



**Rhode Island Medicaid Managed Care Program
Neighborhood Health Plan of Rhode Island, Inc.
(Neighborhood)**

**Annual External Quality Review Technical Report
Reporting Year 2019**

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

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I. EXECUTIVE SUMMARY

Introduction

The Centers for Medicare and Medicaid Services (CMS) require that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). In order to comply with these requirements, the State of Rhode Island Executive Office of Health and Human Services (EOHHS) contracted with Island Peer Review Organization (IPRO) to assess and report the impact of its Medicaid program on the quality, timeliness, and accessibility of health services. Specifically, this report provides IPRO's independent evaluation of the services provided by Neighborhood Health Plan of Rhode Island, Inc. (Neighborhood) for Reporting Year 2019 under the Rite Care and, a Rhode Island Medicaid managed care program.

Neighborhood Health Plan is a for-profit Health Plan that serves Medicaid, Medicare, and Commercial populations.

Rhode Island Medicaid Managed Care Program

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

It is important to note that the provision of health care services to each of the applicable eligibility groups (Core Rite Care, Rite Care for Children with Special Health Care Needs (CSHCN), Rite Care for Children in Substitute Care², Rhody Health Partners (RHP), Rhody Health Options (RHO)³, and Rhody Health Expansion (RHE)) is evaluated in this report. RHP is a managed care organization (MCO) option for Medicaid-eligible adults with disabilities, while RHO includes those that are dual-eligible for Medicaid and Medicare. The RHE population includes Medicaid-eligible adults, ages nineteen (19) to sixty-four (64), who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible or enrolled for mandatory coverage under the State plan. As members of the Health Plan, each of these populations were included in all measure calculations, where applicable. For comparative purposes, results for 2017 and 2018 are displayed when available and appropriate. The framework for this assessment is based on the guidelines established by the CMS EQRO protocols, as well as State requirements.

Scope of External Quality Review Activities

This EQR technical report focuses on the federally mandated EQR activities and one optional EQR activity that were conducted in reporting year 2019. It should be noted that validation of provider network adequacy, though currently a standard in *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(iv)*, was not part

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

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

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

of the CMS *External Quality Review (EQR) PROTOCOLS*⁴ published in October 2019 and therefore not required for the 2019 EQR. As set forth in *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)* EQR activities are:

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

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

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

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

Findings

Validation of Quality Improvement Projects

IPRO’s validation of Neighborhood’s 2019 QIPs confirmed the state’s compliance with the standards of *Title 42 CFR § 438.330(a)(1)*. The results of the validation activity determined that Neighborhood was compliant with the

⁴ [Medicaid.Gov Website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf](https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf)
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standards of *Title 42 CFR § 438.330(d)(2)* for one (1) of two (2) QIPs. QIP summaries and detailed validation results are in **Section IV** of this report.

Opportunities for improvement remain for all six (6) QIPs.

Validation of Performance Measures

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

Information Systems Capabilities Assessment

The 2020 HEDIS FAR for MY 2019 produced by Attest Health Care Advisors indicated that Neighborhood met all of the requirements to successfully report HEDIS data to EOHHS and to NCQA.

HEDIS

Neighborhood's performance on HEDIS® and CAHPS® measures was compared to the performance of other Medicaid managed care Health Plans that reported 2019 HEDIS® and CAHPS® measure rates to the NCQA for Measurement Year (MY) 2019 through the NCQA's *Quality Compass*® national benchmark data.

The HEDIS® **Use of Services Rates** domain assess three (3) measures. The Health Plan's rates for all three (3) measures exceeded the 2019 *Quality Compass*® national Medicaid mean. Additionally, two (2) measures benchmarked at the 2019 *Quality Compass*® 75th percentile and one (1) measure benchmarked at *Quality Compass*® 90th percentile.

The HEDIS® **Effectiveness of Care** domain assesses preventive care and care for chronic conditions. Overall performance in this domain was strong, with five (5) of the eight (8) measures achieving the 2019 *Quality Compass*® 90th percentile, and one (1) measure achieving the 75th percentile. All measures exceeded the Quality Compass mean. The Health Plan demonstrated an opportunity for improvement in this domain, as rates for the remaining two (2) measure benchmarked below the *Quality Compass*® 75th percentiles for 2019.

The HEDIS® **Access and Availability** domain evaluates the proportions of enrollees who access PCPs, ambulatory services, preventive care, and timely and ongoing perinatal care. While rates for all nine (9) reported measures were above the 2019 national Medicaid mean, the percentile rankings for each measure varied across measures and age groups. The Health Plan continued to demonstrate a strong performance for the measures related to perinatal care, with both measures achieving the 2019 *Quality Compass*® 90th percentile. For the *Children and Adolescents' Access to Primary Care Practitioners* measure, rates for three (3) of the four (4) age groups ranked in the 75th percentile for 2019 and one (1) age group measure ranked in the 90th percentile benchmark for 2019. The *Adults' Access to Preventive/Ambulatory Health Services* measure presents an opportunity for improvement, as rates for one (1) of the three (3) age groups ranked below the 75th percentile for 2019. For the *Prenatal and Postpartum care* measures, one (1) benchmarked at the 75th percentile and the other measure benchmarked at 95th percentile.

Performance Goal Program

The 2019 Performance Goal Program includes twenty (20) measures, of which nineteen (19) derive from HEDIS and one (1) is State-specific. These measures are categorized into the following domains of care: utilization, Annual EQR Technical Report 2019—Neighborhood Health Plan of Rhode Island, Inc.

access to care, prevention and screening, women’s health, chronic care and behavioral health. MCOs qualify for an incentive, full or partial, for a performance rate that meets the *Quality Compass* 2018 national Medicaid 75th percentile or the 90th percentile, respectively. A rate that does not meet the national Medicaid 75th does not qualify the MCO for an incentive.

Neighborhood’s rate for the State-specific measure, *HIV Viral Load Suppression*, qualified the MCO for a partial incentive award. Neighborhood’s performance on nine (9) of the nineteen (19) HEDIS measures qualified the MCO for an incentive. Neighborhood rates for the seven (7) measures: *Childhood Immunization Status—Combination 10*, *Adolescent Immunizations—Combination 2*, *Cervical Cancer Screening (21-64 Years)*, *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*, *Controlling High Blood Pressure (18-85 Years)*, *Follow-Up After Hospitalization for Mental Illness—7 Days* and *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* each achieved the *Quality Compass* 2018 national Medicaid 90th percentile, qualifying the MCO for full incentives. Rates for the following two (2) measures achieved the *Quality Compass* 2018 national Medicaid 75th percentile, qualifying Neighborhood for partial incentives: *Postpartum Care* and *Chlamydia Screening in Women (16-20 Years)*.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

IPRO’s review of the results of Neighborhood’s most recent accreditation review confirmed the state’s compliance with evaluating MCO adherence to the standards in *Title 42 CFR Part 438 Subpart D* and *Title 42 CFR § 438.330*. Neighborhood was compliant with these standards. Detailed results of Neighborhood’s review is in Section IV of this report.

Validation of Network Adequacy

IPRO’s evaluation of Neighborhood’s network evaluation reports confirmed the State’s compliance with the requirements of *Title 42 CFR § 438.68 Network adequacy standard (a)* and *(b)*. In the absence of a CMS protocol for *Title 42 CFR § 438.358 Activities related to external quality review (b)(1)(iv)*, IPRO assessed Neighborhood’s compliance with the State’s appointment standards and the MCO’s distance standards.

As required by EOHHS, Neighborhood monitored appointment availability during 2019 using the EOHHS–prescribed secret shopper methodology and reporting template. Surveyed providers across fifteen (15) specialties reported appointment rates below 60% for routine and urgent care. Further, all appointments were untimely when compared to the State’s appointment standards.

Administration or Validation of Quality of Care Surveys

Neighborhood conducted the CAHPS 5.0H Medicaid survey for the adult and child membership in 2020.

Rates for all nine (9) adult satisfaction measures exceeded the *Quality Compass* 2019 national Medicaid mean. Additionally, one (1) measure achieved the *Quality Compass* 2019 national Medicaid 95th percentile, two (2) measures achieved the 90th percentile and five (5) rates benchmarked at or above the 2019 national Medicaid 75th percentile. A rate for one (1) measure ranked below the *Quality Compass* 2019 national Medicaid 75th percentile for 2019.

Rates of the eight (8) child satisfaction measures, two (2) were not reported. All the others exceeded the *Quality Compass* 2019 national Medicaid mean. Rates for (1) measure achieved the *Quality Compass* 2019 national Medicaid 95th percentile and the rate for one (1) measure ranked at the 75th percentile while the remaining four (4) measures ranked below the *Quality Compass* 2019 national Medicaid 75th percentile.

Opportunities for improvement remain for each of the six (6) QIPs, as Neighborhood did not achieve all of the established goals. Specific recommendations for each of the six (6) QIPs can be found in Section XI.

Conclusion

IPRO's external quality review concludes that the Health Plan continued to have a positive impact on the accessibility, timeliness, and quality of services for Medicaid recipients. This is evidenced by the Health Plan's "Excellent" NCQA accreditation status and overall rating of four and a half (4.5) out of five (5), as well as its performance on many of the HEDIS® and CAHPS® measures reported. While Neighborhood demonstrated a strong performance across many of the quality metrics examined in this report, there remain a number of areas in which performance is warranted and others that are consistently identified as opportunities for improvement.

Recommendations

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

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

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

IPRO recommends the following to EOHHS:

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

Recommendations to Neighborhood

MCO-specific recommendations related to the **quality** of, **timeliness** of and **access** to care are in **Section IX** of this report.

II. BACKGROUND

Purpose of This Report

The Balanced Budget Act (BBA) of 1997 established that state agencies contracting with managed care organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of and access to the services included in the contract between the state agency and the MCO. *Title 42 Code of Federal Regulations (CFR) Section (§) 438.350 External quality review (a) through (f)* sets forth the requirements for the annual external quality review (EQR) of contracted MCOs. States are required to contract with an external quality review organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out this review, that the information be obtained from EQR-related activities and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services⁵ (CMS). Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as “the degree to which an MCO, PIHP⁶, PAHP⁷, or PCCM⁸ entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that is consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement.”

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

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

Rhode Island Executive Office of Health and Human Services

2019 State Medicaid Quality Strategy

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

⁵ [Centers for Medicare and Medicaid Services Website: https://www.cms.gov/](https://www.cms.gov/)

⁶ Prepaid Inpatient Health Plan

⁷ Prepaid Ambulatory Health Plan

⁸ Primary Care Case Management

- 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.

Guiding Principles, Goals and Objectives

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

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

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

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

Improvement and Interventions

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

- **Ongoing requirements for MCEs to be nationally accredited:** RI Medicaid MCOs will continue to be required to obtain and maintain NCQA accreditation and to promptly share its accreditation review results and notify the state of any changes in its accreditation status.
- **Tracking participation in APMs related to value-based purchasing (pay for value not volume)**

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

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

- Alternate Payment Methodology (APM) Data Report
- Value Based Payment Report and
- Accountable Entity-specific reports.
- **Pay for Performance Incentives for MCEs and AEs:** RI Medicaid intends create non-financial incentives such as increasing transparency of MCE performance through public reporting of quality metrics & outcomes – both online & in person.
- **Statewide collaboratives and workgroups that focus on quality of care:** RI Medicaid works with MCEs and the EQRO to collect, analyze, compare and share quality and other performance data across plans and programs to support ongoing accountability and performance improvement.
- **Soliciting member feedback through a variety of forums and mechanisms:** empowering members in their care: RI Medicaid will require, compare, and share member experience data to support ongoing managed care accountability and performance improvement

Refer to **Appendix 4** of this report for the full Rhode Island State Medicaid Quality Strategy.

Rhode Island Medicaid Managed Care Program

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

Table 1: Rhode Island Medicaid Managed Care Program Additions

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

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

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

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

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

Refer to **Appendix 1** of this report for a description of the State’s approach to quality and evaluation for the Rite Care and Rhody Health programs.

Neighborhood Health Plan

Neighborhood Health Plan of Rhode Island, Inc. (Neighborhood) is a local, not-for-profit Health Plan that serves Medicaid and Commercial populations. The following table presents Health Plan-specific information for the Medicaid line of business.

Table 2 displays Medicaid enrollment for Neighborhood for year-end 2017 through year-end 2019, as well as the percent change in enrollment each year, according to data reported to Rhode Island Medicaid. Both total enrollment and enrollment by eligibility group (Core Rite Care, Rite Care for Children with Special Health Care Needs, Rite Care for Children in Substitute Care, Rhody Health Partners, Rhody Health Options, and Rhody Health Expansion) are presented. The figures presented below may differ from those in prior reports, as enrollment counts will vary based on when data were extracted due to factors such as retrospective enrollment.

