not Met	Met
Improvement Strategies	Met	Met

UHCP-RI

UHCP-RI conducted the following QIPs in 2019:

- QIP 1 – *Improving Effective Acute Phase Treatment for Major Depression, State-Directed*
- QIP 2 – *Developmental Screening in the 1st, 2nd, 3rd Years of Life, State-Directed*
- QIP 3 – *Improving Lead Screening in Children, State-Directed*
- QIP 4 – *Improving Breast Cancer Screening, MCO-Selected*

UHCP-RI’s QIP validation results are presented in **Table 9**.

Table 9: 2019 UHCP-RI QIP Validation Findings

Validation Element	QIP 1	QIP 2	QIP 3	QIP 4
Selected Topic	Met	Met	Met	Met
Study Question	Met	Met	Met	Met
Indicators	Met	Met	Met	Met
Population	Met	Met	Met	Met
Sampling Methods	Met	Met	Met	Met
Data collection Procedures	Met	Met	Met	Met
Interpretation of Study Results	Met	Not Met	Met	Met
Improvement Strategies	Met	Met	Met	Met

V. Validation of Performance Measures

This subpart of the report presents the results of the evaluation of UHCP-RI performance measures calculated for reporting year 2019. IPRO's validation methodology is consistent with the CMS EQR *Protocol 2. Validation of Performance Measures*.

Information Systems Capabilities Assessment

The ISCA data collection tool allows the state or EQRO to evaluate the strength of each MCO's information system (IS) capabilities to meet the regulatory requirements for quality assessment and reporting. *Title 42 CFR § 438.242 Health information systems* and *Title 42 CFR § 457.1233 Structure and operation standards (d) Health information systems* also require the state to ensure that each MCO maintains a health information system that collects, analyzes, integrates, and reports data for purposes including utilization, claims, grievances and appeals, disenrollment for reasons other than loss of Medicaid or CHIP eligibility, rate setting, risk adjustment, quality measurement, value-based purchasing, program integrity, and policy development. While some portions of the ISCA are voluntary, there are some components that are required to support the execution of the mandatory EQR-related activities protocols.

While the *CMS External Quality Review (EQR) PROTOCOLS* published in October 2019 stated that an ISCA is a required component of the mandatory EQR activities, CMS later clarified that the systems reviews that are conducted as part of the HEDIS audit may be substituted for an ISCA.

UHCP-RI contracted with an NCQA-certified HEDIS compliance auditor for HEDIS MY 2019. Auditors assessed the MCO's compliance with NCQA standards in the following designated IS categories as part of the NCQA HEDIS MY 2019 Compliance Audit:

- **IS 1.0 Medicaid Services Data:** Sound Coding Methods and Data Capture, Transfer and Entry
- **IS 2.0 Enrollment Data:** Data Capture, Transfer and Entry
- **IS 3.0 Practitioner Data:** Data Capture, Transfer and Entry
- **IS 4.0 Medical Record Review Processes:** Training, Sampling, Abstraction and Oversight
- **IS 5.0 Supplemental Data:** Capture, Transfer and Entry
- **IS 6.0 Data Production Processing:** Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity
- **IS 7.0 Data Integration and Reporting:** Accurate Reporting, Control Procedures that Support Measure Reporting Integrity

An MCO meeting all IS standards required for successful HEDIS reporting and submitting HEDIS data to DHS according to the requirements in Medicaid model contract were considered strengths during this evaluation. An MCO not meeting an IS standard was considered an opportunity for improvement during this evaluation.

Table 10 displays the results of the IS audit for each MCO.

Table 10: MCO Compliance with Information System Standards

Information System Standard	Neighborhood	UHC	Tufts
1.0 Medical Services Data	Met	Met	Met
2.0 Enrollment Data	Met	Met	Met
3.0 Practitioner Data	Met	Met	Met
4.0 Medical Record Review Processes	Met	Met	Met
5.0 Supplemental Data	Met	Met	Met
6.0 Data Preproduction Processing	Met	Met	Met
7.0 Data Integration and Reporting	Met	Met	Met

HEDIS Performance Measures

Since Rhode Island MCOs seek NCQA Accreditation and HEDIS performance is an accreditation domain, the MCOs report HEDIS data annually to NCQA and the State.

Objectives

Title 42 CFR § 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an external quality review organization (EQRO) must validate the performance measures that were calculated during the preceding twelve (12) months. The validation activity was conducted in alignment with the CMS EQR *Protocol 2. Validation of Performance Measures*. The primary objectives of the measure validation activity are were:

- Evaluate the MCO’s methodology for rate calculation.
- Determine the accuracy of the rates calculated and reported by the MCO.

Technical Methods of Data Collection and Analysis

Each MCO contracted with an NCQA-certified HEDIS compliance auditor to determine if the MCO has the capabilities for processing medical, member, and provider information as a foundation for accurate and automated performance measurement.

The HEDIS Compliance Audit™ consists of two (2) sections:

1. Information Systems Capabilities: An assessment of the information systems capabilities for collecting, sorting, analyzing, and reporting health information.
2. HEDIS Specification Standards: An assessment of MCO compliance with reporting practices and HEDIS specifications.

The MCOs’ results of the IS review conducted by the compliance auditor as part of the HEDIS Compliance Audit are available in the **Information Systems Capabilities Assessment** section of this report.

The NCQA-certified HEDIS compliance auditor validated the MCO’s reported HEDIS rate and produce formal documents detailing the results of the validation. For each MCO, IPRO obtained a copy of the 2020 HEDIS MY 2019 FAR and a locked copy of the 2020 HEDIS MY 2019 Audit Review Table (ART). The MCO’s NCQA-certified HEDIS compliance auditor produced both information sources.

IPRO used these audit reports as a basis for its evaluation. IPRO’s measure validation included the following steps:

- IPRO reviewed the FAR of the HEDIS results reported by the MCO that was prepared by an NCQA-licensed organization to ensure that appropriate audit standards were followed. The NCQA HEDIS Compliance Audit: Standards, Policies and Procedures document outlines the requirements for HEDIS compliance audits and was the basis for determining the accuracy of the findings stated in the FAR.
- IPRO used available national HEDIS benchmarks, trended data, and knowledge of the MCO's quality improvement activities to assess the accuracy of the reported rates.

IPRO reviewed each FAR and ART to confirm that all of the performance measures were reportable and that calculation of these performance measures aligned with Rhode Island requirements. IPRO compared MCO rates to the NCQA *Quality Compass 2019* national Medicaid benchmarks and analyzed rate-level trends to identify drastic changes in performance.

MCO-calculated rates for HEDIS measures included in this report are compared to the national Medicaid benchmarks when appropriate. The benchmarks utilized were the most currently available at the time this report was prepared. Unless otherwise noted, the benchmarks originate from NCQA's *Quality Compass 2019* for Medicaid (*National – All Lines of Business [Excluding PPOs and EPOs]*) and represent the performance of all health plans that reported Medicaid HEDIS data to NCQA for HEDIS MY 2019¹⁴.

Description of Data Obtained

The FAR included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental, descriptions of system queries used by the auditor to validate the accuracy of the data, results of the medical record reviews, results of the information systems capabilities assessment, and rate status. Rates were determined to be reportable, or not reportable (small denominator, benefit not offered, not reported, not required, biased, or unaudited).

The ART produced by the HEDIS Compliance Auditor displayed performance measure-level detail including data collection methodology (administrative or hybrid), eligible population count, exclusion count, numerator event count by data source (administrative, medical record, supplemental), and reported rate. When applicable, the following information was also displayed in the ART: administrative rate before exclusions; minimum required sample size (MRSS), and MRSS numerator events and rate; oversample rate and oversample record count; exclusions by data source; count of oversample records added; denominator; numerator events by data source (administrative, medical records, supplemental); and reported rate.

Findings

This section of the report explores the utilization of the MCOs' services by examining select measures under the following domains:

- Use of Services – Measures examine the percentage of Medicaid child and adolescent access routine care.
- Effectiveness of Care – Measures how well an MCO provides preventive screenings and care for members with acute and chronic illness.

¹⁴ Annually, the NCQA produces percentile rankings for HEDIS® and CAHPS® measures and publishes them in the *Quality Compass*®. The *Quality Compass*® is a compilation of benchmarks by product line for all Health Plans that report HEDIS® and CAHPS® to the NCQA. The benchmarking percentiles include the average rate, 10th percentile, 25th percentile, 33rd percentile, 50th percentile, 66th percentile, 75th percentile, 90th percentile, and 95th percentile rates. Health Plans, purchasers, and regulators use the *Quality Compass*® benchmarks in order to evaluate the performance of one or more Health Plans against all reporting Health Plans.

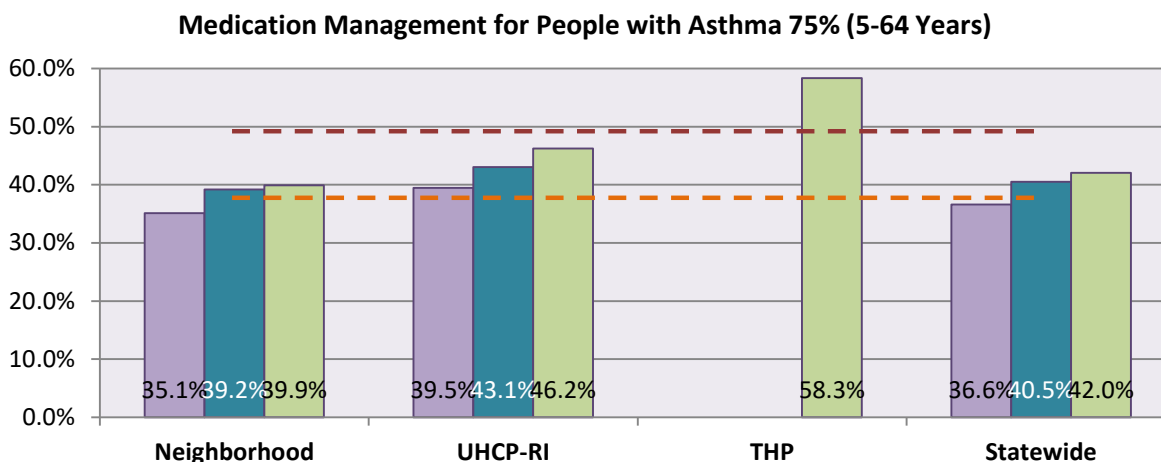
- Access and Availability - Measures examine the percentage of Medicaid children, adolescents, child-bearing women, and adults who received PCP or preventive care services, ambulatory care (adults only), or timely prenatal and postpartum care.

HEDIS® Effectiveness of Care Measures

The HEDIS® **Effectiveness of Care** measures evaluate how well a Health Plan provides preventive screenings and care for members with acute and chronic illnesses. **Figure 2** displays select Effectiveness of Care measure rates for HEDIS® 2016 through HEDIS® 2018 for each Health Plan, as well as the statewide rates, compared to the *Quality Compass*® 2018 national Medicaid benchmarks.

The HEDIS® 2018 rates for seven (7) of the eight (8) reported measures were above the *Quality Compass*® 2019 national Medicaid mean for all Health Plans, as well as statewide. Rates for UHC and Neighborhood continued to perform well on measures related to follow-up care for mental illness, immunizations, and women’s health. *Follow-Up After Hospitalization for Mental Illness—30 Days* and *Follow-Up After Hospitalization for Mental Illness—7 Days*. Rates for all Health Plans, as well as the statewide rates, were reported above the 2019 *Quality Compass*® 75th percentiles for *Follow-Up After Hospitalization for Mental Illness—7 Days*. Regarding childhood immunizations, Neighborhood’s rates, UHCP’s and the statewide rates were reported above the 90th percentile for *Childhood Immunization Status—Combination 10*. Neighborhood’s rate for *Childhood Immunization Status—Combination 3* also ranked in the 90th percentile for 2019. For the two (2) measures related to women’s health, Neighborhood’s rate achieved the 2019 *Quality Compass*® 90th percentile rate for *Cervical Cancer Screening for Women*, while UHCP-RI’s rate benchmarked at the 75th percentile. Neighborhood benchmarked at the 75th percentile for *Chlamydia Screening for Women (16-24 Years)*, while UHCP met the mean. Performance was mixed for the *Medication Management for People with Asthma 75% (5-64 Years)* measure: Neighborhood benchmarked at the *Quality Compass*® mean, while UHCP benchmarked the 90th percentile and Tufts benchmarked at the 75th percentile. For the *Comprehensive Diabetes Care—HbA1c Testing* measure, only UHC benchmarked above the *Quality Compass*® 75th percentile for 2019.

Figure 2: HEDIS® Effectiveness of Care Rates—2017-2019¹⁵



¹⁵ Tufts began enrollment in the Medicaid product line in calendar year 2017; therefore, reporting year 2019 is Tuft’s baseline period.

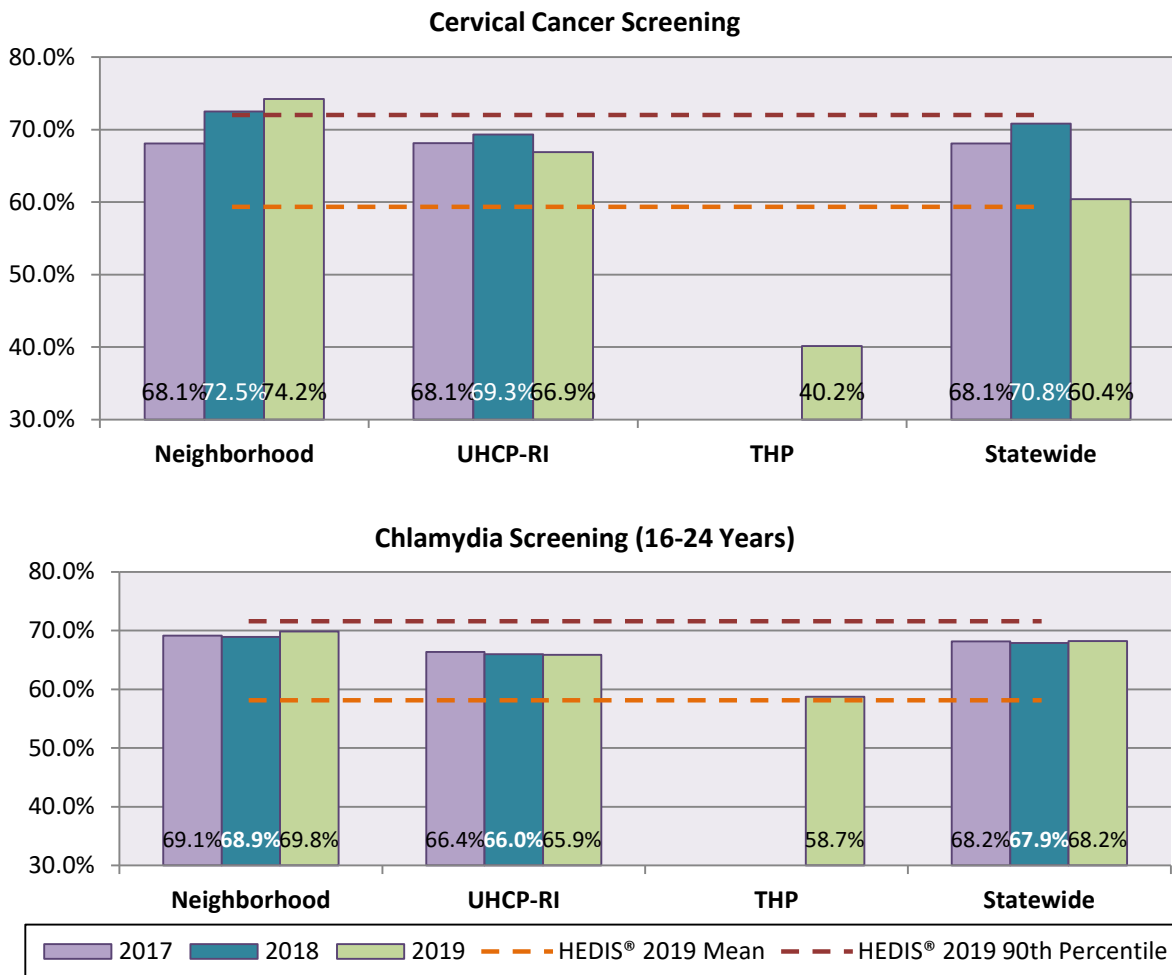
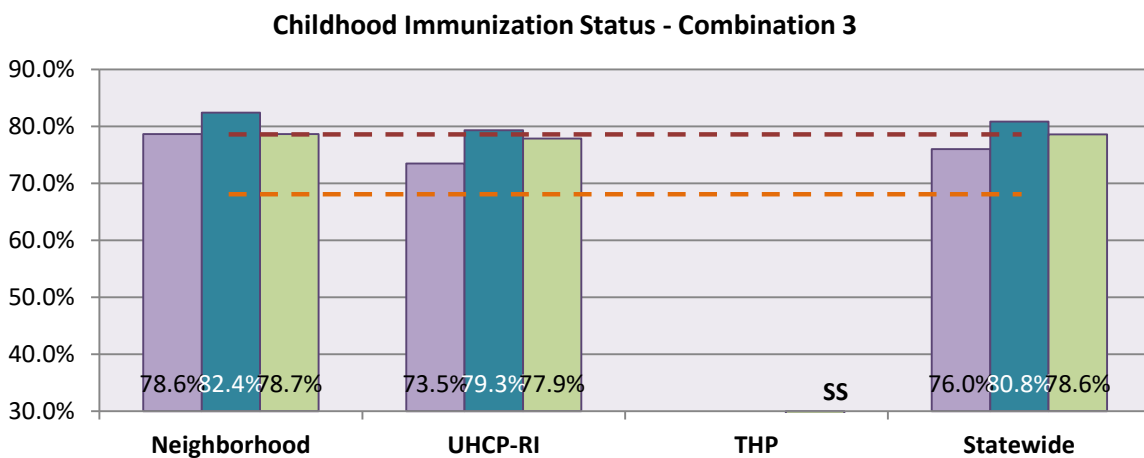


Figure 2: HEDIS® Effectiveness of Care Rates—2017-2019 (continued)¹⁶



¹⁶ Tufts began enrollment in the Medicaid product line in calendar year 2017; therefore, reporting year 2019 is Tuft's baseline period.

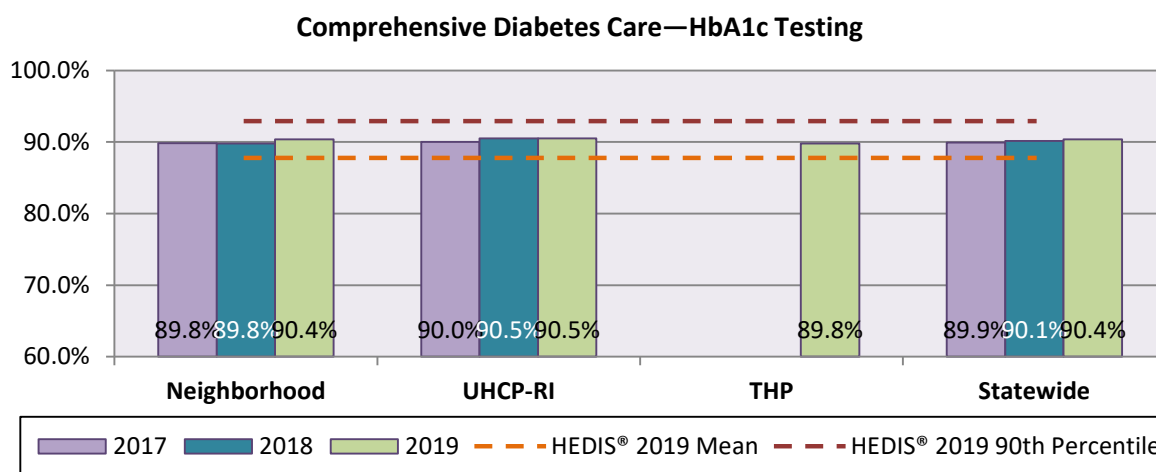
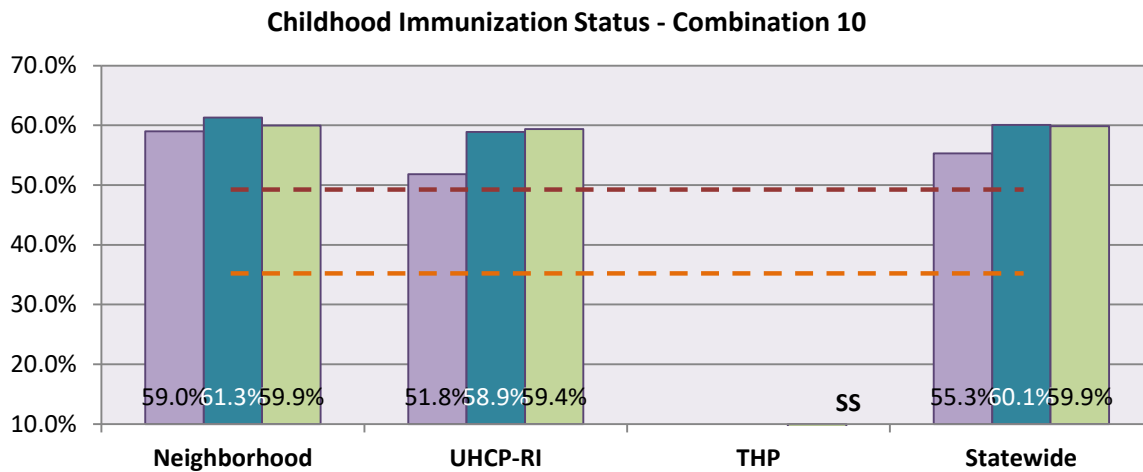
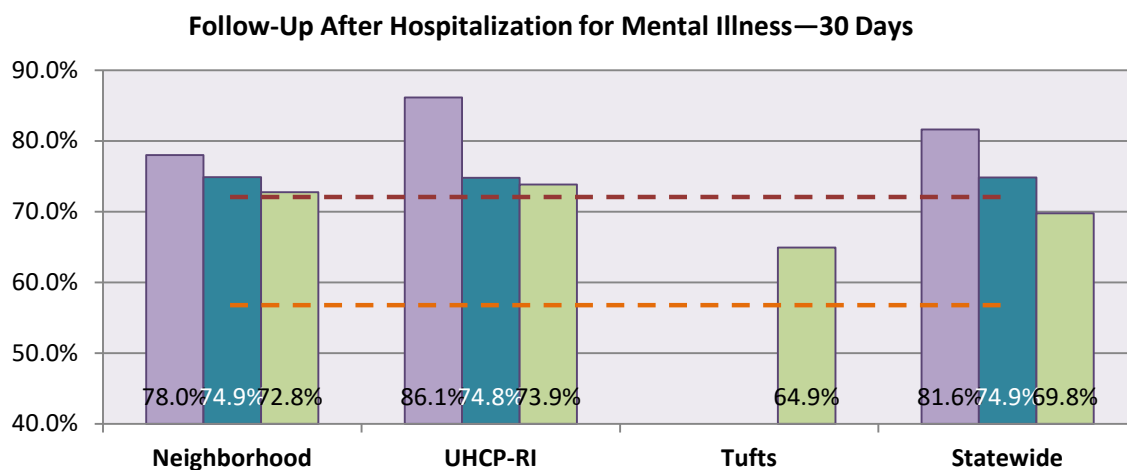
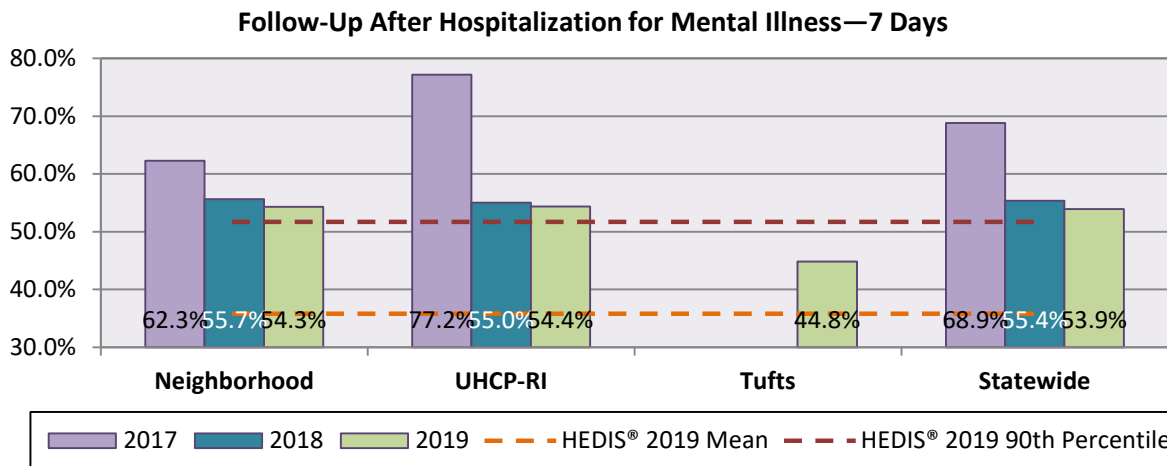


Figure 2: HEDIS® Effectiveness of Care Rates—2017-2019 (continued)¹⁷



¹⁷ Tufts began enrollment in the Medicaid product line in calendar year 2017; therefore, reporting year 2019 is Tuft's baseline period.



