RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

Quality Strategy for the Medicaid Managed Care and Children's Health Insurance Programs 2025–2028

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Introduction

The Rhode Island Executive Office of Health and Human Services (hereafter referred to as EOHHS) is dedicated to ensuring that Medicaid and the Children's Health Insurance Program (hereafter referred to as CHIP) provide high-quality, equitable health care to over 300,000 Rhode Islanders. This Quality Strategy sets forth Rhode Island's vision, goals, and plans for assessing and continuously improving the quality of managed care services delivered across the state.

This strategy aligns with federal Medicaid managed care quality regulations and incorporates state priorities identified in the 2024 Rhode Island EOHHS Strategic Plan. It reflects Rhode Island's commitment to improving health outcomes, reducing disparities, ensuring access to needed services, and engaging stakeholders in transparent quality improvement processes.

Overview of Rhode Island's Managed Care Program

Rhode Island Executive Office of Health and Human Services

The Rhode Island EOHHS serves as "the principal agency of the executive branch of state government" (R.I. Gen. Laws § 42-7)[1], and is responsible for managing the Departments of Health (DOH); Human Services (DHS); Children, Youth and Families (DCYF); and Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). Last year, Rhode Island EOHHS 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 2024 (SFY23), Health and Human Services benefits represented approximately $5.7 billion, or over 41% of the entire State budget.

The Rhode Island EOHHS is the single state agency for Medicaid. Rhode Island EOHHS administers Rhode Island's $3.2 billion Medicaid Program, inclusive of federal funds, general revenues, and restricted receipts. The Rhode Island Medicaid Managed Care Program provides health care coverage for over 250,000 eligible individuals representing nearly one-third (1/3) of all Rhode Islanders of all ages and from various ethnic and racial backgrounds. Medicaid expenditures account for 55.8% of the total EOHHS agency spending and around 22.9% of the entire State budget. Nearly 90% of individuals receiving full Medicaid benefits are enrolled in managed care.

[1] R.I. Gen. Laws § 42-7.2-2 - http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-7.2/42-7.2-2.htm

Rhode Island's Medicaid Managed Care Program

Rhode Island has adopted managed care as a crucial strategy for delivering Medicaid-covered services to eligible beneficiaries. The state initiated the Medicaid Managed Care Program, Rite Care, in 1994, enrolling over 70,000 low-income children and families. Since its inception, Rhode Island has progressively broadened managed care enrollment to encompass diverse populations with complex health care needs.

As of April 2023, the program currently serves individuals through eligibility groups including:

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

For more information regarding Rhode Island Medicaid Managed Care Program enrollment data, interested parties are encouraged to review EOHHS reported enrollment data, 'State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data' on CMS' website[2] and the 2024 Rhode Island Medicaid Managed Care Procurement Library.[3]

Currently, Full-Benefit Dual Eligible (FBDE) members are not served through the MCO contracts for the Medicaid Managed Care Program. Rhode Island participates in the CMS Financial Alignment Initiative (FAI), through which it offers a Medicare-Medicaid Plan (MMP). The MMP is Rhode Island's singular managed care program for FBDEs.

[2] https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360

[3] https://eohhs.ri.gov/?providers-opartners/medicaid-managed-care/2024-medicaid-managed-care-procurement-library

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 rural health care. Most children are enrolled in both an 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.

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

For Rhode Island Medicaid beneficiaries that are determined eligible, long-term services and supports (LTSS) are offered through a variety of delivery systems. Rhode Island 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 and Program for All Inclusive Care for the Elderly (PACE).

Medicare-Medicaid Plan (MMP) Duals

Rhode Island EOHHS, in partnership with CMS and NHP-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.

Under CMS' Final Rule (CMS-4192-F), the MMP demonstration was scheduled to sunset by December 31, 2023. Allowable under the Final Rule, Rhode Island EOHHS has extended the program for two additional years (through December 31, 2025) to transition the MMP into a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP). On December 15, 2023, Rhode Island issued a Request for Proposals (RFP) for a new Medicaid Managed Care Program with enrollment to integrated D-SNPs beginning on January 1, 2026. This RFP was subsequently canceled, and Rhode Island is now moving forward with a plan to convert its MMP into a Fully Integrated Dual-Eligible Special Needs Plan (FIDE-SNP) through a direct capitation State Medicaid Agency Contract (SMAC) with NHPRI on January 1, 2026.

Program for All Inclusive Care for the Elderly (PACE)

This 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 MCOs.

Home and Community Based Services (HCBS)

Rhode Island 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

Rhode Island 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.

RI Medicaid is currently tracking and reporting 22 HCBS quality measures that have been selected by CMS. In preparation for transition to the new HCBS Quality Measures Set announced by CMS in SMD# 22-003, RI EOHHS implemented the National Core Indicators – Aging and Disabilities (NCI-AD) survey during state fiscal year (SFY) 2025. The results will be published later in 2026, and Rhode Island EOHHS is planning the second year of the survey for SFY 2026. The NCI-AD survey will also be a key quality measurement tool for Rhode Island's Money Follows the Person (MFP) program.

