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Rhode Island Medicaid Managed Care Program
Tufts Health Public Plan

2020 External Quality Review
Annual Technical Report

April 2022

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

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I. Executive Summary

Introduction

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care plans (MCPs) 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 MCP. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCPs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCP. 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 the Centers for Medicare and Medicaid Services[1] (CMS). Quality, as it pertains to an EQR, is defined in *42 CFR § 438.320 Definitions* as "the degree to which an MCO[2], PIHP[3], PAHP[4], or PCCM[5] 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."

The standards of *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 MCPs furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the MCPs regarding health care quality, timeliness, and access, as well as make recommendations for improvement.

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 Tufts Health Public Plan, a Rhode Island Medicaid MCP.

It is important to note that the provision of health care services to each of the applicable eligibility groups (Core RIte Care, RIte Care for Children with Special Health Care Needs [CSHCN], RIte Care for Children in Substitute Care[6], Rhody Health Partners [RHP], Rhody Health Options [RHO][7], 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 19 to 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 Medicaid MCPs, each of these populations were

[1] Centers for Medicare and Medicaid Services Website: https://www.cms.gov/
[2] Managed Care Organization.
[3] Prepaid Inpatient Health Plan.
[4] Prepaid Ambulatory Health Plan.
[5] Primary Care Case Management.
[6] Neighborhood is the only Health Plan that serves the Children in Substitute Care population.
[7] Neighborhood is the only Health Plan that serves the Rhody Health Options population.

included in all measure calculations, where applicable. For comparative purposes, results for MY 2018 and MY 2019 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.

Rhode Island Medicaid Managed Care Program

RIte Care, Rhode Island's Medicaid managed care program for children, families, and pregnant women, began enrollment in August 1994. 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, 2023[8]. In 2020 Rhode Island contacted with three MCPs and one dental MCP deliver health care services to Medicaid beneficiaries.

Scope of External Quality Review Activities

This report focuses on the four federally mandatory EQR activities (validation of performance improvement projects [PIPs], validation of performance measures, review of compliance with Medicaid standards, and validation of network adequacy) and one optional EQR activity (validation of quality-of-care surveys) that were conducted. It should be noted that validation of provider network adequacy was instructed at the state's discretion as activity protocols were not included in the CMS *External Quality Review (EQR) Protocols* published in October 2019. As set forth by *42 CFR § 438.358 Activities related to external quality review (b)(1)* EQR activities are:

(i) **Validation[9] of Performance Improvement Projects (Protocol 1) –** This activity validates that MCP 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 MCP 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 MCP compliance with its contract and with state and federal regulations.

(iv) **Validation of Network Adequacy (Protocol 4)** – This activity assesses MCP adherence to state standards for time and distance for specific provider types, as well as the MCP's ability to provide timely care. (CMS has not published an official protocol for this activity.)

(v) **Validation of Quality-of-Care Surveys (Protocol 6) –** The activity assesses MCP compliance with contractual requirements to evaluate member and provider satisfaction annually.

The validation results of these EQR activities are reported in the **High-Level Conclusions and Findings** subsection that immediately follows.

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 National Committee of Quality Assurance (NCQA) HEDIS

[8] In December 2019, 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.

[9] CMS defines validation at *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."

Compliance Audit™ may be substituted for an ISCA. Findings from IPRO's review of Tufts Health Public Plan's HEDIS final audit report (FAR) for MY 2020 are in the Validation of Performance Measures subsection of Section V of this report.

High-Level Conclusions and Findings

Validation of Quality Improvement Projects

IPRO's validation of Tufts Health Public Plan's 2020 QIPs confirmed the state's compliance with the standards of *42 CFR § 438.330(a)(1)*. The results of the validation activity determined that Tufts Health Public Plan Health Public Plan was not compliant with the standards of *42 CFR § 438.330(d)(2)* for either of the two QIPs conducted. IPRO's assessment of Tufts Health Public Plan Health Public Plan's methodology found that Tufts Health Public Plan did not conduct the QIPs using the appropriate framework.

QIP topics included promotion of the MCP's doula program and improvement of member experience and retention. QIP summaries and detailed validation results are in Section V of this report.

Validation of Performance Measures

IPRO's validation of Tufts Health Public Plan's performance measures confirmed the state's compliance with the standards of *42 CFR § 438.330(a)(1)*. The results of the validation activity determined that Tufts Health Public Plan was compliant with the standards of *42 CFR § 438.330(c)(2)*.

Information Systems Capabilities Assessment

The HEDIS MY 2020 FAR produced by Attest Health Care Advisors indicated that Tufts Health Public Plan met all requirements to successfully report HEDIS data to EOHHS and to NCQA.

HEDIS Performance

Unless otherwise noted, the benchmarks referenced below derive from NCQA's *2021 Quality Compass* MY 2020 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 2020.

Concerning the Use of Services measures evaluating child and adolescent access to primary care, the three rates reported by Tufts Health Public Plan did not meet the national Medicaid mean. Two rates performed at the 33.33rd percentile and one rate performed at the 25th percentile.

Concerning the Effectiveness of Care measures evaluating preventive screenings and care for members with acute and chronic illness, four of seven rates reported by Tufts Health Public Plan exceeded the national Medicaid mean. Two rates performed at the 75th percentile, one rate performed at the 66.67th percentile, one rate performed at the 10th percentile, and two rates performed below the 10th percentile.

Concerning Access and Availability, the four rates reported by Tufts Health Public Plan did not meet the national Medicaid mean. All four rates performed below the 10th percentile.

All HEDIS performance measure rates are reported in Section V of this report.

PGP Performance

Tufts Health Public Plan was not included in the Performance Goal Program for 2020 due to small membership.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

IPRO's review of the results of Tufts Health Public Plan's most recent NCQA accreditation review confirmed the state's compliance with evaluating MCP adherence to the standards of *42 CFR Part 438 Subpart D* and *42 CFR Part 438 Subpart E § 438.330.* Tufts Health Public Plan met all federal Medicaid standards.

Detailed results of the MCP's compliance review in Section V of this report.

Validation of Network Adequacy

IPRO's review of Tufts Health Public Plan's network evaluation reports confirmed the state's compliance with the requirements of *42 CFR § 438.68 Network adequacy standard (a)* and *(b).* In the absence of a CMS protocol for *42 CFR § 438.358 Activities related to external quality review (b)(1)(iv),* IPRO assessed Tufts Health Public Plan's compliance with the state-established standards for appointments and time and distance.

In December 2020, Tufts Health Public Plan met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership. It is important to note that Tufts Health Public Plan's geographic time standards for PCPs and OB/GYNs exceeds the states standards.

Tufts Health Public Plan monitored appointment availability during 2020 using the EOHHS–prescribed secret shopper methodology and reporting template. Tufts Health Public Plan reported mean number of days to an appointment for routine adult and pediatric primary care met the 30-calendar day standard; the reported mean for urgent adult and pediatric primary care did not meet the 24-hour standard for any specialty evaluated; and the mean number of days for routine adult behavioral health care did not meet the 10-calendar day standard.

Detailed results of network adequacy assessments are reported in Section V of this report.

Validation of Quality of Care Surveys

Member Satisfaction

Section 2.13.05 of the Contract requires each MCP to annually collect member and provider satisfaction data. IPRO's review of available documentation confirmed Tufts Health Public Plan's compliance with Section 2.13.05. Tufts Health Public Plan evaluated member satisfaction with services received in MY 2020 using NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult Medicaid 5.1H survey tool.

Unless otherwise noted, the benchmarks referenced below derive from NCQA's *Quality Compass 2021* 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 2020.

Member satisfaction with care received and MCP services in MY 2020 was similar to member satisfaction in MY 2019. A single MY 2020 score achieved by Tufts Health Public Plan performed slightly above the national Medicaid mean. Specifically, Tufts Health Public Plan's score for *How Well Doctors Communicate* performed at the 50th percentile.

Of the remaining scores, two scores performed at the 33.33rd percentile, two scores performed at the 25th percentile, one score performed at the 10th percentile, and two scores performed below the 10th percentile.

Detailed results of the member satisfaction survey are reported in Section V of this report.

Provider Satisfaction

Section 2.13.06 of the Contract requires each MCP to annually collect provider satisfaction data. PRO's review of available documentation confirmed Tufts Health Public Plan's compliance with Section 2.13.06. Overall, MY 2020 scores demonstrated improvement from MY 2019. There was a statistically significant increase in providers reporting they were satisfied with Tufts Health Public Plan, overall. There was also an increase in providers reporting they view Tufts Health Public Plan as a strong collaborator in providing quality patient care, and a similar number who indicated that Tufts Health Public Plan is a valuable partner in a crisis. The key drivers for overall satisfaction were "Tufts Health Public Plan's contract arrangement has had a positive impact on my practice" and "*Tufts Health Provider Connect* is easy to navigate."

Tufts Health Public Plan displayed strengths in communicating information to providers, including having a website that is easy to navigate, making it easy to locate information on medical necessity guidelines, and making it easy to determine a member's plan by the ID card.

The provider payment dispute process was a key area identified as needing improvement, as were communications around Tufts Health Public Plan's COVID-19 response.

Detailed results of the provider satisfaction survey are reported in Section V of this report.

Recommendations

Per *42 CFR § 438.364 External quality review results (a)(4)*, this report is required to include recommendations for improving the quality of care health care services furnished by Tufts Health Public Plan and recommendations on how EOHHS can target the goals and the objectives outlined in the state's 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.

EQR Recommendations the Rhode Island Executive Office of Health and Human Services

Recommendations towards achieving the goals of the Medicaid Quality Strategy are in Section III of this report.

EQR Recommendations for Tufts Health Public Plan

MCP specific recommendations related to the quality of, timeliness of and access to care are in Section VIII of this report.