Table 2: Health Plan Enrollment—2017-2019

Eligibility Group	2017	2018	2019
Core Rite Care	102,205	100,923	93,611
Children with Special Health Care Needs ¹	5,396	5,066	5,119
Children in Substitute Care ²	2,786	2,715	2,616
Extended Family Planning ³	809	829	1,265
Rhody Health Partners ⁴	7,284	7,465	7,446
Rhody Health Options ⁵	25,231	15,698	13,875
Rhody Health Expansion ⁶	39,625	38,135	36,640
Medicaid Total	183,336	170,831	160,572
Percent Change from Previous Year	4%	-7%	-6%

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

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

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

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

⁵ Rhody Health Options serves those that are dual-eligible for Medicaid and Medicare.

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

Neighborhood 2019 Quality Improvement Program

EOHHS requires that contracted MCOs have a written quality assurance (QA) or quality management (QM) plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas, including all subcontractors. Emphasis shall be placed on, but need not be limited to, clinical areas related to management of chronic disease, mental health and substance abuse care, members with special needs, and access to services for members.

The QA/QM plan shall include:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

The Quality Assurance Plan also shall:

- Be developed and implemented by professionals with adequate and appropriate experience in QA;
- Detect both under-utilization and over-utilization of services;
- Assess the quality and appropriateness of care furnished to enrollees; and
- Provide for a systematic data collection of performance and patient results, interpretation of these data to practitioners, and making needed changes when problems are found.

Neighborhood Health Plan of Rhode Island's (Neighborhood) Quality Improvement (QI) Program strives to ensure that members have access to high quality health care services that are responsive to their needs and result in positive health outcomes. In order to meet this high level goal, Neighborhood's QI Program targets clinical quality of care, member and provider satisfaction and internal operations. The purpose of the Quality Improvement Program Description is to detail the scope, goals, and objectives of the program; to demonstrate how improvement activities are operationalized within Neighborhood; to describe the methodology used within the program; to outline the structure and functions of the committees and subcommittees that support the program; and to delineate the oversight and guidance provided to the program by Neighborhood's senior management and the Neighborhood Board of Directors. Annually, the Quality Improvement Program Description is approved by the Neighborhood Board of Directors

The overall goal of Neighborhood's QI Program is to ensure that members have access to high quality health care services that are responsive to their needs and result in positive health outcomes. The objectives of the QI Program in support of this goal are to:

- Assure access to high quality medical and behavioral healthcare
- Support members with acute and long-term health care needs
- Monitor and improve coordination of care across settings
- Improve member and provider experience
- Ensure the safety of members in all health care settings
- Monitor quality of care in nursing facilities through Minimum Data Set (MDS) data and other data sources

- Engage members in their own care
- Improve HEDIS and CAHPS performance
- Improve Medicare Health Outcomes Survey (HOS) performance
- Achieve maximum performance under the RI Medicaid Performance Goal Program and other pay for performance initiatives as appropriate
- Achieve optimum performance for Quality Withhold under the INTEGRITY and Medicaid product lines
- Maintain grievance and appeal procedures and mechanisms and assure that members can achieve resolution to problems or perceived problems relating to access and other quality issues
- Maintain collaborative relationships with network providers and state agencies
- Improve operational efficiency in the work performed across the organization
- Ensure Neighborhood’s quality improvement structure and processes adhere to NCQA standards and state and federal requirements
- Assess the QI Program annually and make changes as necessary to improve program effectiveness

The QI Program is structured as follows:

- Board of Directors: Neighborhood’s Board of Directors has final authority and responsibility for the care and service delivered to Neighborhood’s members. The Board of Directors delegates oversight of the Quality Improvement Program to the Clinical Affairs Committee. The Board exercises its oversight of the Program by annually approving the Quality Improvement Program Description and Quality Improvement Work Plan, and by annual review of the Quality Improvement Program Evaluation.
- Clinical Affairs Committee: The Clinical Affairs Committee (CAC) is Neighborhood’s Quality Improvement Committee. The CAC provides direction to the Quality Improvement Program and Neighborhood staff for all activities described in the Quality Improvement Program Description, Annual Evaluation and Work Plan, including those quality improvement activities that have been delegated to the health plan’s behavioral health vendor and other subcontracts. The CAC recommends approval of Neighborhood’s Quality Improvement Program Description and Work Plan to the Board of Directors after review and recommendations. The CAC annually reviews the QI Program Evaluation. The CAC oversees the credentialing and recredentialing processes for providers and facilities and approves or denies their application to be part of Neighborhood’s network. The CAC also reviews and makes network determinations regarding care provided to Neighborhood members for behavioral health providers.
- Chief Medical Officer: The Chief Medical Officer (CMO) is board-certified physician with extensive QI experience in managed care organizations. The Chief Medical Officer guides the direction, delivery, and implementation of Neighborhood’s QI Program and oversees the functions, responsibilities, planning, design and implementation of activities undertaken by the QI committees and subcommittees. The CMO provides guidance to the CAC, the Medicaid & Commercial Quality and Operations Committee, the Pharmacy & Therapeutics Committee, the Clinical Management Committee and the INTEGRITY Quality and Operations Committee.
- Medical Director and Associate Medical Directors: The Medical Director and Associate Medical Directors (MD/AMDs) are Rhode Island-licensed physicians. The AMDs support the MD in assisting the CMO in the role of providing clinical guidance to the organization by directing the development of new clinical programs, evaluating new medical technologies, developing criteria for standards of performance to

evaluate individual provider compliance with clinical practice and preventive health guidelines, and providing oversight to physician reviewer and consultant activities and recruitment.

- Support Committees and Staff: The quality improvement support committees are the Medicaid & Commercial Quality and Operations Committee, the INTEGRITY Quality and Operations Committee, the Clinical Management Committee and the Pharmacy and Therapeutics Committee. Each of these committees performs quality improvement activities within their areas of focus and is accountable to the Chief Medical Officer who provides the day-to-day direction to the QI Program.
- Medicaid & Commercial Quality and Operations Committee: The Medicaid & Commercial Quality and Operations Committee (M&CQOC) provides direction, guidance, and input to the quality improvement activities undertaken and implemented within the organization to monitor and improve the efficiency and operations of Neighborhood's departments and service to members and providers, with primary focus on quality in the Medicaid and Commercial products. M&CQOC advises the CMO on the quality of clinical care, operational performance and member and provider services provided by Neighborhood. The CMO provides oversight and direction to M&CQOC and the INTEGRITY Quality and Operations Committees and is responsible for ensuring that the QI Work Plan and Annual Evaluation presented to the Clinical Affairs Committee address all clinical, service and performance improvement activities undertaken by Neighborhood. Optum® and other subcontractors if applicable also report regularly to the M&CQOC on specific QI activities undertaken in their respective areas.
- INTEGRITY Quality and Operations Committee: The INTEGRITY Quality and Operations Committee monitors and reviews the quality improvement and operational activities of the MMP-INTEGRITY product. Findings and issues are presented to the Clinical Affairs Committee for review and approval and also shared with the Chief Medical Officer and the Vice President for Medicare and Medicaid Integration. The CMO and the Vice President of Medicare and Medicaid Integration provide the oversight and direction to the INTEGRITY Quality and Operations Committee. The INTEGRITY Quality and Operations Committee meets monthly to coordinate reporting activities, review selected measures of program effectiveness and identify areas in need of improvement through review of regular reports and facilitating improvements.
- Clinical Management Committee: Neighborhood's Clinical Management Committee (CMC) provides direction for clinical services such as new and changing medical and behavioral health technology, clinical medical policies, utilization management procedures, and the assurance of consistent medical review criteria and actions. The CMC acts in an advisory capacity to the Chief Medical Officer.
- Pharmacy and Therapeutics Committee: The Pharmacy and Therapeutics Committee (P&T) acts in an advisory capacity to the Chief Medical Officer on the provision of quality pharmaceutical services. The P&T Committee is responsible to regularly review and revise the Neighborhood Formulary for Medicaid and provide oversight for the Exchange and MMP formularies. As part of the evaluation process associated with each new drug or drug class, the P&T Committee reviews utilization data to identify trends in drug use. This information is used to help develop and implement specific initiatives to promote appropriate use of drug therapies.
- Quality Assurance Committee: The Quality Assurance Committee (QAC) is responsible for investigating member complaints about their clinical quality of care as well as concerns that are forwarded by Neighborhood staff from their contact with members. QAC is responsible for making the determination

as to whether the issue is standard of care, is an opportunity for improvement, or is a quality of care concern. QAC notifies the provider of the determination and, when warranted, requests a correction plan be submitted and implemented by the provider.

- Management Team / Staff: In addition to the quality improvement and supporting committees above, the Management Team is critical to the success of the CQI process by leading the creation of an organizational culture that supports CQI. In particular, the Chief Medical Officer or his/her designee is a standing member of the Medicaid & Commercial Quality and Operations and the INTEGRITY Quality and Operations Committees. All staff members are given the responsibility and authority to participate in Neighborhood's quality improvement efforts. Success of CQI is dependent on staff members as they drive the day-to-day work for the organization, and they are the individuals who carry out the tasks and are closest to the potential opportunities for continuous quality improvement.
- Department of Evaluation and Improvement: Reporting to the Chief Medical Officer, the Director of Evaluation and Improvement is accountable for the Plan's performance in the areas of clinical quality and member satisfaction.

NCQA Health Plan Accreditation and Health Plan Rating

CMS' Final Rule 42 CFR §438.358, which defines mandatory activities related to the external quality review, requires a review to determine the Health Plan's compliance with structure and operations standards established by the State to be conducted within the previous three-year reporting period. To guide the review process, CMS further established a protocol for monitoring the Health Plans, which states must use or demonstrate a comparative validation process. In order to comply with these requirements, EOHHS uses a validation process comparable to the CMS protocol that is described in detail in the State's December 2014 quality strategy, entitled *Rhode Island Comprehensive Quality Strategy*¹¹.

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

The NCQA began accrediting Health Plans in 1991 to meet the demand for objective, standardized plan performance information. The NCQA's Health Plan Accreditation is considered the industry's gold standard for assuring and improving quality care and patient experience. It reflects a commitment to quality that yields tangible, bottom-line value. It also ensures essential consumer protections, including fair marketing, sound coverage decisions, access to care, and timely appeals. NCQA Accreditation is recognized or required by the majority of state Medicaid agencies and is utilized to ensure regulatory compliance in many states. The

¹¹ Rhode Island's initial quality strategy was approved by CMS in April 2005. An updated version was submitted in October 2012 and approved by CMS in April 2013. The most recent version of the quality strategy was prepared in June 2014. Upon request from CMS in September 2014, it was revised and resubmitted in December 2014.

accreditation process is a rigorous, comprehensive, and transparent evaluation process through which the quality of key systems and processes that define a Health Plan are assessed. Additionally, accreditation includes an evaluation of the actual results the Health Plan achieved on key dimensions of care, service, and efficacy. Specifically, the NCQA reviews the Health Plan’s quality management and improvement, utilization management, provider credentialing and re-credentialing, members’ rights and responsibilities, standards for member connections, and HEDIS® and CAHPS® performance measures. NCQA Accreditation provides an unbiased, third-party review to verify, score, and publicly report results. The NCQA regularly revises and updates its standards to reflect clinical advances and evolving stakeholder needs. In addition, the NCQA continues to raise the bar and move toward best practices in an effort to achieve continuous improvement.

The survey process consists of on-site and off-site evaluations conducted by survey teams composed of physicians and managed care experts who interview Health Plan staff and review materials such as case records and meeting minutes. The findings of these evaluations are analyzed by a national oversight committee of physicians, and an accreditation level is assigned based on a Health Plan’s compliance with the NCQA’s standards and its HEDIS® and CAHPS® performance. Compliance with standards accounts for fifty percent (50%) of the Health Plan’s accreditation score, while performance measurement accounts for the remainder.

Although the on-site Accreditation Survey occurs once every three (3) years, star ratings are re-calculated annually by the NCQA based on the most recent Accreditation Survey findings and the latest HEDIS® and CAHPS® results. Neighborhood’s 2019 accreditation ratings are based on its 2018 Accreditation Survey (effective through November 15, 2020) and the 2019 HEDIS® and CAHPS® results.

Table 3 summarizes Neighborhood’s overall accreditation status for the Medicaid product line for 2017 through 2019. Notably, Neighborhood earned an “*Excellent*” accreditation status for each of these years.