Accountable Entities Program

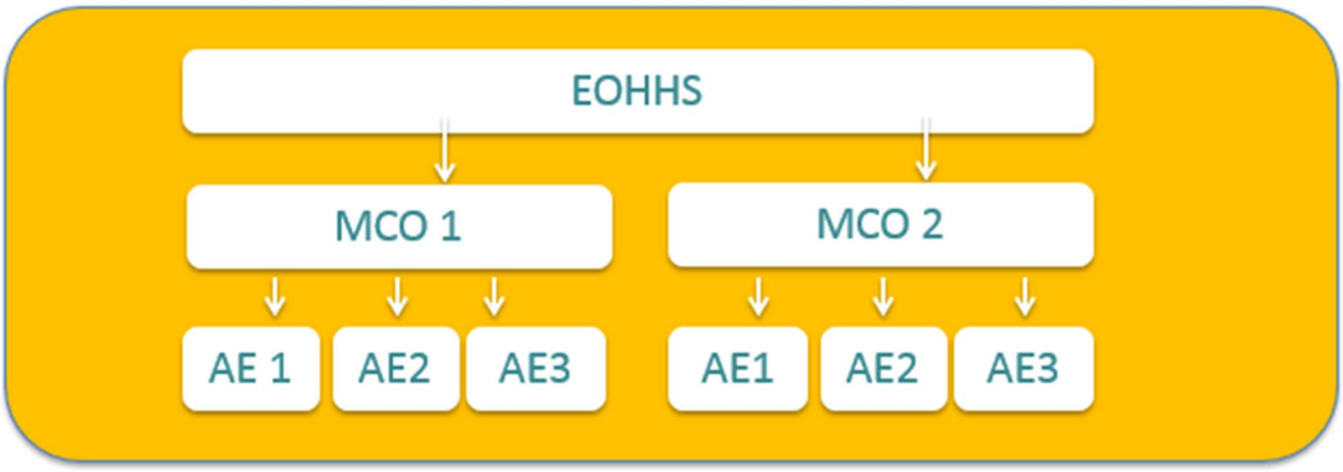
The Rhode Island Health System Transformation Project (HSTP) is a component of the State's CMS-approved Section 1115 Demonstration Waiver. HSTP has guided significant investments and has enabled Rhode Island EOHHS to implement and invest in delivery system changes aimed at achieving the Triple Aim.

From 2017-2024, Rhode Island EOHHS utilized HSTP funding to implement and support the growth and development of Accountable Entities. Accountable Entities are provider-led organizations who are accountable for quality health care, outcomes, and the total cost of care for enrollees. Current Accountable Entities include health centers, hospitals, and primary care providers. All members that are attributed to an Accountable Entity are enrolled in an MCO. Children, families, and the Medicaid Expansion population account for the largest number of Accountable Entity enrollees. As of June 2025, the Accountable Entities serve approximately 192,181members, accounting for approximately seventy percent (70%) of managed care enrollees.

The 1115 Demonstration Waiver authority to claim additional federal funding to support HSTP expired in 2024, and Rhode Island has used the resulting funding pool as prescribed, to establish Accountable Entities. Having reached this new stage, Rhode Island EOHHS will continue to support the Accountable Entity Program by maintaining the technical requirements needed for the TCOC methodology and by working to advance value-based payment across payers and provider types in Rhode Island and to address cost drivers that may not be in an Accountable Entity's direct control. As such, Rhode Island EOHHS is committed to the broader advancement of value-based payment in Medicaid and partnering with the Office of the Health Insurance Commissioner and

key stakeholders within the state to advance policies aimed at containing costs, improving quality of care, and improving population health.

Figure 1: Rhode Island Accountable Entity Model



Rhode Island EOHHS's 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).

Accountable Entities 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 Accountable Entities continues to grow in accordance with Rhode Island EOHHS' effort to pay for value not volume.

Accountable Entity Quality Measures

In accordance with 42 CFR §438.6(c)(2)(ii)(B)1, Accountable Entity quality performance must be measured and reported to the Rhode Island EOHHS using the Medicaid Comprehensive Accountable Entity Common Measure Slate. These measures shall be used to inform the distribution of any shared savings.

Table 1 displays the Accountable Entity 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. Rhode Island 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 Accountable Entities, Rhode Island Medicaid will examine these Accountable Entity 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 Accountable Entities to focus.

Table 1: Accountable Entity Quality Measures

Measures	Steward	Data Source[4]	Specifications	AE Common Measure Slate[5]	
				QPY7 Reporting and Incentive Use	QPY8 Reporting and Incentive Use
HEDIS Measures					
Breast Cancer Screening	NCQA	ECDE[6]	Current HEDIS specifications: QPY7: HEDIS MY 2024 QPY8: HEDIS MY 2025	P4P	P4P
Child and Adolescent Well-Care Visits (Total)	NCQA	Admin		P4P	P4P
Chlamydia Screening in Women (Total)	NCQA	Admin		Reporting-only	P4P
Colorectal Cancer Screening	NCQA	ECDE[7]		Reporting-only	Reporting-only
Controlling High Blood Pressure	NCQA	Admin/ Clinical		P4P	P4P
Eye Exam for Patients with Diabetes	NCQA	Admin/ Clinical		P4P	Reporting-only
Follow-up After Hospitalization for Mental Illness	NCQA	Admin		P4P – 7 days	Reporting-only – 7 days
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	NCQA	Admin/ Clinical		P4P	P4P

[4] "Admin/Clinical" indicates that the measure requires use of both administrative and clinical data.

[5] Please refer to the May 21, 2021, version of the Implementation Manual for more information on the QPY1 and QPY2 measures. Please refer to the April 20, 2022, version for more information on the QPY3 measures, to the September 12, 2022, version for information on the QPY4 measures, and to the February 2, 2024, version for information on the QPY5 and QPY6 measures.

[6] NCQA transitioned to exclusively using the Electronic Clinical Data Systems (ECDS) reporting standard for this measure beginning in MY23. RI EOHHS has adopted this practice to align with NCQA. For more information, see: https://www.ncqa.org/blog/transition-to-ecds-reporting-breast-cancer-screening/

[7] NCQA transitioned to exclusively using the ECDS reporting standard for this measure beginning in MY24. RI EOHHS had adopted this practice to align with NCQA. For more information, see: https://www.ncqa.org/blog/improving-quality-measurement-for-colorectal-cancer-screening/

