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

Updated July 31, 2022

Table of Contents

1 Section: RI Medicaid and Managed Care Overview

1.1 Overview of Rhode Island Executive Office of Health and Human Services

The Executive Office of Health and Human Services ("EOHHS") serves as "the principal agency of the executive branch of state government" (R.I. Gen. Laws § 42-7.2-2) responsible for managing the departments of: Health ("DOH"); Human Services ("DHS"); Children, Youth and Families ("DCYF"); and Behavioral Healthcare, Developmental Disabilities and Hospitals ("BHDDH"). In 2021, these agencies provided direct service to over 300,000 Rhode Islanders as well as an array of regulatory, protective and health promotion services. In State Fiscal Year, 2022, Health and Human Services benefits represent approximately $4.7 billion in spending per year, which is over 42 percent (42%) of the entire state budget.

Rhode Island EOHHS is the single state agency for Medicaid and administers Rhode Island's $2.8 billion[1] Medicaid program, which provides health care coverage for 337,864 eligible individuals representing one third (1/3) of all Rhode Islanders of all ages and from various ethnic and racial backgrounds. Medical Assistance, also referred to as Medicaid, accounts for sixty percent (60%) of the total EOHHS agency spending and twenty-five percent (25%) of the entire State budget.

COVID-19 Pandemic and Public Health Emergency
Since March 2020, EOHHS has responded to critical developments and disruptions impacting Rhode Island's health care landscape and continues to be faced with the ongoing challenges and effects of the COVID-19 pandemic and public health emergency (PHE).

In response to the Families First Coronavirus Response Act (FFCRA; P.L. 116-127) and the COVID-19 Public Health Emergency (PHE), EOHHS changed Medicaid Program operations to protect the benefits of over 337,000 state Medicaid recipients. Most importantly, until the end of the federally declared PHE, individuals that were Medicaid eligible at the start of the PHE have not been terminated and will not be terminated from coverage unless the member moved out of state, passed away, or requested the termination.

Throughout the PHE, EOHHS has continued to closely monitor quality in all of our programs, including managed care. As with many Medicaid programs during the PHE, and particularly during 2020, Rhode Island has observed fluctuations in quality measurements and metrics, due primarily to limited access to services, and/or inability to receive preventive and screening services.

EOHHS has taken steps during the PHE to collaborate with our Managed Care Entities (MCEs) to monitor COVID-19 vaccination rates within Medicaid populations. EOHHS has worked with our MCEs to implement programs to increase vaccine awareness at the community level, and to increase vaccination rates.

[1] This $2.8 billion expenditure is inclusive of federal funds, general revenues, and restricted receipts.

1.2 Overview of the Rhode Island Medicaid Managed Care Program

Rhode Island is committed to managed care as a primary vehicle for the organization and delivery of Medicaid covered services to eligible beneficiaries. Rhode Island initially implemented the Medicaid managed care program, RIte Care in 1994, enrolling over 70,000 low-income children and families. Since that time, Rhode Island has progressively expanded enrollment in managed care to include populations with increasingly complex health care needs. As of the end of July, 2021, the Medicaid managed care program serves 286,533 individuals in the following eligibility groups:

- RIte Care (children and families, including children with health special health care needs and in substitute care)
- Medicaid Expansion (expansion adults nineteen (19) to sixty-four (64) years of age)
- Rhody Health Partners (qualified aged, blind, and disabled adults)

Managed care expenditures for these populations account for approximately sixty percent (60%) or $1.4 billion of Medicaid program expenditures.

Medicaid medical expenditures for each major population group for SFY 2019 are noted below:

- **Adults with disabilities:** Represents ten percent (10%) of the Medicaid population (32,235 individuals) and accounts for $771 million in Medicaid expenditures which is twenty-nine percent (29%) of the total Medicaid expenditures and an average PMPM of $1,993. The major source of expenditures for this population is residential and rehabilitation services for persons with intellectual and developmental disabilities and hospital care.
- **Elders:** Represents seven percent (7%) of the Medicaid population (22,645 individuals) and accounts for $617 million or twenty-three percent (23%) of Medicaid expenditures. Compared to all other Medicaid populations, elders have the highest average PMPM cost at $2,270. Nursing facilities account for fifty-four percent (54%), slightly more than half of the State's expenditures.
- **Children and Families**: Represents fifty-three percent (53%) of the total Medicaid enrollment (164,630 individuals), including low-income children, parents, and pregnant women who meet specific income requirements. This category accounts for twenty-three percent (23%) of the total expenditures ($590 million) and have the lowest PMPM cost of less than $300.
- **Children with Special Health Care Needs (CSHCN):** CSHCN is a relatively small population, as it encompasses four percent (4%) of Medicaid beneficiaries (12,362 individuals) and accounts for seven percent (7%) of expenditures ($175 million).
- **Medicaid Expansion:** Represents twenty-five percent (25%) of the Medicaid population and accounts for eighteen percent (18%) of total expenditures ($477 million). Most of these expenditures are attributed to hospital and professional services.

