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
http://www.eohhs.ri.gov

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Section 1: Managed Care Overview, Goals, and Objectives

Section 1.1 Overview

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

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

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

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

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

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

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

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

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

Section 1.2 Rhode Island Medicaid and CHIP

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

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

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

After the state expanded Medicaid eligibility under the Affordable Care Act, Rhode Island's total Medicaid population increased rapidly, and its uninsured rate dropped to less than four percent. Today, Medicaid is the state's largest health care purchaser covering one out of four Rhode Islanders in a given year. The Medicaid Program constitutes the largest component of the state's annual budget, State General Revenue expenditures are expected to reach $2.9 billion in State Fiscal Year (SFY) 2018. In the context of reinventing Medicaid, expansion and health system transformation, RI Medicaid continues to achieve and sustain national recognition for the quality of services provided.

Section 1.3 History of Medicaid Managed Care Programs

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

Table 1 Rhode Island Medicaid Managed Care Program Additions

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

Today, RI Medicaid and CHIP beneficiaries enrolled in managed care entities include children and families; children in substitute care;[4] children with special health care needs; aged, blind, and disabled adults; low-income adults without children; adults with dual Medicare and Medicaid coverage; and adults who need long-term services and supports (LTSS).

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

Section 1.4 Medicaid and CHIP Managed Care in 2019

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

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

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

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

- **Medicare-Medicaid Plan (MMP) Duals**: EOHHS, in partnership with CMS and Neighborhood launched an innovative program in 2016 that combined the benefits of Medicare and Medicaid into one managed care plan to improve care for some of the state's most vulnerable residents. Enrollment in MMP duals is

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

voluntary and covered benefits include: Medicare Part A, B, and D, and Medicaid Services (including LTSS for those who qualify). (Dental Care and transportation are covered out-of-plan).

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

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

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

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

Section 1.5 Medicaid Guiding Principles and Accountable Entities

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

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

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

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

In alignment with its guiding principles, RI Medicaid developed the AE program as a core part of its managed care quality strategy. AEs are Rhode Island's version of an accountable care organization. AEs represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services. Medicaid MCOs are required to enter into Alternative Payment Model (APM) arrangements with certified AEs. As of early 2019, RI Medicaid has certified six Comprehensive AEs as part of its Health System Transformation Project (HTSP).

RI Medicaid created the AE Initiative to achieve the following goals in Medicaid managed care:[5]

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

The state's MCO contracts stipulate that only Rhode Island residents who are not eligible for Medicare and are enrolled in Medicaid managed care plans are eligible to participate in the AE Program. In early 2019, qualified APM contracts were in place between five AEs and two Medicaid MCOs.

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

Section 1.6 Quality Strategy Goals

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

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

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

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

In its managed care programs, RI Medicaid employs standard measures that have relevance to Medicaid-enrolled populations. Rhode Island has a lengthy experience with performance measurement via collecting and reporting on HEDIS©[6] measures for each managed care subpopulation it serves. RI Medicaid also requires its managed care plans to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS)[7] 5.0 surveys. During this quality strategy period, RI Medicaid will focus on strengthening its current MCE measurement and monitoring activities and benchmarks to continually improve performance and achieve the goals of Medicaid managed care. RI Medicaid will also implement and continually improve AE performance measurement specifications, benchmarks and incentives, consistent with the goals of the AE initiative and this Quality Strategy.

Section 1.7 Quality Strategy Objectives

To support achievement of the Quality Strategy goals, RI Medicaid has established specific objectives as identified in Table 3 below. The state has developed objectives to focus state, MCE and other activities on interventions likely to result in progress toward the eight managed care goals. The right column of the table depicts how each objective aligns with one or more referenced managed care goals as numbered in **Section 1.6**.

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

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

Section 2: Development and Review of Quality Strategy

Section 2.1 Quality Management Structure

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

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

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

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

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

- managed care operations
- quality measurement, benchmarks, and improvement
- managed care financial performance
- Medicaid program integrity

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

As part of the 2019-2022 Quality Strategy, the 1115 Quality and Evaluation Workgroup with state partners will be crucial to monitoring various quality improvement efforts occurring within the broad array of Medicaid programming, sharing lessons learned, and discussing quality and evaluation efforts on the horizon.
In addition to managed medical care, there is also state oversight of the managed dental care provided to Medicaid managed care members. The focus of the RI Medicaid dental quality strategy continues to be on ensuring access to preventive dental services for members under age 21 and effective collaboration between state partners. Along with the RI Medicaid dental contract oversight, the DOH regulates the utilization review and quality assurance, or quality management (UR/QA) functions of all licensed Dental Plans, including RIteSmiles. The Medicaid managed dental plan contractor must comply with all DOH UR/QA standards as well as specific standards described in the dental contract.