II. Introduction

States that provide Medicaid services through contracts with MCPs are required by federal mandate to conduct EQR activities and ensure that the results of those activities are used to perform an external, independent assessment and produce an annual report. EOHHS contracts with IPRO to serve as its EQRO. As part of this agreement, IPRO performs an independent annual analysis of state and MCP performance related to the **quality**, **timeliness**, and **accessibility** of the care and services it provides. This report is the result of IPRO's evaluation and review of activities in 2020.

III. Rhode Island Medicaid Managed Care

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, 2019[10]. 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:

Contracted MCPs 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.

Rhode Island EOHHS contracts with three MCPs: Neighborhood Health Plan of Rhode Island (Neighborhood); UnitedHealthcare Community Plan of Rhode Island (UHCCP-RI), and Tufts Health Public Plan; and one managed dental health plan: United Healthcare Dental (UHC-Dental).

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

[10] 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.

- assuring access to care and services consistent with the state Medicaid managed care contract standards, including for children with special health care needs.

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:

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

Rhode Island 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 goals:

- 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.

Evolving from the state's guiding principles, Rhode Island Medicaid established eight core goals for its Managed Care Quality Strategy from 2019-2022. These goals are displayed in Table 2.

Table 2: Rhode Island Medicaid Quality Strategy Goals, 2019-2022

Rhode Island Medicaid 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
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

To support achievement of the Quality Strategy goals, Rhode Island Medicaid established specific objectives. The state developed these objectives to focus state, MCE, and other activities on interventions likely to result in progress toward the eight managed care goals. These objectives are displayed in Table 3 along with the attached goal(s).

Table 3: Rhode Island Managed Care Quality Objectives

Objectives	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7	Goal 8
Continue to work with MCEs and the EQRO to collect, analyze, compare, and share clinical performance and member experience across plans and programs.	X	X	X	X	X	X	X	X
Work collaboratively with MCPs, 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.	X							
Create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.	X	X						
Review and potentially modify financial incentives (rewards and/or penalties) for MCP performance to benchmarks and improvements over time.	X	X	X	X	X			
Work with MCPs and AEs to better track and increase timely, appropriate preventive care, screening, and follow up for maternal and child health.			X			X		X
Incorporate measures related to screening in managed care and increase the use of screening to inform appropriate services.			X	X	X	X		X
Monitor and assess MCP 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.				X	X			X
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.					X			X
Review trend for disparity-sensitive measures and design interventions to improve health equity, including working with MCPs and AEs to screen members related to social determinants of health and make referrals based on the screens.						X		
Share and aggregate data across all Rhode Island HHS agencies to better address determinants of health. Develop a statewide workgroup to resolve barriers to data-sharing.						X		
Continue to require plans to conduct CAHPS 5.0 surveys and annually share MCP CAHPS survey results with the MCAC.							X	
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.							X	
Explore use of focus groups to solicit additional member input on their experiences & opportunities for improvement.							X	

Improvement and Interventions

To ensure that incentive measures, changes to the delivery system, and related activities result in improvement related to the vision and mission, Rhode Island 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 displayed in **Table 3**. Rhode Island Medicaid's ongoing and expanded interventions for managed care quality and performance improvement include:

- **Ongoing requirements for MCEs to be nationally accredited:** Rhode Island Medicaid MCPs are 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 MCPs are required to submit reports on a quarterly basis that demonstrate their performance in moving towards value-based payment models, including the Alternate Payment Methodology (APM) Data Report, the Value Based Payment Report and the Accountable Entity-specific reports.
- **Pay for Performance Incentives for MCEs and AEs:** Rhode Island Medicaid intends to create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics and outcomes – both online and in person.
- **Statewide collaboratives and workgroups that focus on quality of care:** Rhode Island 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:** Rhode Island Medicaid will require, compare, and share member experience data to support ongoing managed care accountability and performance improvement.

Refer to **Appendix B** of this report for the full *2019-2022 Rhode Island State Medicaid Quality Strategy*.

IPRO's Assessment of the Rhode Island Medicaid Quality Strategy

The EOHHS Medicaid quality strategy aligns with CMS's requirements and provides a framework for MCPs 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 MCP-level activities that expand upon the tracking, monitoring, and reporting of performance as it relates to the Medicaid service delivery system.

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

In working towards the goals of the 2019-2022 strategy, IPRO recommends that the EOHHS consider:

- Establishing appointment availability thresholds for the Medicaid Managed Care program to hold the MCPs accountable for increasing the availability of timely appointments.
- Updating the Medicaid quality strategy to explicitly state how performance towards the goals will be evaluated. Each goal should be attached to an outcome measure along with baseline and target rates. Interim reporting of rate performance should be provided to the EQRO as part of the annual EQR assessment.
- Developing a separate quality strategy for the dental Medicaid managed care program or dedicate a section in the overall Medicaid quality strategy to Rite Smiles.
- Identify opportunities to support the expansion of telehealth capabilities and member access to telehealth services across the state.

IV. Tufts Health Public Plan

Tufts Health Public Plan is a not-for-profit HMO that served the Medicaid populations. Tufts Health Public Plan 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 4 displays Tufts Health Public Plan enrollment for year-end 2018 through year-end 2020, as well as the percent change in enrollment each year, according to data reported to Rhode Island Medicaid. The data presented may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. Tufts Health Public Plan's enrollment increased by 57% from 8,973 members in 2019 to 14,075 members in 2020.

Table 4: Tufts Health Public Plan's Enrollment—2018-2020

Eligibility Group	2018	2019	2020
Core RIte Care	4,281	4,520	6,703
Children with Special Health Care Needs[1]	52	69	87
Rhody Health Partners[2]	505	566	658
Rhody Health Expansion[3]	4,600	3,765	6,571
Extended Family Planning (EFP)[4]	34	53	56
Health Plan Total	**9,472**	**8,973**	**14,075**
Percent Change from Previous Year	**112%**	**-5.6%**	**+56.9%**

[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 MCPs serve CSHCN.

[2] Appendix B of this report describes the eligibility criteria for Rhody Health Partners.

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

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

Tufts Health Public Plan's 2020 Quality Improvement Program

The EOHHS requires that contracted health plans have a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas, including all subcontractors. Emphasis shall be placed on, but need not be limited to, clinical areas relating to management of chronic disease, mental health and substance abuse care, members with special needs, and access to services for members. Tufts Health Public Plan's *2020 Quality Improvement Plan* meets these requirements.

Objectives and Goals

The objective of Tufts Health Public Plan's Quality Improvement (QI) Program is to continuously improve the quality and safety of clinical care and services members receive, including physical and behavioral health and substance abuse care; assure adequate access to and availability of clinical care and services; increase member and provider satisfaction; improve the quality of service providers and members receive from the Health Plan; and improve the health and wellness of members while managing health care costs. The QI Program established the following objectives that encompass all QI activities within the MCP:

- Continuously and systematically monitor the quality of member care to improve member health outcomes and access to care, evaluate the quality of care through the application of objective criteria, identify problems and opportunities to improve quality of care, implement appropriate and coordinated member- and provider-directed actions to improve the quality and safety of member care, and evaluate the impact of corrective actions;
- Ensure quality improvement activities and decision-making are supported by quantitative and qualitative data collection as appropriate, and as directed by CMS and/or EOHHS;
- Foster a supportive environment to help practitioners and providers improve the safety of their practices through member and provider education and link technology solutions to patient safety and quality improvement;
- Arrange for the provision of cost-effective health care by qualified physicians, other designated licensed independent practitioners, and organizational providers;
- Monitor the use and ongoing evaluation of up-to-date, evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals, or where evidence-based practice guidelines do not exist, consensus of health care professionals;
- Identify potential areas of corporate risk due to adverse patient occurrences associated with care or service, to intervene, to prevent and reduce the occurrences that lead to liability, and to manage risk and minimize losses;
- Outline the Health Plan's approach to address the cultural and linguistic needs of membership;
- Ensure quality improvement activities are conducted in a culturally appropriate manner;
- Incorporate experience from members and providers with respect to clinical quality, access and availability, cultural competence of care and services, and continuity and coordination of care in the design, planning, and implementation of QI activities, including, but not limited to, member and provider satisfaction surveys and member advisory councils or boards;
- Coordinate quality activities with the Utilization Management department;
- Assess, participate in, and/or implement programs and initiatives that improve the health and wellness of identified segments of the member community in accordance with CMS and EOHHS quality improvement goals and requirements and public health needs and goals, including programs to impact members with complex health needs and to increase preventive health services;
- Monitor, assess, and develop quality improvement activities to assure appropriate access and availability of quality clinical care and services;
- Seamless continuity and coordination of care and transitions of care across the health care continuum; and
- Ensure that policies, procedures, and processes are in place through which clinical quality, access and availability of health care and services, and coordination of care are assured, including, but not limited to, appeals and grievances and utilization management.

Table 5 displays Tufts Health Public Plan's QI goals as reported in the *2020 Quality Improvement Plan,* revised October 2019.

Table 5: Tufts Health Public Plan's Quality Improvement Goals, 2020

Quality Improvement Goals
1. To continuously improve the quality and safety of clinical care, including physical health and behavioral health (inclusive of mental health and substance use) care, and service, including community-based services and Long-Term Services and Supports (LTSS) that Tufts Health Public Plan members receive from contracting health care providers.
2. To assure adequate access and availability to clinical care and services.
3. To increase member satisfaction.
4. To improve the quality of service that providers and members receive from Tufts Health Public Plan.
5. To increase provider satisfaction.
6. To improve the health and wellness of identified segments of the member community, while responsibly managing health care costs.