HEDIS® Access and Availability Measures

The HEDIS® Access and Availability measures examine the percentage of Medicaid children, adolescents, child-bearing women, and adults who received PCP or preventive care services, ambulatory care (adults only), or timely prenatal and postpartum care. Children and Adolescents’ Access to Primary Care Practitioners measures the percentage of children ages twelve (12) months to six (6) years old who had one (1) or more visits with a Health Plan primary care practitioner during the Measurement Year and the percentage of children ages seven (7) to eleven (11) years old and adolescents ages twelve (12) to nineteen (19) years old who had one (1) or more visits with a Health Plan primary care practitioner during the Measurement Year or the year prior. Adults’ Access to Preventive/Ambulatory Health Services measure the percentage of adults ages twenty (20) years and older who had one (1) or more ambulatory or preventive care visits during the Measurement Year. Prenatal and Postpartum Care measures the percentage of women who received a prenatal care visit in the first trimester or within forty-two (42) days of enrollment in the Health Plan and the percentage of women who had a postpartum visit on or between twenty-one (21) and fifty-six (56) days after delivery.

Figure 3 presents the Access and Availability measure rates for the two (2) Health Plans, as well as the statewide rates, for HEDIS® 2017 through HEDIS® 2019 as compared to national Medicaid benchmarks.

Performance in this domain varied across the measures, with UHC and Neighborhood performing similarly. All three plans achieved the 2019 Quality Compass® Mean benchmark for the Timeliness of Postpartum Care measure. Neighborhood’s rates exceeded the 2019 Quality Compass® national Medicaid mean for all of the nine (9) reported measures, while UHCP-RI’s rates exceeded the Medicaid mean for eight (8) of the nine (9) measures. Neighborhood continued to perform well on the Prenatal and Postpartum Care measures, as the rates for Timeliness of Prenatal Care and Timeliness of Postpartum Care achieved the 2019 Quality Compass® 90th percentile, as did the statewide rates. UHC benchmarked at the 75th percentile for these measures. Tufts benchmarked at the 75th percentile for just the Timeliness of Postpartum Care measure. For the Children and Adolescents’ Access to Primary Care Practitioners measure, UHCP benchmarked below the Quality Compass® 75th percentile for the 12-24 Months, 25 Months-6 Years age groups and 7-11 Years and 12-19 Years age groups. UHC also ranked below the 75th percentile for all Adults Access to Amb/Preventive Care age brackets. Tufts demonstrated an opportunity for improvement regarding the this domain, as rates for only one (1) of eight (8) reported measures were reported above the 2019 Quality Compass® national Medicaid mean.

Figure 3: HEDIS® Access and Availability Rates—2017-2019¹⁸

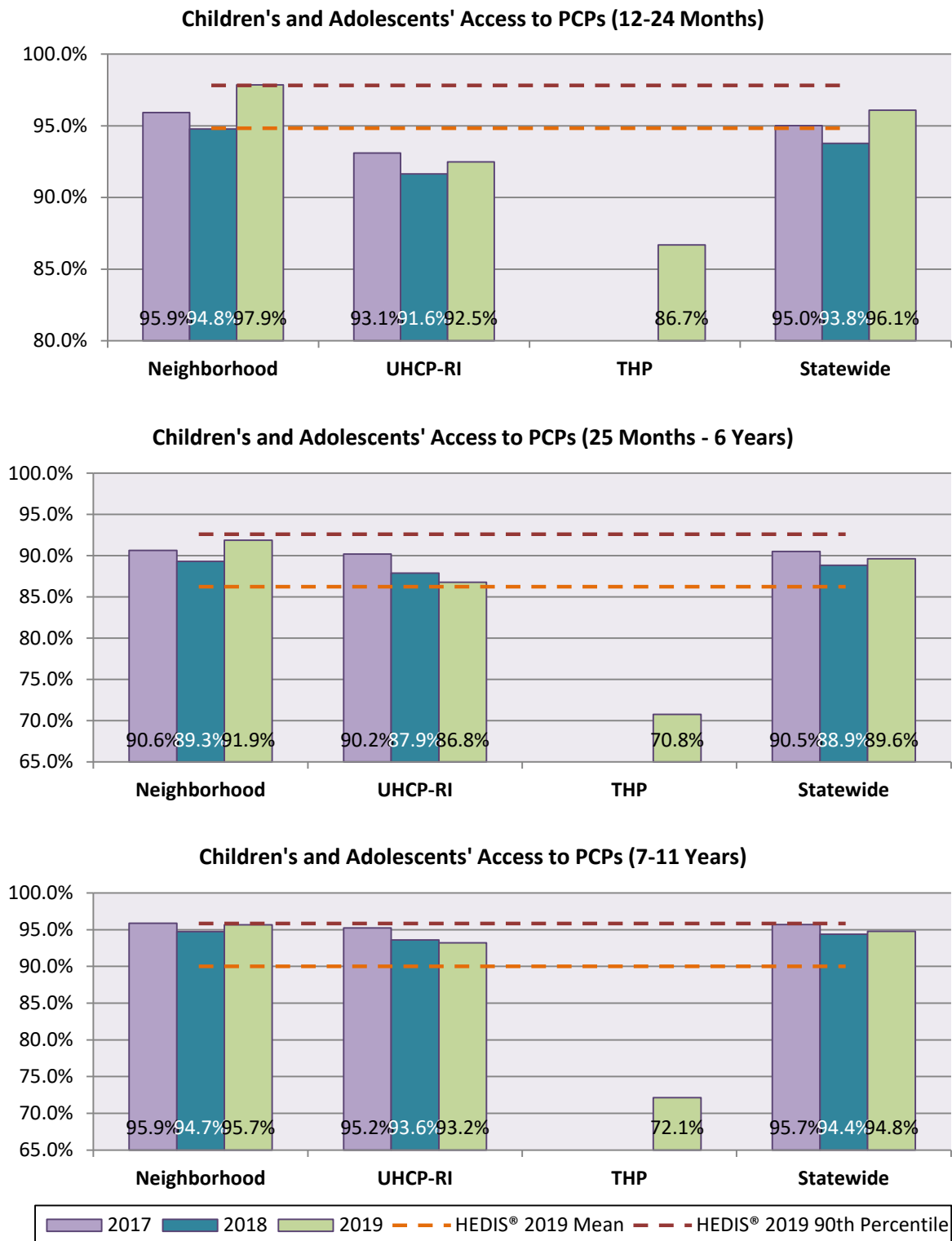
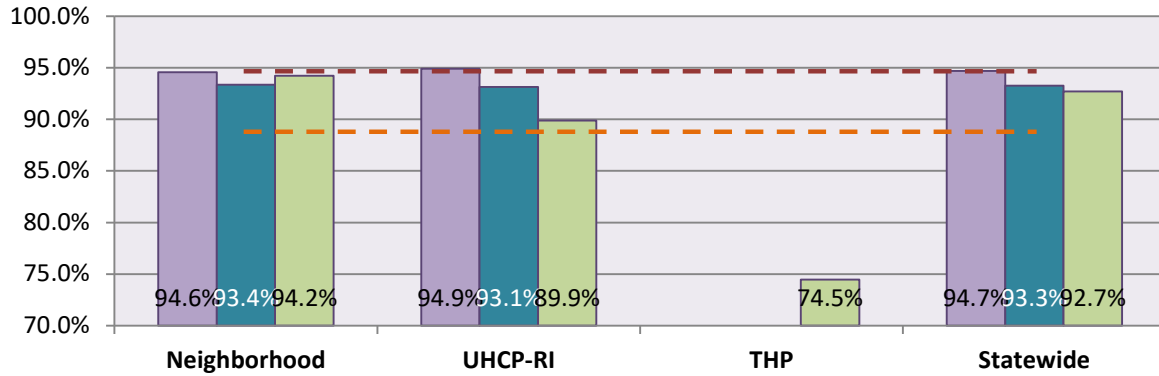


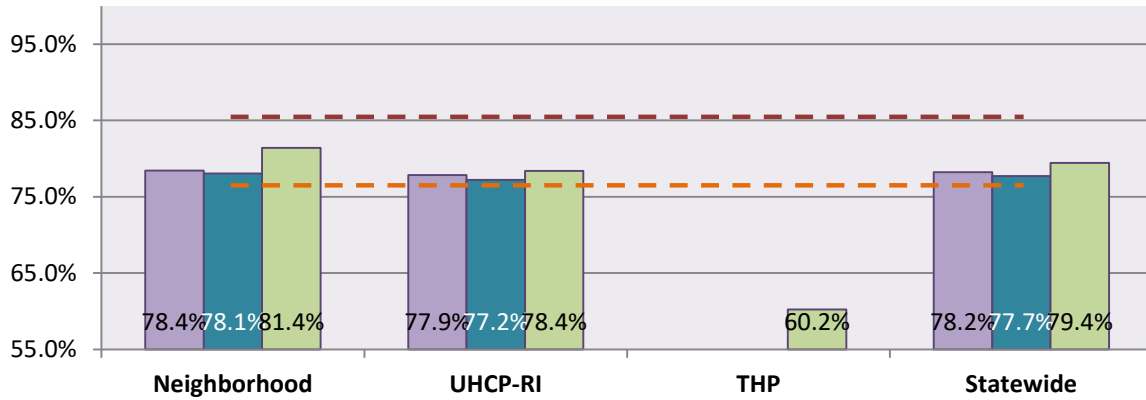
Figure 3: HEDIS® Access and Availability Rates—2017-2019 (continued)¹⁹

¹⁸ Tufts began enrollment in the Medicaid product line in calendar year 2017; therefore, reporting year 2019 is Tuft's baseline period.

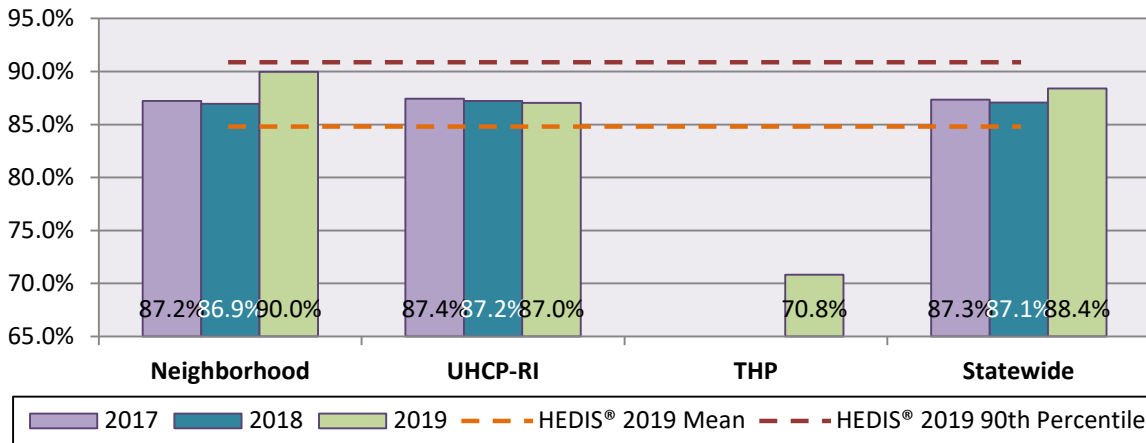
Children's and Adolescents' Access to PCPs (12-19 Years)



Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)

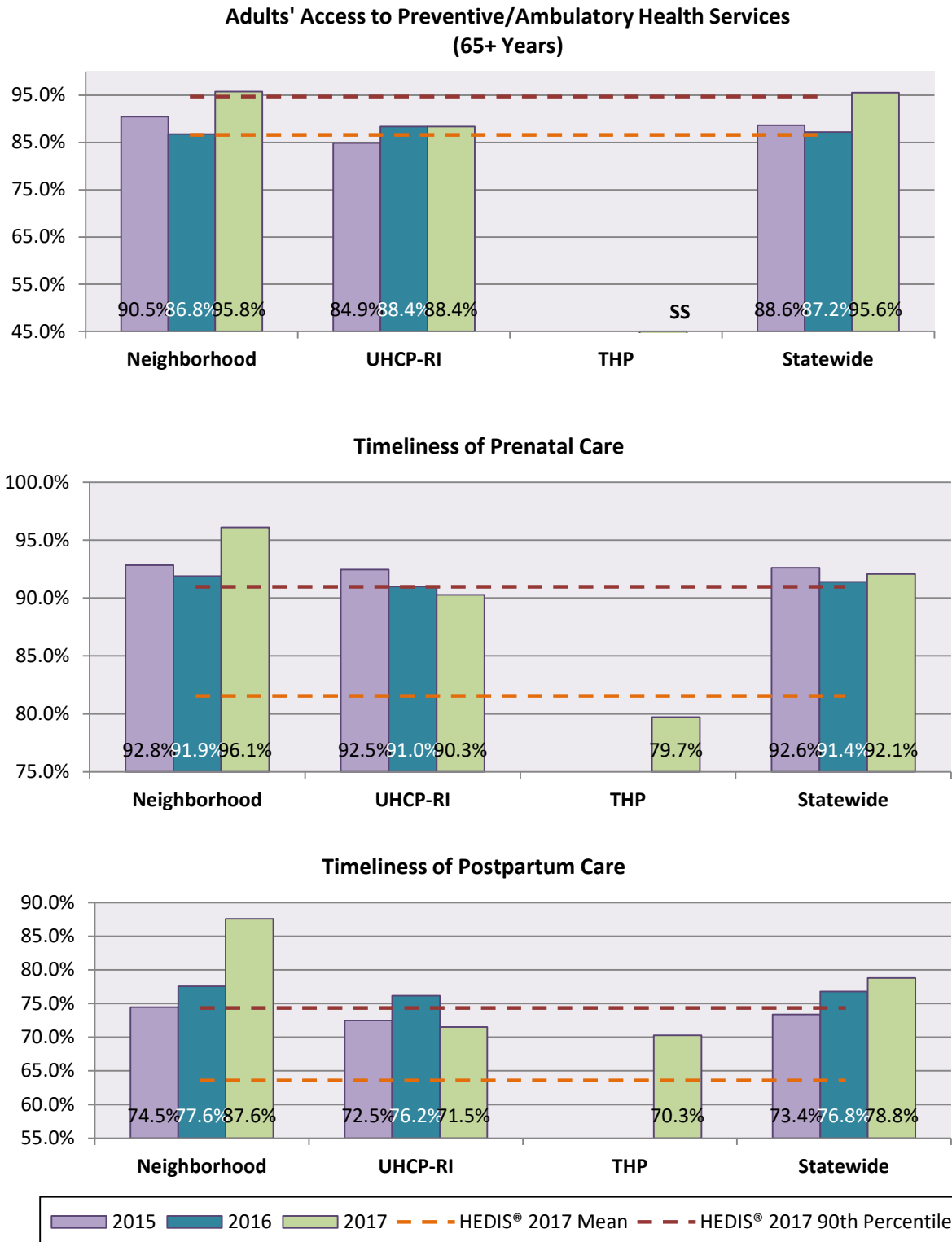


Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)



¹⁹ Tufts began enrollment in the Medicaid product line in calendar year 2017; therefore, reporting year 2019 is Tuft's baseline period.

Figure 3: HEDIS® Access and Availability Rates—2017-2019 (continued)²⁰



HEDIS® Use of Services Measures

²⁰ Tufts began enrollment in the Medicaid product line in calendar year 2017; therefore, reporting year 2019 is Tuft's baseline period.

The HEDIS® **Use of Services** measures evaluate member utilization of Health Plan services. For this domain of measures, performance is assessed by comparing the Health Plans' rates to the 2019 Quality Compass® national Medicaid benchmarks. **Figure 4** displays select Use of Services measure rates for HEDIS® 2018 through HEDIS® 2019, as well as comparisons to the national Medicaid benchmarks.

Rates for all three (3) measures reported for this domain were above the 2019 Quality Compass® national Medicaid mean and 75th percentile for UHC and Neighborhood. Rates for both UHC and Neighborhood, as well as the statewide rate, for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* benchmarked at the *Quality Compass®* 90th percentile. Tufts fell benchmarked below the 75th percentile for the two (2) measures that were reported.

Figure 4: HEDIS® Use of Services Rates—2017-2019²¹

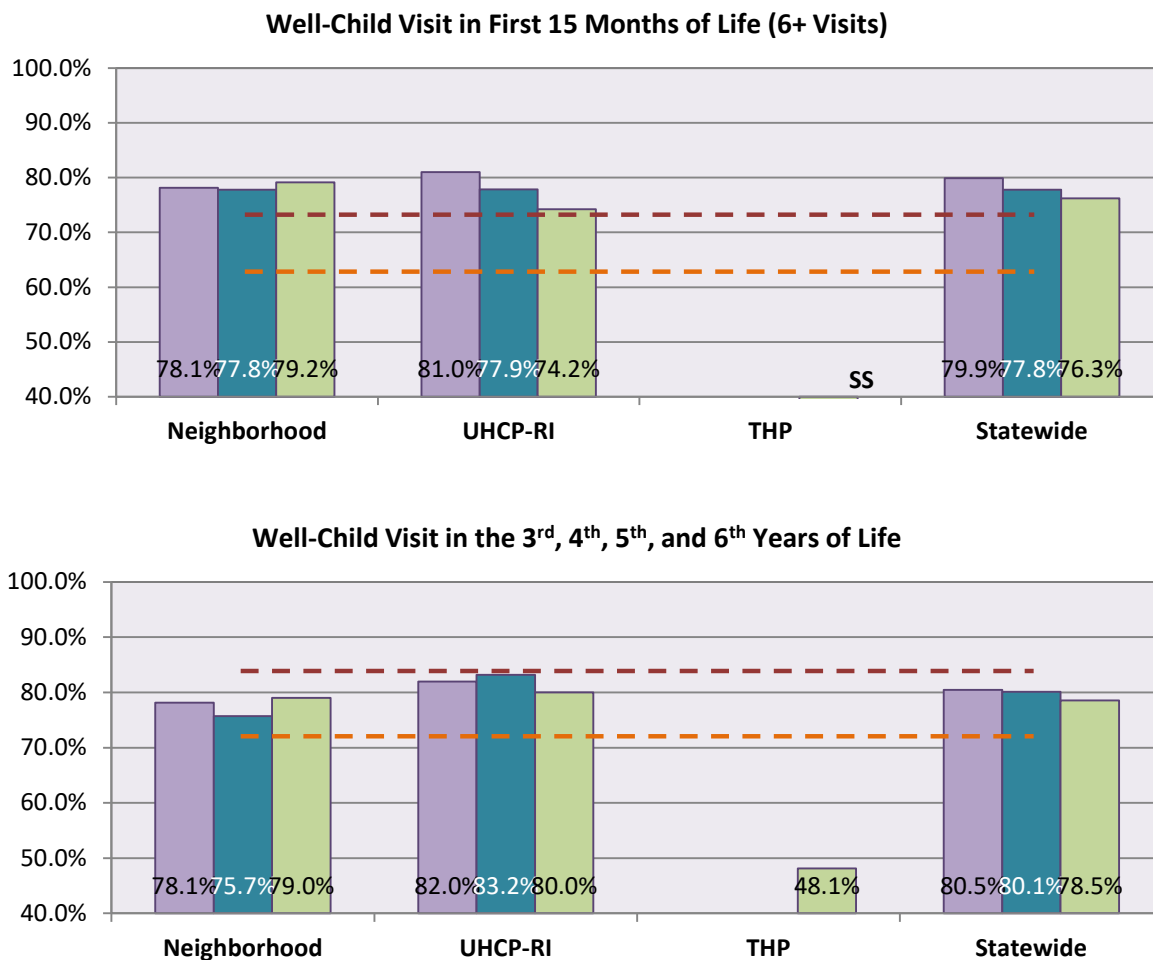
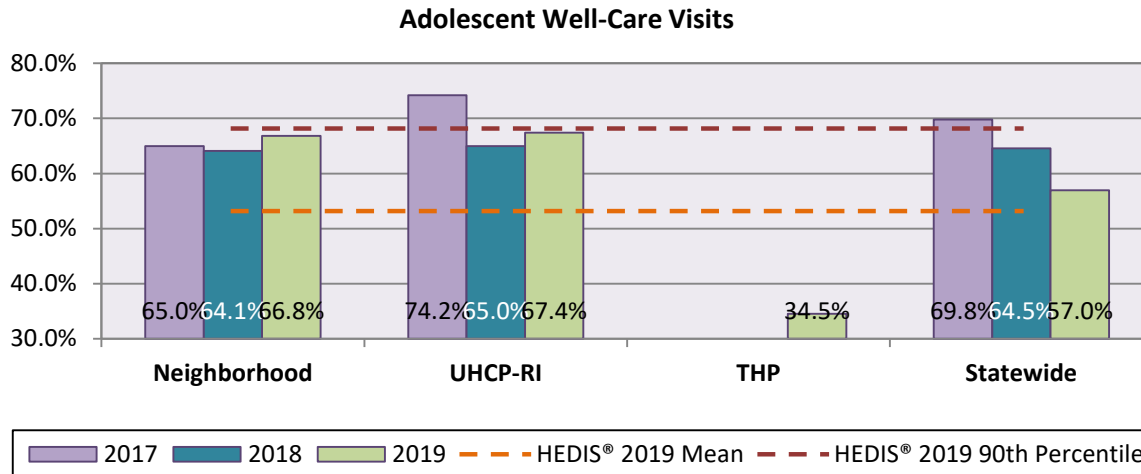


Figure 4: HEDIS® Use of Services Rates—2017-2019²²

²¹ Tufts began enrollment in the Medicaid product line in calendar year 2017; therefore, reporting year 2019 is Tuft's baseline period.



Rhode Island Performance Goal Program²³

Objectives

In 1998, the State initiated the Rhode Island Performance Goal Program, an incentive program that established benchmark standards for quality and access performance measures. Rhode Island was the second state in the nation to implement a value-based purchasing incentive for its Medicaid program. In 2019, the Performance Goal Program entered its twentieth (21st) year.