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

Section 2.2 Review and Update of the Quality Strategy

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

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

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

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

Section 2.3 Evaluating the Effectiveness of the Quality Strategy

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

- routine monitoring of required MCE reports and data submissions that are due to the state according to a contractually-defined reporting calendar
- collection and analysis of key performance indicators to assess MCE progress toward quality goals and targets at least annually.

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

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

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

Section 3: Assessment of Managed Care

Section 3.1 State Procedures for Assessing Care

As part of its Medicaid 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.
2. State-level data collection and monitoring – At least annually, 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. RI's health plans continue to rank in the top percentile of health plans nationally.
3. Performance improvement projects - Each managed care entity is required to complete at least two performance improvement projects annually in accordance with 42 CFR 438.330(d) and the RI Medicaid managed care contracts. In Rhode Island, the MCOs are contractually obligated to conduct 4 PIPs annually. Each MCO can choose two additional areas for improvement based on the needs of their membership.
4. Annual Quality Plan-Each MCE must submit an annual quality plan to RI Medicaid. This plan must align the RI Medicaid's goals and objectives.
5. Accreditation Compliance Audit- As part of the annual EQR, the EQRO conducts an accreditation compliance audit of contracted MCOs.

RI Medicaid oversight and MCE responsibilities for quality management and performance improvement as part of the EQR process is described in more detail in **Section 3.5**.

Section 3.2 Appropriateness of Care

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

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 identify and assess enrollees for ***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.

Commented [MBD1]: Please review definitions here. I did not see a clear definition of special needs other than CSHCN in your contract. I found these child and adult special need definitions in the 2014 Quality Strategy. They should be in your MCE contracts.

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

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

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 members. For example, MCEs 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 can access covered services and communicate with their providers. In addition, MCEs are obligated to adhere to the American Disabilities Act and ensure accessible services for members with a visual, hearing, and/or physical disability.

Analysis by Disability and Gender. The MCES 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 MCOs utilize internal quality and analytic tools such as CAHPS® which is provided in both English and Spanish as well as informal complaints to identify and monitor for potential health disparities.)

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

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

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

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

Section 3.3 Monitoring and Compliance

Rhode Island Medicaid has detailed procedures and protocols to account for the regular oversight, monitoring, and evaluation of its MCEs. For example, RI Medicaid program monitors overall managed care quality and access by:

- Defining quality and access standards in Rhode Island's Contracts with MCEs
- Directing monthly contract compliance meetings with each Health Plan
- Contracting with an EQRO to perform an independent annual review of Medicaid managed care entities.
- Monitoring encounter data to assess trends in service utilization
- Analyzing a series of quarterly reports, including informal complaints, grievances, and appeals
- Conducting member satisfaction surveys
- Analyzing findings from the Health Plans' four contractually required annual quality improvement projects (QIPs)
- Reinforcing the State's requirement that participating MCOs maintain accreditation by the NCQA
- Setting a performance "floor" to ensure that any denial of accreditation by NCQA shall be considered cause for termination of the State's Medicaid Managed Care Services Contract and achievement of no greater than a provisional accreditation status by NCQA shall require a Corrective Action Plan within 30 days of the Health Plan's receipt of its final report from the NCQA and may result in the termination of the State's Medicaid Managed Care Services Contract.
- Routine oversight related to Mental Health Parity. New Contract Language includes:
    - *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.*

Reporting Requirements: Medicaid managed care programs require reporting and analysis of timely information and data regarding the performance of each plan. RI EOHHS monitors managed care plan compliance with contractual, Federal, and state requirements in multiple ways, with the most significant being the Reporting Calendar tool. The Reporting Calendar reflects adherence the monitoring requirements of *§ 42 CFR 438.66 State monitoring requirements* and the RI Medicaid managed care contract. For example, RI Medicaid requires its participating MCOs to submit a comprehensive series of standing monitoring reports, which are used for oversight and monitoring of the State's managed care program. MCO reports are submitted monthly, quarterly and annually depending on the reporting cadence on a variety of topics specified by the state, such as:

- Care Management
- Compliance

- Quality Improvement Projects
- Access
- Grievances and Appeals
- Financial Reports
- Informal Complaints
- Pharmacy Home

These monthly and other 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 Oversight and Monitoring meetings.

