



**Rhode Island Medicaid Managed Care Program  
Tufts Public Health Plan  
(Tufts)**

**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**

April 30, 2021



Better healthcare,  
realized.

Corporate Headquarters  
1979 Marcus Avenue  
Lake Success, NY 11042-1072  
(516) 326-7767  
ipro.org

ISO  
9001:2008  
CERTIFIED

# Table of Contents

---

<b>LIST OF TABLES</b> .....	<b>IV</b>
<b>I. EXECUTIVE SUMMARY</b> .....	<b>1</b>
Introduction.....	1
Rhode Island Medicaid Managed Care Program.....	1
Scope of External Quality Review Activities.....	1
Findings .....	2
Conclusions.....	4
<b>II. BACKGROUND</b> .....	<b>5</b>
Purpose of This Report.....	5
Rhode Island Executive Office of Health and Human Services .....	5
Rhode Island Medicaid Managed Care Program.....	7
Tufts Public Health Plan .....	8
<b>III. EQRO EVALUATION METHODOLOGY</b> .....	<b>13</b>
<b>IV. VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS</b> .....	<b>14</b>
Objectives.....	14
Technical Methods of Data Collection and Analysis .....	14
Description of Data Obtained.....	15
Findings .....	15
<b>V. VALIDATION OF PERFORMANCE MEASURES</b> .....	<b>18</b>
Information Systems Capabilities Assessment.....	18
HEDIS Performance Measures .....	19
Rhode Island Performance Goal Program.....	23
<b>VI. REVIEW OF COMPLIANCE WITH MEDICAID AND CHIP MANAGED CARE REGULATIONS</b> .....	<b>25</b>
Objectives.....	25
Technical Methods of Data Collection and Analysis .....	25
Description of Data Obtained.....	25
<b>VII. VALIDATION OF NETWORK ADEQUACY</b> .....	<b>27</b>
Objectives.....	27
Technical Methods of Data Collection and Analysis .....	28
Description of Data.....	28
Findings .....	28
<b>VIII. VALIDATION OR ADMINISTRATION OF A QUALITY OF CARE SURVEY</b> .....	<b>30</b>
Objectives.....	30
Technical Methods of Data Collection and Analysis .....	30
Description of Data.....	30
Findings .....	31
<b>IX. STRENGTHS, OPPORTUNITIES AND RECOMMENDATIONS</b> .....	<b>32</b>
<b>Strengths</b> .....	32
<b>Opportunities for Improvement</b> .....	32
<b>Recommendations</b> .....	33
<b>X. MCO RESPONSE TO PREVIOUS YEAR’S EQR RECOMMENDATIONS</b> .....	<b>34</b>
<b>XI. REFERENCES</b> .....	<b>35</b>

**APPENDIX 1: RHODE ISLAND MEDICAID MANAGED CARE QUALITY STRATEGY – JULY 2019 .....37**  
**APPENDIX 2: NCQA QUALITY IMPROVEMENT ACTIVITY FORM .....63**

# List of Tables

---

Table 1: Rhode Island Medicaid Managed Care Program Additions.....7

Table 2: Health Plan Enrollment—2017-2019 .....8

Table 3: Tufts 2019 QIP Validation Findings..... 15

Table 4: QIP 2 – Member Experience and Retention ..... 17

Table 5: Tufts Compliance with Information System Standards ..... 19

Table 6: HEDIS® Use of Services Rates—2019..... 21

Table 7: HEDIS® Effectiveness of Care Rates—2019 ..... 22

Table 8: HEDIS® Access and Availability Rates—2019..... 23

Table 9: Evaluation 42 CFR Part 438 Subpart D and QAPI Standards..... 26

Table 10: RI Medicaid Managed Care Contract Appointment Standards ..... 28

Table 11: GeoAccess Provider Network Accessibility..... 28

Table 12: Access and Availability Survey Results—2019..... 29

Table 13: Adult CAHPS® 5.0H Rates—2019..... 31

# 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 Tufts Public Health Plan (Tufts) under Rite Care, a Rhode Island Medicaid managed care program.

Tufts is a not-for-profit health maintenance organization (HMO) that has served the Rhode Island Medicaid population since 2018.

## 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, 2019<sup>1</sup>.

It is important to note that the provision of health care services to each of the applicable eligibility groups (Core Rite Care, Rite Care for Children with Special Health Care Needs (CSHCN), Rite Care for Children in Substitute Care<sup>2</sup>, Rhody Health Partners (RHP), Rhody Health Options (RHO)<sup>3</sup>, and Rhody Health Expansion (RHE)) is evaluated in this report. RHP is a managed care option for Medicaid-eligible adults with disabilities, while RHO members include those that are dual-eligible for Medicaid and Medicare. The RHE population includes Medicaid-eligible adults, ages nineteen (19) to sixty-four (64) years, who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible for mandatory coverage under the state plan. As members of the Health Plans, each of these populations were included in all measure calculations, where applicable. For comparative purposes, results for 2016 and 2017 are displayed when available and appropriate. The framework for this assessment is based on the guidelines established by the CMS EQR protocols, as well as state requirements.