The 2005 reporting year marked a particularly important transition for the PGP, wherein the program was redesigned to be more fully aligned with nationally-recognized performance benchmarks through the use of new performance categories and standardized HEDIS and CAHPS measures. In addition, superior performance levels were clearly established as the basis for incentive awards. For reporting year 2019, the performance categories were redefined into six (6) categories. For Reporting Year 2019, the following performance categories were used to evaluate MCO performance:

- Utilization
- Access to Care
- Prevention and Screening
- Women’s Health
- Chronic Care
- Behavioral Health

Technical Methods of Data Collection and Analysis

Within each of the performance categories is a series of measures, including a variety of standard HEDIS and CAHPS measures, as well as State-specific measures for areas of particular importance to the State that do not have national metrics for comparison. Many of the measures are calculated through the MCO’s HEDIS and CAHPS data submissions. For calendar year 2019, EOHHS 2019 PGP evaluation took place in April 2019.

Description of Data Obtained

²² Tufts began enrollment in the Medicaid product line in calendar year 2017; therefore, reporting year 2019 is Tuft’s baseline period.

²³ The rates for all PGP measures include all Medicaid members, where eligible population criteria were met.

IPRO received a copy of the evaluation reports produced by EOHHS for each MCO included in the PGP for 2019.. The evaluation reports include measure descriptive information such as name and corresponding performance category, rates, and numerators and dominators for each measure by Rhode Island Medicaid managed care program.

Findings

This section of the report evaluates MCO performance on the PGP measures for 2017 through 2019 for all Medicaid populations.

The **Utilization** domain included one (1) HEDIS® measure in reporting Year 2019. For the HEDIS® *Adolescent Well-Care Visits* measure, Neighborhood had a rate that did not meet the quality compass benchmark to qualify for an incentive award and UHCP-RI exceeded the 75th percentile and met the state-specified contract goal for a partial incentive award

The **Access to Care** domain included five (5) HEDIS measures in reporting year 2019. For the HEDIS® *Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)* measure, *Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)* measure and *Initiation of Alcohol and Other Drug Dependence Treatment* measure, Neighborhood and UHCP-RI had rates that did not meet the quality compass benchmark to qualify for an incentive award. For the HEDIS® *Postpartum Care* measure, Neighborhood and UHCP-RI exceeded the 75th percentile and met the state-specified *Contract* goal for a partial incentive award. For the HEDIS® *Engagement of Alcohol and Other Drug Dependence Treatment* measure, Neighborhood did not meet the quality compass benchmark to qualify for an incentive award, and UHCP-RI exceeded the 75th percentile and met the state-specified *Contract* goal for a partial incentive award.

The **Prevention and Screening** domain was comprised of four (4) HEDIS® measures for Reporting Year 2019. For the HEDIS® *Childhood Immunization Status—Combination 10 measure and Adolescent Immunizations—Combination 2* measure, Neighborhood and UHCP-RI exceeded the 90th percentile and met the state-specified *Contract* goal for a full incentive award. For HEDIS® *Lead Screening in Children measure and Breast Cancer Screening* measure, Neighborhood and UHCP-RI both had rates that did not meet the quality compass benchmark to qualify for an incentive award.

The **Women's Health** domain was comprised of two (2) HEDIS® measures for Reporting Year 2019. For the HEDIS® *Chlamydia Screening in Women (16-20 Years)* measure, both Neighborhood and UHCP-RI exceeded the 75th percentile and met the state-specified *Contract* goal for a partial incentive award. For the HEDIS® *Cervical Cancer Screening*, Neighborhood exceeded the 90th percentile and met the state-specified *Contract* goal for a full incentive award. UHCP-RI did not meet the quality compass benchmark to qualify for an incentive award.

The **Chronic Care** domain included two (2) HEDIS® measures and one (1) state-specified measure. For HEDIS® *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure, Neighborhood exceeded the 90th percentile and met the state-specified *Contract* goal for a full incentive award and UHCP-RI exceeded the 75th percentile meeting the state-specified *Contract* goal for a partial incentive award. For HEDIS® *Controlling High Blood Pressure (18-85 Years)* measure, Neighborhood and UHCP-RI both exceeded the 90th percentile and met the state-specified *Contract* goal for a full incentive award. For the state-specified *HIV Viral Load Suppression* measure, both Neighborhood and UHCP-RI met the state specified target for the partial incentive award.

The **Behavioral Health** domain included five (5) HEDIS measures. For the HEDIS® *Follow-Up After Hospitalization for Mental Illness (7 Days)* measure, Neighborhood exceeded the 90th percentile and met the state-specified

Contract goal for a full incentive award and UHCP-RI exceeded the 75th percentile and met the state-specified *Contract* goal for a partial incentive award. For the HEDIS[®] *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure, Neighborhood did not meet the quality compass benchmark to qualify for an incentive award and UHCP-RI exceeded the 75th percentile and met the state-specified *Contract* goal for a partial incentive award. For HEDIS[®] *Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications* measure, Neighborhood and UHCP-RI did not have rates that met the quality compass benchmark to qualify for an incentive award. For HEDIS[®] *Follow-up After Emergency Department Visits for Alcohol and Other Drug Dependence* measure, Neighborhood did not meet the quality compass benchmark to qualify for an incentive award and UHCP-RI exceeded the 75th percentile and met the state-specified *Contract* goal for a partial incentive award. For HEDIS[®] *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure, Neighborhood exceeded the 90th percentile and met the state-specified *Contract* goal for a full incentive award and UHCP-RI exceeded the 75th percentile and met the state-specified *Contract* goal for a partial incentive award.

Table 11 presents the Neighborhood and UHCP-RI rates for the PGP metrics. The HEDIS percentiles displayed were derived from the 2019 Performance Goal Program results, in which rates were benchmarked against the NCQA's *Quality Compass* 2018 for Medicaid.

Table 11: Performance Goal Program Results—2019¹

RI Medicaid Managed Care Performance Goal Program Measures	Neighborhood		UHCP-RI	
	2019 Rate	2018 Target Met ^{2,3}	2019 Rate	2018 Target Met ^{2,3}
Utilization				
HEDIS® Adolescent Well-Care Visits	60.79%	NM	64.0%	PM
Access to Care				
HEDIS® Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)	96.42%	NM	93.3%	NM
HEDIS® Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	88.68%	NM	85.9%	NM
HEDIS® Postpartum Care	71.96%	PM	71.5%	PM
HEDIS® Initiation of Alcohol and Other Drug Dependence Treatment	40.48%	NM	40.8%	NM
HEDIS® Engagement of Alcohol and Other Drug Dependence Treatment	17.21%	NM	18.5%	PM
Prevention and Screening				
HEDIS® Childhood Immunization Status—Combination 10	57.65%	M/E	55.0%	M/E
HEDIS® Lead Screening in Children	78.79%	NM	74.2%	NM
HEDIS® Adolescent Immunizations—Combination 2	48.05%	M/E	47.9%	M/E
HEDIS® Breast Cancer Screening	64.03%	NM	61.4%	NM
Women's Health				
HEDIS® Chlamydia Screening in Women (16-20 Years)	68.95%	PM	65.4%	PM
HEDIS® Cervical Cancer Screening	71.04%	M/E	61.8%	NM
Chronic Care				
HEDIS® Comprehensive Diabetes Care—HbA1c Control (<8.0%)	60.55%	M/E	55.5%	PM
HEDIS® Controlling High Blood Pressure (18-85 Years)	73.24%	M/E	71.3%	M/E
HIV Viral Load Suppression ^{4,6}	73.56%	PM	76.8%	PM
Behavioral Health				
HEDIS® Follow-Up After Hospitalization for Mental Illness—7 Days	57.14%	M/E	53.8%	PM
HEDIS® Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	47.58%	NM	51.7%	PM
HEDIS® Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications	80.25%	NM	80.1%	NM
HEDIS® Follow-Up After Emergency Department Visits for Alcohol and Other Drug Dependence	22.50%	NM	25.0%	PM

RI Medicaid Managed Care Performance Goal Program Measures	Neighborhood		UHCP-RI	
	2019 Rate	2018 Target Met ^{2,3}	2019 Rate	2018 Target Met ^{2,3}
HEDIS® Adherence to Antipsychotic Medications for Individuals with Schizophrenia	78.02%	M/E	67.2%	PM

Note: Rows shaded in gray indicate the plan did not have PGP rates reported for these measures.

M/E: Met or exceeded the state-specified *Contract* goal for a full incentive award; PM: Met or exceeded the state-specified *Contract* goal for a partial incentive award; NM: Did not meet a *Contract* goal to qualify for an incentive award; SS: Sample size too small to report

¹ Performance Goal Program data are based on the previous Contract Year (i.e., 2019 rates are based on Contract Year 2018). Rates may differ from other data published in this report, as this table reflects preliminary HEDIS® rates, while the rates in all other tables reflect final data submitted to the NCQA for all populations.

² For state-specified measures, national benchmarks are not available. Incentive awards were determined using state-selected benchmarks.

³ For HEDIS® measures, incentive awards were based on 2018 *Quality Compass*® national Medicaid 90th and 75th percentile benchmarks.

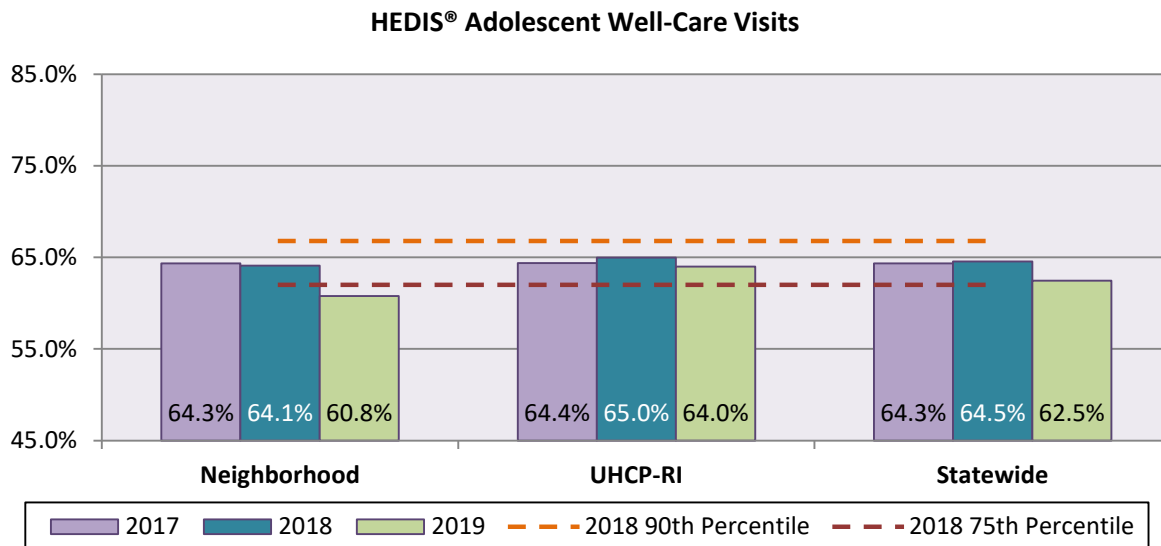
⁴ State-specified measure.

⁵ The benchmark for a full award for this measure was 65% and the benchmark for a partial award was 50%.

⁶ The benchmark for a full award for this measure was 88% and the benchmark for a partial award was 68%.

Figures 6a through 6f display the results of the PGP for Reporting Years 2017 through 2019 for each domain compared to the 2019 *Quality Compass*® benchmarks. Statewide rates presented in each of these figures were calculated by totaling the numerators and denominators for each Health Plan.

Figure 6a: PGP Results 2019—Utilization



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Figure 6b: PGP Results 2019—Access to Care

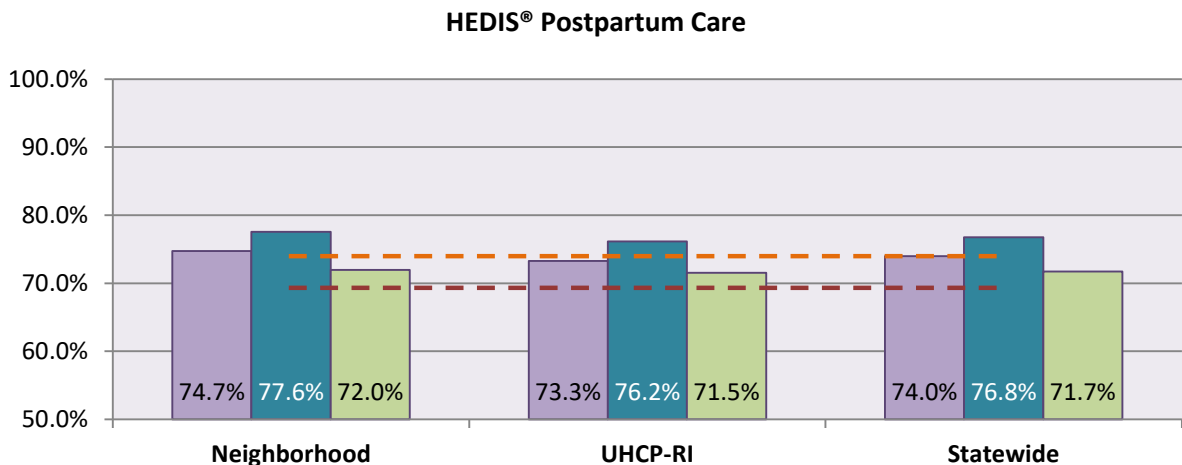
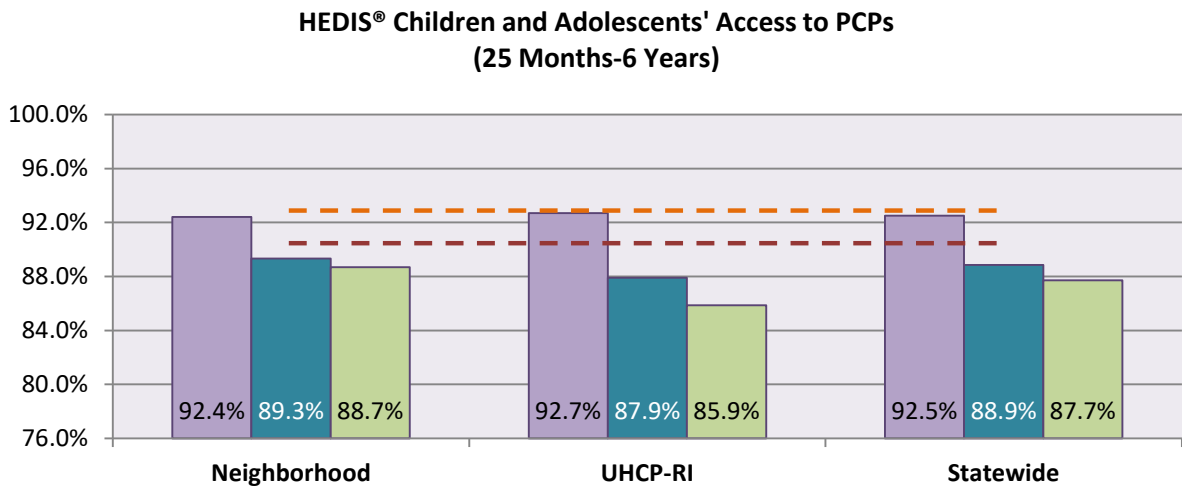
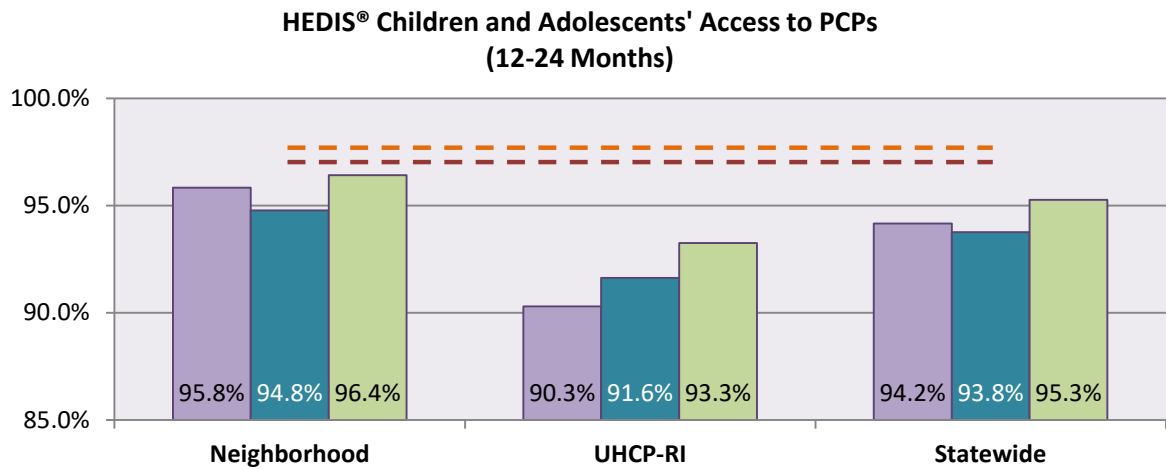


Figure 6b: PGP Results 2019—Access to Care (continued)