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.

Continuous quality improvement is at the core of the oversight and monitoring activities. This is conducted via ongoing analysis of health plan data as it relates to established standards/measures, industry norms, and trends to identify areas of performance improvement and compliance. When compliance and/or performance is deemed to be below the established benchmark or contractual requirement, RI Medicaid will impose a corrective action, provide technical assistance and will potentially impose financial penalties as necessary.
RI Medicaid also 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.

In addition to the oversight and monitoring mechanisms detailed above, RI Medicaid may make modifications or additions to metric development and specification, performance incentives, and additional data and reporting requirements as necessary, e.g., as part of a contract amendment or with the implementation of new programs. Alongside its 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.

To create more meaningful consequences for MCO performance in the future, RI Medicaid will develop and more actively utilize a combination of financial and non-financial incentives for contracted MCEs to meet or exceed performance expectations. To make a stronger business case for MCEs to invest in improved performance on behalf of members, RI Medicaid may amend its MCE policies and contracts to specifically indicate financial penalties on MCEs performing below state-defined minimum benchmarks.
The External Quality Review Organization conducts a compliance review for each MCE as noted in Section 3.5. The compliance review is a mandatory EQR activity and offers valuable feedback to the state and the plans.

Section 3.4 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 in **Attachment X** provide quantifiable performance driven objectives that reflect state priorities and areas of concern for the population covered by MCEs.

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.[8] In 2019, Rhode Island reported on 20 measures from the Adult Core Set and 17 measures from the Child Core Set, with measurement reflecting services delivered to Medicaid beneficiaries in CY2017. RI Medicaid also opts to report on some CMS Health Home core measures.

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

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

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

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

[8] 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

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 correlate to the agency's goals, objectives, and mission. Measures are chosen that align with the State's commercial partners intended to lessen provider burden and streamlines expectations. Clinical and non-clinical measures that represent key areas of interest are chosen accordingly. Many MCO performance measures belong to the CMS Adult and Child Core Measure Sets and the measurement domains for AEs are closely aligned with the MCO measures.

MCE performance is assessed across member experience, clinical performance and measure monitoring. MCE rates are compared to applicably appropriate regional, national and state benchmarks. Currently, many of these performance benchmarks are obtained from NCQA's Medicaid Quality Compass© or OHIC or the all-payer claims database (APCD) for performance comparison across MCEs. EOHHS will use baseline performance and targets established through initial or historical performance (e.g., for new or emerging measures) where external benchmarks are not available.

Section 3.5 External Quality Review

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

In accordance with 42 CFR Part 438, subpart E, the EQRO performs, at minimum, the mandatory activities of the annual EQR. RI Medicaid may ask the EQRO to perform optional activities for the annual EQR. The EQRO provide technical guidance to MCOs/PAHP on the mandatory and optional activities that provide information for the EQR.

These activities will be conducted using protocols or methods consistent with the protocols established by the Secretary in accordance with 42 CFR 438.352Activities- the EQRO must perform the following activities for each MCO/PAHP:

- **Performance Improvement Projects -** Validation of performance improvement projects required in accordance with 42 CFR 438.330(b)(1) that were underway during the preceding 12 months. Currently, the MCOs are required to complete at least four performance improvement projects each year. Additionally, the contract for Rhody Health Options and the Medicare Medicaid Plan requires at least one performance improvement project. The PAHP is required to complete at least two performance improvement projects each year.

- **Performance Goal Program -** Validation of MCO and PAHP performance measures required in accordance with 42 CFR 438.330(b)(2) or MCO/PAHP performance measures calculated by the state during the preceding 12 months. Within the contract for RIte Care, Rhody Health Partners and Rhody Health Expansion, the state requires performance measures through a pay-for-performance program called the Performance Goal Program (PGP). The MCOs can earn financial incentives for achieving specified benchmarks for measures in the following domains: utilization, access to care,

prevention/screening, women's health, and chronic care management, and behavioral health. The contract for the Medicare Medicaid Plan requires performance measures that are tied to withholds. A percentage of payment is withheld from the plan at the beginning of the year. 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.

- **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). 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. In the contracts for Rhody Health Options and Medicare Medicaid Plan the state has specified time and distance standards for long-term services and supports. In the dental contract the state has specified time and distance standards for pediatric dental. Validation of network adequacy will include, but not be limited to a secret shopper survey of MCO and PAHP provider appointment availability in accordance with contractual requirements established by the state.