Quality Improvement Program Activities

Tufts Health Public Plan's 2020 QI program includes, but is not limited to, the following activities:

- Evaluation of quality if clinical care
- Evaluation of safety of clinical care
- Evaluation of quality of service
- Evaluation of member experience
- Monitoring of previously identified issues
- Evaluation of the QI program

Quality Improvement Program Oversight

Tufts Health Public Plan's QI Program Director monitors and evaluates the effectiveness of the QI program. The QI Program Director, in consultation with QI improvement-related committee members, program advisors and internal QI personnel identify opportunities for improvement and track potential deficiencies.

The Tufts Health Public Plan's Board of Directors is the Program's final policy-making body and has ultimate accountability for the Program's success. The Board of Directors has established a multi- disciplinary Care Management Committee (CMC), a Board of Director level committee whose function is to oversee the implementation of the program and the achievement of the program objectives. The Board of Directors shall continuously oversee the CMC through appointment of a Board member and at least annual review of the CMC reports.

An annual evaluation of the QI Program is completed to ascertain that the goals are met, and improvement initiatives are effective. The Quality Improvement Plan designates those resources, which are reasonably determined to be sufficient for the achievement of program goals and objectives. Further, it identifies the individuals and committees responsible for the Quality Improvement program development, oversight and operations and it describes the primary program components. The Quality Improvement plan also directs that each year an Annual Work Plan setting forth specific goals, objectives and activities for the year be developed, implemented, and evaluated which involves all product lines.

Table 6 displays key organizational roles of the Tufts Health Public Plan's QI program.

Table 6: Tufts Health Public Plan's Organizational Structure for Quality Improvement

Title	Responsibilities
Board of Directors	The final policy-making body with ultimate accountability for the QI Program.
Chief Medical Officer	Responsible for developing and implementing comprehensive medical programs and policies and ensuring the delivery of high-quality effective member supports across the care management continuum.
Senior Vice President/Chief Medical Officer	Appointed by Board of Directors to support the Program by providing day-to-day oversight, coordination, and management of quality improvement activities, and by monitoring the sufficiency of Tufts Health Public Plan resources committed to the Program so that Program objectives are achieved.
Vice President of Quality Management	Responsible for the preparation of QI information for the Board of Directors and internal committees and work closely with other QI Program staff as needed to develop, implement, monitor, and evaluate the QI Program, annual quality improvement objectives and clinical QI projects.
Senior Medical Director, Medical Affairs and Quality	Provides clinical support to the teams that manage and process member and provider QI activities; and provides clinical leadership and support to the credentialing functions and clinical quality functions.
Vice President of Population Health Management	Responsible for providing oversight for Population Health Programs which administered across the Tufts Health Plan enterprise and for ensuring compliance with all regulatory and accreditation standards related to the Care Management programs.
Senior Medical Director, Public Plans	Serves as a medical director and policy advisor to the clinical staff including the Utilization Management, Care Management and Quality Management Departments.
Corporate Medical Director for Behavioral health, Health Care Services	A Psychiatrist who provides physician leadership for all behavioral health programs, including both mental health and substance use, and performs and supervises utilization management and quality assurance functions for the behavioral health treatment network, and participates in the development and evaluation of behavioral health quality improvement initiatives and participates in the quality improvement program where behavioral health leadership and/or clinical expertise are needed.
Director of Behavioral Health	Participates in QI workgroups, and behavioral health (mental health/substance use related) QI initiatives and program development.
Vice President of Behavioral Health	Responsible for providing oversight for Behavioral Health Programs administered across all products, and responsible for process workflows, documentation including policies and procedures, and implementation and evaluation of both internal behavioral health programs, and utilization management activities for Behavioral Health services.
Program Director	A clinician/physician who is responsible for day-to-day oversight and management of the QI Program.
Director of Care Management for Public Plans	Oversees a team of medical and behavioral health care managers, community health outreach workers and care coordinators who work as an interdisciplinary care team to support the member's needs across the continuum of care.
Quality Improvement Personnel	Dedicated teams and staff provide end-to-end support of all QI activities and initiatives.

Recommendations on how Tufts Health Public Plan can better achieve the goals in its quality strategy are presented in **Section VIII** of this report.

V. EQRO Findings and Conclusions Related to Quality, Timeliness and Access

In order to assess the impact of the Tufts Health Public Plan MMC program on **quality** of, **timeliness** of, and **access**, IPRO reviewed pertinent information from a variety of sources, including state managed care standards, health plan contract requirements, performance measures, and state monitoring reports.

This section of the report discusses the results, or findings, from the four required EQR activities (validation of QIPs, validation of performance measures, and review of compliance with Medicaid standards) and one optional EQR activity. For each EQR activity, a summary of the objectives, technical methods of data collection and analysis, description of data obtained, and conclusions and findings are presented.

Tufts Health Public Plan's strengths and recommendations related to the **quality** of, **timeliness** of, and **access** to care. These three elements are defined as:

- **Quality** is the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 CFR 438.320 Definitions*.)
- **Timeliness** is the MCP's capacity to provide care quickly after a need is recognized. (Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services)
- **Access** is the timely use of services to achieve health optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements. (*42 CFR 438.320 Definitions*.)

Additionally, **Section VII** of this report includes IPRO's assessment of Tufts Health Public Plan's response to the EQR 2019 per *42 CFR § 438.364 External quality review results (a)(6).*

Validation of Performance Improvement Projects

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 12 months. IPRO performed this activity on behalf of EOHHS for the 2020 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*.

MCPs were required to conduct at least four QIPs directed at the needs of the Medicaid-enrolled population, as well as the MCP-established Communities of Care programs[11]. Tufts Health Public Plan conducted two QIPs in 2020. QIP 1 aimed to improve the accuracy of regulatory reporting and QIP 2 aimed to increase the number of children with preventive health services.

[11] 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.

Technical Methods of Data Collection and Analysis

All QIPs were documented in Microsoft Excel.

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 10 elements:

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

Upon IPRO's review of the 2020 QIP QIA Forms completed by the MCPs 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.
- 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.

Conclusions and Findings

Tufts Health Public Plan conducted the following QIPs in 2020:

- QIP 1 – Promote Doula Program for Maternal and Child Health
- QIP 2 – Member Experience and Retention

The results of the validation activity determined that Tufts Health Public Plan was not compliant with the standards of *42 CFR § 438.330(d)(2)* for either of the two QIPs conducted. IPRO's assessment of Tufts Health Public Plan's methodology found that Tufts Health Public Plan did not conduct the QIPs using the appropriate framework.

Tufts Health Public Plan's conduct of QIP 1 did not meet all standards related to topic selection, data collection, and interpretation of study results. Through the validation process, IPRO determined that for Tufts Health Public Plan's QIP 1:

- The project indicator did not monitor Tufts Health Public Plan's performance at a point in time or over time and did not inform the selection and evaluation of quality improvement activities.
- The data collection plan did not specify the data sources, nor did it link to the data analysis plan to ensure that the appropriate data would be available for QIP reporting. Additionally, the data collection instrument did not allow for consistent and accurate data collection over the period studied.
- The analysis did not include baseline and repeat measures of project outcomes; and the QIP results were not presented in a concise and easily understood manner.
- The improvement strategies were not designed to address root causes or barriers identified through data analysis and quality improvement process, and the QIP did not assess the extent to which the improvement strategy was successful

Tufts Health Public Plan's conduct of QIP 2 did not meet all standards related to topic selection, data collection, and interpretation of study results. Through the validation process, IPRO determined that for Tufts Health Public Plan's QIP 2:

- The QIP topic was not selected through a comprehensive analysis of enrollee needs, care, and services.
- The project indicator did not inform the selection and evaluation of quality improvement activities.
- The data collection instrument did not allow for consistent data collection and reporting over the period studied.
- The QIP results were not presented in a concise and easily understood manner.
- The improvement strategies were not designed to address root causes or barriers identified through data analysis and quality improvement process, and the QIP did not assess the extent to which the improvement strategy was successful.

Table 7 displays a summary of the Tufts Health Public Plan's QIP assessments. Summaries of each QIP immediately follow.

Table 7: QIP Validation Findings, RY 2020

Validation Element	QIP 1 – Promotion of Doula Program	QIP 2 – Member Experience and Retention
Selected Topic	Met	Not Met
Study Question	Insufficient Data	Not Met
Indicators	Insufficient Data	Met
Population	Insufficient Data	Met
Sampling Methods	Insufficient Data	Not Applicable
Data collection Procedures	Insufficient Data	Not Met
Interpretation of Study Results	Insufficient Data	Met
Improvement Strategies	Insufficient Data	Met

QIP 1: Promote Doula Program for Maternal and Child Health

Aim: Tufts Health Public Plan aimed to promote its doula program for maternal and child health.

Indicator/Goal: The MCP did not provide a defined indicator for measuring improvement. The MCP did not establish a target goal.

2020 Member-focused Intervention:

- Distributed member materials electronically to increase knowledge of doula program.

2020 Health Plan-focused Interventions:

- Established internal doula program workgroup and partnered with Health Equity Committee to identify populations for targeted outreach.
- Conducted primary research with both members and prospective members including having in-depth interviews with members who have participated in the doula program to identify value drivers and how to better market this benefit to existing members.
- Deployed the Community Relations team to engage current and prospective members through events such as community baby showers.

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

Table 8 displays the results of QIP 1 including measurement periods.

Table 8: QIP 1 Indicator – Promotion of Doula Program, 2020

Measurement Period	Results = Number of Members Enrolled in Program	Goal
2020 First Quarter	1	Not Provided
2020 Second Quarter	0	Not Provided
2020 Third Quarter	3	Not Provided
2020 Fourth Quarter	0	Not Provided

QIP 2: Member Experience and Retention

Aim: Tufts Health Public Plan aimed improve its average monthly member attrition rate.