Hospitals and nursing homes account for forty percent (40%) of all program expenditures. (Hospitals account for twenty-four percent (24%) and nursing facilities, including hospice, and nursing facilities account for sixteen percent (16%) of expenditures.) Medicaid expenditures are highly concentrated. The top five percent (5%) of Medicaid users, those with more than $25,000 in annual claims expenditures,

account for nearly two thirds (63%) of claims expenditures. High-cost users, defined as recipients that incur more than $15,000 annually, account for seventy-one percent (71%) of Medicaid claims expenditures. These users include individuals residing in institutions or residential facilities, those receiving maternity/delivery services, and others residing in the community, more than half (53%) of which are adults with disabilities and the Medicaid Expansion population.

The managed care program serving RIte Care, Medicaid Expansion and Rhody Health Partners eligible members covers acute care, primary and specialty care, pharmacy, and behavioral health services on a mandatory basis across the state.

Currently, EOHHS contracts with three (3) health plans to provide care for members. The three (3) health plans are:

1) Neighborhood Health Plan of Rhode Island (NHP RI)[2].
2) Tufts Health Public Plan (Tufts); and
3) United Health Care Community Plan (UHC)

1.2.1 Dental Managed Care – RIte Smiles

Similar to the state's strategy 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. Most children are enrolled in both a managed care organization (MCO) and in the dental Prepaid Ambulatory Health Plan (PAHP).

The state contracts with United Healthcare Dental to manage RIte Smiles dental benefits for children enrolled in Medicaid. Enrollment in United Healthcare Dental began in 2006 for children born on or after May 1, 2000.

1.2.2 Medicaid- Medicare Plan (MMP) and Long-Term Services and Supports (LTSS)

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 Health Plan RI launched an innovative pilot 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, such as behavioral health (and LTSS for those who qualify). Certain benefits, such as Dental Care and non-emergency medical transportation are covered out-of-plan.

[2] NHP_RI is the sole plan currently serving the substitute care population.

Under CMS' Final Rule (CMS-4192-F), the MMP demonstration is scheduled to sunset by December 31, 2023. Allowable under the Final Rule, EOHHS has the opportunity for two additional years (through December 31, 2025) to transition the MMP into a more permanent integrated dually eligible special needs plan (D-SNP). While the MMP may be sunsetting, EOHHS remains committed to managing the dually eligible population under a managed care benefit that integrates their Medicare and Medicaid benefits.

- *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.

1.2.3 Home and Community Based Services (HCBS)

RI Medicaid interacts with several state agencies to provide Home and Community Based Services (HCBS) to participants, including but not limited to:

- BHDDH – Behavioral Health Developmental Disabilities and Hospitals
- DCYF – Department of Children, Youth, and Families
- OHA - Office of Healthy Aging
- DHS – Department of Human Services

RI Medicaid is the single state Medicaid Agency responsible for managing the HCBS program, complying with CMS requirements for the program, and developing a Quality Improvement Strategy (QIS). The QIS is designed to ensure high quality services are provided to Rhode Islanders through the HCBS program. The QIS is based on three quality management functions to assess, review, and evaluate the program: Discovery, Remediation, and Improvement. RI Medicaid will collaborate with other agencies and departments to collect quality information, analyze that information, implement remediation plans, and recommend system improvements for HCBS.

1.2.4 Rhode Island Health System Transformation Project ("HSTP")

The Rhode Island Health System Transformation Project ("HSTP") is a component of the State's CMS-approved Section 1115 Demonstration Waiver. HSTP aligns with the goals of the Institute for Health Care Improvement's Triple Aim:

1. Improve the member experience and quality of care
2. Improve population health
3. Reduce the total cost of care

HSTP has guided significant investments and has enabled EOHHS to implement and invest in delivery system changes aimed at achieving all three goals. The HSTP provides the financial and structural support for growth and development of Accountable Entities (AEs).