Table 3: Medicaid Accreditation Status—2017-2019

Reporting Year	Accreditation Status
2017	Excellent
2018	Excellent
2019	Excellent

NCQA Health Plan Rating

In 2015, the NCQA retired its *Health Insurance Plan Rankings* methodology used from 2005 through 2014. Since 2015, the NCQA has calculated numerical ratings for Commercial, Medicare, and Medicaid Health Plans through the *Health Insurance Plan Ratings* methodology. The *Ratings* methodology evaluates Health Plans based on clinical performance (HEDIS® results), member satisfaction (CAHPS® scores), and NCQA Accreditation Standards scores. To be eligible for a rating, Health Plans must authorize public release of their performance data and submit enough data for statistically valid analysis.

The NCQA’s *Health Insurance Plan Ratings* 2019-2020 methodology was used to calculate an overall score comprised of satisfaction measures (*Consumer Satisfaction*) and clinical measures (*Prevention and Treatment*), defined below. The Health Plans received a score for each of these three (3) categories from one (1) to five (5) in half-point increments, with five (5) being the highest score. The scores from each category are then combined

with the Accreditation Standards scores and then weighted and presented as an overall rating of one (1) to five (5), in half-point increments.

- Consumer Satisfaction: Composite of CAHPS® measures for consumer experience with getting care, as well as satisfaction with Health Plan physicians and with Health Plan services.
- Prevention: Composite of clinical HEDIS® measures for how often preventive services are provided (e.g., childhood and adolescent immunizations, women’s reproductive health, and cancer screenings), as well as measures of access to primary and preventive care visits.
- Treatment: Composite of clinical HEDIS® measures for how well Health Plans provide care for people with chronic conditions such as asthma, diabetes, heart disease, hypertension, osteoporosis, alcohol and drug dependence, and mental illness, and whether physicians have advised smokers to quit.

Since 2010, the NCQA used a five-point numerical scale rating system, which compares the Health Plan’s scores to the national average. The scale and definitions for each level are provided below.

NCQA Health Plan Rating Scale

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

The *Health Insurance Plan Ratings* are posted to the NCQA’s website. They are also posted to the *Consumer Reports’* website and published in the November issue of the magazine. **Table 4** presents Neighborhood’s overall rating for Reporting Year 2019, along with its performance in each of the three (3) categories.

Table 4: NCQA Rating by Category—2019

Product Line	Consumer Satisfaction	Prevention	Treatment	2019 Rating	Overall Rating
Medicaid	3.5	4.5	4.0	4.5	

III. EQRO Evaluation Methodology

In order to assess the impact of the UHCP-RI Rite Care and Rhody Health programs on **access**, **timeliness**, and **quality**, IPRO reviewed pertinent information from a variety of sources, including State managed care standards, Health Plan contract requirements, Accreditation Survey findings, member satisfaction surveys, performance measures, and State monitoring reports.

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

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

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

Additionally, **Section VII** describes the communication of IPRO's findings to Neighborhood by EOHHS for follow up, as well as a brief description of Neighborhood's progress related to the *Neighborhood Health Plan Annual External Quality Review Technical Report, Reporting Year 2018*.

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

IV. Validation of Performance Improvement Projects

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

Objectives

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

- There are no validation findings that indicate that the credibility is at risk for the QIP results.

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

- The validation findings generally indicate that the credibility for the QIP results is not at risk; however, results should be interpreted with some caution. Processes that put the Findings at risk are enumerated.
- There were one or more validation findings that indicate a bias in the QIP results. The concerns that put the conclusion at risk are enumerated.

Description of Data Obtained

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

Findings

Neighborhood conducted the following QIPs in 2019:

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

IPRO’s assessment of Neighborhood ‘s methodology found that there were no validation findings that indicated that the credibility of six (6) QIPS was at risk.

Table 5 displays a summary of Neighborhood’s QIP assessments. Summaries of each QIP immediately follow

Table 5: 2019 QIP Validation Findings

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

QIP #1: Children’s and Adolescents’ Access to Primary Care Practitioners (CAP), Ages 12-24 Months & 25 months-6 Years

Indicator(s)/Goal(s): There were two (2) indicators for this QIP:

1. *The number of members 12–24 months who had one or more ambulatory or preventive care visits with a PCP during the measurement year.*

- 2. The number of members 25 months-6 years who had one or more ambulatory or preventive care visits with a PCP during the measurement year.*

The goal for each indicator was to meet or exceed 2018 Medicaid Quality Compass 90th Percentile benchmark rate. Based on the 2018 Medicaid Quality Compass the 90th percentile rate for 12-24 months age group was 97.71% and the 90th percentile rate for the 25 months – 6 years age group was 92.88%.

Member focused Intervention(s):

- Interactive Voice Response: In June 2019, automated voice message to Medicaid members six years and under reminding members to schedule their well visit.
- Social Media Posts: Neighborhood posted to Facebook and Twitter in CY 2019 highlighting CAP.
- Member Newsletter: Developed CAP language to be included in the Summer iteration of the Member Newsletter “Healthy You”.
- Members are eligible to receive a \$25 incentive gift card through the member rewards program for completing an annual well visit at 18 months and between the ages of three and twelve. As of Q4 2019, a total of 73 members received the \$25 incentive.
- Ongoing promotion of the importance of well visits at marketing events.

Provider focused Intervention(s):

- Shared best practices with low performing providers as well as the HEDIS CAP requirement.
- Provider Gap In Care Reports: reports including member names who did not meet the HEDIS measure for CAP and were sent to practices in July and November.

Health Plan focused Intervention(s):

- Enhance the language in the plan’s website highlighting the importance of well visits.
- Importance of Wellness flyer PDF added to Neighborhood’s website.

QIP #2: HEDIS® Improving Developmental Screening Rates in the First Three Years of Life

Indicator(s)/Goal(s): There were four (4) indicators included in this QIP

- 1. The number of children screened for risk of developmental, behavioral, and social delays using a standardized tool in the twelve (12) months preceding their **first** birthday;*
- 2. The number of children screened for risk of developmental, behavioral, and social delays using a standardized tool in the twelve (12) months preceding their **second** birthday;*
- 3. The number of children screened for risk of developmental, behavioral, and social delays using a standardized tool in the twelve (12) months preceding their **third** birthday; and*
- 4. The number of children screened for risk of developmental, behavioral, and social delays using a standardized tool in the twelve (12) months preceding their **first, second, or third** birthday.*

The goal for this indicator was to achieve the 90th percentile of the RI EOHHS State-specified performance goal i.e. 65%.

Member-Focused Intervention(s):

- Distribution of information at marketing events on the importance of well visits, including annual developmental screening.

- Interactive Voice Response: Launched automated voice message to Medicaid members six years and under reminding them to schedule their well visit.
- Distribution of "Importance of Well Visits" flyer at the marketing events.

Provider-Focused Intervention(s):

- Shared best practices with low performing practices including suggestions on scheduling visits to ensure that the visits occur within specified timeframe in order to be compliant with the measure.

Health Plan-Focused Intervention(s):

- Although providers billed up to five screenings prior to having to obtain a prior authorization, a glitch in the system was discovered where claims were being rejected for less than five screenings. To prevent this from occurring, Neighborhood is currently working to remove the limits on the screenings.
- Enhanced the current "Preventive Care" webpage on nhpri.org to encourage well visits and the importance of screenings.

Results: The following are the rates for the indicators:

- Screening by Age 1 increased from 54.10% to 66.87%, and exceeded the QIP goal.
- Screening by Age 2 increased from 54.04% to 67.31%, and exceeded the QIP goal.
- Screening by Age 3 increased from 52.83% to 61.16%, but fell short of the QIP goal.
- Screening in all ages (total rate) increased from 53.64% to 64.99%, just short of the QIP goal.

Overall Credibility of Results: There were no validation findings that call into question the credibility of this QIP.

Strengths:

- The Health plan was able to exceed the goal for two (2) indicators and was just short of the QIP goal for one (1) indicator.
- The health plan created various educational resources for members like voice messages to members, distribution of flyers and distribution of information at marketing events to highlight the importance of well visits.
- The Health Plan showed an increase in rates for all four (4) indicators.

Opportunities for Improvement:

- The Health Plan should continuously monitor the effectiveness of the interventions implemented for this QIP.
- Many of the interventions are passive in nature (i.e. automated messaging, newsletters, etc.). The Health Plan should consider developing and initiating more active interventions.

QIP #3: HEDIS®: Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication (ADHD)

Indicator(s)/Goal(s): There were two (2) indicators for this QIP:

1. **Initiation Phase:** *the number of members 6-12 years of age as of the earliest prescription dispensing date (Index Prescription Start Date) with an ambulatory prescription dispensed for ADHD medication*

who had **one** follow-up visit with the practitioner with prescribing authority during the **30 days** following the Index Prescription Start Date; and

2. **Continuation & Maintenance Phase:** the number of members 6-12 years of age as of the earliest prescription dispensing date (Index Prescription Start Date) with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least seven (7) months (210 days), and in addition to the visit in the Initiation Phase, had **at least two** follow-up visits within **9 months** after the Initiation Phase ends.

The goal for both indicators was to achieve the 2018 *Quality Compass*® 90th percentile benchmark rates. For 2018, the 90th percentile rate for the Initiation Phase was 55.91% and the rate for the Continuation & Maintenance Phase was 69.14%.

Member-Focused Intervention(s):

- To conduct telephone call to the prescribers of members newly prescribed ADHD medication to ensure that members have a follow up appointment scheduled.
- To educate parents of enrollees about ADHD symptom management, medication compliance and the importance of timely follow-up with their practitioner by providing a link on the health plan website to the enrollees' section of the website.

Provider-Focused Intervention(s):

- Optum conducts ongoing education of behavioral health practitioners through an educational email blast. Providers were targeted for having treated one or more children/ adolescents diagnosed with ADHD within the past 12 months. The email content included ADHD best treatment practices, the measure specifications and practitioner resources.

Results: Both Initiation phase rate and continuation and maintenance phase rates did not achieve the QIP goal.

- Neighborhood's preliminary CY 2019 (HEDIS 2020) rate for ADHD Initiation Phase is 47.25%, a decrease compared to CY 2018 rate (47.58%).
- The preliminary CY 2019 rate (HEDIS 2020) for the Continuation Phase is 54.75%, a decrease compared to CY 2018 rate (61.19%).

QIP #4: HEDIS® Social Determinant of Health Measure - Improve the Rate of Lead Screening in Children

Indicator(s)/Goal(s): The number of Neighborhood members who received at least one capillary or venous lead screening test on or before their second birthday.

The goal for this indicator was to meet or exceed National Medicaid Quality Compass 90th percentile for Lead Screening in children. For 2019, the 90th percentile rate was 85.90%.

Member-Focused Intervention(s):

- To offer a \$25 incentive to members for completing a lead screening by the age of two through the Member Rewards Program. In Q4 2019, 13 members received the incentive award for lead screening.
- Social media postings to Facebook and Twitter regarding the importance of Lead Screening and rescreening for elevated blood lead levels.
- Promotion of the importance of well visits and Lead Screening at marketing events.

- Member Post Cards: Neighborhood sent lead test reminder postcards monthly to children turning one years old.
- Interactive Voice Response: In June 2019, automated voice message to Medicaid members six years and under reminding them to schedule their well visit.
- Member Newsletter: Developed lead screening language to be included in the Summer iteration of the Member Newsletter “Healthy You”
- Marketing Events: Neighborhood provided RIDOH LSC materials at any marketing event targeted at parents with children.

Provider-Focused Intervention(s):

- To educate to providers about the HEDIS lead screening measure and tips for compliance.
- Provider Education: Neighborhood met with several high and low performing provider sites to review performance, discuss barriers and best practices/lessons learned in order to achieve the Quality Compass 90th percentile.

Health Plan-Focused Intervention(s):

- Social Determinant of Health: Neighborhood is focusing on poverty level and geographic location for the social determinant of health work. Data is run on a quarterly cadence to identify members who refused services and loss to follow to see if Neighborhood Case Management Department can provide outreach to members.
- Enhanced the language in the Plan’s website highlighting the importance of well visits.

Results: Neighborhood’s preliminary HEDIS 2020 rate (79.19%) for Lead Screening in Children (LSC) increased compared to HEDIS 2019 rate (78.79%) but fell short of meeting the 2019 Medicaid Quality Compass 90th percentile (85.90), and rates at the 2019 Medicaid Quality Compass 66th percentile.