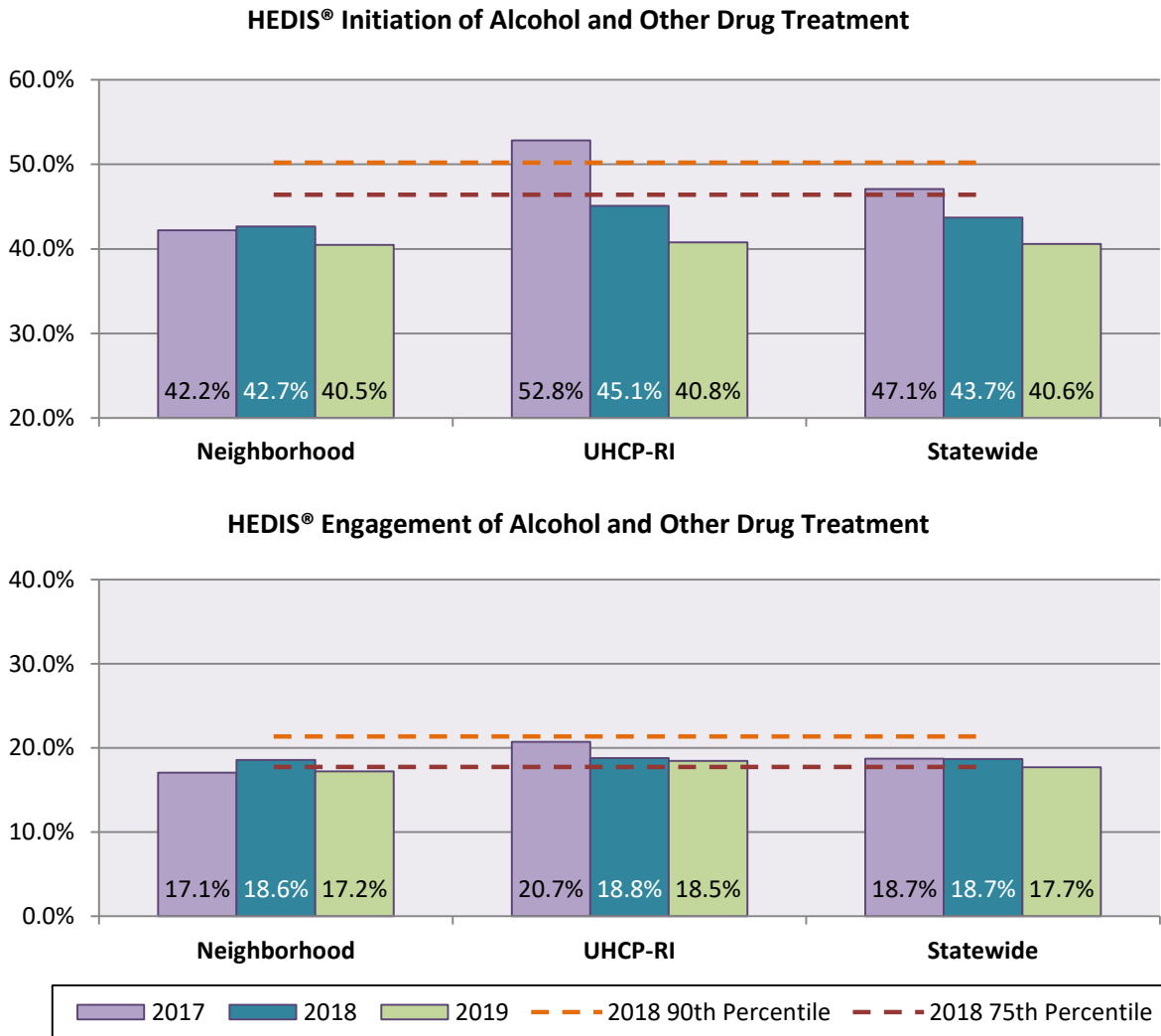


Figure 6c: PGP Results 2017-2019—Prevention and Screening

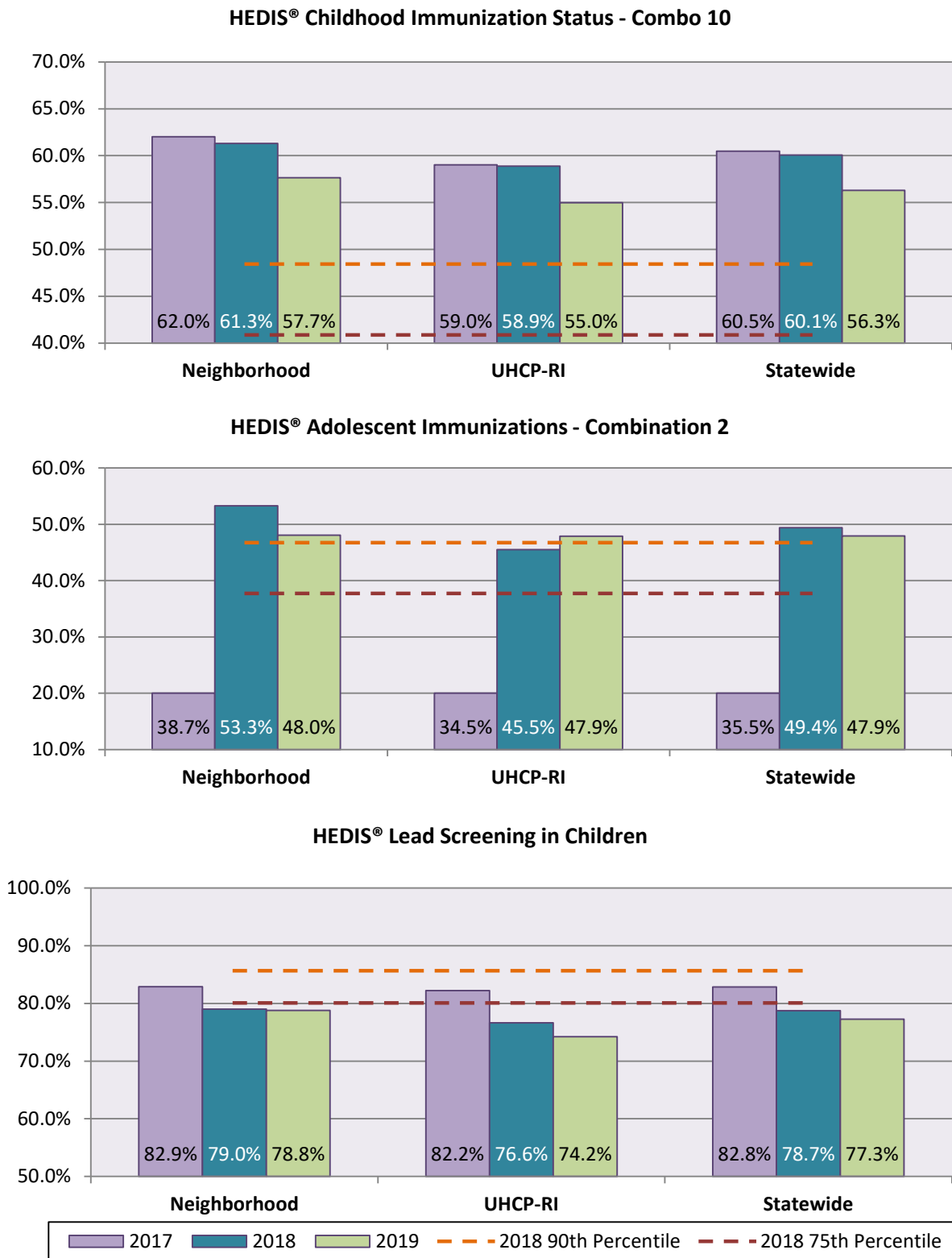
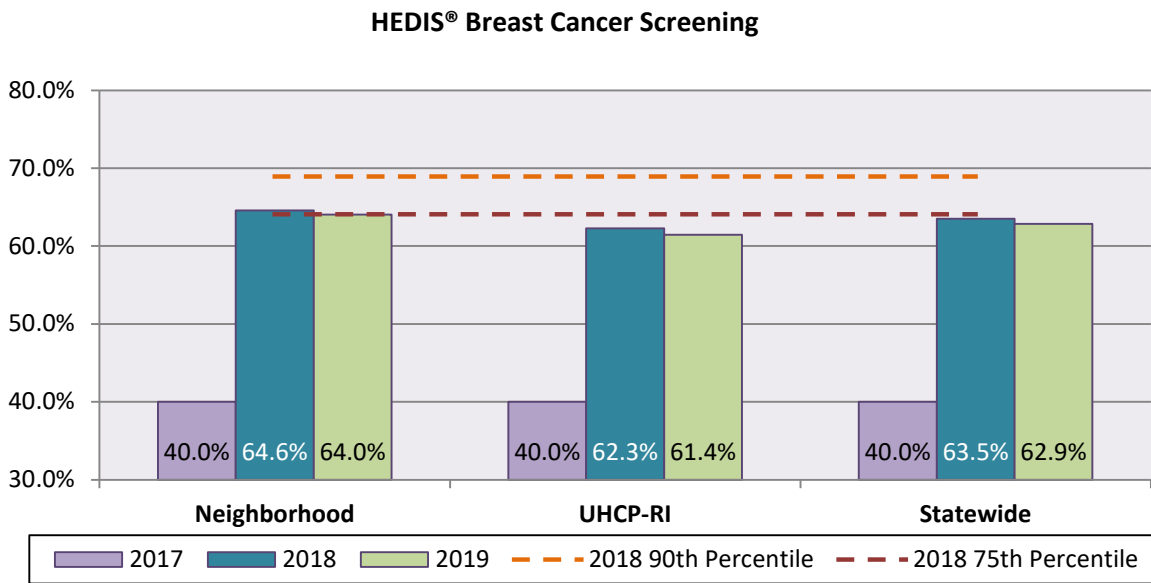
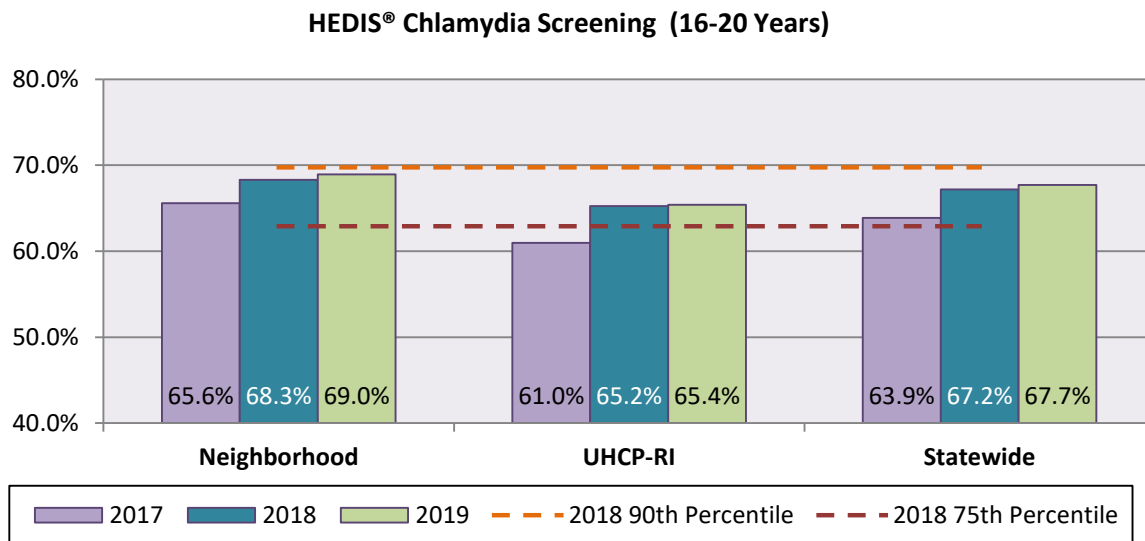
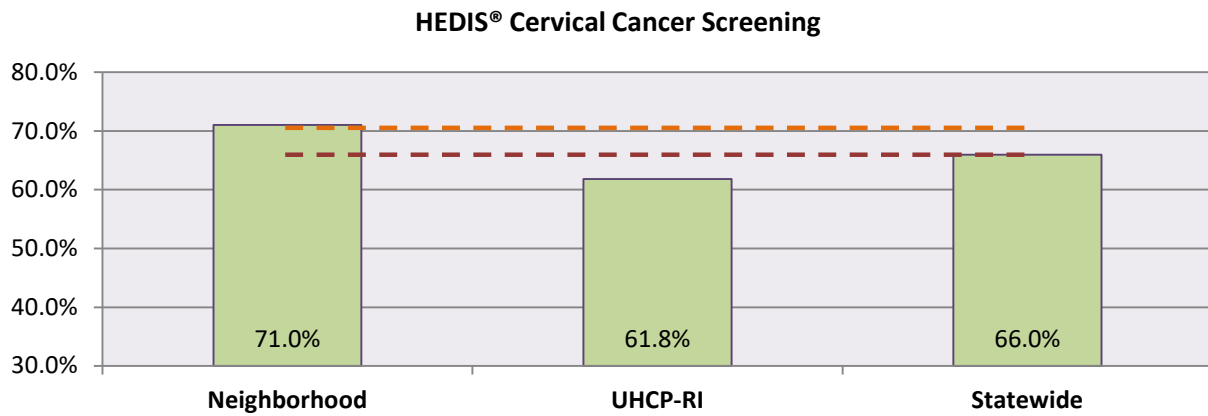


Figure 6c: PGP Results 2017-2019—Prevention and Screening (continued)



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Figure 6d: PGP Results 2019—Women’s Health²⁴



²⁴ Cervical Cancer Screening measure was added to the PGP in report year 2019.

Figure 6e: PGP Results 2017-2019—Chronic Care

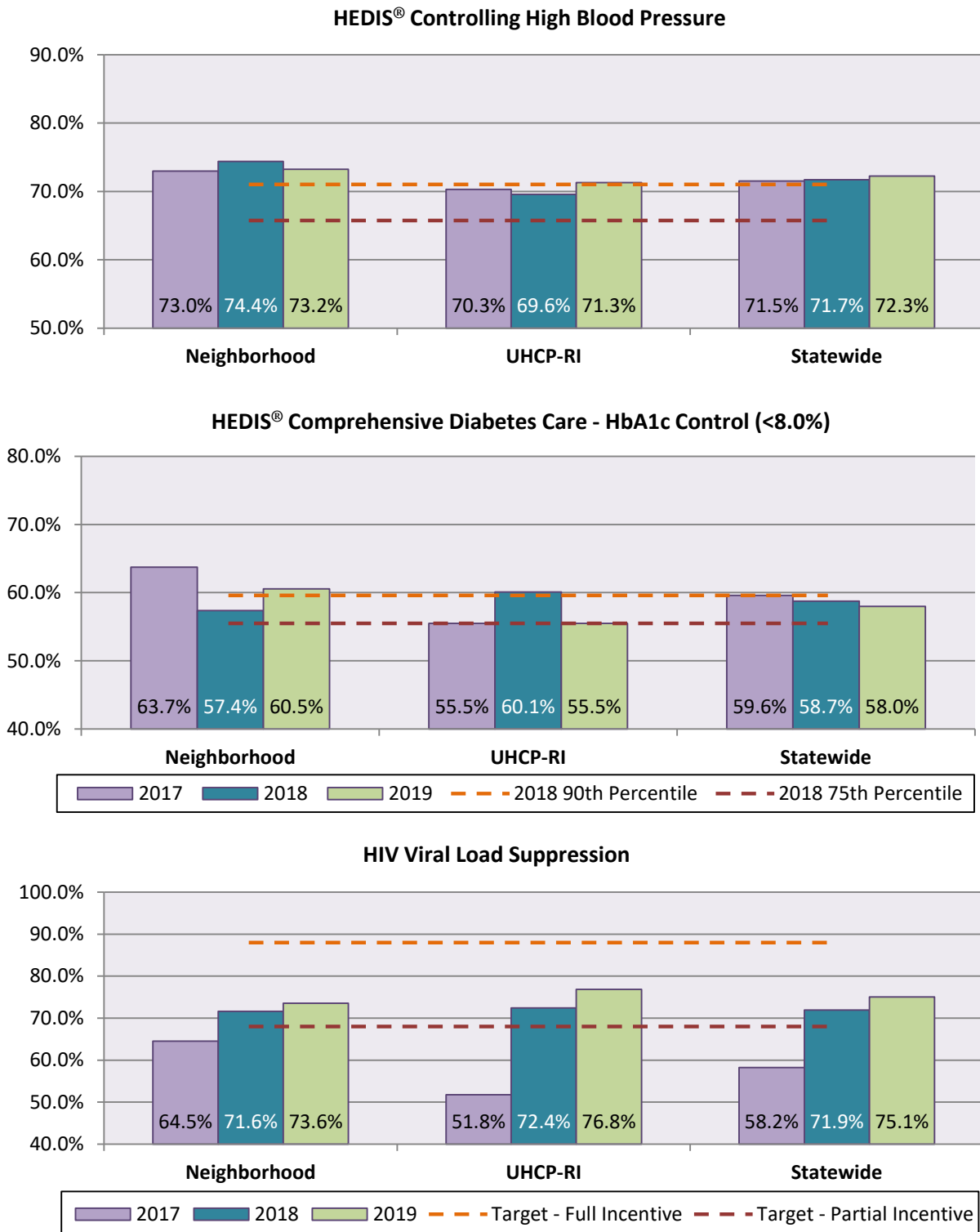
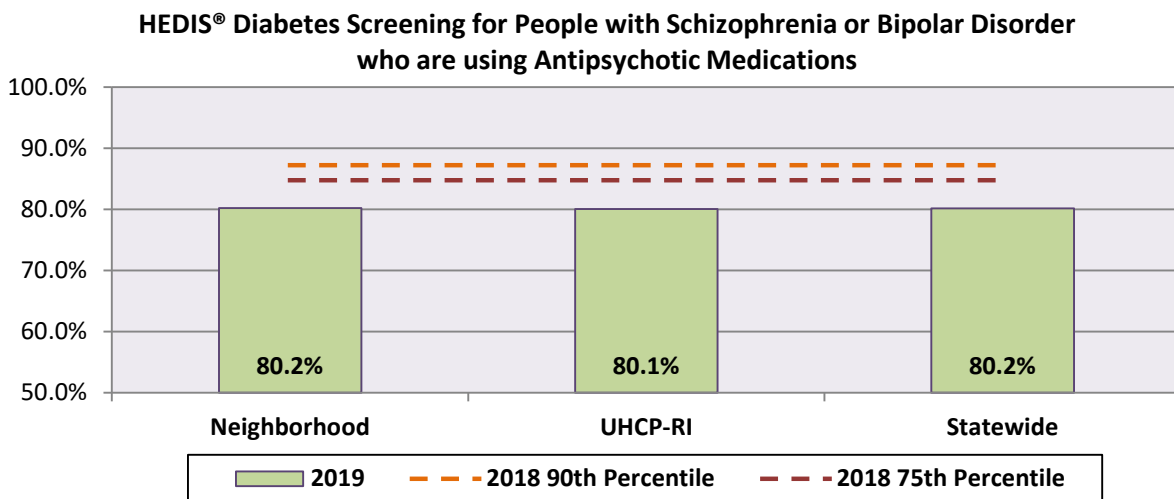
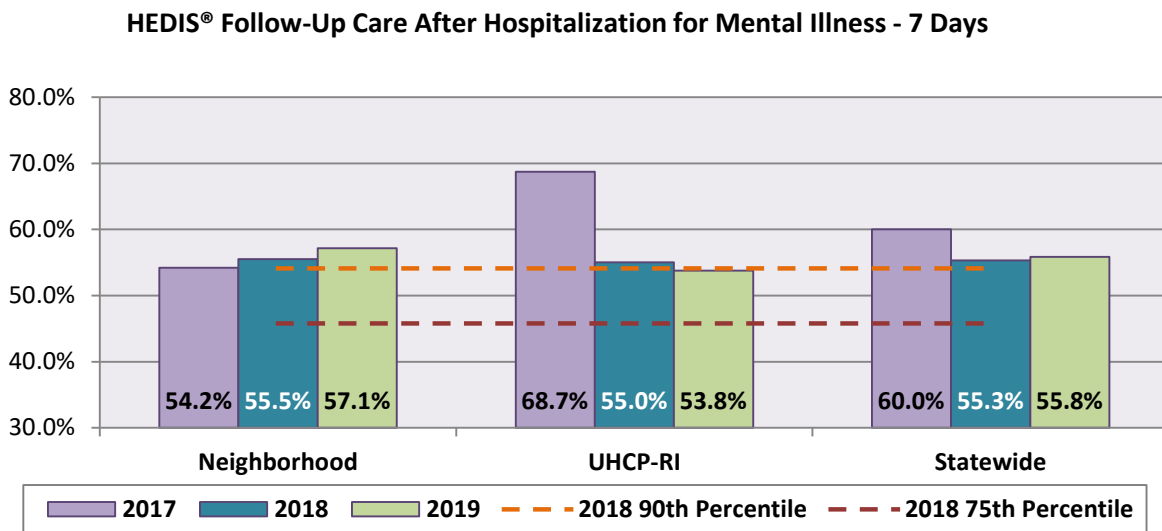
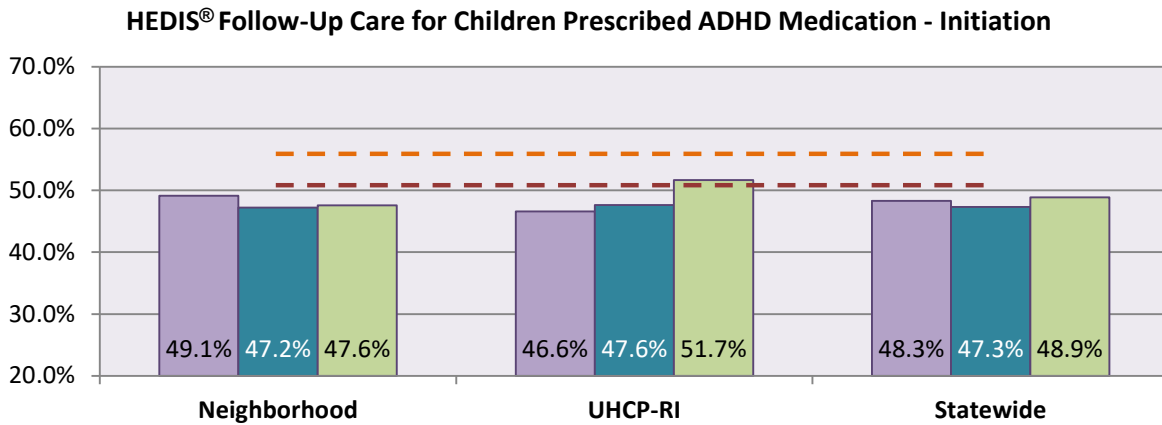
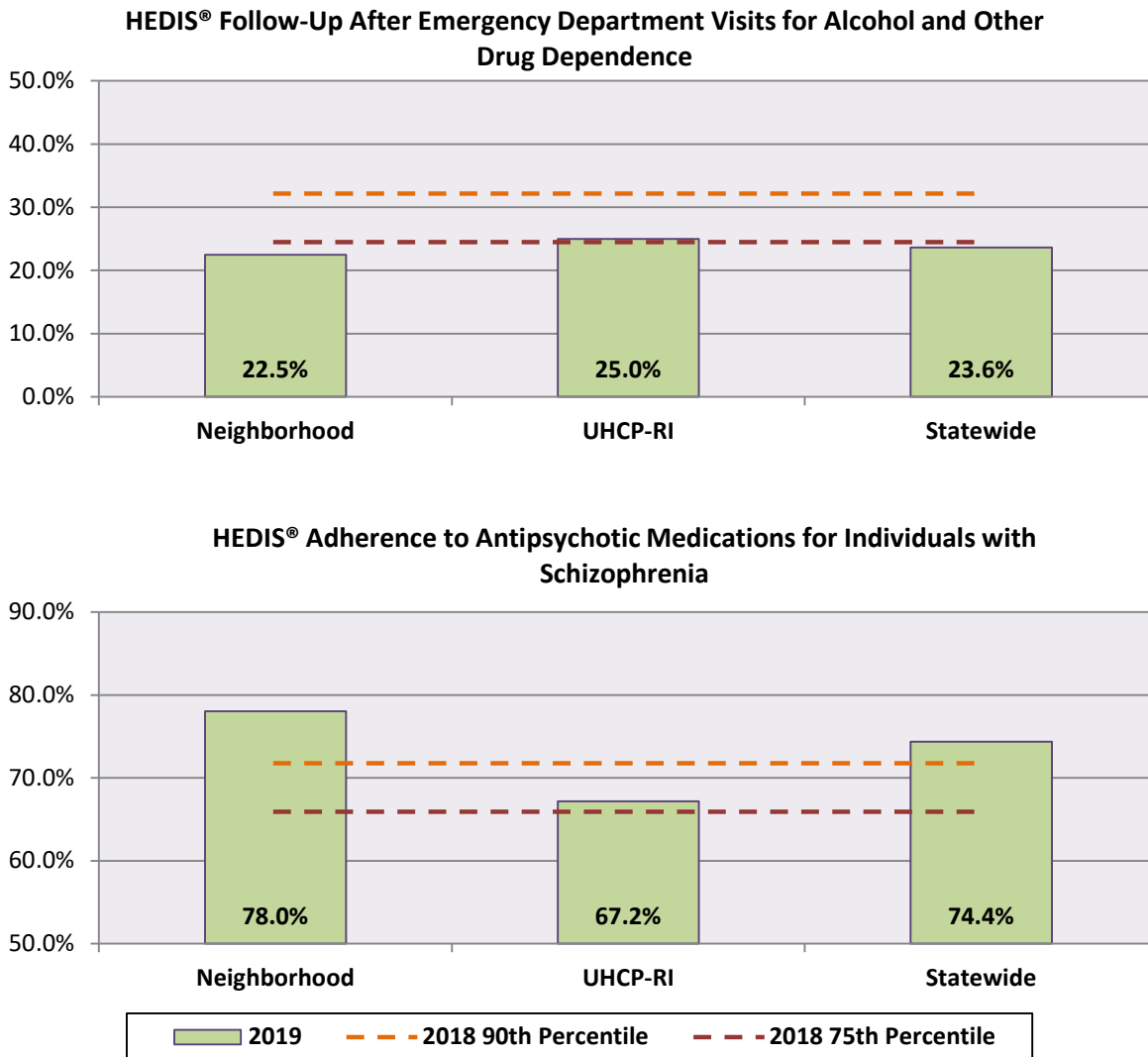


Figure 6f: PGP Results 2017-2019—Behavioral Health²⁵



²⁵ Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications measure was added to the PGP in report year 2019.

Figure 6f: PGP Results 2017-2019—Behavioral Health (continued)²⁶



²⁶ Follow-Up After Emergency Department Visits for Alcohol and Other Drug Dependence and Adherence to Antipsychotic Medications for Individuals with Schizophrenia measures were added to the PGP in report year 2019.

VI. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

Per *Title 42 CFR § 438.360*, in place of a Medicaid administrative review by the state, its agent or EQRO, states can use information obtained from a national accrediting organization review for determining plan compliance with standards established by the state to comply with these requirements.

Technical Methods of Data Collection and Analysis

EOHHS relies on the NCQA Accreditation standards, review process, and findings, in addition to other sources of information, to ensure MCO compliance with many of the structure and operations standards. The State also conducts an annual monitoring review to assess MCO processes and gather data for the State’s Performance Goal Program metrics. Further, EOHHS submitted a crosswalk to CMS, pertaining to comparability of NCQA’s accreditation standards to the federal regulatory requirements for compliance review, in accordance with *Title 42 CFR §438.360(b)(4)*. This strategy was approved by CMS, with the most recent version being submitted to CMS in December 2014.

IPRO received the approved crosswalk and the results of the NCQA Accreditation Survey from EOHHS for each MCO. IPRO verified MCO compliance with federal Medicaid standards of *Title 42 CFR Part 438 Subpart D and Subpart E 438.330*.

Description of Data Obtained

The *Score Summary Overall Results* presented Accreditation Survey results by category code, standard code, review category title, self-assessed score, current score, issues not net, points received and possible points. The crosswalk provided to IPRO EOHHS included instructions on how to use the crosswalk, a glossary, and detailed explanations on how the NCQA accreditation standards support federal Medicaid standards.

Table 12 displays the results of the MCO’s most recent NCQA Accreditation survey. It was determined that all three (3) MCOs were fully compliant with the standards *Title 42 CFR Part 438 Subpart D and Subpart E 438.330*.

Table 12: Evaluation 42 CFR Part 438 Subpart D and QAPI Standards

Part 438 Subpart D and Subpart E 438.330	Neighborhood	Tufts	UHCP-RI
438.206: Availability of Services	Met	Met	Met
438.207: Assurances of adequate capacity and services	Met	Met	Met
438.208: Coordination and continuity of care	Met	Met	Met
438.210: Coverage and authorization of services	Met	Met	Met
438.214: Provider selection	Met	Met	Met
438.224: Confidentiality	Met	Met	Met
438.228: Grievance and appeal system	Met	Met	Met
438.230: Sub-contractual relationships and delegation	Met	Met	Met
438.236: Practice guidelines	Met	Met	Met
438.242: Health information systems	Met	Met	Met
438.330: Quality assessment and performance improvement program	Met	Met	Met

VII. Validation of Network Adequacy

This section of the report presents the results of the evaluation of UHCP-RI's ability to provide Medicaid members with an adequate provider network.

Objectives

In the absence of a CMS protocol for *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(iv)*, IPRO assessed MCO compliance with the standards of *Title 42 CFR § 438.358 Network adequacy standards* and *Section 2.09.02* of the State's *Medicaid Managed Care Services Contract*.

MCOs must ensure that a sufficient number of primary and specialty care providers are available to members to allow for a reasonable choice among providers. This is required by Federal Medicaid requirements, State licensure requirements, NCQA Accreditation standards, and the State's *Medicaid Managed Care Services Contract*.

It is important to note that the *Medicaid Managed Care Services Contract* has never had "reasonable distance" standards. Regarding the provider network, Section 2.08.01 of the State's July 2019 Medicaid Managed Care Services Contract states:

"The Contractor will establish and maintain a robust geographic network designed to accomplish the following goals: (1) offer an appropriate range of services, including access to preventive care, primary care, acute care, specialty care, behavioral health care, substance use disorder, and long-term services for the anticipated number of enrollees in the services area; (2) maintain providers in sufficient number, mix, and geographic areas; and (3) make available all services in a timely manner."