Measures	Steward	Data Source[4]	Specifications	AE Common Measure Slate[5]	
				QPY7 Reporting and Incentive Use	QPY8 Reporting and Incentive Use
Immunizations for Adolescents (Combo 2)	NCQA	Admin/ Clinical		Reporting-only	Reporting-only
Kidney Health Evaluation for Patients with Diabetes	NCQA	Admin/ Clinical			Reporting-only
Lead Screening in Children	NCQA	Admin		P4P	P4P
Non-HEDIS Measures (Externally Developed)					
Developmental Screening in the First Three Years of Life	OHSU	Admin/ Clinical	QPY7-QPY8: CMS Core Set of Children's Health Care Quality Measures for Medicaid and CHIP[8]	Reporting-only	Reporting-only
Screening for Depression and Follow-up Plan	CMS	Admin/ Clinical	QPY7: CMS MIPS 2024, modified by EOHHS (January 25, 2024 version - included in Quality Measure Specifications Manual[9]) QPY8: CMS MIPS 2025 (see Quality Measure Specifications Manual[10] for guidance on defining "follow-up")	P4P	P4P
Non-HEDIS Measures (Rhode Island EOHHS-developed)					

[8] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/child-core-set-reporting-resources/index.html

[9] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

[10] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

Measures	Steward	Data Source[4]	Specifications	AE Common Measure Slate[5]	
				QPY7 Reporting and Incentive Use	QPY8 Reporting and Incentive Use
Patient Engagement with an AE Primary Care Provider	RI EOHHS	Admin	QPY7-QPY8: EOHHS (February 2, 2023 version – included in Quality Measure Specifications Manual[11])	Reporting-only	Reporting-only
Social Determinants of Health Screening	RI EOHHS	Admin/ Clinical	QPY7-QPY8: EOHHS (May 18, 2023 version – included in Quality Measure Specifications Manual[12])	P4P	P4P
Race, Ethnicity, and Language (REL) Data Completeness	RI EOHHS	Clinical	QPY8: EOHHS (November 13, 2024 version – included in Quality Measure Specifications Manual[13])		P4P
Race, Ethnicity, Language and Disability Status (RELD) Stratification	RI EOHHS	Clinical	QPY8: EOHHS (November 13, 2024 version – included in Quality Measure Specifications Manual[14])		Reporting-only

[11] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[12] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[13] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.
[14] Refer to the Quality Measure Specifications Manual, which can be found here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents.

Certified Community Based Behavioral Health Clinics

The Certified Community Behavioral Health Clinic (CCBHC) model represents a groundbreaking national initiative jointly supported by the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA), with Rhode Island being one of only ten states selected for the most recent federal Demonstration Program. Launching on October 1, 2024, the program is a collaborative effort involving the Rhode Island EOHHS the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, and the Department of Children, Youth, and Families. These CCBHCs will provide comprehensive, accessible behavioral health services including 24/7/365 crisis services, psychiatric rehabilitation, outpatient mental health, and substance use services, primary care screening, person-centered treatment planning, veteran-focused mental health care, peer support, and targeted case management. Critically, the program ensures that anyone can access behavioral health care regardless of age, residence, insurance status, or medical history, often working with partner organizations called Designated Collaborating Organizations (DCOs) to maximize service reach and effectiveness.

Managed Care Organizations

EOHHS contracts with three (3) MCOs to provide care for members:

- Neighborhood Health Plan of Rhode Island (NHP-RI) NHP-RI is the sole plan currently serving the substitute care population.
- Tufts Health Public Plan (Tufts)
- United Health Care Community Plan (UHC)

Table 2 shows the distribution of enrollment by eligibility category and by Medicaid managed care plan as of June 2023, as well as the current MMP membership (which is provided as an estimate for the future FBDE population under this RFP). Under the provisions of Rhode Island's CMS approved Medicaid Section 1115 Comprehensive Demonstration Waiver, enrollment in managed care will be mandatory for all eligible populations.

Table 2: Managed Care Enrollment by Eligibility Group SFY 2025

Managed Care Enrollment as of SFY 2025 (By Eligibility Group)				
Medical Assistance Eligibility Group	**NHP-RI**	**Tufts**	**UHC**	**Total**
RIte Care (Children and Families)	108,673	9,340	45,107	163,120
Children with Special Healthcare Needs	5,595	362	1,966	7,923
Medicaid Expansion (Adults ages 18-64)	49,378	5,241	26,848	81,467
Rhody Health Partners (Aged, Blind, and Disabled)	7,018	652	5,197	12,867
Rhody Health Options (Full Benefit Dual Eligibles)	11,917	N/A	N/A	11,917
Managed Care Total as of SFY 2025	**182,581**	**15,595**	**79,118**	**277,294**

Core MCO 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 MCOs 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.

Medicaid Managed Care Quality Strategy

Rhode Island's Medicaid Managed Care Quality Strategy is grounded in a vision of creating resilient, equitable communities that promote health, safety, and independence for all residents. Guided by a mission to build a community-driven, high-quality system of care, the strategy ensures Medicaid members have access to comprehensive, fair, and responsive health services. Key priorities include improving chronic disease management, supporting maternal and infant health, promoting preventive care, integrating behavioral health, and strengthening service coordination through data-driven decisions. By addressing social determinants of health and emphasizing voice, choice, and equity, Rhode Island is committed to advancing health outcomes and reducing disparities statewide.

This Quality Strategy fulfills federal requirements under 42 CFR 438 Subpart E, focusing on Rhode Island Medicaid's oversight of MCOs and PAHPs to monitor compliance and quality performance for Medicaid and CHIP members. Rhode Island Medicaid collaborates with CMS to ensure alignment with all content requirements outlined in 42 CFR 438.340(c)(2).

The revised strategy reflects Rhode Island Medicaid's goal to transition to a statewide, collaborative framework for quality improvement–encompassing measurement development, data collection, monitoring, and evaluation–to drive better care and outcomes for all.

Quality Strategy Goals and Objectives

Rhode Island Medicaid has established six core goals for its Managed Care Quality Strategy from 2022-2025. To support achievement of the Quality Strategy goals, Rhode Island Medicaid has established specific objectives to focus state, MCO and other activities on interventions and improvement projects most likely to result in progress toward the six managed care goals.