Health Plan-Selected QIP #1: HEDIS® Improve Performance for Care for Older Adults HEDIS Measure for INTEGRITY Medicare-Medicaid Plan

Indicator(s)/Goal(s): There were the following indicators for this QIP:

1. *Care for Older Adults: Advanced Care Plan: The number of MMP members 66 years and older who had an Advanced Care Plan in place during the measurement year.*
2. *Care for Older Adults: Medication Review: The number of MMP members 66 years and older who had a Medication Review during the measurement year.*
3. *Care for Older Adults: Functional Status Assessment: The number of MMP members 66 years and older who had a Functional Status Assessment during the measurement year.*
4. *Care for Older Adults: Pain Assessment: The number of MMP members 66 years and older who had a Pain Assessment during the measurement year.*

The goal for this indicator is as follows:

- Advanced Care Plan rate: to exceed the 2019 MMP Quality Withhold benchmark of 45%,
- Medication Review rate: to exceed 2019 MMP Quality Withhold benchmark of 80%.
- Functional Status Assessment rate: to exceed 2019 MMP Quality Withhold benchmark of 68%.
- Pain Assessment rate: to exceed the 2019 MMP Quality Withhold benchmark of 63%.

Provider-Focused Intervention(s):

- Shared best practices with selected providers.

- Neighborhood designed and implemented the COA reference guide for use by providers.
- Distributed the COA Form to the Providence Community Health Centers (PCHC) for daily utilization by the staff; proper completion is required in order for the COA Form to be counted as compliant for the COA measure. The COA Form serves as a reminder for providers to perform all recommended COA services to their patients.
- Provided education to providers on the COA requirements and assistance in improving COA documentation in the provider Electronic Medical Records (EMRs) to facilitate data collection for COA.

Health Plan-Focused Intervention(s):

- Investigated Health Risk Assessment (HRA) and propose modifications to include advanced care planning, pain screening, and functional assessment.
- To continue the off-season medical record data collection to gather additional information on Care for Older Adult measure for the HEDIS supplemental database.
- Obtained feedback on the form from the Plan's Clinical Affairs Committee, which is comprised of community practitioners.

Results:

- Care for Older Adults: Advanced Care Plan rate: 52.28%, exceeded the 2019 MMP Quality Withhold benchmark of 45%;
- Care for Older Adults: Medication Review rate: 56.80%, did not meet the 2019 MMP Quality Withhold benchmark of 80%;
- Care for Older Adults: Functional Status Assessment: 56.41%, did not meet the 2019 MMP Quality Withhold benchmark of 68%;
- Care for Older Adults: Pain Assessment rate: 67.23%, exceeded the 2019 MMP Quality Withhold benchmark of 63%.

Health Plan-Selected QIP #2: HEDIS® Increase the Percentage of Transitions from the Nursing Home to the Community

Indicator(s)/Goal(s): There were the following indicators for this QIP:

1. *Nursing Home Facility Transitions to the Community for RTHP Eligibles: The number of INTEGRITY MMP members who have transitioned out of a nursing facility to the community under the RTHP.*
2. *Percentage of all Transitions from the Nursing Home Facility to the Community: The number of INTEGRITY MMP members who have transitioned out of a nursing facility to the community.*

The goal for this indicator to transition 20 Neighborhood INTEGRITY MMP enrollees eligible for the RTHP from the nursing facility to the community in 2019 and to transition 35% of INTEGRITY MMP members to the community.

Member-Focused Intervention(s):

- Reassessment of members that had chosen to stay in the nursing facility after the initial assessment to identify opportunity for discharge to the community and inform the members of the available resources to them should they transition to the community.
- Distribution of the Enrollee Educational Flyer to members and their families regarding the LTSS services available to them upon transitioning to the community.

Provider-Focused Intervention(s):

- Availability of Health@Home to provide primary care and referrals immediate post discharge helps ensure success in health matters while the individual re-engages with community health care providers.

Health Plan-Focused Intervention(s):

- Collaboration with the State and community to identify and increase subsidized and waiver housing vouchers. Neighborhood had seven vouchers and was not able to use any of the vouchers in Q4 2019 to transition members to the community due to landlords not willing to accept the vouchers and/or housing not being appropriate due to a third floor walk up.
- Improved access to nursing homes' electronic medical records to enhance the understanding and assessment to identify potential candidates.
- Assessment of housing availability by Neighborhood's housing specialist helps to identify possible suitable community locations for residency.

V. Validation of Performance Measures

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

Information Systems Capabilities Assessment

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

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

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

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

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

The 2020 HEDIS FAR for MY 2019 produced by Attest Health Care Advisors indicated that Neighborhood met all of the requirements to successfully report HEDIS data to EOHHS and to NCQA. **Table 6** displays the results of the IS audit.

Table 6: Neighborhood’s Compliance with Information System Standards

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

HEDIS Performance Measures

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

Objectives

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

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

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

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

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

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

Description of Data Obtained

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

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

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

Findings

This section of the report explores the utilization of Neighborhood’s services by examining select measures under the following domains:

- Use of Services – Measures examine the percentage of Medicaid child and adolescent access routine care.
- Effectiveness of Care – Measures how well an MCO provides preventive screenings and care for members with acute and chronic illness.
- Access and Availability - Measures examine the percentage of Medicaid children, adolescents, child-bearing women, and adults who received PCP or preventive care services, ambulatory care (adults only), or timely prenatal and postpartum care.

Use of Services Measures¹⁵

The Health Plan’s rates for all three (3) measures exceeded the 2019 Quality Compass® national Medicaid mean. The HEDIS rate for Well-Child Visits in the First 15 Months of Life (6+ Visits) all three measures Well-Child Visits in the First 15 Months of Life (6+ Visits) exceeded the 90th percentile of Medicaid Benchmark. The HEDIS measures Adolescent Well-Care Visits and the *Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life* measure benchmarked at the 75th percentile. **Table 7** displays Neighborhood’s rates for these measures, as well as the national Medicaid benchmarks achieved by the MCO.

Table 7: HEDIS® Use of Services Rates—2017-2019

Use of Services Measures	HEDIS® 2017	HEDIS® 2018	HEDIS® 2019	Quality Compass® 2019 National Medicaid Benchmark	Quality Compass® 2019 National Medicaid Mean
Well-Child Visits in the First 15 Months of Life (6+ Visits)	80.4%	78.2%	79.2%	95 th	62.8%
Well-Child Visits in the 3 rd , 4 th , 5 th , & 6 th Years of Life	80.8%	78.2%	79.0%	75 th	72.1%
Adolescent Well-Care Visits	64.3%	65.0%	66.8%	75 th	53.2%

HEDIS® Effectiveness of Care Measures

HEDIS® **Effectiveness of Care** measures evaluate how well a Health Plan provides preventive screenings and care for members with acute and chronic illnesses. **Table 8** displays select HEDIS® Effectiveness of Care measure rates for 2019 compared to the *Quality Compass®* 2019 national Medicaid benchmarks, as well as the Health Plan’s rates for the previous two (2) years.

The Health Plan’s rates for all eight (8) measures exceeded the 2019 *Quality Compass®* national Medicaid mean. Neighborhood continued to perform well regarding childhood immunizations, women’s health, and follow-up

¹⁵ The rates for HEDIS® Use of Services measures include all Medicaid members, where eligible population criteria are met.

for mental illness. Both *Follow-Up After Hospitalization for Mental Illness—30 Days* and *Follow-Up After Hospitalization for Mental Illness—7 Days* benchmarked at the 2019 *Quality Compass*® 90th percentile. Similarly, *Childhood Immunization Status—Combination 10* and *Combination 3* also benchmarked at the 2019 *Quality Compass*® 90th percentile. Regarding women’s health, *Cervical Cancer Screening for Women* exceeded the 90th percentile benchmark for 2019, while *Chlamydia Screening for Women (16-24 Years)* benchmarked at the 75th percentile.

The Health Plan continues to demonstrate opportunities for improvement regarding diabetes and asthma care. Neighborhood’s rates for *Comprehensive Diabetes Care—HbA1c Testing* and *Medication Management for People with Asthma 75% (5-64 Years)* both fell below the *Quality Compass*® 75th percentile.

Table 8: HEDIS® Effectiveness of Care Rates—2017-2019

Effectiveness of Care Measures	HEDIS® 2017	HEDIS® 2018	HEDIS® 2019	Quality Compass®	Quality Compass®
				2019 National Medicaid Benchmark	2019 National Medicaid Mean
Medication Management for People with Asthma 75% (5-64 Years)	35.1%	39.2%	39.9%	50 th	37.8%
Cervical Cancer Screening for Women	68.1%	72.5%	74.2%	95 th	59.3%
Chlamydia Screening for Women (16-24 Years)	69.1%	68.9%	69.8%	75 th	58.1%
Childhood Immunization Status—Combination 3	78.6%	82.4%	78.7%	90 th	68.1%
Childhood Immunization Status—Combination 10	59.0%	61.3%	59.9%	95 th	35.2%
Comprehensive Diabetes Care—HbA1c Testing	89.8%	89.8%	90.4%	66.67 th	87.8%
Follow-Up After Hospitalization for Mental Illness—30 Days	78.0%	74.9%	72.8%	90 th	56.8%
Follow-Up After Hospitalization for Mental Illness—7 Days	62.3%	55.7%	54.3%	90 th	35.8%

HEDIS® Access and Availability Measures

The HEDIS® **Access and Availability** measures examine the percentage of Medicaid children, adolescents, child-bearing women, and adults who received PCP or preventive care services, ambulatory care (adults only), or timely prenatal and postpartum care. *Children and Adolescents’ Access to Primary Care Practitioners* measures the percentage of children ages twelve (12) months to six (6) years old who had one (1) or more visits with a Health Plan primary care practitioner during the Measurement Year and the percentage of children ages seven (7) to eleven (11) years old and adolescents ages twelve (12) to nineteen (19) years old who had one (1) or more visits with a Health Plan primary care practitioner during the Measurement Year or the year prior. *Adults’ Access*

to Preventive/Ambulatory Health Services measures the percentage of adults ages twenty (20) years and older who had one (1) or more ambulatory or preventive care visits during the Measurement Year. *Prenatal and Postpartum Care* measures the percentage of women who received a prenatal care visit in the first trimester or within forty-two (42) days of enrollment in the Health Plan and the percentage of women who had a postpartum visit on or between twenty-one (21) and fifty-six (56) days after delivery.

Table 9 presents the HEDIS® 2019 Access and Availability measure rates for Neighborhood compared to national Medicaid benchmarks, as well as the previous two (2) years’ rates.

Neighborhood’s performance in this domain varied across measures. Rates for all nine (9) measures were reported above the 2019 *Quality Compass*® national Medicaid mean.

While the Health Plan demonstrated improvement regarding the *Adults’ Access to Preventive/Ambulatory Health Services*, with the 65+ years age bracket exceeding the 90th percentile benchmark, the 20-44 years age bracket *rate* fell below the 75th percentile and the 45-64 age bracket met the 75th percentile benchmark. For the *Children and Adolescents’ Access to Primary Care Practitioners* measure, the Health Plan’s performance has improved with the rate for 12-24 months age bracket meeting the 90th percentile benchmark. The other age brackets including 25 Months to 6 years, 7-11 years and 12-19 years age groups benchmarked at the *Quality Compass*® 75th percentile for 2019. The HEDIS measures for women’s health have shown an improvement with the *Timeliness of Prenatal Care* exceeding the 90th percentile benchmark and the *postpartum care* measure meeting the 75th percentile benchmark.

Table 9: HEDIS® Access and Availability Rates—2017-2019

Access and Availability measures	HEDIS® 2017	HEDIS® 2018	HEDIS® 2019	Quality Compass® 2019 National Medicaid Benchmark	Quality Compass® 2019 National Medicaid Mean
Children and Adolescents’ Access to PCP					
12-24 Months	95.9%	94.8%	97.9%	90 th	94.8%
25 Months – 6 Years	90.6%	89.3%	91.9%	75 th	86.3%
7-11 Years	95.9%	94.7%	95.7%	75 th	90.0%
12-19 Years	94.6%	93.4%	94.2%	75 th	88.8%
Adults’ Access to Preventive/Ambulatory Health Services					
20-44 Years	78.4%	78.1%	81.4%	66.67 th	76.5%
45-64 Years	87.2%	86.9%	90.0%	75 th	84.8%
65+ Years	90.5%	86.8%	95.8%	95 th	86.6%
Timeliness of Prenatal Care	92.8%	91.9%	96.1%	95 th	81.5%
Postpartum Care	74.5%	77.6%	87.6%	75 th	63.6%

Rhode Island Performance Goal Program¹⁶

Objectives

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

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

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

Technical Methods of Data Collection and Analysis

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

Description of Data Obtained

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

Findings

This section of the report evaluates Neighborhood’s performance on the PGP measures for 2017 through 2019 for all Medicaid populations. **Table 10** presents the rates for the PGP metrics. The HEDIS® percentiles displayed were derived from the 2019 Performance Goal Program results, in which rates were benchmarked against the NCQA’s *Quality Compass*® 2018 for Medicaid.