## 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 for reporting year 2019. It should be noted that validation of provider network adequacy, though currently a standard in *Title 42 Code of Federal Regulations (CFR) Section (§) 438.358 Activities related to external quality review (b)(1)(iv)*, was not part of the CMS *External Quality Review (EQR) PROTOCOLS*<sup>4</sup> 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:

---

<sup>1</sup> 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.

<sup>2</sup> Neighborhood is the only Health Plan that serves the Children in Substitute Care population.

<sup>3</sup> Neighborhood is the only Health Plan that serves the Rhody Health Options population.

<sup>4</sup> Medicaid.Gov Website: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf>

- (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) **Administration of Quality of Care Surveys (Protocol 6)** – Tufts contracted with an NCQA-certified survey vendor to administer the 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS) to measure member 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 Tufts’ 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 Tufts was compliant with the 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.

Results show that Tufts did not meet its goal of reducing the average monthly member attrition rate from 8% to 6%.

### Validation of Performance Measures

IPRO’s validation of Tufts’ 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 Tufts was compliant with the standards of *Title 42 CFR § 438.330(c)(2)*.

## **Information Systems Capabilities Assessment**

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

### **HEDIS**

Tufts' performance on select HEDIS measures was compared to the performance of other Medicaid managed care plans that reported HEDIS data to NCQA for MY 2019.

The HEDIS Use of Services domain includes three (3) measures related to child and adolescent well-care visits. Rates for two (2) of the three (3) measures ranked below the *Quality Compass 2019* national Medicaid mean. A rate for one (1) of the three (3) measures was not reportable due to a small denominator.

The HEDIS Effectiveness of Care domain includes eight (8) measures related to preventive care and care for chronic conditions. Tufts' rates for five (5) of the six (6) measures met the *Quality Compass 2019* national Medicaid mean. One (1) rate achieved the 2019 national Medicaid 90<sup>th</sup> percentile and one (1) rate met the *Quality Compass 2019* national Medicaid 75<sup>th</sup> percentile. Tufts' rates for four (4) measures benchmarked below the *Quality Compass 2019* national Medicaid 75<sup>th</sup> percentiles.

The HEDIS<sup>®</sup> Access and Availability includes nine (9) measures related to member access to primary care and prenatal care. A rate for one (1) of the eight (8) measures was not reportable due to a small denominator. A rate for one (1) of the eight (8) reported measures performed above the *Quality Compass 2019* national Medicaid mean and benchmarked at the *Quality Compass 2019* national Medicaid 75<sup>th</sup> percentile. Rates for the remaining six (6) measures benchmarked around the 2019 national Medicaid 5<sup>th</sup> percentile.

### **Review of Compliance with Medicaid and CHIP Managed Care Regulations**

I PRO's review of the results of Tufts' 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*. Tufts was compliant with these standards. Detailed results of the MCO's compliance review in **Section IV** of this report.

### **Validation of Network Adequacy**

I PRO's evaluation of Tufts' 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)*, I PRO assessed Tufts' compliance with the State's appointment standards and the MCO's distance standards.

As required by EOHHS, Tufts monitored appointment availability during 2019 using the EOHHS-prescribed secret shopper methodology and reporting template. Surveyed providers for adult behavioral health services reported an available appointment rate of 87.5%. Provider types surveyed for pediatric and adult primary care and specialty services reported appointment rates well below 80% for routine and urgent care. Further, the rates for appointment timelines were low.

Tufts established the standard of each Medicaid member having access to at least two (2) primary care providers with thirty (30) minutes of their residence. Tufts met this standard for 100% of its membership.

## Administration or Validation of Quality of Care Surveys

Tufts conducted the CAHPS® 5.0H survey for adult Medicaid members in 2020. A rate for one (1) of the nine (9) measures exceeded both the *Quality Compass* 2019 national Medicaid mean and the 2019 national Medicaid 95<sup>th</sup> percentile. Rates for the remaining measures ranked below *Quality Compass* 2019 national Medicaid mean.

## Conclusions

IPRO's EQR concludes that, in the 2018-2019 measurement period, Tuft's overall impact on the **quality**, **timeliness** and **accessibility** of health services available to Medicaid beneficiaries was mixed.