For primary care, Section 2.08.03.06 of the Contract states:

"The Contractor agrees to assign no more than fifteen hundred (1,500) members to any single PCP in its network. For PCP teams and PCP sites, the Contractor agrees to assign no more than one thousand (1,000) members per single primary care provider within the team or site, e.g., a PCP team with three (3) providers may be assigned up to three thousand (3,000) members."

With respect to access, the *Medicaid Managed Care Services Contract* has always contained service accessibility standards (e.g., days-to-appointment for non-emergency services), including a "travel time" standard in Section 2.09.02 of the State's *Medicaid Managed Care Services Contract*, July 2019, which states as follows:

"The Contractor will develop, maintain, and monitor a network that is geographically accessible to the population being served. Pursuant to 42 CFR 438.68, the Contractor must ensure its network is compliant with the State-established provider-specific network adequacy standards. The Contractor will make available to every member a provider whose office is located within the lesser of the time or distance standard as provided. Members may, at their discretion, select a participating provider located farther from their home."

Consequently, the standards against which reasonable distances are assessed are developed by each MCO, based on MCO-specific criteria. The State's *Medicaid Managed Care Contract* also has a "mainstreaming" provision requiring that, if a network's provider practice is open to any new patients, then the practice must accept Medicaid managed care enrollees.

Technical Methods of Data Collection and Analysis

Neighborhood and UHCP-RI monitor their provider networks for accessibility and network adequacy using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance to their homes.

Neighborhood’s distance requirements vary by provider type. Neighborhood’s goal was to have a minimum of ninety-five percent (95%) of members with access to care within the noted distances.

In 2014, UHCP-RI revised its GeoAccess standards to align with CMS’ criteria for network adequacy. UHCP-RI assessed geographic accessibility through the criteria for large metro and metro county designations²⁷. The goal was to have ninety percent (90%) of network primary care and high-volume and high-impact specialty care providers meet the distance requirements. The distance requirements vary by provider type and geographic access criteria.

Findings

Table 13 shows the percentage of members or providers for which the Health Plans met their respective access standards. Note that the types of high-volume and high-impact specialists may differ for each Health Plan based on Health Plan-specific information and the method of identifying these types of providers.

Table 13: GeoAccess Provider Network Accessibility—2019

Provider Type	Access Standard ¹	% of English Speaking Members or Providers ²	% of Spanish Speaking Members or Providers ²
Neighborhood			
Adult Services			
PCP	2 in 10 miles	99.9%	99.9%
Fam PCP	2 in 10 miles	99.9%	99.7%
Cardiologist	1 in 15 miles	99.8%	99.9%
Dermatologist	1 in 15 miles	99.6%	96.3%
Endocrinologists	1 in 15 miles	99.6%	95.9%
Gastroenterologists	1 in 15 miles	99.4%	97.8%
Pulmonary	1 in 15 miles	97.4%	97.7%
Oncologists	1 in 15 miles	99.6%	99.7%
OBGYN	2 in 10 miles	97.9%	97.7%
INT PCP	2 in 10 miles	99.2%	98.7%
Child Services			
PED PCP's	2 in 10 miles	97.7%	97.3%

²⁷ UHCP-RI’s GeoAccess standards derive from CMS’ Medicare Advantage network adequacy criteria. These criteria evaluate accessibility by county type: large metro, metro, micro, rural, and counties with extreme access consideration (CEAC). County types are defined by population and population density, based on the most recently available census data. All counties in Rhode Island meet criteria for the large metro and metro county designations. Detailed information can be found at www.cms.gov.

Provider Type	Access Standard ¹	% of English Speaking Members or Providers ²	% of Spanish Speaking Members or Providers ²
PED Allergist	1 in 15 miles	97.1%	95.3%
PED Gastroenterologist	1 in 15 miles	85.1%	95.4%
PED Otolaryngologist	1 in 15 miles	99.0%	0.4%
PED Oncologist	1 in 15 miles	76.4%	0%
PED Orthopedics	1 in 15 miles	99.7%	99.9%
PED Neurologist	1 in 15 miles	97.6%	94%
UHCP-RI			
Large Metro	Access Standard	% of Members	
Primary Care Practitioners	1 in 5 miles	99%	
OB/GYN	1 in 5 miles	100%	
Cardiology (High-Impact Specialist/High-Volume Specialist)	1 in 5 miles	99%	
Orthopedics (High-Volume Specialist)	1 in 5 miles	98%	
Oncology (High-Impact Specialist/High-Volume Specialist)	1 in 10 miles	98%	
Dermatology	1 in 15 miles	97%	
Metro	Access Standard	% of Members	
Primary Care Practitioners	1 in 10 miles	100%	
OB/GYN	1 in 10 miles	100%	
Cardiology (High-Impact Specialist/High-Volume Specialist)	1 in 20 miles	100%	
Orthopedics (High-Volume Specialist)	1 in 20 miles	100%	
Oncology (High-Impact Specialist/High-Volume Specialist)	1 in 30 miles	100%	
Dermatology	1 in 30 miles	100%	

¹ The Access Standard is measured in distance to members' addresses.

² The percentages represent the proportion of members or providers for which the Health Plans met the access criteria.

³ Tufts data was not reported for 2018.

In addition to utilizing the GeoAccess program to assess network adequacy and provider accessibility, MCOs are required to conduct routine Access and Availability Survey. This survey employed the “secret shopper” methodology to assess member access to timely appointments. The State’s July 2019 *Medicaid Managed Care Services Contract* outlines appointment timeliness standards in *Section 2.09.04* for many types of appointments, including, but not limited to, routine care, urgent care, behavioral health care, and dental care. Timeliness standards included in the *Contract* are displayed **Table 14**.

Table 14: RI Medicaid Managed Care Contract Appointment Standards

Appointment Type	Access Standard
After-Hours Care (telephone)	24 hours a day, 7 days a week
Emergency Care	Immediately
Urgent Care	Within 24 hours
Routine Care	Within 30 calendar days
Physical Exam	Within 180 calendar days
EPSDT	Within 6 weeks
New Member	Within 30 calendar days
Non-Emergent/Non-Urgent Mental Health	Within 10 calendar days

Table 15 displays the results of the 2019 Access and Availability Survey conducted by the MCOs. Availability of both routine and urgent care appointments was assessed. The results of these surveys indicate there is opportunity for improvement in the area of appointment availability, as rates for timely appointments were low for many appointment types.

Table 15: Access and Availability Survey Results—2019

Appointment Type	Neighborhood			UHCP-RI			Tufts		
	Providers Surveyed	Appt. Made	% Timely Appt. ⁴	Providers Surveyed	Appt. Made	% Timely Appt. ^{4,5}	Providers Surveyed	Appt. Made	% Timely Appt. ⁴
Routine Care									
Primary Care Practitioners	30	10	26.7%	20	3		43	14	18.6%
Specialty Care—Adults	30	1	3.3%	28	15		14	6	28.6%
Specialty Care—Pediatrics	30	4	13.3%	18	3		7	3	42.9%
Behavioral Health ¹	30	11	30.0%	5	0		16	14	75%
Urgent Care									
Primary Care Practitioners	30	5	10.0%	20	4		44	13	9.1%
Specialty Care—Adults	30	3	6.7%	23	10		20	6	0.0%
Specialty Care—Pediatrics	30	5	10.0%	22	5		9	2	11.1%

¹ Behavioral health providers were not surveyed in 2018 for Neighborhood.

² The rate of timely appointments is based on the number of providers surveyed, and not the number of appointments made.

³ UHC did not report the percent of timely appointment rates in 2019.

VIII. Validation or Administration of a Quality of Care Survey

Objectives

The RI EOHHS requires, as part of the *Medicaid Managed Care Services Contract*, that each MCO collect member satisfaction data through an annual survey of a representative sample of its Medicaid members.

The overall objective of the member satisfaction survey is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement, which could aid plans in increasing the quality of provided care.

All three (3) MCOs independently contracted with Symphony Performance Health, Inc. (SPH), an NCQA-certified survey vendors to administer the 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Technical Methods of Data Collection and Analysis

SPH administered the 2020 CAHPS Adult Medicaid 5.0 survey using an NCQA approved methodology. Members eligible for the survey were those 18 years and older (as of December 31 of the measurement year) who had been continuously enrolled in the plan for at least five of the last six months of the measurement year. Surveys were collected via a mail and phone methodology.

SPH administered the 2020 CAHPS Child Medicaid 5.0 CAHPS survey using an NCQA approved methodology. Members eligible for the survey were parents of those 17 years and younger (as of December 31 of the measurement year) who had been continuously enrolled in the plan for at least five of the last six months of the measurement year. Surveys were collected via a mail and phone methodology.

In the CAHPS tables that follow, scores were calculated in the following ways:

- Composite measures were calculated using responses of “usually,” “always” or “yes”.
 - *Getting Needed Care*
 - *Getting Care Quickly*
 - *How Well Doctors Communicate*
 - *Customer Service*
 - *Shared Decision Making*
- Rating measures were calculated using responses of “8” or “9” or “10”.
 - *Rating of All Health Care*
 - *Rating of Personal Doctor*
 - *Rating of Specialist Seen Most Often*
 - *Rating of Health Plan*

Description of Data

IPRO received a copy of the final CAHPS reports produced by SPH and utilized the results to assess UHCP-RI's performance compared to the national Medicaid benchmarks.

Findings

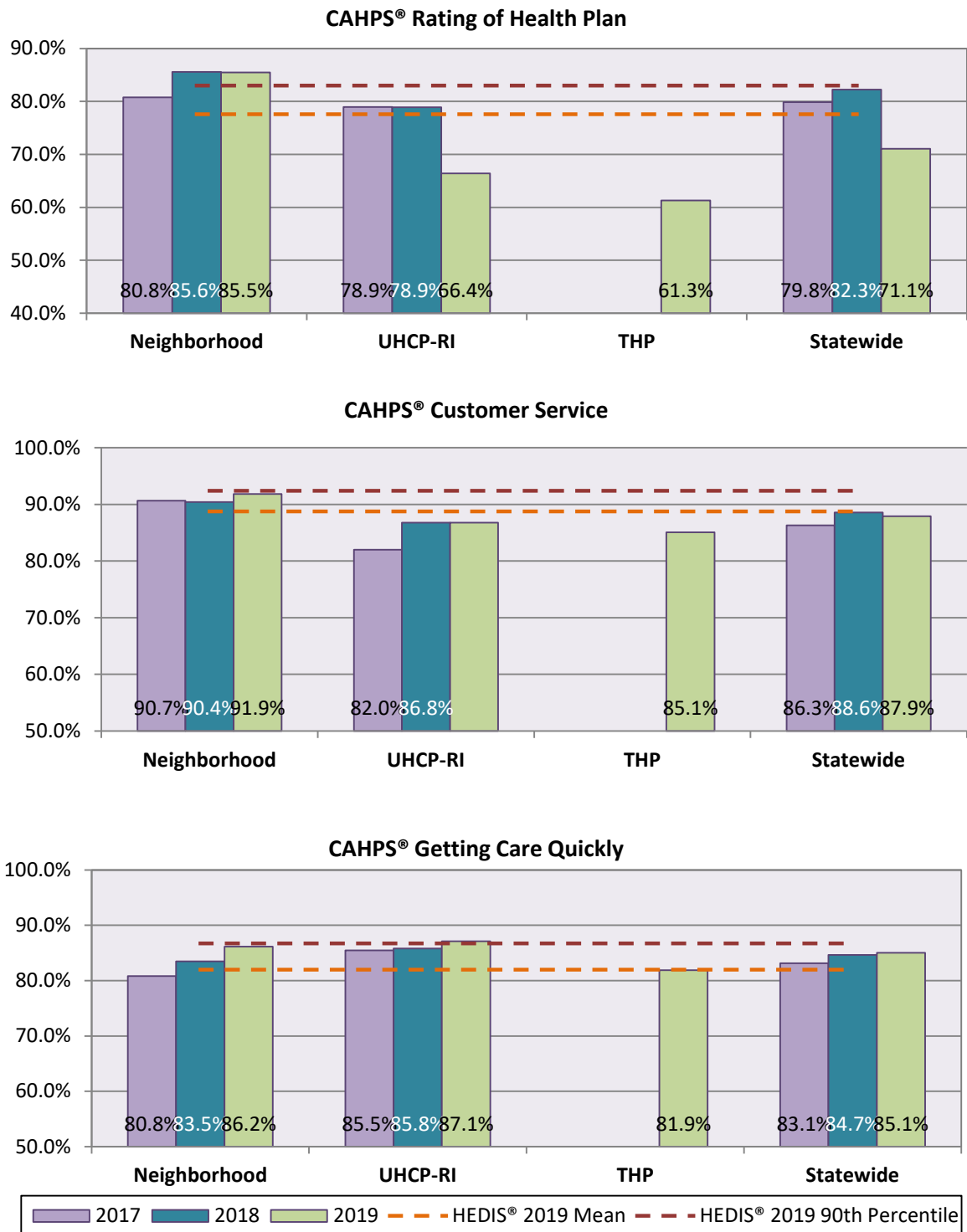
Adult CAHPS

Figure 5a displays the MCOs' rates for the satisfaction measures and composites for 2017 through 2019, as well as the statewide rates, compared to 2019 *Quality Compass*[®] national Medicaid benchmarks. In 2014, the NCQA introduced the *Flu Vaccinations for Adults (18-64 Years)* measure to the adult CAHPS[®] 5.0H survey. Additionally, the composite measure *Shared Decision Making* was modified for the 2015 survey cycle²⁸.

Neighborhood's rates exceeded the 2019 *Quality Compass*[®] national Medicaid mean for five (5) of the six (6) measures presented in Figure 5a, while UHCP-RI's rates exceeded the 2019 *Quality Compass*[®] national Medicaid mean for 5 (five) of the eight (8) measures reported. Neighborhood's, UHCP-RI's and the statewide rates for *Rating of All Health Care* exceeded the 90th percentile. All Neighborhood and UHC reported rates did not meet or exceeded the 2019 *Quality Compass*[®] 75th percentile for the following measures. The measures not qualifying for a partial reward are: *Rating of Specialist Seen Most Often*, *Shared Decision Making*, *Customer Service*, *Getting Care Quickly*, *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of Health Care*, *Rating of Personal Doctor*, *Rating of Personal Doctor* and *Rating of Specialist*.

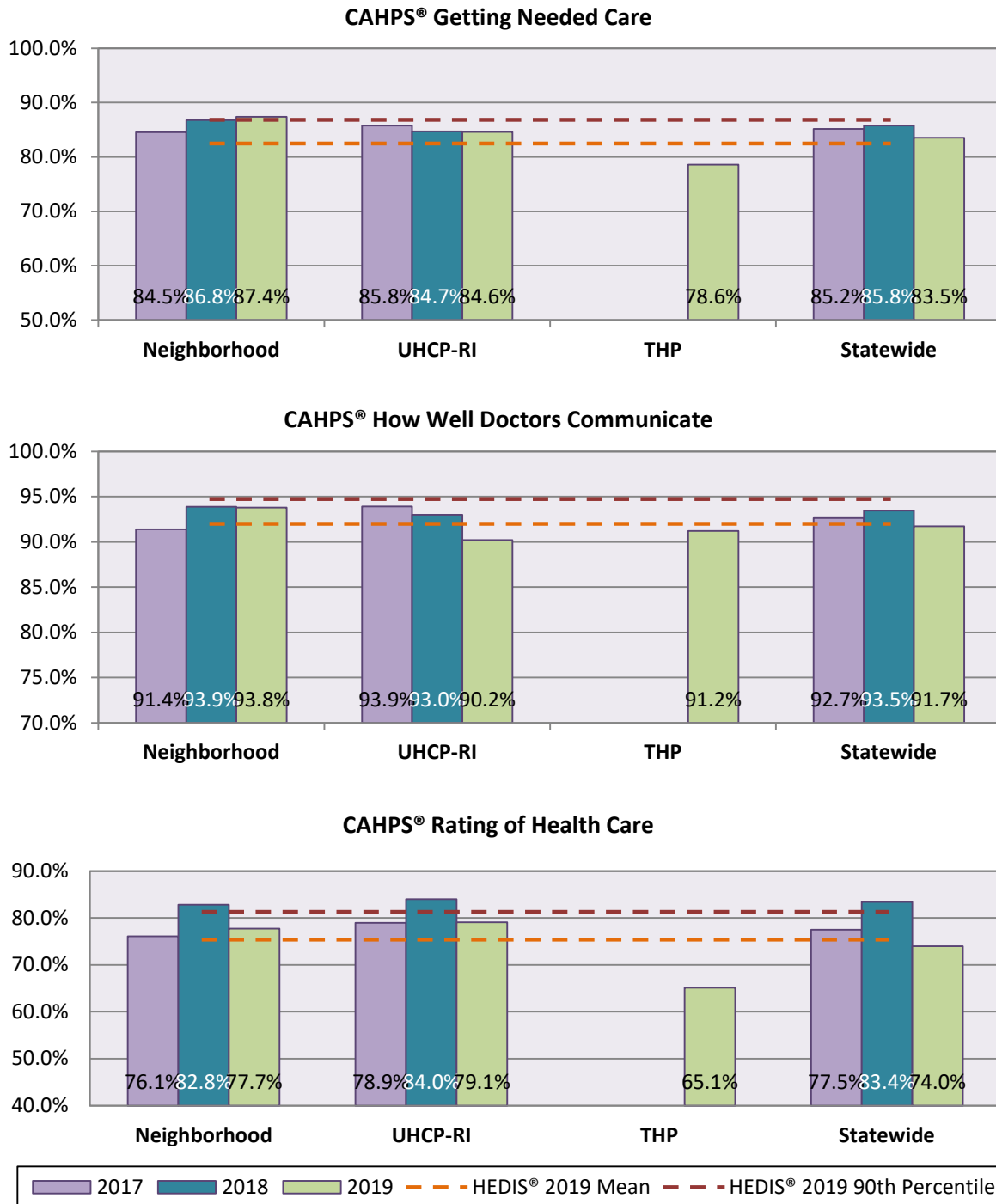
²⁸ In 2015, the questions included in the *Shared Decision Making* composite measure were modified and the responses were changed to "Yes" and "No", rather than "A Lot", "Some", "A Little", and "Not At All": Q10—Did you and a doctor or other health provider talk about the reasons you might want to take a medicine? Q11—Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine? Q12—When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

Figure 5a: Adult CAHPS® Member Satisfaction Rates—2017-2019¹



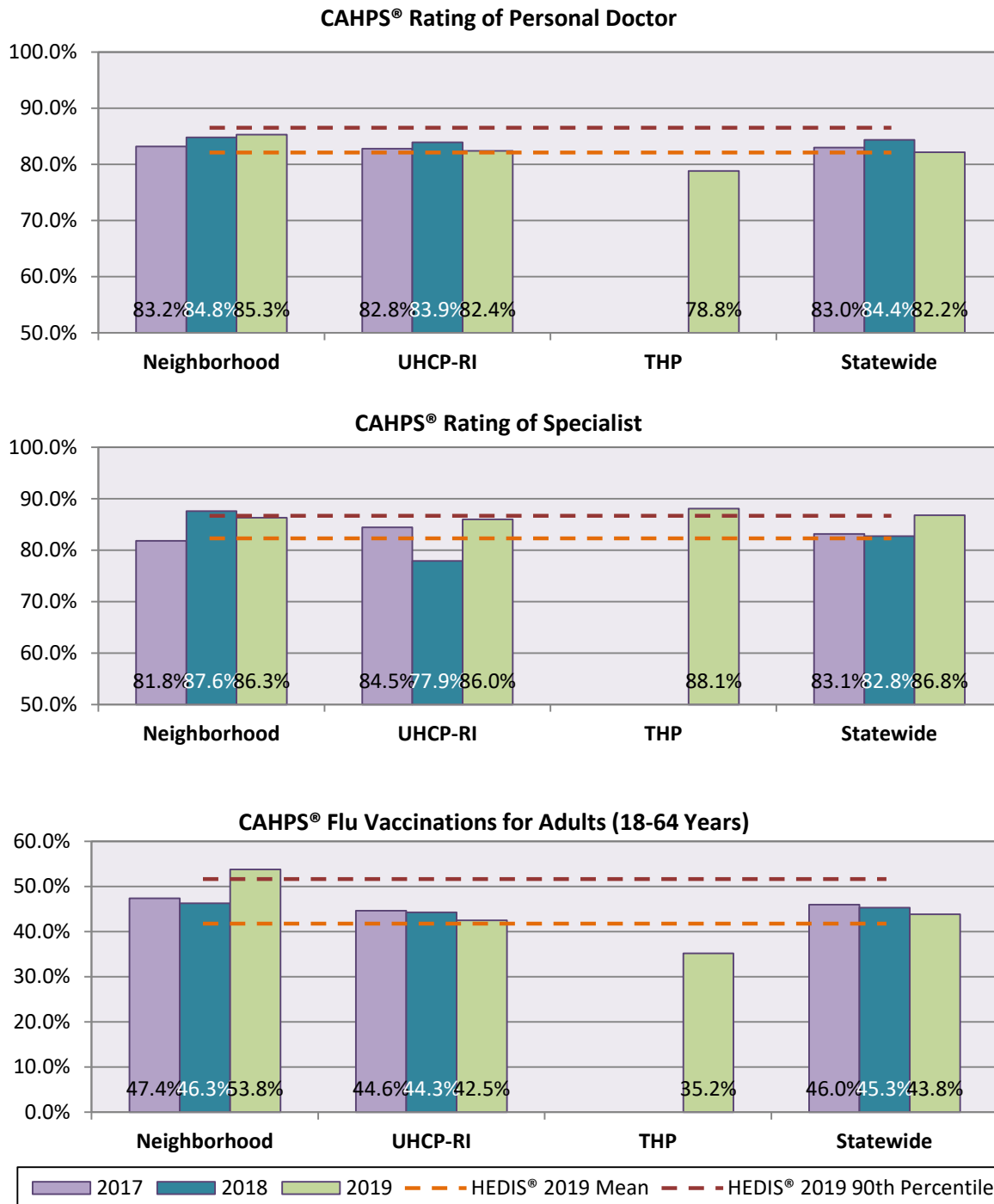
¹ The statewide rate for each of these bar charts was determined by calculating an unweighted average of Neighborhood and UHCP-RI's CAHPS® rates, since the size of the survey populations was similar and numerators and denominators were not available. Tufts did not conduct a CAHPS® survey for 2017 and 2018.

Figure 5a: Adult CAHPS® Member Satisfaction Rates—2017-2019¹ (continued)



1 The statewide rate for each of these bar charts was determined by calculating an unweighted average of Neighborhood and UHCP-RI's CAHPS® rates, since the size of the survey populations was similar and numerators and denominators were not available. Tufts did not conduct a CAHPS® survey for 2017 and 2018.

Figure 5a: Adult CAHPS® Member Satisfaction Rates—2017-2019¹ (continued)



¹ The statewide rate for each of these bar charts was determined by calculating an unweighted average of Neighborhood and UHCP-RI's CAHPS® rates, since the size of the survey populations was similar and numerators and denominators were not available. Tufts did not conduct a CAHPS® survey for 2017 and 2018.

Child CAHPS

In addition to the adult CAHPS® survey, both Neighborhood and UHCP-RI elected to conduct the child CAHPS® 5.0 survey. Neighborhood surveyed the Children with Chronic Conditions (CCC) population while UHCP-RI surveyed the Child General population. Although reporting of the child CAHPS® survey is not required, this extended effort demonstrates a commitment to providing quality health care to all members. Comparisons across Health Plans and to statewide rates could not be made due to the differences in populations surveyed.