¹⁶ The rates for all PGP measures include all Medicaid members, where eligible population criteria were met.

The **Utilization** domain included one (1) HEDIS® measure for Reporting Year 2019. For the HEDIS® *Adolescent well-care visit measure*, Neighborhood had a rate that did not meet the quality compass benchmark to qualify for an incentive award.

Of the five (5) HEDIS® measures included in the **Access to Care** domain, Neighborhood reported rates that did not meet the quality compass benchmark to qualify for an incentive award for four (4) of the measures namely *Child and Adolescent Access to Primary Care Practitioner (12-24 months)*, *Child and Adolescent Access to Primary Care Practitioner (25 months-6 Years)*, *Initiation of Alcohol and Other Drug Dependence Treatment and Engagement of Alcohol and Other Drug Dependence Treatment*. Neighborhood reported a rate that exceeded the 2018 *Quality Compass*® 75th percentile for the measure *Prenatal Postpartum Care* qualifying for a partial incentive award.

The **Prevention and Screening** domain was comprised of four (4) HEDIS® measures. Neighborhood reported rates that did not meet the quality compass benchmark to qualify for an incentive award for two (2) of the measures namely *Lead Screening in Children and Breast Cancer Screening*. Neighborhood reported rates that exceeded the 2018 *Quality Compass*® 90th percentile for the measures *Childhood immunization status – Combination 10* and *Immunizations for Adolescents – Combination 2*, qualifying for a full incentive award.

In the **Women’s Health** domain, Neighborhood’s rate exceeded the 2018 *Quality Compass*® 90th percentile and qualified for a full incentive award for the HEDIS® *Cervical Cancer Screening (21-64 Years)*. Neighborhood’s rate for HEDIS® *Chlamydia Screening in Women (16-20 Years)* exceeded the 2018 *Quality Compass*® 75th percentile, qualifying for a partial incentive award.

For Reporting Year 2019, the **Chronic Care Management** domain included two (2) HEDIS® measures and one (1) State-specified measure. For the State-specified measure *HIV Viral Load Suppression*, Neighborhood reported a rate that exceeded the State-selected *Contract* goal of 68% to qualify for a partial incentive award. Regarding the two (2) HEDIS® measures, Neighborhood’s rate for *Comprehensive Diabetes Care—HbA1c Control (<8.0%) and Controlling High Blood Pressure (18-85 Years)*, benchmarked at the 2018 *Quality Compass*® 90th percentile and qualified for a full incentive award.

The **Behavioral Health** domain included five (5) HEDIS® measures. Neighborhood’s rates for the HEDIS® *Follow-Up After Hospitalization for Mental Illness—7 Days*, and *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure exceeded the 90th percentile benchmark qualifying for a full incentive award. The following measures did not meet a *Quality Compass*® benchmark to qualify for an incentive award in 2019; *Follow-Up Care for Children prescribed ADHD Medication—Initiation Phase*, *Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications* and *Follow-Up After Emergency Department Visits for Alcohol and Other Drug Dependence*

Table 10: Performance Goal Program Results—2017-2019¹

RI Medicaid Managed Care Performance Goal Program Measures	2017	2018	2019	Rhode Island Medicaid <i>Contract Goal</i>	
				State-Specified <i>Contract Goal</i> ²	Quality <i>Compass</i> [®] 2018 <i>Percentile Met</i> ³
Utilization					
HEDIS [®] Adolescent Well-Care Visits	65.0%	64.1%	60.79%		NM
Access to Care					
HEDIS [®] Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)	95.9%	94.8%	96.42%		NM
HEDIS [®] Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	90.7%	89.3%	88.68%		NM
HEDIS [®] Postpartum Care	74.5%	77.6%	71.96%		PM
HEDIS [®] Initiation of Alcohol and Other Drug Dependence Treatment	46.4%	42.7%	40.48%		NM
HEDIS [®] Engagement of Alcohol and Other Drug Dependence Treatment	26.0%	18.6%	17.21%		NM
Prevention and Screening					
HEDIS [®] Childhood Immunization Status—Combination 10	59.0%	61.3%	57.65%		M/E
HEDIS [®] Lead Screening in Children	78.2%	79.0%	78.79%		NM
HEDIS [®] Adolescent Immunizations—Combination 2	38.7%	53.3%	48.05%		M/E
HEDIS [®] Breast Cancer Screening	63.0%	64.6%	64.03%		NM
Women's Health					
HEDIS [®] Chlamydia Screening in Women (16-20 Years)	67.1%	68.3%	68.95%		PM
HEDIS [®] Cervical Cancer Screening (21-64 Years) ⁴			71.04%		M/E
Chronic Care					
HEDIS [®] Comprehensive Diabetes Care—HbA1c Control (<8.0%)	58.1%	57.4%	60.55%		M/E
HEDIS [®] Controlling High Blood Pressure (18-85 Years)	73.1%	74.4%	73.24%		M/E
HIV Viral Load Suppression ²	66.6%	71.6%	73.56%	PM	
Behavioral Health					
HEDIS [®] Follow-Up After Hospitalization for Mental Illness—7 Days	62.0%	55.5%	57.14%		M/E
HEDIS [®] Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	48.5%	47.2%	47.58%		NM
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications ⁴			80.25%		NM

Follow-Up After Emergency Department Visits for Alcohol and Other Drug Dependence ⁴			22.50%		NM
Adherence to Antipsychotic Medications for Individuals with Schizophrenia ⁴			78.02%		M/E

M/E: Met or exceeded the State-specified *Contract* goal for a full incentive award; PM: Met or exceeded the State-specified *Contract* goal for a partial incentive award; NM: Did not meet a *Contract* goal to qualify for an incentive award

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

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

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

⁴ This measure was not included in the PGP metrics for Reporting Years 2017 and 2018.

⁵ State-specified measure.

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

Objectives

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

Technical Methods of Data Collection and Analysis

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

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

Description of Data Obtained

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

Findings

Neighborhood's accreditation was granted by NCQA on October 29, 2020. **Table 11** displays the results of Neighborhood's most recent NCQA Accreditation survey. It was determined that Neighborhood was fully compliant with the standards *Title 42 CFR Part 438 Subpart D and Subpart E 438.330*.

Table 11: Evaluation 42 CFR Part 438 Subpart D and QAPI Standards

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

I. Validation of Network Adequacy

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

Objectives

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

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

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

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

For primary care, Section 2.08.03.06 of the *Contract* states:

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

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

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

Consequently, the standards against which reasonable distances are assessed are developed by each Health Plan, based on Health Plan-specific criteria. The State's *Medicaid Managed Care Contracts* also have a

“mainstreaming” provision requiring that, if a network’s provider practice is open to any new patients, then the practice must accept Medicaid managed care enrollees.

Neighborhood monitors its provider network for accessibility and network adequacy using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes. Neighborhood’s distance requirements vary by provider type. Neighborhood’s goal was to have a minimum of ninety-five percent (95%) of members with access within the geographic distances.

Table 12 shows the percentage of members for whom the geographic access standards were met. The results of this analysis show that Neighborhood exceeded its geographic accessibility standards for all provider types reported.

Table 12: GeoAccess Provider Network Accessibility—2019

Provider Type	Access Standard ¹	% of English Speaking Members ²	% of Spanish Speaking Members ²
Adult Services			
PCP	2 in 10 miles	99.9%	99.9%
Fam PCP	2 in 10 miles	99.9%	99.7%
Cardiologist	1 in 15 miles	99.8%	99.9%
Dermatologist	1 in 15 miles	99.6%	96.3%
Endocrinologists	1 in 15 miles	99.6%	95.9%
Gastroenterologists	1 in 15 miles	99.4%	97.8%
Pulmonary	1 in 15 miles	97.4%	97.7%
Oncologists	1 in 15 miles	99.6%	99.7%
OBGYN	2 in 10 miles	97.9%	97.7%
INT PCP	2 in 10 miles	99.2%	98.7%
Child Services			
PED PCP's	2 in 10 miles	97.7%	97.3%
PED Allergist	1 in 15 miles	97.1%	95.3%
PED Gastroenterologist	1 in 15 miles	85.1%	95.4%
PED Otolaryngologist	1 in 15 miles	99.0%	0.4%
PED Oncologist	1 in 15 miles	76.4%	0%
PED Orthopedics	1 in 15 miles	99.7%	99.9%
PED Neurologist	1 in 15 miles	97.6%	94%

¹ The Access Standards are measured in distance to members’ addresses.

² The percentages represent the proportion of members for whom the Access Standards were met.

In addition to utilizing the GeoAccess program to assess network adequacy and provider accessibility, the State of Rhode Island Executive Office of Health and Human Services (EOHHS) conducted an Access and Availability

Survey. This survey employed the “secret shopper” methodology to assess member access to timely appointments. The State’s July 2019 *Medicaid Managed Care Services Contract* outlines appointment timeliness standards in Section 2.09.04 for many types of appointments, including, but not limited to, routine care, urgent care, behavioral health care, and dental care. Timeliness standards included in the *Contract* are displayed **Table 13**.

Table 13: RI Medicaid Managed Care Contract Appointment Standards

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

Table 14 presents the results of the 2019 Access and Availability Survey conducted for Neighborhood. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 14: Access and Availability Survey Results—2019

Provider Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made ¹	Mean Number of Days to Appointment
Family/General Practice—Routine	10	3	30.0%	30%	5
Family/General Practice—Urgent	10	1	10.0%		4
Pediatricians—Routine	10	2	20.0%	20%	3
Pediatricians—Urgent	10	1	10.0%	10%	1
OB/GYNs—Routine	10	5	50.0%	30%	30
OB/GYNs—Urgent	10	3	30.0%	20%	4
Cardiology—Routine	6	1	16.7%	16.7%	1
Cardiology—Urgent	6	1	16.7%	16.7%	1
Dermatology—Routine	6	0	-	-	-
Dermatology—Urgent	6	0	-	-	-
Endocrinology—Routine	6	0	-	-	-
Endocrinology—Urgent	6	0	-	-	-
Gastroenterology—Routine	6	0	-	-	-
Gastroenterology—Urgent	6	2	33.3%	16.67%	7
Pulmonary—Routine	6	0	-	-	-
Pulmonary—Urgent	6	0	-	-	-
Pediatric Allergy—Routine	6	1	16.7%	16.67%	1
Pediatric Allergy—Urgent	6	3	50.0%	33.33%	3
Pediatric Gastroenterology—Routine	6	0	-	-	-
Pediatric Gastroenterology—Urgent	6	0	-	-	-
Pediatric Neurology—Routine	6	0	-	-	-
Pediatric Neurology—Urgent	6	0	-	-	-
Pediatric Orthopedics—Routine	6	2	33.3%	33.33%	11
Pediatric Orthopedics—Urgent	6	1	16.7%	16.67%	1
Pediatric Otolaryngology—Routine	6	1	16.7%	16.67%	15
Pediatric Otolaryngology—Urgent	6	1	16.7%		20
Adult Behavioral Health—Routine	15	7	46.7%	40.0%	4
Pediatric/Adolescent Behavioral Health—Routine	15	4	26.7%	20.0%	6

¹ The rate of timely appointments is based on the number of providers surveyed, and not the number of appointments made.

VII. Validation or Administration of Quality of Care Survey

Objectives

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

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

Neighborhood contracted with SPH Analytics, an NCQA-certified survey vendor to administer the 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Although reporting of child CAHPS survey results is not required, Neighborhood exceeded its contractual requirements by including this survey as part of its continuous quality improvement strategy.

Technical Methods of Data Collection and Analysis

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

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

The survey sample size for the Adult CAHPS was 3375. Neighborhood achieved a response rate of 20.68%, or 691 completed surveys.

The survey sample size for the Child CAHPS was 1980. Neighborhood achieved a response rate of 12.67%, or 250 completed surveys.