Tuft's overall performance in the Use of Services, Effectiveness of Care, and Access and Availability domains indicate that level of care Medicaid members receive under Tuft's is at times average or below average. Additionally, despite Tuft's achievement in meeting network distance standards for its entire Medicaid membership, appointment availability and timely access to care are an opportunity for improvement.

Tuft's members reported being highly satisfied with specialists most seen but highly dissatisfied with the health plan and customer services, the speed at which needed care can be accessed, assigned provider and effectiveness of provider communication, and overall health care received. Further, Tufts was unable to reduce the QIP goal of reducing the average monthly member attrition rate.

Despite number of existing opportunities for improvement, Tufts' performance related to asthma medication management, appointment availability of network behavioral health providers, and follow-up after a hospitalization for mental illness.

## 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 Tufts

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 an MCO 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 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 CMS. Quality, as it pertains to an EQR, is defined in *Title 42 CFR § 438.320 Definitions* as “the degree to which an MCO, PIHP<sup>5</sup>, PAHP<sup>6</sup>, or PCCM<sup>7</sup> 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*, 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 Tufts in 2019. For comparative purposes, results for 2017 and 2018 are also displayed when available and appropriate<sup>8</sup>. The framework for IPRO’s assessment is based on the guidelines and protocols established by CMS, as well as State requirements. Tufts began enrollment for the Medicaid product line in 2018; therefore, data are not available for many aspects of this report. All available data has been included in this report.

### Rhode Island Executive Office of Health and Human Services

#### 2019 State Medicaid Quality Strategy

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

- Ensuring a robust network beyond safety-net providers and inclusive of specialty providers,

---

<sup>5</sup> Prepaid Inpatient Health Plan

<sup>6</sup> Prepaid Ambulatory Health Plan

<sup>7</sup> Primary Care Case Management

<sup>8</sup> It is important to note that Tufts began enrollment in January 2017; therefore, available data for 2016 and 2017 are limited.

- 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 goals<sup>9</sup>:

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**

Rhode Island’s ongoing and expanded interventions for Medicaid 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)**  
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

---

<sup>9</sup> RI Medicaid Accountable Entity Roadmap  
[http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Acc\\_Entities/AERoadmap041117v6.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Acc_Entities/AERoadmap041117v6.pdf)

- 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 1** 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, 2019<sup>10</sup>. 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:

RI Medicaid contracts with three (3) MCOs: Neighborhood Health Plan of Rhode Island (Neighborhood); United Healthcare Community Plan of Rhode Island (UHC-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.

<sup>10</sup> 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.

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

### Tufts Public Health Plan

Tufts is a not-for-profit HMO that served the Medicaid populations. Tufts served the following eligibility groups: Core Rlte Care, Rlte Care for Children with Special Health Care Needs, Rhody Health Partners, and Rhody Health Expansion.

**Table 2** displays Tufts’ Medicaid enrollment for year-end 2017 through year-end end 2019, as well as the percent change in Medicaid enrollment year-to-year. The data presented may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted.

**Table 2: Health Plan Enrollment—2017-2019**

Eligibility Group	2017	2018	2019
Core Rlte Care	1,582	4,281	4,520
Children with Special Health Care Needs <sup>1</sup>	21	52	69
Rhody Health Partners <sup>2</sup>	517	505	566
Rhody Health Expansion <sup>3</sup>	2,325	4,600	3,765
Extended Family Planning (EFP) <sup>4</sup>		34	53
Health Plan Total	<b>4,445</b>	<b>9,472</b>	<b>8,973</b>
Percent Change from Previous Year <sup>5</sup>	-	<b>112%</b>	<b>-5.6%</b>

<sup>1</sup> Children with Special Health Care Needs (CSHCN) were enrolled in Rlte 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 Rlte Care-eligible CSHCN who do not have another primary health insurance coverage. All of the State’s current Medicaid-participating Health Plans serve CSHCN.

<sup>2</sup> Appendix 1 of this report describes the eligibility criteria for Rhody Health Partners.

<sup>3</sup> 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.

<sup>4</sup> The EFP population includes women who lose Medicaid coverage at 60 days postpartum who do not have access to creditable health insurance.

<sup>5</sup> Note that the percent change from 2017 to 2018 is inflated due to the fact that Tufts began enrollment in the Medicaid product line in 2017.

### Tufts 2019 Quality Improvement Program

The State of Rhode Island Executive Office of Health and Human Services requires that contracted Health Plans 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.

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

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

- Monitor, assess, and develop quality improvement activities to assure appropriate access and availability of quality clinical care and services;
- Seamless continuity and coordination of care and transitions of care across the health care continuum; and
- Ensure that policies, procedures, and processes are in place through which clinical quality, access and availability of health care and services, and coordination of care are assured, including, but not limited to, appeals and grievances and utilization management.