Indicator/Goal: The performance indicator and goal are improvement of the monthly member attrition rate by two percentage points from the baseline rate of 8% to 6%. (A lower rate is desired.)

2020 Member-focused Intervention:

- Created a new member onboarding content enhancement.

2020 Provider-focused Intervention:

- Expanded the provider network to incentivize prospective and current members to select Tufts Health Public Plan's RITogether product.

2020 Health Plan-focused Interventions:

- Conducted awareness and acquisition campaigns.
- Leveraged Healthsource RI Support to increase awareness of MCP offerings.

- Established a community commitment by agreeing to involve the development and construction of two soccer fields in Central Falls.

Results: It is unclear how performance in these areas impacted the health outcomes of Tufts Health Public Plan's Medicaid membership. There were one or more validation findings that indicate a bias in the QIP results. The concerns that put the conclusion at-risk were enumerated above.

Table 9 displays the results of QIP 2 including measurement periods and overall project goal.

Table 9: QIP 2 Indicator – Member Experience and Retention, RY 2019-RY 2020

Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
January 2019	Baseline	Not Provided	Not Provided	8%	Not Applicable
February 2019	Re-measurement 1	Not Provided	Not Provided	5%	6%
March 2019	Re-measurement 2	Not Provided	Not Provided	7%	6%
April 2019	Re-measurement 3	Not Provided	Not Provided	7%	6%
May 2019	Re-measurement 4	Not Provided	Not Provided	5%	6%
June 2019	Re-measurement 5	Not Provided	Not Provided	5%	6%
July 2019	Re-measurement 6	Not Provided	Not Provided	5%	6%
August 2019	Re-measurement 7	Not Provided	Not Provided	7%	6%
September 2019	Re-measurement 8	Not Provided	Not Provided	5%	6%
October 2019	Re-measurement 9	Not Provided	Not Provided	11%	6%
November 2019	Re-measurement 10	Not Provided	Not Provided	9%	6%
December 2019	Re-measurement 11	Not Provided	Not Provided	5%	6%
2020 First Quarter	Re-measurement 12	Not Provided	Not Provided	6%	6%
2020 Second Quarter	Re-measurement 13	Not Provided	Not Provided	2%	6%
2020 Third Quarter	Re-measurement 14	Not Provided	Not Provided	2%	6%
2020 Fourth Quarter	Re-measurement 15	Not Provided	Not Provided	Not Provided	Not Provided

IPRO's assessment of Tufts Health Public Plan's strengths and opportunities for improvement related to QIPs, as well as recommendations to improve **quality**, **timeliness** and **access** are presented in **Section VIII** of this report.

Validation of Performance Measures

Information Systems Capabilities Assessment

The ISCA data collection tool allows the state or EQRO to evaluate the strength of each MCP's information system (IS) capabilities to meet the regulatory requirements for quality assessment and reporting. *Title 42 CFR § 438.242 Health information systems* and *42 CFR § 457.1233 Structure and operation standards (d) Health information systems* also require the state to ensure that each MCP 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.

Tufts Health Public Plan contracted with a NCQA-certified HEDIS compliance auditor for HEDIS MY 2020. Auditors assessed the MCP's compliance with NCQA standards in the following designated IS categories as part of the NCQA HEDIS MY 2020 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

The term "IS" – Information Systems – included the computer and software environment, data collection procedures, and abstraction of medical records for hybrid measures. The IS evaluation included a review of any manual processes used for HEDIS reporting. The compliance auditor determined the extent to which the MCPs had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

An MCP 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 MCP not meeting an IS standard was considered an opportunity for improvement during this evaluation.

HEDIS Performance Measures

Objectives

EOHHS utilizes performance measures to evaluate the quality and accessibility of services furnished to Medicaid beneficiaries and to promote positive health outcomes. Section 2.12.03.03 of the Contractor requires each MCP to provide performance measure data, specifically HEDIS, to EOHHS within 30 days following the presentation of these results to the MCPs quality improvement committee.

Further, Rhode Island Medicaid MCPs are required to seek and maintain NCQA Accreditation and to provide evidence of the accreditation to EOHHS. As part its accreditation process, HEDIS data reported by the applying MCP to NCQA is used to effectively measure care and service performance.

Title 42 CFR § 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an EQRO must validate the performance measures that were calculated during the preceding 12 months. EOHHS contracted with IPRO to perform this activity for MY 2020.

Technical Methods of Data Collection and Analysis

All MCP submitting HEDIS data to NCQA must undergo a HEDIS Compliance Audit, which may only be performed by licensed organizations and certified auditors. Tufts Health Public Plan contracted with Attest Health Care Advisors as its HEDIS Compliance Auditor for HEDIS MY 2020.

In accordance with the 2020 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures*, Volume 5, the compliance auditor evaluated compliance with NCQA's IS standards. NCQA's IS standards detail the minimum requirements of an MCP's IS, as well as criteria that must be met for any manual processes used to report HEDIS information.

The NCQA-certified HEDIS compliance auditor validated the MCP's reported HEDIS rate and produce formal documents detailing the results of the validation. For each MCP, IPRO obtained a copy of the HEDIS MY 2020 FAR and a locked copy of the HEDIS MY 2020) Audit Review Table (ART). The MCP's NCQA-certified HEDIS compliance auditor produced both information sources. IPRO used these audit reports as the foundation for its evaluation.

IPRO's validation of Tufts Health Public Plan's performance measures was conducted in alignment with the CMS EQR *Protocol 2-Validation of Performance Measures*. IPRO evaluated the Tufts Health Public Plan's methodology for rate calculation to determine the accuracy of the reported rates using the following approach:

- Review of the HEDIS MY 2020 FAR which includes a summary of findings of the compliance auditor's IS reviews, medical record validation, and rate-level reporting designations.
- Assessment of the accuracy of reported HEDIS MY 2020 rates through appropriate benchmarking, review of trended data, and evaluation of the impact the MCP's QI activities have on health outcomes.

IPRO reviewed the HEDIS MY 2020 FAR and ART produced by Attest Health Care Advisors to ensure that that Tufts Health Public Plan calculated its rates based on complete and accurate data using NCQA's established standards and that calculation of these rates also aligned with EOHHS requirements. Specifically, IPRO evaluated Tufts Health Public Plan's IS capabilities that could affect the HEDIS Medicaid reporting set and verified that all performance measures were reportable.

Once Tufts Health Public Plan's compliance with NCQA's established standards was examined, IPRO objectively analyzed the MCP's HEDIS MY 2020 results and evaluated Tufts Health Public Plan's current performance levels relative to *Quality Compass 2021* (MY 2020) national Medicaid percentiles.

Unless otherwise noted, benchmarks references in this report derive from NCQA's *Quality Compass 2021* 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 2020.

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.

Conclusions and Findings

Validation of Performance Measures

Tufts Health Public Plan's HEDIS MY 2020 FAR produced by Attest Health Care Advisors indicated that Tufts Health Public Plan met all the requirements to successfully report HEDIS data to EOHHS and to NCQA. **Table 10** displays the results of the IS audit.

Table 10: Tufts Health Public Plan's Compliance with Information System Standards

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

Performance Measure Results

This section of the report explores the utilization of Tufts Health Public Plan's services by examining select measures under the following domains:

- Use of Services – Two measures (three rates) examine the percentage of Medicaid child and adolescent access routine care
- Effectiveness of Care – Five measures (seven rates) examine how well an MCP provides preventive screenings and care for members with acute and chronic illness
- Access and Availability – Three measures (five rates) 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

Concerning the Use of Services measures, the three rates reported by Tufts Health Public Plan did not meet the national Medicaid mean. The *Well-Child Visits in the First 30 Months of Life – First 15-30 Months* rate and *Child and Adolescent Well-Care Visits* rate performed at the 33.33rd percentile. The *Well-Child Visits in the First 30 Months of Life – First 15 Months* rate performed at the 25th percentile.

Concerning the Effectiveness of Care measures, four of seven rates reported by Tufts Health Public Plan exceeded the national Medicaid mean. Rates for *Childhood Immunization – Combination 10* and *Follow-Up After Hospitalization for Mental Illness – 7 Days* performed at the 75th percentile. The *Childhood Immunization – Combination 3* rate and F*ollow-Up After Hospitalization for Mental Illness – 30 Days* rate performed at the 66.67th percentile. The *Chlamydia Screening in Women* rate performed at the 10th percentile, while rates for *Cervical Cancer Screening* and *Comprehensive Diabetes Care – HbA1c Testing* performed below the 10th percentile.

Concerning Access and Availability, the four rates reported by Tufts Health Public Plan did not meet the national Medicaid mean. The Timeliness of Prenatal Care rate performed at the 10th percentile, while the rates for *Postpartum Care* and *Adults' Access to Preventive/Ambulatory Health Services,* age cohorts 20-44 years and 45-64 years, performed below the 10th percentile. The denominator, or sample size, for *Adults' Access to Preventive/Ambulatory Health Services* age cohort 65+ years was less than 30 members and therefore the rate for this measure is not suited for public reporting.

Table 11 displays Tufts Health Public Plan's MY 2020 HEDIS rates, as well as the national Medicaid benchmarks achieved by the MCP, and the national Medicaid means.