Neighborhood's rates exceeded the 2019 Quality Compass® national Medicaid mean for all of the six (6) measures reported. Neighborhood also achieved the 90th percentile for the *Rating of Health Plan* measure, but fell below the 75th percentile for the following measures: *Getting Care Quickly*, *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of All Health Care* and *Rating of Personal Doctor*.

UHCP-RI's rates exceeded the 2019 Quality Compass® national Medicaid mean for five (5) of the six (6) measures reported. UHCP-RI achieved the 90th percentile for the *Rating of Health Plan* measure. The following measures fell below the 75th percentile: *Getting Care Quickly*, *How Well Doctors Communicate*, *Getting Needed Care*, *Rating of All Health Care* and *Rating of Personal Doctor*.

APPENDIX 1: RHODE ISLAND MEDICAID MANAGED CARE QUALITY STRATEGY

– July 2019

Section 1.1 Overview

For over 25 years, Rhode Island (RI) has utilized managed care as a strategy for improving access, service integration, quality and outcomes for Medicaid beneficiaries while effectively managing costs. Most RI Medicaid members are enrolled in managed care for at least acute care, including behavioral health services, and most children are enrolled in both a managed care organization (MCO) and in the dental Prepaid Ambulatory Health Plan (PAHP). Similar to the state’s rationale for managed medical and behavioral health services, the managed dental program (Rite Smiles) was designed to increase access to dental services, promote the development of good oral health behaviors, decrease the need for restorative and emergency dental care, and better manage Medicaid expenditures for oral health care.

To achieve its goals for improving the quality and cost-effectiveness of Medicaid services for beneficiaries, over time Rhode Island has increasingly transitioned from functioning simply as a payer of services to becoming a purchaser of medical, behavioral, and oral health delivery systems. Among other responsibilities, the contracted managed care entities (MCEs) program are charged with:

- ensuring a robust network beyond safety-net providers and inclusive of specialty providers,
- increasing appropriate preventive care and services, and
- assuring access to care and services consistent with the state Medicaid managed care contract standards, including for children with special health care needs.

In the context of reinventing Medicaid, expansion and health system transformation, RI Medicaid continues to achieve and sustain national recognition for the quality of services provided. The State contracts with three MCOs that are consistently ranked among the top Medicaid plans nationally according to the National Committee for Quality Assurance (NCQA).¹ RI Medicaid operates a Medicaid-Medicare Plan with one of its MCOs to serve dually-eligible members in managed care. In addition, RI Medicaid contracts with one dental plan. Rhode Island does not contract with any Prepaid Inpatient Health Plans (PIHP).

RI Medicaid’s Managed Care Quality Strategy is required by the Medicaid Managed Care rule, 42 CFR 438 Subpart E.² This strategy focuses on RI Medicaid’s oversight of MCO and PAHP compliance and quality performance to monitor the quality of care provided to Medicaid and CHIP members.³ RI Medicaid will work with CMS to ensure that the Quality Strategy meets all content requirements set forth in 42 CFR 438.340 (c)(2).

Throughout this document, the MCOs and the PAHP will be collectively referred to as Managed Care Entities (MCEs), unless otherwise noted. Demonstrating compliance with federal managed care rules, this revised Quality Strategy reflects RI Medicaid’s objective to transition to a state-wide collaborative framework for quality improvement activities, including measurement development, data collection, monitoring, and evaluation.

Rhode Island contracts with IPRO, a qualified External Quality Review Organization (EQRO) to conduct external quality reviews (EQRs) of its MCEs in accordance with 42 CFR 438.354.

Section 1.2 Rhode Island Medicaid and CHIP

The Executive Office of Health and Human Services (EOHHS) is the single state agency for Rhode Island’s Medicaid program and, as such, is responsible for the fiscal management and administration of the Medicaid program. As health care coverage funded by CHIP is administered through the State’s Medicaid program, the

EOHHS also serves as the CHIP State Agency under Federal and State laws and regulations.

In 2019, over 317,000 Rhode Island residents are covered by Medicaid under one of the following eligibility categories:

1. Adults with incomes up to 138 percent of poverty,
2. Pregnant women with household incomes up to 253 percent of poverty,
3. Children with household incomes up to 261 percent of poverty, and
4. Persons eligible under categories for persons who are aged, blind, or those with a disability.

After the state expanded Medicaid eligibility under the Affordable Care Act, Rhode Island’s total Medicaid population increased rapidly, and its uninsured rate dropped to less than four percent. Today, Medicaid is the state’s largest health care purchaser covering one out of four Rhode Islanders in a given year. The Medicaid Program constitutes the largest component of the state’s annual budget, State General Revenue expenditures are expected to reach \$2.9 billion in State Fiscal Year (SFY) 2018.

In the context of reinventing Medicaid, expansion and health system transformation, RI Medicaid continues to achieve and sustain national recognition for the quality of services provided. The State contracts with MCOs that are consistently ranked among the top Medicaid plans nationally according to the National Committee for Quality Assurance (NCQA).⁴

Section 1.3 History of Medicaid Managed Care Programs

The State’s initial Medicaid and CHIP managed care program, Rite Care, began in 1994. As shown in Table 1 below, in the 25 years since, there has been a steady increase in the managed care populations and services, including carving in behavioral health services and serving populations with more complex needs.

Table 1 Rhode Island Medicaid Managed Care Program Additions

Year	Managed Care Program Additions
1994	<ul style="list-style-type: none"> • Rite Care • SCHIP
2000	<ul style="list-style-type: none"> ▪ Children in Substitute Care ▪ Rite Share
2003	<ul style="list-style-type: none"> • Children with Special Needs • Rite Smiles
2008	a. Rhody Health Partners
2014	<ol style="list-style-type: none"> 1. Medicaid Expansion 2. Behavioral Health carved in to managed care
2015	I. Accountable Entities Pilot
2016	1. Medicare-Medicaid Plan (MMP)
2018	1. MCO-Certified Accountable Entities APMs

Today, RI Medicaid and CHIP beneficiaries enrolled in managed care entities include children and families; children in substitute care;⁵ children with special health care needs; aged, blind, and disabled adults; low-income adults without children; adults with dual Medicare and Medicaid coverage; and adults who need long-term services and supports (LTSS).

This increase in Medicaid managed care population and services has led RI Medicaid to progressively transition from a fee-for-service claims payer to a more active purchaser of care. Central to this transition has been the state's focus on improved access to and quality of care for Medicaid beneficiaries along with better cost control. Rhode Island Medicaid is committed to managed care as a primary vehicle for the organization and delivery of covered services to eligible Medicaid beneficiaries.

Section 1.4 Medicaid and CHIP Managed Care in 2019

Approximately 90 percent of Medicaid and CHIP members are enrolled in managed care entities for acute care and/or for dental services. Currently, RI Medicaid contracts with three MCOs and one managed dental health plan. These risk-based managed care contractors are paid per member per month (PMPM) capitation arrangements and include the following MCEs:

- a. **MCOs:** Rhode Island's three MCOs include: Neighborhood Health Plan of Rhode Island (Neighborhood); United Healthcare Community Plan of Rhode Island (UHC-RI), and Tufts Health Public Plan (Tufts). Neighborhood and UHC-RI began accepting Medicaid members in Rhode Island's initial managed care program in 1994. Tufts began accepting RI Medicaid members in July 2017. MCOs enroll Medicaid beneficiaries in the following lines of business (LOBs):
 - b. Rite Care Core (children and families)
 - c. Rite Care Substitute Care (children in substitute care)
 - d. Rite Care CSHCN (children with special healthcare needs)
 - e. Rhody Health Expansion (low income adults without children)
 - f. Rhody Health Partners (aged, blind, disabled adults)

- D. **Dental MCE:** The state contracts with United Healthcare Dental to manage the Rite Smile dental benefits for children enrolled in Medicaid. Enrollment in United Healthcare Dental began in 2006 for children born on or after May 1, 2000.

For RI Medicaid beneficiaries that are determined eligible, long-term services and supports (LTSS) are offered through a variety of delivery systems. RI Medicaid programs for persons dually eligible for Medicare and/or meeting high level of care determinations, including eligibility for LTSS include:

- E. **Medicare-Medicaid Plan (MMP) Duals:** EOHHS, in partnership with CMS and Neighborhood launched an innovative program in 2016 that combined the benefits of Medicare and Medicaid into one managed care plan to improve care for some of the state's most vulnerable residents. Enrollment in MMP duals is voluntary and covered benefits include: Medicare Part A, B, and D, and Medicaid Services (including LTSS for those who qualify). (Dental Care and transportation are covered out-of-plan).

- F. **Program for All Inclusive Care for the Elderly (PACE)** is a small voluntary program for qualifying eligible individuals over age 55 who require a nursing facility level of care. PACE provides managed care through direct contracts with PACE providers rather than through MCEs.

Table 2 displays MCO and PAHP enrollment in RI Medicaid managed care as of January 2019.

Table 2: Enrollment in Medicaid and CHIP Managed care as of January 2019

Managed Care Program	Members Enrolled in Program	Eligible MCEs
RiTe Care Core (children and families)	157,376	Neighborhood Tufts UHC-RI
RiTe Care Substitute Care (children in substitute care)	2,631	Neighborhood
RiTe Care CSHCN (children with special healthcare needs)	6,967	Neighborhood Tufts UHC-RI
Rhody Health Expansion (low income adults without children)	71,456	Neighborhood Tufts UHC-RI
Rhody Health Partners (aged, blind, disabled adults)	14,834	Neighborhood Tufts UHC- RI
Medicare/Medicaid Plan	15,577	Neighborhood
Grand Total MCO Members	264,841	
Dental PAHP Members RiTe Smiles	114,101	United HealthCare

Section 2.1 Medicaid Guiding Principles and Accountable Entities

Rhode Island’s Medicaid managed care program is dedicated to improving the health outcomes of the state’s diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well-being, independence and quality of life.

In 2015, Governor Gina Raimondo established the “Working Group to Reinvent Medicaid,” tasked with presenting innovative recommendations to modernize the state’s Medicaid program and increase efficiency. The Working Group established **four guiding principles**:

- a. pay for value, not volume,
- b. coordinate physical, behavioral, and long-term health care,
- c. rebalance the delivery system away from high-cost settings, and
- d. promote efficiency, transparency and flexibility.

Rhode Island’s vision, as expressed in the Reinventing Medicaid report is for “...a reinvented Medicaid in which our Medicaid managed care organizations (MCOs) contract with Accountable Entities (AEs), integrated provider organizations that will be responsible for the total cost of care and healthcare quality and outcomes of an attributed population.”

In alignment with its guiding principles, RI Medicaid developed the AE program as a core part of its managed care quality strategy. AEs are Rhode Island’s version of an accountable care organization. AEs represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to

address services outside of the traditional medical model which includes behavioral health and social support services. Medicaid MCOs are required to enter into Alternative Payment Model (APM) arrangements with certified AEs. As of early 2019, RI Medicaid has certified six Comprehensive AEs as part of its Health System Transformation Project (HTSP).

RI Medicaid created the AE Initiative to achieve the following goals in Medicaid managed care:⁶

- transition Medicaid from fee for service to value-based purchasing at the provider level
- focus on Total Cost of Care (TCOC)
- create population-based accountability for an attributed population
- build interdisciplinary care capacity that extends beyond traditional health care providers
- deploy new forms of organization to create shared incentives across a common enterprise, and
- apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs.

The state’s MCO contracts stipulate that only Rhode Island residents who are not eligible for Medicare and are enrolled in Medicaid managed care plans are eligible to participate in the AE Program. In early 2019, qualified

APM contracts were in place between five AEs and two Medicaid MCOs. Combined, close to 150,000 RI Medicaid managed care members are attributed to an AE. These RI Medicaid members include participants in the following programs: Rite Care, Rhody Health Partners, and the Rhody Health Expansion Population. RI Medicaid contracts directly with the MCO, certifies the AEs and works closely with the dyads to improve quality as outlined in the 1115 waiver. More information on AEs is included in *Section 7: Delivery System Reform*.

Section 2.2 Quality Strategy Goals

Evolving from the state’s guiding principles, RI Medicaid established eight core goals for its Managed Care Quality Strategy from 2019-2022 as depicted in Table 3 below.

Table 3: Managed Care Quality Strategy Goals	
1.	Maintain high level managed care performance on priority clinical quality measures
2.	Improve managed care performance on priority measures that still have room for improvement (i.e., are not ‘topped out’)
3.	Improve perinatal outcomes
4.	Increase coordination of services among medical, behavioral, and specialty services and providers
5.	Promote effective management of chronic disease, including behavioral health and comorbid conditions
6.	Analyze trends in health disparities and design interventions to promote health equity
7.	Empower members in their healthcare by allowing more opportunities to demonstrate a voice and choice
8.	Reduce inappropriate utilization of high-cost settings

This strategic quality framework will be used as a tool for RI Medicaid to better facilitate alignment of agency-wide initiatives that assess managed care progress to date and identify opportunities for improvement to better serve RI Medicaid and CHIP managed care populations in a cost-effective manner. Each of the eight managed care goals is aligned with one or more quality objectives outlined in **Section 1.7**

In its managed care programs, RI Medicaid employs standard measures that have relevance to Medicaid-enrolled populations. Rhode Island has a lengthy experience with performance measurement via collecting and reporting on HEDIS^{®7} measures for each managed care subpopulation it serves. RI Medicaid also requires its managed care plans to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS)⁸ 5.0 surveys. During this quality strategy period, RI Medicaid will focus on strengthening its current MCE measurement and monitoring activities and benchmarks to continually improve performance and achieve the goals of Medicaid managed care. RI Medicaid will also implement and continually improve AE performance measurement specifications, benchmarks and incentives, consistent with the goals of the AE initiative and this Quality Strategy.

Section 2.3 Quality Strategy Objectives

To support achievement of the Quality Strategy goals, RI Medicaid has established specific objectives as identified in Table 3 below. The state has developed objectives to focus state, MCE and other activities on interventions likely to result in progress toward the eight managed care goals. The right column of the table depicts how each objective aligns with one or more referenced managed care goals as numbered in **Section 2.2**.

Table 3: Managed Care Quality Objectives	Aligned with Goal
A. Continue to work with MCEs and the EQRO to collect, analyze, compare and share clinical performance and member experience across plans and programs.	1-8
B. Work collaboratively with MCOs, AEs, OHIC and other stakeholders to strategically review and modify measures and specifications for use in Medicaid managed care quality oversight and performance incentives. Establish consequences for declines in MCE performance.	1
C. Create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.	1,2
D. Review and potentially modify financial incentives (rewards and/or penalties) for MCO performance to benchmarks and improvements over time.	1-5
E. Work with MCOs and AEs to better track and increase timely, appropriate preventive care, screening, and follow up for maternal and child health.	3, 6, 8
F. Incorporate measures related to screening in managed care and increase the use of screening to inform appropriate services.	3, 4, 5, 6, 8
G. Increase communication and the provision of coordinated primary care and behavioral health services in the same setting for members attributed to AEs.	4,5,8
H. Monitor and assess MCO and AE performance on measures that reflect coordination including: follow up after hospitalization for mental health and data from the new care management report related to percentage/number of care plans shared with PCPs.	4,5,8
I. Develop a chronic disease management workgroup and include state partners, MCEs and AEs, to promote more effective management of chronic disease, including behavioral health and co-morbid conditions.	5,8
J. Review trend for disparity-sensitive measures and design interventions to improve health equity, including working with MCOs and AEs to screen members related to social determinants of health and make referrals based on the screens.	6
K. Share and aggregate data across all RI HHS agencies to better address determinants of health. Develop a statewide workgroup to resolve barriers to data-sharing.	6
L. Continue to require plans to conduct CAHPS 5.0 surveys and annually share MCO CAHPS survey results with the MCAC.	7

M. Explore future use of a statewide survey to assess member satisfaction related to AEs, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from AEs.	7
N. Explore use of focus groups to solicit additional member input on their experiences & opportunities for improvement.	7

Section 3.1 Quality Management Structure

The EOHHS is designated as the administrative umbrella that oversees and manages publicly funded health and human services in Rhode Island, with responsibility for coordinating the organization, financing, and delivery of services and supports provided through the State’s Department of children, Youth and Families (DCYF), the Department of Health (DOH), the Department of Human Services (DHS) including the divisions of Elderly Affairs and Veterans Affairs, and the Department of Mental Healthcare, Developmental Disabilities and Hospitals (BHDDH). Serving as the State’s Medicaid agency, EOHHS has responsibility for the State’s Comprehensive 1115 Demonstration.

RI Medicaid oversees and monitors all contractual obligations of the MCEs to further enhance the goals of improving access to care, promote quality of care and improve health outcomes while containing costs. RI Medicaid also provides technical assistance to MCEs and when necessary takes corrective action to enhance the provision of high quality, cost- effective care.

Medicaid Quality functions include:

- measurement selection and/or development,
- data collection,
- data analysis and validation,
- identification of performance benchmarks,
- presentation of measurement and analysis results, including changes over time, and
- quality improvement activities.

The above functions are conducted at different levels including: RI Medicaid program level, the MCE level, the AE level, and the provider level, where appropriate and feasible. The cadence of each activity aligns with federal guidelines and best practices. The RI Medicaid managed care quality strategy demonstrates an increase in alignment of priorities and goals across state agencies and Medicaid MCEs. This quality strategy will continue to evolve in the next few years to increase the strategic focus and measurement linked to state objectives for managed care.

RI Medicaid conducts oversight and monitoring meetings with all managed care entities. These monthly meetings are conducted separately with each of the MCEs. Meeting agendas focus on routine and emerging items accordingly. The following content areas are addressed on at least a quarterly basis:

1. managed care operations
2. quality measurement, benchmarks, and improvement
3. managed care financial performance
4. Medicaid program integrity

RI Medicaid utilizes a collaborative approach to quality improvement activities at the State level. RI Medicaid coordinates with state partners across health and human services agencies. On a routine basis, representatives from DCYF, BHDDH, DOH join RI Medicaid in routine oversight activities to lend their expertise related to subject matter and populations served. This collaborative approach has proven to be sustainable and efficient.

As part of the 2019-2022 Quality Strategy, the 1115 Quality and Evaluation Workgroup with state partners will be crucial to monitoring various quality improvement efforts occurring within the broad array of Medicaid programming, sharing lessons learned, and discussing quality and evaluation efforts on the horizon.

In addition to managed medical care, there is also state oversight of the managed dental care provided to Medicaid managed care members. The focus of the RI Medicaid dental quality strategy continues to be on ensuring access to preventive dental services for members under age 21 and effective collaboration between state partners. Along with the RI Medicaid dental contract oversight, the DOH regulates the utilization review and quality assurance, or quality management (UR/QA) functions of all licensed Dental Plans, including RlTeSmiles. The Medicaid managed dental plan contractor must comply with all DOH UR/QA standards as well as specific standards described in the dental contract.

Section 3.2 Review and Update of the Quality Strategy

RI Medicaid will conduct an annual review of the Medicaid Managed Care Quality Strategy and complete an update to its quality strategy as needed but note less frequently than every three years. As part of the review, RI Medicaid and its contracted MCEs will meet with interested parties, state partners, and consumer advisors to share annual EQRO results and other data to assess the strategy's effectiveness.

To obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final, the State put the proposed Medicaid Managed Care Quality Strategy on the March 2019 agenda of the Medical Care Advisory Committee (MCAC) for discussion. In April 2019, Rhode Island will post the final draft Medicaid Managed Care Quality Strategy on the RI EOHHS Website for 30 days for public comment. After public comments are received and reviewed, the Quality Strategy will be finalized, and copies will be forwarded to CMS Central and Regional Offices. EOHHS will post the most recent version of the Quality Strategy on its website.

In accordance with 42 CFR 438.204(b)(11), Rhode Island has defined what constitutes a "significant change" that would require revision of the Quality Strategy more frequently than every three years. Rhode Island will update its Quality Strategy whenever any of the following significant changes and/or temporal events occur:

- a new population group is to be enrolled in Medicaid managed care;
- a Medicaid managed care procurement takes place
- substantive changes to quality standards or requirements resulting from regulatory authorities or legislation at the state or federal level, or
- significant changes in managed care membership demographics or provider network as determined by EOHHS.

Section 3.3 Evaluating the Effectiveness of the Quality Strategy

Rhode Island engages in regular activities to assess the effectiveness of its Medicaid managed care quality strategy including:

5. routine monitoring of required MCE reports and data submissions that are due to the state according to a contractually-defined reporting calendar
6. collection and analysis of key performance indicators to assess MCE progress toward quality goals and targets at least annually.
7. annual review of EQR reports to assess the effectiveness of managed care program in providing quality services in an accessible manner.
8. annual strategy review conducted by internal stakeholders for each type of managed care program:

acute MCO (including AEs), managed dental, and managed LTSS/Duals.

As MCE, EQR, and other quality reports are reviewed, opportunities may be identified for additional reporting requirements to ensure RI Medicaid is meeting the mission statement assuring access to high quality and cost-effective services that foster the health, safety, and independence of all Rhode Islanders.

Internal and external stakeholders provide input to the development of Rhode Island's Medicaid quality programs, and to the Medicaid Managed Care Quality Strategy itself. Through committees, work groups and opportunities for comment, stakeholders identify areas that merit further discussion to ensure the advancement of person-centered, integrated care and quality outcomes for Medicaid managed care members. For example, in 2019, EOHHS convened a series of stakeholder meetings with the AEs and MCOs to discuss the implementation of the AE Total Cost of Care quality measures, pay-for-performance methodology, and the outcome measures and incentive methodology to ensure measures and methodology met the intended program goals. Similarly, RI Medicaid also convened an MCO and AE workgroup to discuss further refinement of the Social Determinants of Health screening measure.

Section 4.1 State Monitoring of Managed Care Entities

To assess the health care and services furnished by Medicaid MCEs, RI Medicaid has a managed care monitoring system which addresses all aspects of the MCE program consistent with 42 CFR 438.66. For example, the state's oversight and monitoring efforts include assessing performance of each MCE to contract requirements in the following areas:

- administration and management
- appeal and grievance systems
- claims management
- enrollee materials and customer services, including the activities of the beneficiary support system.
- finance, including new medical loss ratio (MLR) reporting requirements,
- Information systems, including encounter data reporting,
- marketing,
- medical management, including utilization management and case management.
- program integrity,
 - provider network management, including provider directory standards,
 - availability and accessibility of services, including network adequacy standards,
 - quality improvement, and
 - for MMPs, areas related to the delivery of LTSS not otherwise included above and as applicable to the MMP contract.

RI uses data collected from its monitoring activities to improve the performance of its MCE programs. For example, the state MCE oversight includes reviewing:

9. enrollment and disenrollment trends in each MCE and other data submitted by the RI Medicaid enrollment broker related to MCE performance
10. member grievance and appeal logs,
11. provider complaint and appeal logs,
12. findings from RI's EQR process,
13. results from enrollee and provider satisfaction surveys conducted by the State/EQRO or MCE,
14. MCE performance on required quality measures,
15. MCE medical management committee reports and minutes,
16. the annual quality improvement plan for each MCE.

17. audited financial and encounter data submitted by each MCE,
18. the MLR summary reports required by 42 CFR 438.8.
19. customer service performance data submitted by each MCE, and
20. for the MMP contract, other data related to the provision of LTSS not otherwise included above as applicable to the MMP contract.