The QI Program is structured as follows:

- Tufts Health Plan Board of Directors (BOD): The BOD is the Program’s final policy-making body and has ultimate accountability for the Program’s success. The BOD has established a multi-disciplinary Care Management Committee (CMC), which the BOD continuously oversees through the appointment of a Board member to the CMC, at least annual review of CMC reports, annual review and evaluation of the Program, and approval of the Annual Quality Improvement Workplan and Workplan Evaluation.
- Care Management Committee (CMC): The CMC is responsible for overseeing and monitoring the implementation of the QI Program so that program activities and goals are supported. The CMC is a BOD subcommittee and provides updates to the BOD. CMC members include Directors proposed by the Chairman of the Board or “Lead Director” elected by the Board, including, but not limited to: the Senior Vice President/Chief Medical Officer (CMO), Vice President of Medical Management and Quality, and an Associate General Counsel. The CMC is chaired by a designated Board member, who has the discretion to have additional staff attend CMC meetings as needed. The CMC meets at a minimum of three (3) times per year, and at the discretion of the Committee, and makes at least annual presentations and reports to the Board of Directors.
- Quality Executive Committee (QEC): The QEC is responsible for ensuring quality program activities and goals are consistently implemented and supported, and to function as a cross-division committee where strategic decisions are made which impact the quality program. The QEC provides strategic direction to quality stakeholders, workgroup leaders, and members, and engages in critical discussions, providers input, and makes decisions related to strategy quality initiatives. The QEC is chaired by the Senior Vice President/Chief Medical Officer (CMO), and includes the Vice President of Medical Management and Quality, representatives from all business lines, including, but not limited to, the Presidents and CMOs, and other enterprise senior leaders as requested by the Chair. The QEC meets at least annually and provides relevant updates to the CMC at least annually and as needed.
- Quality of Care Committee (QCC): The QCC is a Board-level medical peer review committee. Program activities conducted by, or at the direction of, the QCC are confidential and privileged medical peer review activities and subject to all confidentiality, privilege, and immunity protections of a medical peer review committee or its equivalent under applicable State law. The QCC is responsible for carrying out Program components which require medical peer review, including, but not limited to: evaluating the quality of care and services provided to members, determining whether health care services were performed in compliance with applicable standards of care, directing corrective measures, reviewing qualifications of participating providers, and taking appropriate disciplinary action against providers who fail to meet standards or legal requirements. The QCC also approves operating policies and procedures relevant to provider credentialing

and case review. The Committee assesses and evaluates performance results and root causes reported for policy decisions and identified actions, and ensures follow-up as appropriate. Membership in the QCC includes the Chair, appointed by the Senior Vice President/CMO or his or her designee; at least one (1) member of the Board of Directors, who may be a physician or not, appointed by the Chair of the Board; three (3) Health Plan physicians, one (1) representing each line of business, unless delegated to an enterprise-level physician; and at least four (4) Health Plan-participating, credentialed, and active physicians representing both primary care and specialty care who are invited to join the Committee by the QCC Chair. The QCC Chair may designate non-voting quality improvement personnel from various departments to attend meetings and provide assistance as needed. Additionally, a non-voting representative of the Office of General Counsel attends QCC to advise on legal risk. When appropriate, the QCC may invite individuals with special expertise for advice and consultation. The QCC meets monthly and an annual report is delivered to the CMC.

- Quality Performance Improvement Team (QPIT): The QPIT focuses on the improvement of the quality of health care and services by developing, implementing, reviewing, and evaluating processes, programs, and measurement activities, including the annual QI Workplan, corporate quality metrics, and NCQA and quality regulation readiness. The QPIT assesses, identifies, and recommends approval of new quality initiatives from workgroups, performs assessment and development for potential new initiatives to define project scope, and facilitates decision-making regarding implementation. The QPIT also performs analysis to prioritize actions through work completed on the QI Workplan Evaluation and carried over to the QI Workplan. Membership includes the Program Director or designee and appropriate Medical Directors, Directors, Managers, and staff representing various departments, including, but not limited to, Health Care Services, Operations, and Marketing. The QPIT meets at a minimum of twice per year, and more frequently with various workgroups, and reports to the CMC annually.
- Utilization Management/Customer Service (UMCS) Committee: The UMCS Committee is the forum used to defined the parameters of the UM Program, evaluate and report results of department audits, and identify corrective action plans when needed. The UMCS Committee reviews, discusses, and approves UM-related policies and procedures, delegation issues, and audit results and facilitates decision-making with all UM-related projects and processes with the goal of monitoring satisfaction measures and identifying opportunities for improvement through customer satisfaction results related to Appeals and Grievances reports, results from CAHPS®, satisfaction with Member Services, provider access, and specialty provider availability. Additionally, the Committee is responsible for the annual review, revision, and approval of the UM Program Plan and Policy Manual, and for implementing operations to comply with regulatory and accreditation requirements and quality improvement initiatives. The Committee is chaired by a representative of the CQI Department, responsible for company-wide UM compliance, and consists of delegated staff within the following departments: Inpatient Management, Behavioral Health, Pre-Certification Operations, Pharmacy Utilization Management, Appeals & Grievances, Medical Affairs, Care Management, Marketing Research, and Medical Policy. Committee meetings are held at a minimum of four (4) times a year and reports are made to the QPIT annually.
- Public Plans Quality Improvement Committee (PPQIC): The PPQIC monitors quality improvement programs required by State and/or Federal contracts and regulatory requirements for Medicaid. The PPQIC maintains compliance with State, Federal, and regulatory compliance pertaining to the quality management and improvement of public plans. Members include the Senior Manager of Quality Programs for Government