AEs are provider organizations that are accountable for quality health care, outcomes, and the total cost of care for enrollees. Current AEs include health centers, hospitals, and primary care providers. All members that are attributed to an AE are also enrolled in a managed care Health Plan. Children, families, and the Medicaid Expansion population account for the largest number of AE enrollees. Since implementation in 2016, and as of July 2021, the AEs serve approximately 203,699 members, accounting for approximately sixty-eight percent (68%) of managed care enrollees.

1.3 External Quality Review

Rhode Island contracts with Island Peer Review Organization (IPRO), a qualified External Quality Review Organization (EQRO) to conduct external quality reviews (EQRs) of its MCEs in accordance with 42 CFR 438.354. Details regarding EQR activities can be found in section 4.5.

1.4 MCE Core Responsibilities

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. The contracted managed care entities (MCEs) are responsible for:

- 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.

1.5 Medicaid Managed Care Quality Strategy

RI Medicaid's Managed Care Quality Strategy is required by the Medicaid Managed Care rule, 42 CFR 438 Subpart E.[3] 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.[4] 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

[3] 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.

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

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.

Table 1 below shows the distribution of enrollment by eligibility category and by health plan as of the end of July 2021:

Managed Care Enrollment as of July 31, 2021 (By Eligibility Group)				
Medical Assistance Eligibility Group	**NHPRI**	**Tufts**	**UHC**	**Total**
RIte Care	104,067	7,721	53,092	164,880
Extended Family Planning	1,076	46	321	1,443
Children with Special Health Care Needs	5,240	98	1,879	7,217
Children in Substitute Care *	2,627	0	0	2,627
Rhody Health Partners	7,508	770	6,373	14,651
Medicaid Expansion	53,631	8,222	35,305	97,158
Total	**174,149****	**16,857**	**96,970**	**287,976**
% of Total Medicaid	**51.5%**	**5.1%**	**28.6%**	**85.2%**

* Children in substitute care arrangements (i.e., foster homes, group homes or in other DCYF designated/approved living arrangements) are currently enrolled in one contracted health plan, Neighborhood Health Plan of Rhode Island.

** Total for NHPRI does not include 12,768 individuals who were enrolled in Rhody Health Options as of July 31, 2021.

2 Managed Care Quality Goals and Objectives

2.1 Quality Strategy Goals and Objectives

RI Medicaid has established six core goals for its Managed Care Quality Strategy from 2022-2025.

To support achievement of the Quality Strategy goals, RI Medicaid has established specific objectives to focus state, MCE and other activities on interventions and improvement projects most likely to result in progress toward the six managed care goals.

Table 2.1 – Quality Goals and Objectives

Goal/Objective	Objective Description	Quality Measure
Goal 1: Members receive quality care within all managed care delivery systems.		
1.1	Continue to work with MCEs and the EQRO to collect, analyze, compare and share clinical performance and member experience across plans and programs.	See Table 2.2 for a list of quality measures.
1.2	Collaborate with MCOs, AEs, OHIC and other stakeholders to review and modify measures used in Medicaid managed care quality oversight.	See Table 2.2 for a list of quality measures.
1.3	Monitor MCO performance for dual-eligible Medicare Medicaid population.	• Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers • Care for Older Adults: Functional Status Assessment
Goal 2: Focus on quality performance and improvement in the following key areas: • **Chronic Disease Management** • **Maternal/Infant Health** • **Preventive Care for Children** • **Preventive Care for Adults** • **Behavioral Health**		
2.1	Continue oversight of MCOs and AEs to increase timely preventive care, screening, and follow-up for adult and child health.	• Breast Cancer Screening (BCS-AD) • Cervical Cancer Screening (CCS-AD) • Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)
2.2	Monitor and assess MCO and AE performance improvement on quality measures related to chronic conditions.	• Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing, and HbA1c Poor Control (>9.0%) (HPC-AD) • Controlling High Blood Pressure (CBP-AD) • Asthma Medication Ratio: Ages 5 to 18 (AMR-CH)
2.3	Increase the use of prenatal and postpartum services.	• Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)
2.4	Increase the number and percentage of well-child visits.	• Child and Adolescent Well-Care Visits (WCV-CH)
2.5	Monitor child immunization rates to maintain high performance.	• Childhood Immunization Status (CIS-CH)