Table 11: HEDIS Use of Services Rates—MY 2020

Domain/Measures	Tufts Health Public Plan HEDIS MY 2020	*Quality Compass* MY 2020 National Medicaid Benchmark (Met/Exceeded)	*Quality Compass* MY 2020 National Medicaid Mean
Use of Services			
Well-Child Visits in the First 30 Months of Life – First 15 Months	48.13%	25th	52.93%
Well-Child Visits in the First 30 Months of Life – First 15 to 30 Months	69.43%	33.33rd	71.02%
Child and Adolescent Well-Care Visits	42.75%	33.33rd	46.12%
Effectiveness of Care			
Cervical Cancer Screening for Women	38.93%	<10th	56.84%
Chlamydia Screening for Women	46.98%	10th	54.49%
Childhood Immunization Status – Combination 3	72.08%	66.67th	67.60%
Childhood Immunization Status – Combination 10	49.81%	75th	38.88%
Comprehensive Diabetes Care – HbA1c Testing	74.80%	<10th	82.82%
Follow-Up After Hospitalization for Mental Illness – 7 Days	53.75%	75th	39.36%
Follow-Up After Hospitalization for Mental Illness – 30 Days	67.50%	66.67th	58.92%
Access and Availability			
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	57.92%	<10th	74.05%
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	66.53%	<10th	82.08%
Adults' Access to Preventive/Ambulatory Health Services – 65+ Years	Small Sample	Not Applicable	82.43%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	66.67%	<10th	83.82%
Prenatal and Postpartum Care – Postpartum Care	60.14%	<10th	75.07%

IPRO's assessment of Tufts Health Public Plan's strengths and opportunities for improvement related to the performance measures, as well as recommendations to improve **quality**, **timeliness** and **access** are presented in **Section VIII** of this report.

Rhode Island Performance Goal Program

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 2020, the Performance Goal Program entered its twentieth 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 2020, the performance categories were redefined into six categories. For Reporting Year 2020, the following performance categories were used to evaluate MCP performance:

1. Utilization
2. Access to Care
3. Prevention and Screening
4. Women's Health
5. Chronic Care
6. 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 MCP's HEDIS and CAHPS data submissions.

Benchmarks referenced in the evaluation of PGP results derive from NCQA's Quality Compass 2020 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 2029.

Description of Data Obtained

IPRO received a copy of the evaluation reports produced by EOHHS for each MCP included in the PGP for 2020. 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.

Conclusions and Findings

Tufts Health Public Plan was not included in the Performance Goal Program for 2020 due to small membership.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

Title *42 CFR §438.358*, a review must be conducted within the previous 3-year period that determines a plan's adherence to standards established by the state related to member rights and protections, access to services,

structure and operations, measurement and improvement, and grievance system standards, as well as applicable elements of EOHHS's MMC provider agreement with the plans.

Per *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 MCP compliance with many of the structure and operations standards. The state also conducts an annual monitoring review to assess MCP 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 *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 MCP. IPRO verified MCP compliance with federal Medicaid standards of *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 met, 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.

Conclusions and Findings

Tufts Health Public Plan's accreditation was granted by NCQA on April 29, 2021. **Table 12** displays the results of Tufts Health Public Plan's most recent NCQA Accreditation survey. It was determined that Tufts Health Public Plan was fully compliant with the standards *42 CFR Part 438 Subpart D* and *Subpart E 438.330*.

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

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

Validation of Network Adequacy

Objectives

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

MCPs 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.

Per section *2.08.01 Network Composition* of the Contract, MCPs are required to "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 and supports (including nursing homes and home and community-based care) 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. Pursuant to *42 CFR 438.206(c)(3)*, the Contractor will ensure that its contracted providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities."

Network and appointment timeliness standards included in the State's *Medicaid Managed Care Contract* are displayed in Table 13.

Table 13: Rhode Island Medicaid Managed Care Contract Network Standards

Network Standards
Time and Distance
▪ Primary Care, Adult and Pediatric Within 20 Minutes or 20 Miles
▪ OB/GYN Within 45 Minutes or 30 Miles
▪ Top 5 Adult Specialties Within 30 Minutes or 30 Miles
▪ Top 5 Pediatric Specialties Within 45 Minutes or 45 Miles
▪ Hospital Within 45 Minutes or 30 Miles
▪ Pharmacy Within 10 Minutes or 10 Miles
▪ Imaging Within 45 Minutes or 30 Miles
▪ Ambulatory Surgery Centers Within 45 Minutes or 30 Miles
▪ Dialysis Within 30 Minutes or 30 Miles
▪ Adult Prescribers Within 30 Minutes or 30 Miles
▪ Pediatric Prescribers Within 45 Minutes or 45 Miles
▪ Adult Non-Prescribers Within 20 Minutes or 20 Miles
▪ Pediatric Non-Prescribers Within 20 Minutes or 20 Miles
▪ Substance Use Prescribers Within 30 Minutes or 30 Miles
▪ Substance Use Non-Prescribers Within 20 Minutes or 20 Miles
Appointment Standards
▪ After-Hours Care (telephone) Available 24 Hours a Day, 7 Days a Week
▪ Emergency Care Available Immediately
▪ Urgent Care Within 24 Hours

Network Standards
▪ Routine Care Within 30 Calendar Days
▪ Physical Exam Within 180 Calendar Days
▪ EPSDT Within 6 Weeks
▪ New Member Within 30 Calendar Days
▪ Non-Emergent or Non-Urgent Mental Health or Substance Use Services Within 10 Calendar Days
Member-to-PCP Ratio Standards
▪ No more than 1,500 members to any single PCP
▪ No more than 1,000 members per single PCP within a PCP team
24 Hour Coverage
▪ On a 24-hours a day, 7 days a week basis access to medical and behavioral health services must be available to members either directly through the MCP or PCP
Other
▪ Each Medicaid network should include Patient Centered Medical Homes (PCMH) that serve as PCPs

Technical Methods of Data Collection and Analysis

IPRO's evaluation was performed using network data submitted by Tufts Health Public Plan in the *RI Together Network Access Analysis Report (*printed December 15, 2020) and in the Tufts Health Public Plan *Access Survey Report* for the October-December 2020 timeframe. IPRO's evaluation included a comparison of Tufts Health Public Plan access data to state standards for appointment availability and time and distance. Tufts Health Public Plan's access standards for PCPs is two providers in 30 minutes, and one provider is 30 minutes for OB/GYN providers

Description of Data Obtained

Tufts Health Public Plan monitors its provider network 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 from their homes.

Tufts Health Public Plan monitors its network's ability to provide timely routine and urgent appointments through secret shopper surveys. The data includes the number of providers surveyed, the number of appointments made and not made, the total number of appointments meeting the timeframe standards and appointment rates.

Conclusions and Findings

In December 2020, Tufts Health Public Plan met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.

Table 14 displays Tufts Health Public Plan's performance against the geographic access standards by provider type; while **Table 15** displays the results of the appointment availability survey conducted in the fourth quarter of 2020.

Table 14: GeoAccess Provider Network Accessibility, December 2020

Provider Type	Access Standard[1]	% of Members with Access
Pediatrics	2 PCPs Within 30 Minutes	100%
Internal Medicine	2 PCPs Within 30 Minutes	100%
Family Practice	2 PCPs Within 30 Minutes	100%
OB/GYN	1 Provider Within 30 Minutes	100%
Licensed Clinical Social Worker	1 Provider Within 30 Minutes	100%
Licensed Medical Health Center	1 Provider Within 30 Minutes	100%
Cardiology	1 Provider Within 30 Minutes	100%
Ophthalmology	1 Provider Within 30 Minutes	97.8%
Orthopedics	1 Provider Within 30 Minutes	100%
Otolaryngology	1 Provider Within 30 Minutes	100%
Dermatology	1 Provider Within 30 Minutes	100%
Gastroenterology	1 Provider Within 30 Minutes	100%
Endocrinology	1 Provider Within 30 Minutes	98.3%
Oncology	1 Provider Within 30 Minutes	100%
Pulmonology	1 Provider Within 30 Minutes	100%
Surgery	1 Provider Within 30 Minutes	100%

[1] The Access Standard is measured in travel time from a member's home to provider offices.

Table 15: Appointment Availability for Network Providers, Fourth Quarter of 2020

Provider Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]	Mean Number of Days to Appointment
Primary Care					
Routine Appointments					
Family/General Practice	6	3	50.0%	50.0%	19
Pediatricians	10	1	10.0%	10.00%	15
Urgent Appointments					
Family/General Practice	37	14	37.8%	5.4%	31
Pediatricians	21	5	23.8%	14.3%	5
Adult Specialty Care					
Routine Appointments					
Cardiology	1	0	0%	0%	Not Applicable
Dermatology	1	0	0%	0%	Not Applicable
Endocrinology	1	1	100%	100%	25
Pulmonary	2	2	100%	0%	49
Urgent Appointments					
Cardiology	2	0	0%	0%	Not Applicable
Dermatology	2	1	50.0%	0%	69
Endocrinology	1	0	0%	0%	Not Applicable
Gastroenterology	2	0	0%	0%	Not Applicable
Pulmonary	2	1	50.0%	0%	168
Pediatric Specialty Care					
Routine Appointments					
Allergy/Immunology	1	1	100%	100%	7

Provider Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]	Mean Number of Days to Appointment
Gastroenterology	1	1	100%	100%	Not Provided
Neurology	3	0	0%	0%	Not Applicable
Orthopedics	3	0	0%	0%	Not Applicable
Urgent Appointments					
Neurology	1	1	100%	0%	131
Behavioral Health Care Routine Appointments					
Adult Behavioral Health	4	1	25.0%	0%	63

IPRO's assessment of Tufts Health Public Plan's strengths and opportunities for improvement related to network adequacy, as well as recommendations to improve **quality**, **timeliness,** and **access** are presented in **Section VIII** of this report.

Validation of Quality of Care Surveys – Member Satisfaction

Objectives

The EOHHS requires contracted health plans to evaluate and report on member satisfaction annually. Tufts Health Public Plan utilizes the CAHPS Medicaid Adult Survey to capture such data. The CAHPS survey is a standardized questionnaire that asks enrollees to report on their experiences with care and services from the MCP, the providers, and their staff.

The overall objective of the CAHPS study 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 can aid plans in increasing the quality of provided care.