Programs and appropriate Medical Directors, Directors, Managers, and staff representing various departments, including, but not limited to, Health Care Services, Operations, and Marketing. The PPQIC meets twice per year, or as determined by the Chair, and reports to the QPIT annually.

- Quality Improvement Work Groups: QI work groups are responsible for developing and conducting Program activities in their respective subject areas, including, but not limited to: establishing appropriate policies and procedures; program and project development and implementation; compliance with regulatory, accrediting, and legal requirements; and evaluation of their work. The QPIT establishes work groups as appropriate to achieve Program objectives, including utilization management, customer satisfaction, credentialing and re-credentialing, and mental health. The PPQIC establishes work groups as appropriate to maintain compliance with State and/or Federal requirements. Work groups meet as needed, and periodically report to the applicable Committee(s).
- Quality Improvement Project Teams: Teams are responsible for the development, implementation, and evaluation of specific, focused programs as directed by the QPIT, PPQIC, work groups, or the Program Director. Teams meet as needed and maintain close consulting relationships with relevant clinical experts and physician-based committees to monitor the impact of these programs on network providers. Project teams are accountable to the applicable Committee(s) or work group(s).
- Delegation Steering Committee: This Committee defines the parameters of the Delegation Program. The Quality and Accreditation Program Manager or designee chairs the Committee. Participants include managers, directors, a designated Medical Director, and program managers with involvement in the Delegation Program and its processes. The ultimate approval for new quality improvement, disease management, medical management, or other delegated arrangements and the responsibility for the oversight and re-evaluation of current delegates lies with this Committee.



### III. EQRO Evaluation Methodology

---

In order to assess the impact of the Tufts' 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 Tufts' results, or findings, from the required EQR activities (validation of PIPs, validation of performance measures, and review of compliance with Medicaid standards) and one optional EQR activity; while Section VII discuss Tufts' 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.<sup>11</sup>
- 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 Tufts by EOHHS for follow up, as well as a brief description of Tufts' progress related to the *Tufts Public Health Plan Annual External Quality Review Technical Report, Reporting Year 2018*.

---

<sup>11</sup>Institute 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 programs<sup>12</sup>.

### 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.
- 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.

---

<sup>12</sup> 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.

- 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

Tufts conducted the following QIPs in 2019:

- QIP 1 – *Timely and Accurate Reporting*
- QIP 2 – *Member Experience and Retention*

IPRO’s assessment of Tufts methodology found that there were no validation findings that indicated that the credibility of the QIP 2 results was at risk. However, IPRO’s assessment of QIP 1 determined that Tufts did not conduct the QIP using the appropriate framework. **Table 3** displays a summary of Tufts QIP assessments. Summaries of each QIP immediately follow.

**Table 3: Tufts 2019 QIP Validation Findings**

Validation Element	QIP 1	QIP 2
<b>Selected Topic</b>	Not Met	Met
<b>Study Question</b>	Not Met	Met
<b>Indicators</b>	Not Met	Met
<b>Population</b>	Not Applicable	Met
<b>Sampling Methods</b>	Not Applicable	Met
<b>Data collection Procedures</b>	Not Met	Met
<b>Interpretation of Study Results</b>	Not Met	Met
<b>Improvement Strategies</b>	Met	Met

### QIP #1: Timely and Accurate Reporting

Aim: Tufts aimed to streamline and improve internal reporting processes to prevent submissions errors and delays.

Indicator(s)/Goals: The performance indicators are correct file name accuracy, correct template accuracy and submission on time. The goal was to achieve 100% for all three (3) indicators.