- **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).

- **Special enhancement activities** as needed. In addition, the State reserves the option to direct the External Quality Review Organization 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.

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

- A description of the way data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to care furnished by the MCEs.
- For each Mandatory and, if directed by the State, Optional Activity conducted the objectives, technical methods of data collection and analysis, description of data obtained (including validated performance measurement data for each activity conducted), and conclusions drawn from the data.
- An assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of health care services furnished by each MCE including how the State can establish target goals and objective in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid

beneficiaries.
- An assessment of the degree to which each MCE has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.
- An evaluation of the effectiveness of the State's quality strategy and recommendations for updates based on the results of the EQR.

Concurrently, each MCE is presented with the EQRO's report, in conjunction with the State's annual continuous quality improvement cycle, as well as correspondence prepared by RI Medicaid which summarizes the key findings and recommendations from the EQRO. Subsequently, each MCO must make a presentation outlining the MCO's response to the feedback and recommendations made by the EQRO to the State formally.
The EQRO presents clear and concrete conclusions and recommendations to assist each MCO, PAHP, and RI Medicaid in formulating and prioritizing interventions to improve performance and to consider when updating the State's managed care quality strategy and other planning documents. A recent EQR can be found here: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/2016AggregateEQRTechnicalReport.pdf

Each MCO and PAHP is required to respond the EQRO's recommendations and to state any improvement strategies that were implemented. The MCO and PAHP responses to previous recommendations are included in the report. Recommendations for improvement that are repeated from the prior year's report are closely monitored by the EQRO and RI Medicaid. The EQRO produces a technical report for each MCO and PAHP and one aggregate report for RI Medicaid. The aggregate report includes methodologically appropriate comparative information about all MCEs. The EQRO reviews the technical reports with the State and MCEs prior to the State's submission to CMS and posting to the State's website; however, the State or MCEs may not substantively revise the content of the final EQR technical report without evidence of error or omission.
In conjunction with the State's annual continuous quality improvement cycle, findings from the annual EQR reports are presented to RI Medicaid's Quality Improvement Committee for discussion by the State's team which oversees the MCEs. The information provided as a result of the EQR process informs the dialogue between the EQRO and the State. Rhode Island incorporates recommendations from the EQRO into the State's oversight and administration of RIte Care, Rhody Health Partners, RIte Smiles and the Medicare-Medicaid Dual Demonstration program.

Section 5: State Standards

Section 5.1 State Medicaid and CHIP 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."*[9]

Appendix A, Exhibit 1: **MCO standards** includes specific MCO Contract sections that relate to RI Medicaid network adequacy and availability of services standards for MCOs as required by 42 CFR §§438.68 and 438.206 as well as the requirement for MCOs to have evidence-based clinical practice guidelines in accordance with 42 CFR §438.236.

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

Appendix A, Exhibit 2: MMP Standards includes network adequacy and availability of service standards included in MMP contract with Neighborhood that are specific to members who are dually eligible for Medicare and Medicaid and enrolled in this managed care plan. Network requirements under the State's MMP contract are similar to those for managed medical and behavioral health care.

Although methods and tools may vary depending on the program, 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.

Appendix A, Exhibit 3: Dental Plan Standards includes network adequacy and availability of service standards included in the RIte Smiles managed dental contract. Network requirements under the State's managed dental care contract are broadly like those for managed medical and behavioral health care. The Dental Plan is contractually required to establish and maintain a geographically accessible statewide network of general and specialty dentists in numbers enough 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.

Section 6: Improvement and Interventions

Section 6.1 Improvement and Interventions

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:

1) 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.

2) Statewide collaboratives and workgroups that focus on quality of care

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:

- Long-term care coordinated council
- Integrated Care Initiative implementation council
- Behavioral Health work group for children
- Behavioral Health workgroup for adults
- Governor's Overdose Taskforce
- Accountable Entity Advisory Committee
- 1115 waiver demonstration quality workgroup

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

Performance and satisfaction surveys are sent to participants and/or their representatives. RI Medicaid is also considering the use of managed care focus groups to better identify improvement opportunities and develop measures and strategies to ensure better outcomes that matter to members.

Section 6.2 Intermediate Sanctions

As applicable, EOHHS may use intermediate sanctions as a vehicle for addressing MCO quality of care problems. All of Rhode Island's Medicaid MCO Contracts clearly defines 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 the Medicaid MCO 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 4) suspend payment for new enrollments to the Contractor.