Table 3: Quality Goals and Objectives

Objective	Objective Description	Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective
Goal 1: Members receive quality care within all managed care delivery systems.				
1.1	Continue to work with MCOs and the EQRO to collect, analyze, compare, and share clinical performance and member experience across plans and programs.	See Table 4 for a list of quality measures.	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
1.2	Collaborate with MCOs, AEs, OHIC and other stakeholders to review and modify measures used in Medicaid managed care quality oversight.	See Table 4 for a list of quality measures.	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
1.3	Monitor MCO performance for dual-eligible Medicare Medicaid population.	Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
		Care for Older Adults: Functional Status Assessment	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)

Objective	Objective Description	Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective
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)	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
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)	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
2.3	Increase the use of prenatal and postpartum services.	• Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
2.4	Increase the number and percentage of well-child visits.	•Child and Adolescent Well-Care Visits (WCV- CH)	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business

Objective	Objective Description	Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective
				(Measurement Year)
2.5	Monitor child immunization rates to Maintain high performance.	• Childhood Immunization Status (CIS-CH)	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
2.6	Increase engagement, treatment, and follow-up care for substance abuse. Implementation of overdose programs certified Community Behavioral Health Clinics (CCHBC). Number of Overdose Fatalities and Non -Fatalities	• 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)	See Table 4	90th Percentile NCQA 90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
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) • Percentage diagnosed with major depression who were treated with and remained on antidepressant medication: Ages 18 to 64 (AMM-AD)	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
3.2	Improve integration with medical MCOs and RIte Smiles (UHC Dental).	Topical Fluoride for Children (TFL-CH)- Dental Services or Oral Health Services (Medicaid and CHIP)	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
		Topical Fluoride for Children- Dental	See Table 4	90th Percentile

Objective	Objective Description	Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective
		Services (Medicaid and CHIP)		NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
		Topical Fluoride for Children- Oral Health Services (Medicaid and CHIP)	See Table 4	90th Percentile NCQA Quality Compass for Medicaid, All Lines of Business (Measurement Year)
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.	Not Applicable	Not Applicable	Not Applicable
4.2	Migrate to value-based payment programs based on quality measures and MCO quality improvement projects (QIPs).	Not Applicable	Not Applicable	Not Applicable
4.3	Accountable Entity program objectives.	See Table 1 for a list of quality measures.	Not Applicable	Not Applicable
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.	Not Applicable	Not Applicable	Not Applicable
5.2	Require MCOs to provide strategic plans to address SDOH, including organizational strategy and stakeholder strategy to improve care delivery	Accountable Entity Reporting Requirements	Not Applicable	Not Applicable

Objective	Objective Description	Quality Measure	Statewide Performance Baseline	Statewide Performance Target for Objective
	model.			
5.3	Assess quality measures that could be stratified by REL (race, ethnicity, and language).	Core Set Measures	Not Yet Available	Not Applicable
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)	Not Applicable	Not Applicable
6.2	Conflict free case management	HCBS Quality Metrics	Not Applicable	Not Applicable

Intermediate Sanctions

Managed care entity failure to comply with the service agreement provisions may subject the managed care entity to intermediate sanctions including:

- Civil monetary penalties in the amounts specified in 42 CFR 438.704.
- Appointment of temporary management for the Contractor as specified 42 CFR 438.706.
- Granting members the right to terminate enrollment without cause and notifying the affected Members of their right to disenroll.
- Suspension of all new enrollment, including default enrollment, after the date the CMS or the Rhode Island EOHHS notifies the managed care entity of a determination of a violation of any requirement under sections 1903(m) or 1932 of the Act.
- Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the Rhode Island EOHHS is satisfied that the reason for the sanction no longer exists and is not likely to recur.

Rhode Island EOHHS retains the authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 CFR 438.700, as well as any additional areas of noncompliance. As set forth in 42 CFR 438.710(a), Rhode Island EOHHS will provide the managed care entity written notice thirty (30) days prior to imposing any intermediate sanction. The notice will include the basis for the sanction and any available appeal rights.

Health Information Technology

In early 2015, Rhode Island was awarded a State Innovation Model (SIM) test award from CMMI and developed a SIM model test around a broad shift to value-based payment. As part of the SIM model test, Rhode Island conducted strategic statewide alignment in quality measurement for healthcare outcomes. Rhode Island EOHHS as the state Medicaid authority and the Office of the Health Insurance Commissioner (OHIC) as the regulatory body for commercial plans in RI adopted the SIM Aligned Measure Set (now the OHIC Aligned Measure Set) to further statewide Medicaid/commercial alignment in use of quality measures for value-based contracts. Throughout this effort, RI conducted extensive stakeholder engagement, and soon identified an unmet need in terms of mounting administrative burden to providers in meeting requirements for electronic clinical data measurement (eCQM). In addition, Medicaid MCOs expressed a need for standard supplemental clinical data exchange to meet NCQA HEDIS requirements for reporting. A system meeting this need for MCOs would further support providers in reducing or eliminating the need for chart reviews.

A small-scale, initial pilot of the statewide eCQM system, named the Rhode Island Quality Reporting System (RI QRS), was conducted using SIM funding at 8 large Medicaid provider sites. After SIM ended, funding continued under Rhode Island's HITECH IAPD and then MES IAPD approval. Currently, all of RI's certified Comprehensive Accountable Entities (AEs) use the QRS to meet AE requirements for electronic clinical data exchange (ECDE) with their contracted MCOs. Shared-risk contracts and the underlying quality and outcome performance measurements are cornerstones of the Medicaid AE program, and building a single, unified solution for all Medicaid providers in the AE program is the most efficient and economical use of resources for RI Medicaid.

Extensive strategic thinking went into RI's approach to a Quality Reporting System. We were not initially able to utilize the statewide Health Information Exchange (HIE), CurrentCare, due to the requirements of the 2008 establishing statute to obtain affirmative "opt-in" consent from each individual. Approximately 50% of Rhode Islanders are typically enrolled in CurrentCare, and approximately 40% of all Medicaid beneficiaries.

Accordingly, Rhode Island issued a Request for Proposals in 2017 and selected IMAT Solutions as the vendor for the existing QRS standalone system through competitive award. The primary alternate approach to the QRS is to allow each MCO to develop and establish separate interfaces with each Medicaid provider, which was assessed as inefficient, cost-prohibitive, and burdensome.