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

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

- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Description of Data

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

Findings

Member Satisfaction: Adult and Child CAHPS® 5.0H¹⁷

Adult CAHPS

Neighborhood performed well on the 2019 adult CAHPS® survey overall. Rates for all nine (9) measures were reported as exceeding the 2019 *Quality Compass*® national Medicaid mean. Additionally, rates for five (5) of the nine (9) measures reported demonstrated an improvement from the previous year. In terms of *Quality Compass*® percentile ranking, the *Rating of Health Plan* measure met the 2019 *Quality Compass*® 95th percentile. The *Flu Vaccinations for Adults* and *Getting Needed Care* measure benchmarked at the 90th percentile for 2019. Additionally, Five (5) measures met the 2019 *Quality Compass*® 75th percentile: *Customer Service*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Specialist*.

Table 15 displays the 2017, 2018 and 2019 results of Neighborhood's Adult CAHPS. The table also displays the *Quality Compass* 2019 national Medicaid percentile achieved by each rate and the 2019 national Medicaid means.

¹⁷ The rates for CAHPS® measures include all Medicaid members in the survey sample, where eligible population criteria are met. As such, the RHP and RHE populations were included in the adult CAHPS® sample and the CSHCN and SC populations were included in the child CAHPS® sample.

Table 15: Adult CAHPS® 5.0H Rates—2017-2019

Access and Availability Measures	HEDIS® 2017	HEDIS® 2018	HEDIS® 2019	Quality Compass® 2019	Quality Compass® 2019
				National Medicaid Benchmark	National Medicaid Mean
Flu Vaccinations for Adults (18-64 Years)	47.4%	46.3%	53.8%	90 th	41.8%
Rating of Health Plan ¹	80.8%	85.6%	85.5%	95 th	77.6%
Customer Service ²	90.7%	90.4%	91.9%	75 th	88.8%
Getting Care Quickly ²	80.8%	83.5%	86.2%	75 th	82.0%
Getting Needed Care ²	84.5%	86.8%	87.4%	90 th	82.5%
How Well Doctors Communicate ²	91.4%	93.9%	93.8%	75 th	92.0%
Rating of All Health Care ¹	76.1%	82.8%	77.7%	66.67 th	75.4%
Rating of Personal Doctor ¹	83.2%	84.8%	85.3%	75 th	82.1%
Rating of Specialist ¹	81.8%	87.6%	86.3%	75 th	82.3%

¹ “Rating of” measures are based on the percentage of respondents who gave a rating of 8, 9, or 10 (with 10 being the “best possible”). For measures that call for respondents to answer with “Always”, “Usually”, “Sometimes”, or “Never”, the rate is based on responses of “Always” or “Usually”.

² These indicators are composite measures.

Child CAHPS

Overall, Neighborhood’s performance was mixed on the 2019 Children with Chronic Conditions CAHPS® survey. Rates for *Customer Service* and *Rating of Specialist* could not be reported, as the sample size was too small. Of the remaining six (6) measures, all rates were reported as exceeding the 2019 *Quality Compass*® national Medicaid mean. All rates showed an increase from 2018. The measure *Rating of Health Plan* exceeded the 90th percentile benchmark and the measure *Getting Needed Care* met the 75th percentile benchmark.

There were two (2) measures that did demonstrate gradual improvement year-over-year: *The Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor* and *Getting Needed Care* measure. The Health Plan’s rates for *Getting Care Quickly*, *How Well Doctors communicate*, *Rating of All Health Care* and *Rating of Personal Doctor* continue to have room for improvement, as they fell below the 75th percentile benchmark.

Table 16 displays the 2017, 2018 and 2019 results of Neighborhood’s Child CAHPS. The table also displays the *Quality Compass* 2019 national Medicaid percentile achieved by each rate and the 2019 national Medicaid means.

Table 16 :Child CAHPS® 5.0 Rates—2018-2019

Access and Availability Measures	HEDIS® 2017	HEDIS® 2018	HEDIS® 2019	Quality Compass® 2019	Quality Compass® 2019
				National Medicaid Benchmark Met/Exceeded	National Medicaid Mean
Rating of Health Plan ¹	86.1%	89.7%	92.2%	95th	86.5 %
Customer Service ^{2,3}	87.5%	N/A	N/A	-	89.7%
Getting Care Quickly ²	92.3%	87.2%	90.8%	50th	89.4%
Getting Needed Care ²	86.6%	87.0%	89.4%	75th	84.5%
How Well Doctors Communicate ²	93.7%	95.5%	95.5%	66.67th	94.0%
Rating of All Health Care ¹	84.7%	85.6%	89.3%	50th	87.5%
Rating of Personal Doctor ¹	88.5%	90.7%	91.6%	66.67th	90.1%
Rating of Specialist ¹	83.3%	89.0%	N/A	-	73.9%

N/A: Not available

¹ “Rating of” measures are based on the percentage of respondents who gave a rating of 8, 9, or 10 (with 10 being the “best possible”). For measures that call for respondents to answer with “Always”, “Usually”, “Sometimes”, or “Never”, the rate is based on responses of “Always” or “Usually”.

² These indicators are composite measures.

³ The “N/A” designation was given for this measure as a result of a small sample size. Fewer than 100 member responses were available for the rate calculation.

VIII. Strengths, Opportunities and Recommendations

IPRO's external quality review concludes that, in the measurement years 2017-2019, Neighborhood's program has had a positive impact on the quality and access of services provided to Medicaid recipients, which is supported by the improved performance in all of the HEDIS® domains reported.

Strengths

Concerning **quality**, NHP demonstrated the following strengths:

- Neighborhood's rates for all three (3) measures in the HEDIS® Use of Services domain exceeded the National Medicaid average. One (1) measure met the Quality Compass® 95th percentile and two (2) measures met the Quality Compass® 75th percentile.
- Neighborhood's rate for all eight (8) measures in the HEDIS® Effectiveness of Care domain exceeded the national Medicaid average. Two (2) of the measures met the Quality Compass® 95th percentile, three (3) measures met the Quality Compass® 90th percentile, one (1) measure met the Quality Compass® 75th percentile, one (1) measure met the Quality Compass® 66.67th percentile, and one (1) measure met the Quality Compass® 50th percentile.
- In regards to the 2019 Performance Goal Program, Neighborhood received a full incentive award for seven (7) measures and a partial incentive award for three (3) measures.
- In regards to the 2019 Adult CAHPS survey, Neighborhood had rates exceeding the National Medicaid average for all nine (9) measures.
- In regards to the 2019 Child CAHPS survey (general population); Neighborhood had rates exceeding the National Medicaid average for all six (6) of the measures.
- Regarding Neighborhood's QIPs;
 - *Improving Developmental Screening Rates in the First Three Years of Life*: NHP had an increase in rates for all four (4) indicators. NHP exceeded its goals for the *Screening by Age 1* and *Screening by Age 2* indicators.
 - *Improve Performance for Care for Older Adults HEDIS Measure for INTEGRITY Medicare-Medicaid Plan*: Neighborhood exceeded its goals for the *Care for Older Adults: Advanced Care Plan* and *Care for Older Adults: Pain Assessment* indicators.
 - *Increase the Percentage of Transitions from the Nursing Home to the Community*: NHP exceeded its goals for transitioning INTEGRITY MMP members into the community through both the RTHP and the Nursing Home Transition Program.

Concerning **timeliness** and **access**, NHP demonstrated the following strengths:

- Neighborhood's rates for all nine (9) measures in the HEDIS® Access and Availability domain exceeded the National Medicaid average. Two (2) of the measures met the Quality Compass® 95th percentile, one (1) measure met the Quality Compass® 90th percentile, five (5) measures met the Quality Compass® 75th percentile, and one (1) measure met the Quality Compass® 66.67th percentile.
- Neighborhood exceeded its provider network adequacy goal of ninety-five (95%) for fifteen (15) of the 17 provider types reviewed.

Opportunities for Improvement

In regard to **quality** and **access**, Neighborhood demonstrates an opportunity for improvement in the following areas:

- Regarding Neighborhood's QIPs:
 - *Children's and Adolescents' Access to Primary Care Practitioners (CAP)*: NHP did not achieve the goals of 97.71% for ages 12-24 Months and 92.88% for ages 25 Months – 6 Years.
 - *Improving Developmental Screening Rates in the First Three Years of Life*: NHP did not meet its goals for the following indicators: *Screening by Age 3* and *Screening in all ages (total rate)*.
 - *Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication (ADHD)*: NHP did not meet its goals for both the initiation and maintenance phase rates.
 - *Social Determinant of Health Measure - Improve the Rate of Lead Screening in Children*: NHP did not meet the goal of 85.90%.
 - *Improve Performance for Care for Older Adults HEDIS Measure for INTEGRITY Medicare-Medicaid Plan*: NHP did not meet the goals for the following indicators; *Care for Older Adults - Medication Review rate* and *Care for Older Adults - Functional Status Assessment*.
 - *Increase the Percentage of Transitions from the Nursing Home to the Community*: Although NHP were successful in transitioning members through the RTHP to the community, the rate was slightly below the project goal of 20 members.
- Regarding the Performance Goal Program results, Neighborhood did not receive an award for ten (10) of the 20 measures.

Recommendations

- To improve timeliness and access, Neighborhood should continue monitoring the access and availability of routine and urgent care appointments. In 2019, all provider types surveyed had an appointment rate at or below 50%, Neighborhood should re-educate network providers of appointment standards and request providers submit a plan of correction should standards continue to not be met.
- The QIPs were comprised of multi-faceted intervention strategies that targeted members, providers, and Health Plan systems and processes. Opportunities for improvement remain for all of the QIPs, as the Health Plan did not achieve the established project goals for some of the indicators. Neighborhood should continuously monitor the effectiveness of the interventions implemented for the QIPs. Many of the interventions are passive in nature (i.e. automated messaging, newsletters, etc.). The Health Plan should consider developing and initiating more active interventions. The Health Plan should also include additional provider focused interventions.

IX. MCO Response to Previous Year’s EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) require each annual technical report include “an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has

Recommendations Identified by IPRO	Neighborhood’s Response
<i>Measures</i>	
<i>Quality of Care</i>	
<p>As the Health Plan’s numerical score for the Getting Better domain in the NCQA Accreditation Survey demonstrated notable improvement, Neighborhood should continue with the interventions implemented under its Medicaid Quality Improvement Plan that drive the accreditation score. The Health Plan should routinely monitor the effectiveness of its Medicaid Quality Improvement Plan and modify it as needed.</p>	<p>Neighborhood will continue with the interventions identified and implemented under the quality improvement work groups identified through the “Medicaid Quality Improvement Plan”. In November of 2020, Neighborhood will assess the effectiveness of the “Medicaid Quality Improvement Plan” and adjust it as necessary.</p>
<p>Neighborhood will continue with the interventions identified and implemented under the quality improvement work groups identified through the “Medicaid Quality Improvement Plan”. In November of 2020, Neighborhood will assess the effectiveness of the “Medicaid Quality Improvement Plan” and adjust it as necessary.</p>	<p>Neighborhood will continue with the interventions identified and implemented under the quality improvement work groups identified through the “Medicaid Quality Improvement Plan”. In November of 2020, Neighborhood will assess the effectiveness of the “Medicaid Quality Improvement Plan” and adjust it as necessary.</p>
<p>While the Health Plan continues to demonstrate an opportunity for improvement in regard to member satisfaction, all but one of Neighborhood’s scores have trended upward suggesting that the improvement strategy described in the Health Plan’s response to last year’s recommendation is effective. Therefore, Neighborhood should continue with its improvement strategy and consider enhancing it by conducting routine audits on the accuracy of its provider directories, educating providers on appointment standards, and working with network provider sites to offer extended hours operation.</p>	<p>Neighborhood will continue with the improvement strategy described in last year’s response and adjust the strategy based on current member satisfaction results. Neighborhood annually conducts Provider Directory Accuracy Assessment and updates the directory based on the information it collects during this review. Neighborhood is working to improve its provider data integrity to ensure the directory meets the needs of our members and will assess the ability to conduct regular audits. The plan is working to streamline the process by which providers request changes to their directory information. Neighborhood is improving its provider communication efforts and will be implementing electronic notifications to supplement our current communication methods. We will use this strategy to reinforce education about appointment standards and extended hours of operation.</p>
<i>Access to/Timeliness of Care</i>	