SPH Analytics, a certified CAHPS vendor, administered the CAHPS Medicaid Adult Survey on behalf of Tufts Health Public Plan for MY 2020.

Technical Methods of Data Collection and Analysis

The CAHPS Medicaid Adult Survey 5.1H tool was utilized to meet the objectives of the Tufts Health Public Plan study.

All data were collected by SPH Analytics using a mail and telephone methodology between February 2021 and May 2021.

Members eligible for the survey were those 18 years and older (as of December 31 of the MY) who were continuously enrolled in the plan for at least five of the last six months of the MY. Tufts Health Public Plan supplied the sample to the vendor, including names and contact information, for 2,700 eligible members. A total of 215 completed surveys were obtained resulting in a response rate of 8.1%. SPH Analytics processed all completed surveys and analyzed the results.

Member responses to questionnaire items are summarized as achievement scores. Responses that indicate a positive experience are labeled as achievements, and an achievement score is computed equal to the proportion

of responses qualifying as achievements. In general, somewhat positive responses are included with positive responses as achievements. Specifically, a response of "Usually" or "Always" is considered an achievement, as are responses of "8", "9", or "10" to rating questions.

All statistical testing was performed at a 95% confidence interval.

Description of Data Obtained

IPRO received a copy of the final study report produced by SPH Analytics for Tufts Health Public Plan and utilized the reported results to assess member satisfaction with healthcare services delivered by Tufts Health Public Plan.

Conclusions and Findings

Overall, member satisfaction among Tufts Health Public Plan enrollees in MY 2020 was similar to member satisfaction in MY 2019. There were no statistically significant changes in CAHPS scores observed between MY 2019 and MY 2020.

For the eight measures for which NCQA benchmarks were available, one score achieved by Tufts Health Public Plan performed slightly above the national Medicaid mean. Specifically, Tufts Health Public Plan's score for *How Well Doctors Communicate* performed at the 50th percentile.

Of the remaining scores, two scores performed at the 33.33rd percentile, two scores performed at the 25th percentile, one score performed at the 10th percentile, and two scores performed below the 10th percentile.

Table 16 displays the results of the 2018, 2019 and 2020 CAHPS Adult Medicaid Survey administered for Tufts Health Public Plan.

Table 16: Adult Member CAHPS Results, MY 2020

Measures	Tufts Health Public Plan CAHPS MY 2018	Tufts Health Public Plan CAHPS MY 2019	Tufts Health Public Plan CAHPS MY 2020	*Quality Compass* MY 2020 National Medicaid Benchmark (Met/Exceeded)	*Quality Compass* MY 2020 National Medicaid Mean
Rating of Health Plan[1]	61.3%	72.3%	72.1%	<10th	78.32%
Rating of All Health Care	65.1%	76.4%	76.0%	25th	77.63%
Rating of Personal Doctor[1]	78.8%	89.7%	82.3%	33.33rd	83.23%
Rating of Specialist[1]	88.1%	84.6%	80.6%	10th	83.56%
Getting Care Quickly[2]	81.9%	80.4%	81.2%	33.33rd	81.83%
Getting Needed Care[2]	78.6%	84.8%	77.3%	<10th	83.58%
Customer Service[2]	85.1%	81.9%	87.2%	25th	88.94%
How Well Doctors Communicate[2]	91.2%	94.8%	92.9%	50th	92.17%
Coordination of Care[2]	87.2%	85.4%	82.7%	No Benchmark	No Benchmark

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible").
[2] Rates reflect responses of "always" or "usually."

Validation of Quality of Care Surveys – Provider Satisfaction Survey

Objectives

The EOHHS requires contracted health plans to evaluate and report on provider satisfaction annually. For 2020, Tufts Health Public Plan captured such data through the RITogether Provider Satisfaction Survey.

The provider satisfaction survey study evaluates providers' satisfaction with various aspects of working with Tufts Health Public Plan to further process improvements and efficiencies, to direct Tufts Health Public Plan's efforts to improve provider satisfaction and likelihood of recommending the plan through process improvements and to compare providers' perceptions of Tufts Health Public Plan, Neighborhood, and UHCCP-RI.

Technical Methods of Data Collection and Analysis

Due to the COVID-19 pandemic, three waves of mailings were sent to 608 PCPs and 3,611 specialists on July 20, August 9, and September 7, of 2020. PCPs and specialists who had at least one claim for a RITogether member were eligible for participation in the survey. A total of 196 surveys were completed, resulting in a response rate of 4.6%

All data were collected and analyzed by Tufts Health Plan Market Research Description of Data Obtained

IPRO received a copy of the final study report produced by Tufts Health Plan Market Research The report summarized the survey objectives and scope, methodology, measures and rates, and key findings.

Conclusions and Findings

Tufts Health Public Plan's MY 2020 score for the *Overall Satisfaction with Tufts Health Public Plan* measure was statistically significantly higher than the MY 2019 score. **Table 17** and **Table 18** display MY 2019 and MY 2020 survey results.

Table 17: Provider Satisfaction Survey Summary, MY 2019 and MY 2020

Measures	Tufts Health Public Plan Summary Rate MY 2019	Tufts Health Public Plan Summary Rate MY 2020
Overall Satisfaction[1]	61.1%	75.6% ▲
Collaboration[2]	69.2%	74.4%
Collaboration in a Crisis[2]		78.4%

[1] Proportions represent percentage of providers that are Completely/Very/Somewhat Satisfied
[2] Proportions represent percentage of providers that Agree/Agree Strongly

Table 18: Provider Satisfaction Survey Individual Attribute Scores, MY 2019 and MY 2020

Measures	Tufts Health Public Plan Summary Rate MY 2019	Tufts Health Public Plan Summary Rate MY 2020
Provider Communication, Education and Support		
Tufts Health Public Plan informs providers about new/revised plan policies and procedures[1]	80.0%	81.8%
Tufts Health Public Plan provided clear comm. re: policy procedure changes due to COVID-19[1]		74.7%
Tufts Health Public Plan provided timely comm. re: policy/procedure changes due to COVID-19[1]		74.2%
I understand Tufts Health Public Plan's payment policies[1]	67.5%	75.2%
I understand the Tufts Health Public Plan product[1]	70.0%	71.9%
Utilization Management Programs		

Measures	Tufts Health Public Plan Summary Rate MY 2019	Tufts Health Public Plan Summary Rate MY 2020
Tufts Health Public Plan's medical necessity guidelines make it easy for me/my staff to determine which procedures require priori authorization[1]		78.6%
It is easy to locate Tufts Health Public Plan's medical necessity guidelines on the website		78.3%
Financial Reimbursement		
Tufts Health Public Plan's contract arrangement has had a positive impact on my practice[1]	60.0%	68.5%
Provider Payment Dispute Process		
The payment dispute process is conducted in a fair and complete manner[1]	70.8%	74.3%
The payment dispute process is conducted in a timely manner[1]	68.8%	69.8%
It is easy to access information regarding the payment dispute process[1]	65.5%	60.9%
Member Education		
It is easy to determine which plan members are on by looking at the member's identification card[1]	72.3%	82.6%
Tufts Health Public Plan provides me with useful tools/information to assist me when patients ask questions[1]	60.7%	69.7%
Information/Technology		
Tufts Health Public Provider Connect is easy to navigate[1]		86.2%
Tufts Health Public Plan's technology options make transactions more efficient for my practice[1]	77.1%	83.1%
Overall, Tufts Health Public Plan's website provides useful information for my practice[1]	85.7%	79.4%
I often use Tufts Health Public Provider Connect to complete administrative tasks[1]	68.2%	73.3%

[1] Percentage of providers that agree or strongly agree with individual statements

▲ Indicates statistically significant improvement from previous year at the 95% confidence level.

VI. NCQA Accreditation

Objectives

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.

Technical Methods of Data Collection and Analysis

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.

Beginning with Health Plan Accreditation 2020 and the 2020 HEDIS reporting year, the Health Plan Ratings and Accreditation were aligned to improve consistency between the two activities and to simplify the scoring methodology for Accreditation. An aggregate summary of MCP performance on these two activities in summarized in the NCQA Health Plan Report Cards.

To earn NCQA Accreditation, each MCP must meet at last 80% of applicable points in each standards category, submit HEDIS and CAHPS during the reporting year after the first full year of Accreditation, and submit HEDIS and CAHPS annually thereafter. The standards categories include quality management, population health management, network management, utilization management, credentialing and recredentialing, and member experience.

To earn points in each standards category, MCPs are evaluated on the factors satisfied in each applicable element and earn designation of 'met,' partially met' or 'not met' for each element. Elements are worth one or two points and are award to the based on the following:

- Met = Earns all applicable points (either 1 or 2 points)
- Partially Met = Earns half of applicable points (either 0.5 or 1 point)
- Not Met = Earns no points (0 points)

Within each standards category, the total number of points is added. MCPs achieve one of three accreditation levels based on how they score on each standards category. Table 19 displays the accreditation determination levels and points needed to achieve each level.

Table 19: NCQA Accreditation Levels and Points

Accreditation Status	Points Needed
Accredited	At least 80% of applicable points
Accredited with Provisional Status	Less than 80% but no less than 55% of applicable points
Denied	Less than 55%^ of applicable points

To distinguish quality among the accredited MCPs, NCQA calculates an "overall rating" for each MCP as part of its *Health Plan Ratings* program. The "overall rating" is the weighted average of a MCP's HEDIS and CAHPS measure

ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars.

Overall ratings are recalculated annually and presented in the *Health Plan Ratings* that is released every September. However, in response to COVID-19's impact to health plans and the changes to HEDIS and CAHPS for MY 2019, NCQA did not calculate the *Health Plan Ratings 2020*.