Goal/Objective	Objective Description	Quality Measure
2.6	Increase engagement, treatment, and follow-up care for substance abuse.	• Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
Goal 3: Improve care and service coordination and management, with focus on coordination of services among medical, behavioral, dental and specialty services providers.		
3.1	Increase availability of coordinated primary care and behavioral health services.	• Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH) • Follow-Up After Emergency Department Visit for Mental Illness (FUM) • Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) • Percentage diagnosed with major depression who were treated with and remained on antidepressant medication: Ages 18 to 64 (AMM-AD)
3.2	Improve integration with medical MCOs and RIte Smiles (UHC Dental).	• Topical Fluoride for Children (TFL-CH)
Goal 4: Enhance financial & data analytic oversight of Managed Care Organizations (MCOs)		
4.1	Ensure timely, complete, and correct encounter data within the 98% acceptance threshold.	N/A
4.2	Migrate to value-based payment programs based on quality measures and MCO quality improvement projects (QIPs).	N/A
Goal 5: Increase health equity by improving capabilities to collect and analyze data related to social determinants of health, including race, ethnicity, and language (REL) data.		
5.1	Implementation of race, ethnicity, and language (REL) data collection process to identify gaps in care.	N/A
5.2	Require MCOs to provide strategic plans to address SDOH, including organizational strategy and stakeholder strategy to improve care delivery model.	N/A

Goal/Objective	Objective Description	Quality Measure
5.3	Assess quality measures that could be stratified by REL (race, ethnicity, and language).	Assessment in progress.
Goal 6: Empower members to make informed choices about their health plans and care.		
6.1	Continue to require MCOs to conduct CAHPS surveys and share survey results with stakeholders.	• Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey 5.1H, Adult Version (Medicaid) (CPA-AD)
6.2	Develop person-centered goals for MCEs. Consider ways to increase development and implementation of Individual Care Plans (ICPs) for members.	N/A

Table 2.2 – Quality Measures and Baselines

Measure/Metric Name	Metric specifications	Baseline performance (year)	Program	
			Medicaid	CHIP
Breast Cancer Screening (BCS-AD)				
Breast Cancer Screening (BCS-AD)	Adult Core Set	65.0 (2020)	x	
Cervical Cancer Screening (CCS-AD)				
Cervical Cancer Screening (CCS-AD)	Adult Core Set	59.6 (2020)	x	
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)				
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)	Child Core Set	TBD*		x
Comprehensive Diabetes Care (CDC)				
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	HEDIS	82.2 (2020)	x	
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	Adult Core Set	33.2 (2020)	x	
Controlling High Blood Pressure (CBP-AD)				
Controlling High Blood Pressure (CBP-AD)	Adult Core Set	70.7 (2020)	x	
Asthma Medication Ratio (AMR)				
Ages 5 to 18 Total (AMR-CH)	Child Core Set	65.6 (2020)		x
Ages 19-64 Total (AMR-AD)	Adult Core Set	53.7 (2020)	x	

Measure/Metric Name	Metric specifications	Baseline performance (year)	Program	
			Medicaid	CHIP
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-AD-CH)				
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-AD-CH)	Adult and Child Core Set	TBD*	x	x
Child and Adolescent Well-Care Visits (WCV-CH)				
Ages 3-11	Child Core Set	TBD*		x
Ages 12-17	Child Core Set	TBD*		x
Ages 18-21	Child Core Set	TBD*		x
Total	Child Core Set	TBD*		x
Childhood Immunization Status (CIS)				
Childhood Immunization Status (CIS) – Combination 10	HEDIS	61.0 (2021)		x
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD - Total	HEDIS	44.8 (2020)	x	x
Engagement of AOD - Total	HEDIS	17.9 (2020)	x	x
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
Ages 13-17 within 7 days (FUA-CH)	Child Core Set	TBD*		x
Ages 13-17 within 30 days (FUA-CH)	Child Core Set	TBD*		x
Age 18+ within 7 days (FUA-AD)	Adult Core Set	12.7 (2020)	x	
Age 18+ within 30 days (FUA-AD)	Adult Core Set	23.8 (2020)	x	
Follow-Up After Hospitalization for Mental Illness (FUH)				
Ages 6-17 within 7 days (FUH-CH)	Child Core Set	56.8 (2020)		x
Ages 6-17 within 30 days (FUH-CH)	Child Core Set	76.6 (2020)		x
Age 18 + within 7 days (FUH-AD)	Adult Core Set	57.2 (2020)	x	
Age 18 + within 30 days (FUH-AD)	Adult Core Set	71.7 (2020)	x	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
Ages 6-17 within 7 days (FUM-CH)	Child Core Set	TBD*		x
Ages 6-17 within 30 days (FUM-CH)	Child Core Set	TBD*		x
Age 18 + within 7 days (FUM-AD)	Adult Core Set	64.6 (2020)	x	
Age 18 + within 30 days (FUM-AD)	Adult Core Set	74.8 (2020)	x	
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)				
Percentage Advised to Quit	Adult Core Set	80.7 (2020)	x	
Percentage discussed or recommended cessation medications	Adult Core Set	67.0 (2020)	x	