In the July 2021 legislative session, Governor McKee enacted a statutory change to the HIE participation consent model from opt-in to opt-out. The multi-year timeline for conversion to the opt-out model would not allow Medicaid to conduct quality performance payments on the desired timeframe for the AE program, so we continued to pursue the legacy approach with the standalone QRS system. However, as we approached go-live for the new HIE system in April 2025, we recognized the significant possible efficiencies represented by leveraging HIE data feeds for quality reporting.

Rhode Island EOHHS seeks to execute a strategic redirection throughout CY2025-2026 in our approach to the QRS whereby we will leverage newly existing opt-out HIE data feeds to support quality reporting. Separately, to meet growing needs to perform statewide Medicaid quality measurement (MCO, FFS, and specialty populations such as HCBS). We also intend to utilize this capability to support better standardization of proposed evaluation plans for State-Directed Payments and to support the implementation of our recently awarded AHEAD model.

Quality Metrics and Performance Targets

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™ 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 requires managed care plans to conduct Consumer Assessment of Healthcare Providers and Systems (CAHPS) Version 5.1 surveys. Rhode Island Medicaid consults with its EQRO in establishing and assessing CAHPS survey requirements and results for MCOs. All MCOs are required to conduct CAHPS Version 5.1 member experience surveys, including Supplemental Questions for Children with Chronic Conditions. MCOs submit CAHPS Survey reports to Rhode Island EOHHS on member satisfaction with the plan. MCOs also submit CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) database.

During this quality strategy period, RI Medicaid will focus on strengthening its current MCO 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. Data are reported annually and publicly posted to ensure transparency.

Table 4: Rhode Island Quality Performance Measures

Performance Measure (Abbreviation)	Measure Specifications	Baseline Performance (Measurement Year)	Statewide Performance Measurement Year 2023	Statewide Performance Measurement Year 2024	Program	
					Medicaid	CHIP
Breast Cancer Screening (BCS-AD)	Adult Core Set	65.0 (2020)	64.38	63.99	✓	
Cervical Cancer Screening (CCS-AD)	Adult Core Set	59.6 (2020)	66.09	63.41	✓	
Screening for Depression and Follow-Up Plan: Ages 12-17 Years (CDF-CH)	Child Core Set	TBD*	8.24	7.60		✓
Comprehensive Diabetes Care: HbA1c Testing	HEDIS	82.2 (2020)	Not Available		✓	
Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%) (HPC-AD)	Adult Core Set	33.2 (2020)	27.03		✓	
Controlling High Blood Pressure (CBP-AD)	Adult Core Set	70.7 (2020)	73.86	74.06	✓	
Ages 5 to 18 Total (AMR-CH)	Child Core Set	65.6 (2020)	57.59			✓
Ages 19-64 Total (AMR-AD)	Adult Core Set	53.7 (2020)	52.95		✓	
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-AD-CH)	Adult and Child Core Set	TBD*	83.6 (Child) 93.4 (Adult)		✓	✓
Child and Adolescent Well-Care Visits (WCV-CH)						
Ages 3-11 Years	Child Core Set	TBD*		68.86		✓
Ages 12-17 Years	Child Core Set	TBD*		62.56		✓
Ages 18-21 Years	Child Core Set	TBD*		42.57		✓
Ages 3-21 (Total)	Child Core Set	Not Available	61.20	62.85		✓

Performance Measure (Abbreviation)	Measure Specifications	Baseline Performance (Measurement Year)	Statewide Performance Measurement Year 2023	Statewide Performance Measurement Year 2024	Program	
					Medicaid	CHIP
Childhood Immunization Status (CIS) – Combination 10	HEDIS	61.0 (2021)	52.29	49.82		✓
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)						
Initiation of AOD – Total	HEDIS	44.8 (2020)	40.70	39.99	✓	✓
Engagement of AOD – Total	HEDIS	17.9 (2020)	14.92	15.83	✓	✓
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-CH)						
Within 7 Days, Ages 13-17 Years	Child Core Set	TBD*	25.33	36.00		✓
Within 30 Days, Ages 13-17 Years	Child Core Set	TBD*	49.33	52.00		✓
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)						
Within 7 Days, Ages 18+ Years	Adult Core Set	12.7 (2020)	32.61	32.90	✓	
Within 30 Days, Ages 18+ Years	Adult Core Set	23.8 (2020)	48.25	48.86	✓	
Follow-Up After Hospitalization for Mental Illness (FUH-CH)						
Within 7 Days, Ages 6-17 Years	Child Core Set	56.8 (2020)	59.73	63.29		✓
Within 30 Days, Ages 6-17 Years	Child Core Set	76.6 (2020)	77.51	82.28		✓
Follow-Up After Hospitalization for Mental Illness (FUH-AD)						

Performance Measure (Abbreviation)	Measure Specifications	Baseline Performance (Measurement Year)	Statewide Performance Measurement Year 2023	Statewide Performance Measurement Year 2024	Program	
					Medicaid	CHIP
Within 7 Days, 18+ Years	Adult Core Set	57.2 (2020)	59.73		✓	
Within 30 Days, 18+ Years	Adult Core Set	71.7 (2020)	77.51		✓	
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH)						
Within 7 Days, Ages 13-17 Years	Child Core Set	Not Available	57.89	47.23		✓
Within 30 Days, Ages 13-17 Years	Child Core Set	Not Available	74.58	68.34		✓
Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)						
Within 7 Days, 18+ Years	Adult Core Set	64.6 (2020)	57.89		✓	
Within 30 Days, 18+ Years	Adult Core Set	74.8 (2020)	74.58		✓	
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)						
Percentage Advised to Quit	Adult Core Set	80.7 (2020)	Not Available		✓	
Percentage Discussed or Recommended Cessation Medications	Adult Core Set	67.0 (2020)	Not Available		✓	
Percentage Discussed or Recommended Cessation Strategies	Adult Core Set	59.9 (2020)		Not Available	✓	
Percentage diagnosed with major depression who were treated with and remained on antidepressant medication (AMM-AD)						