The *Health Insurance Plan Ratings 2021* methodology used to calculate an "overall rating" is based on MCP performance on dozens of measures of care and is calculated on a 0–5 scale in half points, with five being the highest. Performance includes these three subcategories (also scored 0–5 in half points):

1. Patient Experience: Patient-reported experience of care, including experience with doctors, services, and customer service (measures in the Patient Experience category).
2. Rates for Clinical Measures: The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).
3. NCQA Health Plan Accreditation: For a plan with an Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounded to the nearest half point and displayed as stars. A plan with an Interim status receives 0.15 bonus points added to the overall rating before rounded to the nearest half point and displayed as stars.

The rating scale and definitions for each are displayed in Table 20.

Table 20: NCQA Health Plan Star Rating Scale

Ratings	Rating Definition
5	The top 10% of health plans, which are also statistically different from the mean.
4	Health plans in the top one-third of health plans that are not in the top 10% and are statistically different from the mean.
3	The middle one-third of health plans and health plans that are not statistically different from the mean.
2	Health plans in the bottom one-third of health plans that are not in the bottom 10% and are statistically different from the mean.
1	The bottom 10% of health plans, which are also statistically different from the mean.

For 2021 only, NCQA implemented a special "Overall Rating Policy" for NCQA-accredited plans. The *Health Plan Ratings 2021* displays the better of the overall rating score between the *Health Plan Ratings 2019* and *Health Plan Ratings 2021*, for plans with accredited, provisional, and interim status as of June 30, 2021. Individual measures, sub composites and composites continued to be scored and displayed using *Health Plan Rating 2021* performance (i.e., MY 2020 data) for all plans.

Description of Data Obtained

IPRO accessed the NCQA Health Plan Reports website to review the *Health Plan Report Cards 2021* for Tufts Health Public Plan. For each MCP, star ratings, accreditation status, plan type and distinctions were displayed. At the MCP-specific pages, information displayed was related to membership size, accreditation status, survey type and schedule, and star ratings for each measure and overall. The data presented here was as of June 30, 2021.

Conclusions and Findings

Tufts Health Public Plan was compliant with the state's requirement to achieve and maintain NCQA Accreditation.

Tufts Health Public Plan does not have an *Overall Rating* due to partial data reported. **Table 21** displays the MCPs' overall health plan star ratings, as well as the ratings for the three overarching categories and their subcategories under review. Tufts Health Public Plan did not have a rating for these categories due to insufficient data reported.

Table 21: Tufts Health Public Plan's NCQA Rating by Category, 2021

Performance Measure/Area	Tufts Health Public Plan's Rating (Highest Possible Star Rating is 5 Stars)
Overall Rating	**Partial Data Reported, No Overall Rating**
Patient Experience	**Insufficient Data**
Getting Care	No Credit
Satisfaction with Plan Physicians	No Credit
Satisfaction with Plan Services	No Credit
Prevention	**Insufficient Data**
Children and Adolescent Well Care	No Credit
Women's Reproductive Health	No Credit
Cancer Screening	No Credit
Other Preventive Services	No Credit
Treatment	**Insufficient Data**
Asthma	No Credit
Diabetes	No Credit
Heart Disease	No Credit
Mental and Behavioral Health	No Credit

Note: Getting Need Care includes two measures; Satisfaction with Plan Physicians includes four measures; Satisfaction with Plan Services includes one measure; Children and Adolescent Well-Care includes four measures; Women's Reproductive Health includes two measures; Cancer Screening includes two measures; Other Preventive Services includes two measures; Asthma includes one measure; Diabetes includes five measures; Heart Disease includes five measures; and Mental and Behavioral Health includes 10 measures; and Other Treatment Measures which is not included in the table includes nine measures.

VII. Tufts Health Public Plan's Response to the 2019 EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include "an assessment of the degree to which each MCO. PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR." **Table 22** displays the assessment categories used by IPRO to describe MCP progress towards addressing the to the 2019 EQR recommendations. **Table 23** display's Tufts Health Public Plan's progress related to the *Tufts Health Public Plan Annual External Quality Review Technical Report, Reporting Year 2019*, as well as IPRO's assessment of Tufts Health Public Plan's response.

Table 22: MCP Response to Recommendation Assessment Levels

Assessment Determinations and Definitions
Addressed
MCP's quality improvement response resulted in demonstrated improvement.
Partially Addressed
MCP's quality improvement response was appropriate; however, improvement is still needed.
Remains an Opportunity for Improvement
MCP's quality improvement response did not address the recommendation; improvement was not observed, or performance declined.

Table 23: IPRO's Assessment of Tufts Health Public Plan's Response to the 2019 EQR Recommendations

2019 EQR Recommendation	IPRO's Assessment of MCP Response
Tufts Health Public Plan should focus on improving health outcomes of its Medicaid membership by improving the quality of care members have access to and promoting member accountability for the status of their health.	Partially Addressed
Tufts Health Public Plan should continue to monitor its provider network and address inadequacies related to the quality and size of the network. Tufts Health Public Plan should re-educate network providers of appointment standards and request plans of correction should standards continue to not be met.	Partially Addressed
Tufts Health Public Plan should continue the QIP aiming to decrease attrition by improving member experience, the quality improvement strategy should be updated to address the issues members experience, or perceive, when attempting to access care.	Partially Addressed

VIII. Strengths, Opportunities and 2020 Recommendations Related to Quality, Timeliness and Access

The MCP's strengths and opportunities for improvement identified during IPRO's EQR of the activities described are enumerated in this section. For areas needing improvement, recommendations to improve the **quality** of, **timeliness** of and **access** to care are presented. These three elements are defined as:

- **Quality** is the degree to which an MCP increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 CFR 438.320 Definitions*.)
- **Timeliness** is the MCP's capacity to provide care quickly after a need is recognized. (Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services)
- **Access** is the timely use of services to achieve health optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements. (*42 CFR 438.320 Definitions*.)

The strengths and opportunities for improvement based on MY 2020 performance, as well recommendations for improving quality, timeliness and access to care are presented in **Table 24**. In this table, links between strengths, opportunities, and recommendations to **quality**, **timeliness** and **access** are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by shading). Unless otherwise noted, the benchmarks referenced in this table derive from NCQA's *Quality Compass 2021* 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 2020.

Table 24: Strengths, Opportunities and Recommendations for Improvement, MY 2020

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
QIPS	None.			
Performance Measures	Tufts Health Public Plan met all IS and validation requirements to successfully report HEDIS data to EOHHS and NCQA.			
	Tufts Health Public Plan reported MY 2020 HEDIS rates that exceeded the national MY 2020 Medicaid mean for two measures related to childhood immunizations and for two rates related to behavioral health care. One childhood immunization rate benchmarked at the national Medicaid MY 2020 75th percentile.	X	X	X
Compliance with Medicaid Standards	Tufts Health Public Plan was fully compliant with the federal Medicaid standards. Tufts Health Public Plan achieved NCQA Accreditation.	X	X	X
Network Adequacy	Tufts Health Public Plan's time standards for PCPs and OB/GYNs exceeds the states standards.		X	X

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	Tufts Health Public Plan met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.		X	X
Quality of Care Survey – Member Satisfaction	Tufts Health Public Plan's score for *How Well Doctors Communicate exceeded the National Medicaid Mean* and performed at 50th percentile.	X		X
Quality of Care Survey – Provider Satisfaction	Tufts Health Public Plan's MY 2020 score for *Provider Overall Satisfaction with Tufts Health Public Plan* was statistically significantly higher than the MY 2019 score.			
Opportunities for Improvement				
Annual Quality Strategy/Annual Evaluation	The 2020 Quality Improvement Plan did not include sufficient data to track Tufts Health Public Plan's performance towards its goals. Specifically, there were no defined indicators, performance rates, or target rates made available in the 2020 Quality Improvement Plan.	X	X	X
QIPs	Tufts Health Public Plan's conduct of QIP 1 and QIP 2 did not meet all standards related to topic selection, data collection, and interpretation of study results.	X	X	X
Performance Measures	Ten (10) of Tufts Health Public Plan's MY 2020 HEDIS rates related to child and adult access to primary care, women's preventive screenings, and prenatal and postpartum care did not meet the national Medicaid MY 2020 mean. Two rates met the 33.33rd percentile, one rate met the 25th percentile, and seven rates performed at or below the 10th percentile.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	Tufts Health Public Plan's reported mean number of days to an appointment for urgent adult and pediatric primary care did not meet the 24-hour standard for any specialty evaluated.		X	X
	Tufts Health Public Plan's reported mean number of days to an appointment for routine adult behavioral health care did not meet the 10-calendar day standard.		X	X
Quality of Care Surveys – Member Satisfaction	Seven of nine Tufts Health Public Plan CAHPS scores declined in MY 2020 from MY 2019. Of the eight measures with national Medicaid MY 2020 benchmarks, none of Tufts Health Public Plan scores for these measures achieved the 75th percentile.	X		X
Quality of Care Survey – Provider Satisfaction	The provider payment dispute process was a key area identified as needing improvement, as were communications around Tufts Health Public Plan's COVID-19 response.			
Recommendations to Tufts Health Public Plan to Address Quality, Timeliness and Access				

EQR Activity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Annual Quality Strategy/Annual Evaluation	Consider enhancing the annual quality strategy with linking objectives to goals and goals to quantifiable indicators.	X	X	X
QIPs	To ensure future QIP methodologies are effectively designed and managed, Tufts Health Public Plan staff should complete QIP trainings, consult the CMS protocol to ensure QIPs meet all validation requirements, and fully address issues identified by the EQRO.	X	X	X
Compliance with Medicaid Standards	None.			
Performance Measures	The MCP should investigate opportunities to improve the HEDIS measures that performed below the national Medicaid mean.	X	X	X
Network Adequacy	The MCP should investigate opportunities to improve members access to urgent care, primary care, and behavioral health providers.		X	X
Quality of Care Survey – Member Satisfaction	The MCP should evaluate the adult CAHPS scores to identify opportunities to improve member experience with the MCP.	X		X

Appendix A: 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 *and* why there is an opportunity for improvement.	
B. Quantifiable Measures. List and define *all* 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.	
Quantifiable Measure #1:	
Numerator:	
Denominator:	
First measurement period dates:	
Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #2:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #3:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
C. Baseline Methodology.	