Measure/Metric Name	Metric specifications	Baseline performance (year)	Program	
			Medicaid	CHIP
Percentage discussed or recommended cessation strategies	Adult Core Set	59.9 (2020)	x	
Percentage diagnosed with major depression who were treated with and remained on antidepressant medication: Ages 18 to 64 (AMM-AD)				
Treated for 12-week Acute Phase	Adult Core Set	58.9 (2020)	x	
Treated for 6-month Continuation Phase	Adult Core Set	44.0 (2020)	x	
Topical Fluoride for Children (TFL-CH)				
Topical Fluoride for Children (TFL-CH)	Child Core Set	TBD*		x
Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers				
Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers	Rhode Island Specific MMP	8.6 (2020)	x	
Care for Older Adults: Functional Status Assessment				
Care for Older Adults: Functional Status Assessment	Rhode Island Specific MMP	58.8 (2020)	x	

* New Child and Core Set Measure for 2021 or 2022. Baseline statistic to be determined.

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 and identify opportunities for improvement to better serve RI Medicaid and CHIP managed care populations in a cost-effective manner.

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©[5] measures for each managed care subpopulation it serves. In this quality strategy update, Rhode Island has increased our focus on CMS Child and Adult Core Set Measures to monitor and manage health care quality improvements. RI Medicaid also requires managed care plans to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS)[6] 5.1 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.

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

[6] 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

3 Development and Review of Quality Strategy

3.1 Quality Management Structure

Rhode Island 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 Behavioral 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, promoting quality of care, and improving health outcomes while containing costs. RI Medicaid also provides technical assistance to MCEs, and takes corrective action when necessary 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: the 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 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, DHS, 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.

In addition to managed medical care, there is also state oversight of 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 the RIte Smiles Medicaid plan. The Medicaid managed dental plan contractor must comply with all DOH UR/QA standards as well as specific standards described in the dental contract.

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 not less frequently than every three years. As part of the review, RI Medicaid and its contracted MCEs will meet with interested parties and state partners to share annual EQRO results and other data to assess the strategy's effectiveness. 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.

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 technical reports to assess the effectiveness of managed care programs in providing quality services in an accessible manner.
- annual strategy review conducted by internal stakeholders for each type of managed care program: acute MCO (including AEs), managed dental, and managed LTSS/Duals.

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

Internal and external stakeholders provide input to the development of Rhode Island's Medicaid quality programs, and to the Medicaid Managed Care Quality Strategy itself. Through committees, work groups and opportunities for comment, stakeholders identify areas that merit further discussion to ensure the advancement of person-centered, integrated care and quality outcomes for Medicaid managed care members.

4 Assessment of Managed Care

4.1 State Monitoring of Managed Care Entities

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

- administration and management
- appeal and grievance systems
- claims management
- enrollee materials and customer services, including the activities of the beneficiary support system
- finance, including new medical loss ratio (MLR) reporting requirements
- Information systems, including encounter data reporting
- marketing
- medical management, including utilization management and case management
- program integrity
- provider network management, including provider directory standards
- availability and accessibility of services, including network adequacy standards
- quality improvement
- delivery of LTSS services for MMP dual-eligible members 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
- MLR summary reports required by 42 CFR 438.8
- customer service performance data submitted by each MCE
- data related to the provision of LTSS not otherwise included above as applicable to the MMP contract.

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.

3. 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 (QIPs)
    - Access, secret shopper, provider panel
    - Grievances and Appeals
    - Financial Reports
    - Informal Complaints
    - Pharmacy Home

    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.