As set for in 42 CFR 438.710, EOHHS will give a Medicaid MCO written notice thirty (30) days prior to imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeals rights.

Section 6.3 Health Information Technology

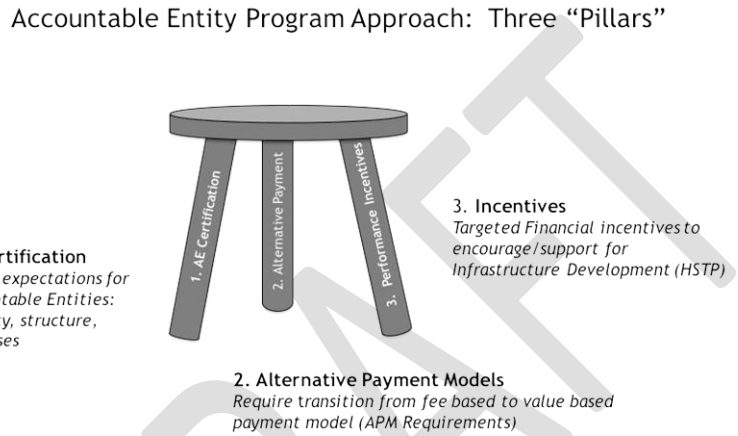
Rhode Island's All Payer Claims Database (APCD) was initiated in 2008. Rhode Island's APCD is an interagency initiative to develop and maintain a central repository of membership, medical, behavioral health and pharmacy claims from all commercial insurers, the self-insured, Medicare, and Medicaid. The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

Rhode Island seeks to expand its' Health Information Technology systems to streamline and automate the quality reporting process to inform policy level interventions and data-driven decision making. State-level Health and Human Service agencies have partnered to share information and collaborate towards achieving positive health outcomes and reducing disparities. This has culminated with the development of an eco-system that collects data from each HHS agency that can be shared within each agency. The ecosystem is still in its infancy but is expected to be a promising tool used in quality reporting and active contract management.
The Rhode Island Department of Health (DOH) also provides oversight functions related to the State's HIT/EHR initiatives with strategies, policies, and clinical guidelines established at the state government level. The Department of Health manages several key HIT initiatives to support data-focused public health and the EHR Incentive Program. These include:

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

Section 7: Delivery System Reform

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



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

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

To secure full funding, AEs must earn payments by meeting metrics defined by EOHHS and its MCO partners and approved by CMS. Actual incentive payment amounts to AEs will be based on demonstrated AE performance. Shared priorities are being developed through a joint MCO/AE working group that includes clinical leadership from both the MCOs and the AEs using a data driven approach. RI Medicaid is actively engaged in this process for identifying performance metrics and targets with the MCOs and the AEs.

Below is the initial list of AE performance measures as developed by RI Medicaid. The state identified these AE performance metrics after examining the Medicaid MCO measures, Adult and Child Core Measure Sets, and the OHIC standardized measures for commercial insurers developed as part of Healthy RI. The state's quality

strategy for AEs, as with MCEs, continues to include alignment with other payers in the market and regionally to reduce confusion and administrative burden at the provider level where possible, while continuing to focus efforts on performance improvement.

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

RI Medicaid will examine the AE performance metrics annually as part of its ongoing quality strategy for MCOs and AEs. Certain measures may be cycled out due to exemplar performance rates in some areas and allow for other opportunities for improvement which the state wants MCOs and AEs to focus.
For example, RI Medicaid is removing Adult BMI Assessment from the measure slate and moving the tobacco use measure to "reporting only." For the same time period, RI Medicaid will add two new AE HEDIS measures: Adolescent Well Care Visits and Comprehensive Diabetes Care: Eye Exam for AE Performance Year 3.

Section 8: Conclusions and Opportunities

Rhode Island is committed to ongoing development, implementation, monitoring and evaluation of a vigorous quality management program that will effectively and efficiently improve and monitor quality of care for its Medicaid managed care members. Our goals include improving the health outcomes of the state's diverse Medicaid and CHIP population by providing access to integrated health care services that promote health, well-being, independence and quality of life.

We are excited by the progress in our AE program and the collaboration between RI Medicaid our contracted MCOs and the state-certified AEs. Today, close to 150,000 RI Medicaid MCO members are attributed to an AE. Consistent with our overall managed care approach, RI Medicaid is developing and refining an AE performance

measure set and detailed measure specifications to assess AE performance over time as part of a joint workgroup with the state, the MCOs and their contracted AEs.

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

Appendices