Recommendations Identified by IPRO	Neighborhood's Response
<p>In regard to the overall aspect of access to care, the Health Plan demonstrates an opportunity for improvement with its provider network. Specifically, Neighborhood should assess the breadth and quality of its provider network as the network seems to be the driving force behind low member satisfaction scores, low rates of primary care access and low HEDIS and PGP rates.</p>	<p>Neighborhood's HEDIS 2020 rates for several of the primary care access measures improved in CY 2019 compared to CY 2018. The rates for Children's Access to Primary Care measure improved for all age group: for ages 12-24 the rate improved from 96.42 to 97.86, for ages 25 month – 6 years the rate improved from 88.68 to 91.88, for ages 7-11 years the rate improved from 93.45 to 95.68 and for ages 12-19 years the rate improved from 92.48 to 94.24. The Well-Child Visit in the First 15 Months of Life, the rate improved from 78.04 to 79.17 and for Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life the rate improved from 76.04 to 79.00. The Adolescent Well Care Visits also improved from 60.79 to 66.84.</p> <p>In terms of breadth and quality of Neighborhood's provider network, Neighborhood annually assesses the geographic availability of practitioners in its network for the purpose of developing, maintaining and improving its network as necessary to ensure that its members have access to appropriate practitioners "close to home". The 2020 assessment result showed that Neighborhood's provider network met or exceeded geographic availability standards for all primary care, high-impact and high-volume specialty provider types.</p> <p>Access to medical services rendered by network practitioners is a critical measure of Neighborhood's mission to deliver high quality, cost-effective health care for Rhode Island's residents. The primary care provider is the central access point for Neighborhood's members and serves as the member's medical home, affording each member continuity of care and coordination of services with Neighborhood's specialty provider network.</p> <p>Neighborhood is proactive in the assessment of appointment availability. First, by surveying the provider network, in accordance with established standards, on a quarterly basis. Then, engaging practices, as required, to offer education and assistance in meeting Neighborhood's expectations with regard to appointment availability.</p>
<p>Measures</p>	

Recommendations Identified by IPRO	Neighborhood's Response
<p>As child, adolescent and adult access to primary care rates have all trended downward from the previous reporting period, the Health Plan should conduct root cause analysis to determine why members are not accessing care. Neighborhood should monitor complaints and grievances to identify issues related to access. In addition to reminding members about the importance of primary care, Neighborhood should consider offering assistance with making medical appointments.</p>	<p>As child, adolescent and adult access to primary care rates have all trended downward from the previous reporting period, the Health Plan should conduct root cause analysis to determine why members are not accessing care.</p> <p>Neighborhood should monitor complaints and grievances to identify issues related to access. In addition to reminding members about the importance of primary care, Neighborhood should consider offering assistance with making medical appointments.</p>

Appendix 1: Rhode Island State Quality Strategy, Rhode Island State Quality Strategy – July 2019

Section 1.1 Overview

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

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

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

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

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

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

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

Section 1.2 Rhode Island Medicaid and CHIP

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

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

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

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

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

Section 1.3 History of Medicaid Managed Care Programs

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

Table 1 Rhode Island Medicaid Managed Care Program Additions

Year	Managed Care Program Additions
1994	<ul style="list-style-type: none"> • Rlte Care • SCHIP
2000	<ul style="list-style-type: none"> ▪ Children in Substitute Care ▪ Rlte Share
2003	<ul style="list-style-type: none"> • Children with Special Needs • Rlte Smiles
2008	a. Rhody Health Partners

2014	1. Medicaid Expansion 2. Behavioral Health carved in to managed care
2015	I. Accountable Entities Pilot
2016	1. Medicare-Medicaid Plan (MMP)
2018	1. MCO-Certified Accountable Entities APMs

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

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

Section 1.4 Medicaid and CHIP Managed Care in 2019

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

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

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

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

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

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

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

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

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

Section 2.1 Medicaid Guiding Principles and Accountable Entities

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

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

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

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

In alignment with its guiding principles, RI Medicaid developed the AE program as a core part of its managed

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

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

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

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

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

Section 2.2 Quality Strategy Goals

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

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

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

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

Section 2.3 Quality Strategy Objectives

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

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

J. Review trend for disparity-sensitive measures and design interventions to improve health equity, including working with MCOs and AEs to screen members related to social determinants of health and make referrals based on the screens.	6
K. Share and aggregate data across all RI HHS agencies to better address determinants of health. Develop a statewide workgroup to resolve barriers to data-sharing.	6
L. Continue to require plans to conduct CAHPS 5.0 surveys and annually share MCO CAHPS survey results with the MCAC.	7
M. Explore future use of a statewide survey to assess member satisfaction related to AEs, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from AEs.	7
N. Explore use of focus groups to solicit additional member input on their experiences & opportunities for improvement.	7

Section 3.1 Quality Management Structure

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

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

Medicaid Quality functions include:

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

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

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

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

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

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

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

Section 3.2 Review and Update of the Quality Strategy

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

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

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

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

Section 3.3 Evaluating the Effectiveness of the Quality Strategy

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

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

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

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

Section 4.1 State Monitoring of Managed Care Entities

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

- administration and management
- appeal and grievance systems
- claims management
- enrollee materials and customer services, including the activities of the beneficiary support system.
- finance, including new medical loss ratio (MLR) reporting requirements,
- Information systems, including encounter data reporting,
- marketing,
- medical management, including utilization management and case management.
- program integrity,

- provider network management, including provider directory standards,
- availability and accessibility of services, including network adequacy standards,
- quality improvement, and
- for MMPs, areas related to the delivery of LTSS not otherwise included above and as applicable to the MMP contract.

RI uses data collected from its monitoring activities to improve the performance of its MCE programs.

For example, the state MCE oversight includes reviewing:

9. enrollment and disenrollment trends in each MCE and other data submitted by the RI Medicaid enrollment broker related to MCE performance
10. member grievance and appeal logs,
11. provider complaint and appeal logs,
12. findings from RI's EQR process,
13. results from enrollee and provider satisfaction surveys conducted by the State/EQRO or MCE,
14. MCE performance on required quality measures,
15. MCE medical management committee reports and minutes,
16. the annual quality improvement plan for each MCE.
17. audited financial and encounter data submitted by each MCE,
18. the MLR summary reports required by 42 CFR 438.8.
19. customer service performance data submitted by each MCE, and
20. for the MMP contract, other data related to the provision of LTSS not otherwise included above as applicable to the MMP contract.

Section 4.2 Specific MCE Oversight Approaches Used by RI Medicaid

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

- Contract management - All managed care contracts and contracts with entities participating in capitated payment programs include quality provisions and oversight activities. Contracts include requirements for quality measurement, quality improvement, and reporting. Active Contract Management is a crucial tool in RI Medicaid's oversight. Routine reporting allows RI Medicaid to identify issues, trends and patterns early and efficiently to mitigate any potential concerns. Another key part of its contract management approach are monthly oversight meetings that RI Medicaid directs with each MCE. One topic that may be included in contract oversight meetings, for example, is mental health parity. The state may use this meeting as a forum to address compliance issues or questions related to the updated MCO Contract language related to mental health parity:
 - *The Contractor must comply with MHPAEA requirements and establish coverage parity between mental health/substance abuse benefits and medical/surgical benefits. The Contractor will cover mental health or substance use disorders in a manner that is no more restrictive than the coverage for medical/surgical conditions. The Contractor will publish any processes, strategies, evidentiary standards, or other factors used in applying Non-Qualitative Treatment Limitations (NQTL) to mental health or substance use disorder benefits and ensure that the classifications are comparable to, and are applied no more stringently than, the*

processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. The Contractor will provide EOHHS with its analysis ensuring parity compliance when: (1) new services are added as an in-plan benefit for members or (2) there are changes to non-qualitative treatments limitations. The Contractor will publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence. In the event of a suspected parity violation, the Contractor will direct members through its internal complaint, grievance and appeals process as appropriate. If the matter is still not resolved to the member's satisfaction, the member may file an external appeal (medical review) and/or a State Fair Hearing. The Contractor will track and trend parity complaints, grievances and appeals on the EOHHS approved template at a time and frequency as specified in the EOHHS Managed Care Reporting Calendar and Templates.

- State-level data collection and monitoring – RI Medicaid collects data to compare MCE performance to quality and access standards in the MCE contracts. At least annually, for example, Rhode Island collects HEDIS and other performance measure data from its managed care plans and compares plan performance to national benchmarks, state program performance, and prior plan performance. In addition, the state monitors MCE encounter data to assess trends in service utilization, as well as analyzing a series of quarterly reports, including informal complaints, grievances, and appeals.

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

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

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

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

- Performance Incentives - Within the contract for Rite Care, Rhody Health Partners and Rhody Health Expansion, the state requires performance measures through a pay-for-performance program called the Performance Goal Program (PGP). MCOs can earn financial incentives for achieving specified benchmarks

for measures in the following domains: utilization, access to care, prevention/screening, women’s health, and chronic care management, and behavioral health. The contract for the MMP requires performance measures that are tied to withholds. The plan can earn the withhold payment by meeting benchmarks as outlined in the contract. The PAHP has one required performance measure that is calculated using a HEDIS methodology.

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

- Performance improvement projects - Each managed care entity is required to complete at least two performance improvement projects (PIPs) annually in accordance with 42 CFR 438.330(d) and the RI Medicaid managed care contracts. RI Medicaid MCOs are contractually obligated to conduct 4 PIPs annually. The dental plan has two contractually required PIP(s). The MMP is also required to perform one additional PIP specific to that population and their service needs. After analysis and discussion, MCEs are required to act on findings from each contractually required quality improvement project.
- Annual Quality Plan-Each MCE must submit an annual quality plan to RI Medicaid. This plan must align the RI Medicaid’s goals and objectives. RI Medicaid contracts with an EQRO to perform an independent annual review of each Medicaid MCE. The state’s EQRO is involved in reviewing the MCE quality plans as part of its broader role in performing the external quality review of each managed care entity and program.
- Accreditation Compliance Audit- As part of the annual EQR, the EQRO conducts an annual accreditation compliance audit of contracted MCOs. The compliance review is a mandatory EQR activity and offers valuable feedback to the state and the plans. Based on NCQA rankings, RI’s Medicaid health plans continue to rank in the top percentiles of Medicaid plans nationally. The state and the EQR reinforces the State’s requirement that participating MCOs maintain accreditation by the NCQA. The state reviews and acts on changes in any MCO’s accreditation status and has set a performance “floor” to ensure that any denial of accreditation by NCQA is considered cause for termination of the RI Medicaid MCO Contract. In addition, MCO achievement of no greater than a provisional accreditation status by NCQA requires the MCO to submit a Corrective Action Plan within 30 days of the MCO’s receipt of its final report from the NCQA.

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

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

implementation of new managed care programs.

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

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

Section 4.3 Appropriateness of Care in Managed Care

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

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

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

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

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

2. Persons with Special Health Care Needs

A critical part of providing appropriate care is identify Medicaid beneficiaries with special health care needs as defined in the MCE contracts. Each MCE must have mechanisms in place to assess enrollees identified as having **special health care needs**. Rhode Island defines children with special health care needs (CSHCN) as: persons up to the age of twenty-one who are blind and/or have a disability and are eligible for Medical Assistance on the basis of SSI; children eligible under Section 1902(e) (3) of the Social Security Administration up to nineteen

years of age (“Katie Beckett”); children up to the age of twenty-one receiving subsidized adoption assistance, and children in substitute care or “Foster Care”. The State defines adults with special health care needs as adults twenty-one years of age and older who are categorically eligible for Medicaid, not covered by a third-party insurer such as Medicare, and residing in an institutional facility.

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

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

3. Cultural Competency

At the time of enrollment, individuals are asked to report their race and ethnicity and language. These data are captured in an enrollment file and can be linked to MMIS claims data and analyzed. This data is used to ensure the delivery of culturally and linguistically appropriate services to Health Plan members. For example, Health Plans are required to provide member handbook and other pertinent health information and documents in languages other than English, including the identification of providers who speak a language other than English as well as to provide interpreter services either by telephone or in-person to ensure members are able to access covered services and communicate with their providers. In addition, Health Plans are obligated to adhere to the American Disabilities Act and ensure accessible services for members with a visual, hearing, and/or physical disability.

4. Health Disparity Analysis

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

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

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

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

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

Section 4.4 MCE Performance Measures and Targets

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

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

RI Medicaid has employed use of standard measures that are nationally endorsed, by such entities as the National Quality Forum (NQF). Rhode Island collects and voluntarily reports on most CMS Adult and Child Core Measure Set performance measures.⁹ In 2019, Rhode Island reported on 20 measures from the Adult Core Set and 17 measures from the Child Core Set, with measurement reflecting services delivered to Medicaid beneficiaries in CY2017. RI Medicaid also opts to report on some CMS Health Home core measures.

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

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

RI Medicaid consults with its EQRO in establishing and assessing CAHPS survey requirements and results for MCEs. All MCEs are required to conduct CAHPS 5.0 member experience surveys and report to RI Medicaid and its EQR on member satisfaction with the plan. RI Medicaid is exploring the use of additional member satisfaction

surveys to assess AE performance in the future. For example, Rhode Island will explore the future use of a statewide CAHPS survey to assess consumer satisfaction with members in AEs, such as the potential use of the Clinician Group CG-CAHPS version survey for adults and children receiving primary care services from AEs.