#### MCO-focused Intervention(s):

- Revised and issued a reporting process job aid to enterprise stakeholders to improve understanding of RI Together deliverable workflow and expectations.
- Developed resource materials for directors responsible for RI Together deliverables oversight.
- Established a connection’s page to store instructions, resource materials, RI submission templates and guides so there’s one source of up to date documents for enterprise stakeholders

Results: Tufts did not submit sufficient data to allow IPRO to evaluate the overall conduct of the QIP or the progress towards demonstrating improvement.

## **QIP #2: Member Experience and Retention**

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

Indicator(s)/Goals: The performance indicator and goal are improvement of the monthly member attrition rate by two (2) percentage points from the baseline rate of 8% to 6%. (A lower rate is desired.)

### Member - Focused Intervention(s):

- Conducted member focus groups in order to understand barriers to market entry and membership retention.
- Conducted new member onboarding using ConsejoSano for multichannel, multilingual outreach for members new to THP including revision of welcome kit materials to address the auto assignment process and misconceptions about plan benefits compared to competitors and promote value-add programs and incentives offered by THP as well as improving welcome outreach call to strengthen relationship with new members to RI.

### Provider - Focused Intervention(s):

- Collaborated with Accountable Entity (AE) program provider partners to educate front-line staff about THP and support potential transition of members.
- Continued to expand the provider network to increase perceived incentives for selecting Tufts Health RITogether as their Medicaid program.

### Health Plan-Focused Intervention(s):

- Launched an awareness and acquisition campaign for marketing and outreach, localized based on RI Medicaid geographic concentration, anchored in key communities and culturally and linguistically tailored including corporate brand campaign, THP Medicaid-specific marketing campaign and community engagement campaign.
- HealthSource RI Support: to Work with HSRI staff and navigators to increase awareness of THP and better assist members during selection process

Results: Tufts reported a year-to-date monthly average attrition rate of 6.58%, which was higher than the desired goal of 6%. (A lower rate is desired.) **Table 4** displays the results of the QIP including measurement periods and overall project goal.

**Table 4: QIP 2 – Member Experience and Retention**

<b>Time Period Measurement Covers</b>	<b>Measurement</b>	<b>Results</b>	<b>Goal</b>
<b>January 2019</b>	Baseline	8%	Not Applicable
<b>February 2019</b>	Re-measurement 1	5%	6%
<b>March 2019</b>	Re-measurement 2	7%	6%
<b>April 2019</b>	Re-measurement 3	7%	6%
<b>May 2019</b>	Re-measurement 4	5%	6%
<b>June 2019</b>	Re-measurement 5	5%	6%
<b>July 2019</b>	Re-measurement 6	5%	6%
<b>August 2019</b>	Re-measurement 7	7%	6%
<b>September 2019</b>	Re-measurement 8	5%	6%
<b>October 2019</b>	Re-measurement 9	11%	6%
<b>November 2019</b>	Re-measurement 10	9%	6%
<b>December 2019</b>	Re-measurement 11	5%	6%

## V. Validation of Performance Measures

---

This subpart of the report presents the results of the evaluation of Tuft's 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.

Tufts 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 Tufts met all of the requirements to successfully report HEDIS data to EOHS and to NCQA. **Table 5** displays the results of the IS audit.

**Table 5: Tufts 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.

Tufts’ 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 2019<sup>13</sup>.

### **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.

This section of the report explores the utilization of Tufts' 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.

---

<sup>13</sup> 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, 10<sup>th</sup> percentile, 25<sup>th</sup> percentile, 33<sup>rd</sup> percentile, 50<sup>th</sup> percentile, 66<sup>th</sup> percentile, 75<sup>th</sup> percentile, 90<sup>th</sup> percentile, and 95<sup>th</sup> 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.



- 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 Measures<sup>14</sup>

Tufts' rates for the three (3) measures reported did not meet the *Quality Compass* 2019 national Medicaid mean. Additionally, the rate for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* had too small a denominator to be reported. The rates for both *Adolescent Well-Care Visits* and the *Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, & 6<sup>th</sup> Years of Life* measure benchmarked at or below the 5<sup>th</sup> percentile. **Table 6** displays Tufts' rates for these measures, as well as the national Medicaid benchmarks achieved by the MCO.