Section 4.2 Specific MCE Oversight Approaches Used by RI Medicaid

Rhode Island Medicaid has detailed procedures and protocols to account for the regular oversight, monitoring, and evaluation of its MCEs in the areas noted above. As part of its managed care program, RI Medicaid employs a variety of mechanisms to assess the quality and appropriateness of care furnished to all MCO and PAHP members including:

- Contract management - All managed care contracts and contracts with entities participating in capitated payment programs include quality provisions and oversight activities. Contracts include requirements for quality measurement, quality improvement, and reporting. Active Contract Management is a crucial tool in RI Medicaid’s oversight. Routine reporting allows RI Medicaid to identify issues, trends and patterns early and efficiently to mitigate any potential concerns. Another key part of its contract management approach are monthly oversight meetings that RI Medicaid directs with each MCE. One topic that may be included in contract oversight meetings, for example, is mental health parity. The state may use this meeting as a forum to address compliance issues or questions related to the updated MCO Contract language related to mental health parity:
 - *The Contractor must comply with MHPAEA requirements and establish coverage parity between mental health/substance abuse benefits and medical/surgical benefits. The Contractor will cover mental health or substance use disorders in a manner that is no more restrictive than the coverage for medical/surgical conditions. The Contractor will publish any processes, strategies, evidentiary standards, or other factors used in applying Non-Qualitative Treatment Limitations (NQTL) to mental health or substance use disorder benefits and ensure that the classifications are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. The Contractor will provide EOHHS with its analysis ensuring parity compliance when: (1) new services are added as an in-plan benefit for members or (2) there are changes to non-qualitative treatments limitations. The Contractor will publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence. In the event of a suspected parity violation, the Contractor will direct members through its internal complaint, grievance and appeals process as appropriate. If the matter is still not resolved to the member's satisfaction, the member may file an external appeal (medical review) and/or a State Fair Hearing. The Contractor will track and trend parity complaints, grievances and appeals on the EOHHS approved template at a time and frequency as specified in the EOHHS Managed Care Reporting Calendar and Templates.*
- State-level data collection and monitoring – RI Medicaid collects data to compare MCE performance to quality and access standards in the MCE contracts. At least annually, for example, Rhode Island collects HEDIS and other performance measure data from its managed care plans and compares plan performance to national benchmarks, state program performance, and prior plan performance. In addition, the state monitors MCE encounter data to assess trends in service utilization, as well as analyzing a series of quarterly reports, including informal complaints, grievances, and appeals.

RI Medicaid's enhanced Reporting Calendar tool helps MCOs and the state better track, manage, and assess a comprehensive series of standing reports used for oversight and monitoring of the State's managed care programs. MCO reports are submitted monthly, quarterly and annually depending on the reporting cadence on a variety of topics specified by the state, such as:

- Care Management
- Compliance
- Quality Improvement Projects
- Access, secret shopper, provider panel
- Grievances and Appeals
- Financial Reports
- Informal Complaints
- Pharmacy Home

See **Appendix C** for an abbreviated copy of the MCO Reporting Attestation Form developed by RI Medicaid. The scheduled MCE reports allow RI Medicaid to identify emerging trends, potential barriers or unmet needs, and/or quality of care issues for managed care beneficiaries. The findings from the MCE reports are analyzed by the state and discussed with contracted health plans during monthly MCE Oversight and Monitoring meetings. During this Quality Strategy period, RI Medicaid will expand the enhanced Reporting Calendar tool to apply to the dental PAHP and to the MMP.

In addition, MCEs are required to submit information for financials, operations, and service utilization through the encounter data system. RI Medicaid maintains and operates a data validation plan to assure the accuracy of encounter data submissions.

- Performance Incentives - Within the contract for Rite Care, Rhody Health Partners and Rhody Health Expansion, the state requires performance measures through a pay-for-performance program called the Performance Goal Program (PGP). MCOs can earn financial incentives for achieving specified benchmarks for measures in the following domains: utilization, access to care, prevention/screening, women's health, and chronic care management, and behavioral health. The contract for the MMP requires performance measures that are tied to withholds. The plan can earn the withhold payment by meeting benchmarks as outlined in the contract. The PAHP has one required performance measure that is calculated using a HEDIS® methodology.

To create more meaningful consequences for MCE performance in the future, RI Medicaid will develop and more actively utilize a combination of financial and non-financial incentives for contracted MCEs to meet or exceed performance expectations. To make a stronger business case for MCEs to invest in improved performance on behalf of members, RI Medicaid may amend its MCE policies and contracts to specifically require more transparency on performance and to specify financial penalties on MCEs performing below state-defined minimum benchmarks for certain key measures.

- Performance improvement projects - Each managed care entity is required to complete at least two performance improvement projects (PIPs) annually in accordance with 42 CFR 438.330(d) and the RI Medicaid managed care contracts. RI Medicaid MCOs are contractually obligated to conduct 4 PIPs annually. The dental plan has two contractually required PIP(s). The MMP is also required to perform one additional PIP specific to that population and their service needs. After analysis and discussion, MCEs are required to act on findings from each contractually required quality improvement project.
- Annual Quality Plan-Each MCE must submit an annual quality plan to RI Medicaid. This plan must align the

RI Medicaid’s goals and objectives. RI Medicaid contracts with an EQRO to perform an independent annual review of each Medicaid MCE. The state’s EQRO is involved in reviewing the MCE quality plans as part of its broader role in performing the external quality review of each managed care entity and program.

- Accreditation Compliance Audit- As part of the annual EQR, the EQRO conducts an annual accreditation compliance audit of contracted MCOs. The compliance review is a mandatory EQR activity and offers valuable feedback to the state and the plans. Based on NCQA rankings, RI’s Medicaid health plans continue to rank in the top percentiles of Medicaid plans nationally. The state and the EQR reinforces the State’s requirement that participating MCOs maintain accreditation by the NCQA. The state reviews and acts on changes in any MCO’s accreditation status and has set a performance “floor” to ensure that any denial of accreditation by NCQA is considered cause for termination of the RI Medicaid MCO Contract. In addition, MCO achievement of no greater than a provisional accreditation status by NCQA requires the MCO to submit a Corrective Action Plan within 30 days of the MCO’s receipt of its final report from the NCQA.

RI Medicaid conducts monthly internal staff meetings to discuss MCE attainment of performance goals and standards related to access, quality, health outcomes, member services, network capacity, medical management, program integrity, and financial status. Continuous quality improvement is at the core of RI Medicaid’s managed care oversight and monitoring activities. The state conducts ongoing analysis of MCE data as it relates to established standards/measures, industry norms, and trends to identify areas of performance improvement and compliance. When MCE compliance and/or performance is deemed to be below the established benchmark or contractual requirement, RI Medicaid will impose a corrective action, provide technical assistance and will potentially impose financial penalties as necessary.

In addition to the MCE oversight and monitoring mechanisms detailed in this section, RI Medicaid may make modifications or additions to metric development and specification, performance incentives, and data and reporting requirements as necessary, e.g., as part of a contract amendment, a new procurement, or with the implementation of new managed care programs.

The remainder of **Section 4** summarizes components of the RI Medicaid Managed Care Quality Strategy related to oversight of:

21. appropriateness of care in managed care (Section 4.3),
22. MCE performance levels and targets (Section 4.4) and
23. The External Quality Review (Section 4.5).

Section 4.3 Appropriateness of Care in Managed Care

RI Medicaid’s oversight of appropriateness of care for Medicaid managed care members includes a variety of state requirements and processes, including early identification and swift treatment, consideration of persons with special health care needs, cultural competency and considerations to measure and address health disparities. This section summarizes key components of the Quality Strategy related to appropriateness of care.

1. EPSDT: Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Appropriateness of care begins with early identification and swift treatment. As part of its MCE oversight, RI Medicaid monitors provision of Early Periodic Screening, Diagnosis and Treatment (EPSDT) to managed care members. The *State’s CMS 416: Annual EPSDT Participation Report* is produced annually. Medicaid beneficiaries under age 21 are entitled to EPSDT services, whether they are enrolled in a managed care plan or receive services in a fee-for-service delivery system. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Rhode Island uses findings from the CMS 416 Report as part of its Medicaid Quality Strategy to monitor trends over time, differences across managed care contractors, and to compare RI results to data reported by other states. RI Medicaid will share the 416 report results with the MCEs annually, discuss opportunities for improvement and modifications to existing EPSDT approaches as necessary. For example, the CMS 416 report includes but is not limited to the following measures:

- Screening Ratio
- Participant Ratio
- Total Eligibles Receiving Any Dental Services
- Total Eligibles Receiving Preventive Dental Services
- Total Eligibles Receiving Dental Treatment Services
- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth
- Total Eligibles Receiving Dental Diagnostic Services
- Total Number of Screening Blood Lead Tests

2. Persons with Special Health Care Needs

A critical part of providing appropriate care is identify Medicaid beneficiaries with special health care needs as defined in the MCE contracts. Each MCE must have mechanisms in place to assess enrollees identified as having **special health care needs**. Rhode Island defines children with special health care needs (CSHCN) as: persons up to the age of twenty-one who are blind and/or have a disability and are eligible for Medical Assistance on the basis of SSI; children eligible under Section 1902(e) (3) of the Social Security Administration up to nineteen years of age (“Katie Beckett”); children up to the age of twenty-one receiving subsidized adoption assistance, and children in substitute care or “Foster Care”. The State defines adults with special health care needs as adults twenty-one years of age and older who are categorically eligible for Medicaid, not covered by a third-party insurer such as Medicare, and residing in an institutional facility.

For each enrollee that the managed care program deems to have special health care needs, the MCE must determine ongoing treatment and monitoring needs. In addition, for members including but not limited to enrollees with special health care needs, who are determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each MCO must have a mechanism in place to allow such enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee’s condition and identified needs. Access to Specialists is monitored through a monthly report from the managed care entity.

For populations determined to have special healthcare needs, continuity of care and subsequent planning is crucial. As such, Medicaid MCOs are required to continue the out-of-network coverage for new enrollees for a period of up to six months, and to continue to build their provider network while offering the member a provider with comparable or greater expertise in treating the needs associated with that member's medical condition. See **Appendix A** for a copy of RI Medicaid’s currently proposed Transition of Care (TOC) Policy. This TOC policy is being finalized simultaneously with this Quality Strategy.

3. Cultural Competency

At the time of enrollment, individuals are asked to report their race and ethnicity and language. These data are captured in an enrollment file and can be linked to MMIS claims data and analyzed. This data is used to ensure the delivery of culturally and linguistically appropriate services to Health Plan members. For example, Health Plans are required to provide member handbook and other pertinent health information and documents in

languages other than English, including the identification of providers who speak a language other than English as well as to provide interpreter services either by telephone or in-person to ensure members are able to access covered services and communicate with their providers. In addition, Health Plans are obligated to adhere to the American Disabilities Act and ensure accessible services for members with a visual, hearing, and/or physical disability.

4. Health Disparity Analysis

MCOs are required to submit their annual HEDIS® submission stratified by Core Rlte Care only and for All Populations, including special needs population such as Rhody Health Partners. As part of Rhode Island's External Quality Review process, analysis is completed to identify differences in rates between the Core Rlte Care only group and those including All Populations. (The Health Plans utilize internal quality and analytic tools such as CAHPS® which is provided in both English and Spanish as well as informal complaints to identify and monitor for potential health disparities.)

In addition, since 2014, (for CY 2013) the Health Plans have provided the following four HEDIS® measures stratified by gender, language, and SSI status:

- 24. *Controlling high blood pressure (CBP)*
- 25. *Cervical cancer screening (CCS)*
- 26. *Comprehensive diabetes care HbA1c Testing (CDC)*
- 27. *Prenatal and Postpartum care: Postpartum care rate (PPC)*

With assistance from the EQRO, the state and MCOs are assessing trends in the disparities shown in these disparity-sensitive national performance measures over time. The state and MCEs are also working to design quality improvement efforts to address social determinants of health and hopefully improve health equity. As part of this Managed Care Quality Strategy, RI Medicaid will support these efforts by:

- 28. working with MCOs and AEs to screen members related to social determinants of health and make referrals based on the screens, and
- 29. developing a statewide workgroup to resolve barriers to data-sharing and increase the sharing and
- 30. aggregating of data across all state Health and Human Service agencies to better address determinants.

Section 4.4 MCE Performance Measures and Targets

The development of quality measures and performance targets is an essential part of an effective Medicaid program. RI Medicaid identifies performance measures specific to each managed care program or population served across different types of measurement categories. The State works with its MCEs and its EQRO to collect, analyze, and compare MCE and program performance on different types of measures and measure sets that include both clinical performance measures and member experience measures. The MCE measure sets described in this section and the MCO performance measures in **Appendix B** provide quantifiable performance driven objectives that reflect state priorities and areas of concern for the population covered.

Rhode Island uses HEDIS and CAHPS results as part of its quality incentive programs and to inform its approach to quality management work undertaken with managed care entities. The RI Medicaid staff work collaboratively with MCOs, AEs, the Office of the Health Insurance Commissioner OHIC and other internal and external stakeholders to strategically review and where needed modify, measures and specifications for use in Medicaid managed care quality oversight and incentive programs.

RI Medicaid has employed use of standard measures that are nationally endorsed, by such entities as the

National Quality Forum (NQF). Rhode Island collects and voluntarily reports on most CMS Adult and Child Core Measure Set performance measures.⁹ In 2019, Rhode Island reported on 20 measures from the Adult Core Set and 17 measures from the Child Core Set, with measurement reflecting services delivered to Medicaid beneficiaries in CY2017. RI Medicaid also opts to report on some CMS Health Home core measures.

Rhode Island uses HEDIS and CAHPS results as part of its quality incentive programs and to inform its approach to quality management work undertaken with managed care entities. For example, the Child and Adult Core Measure Sets inform the measures used in RI Medicaid's MCO Performance Goal Program (PGP). In addition, all applicable PGP measures are benchmarked on a national level using the Quality Compass[®]. Historically, the MCO PGP has provided financial incentives to the health plans for performing in the 90th and 75th national Medicaid percentiles according to Quality Compass rankings.

As RI Medicaid moves forward with new performance measures, specifications and incentive approaches with its AE program, the state also intends to re-visit the MCO performance measures, specifications, and incentives used to support and reward quality improvement and excellence. Similarly, as the state prepares to re-procure its managed dental program, RI Medicaid intends to review the performance measures, expectations, and incentives for future dental plan contractors.

RI Medicaid consults with its EQRO in establishing and assessing CAHPS survey requirements and results for MCEs. All MCEs are required to conduct CAHPS 5.0 member experience surveys and report to RI Medicaid and its EQR on member satisfaction with the plan. RI Medicaid is exploring the use of additional member satisfaction surveys to assess AE performance in the future. For example, Rhode Island will explore the future use of a statewide CAHPS survey to assess consumer satisfaction with members in AEs, such as the potential use of the Clinician Group CG-CAHPS version survey for adults and children receiving primary care services from AEs.

Rhode Island Medicaid has historically relied heavily on HEDIS and NCQA to identify measures and specifications. This has proven to be a crucial component of the success of RI's MCOs as evidenced by their high NCQA rankings. However, recently there have been significant changes in RI's managed care delivery system that may require a more customized approach to at least some managed care performance measures and targets. The catalyst for this shift is inherently connected to the AE program and the future vision of RI Medicaid. With behavioral health benefits carved in and the addition of the AE program, a vast array of managed care services and providers are or will be involved in collecting and reporting on quality data in a new way. RI Medicaid is working to ensure that contracted MCEs, their AE provider partners and behavioral health network providers are equipped to adequately collect and report on quality measures. RI Medicaid has required the MCEs to support provider readiness related to quality. As part of its managed care quality strategy, RI Medicaid will continue to monitor MCE, AE, and provider progress via a variety of oversight and reporting activities.

RI Medicaid has obtained technical assistance from experts in quality to support state efforts and ensure RI Medicaid has a mechanism to track and achieve its goals. RI Medicaid now has some additional capacity to develop measures, collect data, analyze findings and enforce accountability (penalties/incentives). Over the next three years, RI Medicaid will look to include state custom measures into managed care oversight activities. The states modifications to its managed care performance measures and specifications over time will be designed to ensure that the MCE and AE programs are capturing accurate data to reflect activities related to the state's unique approaches to achieving its quality goals.

Rhode Island Medicaid works to ensure that its performance measures tie back to the agency's goals, objectives, and mission. Measures are chosen that align with the State's commercial partners which lessens provider burden and streamlines expectations. Clinical and non-clinical measures that represent key areas of interest are chosen accordingly. Many MCO performance measures belong to the CMS Adult and Child Core Measure Sets

and the measurement domains for AEs are closely aligned with the MCO measures.

To assess MCE performance and establish targets across areas of member experience, clinical performance and monitoring measures, MCE rates are compared to appropriate regional, national, or state benchmarks as available and applicable. As is currently the practice at RI Medicaid, many of these performance benchmarks will be obtained from the NCQA's Medicaid Quality Compass, from performance comparison across MCEs and, when feasible, from the state's OHIC or its all-payer claims database. Where external benchmarks are not available, EOHHS will use baseline performance and targets established through initial or historical performance (e.g., for new or emerging measures).

Alongside efforts to create new AE performance benchmarks, targets, and quality incentives to support its delivery system reform efforts, during 2019, RI Medicaid will re-examine its MCE performance benchmarks, targets, and consider modifications to financial and non-financial MCO performance incentives. EOHHS shall also consider refinements to the measures used in the Total Cost of Care Program and Medicaid Infrastructure Incentive Program for AEs.

Section 4.5 External Quality Review

As required by 42 CFR 438.350, an annual External Quality Review (EQR) of Rhode Island's Medicaid managed care program must be conducted by an independent contractor and submitted to the CMS annually. IPRO is under contract with RI Medicaid to conduct the EQR function for the State. Rhode Island's current Medicaid managed care EQR contract with IPRO runs from January 2019 through January 2020. The contract period for this effort begins on January 1, 2019 through December 31, 2021, with the potential for up to three one-year extensions.

In accordance with 42 CFR Part 438, subpart E, the EQRO performs, at minimum, the mandatory activities of the annual EQR. RI Medicaid may ask the EQRO to perform optional activities for the annual EQR. The EQRO provide technical guidance to MCOs/PAHP on the mandatory and optional activities that provide information for the EQR. These activities will be conducted using protocols or methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352 Activities- the EQRO must perform the following activities for each MCO/PAHP:

1. **Performance Improvement Projects** - Validation of PIPs required in accordance with 42 CFR 438.330(b)(1) that were underway during the preceding 12 months. Currently, MCOs are required to complete at least four PIPs each year. Additionally, the contract for the MMP requires at least one more PIP. The PAHP is required to complete at least two performance improvement projects each year.
2. **Performance Goal Program** - Validation of MCO and PAHP performance measures required in accordance with 42 CFR 438.330(b)(2) or MCO/PAHP performance measures calculated by the state during the preceding 12 months.
3. **Access** -Validation of MCO and PAHP network adequacy during the preceding 12 months to comply with requirements set forth in 42 CFR 438.68 and 438.14(b)(1) and state standards established in the respective MCE contracts as summarized in **Section 5**. Validation of network adequacy will include, but not be limited to a secret shopper survey of MCO and dental PAHP provider appointment availability in accordance with contractual requirements established by the state.
4. **Accreditation Compliance Review** - A review, conducted within the previous three-year period, to determine each MCO's and PAHP's compliance with the standards set forth in 42 CFR Part 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR 438.330. Within the contracts for Rite Care, Rhody Health Partners Rhody Health Expansion, Rhody Health Options, and Medicare Medicaid Plan the state requires the MCOs to be accredited by the National Committee for Quality Assurance as a Medicaid Managed Care organization. The PAHP is accredited by

the Utilization Review Accreditation Commission (URAC).

5. **Special enhancement activities** as needed. In addition, the State reserves the option to direct the EQRO to conduct additional tasks to support the overall scope of this EQR work in order to have flexibility to bring on additional technical assistance and expertise in a timely manner to perform activities which require similar expertise and work functions as those described in 1 to 4 above. One example of this may be the EQRO's future assistance in conducting a CAHPs satisfaction survey for Medicaid members attributed to an AE.

The EQRO is responsible for the analysis and evaluation of aggregated information on quality outcomes, timeliness of, and access to the services that a managed care entity or its contractors furnish to Medicaid enrollees. The EQRO produces an annual detailed technical report that summarizes the EQR findings on access and quality of care for MCEs including:

31. A description of the way data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to care furnished by the MCEs.
32. For each Mandatory and, if directed by the State, Optional Activity conducted the objectives, technical methods of data collection and analysis, description of data obtained (including validated performance measurement data for each activity conducted), and conclusions drawn from the data.
33. An assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
34. Recommendations for improving the quality of health care services furnished by each MCE including how the State can establish target goals and objective in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
35. An assessment of the degree to which each MCE has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.
36. An evaluation of the effectiveness of the State's quality strategy and recommendations for updates based on the results of the EQR.

Concurrently, each MCE is presented with the EQRO's report, in conjunction with the State's annual continuous quality improvement cycle, as well as correspondence prepared by RI Medicaid which summarizes the key findings and recommendations from the EQRO. Subsequently, each MCO must make a presentation outlining the MCO's response to the feedback and recommendations made by the EQRO to the State formally.

The EQRO presents clear and concrete conclusions and recommendations to assist each MCO, PAHP, and RI Medicaid in formulating and prioritizing interventions to improve performance and to consider when updating the State's managed care quality strategy and other planning documents. A recent EQR can be found here: <http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/2016AggregateEQRTechnicalReport.pdf>

Each MCO and PAHP is required to respond the EQRO's recommendations and to state any improvement strategies that were implemented. The MCO and PAHP responses to previous recommendations are included in the report. Recommendations for improvement that are repeated from the prior year's report are closely monitored by the EQRO and RI Medicaid. The EQRO produces a technical report for each MCO and PAHP and one aggregate report for RI Medicaid. The aggregate report includes methodologically appropriate comparative information about all MCEs. The EQRO reviews the technical reports with the State and MCEs prior to the State's submission to CMS and posting to the State's website; however, the State or MCEs may not substantively revise the content of the final EQR technical report without evidence of error or omission.

In conjunction with the State’s annual continuous quality improvement cycle, findings from the annual EQR reports are presented to RI Medicaid’s Quality Improvement Committee for discussion by the State’s team which oversees the MCEs. The information provided as a result of the EQR process informs the dialogue between the EQRO and the State. Rhode Island incorporates recommendations from the EQRO into the State’s oversight and administration of Rite Care, Rhody Health Partners, Rite Smiles and the Medicare-Medicaid Dual Demonstration program.

Section 5.1 RI Managed Care Standards

Rhode Island’s Medicaid managed care contracts have been reviewed by CMS for compliance with the Medicaid managed care rule and the 2017 version of the “*State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval.*”¹⁰ The State is concurrently amending its dental plan contract to clarify the contractor’s requirement to specifically comply with all applicable PAHP requirements in 42 CFR 438 per CMS feedback. RI Medicaid is also preparing to make additional changes to its managed dental program when it re-procures its dental contract prior to July 2020. The state seeks to contract with two qualified, statewide Medicaid dental plans by mid-2020.

All RI Medicaid MCEs are required to maintain standards for access to care including availability of services, care coordination and continuity of care, and coverage and authorization of services required by 42 CFR 438.68 and 42 CFR 438.206-438.210.

For example, in accordance with the standards in 42 CFR 438.206 RI Medicaid ensures that services covered under MCE contracts are accessible and available to enrollees in a timely manner. Each plan must maintain and monitor a network of appropriate providers that is supported by written agreements and sufficient to provide adequate access to all services covered under the MCE contract. The RI Medicaid MCE contracts require plans to monitor access and availability standards of the provider network to determine compliance with state standards and take corrective action if there is a failure to comply by a network provider(s).

Section 5.2 MCO Standards

In the contracts for Rite Care, Rhody Health and Partners Rhody Health Expansion the state has specified time and distance standards for adult and pediatric primary care, obstetrics and gynecology, adult and pediatric behavioral health (mental health and substance use disorder), adult and pediatric specialists, hospitals, and pharmacies.