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

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

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

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

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

Section 4.5 External Quality Review

As required by 42 CFR 438.350, an annual External Quality Review (EQR) of Rhode Island's Medicaid managed care program must be conducted by an independent contractor and submitted to the CMS annually. IPRO is

under contract with RI Medicaid to conduct the EQR function for the State. Rhode Island's current Medicaid managed care EQR contract with IPRO runs from January 2019 through January 2020. The contract period for this effort begins on January 1, 2019 through December 31, 2021, with the potential for up to three one-year extensions.

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

1. **Performance Improvement Projects** - Validation of PIPs required in accordance with 42 CFR 438.330(b)(1) that were underway during the preceding 12 months. Currently, MCOs are required to complete at least four PIPs each year. Additionally, the contract for the MMP requires at least one more PIP. The PAHP is required to complete at least two performance improvement projects each year.
2. **Performance Goal Program** - Validation of MCO and PAHP performance measures required in accordance with 42 CFR 438.330(b)(2) or MCO/PAHP performance measures calculated by the state during the preceding 12 months.
3. **Access** -Validation of MCO and PAHP network adequacy during the preceding 12 months to comply with requirements set forth in 42 CFR 438.68 and 438.14(b)(1) and state standards established in the respective MCE contracts as summarized in **Section 5**. Validation of network adequacy will include, but not be limited to a secret shopper survey of MCO and dental PAHP provider appointment availability in accordance with contractual requirements established by the state.
4. **Accreditation Compliance Review** - A review, conducted within the previous three-year period, to determine each MCO's and PAHP's compliance with the standards set forth in 42 CFR Part 438, subpart D and the quality assessment and performance improvement requirements described in 42 CFR 438.330. Within the contracts for Rite Care, Rhody Health Partners Rhody Health Expansion, Rhody Health Options, and Medicare Medicaid Plan the state requires the MCOs to be accredited by the National Committee for Quality Assurance as a Medicaid Managed Care organization. The PAHP is accredited by the Utilization Review Accreditation Commission (URAC).
5. **Special enhancement activities** as needed. In addition, the State reserves the option to direct the EQRO to conduct additional tasks to support the overall scope of this EQR work in order to have flexibility to bring on additional technical assistance and expertise in a timely manner to perform activities which require similar expertise and work functions as those described in 1 to 4 above. One example of this may be the EQRO's future assistance in conducting a CAHPs satisfaction survey for Medicaid members attributed to an AE.

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

31. A description of the way data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to care furnished by the MCEs.
32. For each Mandatory and, if directed by the State, Optional Activity conducted the objectives, technical methods of data collection and analysis, description of data obtained (including validated performance measurement data for each activity conducted), and conclusions drawn from the data.

33. An assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
34. Recommendations for improving the quality of health care services furnished by each MCE including how the State can establish target goals and objective in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
35. An assessment of the degree to which each MCE has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.
36. An evaluation of the effectiveness of the State's quality strategy and recommendations for updates based on the results of the EQR.

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

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

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

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

Section 5.1 RI Managed Care Standards

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

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

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

Section 5.2 MCO Standards

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

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

TABLE 4: MCO ACCESS TO CARE STANDARDS	
Provider Type	Time and Distance Standard <i>Provider office is located within the lesser of</i>
Primary care, adult and pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
OB/GYN specialty care	Forty-five (45) minutes or thirty (30) miles from the member's home
Outpatient behavioral health-mental health	
Prescribers-adult	Thirty (30) minutes or thirty (30) miles from the member's home.
Prescribers-pediatric	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Non-prescribers-adult	Twenty (20) minutes or twenty (20) miles from the member's home.
Non-prescribers-pediatric	Twenty (20) minutes or twenty (20) miles from the member's home.
Outpatient behavioral health-substance use	
Prescribers	Thirty (30) minutes or thirty (30) miles from the member's home.
Non-prescribers	Twenty (20) minutes or twenty (20) miles from the member's home.
Specialist	
The Contractor to identify top five adult specialties by volume	Thirty (30) minutes or thirty (30) miles from the member's home.
The Contractor to identify top five pediatric specialties by volume	Forty-five (45) minutes or forty-five (45) miles from the member's home.

TABLE 4: MCO ACCESS TO CARE STANDARDS	
Provider Type	Time and Distance Standard <i>Provider office is located within the lesser of</i>
Hospital	Forty-five (45) minutes or thirty (30) miles from the member's home
Pharmacy	Ten (10) minutes or ten (10) miles from the member's home
Imaging	Forty-five (45) minutes or thirty (30) miles from the member's home
Ambulatory Surgery Centers	Forty-five (45) minutes or thirty (30) miles from the member's home
Dialysis	Thirty (30) minutes or thirty (30) miles from the member's home.

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

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

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

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

Section 5.3 MMP Standards

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

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

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

Section 5.4 Dental PAHP Standards

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

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

Section 6.1 Improvement and Interventions

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

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

a. Ongoing requirements for MCEs to be nationally accredited

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

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

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

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

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

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

c. Pay for Performance Incentives for MCEs and AEs

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

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

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

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

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

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

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

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

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

Section 6.2 Intermediate Sanctions

Rhode Island’s Medicaid MCO Contracts clearly define intermediate sanctions, as specified in CFR 438.702 and 438.704, which EOHHS will impose if it makes any of the following determinations or findings against an MCO from onsite surveys, enrollee or other complaints, financial status or any other source:

- EOHHS determines that a Medicaid MCO acts or fails to act as follows:
 - Fails substantially to provide medically necessary services that it is required to provide, under law or under its contract with the State, to an enrollee covered under the contract; EOHHS may impose a

civil monetary penalty of up to \$25,000 for each instance of discrimination.

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

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

Section 6.3 Health Information Technology

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

Rhode Island seeks to expand its' Health Information Technology systems to streamline and automate the quality reporting process to inform policy level interventions and data-driven decision making. State-level Health

and Human Service agencies have partnered to share information and collaborate towards achieving positive health outcomes and reducing disparities. This has culminated with the development of an eco-system that collects data from each HHS agency that can be shared within each agency. The ecosystem is still in its infancy but is expected to be a promising tool used in quality reporting and active contract management.

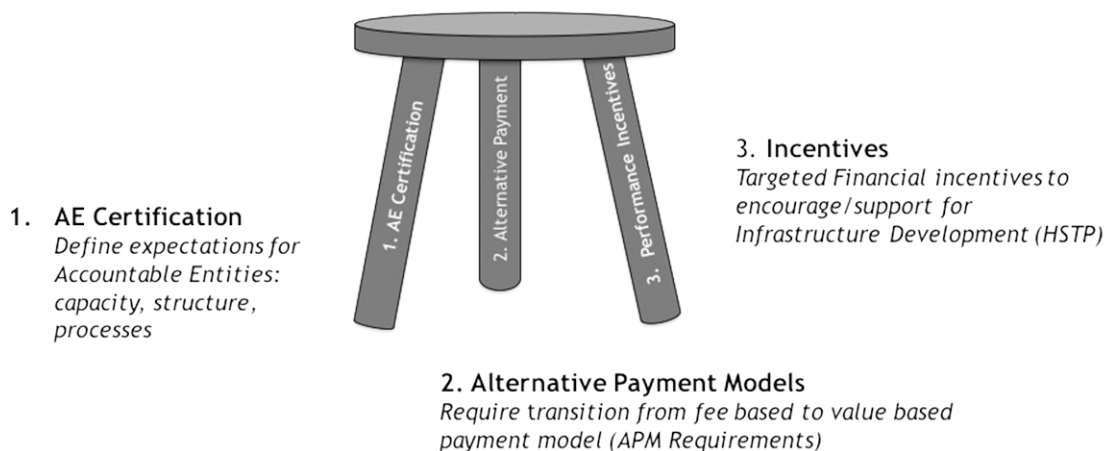
The Rhode Island Department of Health (DOH) also provides oversight functions related to the State’s HIT/EHR initiatives with strategies, policies, and clinical guidelines established at the state government level. The Department of Health manages several key HIT initiatives to support data-focused public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

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

Section 7: Delivery System Reform

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

Accountable Entity Program Approach: Three “Pillars”



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

EOHHS certifies Accountable Entities which are then eligible to enter into EOHHS-approved alternative payment model contractual arrangements with the Medicaid MCOs. To date, six Comprehensive Accountable

Entities have been certified, and qualified APM contracts are in place between five AEs and Medicaid MCOs. The percentage of members attributed to AEs continues to grow in accordance with EOHHS effort to pay for value not volume.

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

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

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

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

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

Section 8: Conclusions and Opportunities

Rhode Island is committed to ongoing development, implementation, monitoring and evaluation of a vigorous quality management program that will effectively and efficiently improve and monitor quality of care for its Annual EQR Technical Report 2019—Neighborhood Health Plan of Rhode Island

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

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

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

APPENDIX 2: NCQA Quality Improvement Activity Form

QUALITY IMPROVEMENT FORM

NCQA Quality Improvement Activity Form

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

First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
<i>Quantifiable Measure #3:</i>	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
C. Baseline Methodology.	
C.1 Data Sources.	
<input type="checkbox"/> Medical/treatment records <input type="checkbox"/> Administrative data: <input type="checkbox"/> Claims/encounter data <input type="checkbox"/> Complaints <input type="checkbox"/> Appeals <input type="checkbox"/> Telephone service data <input type="checkbox"/> Appointment/access data <input type="checkbox"/> Hybrid (medical/treatment records and administrative) <input type="checkbox"/> Pharmacy data <input type="checkbox"/> Survey data (attach the survey tool and the complete survey protocol)	
C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.	

<p>If medical/treatment records, check below:</p> <p><input type="checkbox"/> Medical/treatment record abstraction</p> <p>If survey, check all that apply:</p> <p><input type="checkbox"/> Personal interview</p> <p><input type="checkbox"/> Mail</p> <p><input type="checkbox"/> Phone with CATI script</p> <p><input type="checkbox"/> Phone with IVR</p> <p><input type="checkbox"/> Internet</p> <p><input type="checkbox"/> Incentive provided</p> <p><input type="checkbox"/> Other (list and describe):</p> <p>_____</p>	<p>If administrative, check all that apply:</p> <p><input type="checkbox"/> Programmed pull from claims/encounter files of all eligible members</p> <p><input type="checkbox"/> Programmed pull from claims/encounter files of a sample of members</p> <p><input type="checkbox"/> Complaint/appeal data by reason codes</p> <p><input type="checkbox"/> Pharmacy data</p> <p><input type="checkbox"/> Delegated entity data</p> <p><input type="checkbox"/> Vendor file</p> <p><input type="checkbox"/> Automated response time file from call center</p> <p><input type="checkbox"/> Appointment/access data</p> <p><input type="checkbox"/> Other (list and describe):</p> <p>_____</p>
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C.3 Sampling. If sampling was used, provide the following information.

Measure	Sample Size	Population	Method for Determining Size (<i>describe</i>)	Sampling Method (<i>describe</i>)

C.4 Data Collection Cycle.	Data Analysis Cycle.
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<input type="checkbox"/> Once a year <input type="checkbox"/> Twice a year <input type="checkbox"/> Once a season <input type="checkbox"/> Once a quarter <input type="checkbox"/> Once a month <input type="checkbox"/> Once a week <input type="checkbox"/> Once a day <input type="checkbox"/> Continuous <input type="checkbox"/> Other (list and describe): Annual HEDIS data collection in Spring, and interim measure in Summer preceding close of the HEDIS 2008 year (Summer 2007)	<input type="checkbox"/> Once a year <input type="checkbox"/> Once a season <input type="checkbox"/> Once a quarter <input type="checkbox"/> Once a month <input type="checkbox"/> Continuous <input type="checkbox"/> Other (list and describe): <hr/> <hr/>
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C.5 Other Pertinent Methodological Features. Complete only if needed.

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

Include, as appropriate:

- Measure and time period covered
- I. Type of change
- II. Rationale for change
- III. Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method
- IV. Any introduction of bias that could affect the results

Section II: Data/Results Table

Complete for each quantifiable measure; add additional sections as needed.

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

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

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That Analysis Covers.

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

B.1 For the quantitative analysis:

B.2 For the qualitative analysis:

- Opportunities identified through the analysis

Impact of interventions

- Next steps

Section IV: Interventions Table

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

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

Section V: Chart or Graph (Optional)

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