**Table 6: HEDIS® Use of Services Rates—2019**

Use of Services Measures	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)	Small Sample	Not Applicable	62.8%
Well-Child Visits in the 3 <sup>rd</sup> , 4 <sup>th</sup> , 5 <sup>th</sup> , & 6 <sup>th</sup> Years of Life	48.1%	< 5 <sup>th</sup>	72.1%
Adolescent Well-Care Visits	34.5%	5 <sup>th</sup>	53.2%

### HEDIS® Effectiveness of Care Measures

Tufts' rates for five (5) of the six (6) reported measures met the *Quality Compass* 2019 national Medicaid mean. Tufts performed well in regard to asthma medication management and behavioral health follow-ups. The MCO demonstrates an opportunity for improvement concerning women's health.

The *Medication Management for People with Asthma 75% (5-64 Years)* measure benchmarked in the 95<sup>th</sup> percentile for 2019, while the *Follow-Up After Hospitalization for Mental Illness—7 Days* measure benchmarked at the 75<sup>th</sup> percentile. *Cervical Cancer Screening for Women*, *Chlamydia Screening for Women*, *Comprehensive Diabetes Care—HbA1c Testing*, and *Follow-Up After Hospitalization for Mental Illness—30 Days* benchmarked below the 2019 *Quality Compass*® 75<sup>th</sup> percentile. The MCO's rate for *Cervical Cancer Screening for Women* benchmarked below the 5<sup>th</sup> percentile.

Denominators, or sample sizes, for *Childhood Immunization Status—Combination 3* and *Childhood Immunization Status—Combination 10* were less than thirty (30), and therefore rates for these measures are not suited for public reporting.

**Table 7** displays select HEDIS Effectiveness of Care measure rates for measurement year 2019 compared to the NCQA 2019 *Quality Compass* national Medicaid benchmarks.

<sup>14</sup> The rates for HEDIS® Use of Services measures include all Medicaid members, where eligible population criteria were met.

**Table 7: HEDIS® Effectiveness of Care Rates—2019**

Effectiveness of Care Measures	HEDIS 2019	Quality Compass® 2019 National Medicaid Benchmark	Quality Compass® 2019 National Medicaid Mean
Medication Management for People with Asthma 75% (5-64 Years)	58.3%	95 <sup>th</sup>	37.8%
Cervical Cancer Screening for Women	40.2%	< 5 <sup>th</sup>	59.3%
Chlamydia Screening for Women (16-24 Years)	58.7%	50 <sup>th</sup>	58.1%
Childhood Immunization Status—Combination 3	Small Sample	Small Sample	68.1%
Childhood Immunization Status—Combination 10	Small Sample	Small Sample	35.2%
Comprehensive Diabetes Care—HbA1c Testing	89.8%	66.67 <sup>th</sup>	87.8%
Follow-Up After Hospitalization for Mental Illness—30 Days	64.9%	66.67 <sup>th</sup>	56.8%
Follow-Up After Hospitalization for Mental Illness—7 Days	44.8%	75 <sup>th</sup>	35.8%

**HEDIS® Access and Availability Measures**

Tufts' performance in this domain varied. A rate for one (1) of the eight (8) reported measures exceeded the 2019 *Quality Compass*® national Medicaid mean. While Tufts' *Postpartum Care* rate ranked above the 75<sup>th</sup> percentile, the MCO's rate for *Timeliness of Prenatal Care* benchmarked at the 25<sup>th</sup> percentile. All reported rates for child, adolescent and adult access to care measures were at or below the 5<sup>th</sup> percentile demonstrating opportunities for improvement concerning access to care.

Denominators, or sample sizes, for *Adults' Access to Preventive/Ambulatory Health Services – 65+ years* was less than thirty (30), and therefore the rate for this measure is not suited for public reporting.

**Table 8** displays Tufts' Access and Availability rates for MY 2019 compared to the *Quality Compass* 2019 national Medicaid benchmarks.

**Table 8: HEDIS® Access and Availability Rates—2019**

Access and Availability Measures	HEDIS® 2019	Quality Compass® 2019 National Medicaid Benchmark	Quality Compass® 2019 National Medicaid Mean
<b>Children and Adolescents' Access to Primary Care Practitioners</b>			
12-24 Months	86.7%	<5 <sup>th</sup>	94.8%
25 Months – 6 Years	70.8%	<5 <sup>th</sup>	86.3%
7-11 Years	72.1%	<5 <sup>th</sup>	90.0%
12-19 Years	74.5%	<5 <sup>th</sup>	88.8%
<b>Adults' Access to Preventive/Ambulatory Health Services</b>			
20-44 Years	60.2%	5 <sup>th</sup>	76.5%
45-64 Years	70.8%	<5 <sup>th</sup>	84.8%
65+ Years	Small Sample	Not Applicable	Not Applicable
<b>Timeliness of Prenatal Care</b>	79.7%	25 <sup>th</sup>	81.5%
<b>Postpartum Care</b>	70.3%	75 <sup>th</sup>	63.6%

### Rhode Island Performance Goal Program <sup>15</sup>

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.