C.1 Data Sources.

[ ] Medical/treatment records
[ ] Administrative data:
[ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] 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 NCQA 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:
[ ] Medical/treatment record abstraction

If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

If administrative, check all that apply:
[ ] Programmed pull from claims/encounter files of all eligible members
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

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.

[ ] Once a year
[ ] Twice a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Once a week
[ ] Once a day
[ ] Continuous
[ ] Other (list and describe):
_Annual HEDIS data collection in Spring, and interim measure in Summer preceding close of the HEDIS 2008 year (Summer 2007

Data Analysis Cycle.

[ ] Once a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Continuous
[ ] Other (list and describe):

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: I. Measure and time period covered II. Type of change III. Rationale for change IV. Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method V. 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*
	Baseline:						

#2 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

#3 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

* 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.

Appendix B: Rhode Island Medicaid Managed Care Quality Strategy, 2019-2022

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RHODE ISLAND
MEDICAID MANAGED CARE QUALITY STRATEGY

Rhode Island Executive Office of Health and Human Services

Rhode Island Medicaid Virks Building,
3 West Road Cranston, Rhode Island 02920
(401) 462-0140
Fax: (401) 462-6353
http://www.eohhs.ri.gov

July 31, 2019

Section 1: RI Medicaid Managed Care Overview

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 is 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.

[1] http://healthinsuranceratings.ncqa.org/2018/search/Medicaid

[2] This Quality Strategy incorporates CMS guidance from its initial "Quality Considerations for Medicaid and CHIP programs," communicated by CMS in its November 2013 State Health Official Letter and the Quality Strategy Toolkit for States.

[3] Throughout this document, reference to Medicaid managed care programs and members also includes CHIP members served under the same managed care programs and contracts.

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:

- Adults with incomes up to 138 percent of poverty,
- Pregnant women with household incomes up to 253 percent of poverty,
- Children with household incomes up to 261 percent of poverty, and
- 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.

[4] http://healthinsuranceratings.ncqa.org/2018/search/Medicaid

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

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.

[5] Under the provisions of Rhode Island's 1115 waiver, enrollment in managed care is mandatory for each of these populations except for children in legal custody of the State Department of Children, Youth and Families referenced as Children in Substitute Care.

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:

- 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 Health Public Plan). Neighborhood and UHC-RI began accepting Medicaid members in Rhode Island's initial managed care program in 1994. Tufts Health Public Plan began accepting RI Medicaid members in July 2017. MCOs enroll Medicaid beneficiaries in the following lines of business (LOBs):
    - 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)
- 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:

- 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).
- 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 Health Public Plan 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 Health Public Plan UHC-RI
Rhody Health Expansion (low-income adults without children)	71,456	Neighborhood Tufts Health Public Plan UHC-RI
Medicare/Medicaid Plan	15,777	Neighborhood
Grand Total MCO Members	264,841	
Dental PAHP Members Rite Smiles	114,101	United Healthcare

Section 2: Guiding Principles, Goals and Objectives

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:

- 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.

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]

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.

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*.

[6] RI Medicaid Accountable Entity Roadmap http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Acc_Entitites/AEroadmap041117v6.pdf

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.

[7] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[8] CAHPS surveys are developed by the Agency for Healthcare Research and Quality (AHRQ), a government organization and administered by qualified vendors. https://www.ahrq.gov/cahps/index.html

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: Development and Review of Quality Strategy

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:

1. measurement selection and/or development,
2. data collection,
3. data analysis and validation,
4. identification of performance benchmarks,
5. presentation of measurement and analysis results, including changes over time, and
6. 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:

- managed care operations
- quality measurement, benchmarks, and improvement
- managed care financial performance
- 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 RIteSmiles. 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. a new population group is to be enrolled in Medicaid managed care;
b. a Medicaid managed care procurement takes place
c. substantive changes to quality standards or requirements resulting from regulatory authorities or legislation at the state or federal level, or
d. 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:

- routine monitoring of required MCE reports and data submissions that are due to the state according to a contractually-defined reporting calendar

- collection and analysis of key performance indicators to assess MCE progress toward quality goals and targets at least annually.
- annual review of EQR reports to assess the effectiveness of managed care program in providing quality services in an accessible manner.
- annual strategy review conducted by internal stakeholders for each type ofmanaged 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: Assessment of Managed Care

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 supportsystem.
- 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:

- enrollment and disenrollment trends in each MCE and other data submitted by the RI Medicaid enrollment broker related to MCE performance
- member grievance and appeal logs,
- provider complaint and appeal logs,
- findings from RI's EQR process,
- results from enrollee and provider satisfaction surveys conducted by the State/EQRO or MCE,
- MCE performance on required quality measures,
- MCE medical management committee reports and minutes,
- the annual quality improvement plan for each MCE.
- audited financial and encounter data submitted by each MCE,
- the MLR summary reports required by 42 CFR 438.8.
- customer service performance data submitted by each MCE, and
- 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:

1. 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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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:

- appropriateness of care in managed care (Section 4.3),
- MCE performance levels and targets (Section 4.4) and
- 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 RIte 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 RIte 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:

- *Controlling high blood pressure (CBP)*
- *Cervical cancer screening (CCS)*
- *Comprehensive diabetes care HbA1c Testing (CDC)*
- *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:

- working with MCOs and AEs to screen members related to social determinants of health and make referrals based on the screens, and
- developing a statewide workgroup to resolve barriers to data-sharing and increase the sharing and
- 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

[9] https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-child-core-set.pdf and https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf

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 deigned 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 438.352Activities- 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.
6. 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:
    - 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.
    - 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.
    - An assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
    - 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.
    - 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.
    - 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: State Standards

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.

[10] https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf

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** **Provider office is located within the lesser of**
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.
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:

- offer an appropriate range of preventive, primary care, and specialty services,
- maintain network sufficient in number, mix, and geographic distribution to meet the needs of enrollees,
- 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,
- ensure female enrollees have direct access to a women's health specialist,
- provide for a second opinion from a qualified health care professional,
- adequately and timely cover services not available in network,
- provide the state and CMS with assurances of adequate capacity and services as well as assurances and documentation of capacity to serve expected enrollment,
- have evidence-based clinical practice guidelines in accordance with 42 CFR §438.236, and
- 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 with Neighborhood 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:

- 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,
- 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,

- Covered services provided to the individual is based on the assessment and service plan,
- providers maintain required licensure and certification standards,
- training is provided in accordance with state requirements,
- 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
- 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: Improvement and Interventions

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:

1. 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.

2. 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:

a. Alternate Payment Methodology (APM) Data Report
b. Value Based Payment Report and
c. 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.

3. 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.

4. 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.

5. 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:

1. EOHHS determines that a Medicaid MCO acts or fails to act as follows:
   a. 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.
   b. 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.
   c. 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.
   d. 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.
   e. 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.
   f. 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.

g. 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.
h. 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-convener 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.

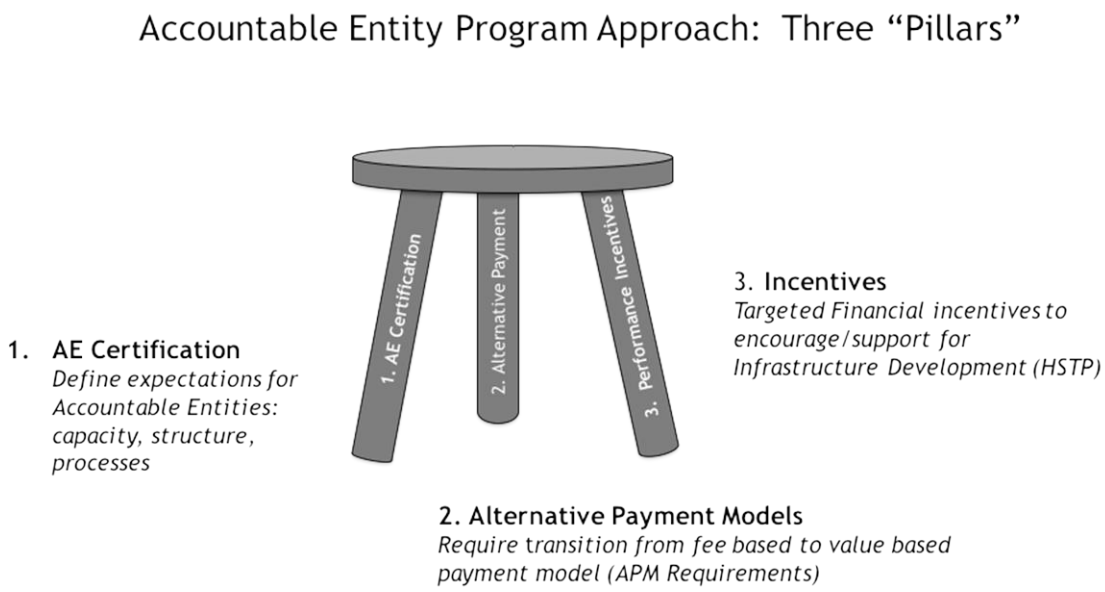
Rhode Island seeks to expand its' Health Information Technology systems to streamline and automate the quality reporting process to inform policy level interventions and data-driven decision making. State-level Health and Human Service agencies have partnered to share information and collaborate towards 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.



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.