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.

4. Performance Goal Program – Rhode Island Medicaid had implemented the Performance Goal Program (PGP), a pay-for-performance program that enabled MCOs to earn financial incentives for achieving specified benchmarks in state selected quality measures. The financial incentive component of the PGP program expired in 2021, however some of the measures are still required to be reported by the MCOs. RI Medicaid will be streamlining reporting of these measures by integrating them into the overall Managed Care Quality Program.

   RI Medicaid is evaluating the potential for additional value-based payment programs for MCEs based on meeting or exceeding quality and 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 incentives or penalties.

5. MMP Quality Withholds - 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.

6. Quality Improvement Projects (QIPs) - Each managed care entity is required to complete at least four quality improvement projects (QIPs) 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 QIPs and will be adding two more in 2023. The MMP is also required to perform one additional QIP specific to that population and their service needs. After analysis and discussion, MCEs are required to act on findings from each contractually required QIP. Each medical and dental plan is required to submit monthly QIP reports to RI Medicaid, and the RI Medicaid quality team holds quarterly meetings with each medical and dental plan to review the QIP reports, discuss barriers to quality improvement, and review activities and interventions by the health and dental plans for quality improvement.

7. Annual Quality Plan - Each MCE must submit an annual quality plan to RI Medicaid. This plan must align with 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.

8. 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.

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
- External Quality Review (Section 4.5).

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.

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, 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.

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 Table 2.2 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.[7] 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.

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 5.1 member experience surveys and report to RI Medicaid and its EQRO 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

[7] 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

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 are included in 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.

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 has recently been extended through June 30, 2023.

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. **Quality Improvement Projects -** Validation of QIPs 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 QIPs each year. Additionally, the contract for the MMP requires at least one more QIP. The PAHP is required to complete at least two performance improvement projects each year.

2. **Performance Goal Program (PGP) -** 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. As mentioned above, the PGP program no longer provides a financial incentive for performance, however the State still requires reporting of the measures by the MCOs and PAHP.

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. Recent examples of special activities performed by the EQRO include:
    - Behavioral Health Utilization Reviews
    - MCO Encounter Validations
    - Home and Community Based Services Validation Projects

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 effectively addressed effectively the recommendations 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.

Quality Improvement Project Topics

MCO/PAHP	Quality Improvement Project (QIP) Topic
Neighborhood Health Plan of RI (NHPRI)	Improve the ADHD HEDIS Rate
	Improve Developmental Screening Rates in the First Three Years of Life
	Improve the Rate of Lead Screening in Children - Social Determinant of Health Measure
	Improve Child & Adolescents' Well Care Visits (WCV), Ages 3-21 Years
	Improve Performance for Care for Older Adults - HEDIS® Measure
	Increase the Percentage of Transitions from the Nursing Home to the Community
United Healthcare (UHC)	Improve Effective Acute Phase Treatment for Major Depression
	Improve Breast Cancer Screening
	Improve Developmental Screening in the 1st, 2nd, 3rd Years of Life
	Improve Lead Screening in Children
Tufts Health Plan (THP)	Improve the rate of developmental screening for Rhode Island members in their first 3 years of life.

MCO/PAHP	Quality Improvement Project (QIP) Topic
	Improve Behavioral Health Screenings and follow-up among Adolescent members
	Improve Behavioral Health Antidepressant Medication Management and Initiation and Engagement of Drug and Alcohol Treatment
	Improve Follow-Up After Mental Health Hospitalization
United Healthcare Dental	Increase the percentage of eligible children, ages 15-18, receiving preventive health services.
	Increase percentage of children, ages 1-20 years, who received at least two topical fluoride applications within the reporting year. (new QIP topic for 2022)
	Increase percentage of children under age 21 who received at least one dental service within the reporting year. (Reporting only in 2022. Implement in 2023)
	Increase percentage of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year. (Reporting only in 2022. Implement in 2023)

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. EQR Technical Reports are posted on the EOHHS website here:

https://eohhs.ri.gov/reference-center/reports-government-partners

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.

5 State Standards

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).

5.2 MCO Standards

In the contracts for RIte Care, Rhody Health and Partners Rhody Health Expansion the state has specified time and distance standards for adult and pediatric primary care, obstetrics and gynecology, adult and pediatric behavioral health (mental health and substance use disorder), adult and pediatric specialists, hospitals, and pharmacies. **Table 4** below includes time and distance standards for contracted Medicaid MCOs:

TABLE 4: MCO ACCESS TO CARE STANDARDS	
Provider Type	**Time and Distance Standard** *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.