Performance Measure (Abbreviation)	Measure Specifications	Baseline Performance (Measurement Year)	Statewide Performance Measurement Year 2023	Statewide Performance Measurement Year 2024	Program	
					Medicaid	CHIP
Treated for 12 Weeks, Acute Phase	Adult Core Set	58.9 (2020)	61.32		✓	
Treated for 6 months, Continuation PhaMe	Adult Core Set	44.0 (2020)	43.66		✓	
Topical Fluoride for Children (TFL-CH)	Child Core Set	TBD*	See Table 4 ATR			✓
Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers	Rhode Island-Specific MMP	8.6 (2020)	8.5		✓	
Care for Older Adults: Functional Status Assessment	Rhode Island-Specific MMP	58.8 (2020)	8.8		✓	

Progress On Quality Strategy Goals and Objectives and Goal Revision

The annual EQR report provides a comprehensive update on the State's progress toward achieving its Quality Strategy goals. This report includes the most current quality metrics, detailed analyses of statewide performance, and descriptions of any changes to quality improvement initiatives. The EQR's findings and recommendations are used to inform ongoing enhancements to quality measurement, program oversight, and strategic planning for Rhode Island Medicaid managed care programs.

Quality Improvement Projects

The Rhode Island EOHHS requires managed care plans to conduct performance improvement projects targeting priority areas such as well-child visits, chronic disease management, and hospital readmission reduction. These projects include clear aims, defined interventions, and measurable outcomes. The performance improvement project results undergo validation during annual external quality reviews per CMS Protocol 1. Concurrently, each MCO is presented with the EQRO's report, in conjunction with the State's annual continuous quality improvement cycle, as well as correspondence prepared by Rhode Island 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. Rhode Island EQR Technical Reports are posted on the RI EOHHS website here: https://eohhs.ri.gov/reference-center/reports-government-partners

Table 5: Quality Improvement Project Topics by MCO/PAHP

MCO/PAHP Quality Improvement Topics
Neighborhood Health Plan of Rhode Island (NHP-RI)
Improve the ADHD HEDIS Rate
Improve the Rate of Lead Screening in Children – Social Determinant of Health Measure
Improve Child & Adolescents' Well Care Visits, 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 Child and Adolescent Well Visits
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 Prenatal/Postpartum Care
Member Experience and Retention
Improve Flu Vaccination Rate
Improve Follow-Up After Hospitalization for Mental Illness, 7 Day Rate
United Healthcare Dental
Increase the Percentage of Eligible Children, Ages 1-20 Years, Receiving at Least 2 Topical Fluoride Applications (DQA Measure TFL-CH)
Increase the Percentage of Eligible Children, Ages 15-18 Years, Who Received Any Defined Preventive Health Services
Increase the Percentage of Eligible Members, Ages 19-20 Years Utilizing Dental Services (DQA Measure UTL-CH)
Increase the Percentage of Eligible Children Receiving At least One Sealant on a Permanent First Molar by Their 10th Birthday (DQA Measure SFM-CH)

Transition of Care Policies

The Rhode Island EOHHS requires managed care entities to maintain continuity of care during key transitions, including new enrollment or plan switches, discharge from inpatient to community settings, and when members move from out-of-network to in-network providers. Contracts mandate up to six months of out-of-network coverage when clinically appropriate, timely member notifications, and transfer of medical records and referrals within specified timeframes to ensure uninterrupted access to services.

The contracts must contain specific policies as follows:

- Health Risk Assessment Scope
- Health Risk Assessment - Purpose
- Transitioning Members between Plans
- Continuity of Care for Former Qualified Health Plan Members
- Network Composition
- Transitioning between Non-Network and Network Providers for Medical and Behavioral Health (Primary Care)
- Transitioning between Non-Network and Network Providers (Substance Use Providers)
- Mental Health, Substance Use, and Developmental Disability Services for Children
- Care Coordination & Discharge Planning for Children
- Behavioral Health and Substance Use Services for Adults
- Care Coordination & Discharge Planning for Adults
- Contractor Responsibilities (Continuity of Care requirements)
- Care Management Protocols for All Members

Disparities Reduction Plan

Rhode Island EOHHS prioritizes reducing disparities by identifying gaps through stratified data analysis and engaging communities disproportionately affected by health inequities. Coordination with public health and community partners supports targeted interventions to improve equity in care access and outcomes.

Rhode Island's Cross Cutting Priority attempts to address health inequities that are systemic, avoidable, unfair, and unjust differences in health status across population groups. RIDOH recognizes that the conditions in which people are born, grow, live, learn, work, and play affect health in powerful ways. Public health research and data show that many adverse health outcomes have resulted from generations-long social, economic, and environmental inequities. These inequities include poverty, discrimination, racism, and their consequences. For example, segregation in housing and education and racist mortgage lending and zoning policies have affected communities differently and have had a greater influence on health outcomes than genetics, individual choices, or access to healthcare. Removing obstacles to health and improving access to good jobs with fair pay, quality education and housing, safe environments, and healthcare can help reduce health inequities and improve opportunities for every Rhode Islander.

For the first time in 2022, the state received HEDIS data from our MCOs that is stratified by race and ethnicity. Additional HEDIS measures are stratified by age. The state has also added a measure for Social Determinants of Health (SDOH) screening to our Accountable Entities program. Two of our MCOs are also focusing on Lead Screening for Children as PIPs. The lead screening PIPs address health disparities due to the nature of older housing with higher lead risk being concentrated in lower income areas in Rhode Island.

The state has also been providing supplemental data to our MCOs designed to improve data quality for race, ethnicity, and language (REL) demographics for Medicaid beneficiaries. Supplemental REL data is provided twice annually to all MCOs, enabling them to update their membership files based on EOHHS data. MCOs have been also been providing supplemental data to the state for Core Set reporting, including additional stratification categories, such as gender and geography, for certain quality measures.