Table 4 below includes time and distance standards for contracted Medicaid MCOs:

TABLE 4: MCO ACCESS TO CARE STANDARDS	
Provider Type	Time and Distance Standard <i>Provider office is located within the lesser of</i>
Primary care, adult and pediatric	Twenty (20) minutes or twenty (20) miles from the member’s home.
OB/GYN specialty care	Forty-five (45) minutes or thirty (30) miles from the member’s home
Outpatient behavioral health-mental health	
Prescribers-adult	Thirty (30) minutes or thirty (30) miles from the member’s home.
Prescribers-pediatric	Forty-five (45) minutes or forty-five (45) miles from the member’s home.

TABLE 4: MCO ACCESS TO CARE STANDARDS	
Provider Type	Time and Distance Standard <i>Provider office is located within the lesser of</i>
Non-prescribers-adult	Twenty (20) minutes or twenty (20) miles from the member's home.
Non-prescribers-pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
Outpatient behavioral health-substance use	
Prescribers	Thirty (30) minutes or thirty (30) miles from the member's home.
Non-prescribers	Twenty (20) minutes or twenty (20) miles from the member's home.
Specialist	
The Contractor to identify top five adult specialties by volume	Thirty (30) minutes or thirty (30) miles from the member's home.
The Contractor to identify top five pediatric specialties by volume	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Hospital	Forty-five (45) minutes or thirty (30) miles from the member's home
Pharmacy	Ten (10) minutes or ten (10) miles from the member's home
Imaging	Forty-five (45) minutes or thirty (30) miles from the member's home
Ambulatory Surgery Centers	Forty-five (45) minutes or thirty (30) miles from the member's home
Dialysis	Thirty (30) minutes or thirty (30) miles from the member's home.

The RI Medicaid MCO contract, (Section 2.09.04 Appointment Availability) also includes the following state standards. The contracted MCOs agree to make services available to Medicaid members as set forth below:

Table 5: MCO Timeliness of Care Standards	
Appointment	Access Standard
After Hours Care Telephone	24 hours 7 days a week
Emergency Care	Immediately or referred to an emergency facility
Urgent Care Appointment	Within 24 hours
Routine Care Appointment	Within 30 calendar days
Physical Exam	180 calendar days
EPSDT Appointment	Within 6 weeks
New member Appointment	30 calendar days
Non-Emergent or Non-Urgent Mental Health or Substance Use Services	Within 10 calendar days

Among other federal and state requirements, MCE contract provisions related to availability of services require RI Medicaid MCEs to:

37. offer an appropriate range of preventive, primary care, and specialty services,
38. maintain network sufficient in number, mix, and geographic distribution to meet the needs of enrollees,
39. require that network providers offer hours of operation that are no less than the hours of operation offered to commercial patients or comparable to Medicaid fee-for-service patients if the provider does not see commercial patients,
40. ensure female enrollees have direct access to a women's health specialist,
41. provide for a second opinion from a qualified health care professional,
42. adequately and timely cover services not available in network,
43. provide the state and CMS with assurances of adequate capacity and services as well as assurances and documentation of capacity to serve expected enrollment,
44. have evidence-based clinical practice guidelines in accordance with 42 CFR §438.236, and
45. comply with requests for data from the EOHHS' EQRO.

Section 5.3 MMP Standards

In the contracts for Rhody Health Options and Medicare Medicaid Plan the state has specified time and distance standards for long-term services and supports.

MMP standards are included in the RI Medicaid MCO contract and are specific to members who are dually eligible for Medicare and Medicaid and enrolled in this managed care plan. Network requirements, including network adequacy and availability of services under the State's MMP contract are similar to those for managed medical and behavioral health care but also take into account Medicare managed care standards and related federal requirements for plans serving dual-eligibles. Although methods and tools may vary, each long-term service and supports (LTSS) delivery model is expected to ensure that, for example:

46. an individual residing in the community who has a level of care of "high" or "highest" will have, at a minimum, a comprehensive annual assessment,
47. an individual residing in the community who has a level of care of "high" or "highest" will have, at a minimum, an annual person-centered care/service plan,
48. Covered services provided to the individual is based on the assessment and service plan,
49. providers maintain required licensure and certification standards,
50. training is provided in accordance with state requirements,
51. a critical incident management system is instituted to ensure critical incidents are investigated and substantiated and recommendations to protect health and welfare are acted upon, and
52. providers will provide monitoring, oversight and face-to-face visitation per program standards.

Section 5.4 Dental PAHP Standards

In the Medicaid managed dental contract, Rhode Island has specified time and distance standards for pediatric dental. RI Medicaid network adequacy and availability of service requirements under the State's managed dental care contract are broadly similar to those for managed medical and care but focused on covered dental services for Medicaid enrollees under age 21. The Dental Plan is contractually required to establish and maintain a geographically accessible statewide network of general and specialty dentists in numbers sufficient to meet specified accessibility standards for its membership. The Dental Plan is also required to contract with all FQHCs providing dental services, as well as with both hospital dental clinics in Rhode Island, and State-approved mobile dental providers.

For example, the Dental PAHP is required to make available dental services for Rite Smiles members within forty-eight (48) hours for urgent dental conditions. The Dental Plan also is required to make available to every member a dental provider, whose office is located within twenty (20) minutes or less driving distance from the member's home. Members may, at their discretion, select a dental provider located farther from their homes. The Dental plan is required to make services available within forty-eight (48) hours for treatment of an Urgent Dental Conditions and to make services available within sixty (60) days for treatment of a non-emergent, non-urgent dental problem, including preventive dental care. The Dental Plan is also required to make dental services available to new members within sixty (60) days of enrollment.

Section 6.1 Improvement and Interventions

Improvement strategies described throughout this RI Medicaid Quality Strategy document are designed to advance the quality of care delivered by MCEs through ongoing measurement and intervention. To ensure that incentive measures, changes to the delivery system, and related activities result in improvement related the vision and mission, RI Medicaid engages in multiple interventions. These interventions are based on the results of its MCE assessment activities and focus on the managed care goals and objectives described in **Section 2**.

RI Medicaid's ongoing and expanded interventions for managed care quality and performance improvement include:

a. Ongoing requirements for MCEs to be nationally accredited

RI Medicaid MCOs will continue to be required to obtain and maintain NCQA accreditation and to promptly share its accreditation review results and notify the state of any changes in its accreditation status. As NCQA increases and modifies its Medicaid health plan requirements over time based on best practices nationally, the standards for RI Medicaid plans are also updated. Loss of NCQA accreditation, or a change to provisional accreditation status will continue to trigger a corrective action plan requirement for RI Medicaid plans and may result in the state terminating an MCO contract. As previously noted, the dental PAHP is accredited by URAC which similarly offers ongoing and updated dental plan utilization review requirements over time. In addition, RI Medicaid uses its EQRO to conduct accreditation reviews of its MCE plans.

During its upcoming re-procurement of the managed dental contract, RI Medicaid will explore modifications to its existing plan accreditation requirements, as well as modifications to contract language related to consequences for loss of sufficient accreditation for its dental plans.

b. Tracking participation in APMs related to value-based purchasing (pay for value not volume)

Medicaid MCOs will be required to submit reports on a quarterly basis that demonstrate their performance in moving towards value-based payment models, including:

- i. Alternate Payment Methodology (APM) Data Report
- ii. Value Based Payment Report and
- iii. Accountable Entity-specific reports.

RI Medicaid will review these reports internally and with contracted MCEs and AEs to determine how the progress to date aligns with the goals and objectives identified in this Medicaid managed care Quality Strategy. This APM data and analysis will also inform future state, MCE, AE and work group interventions and quality improvement efforts.

c. Pay for Performance Incentives for MCEs and AEs

As noted in the Managed Care Quality Strategy Objectives in **Section 2**, RI Medicaid intends create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.

In addition, as part of this Quality Strategy, RI Medicaid will review and potentially modify financial incentives (rewards and/or penalties) for MCO performance to benchmarks and improvements over time. RI Medicaid will also consider modifications to AE measures and incentives over time based on results of its MCO and AE assessments and its managed care goals and objectives.

Finally, as part of its upcoming managed dental procurement, RI Medicaid intends to both strengthen its model contract requirements related to dental performance, transparency of performance, and consider the use of new or modified financial and/or non-financial performance incentives for its managed dental plans in the future.

d. Statewide collaboratives and workgroups that focus on quality of care

RI Medicaid will continue to work with MCEs and the EQRO to collect, analyze, compare and share quality and other performance data across plans and programs to support ongoing accountability and performance improvement. EOHHS convenes various collaborative workgroups to ensure stakeholders have opportunities to advise, share best practices, and contribute to the development of improvement projects and program services. Examples of these workgroups include:

- Accountable Entity Advisory Committee
- Behavioral Health Workgroup for Children
- Behavioral Health Workgroup for Adults
- 1115 waiver Demonstration Quality Workgroup
- Integrated Care Initiative Implementation Council
- Governor’s Overdose Taskforce
- Long-term Care Coordinated Council

During the period of this Quality Strategy, RI Medicaid will consider how the work of these groups can better align with and support the goals and objectives identified in this Medicaid managed care Quality Strategy. In addition, as noted in **Section 2**, the State will develop a chronic disease management workgroup and include state partners, MCEs and AEs, to promote more effective management of chronic disease, including behavioral health and co-morbid conditions.

e. Soliciting member feedback through a variety of forums and mechanisms: empowering members in their care

As previously noted, MCEs and the EQRO are involved in administering and assessing performance and satisfaction surveys sent to Medicaid managed care participants and/or their representatives. RI Medicaid will require, compare, and share member experience data to support ongoing managed care accountability and performance improvement. In addition, as part of its managed care objectives, RI Medicaid will explore future use of a statewide survey to assess member satisfaction related to AEs, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from AEs. RI Medicaid is also considering the use of managed care focus groups to better identify improvement opportunities and develop measures and strategies to ensure better outcomes that matter to members.

Section 6.2 Intermediate Sanctions

Rhode Island’s Medicaid MCO Contracts clearly define intermediate sanctions, as specified in CFR 438.702 and

438.704, which EOHHS will impose if it makes any of the following determinations or findings against an MCO from onsite surveys, enrollee or other complaints, financial status or any other source:

- EOHHS determines that a Medicaid MCO acts or fails to act as follows:
 - Fails substantially to provide medically necessary services that it is required to provide, under law or under its contract with the State, to an enrollee covered under the contract; EOHHS may impose a civil monetary penalty of up to \$25,000 for each instance of discrimination.
 - Imposes on Members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program; the maximum amount of the penalty is \$25,000 or double the amount of the excess charges, whichever is greater.
 - Acts to discriminate among enrollees on the basis of their health status or need for health care services; the limit is \$15,000 for each Member EOHHS determines was not enrolled because of a discriminatory practice, subject to an overall limit of \$100,000.
 - Misrepresents or falsifies information that it furnishes to CMS or to EOHHS; EOHHS may impose a civil monetary penalty of up to \$100,000 for each instance of misrepresentation.
 - Misrepresents or falsifies information that it furnishes to a Member, potential Member, or health care provider; EOHHS may impose a civil monetary penalty of up to \$25,000 for each instance of misrepresentation.
 - Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in CFR 422.208 and 422.210 EOHHS may impose a civil monetary penalty of up to \$25,000 for each failure to comply.
 - EOHHS determines whether the Contractor has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by EOHHS or that contain false or materially misleading information. EOHHS may impose a civil monetary penalty of up to \$25,000 for each failure to comply.
 - EOHHS determines whether Contractor has violated any of the other applicable requirements of sections 1903(m) or 1932 of the Act, and any implementing regulations.

In addition to any civil monetary penalty levied against a Medicaid MCE as an intermediate sanction, EOHHS may also: a) appoint temporary management to the Contractor; b) grant members the right to disenroll without cause; c) suspend all new enrollment to the Contractor; and/or d) suspend payment for new enrollments to the Contractor. As required in 42 CFR 438.710, EOHHS will give a Medicaid MCE written notice thirty (30) days prior to imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeals rights.

Section 6.3 Health Information Technology

Rhode Island's All Payer Claims Database (APCD) was initiated in 2008. Rhode Island's APCD is an interagency initiative to develop and maintain a central repository of membership, medical, behavioral health and pharmacy claims from all commercial insurers, the self-insured, Medicare, and Medicaid. The purpose of APCD is to build a robust database that helps identify areas for improvement, growth, and success across Rhode Island's health care system. The production of actionable data and reports that are complete, accessible, trusted, and relevant allow for meaningful comparison and help inform decisions made by consumers, payers, providers, researchers, and state agencies. As a co-convenor of APCD, EOHHS was one of the drivers of the project, and continues to be actively involved in its implementation. EOHHS has access to, and the ability to analyze APCD data including Medicaid and Medicare data in the APCD via a business intelligence tool supported by the APCD analytic Vendor. APCD data will be able to be used to report quality measures derived from claims data across the various Medicaid delivery systems.

Rhode Island seeks to expand its' Health Information Technology systems to streamline and automate the quality reporting process to inform policy level interventions and data-driven decision making. State-level Health and Human Service agencies have partnered to share information and collaborate towards achieving positive health outcomes and reducing disparities. This has culminated with the development of an eco-system that collects data from each HHS agency that can be shared within each agency. The ecosystem is still in its infancy but is expected to be a promising tool used in quality reporting and active contract management.

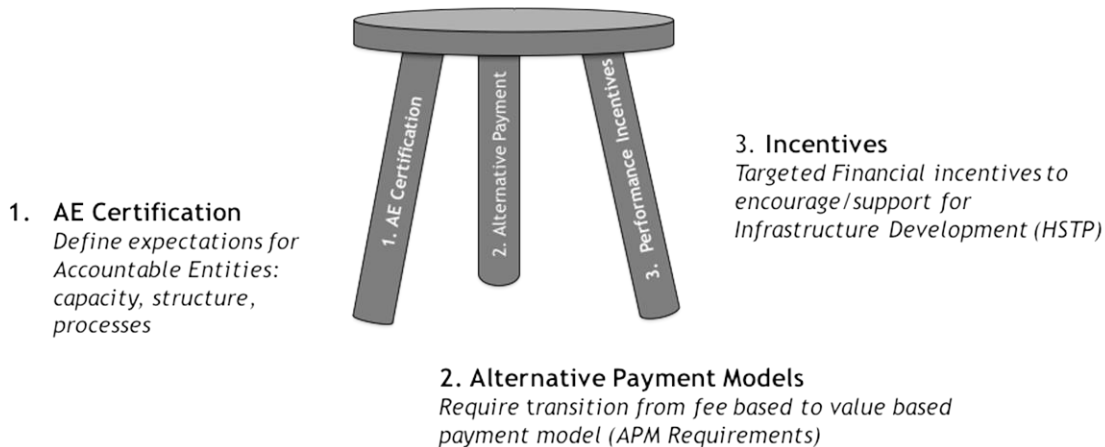
The Rhode Island Department of Health (DOH) also provides oversight functions related to the State's HIT/EHR initiatives with strategies, policies, and clinical guidelines established at the state government level. The Department of Health manages several key HIT initiatives to support data-focused public health and the EHR Incentive Program. These include:

- KIDSNET Childhood Immunization Registry
- Syndromic Surveillance Registry
- Electronic Lab Reporting
- Prescription Drug Monitoring Program (PDMP)

Section 7: Delivery System Reform

AEs represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model, including but not limited to, behavioral health and social support services. The percentage of members attributed to AEs continues to grow in accordance with EOHHS effort to pay for value not volume.

Accountable Entity Program Approach: Three “Pillars”



In late 2015, RI Medicaid provisionally certified Pilot AEs and in late 2017, CMS approved the state's AE Roadmap outlining the State's AE Program, Alternative Payment Methodologies (APMs) and the Medicaid Infrastructure Incentive Program (MIIP). The MIIP consists of three core programs: (1) Comprehensive AE Program; (2) Specialized LTSS AE Pilot Program; and (3) Specialized Pre-eligibles AE Pilot Program.

EOHHS certifies Accountable Entities which are then eligible to enter into EOHHS-approved alternative

payment model contractual arrangements with the Medicaid MCOs. To date, six Comprehensive Accountable Entities have been certified, and qualified APM contracts are in place between five AEs and Medicaid MCOs. The percentage of members attributed to AEs continues to grow in accordance with EOHHS effort to pay for value not volume.

To secure full funding, AEs must earn payments by meeting metrics defined by EOHHS and its MCO partners and approved by CMS. Actual incentive payment amounts to AEs will be based on demonstrated AE performance.

Shared priorities are being developed through a joint MCO/AE working group that includes clinical leadership from both the MCOs and the AEs using a data driven approach. RI Medicaid is actively engaged in this process for identifying performance metrics and targets with the MCOs and the AEs.

Below is the initial list of AE performance measures as developed by RI Medicaid. The state identified these AE performance metrics after examining the Medicaid MCO measures, Adult and Child Core Measure Sets, and the OHIC standardized measures for commercial insurers developed as part of Healthy RI. The state’s quality strategy for AEs, as with MCEs, continues to include alignment with other payers in the market and regionally to reduce confusion and administrative burden at the provider level where possible, while continuing to focus efforts on performance improvement.

Initial AE Performance Measures	Steward
Breast Cancer Screening	NCQA
Weight Assessment & Counseling for Physical Activity, Nutrition for Children and Adolescents	NCQA
Developmental Screening in the 1st Three Years of Life	OHSU
Adult BMI Assessment	NCQA
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI
Comp. Diabetes Care: HbA1c Control (<8.0%)	NCQA
Controlling High Blood Pressure	NCQA
Follow-up after Hospitalization for Mental Illness (7 days & 30 days)	NCQA
Screening for Clinical Depression & Follow-up Plan	CMS
Social Determinants of Health (SDOH) Screen	RI EOHHS

As part of its ongoing quality strategy for MCOs and AEs, RI Medicaid will examine these AE performance metrics annually to determine if and when certain measures will be cycled out, perhaps because performance in some areas have topped out in Rhode Island and there are other opportunities for improvement on which the state wants MCOs and AEs to focus. For example, for AE performance year three, RI Medicaid is removing Adult BMI Assessment from the measure slate and moving the tobacco use measure to “reporting only.” For the same time period, RI Medicaid will add two new AE HEDIS measures: Adolescent Well Care Visits and Comprehensive Diabetes Care: Eye Exam.

Section 8: Conclusions and Opportunities

Rhode Island is committed to ongoing development, implementation, monitoring and evaluation of a vigorous quality management program that will effectively and efficiently improve and monitor quality of care for its

Medicaid managed care members. Our goals include improving the health outcomes of the state's diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well-being, independence and quality of life.

We are excited by the progress in our AE program and the collaboration between RI Medicaid our contracted MCOs and the state-certified AEs. Today, close to 150,000 RI Medicaid MCO members are attributed to an AE. Consistent with our overall managed care approach, RI Medicaid is developing and refining an AE performance measure set and detailed measure specifications to assess AE performance over time as part of a joint workgroup with the state, the MCOs and their contracted AEs.

While strides have been made in Medicaid managed care accountability and value-based purchasing, Rhode Island continues to work towards a focus on accountability for health outcomes inclusive of population health and social determinants. Rhode Island is on the forefront of a shift from a fee for service model to a value-based payment system; this paradigm shift requires collaboration across delivery systems and stakeholders. There is also limited capacity within Medicaid managed care to address broader social needs, which often overshadow and exacerbate members' medical needs – e.g., housing/housing security, food security, domestic violence/sexual violence. These issues are particularly problematic when serving the most complex Medicaid populations. In the future, RI Medicaid anticipates taking lessons learned from its AE initiative and its care management initiatives as part of its efforts to improve cost-effective, quality care for the most complex Medicaid populations, including those with long-term care needs.

APPENDIX 2: NCQA Quality Improvement Activity Form

QUALITY IMPROVEMENT FORM NCQA Quality Improvement Activity Form

Activity Name:	
Section I: Activity Selection and Methodology	
A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners <i>and</i> why there is an opportunity for improvement.	
B. Quantifiable Measures. List and define <i>all</i> quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
<i>Quantifiable Measure #1:</i>	
Numerator:	
Denominator:	
First measurement period dates:	
Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	
<i>Quantifiable Measure #2:</i>	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
<i>Quantifiable Measure #3:</i>	
Numerator:	
Denominator:	

First measurement period dates:				
Benchmark:				
Source of benchmark:				
Baseline goal:				
C. Baseline Methodology.				
C.1 Data Sources.				
<input type="checkbox"/> Medical/treatment records <input type="checkbox"/> Administrative data: <input type="checkbox"/> Claims/encounter data <input type="checkbox"/> Complaints <input type="checkbox"/> Appeals <input type="checkbox"/> Telephone service data <input type="checkbox"/> Appointment/access data <input type="checkbox"/> Hybrid (medical/treatment records and administrative) <input type="checkbox"/> Pharmacy data <input type="checkbox"/> Survey data (attach the survey tool and the complete survey protocol) <input type="checkbox"/> Other (list and describe): The Plan also uses a local access database to track all pregnant members as part of our Healthy First Steps Program. Although this database was not used as an administrative database from NCOA perspective, it was used by local Plan team members to identify and outreach to pregnant members. In addition, we used this database to track number of members who participated in our Diaper Reward Program.				
C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.				
If medical/treatment records, check below: <input type="checkbox"/> Medical/treatment record abstraction If survey, check all that apply: <input type="checkbox"/> Personal interview <input type="checkbox"/> Mail <input type="checkbox"/> Phone with CATI script <input type="checkbox"/> Phone with IVR <input type="checkbox"/> Internet <input type="checkbox"/> Incentive provided <input type="checkbox"/> Other (list and describe): <hr/>	If administrative, check all that apply: <input type="checkbox"/> Programmed pull from claims/encounter files of all eligible members <input type="checkbox"/> Programmed pull from claims/encounter files of a sample of members <input type="checkbox"/> Complaint/appeal data by reason codes <input type="checkbox"/> Pharmacy data <input type="checkbox"/> Delegated entity data <input type="checkbox"/> Vendor file <input type="checkbox"/> Automated response time file from call center <input type="checkbox"/> Appointment/access data <input type="checkbox"/> Other (list and describe): <hr/>			
C.3 Sampling. If sampling was used, provide the following information.				
Measure	Sample Size	Population	Method for Determining Size (describe)	Sampling Method (describe)

C.4 Data Collection Cycle.			Data Analysis Cycle.	
<input type="checkbox"/> Once a year <input type="checkbox"/> Twice a year <input type="checkbox"/> Once a season <input type="checkbox"/> Once a quarter <input type="checkbox"/> Once a month <input type="checkbox"/> Once a week <input type="checkbox"/> Once a day <input type="checkbox"/> Continuous <input type="checkbox"/> Other (list and describe): _Annual HEDIS data collection in Spring, and interim measure in Summer preceding close of the HEDIS 2008 year (Summer 2007)			<input type="checkbox"/> Once a year <input type="checkbox"/> Once a season <input type="checkbox"/> Once a quarter <input type="checkbox"/> Once a month <input type="checkbox"/> Continuous <input type="checkbox"/> Other (list and describe): <hr/> <hr/>	
C.5 Other Pertinent Methodological Features. Complete only if needed.				
D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.				
Include, as appropriate: <ul style="list-style-type: none"> ▪ Measure and time period covered <ol style="list-style-type: none"> I. Type of change II. Rationale for change III. Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method IV. Any introduction of bias that could affect the results 				

Section II: Data/Results Table
 Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure:							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	<i>Baseline:</i>						
#2 Quantifiable Measure:							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	<i>Baseline:</i>						
#3 Quantifiable Measure:							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	<i>Baseline:</i>						

* If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

Section III: Analysis Cycle
 Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That Analysis Covers.

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

B.1 For the quantitative analysis:

B.2 For the qualitative analysis:

- Opportunities identified through the analysis

Impact of interventions

- Next steps

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., “hired 4 UM nurses” as opposed to “hired UM nurses”). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.

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