5.3 MMP Standards

In the contract for Medicare Medicaid Plan (MMP) 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 Health Plan 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.

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.

6 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**.

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

6.1.1 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.

6.1.2 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.

6.1.3 Pay for Performance Incentives for MCEs and AEs

As noted in the Managed Care Quality Strategy Objectives in **Section 2**, RI Medicaid intends to 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.

6.1.4 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.

6.1.5 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.

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.

6.3 Health Information Technology

RI EOHHS recently engaged in a multi-year HIT planning effort with contracted consultants and released the Rhode Island HIT Strategic Roadmap in July 2020. The full documents are available here: https://eohhs.ri.gov/initiatives/health-information-technology

Consensus issues and current initiatives addressed in the HIT Strategic Roadmap are as follows:

- Developing a new governance and coordination process to ensure statewide alignment. We established the Rhode Island HIT Steering Committee in December 2020, a public/private partnership aimed at improving knowledge-sharing, alignment, and shared decision-making.
- Adopting an e-referral system to help address social determinants of health (SDOH). EOHHS issued a Request for Proposals and contracted with Unite Us in May 2021 to implement a statewide social services e-referral platform for Medicaid beneficiaries. It is currently funded through an approved MES APD.
- Improving and enhancing CurrentCare, including a new opt-out consent policy to increase use. The Rhode Island state assembly revised the RI HIE Act of 2008 to shift to an opt-out consent policy, and the governor signed the revision into law in July 2021. We are currently planning implementation through an approved MES APD.
- Accessing and increasing data availability and sharing, including key demographic data such as race and ethnicity needed to address health disparities. The RI HIT Steering Committee is actively engaged in a series of conversations on this topic; RIDOH is leveraging a health disparities grant from CDC in part to improve data collection and data-sharing efforts; and EOHHS now receives a data file from CurrentCare containing demographic data on Medicaid beneficiaries sourced from provider EHRs.
- Enhancing behavioral health records-sharing through aligned interpretation of regulations and stakeholder convening. EOHHS and BHDDH have jointly submitted a legislative concept for the 2022 state legislative session recommending a revision to the state mental health law in order to introduce clarity around electronic mental health records-sharing, particularly through the HIE. In addition, Medicaid is considering investing Health System Transformation Project (HSTP) funds in a variety of initiatives aimed at improving behavioral health data-sharing.
- Continuing the development of the Quality Reporting System (QRS). EOHHS successfully connected over 40 Medicaid primary care providers' EHRs to the QRS in September 2021 and achieved Data Aggregator Validation certification from NCQA in February 2022 for the majority of data submitters. We are now looking to assess the feasibility of utilizing QRS for value-based payment performance metrics in the MCO contracts beginning in 2023. The QRS is funded through an approved MES APD.
- Continuing work to improve information sharing during transitions of care, such as between hospitals, primary care practices, and skilled nursing facilities. Work on this has continued between EOHHS, RIDOH, CurrentCare, and community stakeholders; however, the COVID-19 pandemic has significantly delayed progress.

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.

7 Accountable Entity (AE) Program

Rhode Island Executive Office of Health and Human Services' (EOHHS) Health System Transformation Project (HSTP) is focused on the establishment and implementation of the Accountable Entity (AE) Program. The core strategic goal of the AE program is to transition the Medicaid payment system away from fee-for-service to alternative payment models. A fundamental element of the program, in the transition to alternative payment models, is to drive delivery system accountability to improve quality, member satisfaction, and health outcomes, while reducing total cost of care (TCOC).

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.

7.1 Accountable Entity Quality Measures

- In accordance with 42 CFR §438.6(c)(2)(ii)(B)1, AE quality performance must be measured and reported to EOHHS using the Medicaid Comprehensive AE Common Measure Slate. These measures shall be used to inform the distribution of any shared savings.
- The following table depicts the AE Common Measure Slate, required measure specifications, and whether the measure is pay-for-reporting (P4R), pay-for-performance (P4P), or reporting-only, by quality performance year. EOHHS expects that performance on each Common Measure Slate measure will be reported annually for the full Quality Measures Performance Year.
- 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.