Health Equity

Rhode Island has adopted 15 health equity indicators as statewide measures to overarchingly assess health equity in the state. These indicators span across five domains (integrated healthcare, community, physical environment, socioeconomics, and community trauma), which are further broken down in measuring key determinants of health that can be reported by city/town and race/ethnicity and monitored annually using various state agency, census, and survey data.

Accountable Entities engage with community partners to help reach their goals and address social determinants of health.

Rhode Island EOHHS identified four steps for Accountable Entities to use to develop meaningful community-based partnerships in Rhode Island.

First, it is necessary to identify the appropriate partners to assist in addressing SDOH within a particular community. The next step is to formalize the agreement between the Accountable Entities and the community partner to establish expectations and hold each party accountable for their responsibilities. The third step is to establish bi-directional care management tracking so that all parties, including the MCO, are as up-to-date as possible on the care of patients within the Accountable Entities. Finally, partners develop metrics for measuring the SDOH efforts and need for any adjustments to maximize the impact of the partnership.

Identification of Persons with Special Health Care Needs

Rhode Island EOHHS defines disability status as anyone who has been determined to be disabled by the federal Social Security Administration (SSA) or by the Rhode Island Department of Human Services (DHS).

Rhode Island 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.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Appropriateness of care begins with early identification and swift treatment. As part of its MCO oversight, Rhode Island 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 (See EPSDT report in **Appendix A**.)

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 MCOs 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 identifying Medicaid beneficiaries with special health care needs as defined in the MCO contracts. Each MCO 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 MCO 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.

Cultural Competency

At the time of enrollment, individuals are asked to report their race, 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.

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 MCOs 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.

Monitoring and Compliance

State Monitoring of Managed Care Organizations

To assess the health care and services furnished by Medicaid MCOs, Rhode Island Medicaid has a managed care monitoring system which addresses all aspects of the MCO program consistent with 42 CFR 438.66. For example, the state's oversight and monitoring efforts include assessing performance of each MCO 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.

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

- enrollment and disenrollment trends in each MCO and other data submitted by the RI Medicaid enrollment broker related to MCO 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 MCO
- MCO performance on required quality measures
- MCO medical management committee reports and minutes
- the annual quality improvement plan for each MCO
- audited financial and encounter data submitted by each MCO
- MLR summary reports required by 42 CFR 438.8

- customer service performance data submitted by each MCO
- data related to the provision of LTSS not otherwise included above as applicable to the MMP contract.

The state enforces network adequacy standards and clinical practice guidelines to ensure access and quality. Compliance is monitored regularly, with corrective actions and sanctions applied as needed to maintain high standard.

Specific MCO 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 MCOs in the areas noted above. As part of its managed care program, RI Medicaid employs a variety of mechanisms to assess the quality and appropriateness of care furnished to all MCO and PAHP members including:

Contract Management

All managed care contracts and contracts with entities participating in capitated payment programs include quality provisions and oversight activities. Contracts include requirements for quality measurement, quality improvement, and reporting. Active Contract Management is a crucial tool in RI Medicaid's oversight. Routine reporting allows RI Medicaid to identify issues, trends, and patterns early and efficiently to mitigate any potential concerns. Another key part of its contract management approach is monthly oversight meetings that RI Medicaid directs with each MCO. 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:

Mental Health Parity and Addiction Act

The Contractor must comply with Mental Health Parity and Addiction Act (MHPAEA) requirements and establish coverage parity between mental health/substance abuse benefits and medical/surgical benefits. The Contractor will cover mental health or substance use disorders in a manner that is no more restrictive than the coverage for medical/surgical conditions. The Contractor will publish any processes, strategies, evidentiary standards, or other factors used in applying Non-Qualitative Treatment Limitations (NQTL) to mental health or substance use disorder benefits and ensure that the classifications are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. The Contractor will provide EOHHS with its analysis ensuring parity compliance when: (1) new services are added as an in-plan benefit for members or (2) there are changes to non-qualitative treatments limitations. The Contractor will publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence. In the event of a suspected parity violation, the Contractor will direct members through its internal complaint, grievance, and appeals process as appropriate. If the matter is still not resolved to the member's satisfaction, the member may file an external appeal (medical review) and/or a State Fair Hearing. The Contractor will track and trend parity complaints, grievances and appeals on the EOHHS approved template at a time and frequency as specified in the EOHHS Managed Care Reporting Calendar and Templates.

State-level Data Collection and Monitoring

RI Medicaid collects data to compare MCO performance to quality and access standards in the MCO 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 MCO encounter data to assess

trends in service utilization, as well as analyzing a series of quarterly reports, including informal complaints, grievances, and appeals.

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

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

The scheduled MCO 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 MCO reports are analyzed by the state and discussed with contracted health plans during monthly MCO Oversight and Monitoring meetings.

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

Performance Goal Program

Rhode Island Medicaid 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.

Rhode Island Medicaid is evaluating the potential for additional value-based payment programs for MCOs based on meeting or exceeding quality and performance expectations. To make a stronger business case for MCOs to invest in improved performance on behalf of members, RI Medicaid may amend its MCO policies and contracts to specifically require more transparency on performance, and to specify financial incentives or penalties.

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.

Quality Improvement Projects

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, MCOs 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.

Annual Quality Plan

Each MCO 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 MCO. The state's EQRO participates in reviewing the MCO quality plans as part of its broader role in performing the external quality review of each managed care entity and program.

Accreditation Compliance Audit

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

RI Medicaid conducts monthly internal staff meetings to discuss MCO 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 MCO data as it relates to established standards/measures, industry norms, and trends to identify areas of performance improvement and compliance.

In addition to the MCO 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.

Evidence-Based Clinical Practices

Rhode Island's Medicaid Care Quality Strategy prioritizes the development and implementation of comprehensive Clinical Practice Guidelines (CPGs) as a fundamental element of its approach to enhancing health care quality and equity across the Medicaid population. CPGs such as ADA Standards of Care for Diabetes and ACOG guidelines for prenatal/postpartum care provide evidence-based recommendations that help standardize care delivery, improve patient outcomes, and support healthcare providers in delivering high-quality services.