Measures	Steward	Data Source[3]	Specifications	AE Common Measure Slate[4]		
				QPY3 Reporting and Incentive Use	QPY4 Reporting and Incentive Use	QPY5 Reporting and Incentive Use
HEDIS Measures						
Adult BMI Assessment	NCQA	Admin/ Clinical	Current HEDIS specifications: QPY3: HEDIS MY 2020 QPY4: HEDIS MY 2021 QPY5: HEDIS MY 2022	P4P/P4R		
Breast Cancer Screening	NCQA	Admin		P4P	P4P	P4P
Child and Adolescent Well-Care Visits (adolescent age stratifications only)[5]	NCQA	Admin		Reporting-only	Reporting-only	P4P
Child and Adolescent Well-Care Visits (2 components: 3-11 years and total)	NCQA	Admin			Reporting-only	Reporting-only
Controlling High Blood Pressure	NCQA	Admin/ Clinical		P4P/P4R	P4P	P4P
Eye Exam for Patients with Diabetes	NCQA	Admin/ Clinical		Reporting-only	P4P	P4P
Follow-up after Hospitalization for Mental Illness	NCQA	Admin		P4P – 7 or 30 days (the follow-up rate that is not P4P is reporting-only)	P4P – 7 days (30 days is reporting-only)	P4P – 7 days (30 days is reporting-only)
Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Control (<8.0%)	NCQA	Admin/ Clinical		P4P/P4R	P4P	P4P
Lead Screening in Children	NCQA	Admin				P4R
Weight Assessment & Counseling for Physical Activity, Nutrition for Children & Adolescents	NCQA	Admin/ Clinical		P4P/P4R	P4P	
Non-HEDIS Measures (Externally Developed)						
Developmental Screening in the First Three Years of Life	OHSU	Admin/ Clinical	QPY3: CTC-RI/OHIC (December 2018 version)[6] QPY4: CTC-RI/OHIC (December 2020 version)[7]	P4P/P4R	P4P	P4P
			QPY5: CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[8]			

Measures	Steward	Data Source[3]	Specifications	AE Common Measure Slate[4]		
				QPY3 Reporting and Incentive Use	QPY4 Reporting and Incentive Use	QPY5 Reporting and Incentive Use
Screening for Depression and Follow-up Plan	CMS	Admin/ Clinical	QPY3: CMS MIPS 2020[9] QPY4: CMS MIPS 2021, modified by EOHHS (April 8, 2021 version) QPY5: CMS MIPS 2022, modified by EOHHS (February 14, 2022 Version)	P4P/P4R	P4P for July 1, 2021 – December 31, 2021[10]	P4P
Tobacco Use: Screening and Cessation Intervention	AMA-PCPI	Admin/ Clinical	QPY3: CMS MIPS 2020 QPY4: CMS MIPS 2021 QPY5: CMS MIPS 2022	P4P/P4R	Reporting- only	Reporting-only
Non-HEDIS Measures (EOHHS-developed)						
Social Determinants of Health Infrastructure Development	EOHHS	Admin/ Clinical	QPY3: EOHHS (August 6, 2020 version)	Reporting-only Yes		
Social Determinants of Health Screening	EOHHS	Admin/ Clinical	QPY3: EOHHS (August 6, 2020 version) QPY4: EOHHS (July 29, 2021 version) QPY5: EOHHS (February 14, 2022 version)	Reporting-only[11] Yes	P4P	P4P

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.

In partnership with MCEs, EOHHS' vision is to continue to deliver high quality care to members in an accessible, affordable coordinated, cost-effective manner, improving the population health of Medicaid beneficiaries, while reducing the per capita cost of health care.

EOHHS seeks to continue to evolve to deliver a system of care in which the member (or family) is at the center of all care planning and has autonomy over all care decisions, meaning that members are active participants in the development of care plans and identification of care goals. A person-centered system is holistic and integrated, meaning that a person's health is viewed inclusive of medical, dental, behavioral health, and social needs. This system of care has the primary care team closest to the member, who acts as the primary point of contact for the member assisting them as they navigate their care. As members' needs grow in complexity, additional, tailored supports are provided as extensions of the primary care team, through AE deployed complex case management, Integrated Health Homes ("IHH") and Assertive Community Treatment ("ACT") teams, or other specialized programming for particular sub-populations.

EOHHS and RI Medicaid to continue to focus on our goals to provide high quality care, improve care and service coordination, increase health equity, and empower members in their health care choices.