Objectives of Clinical Practice Guidelines

- **Evidence-Based Care**: CPGs are grounded in the latest clinical evidence and best practices, ensuring that Medicaid beneficiaries receive care that is both effective and appropriate for their specific health needs. These guidelines help to minimize variations in care that can contribute to health disparities.
- **Standardization Across Managed Care**: By establishing standardized guidelines for clinical practice, Rhode Island aims to ensure that all Medicaid beneficiaries, regardless of their managed care plan, receive consistent and high-quality care. This approach helps to reduce disparities in treatment and outcomes.
- **Focus on Health Equity**: The development of CPGs will include a focus on health equity, addressing the unique needs of diverse populations served by Medicaid. This includes considerations of social determinants of health, cultural competence, and approaches to mitigate barriers to access. Continuous Improvement: Rhode Island will regularly review and update its CPGs to reflect new evidence, feedback from healthcare providers, and input from community stakeholders. This continuous improvement process is essential to maintaining the relevance and effectiveness of the guidelines in addressing the evolving health care landscape.

Access to Clinical Practice Guidelines

To facilitate the implementation of these clinical practice guidelines, Rhode Island's MCOs provide access to their specific guidelines through their respective websites. Below are links to the clinical practice guideline pages for each MCO operating in Rhode Island:

- **Blue Cross & Blue Shield of Rhode Island**

  BCBSRI Clinical Practice Guidelines (https://www.bcbsri.com/providers/guidelines)
  https://www.bcbsri.com/providers/medicalpolicies

- **Neighborhood Health Plan of Rhode Island**

  Neighborhood Health Clinical Practice Guidelines: Clinical Resources – NHPRI.org

- **Tufts Health Plan**

  Tufts Health Plan Clinical Practice Guidelines: Clinical practice guidelines | Point32Health)

- **UnitedHealthcare**

  UnitedHealthcare Clinical Practice Guidelines: Clinical Guidelines | UHCprovider.com

Rhode Island Managed Care Standards

State 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 Rhode Island Medicaid MCOs 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 MCO 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 MCO contract. The RI Medicaid MCO 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).

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 6** below includes time and distance standards for contracted Medicaid MCOs.

Table 6: MCO Time and Distance Standards

MCO Access to Care Standards	
Provider Type	**Time and Distance Standard** *Provider office is located within the lesser of*
Primary Care	
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.

MCO Access to Care Standards	
Provider Type	**Time and Distance Standard** *Provider office is located within the lesser of*
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 Rhode Island 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 7: MCO Appointment Wait Time Standards

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, MCO contract provisions related to availability of services require Rhode Island Medicaid MCOs 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 Rhode Island EOHHS' EQRO.

Medicare Medicaid Plan (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 Rhode Island 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 like those for managed medical and behavioral health care but also consider 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 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 are 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.

Dental PAHP Standards

In the Medicaid managed dental contract, Rhode Island has specified time and distance standards for pediatric dental. Rhode Island's Medicaid network adequacy and availability of service requirements under the State's managed dental care contract are broadly similar to those for managed medical 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.

Table 8: Dental PAHP Time and Distance Standards

Dental PAHP Access to Care Standards	
Provider Type	**Time and Distance Standard** *Provider office is located within the lesser of*
Dental Provider	Twenty (20) minutes from the member's home.

Table 9: Dental PAHP Appointment Wait Time Standards

Dental PAHP Timeliness of Care Standards	
Appointment	**Access Standard**
Routine and Preventive Dental Care	Within 60 Days
Urgent Dental Care	Within 48 Hours
New Member Dental Care	Within 60 Days

External Quality Review Arrangements

Rhode Island does not leverage the EQR non-duplication option; 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 Rhode Island 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, 2027.

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 provides 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:

- 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.
- 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.
- 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 MCO 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.
- 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 MCO. 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 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 Validation

- Home and Community Based Services Validation Project

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 MCOs 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 MCOs.
- 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 MCO'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 MCO including how the State can establish target goals and objectives 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 MCO has effectively addressed 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 MCO 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 evaluations, 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 to 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 MCOs. The EQRO reviews the technical reports with the State and MCOs prior to the State's submission to CMS and posting to the State's website; however, the State or MCOs 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 MCOs. 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.

Public and Stakeholder Engagement

Rhode Island EOHHS ensures transparency and collaboration by engaging public, Tribal, beneficiary, provider, and community stakeholders, together with the State's EQRO, in the development and periodic update of the Medicaid Managed Care Quality Strategy. Stakeholder input is solicited through advisory committees, work groups, and public comment opportunities to promote person-centered, integrated care. Draft strategies are posted for public review, and all comments with State responses are published online. In accordance with 42 CFR §438.340(c)(3), EOHHS conducts Tribal consultation under the State's Tribal policy whenever updates may affect Tribal members. Notification is provided via email to the Director of the Narragansett Indian Health Center, including a link to the draft strategy on the EOHHS website and instructions for requesting a hard copy by phone.

Quality Strategy Review and Updates

Rhode Island EOHHS conducts an annual review of the Medicaid Managed Care Quality Strategy and updates the strategy as needed when significant changes occur, but no less frequently than every three years. As part of this review, Rhode Island Medicaid collaborates with contracted MCOs, state partners, and stakeholders to share annual EQRO findings and other data to assess effectiveness. The most current version of the Quality Strategy is posted on the Rhode Island EOHHS website.

In accordance with 42 CFR §438.204(b)(11), Rhode Island defines "significant change" as any event requiring revision of the Quality Strategy more frequently than every three years, including:

- enrollment of a new population group in Medicaid managed care;
  a Medicaid managed care procurement;
- substantive changes to quality standards or requirements resulting from state or federal regulatory or legislative action; or
- significant changes in managed care membership demographics or provider networks as determined by Rhode Island EOHHS.

Appendix – EPSDT Schedule

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EPSDT

RHODE ISLAND MEDICAID EARLY PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT PREVENTIVE PEDIATRIC SCHEDULE