<sup>15</sup> The rates for all PGP measures include all Medicaid members, where eligible population criteria were met.

**Description of Data Obtained.**

I PRO 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**

Tufts was not included in the Performance Goal Program for 2019 due to small membership.

## 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.

IPRO received the approved crosswalk and the results of the NCQA Accreditation Survey from EOHHS for each MCO. IPRO 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 IPRO EOHHS included instructions on how to use the crosswalk, a glossary, and detailed explanations on how the NCQA accreditation standards support federal Medicaid standards.

Tufts' accreditation was granted by NCQA on April 29, 2020. **Table 9** displays the results of Tufts' most recent NCQA Accreditation survey. It was determined that Tufts was fully compliant with the standards *Title 42 CFR Part 438 Subpart D* and *Subpart E 438.330*.

**Table 9: Evaluation 42 CFR Part 438 Subpart D and QAPI Standards**

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

## VII. Validation of Network Adequacy

---

This section of the report presents the results of the evaluation of Tufts' 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*.

MCOs 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 had "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 *Medicaid Managed Care Services 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 Medicaid Managed Care Services Contract*, July 2019, 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 MCO, based on MCO-specific criteria. The *State's Medicaid Managed Care Contract* also has 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.

## Technical Methods of Data Collection and Analysis

IPRO’s evaluation was performed using network data submitted by Tufts in the *RI Together Network Access Analysis Report* (printed December 10, 2019) and in the Tufts’ *Access Survey Report* for the October-December 2019 timeframe. IPRO’s evaluation included a comparison of Tufts access data to the MCO-determined time and distance standards and a comparison of Tufts’ appointment availability rates to the State’s appointment standards. For Tufts, the access standard for all provider types was two (2) providers within twenty (20) miles. Appointment timeliness standards included in the State’s *Medicaid Managed Care Contract* are displayed in **Table 10**.

**Table 10: 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

## Description of Data

Tufts monitors its provider network for accessibility and network adequacy using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance from their homes.

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

## Findings

Tufts met primary care access standards for one hundred percent (100%) of its Medicaid membership. **Table 11** displays the provider types for which Tufts met its geographic access standards across the state.

**Table 11: GeoAccess Provider Network Accessibility**

Provider Type	Access Standard <sup>1</sup>	% of Members
Pediatric PCPs	2 within 30 minutes	100%
Internal Medicine PCPs	2 within 30 minutes	100%
Family Medicine PCPs	2 within 30 minutes	100%

<sup>1</sup> The Access Standard is measured in travel time from member’s homes to provider offices.

Note: Data presented in this table covers the period of October-December 2019.



**Table 12** displays the results of the Tufts’ 2019 Access and Availability Survey conducted for Tufts. Timeliness and availability of both routine and urgent care appointments was assessed.

**Table 12: Access and Availability Survey Results—2019**

Provider Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made <sup>1</sup>	Mean Number of Days to Appointment
Family/General Practice—Routine	32	12	37.5%	25.0%	29
Family/General Practice—Urgent	34	12	35.3%	8.8%	20
Pediatricians—Routine	11	2	18.2%	0.0%	61
Pediatricians—Urgent	10	1	10.0%	10.00%	
Cardiology—Routine	6	3	50.0%	33.33%	51
Cardiology—Urgent	8	2	25.0%	0.0%	16
Dermatology—Routine	3	2	66.7%	66.7%	18
Dermatology—Urgent	3	2	66.7%	0.0%	121
Endocrinology—Routine	1	0	0.0%	-	-
Gastroenterology—Routine	3	1	33.3%	0.0%	72
Gastroenterology—Urgent	6	1	16.7%	0.0%	3
Pulmonary—Routine	1	0	0.0%	-	-
Pulmonary—Urgent	3	1	33.3%	0.0%	8
Pediatric Allergy—Routine	2	1	50.0%	50.0%	2
Pediatric Allergy—Urgent	2	0	0.0%	-	-
Pediatric Gastroenterology—Routine	1	0	0.0%	-	-
Pediatric Neurology—Urgent	1	0	0.0%	-	-
Pediatric Orthopedics—Routine	4	2	50.0%	50.0%	13
Pediatric Orthopedics—Urgent	5	2	40.0%	20.00%	1
Pediatric Otolaryngology—Urgent	1	0	0.0%	-	-
Adult Behavioral Health—Routine	16	14	87.50%	75.00%	21

## VIII. Validation or Administration of a 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.

Tufts contracted with Symphony Performance Health, Inc. (SPH), an NCQA-certified survey vendor to administer the 2019 Consumer Assessment of Healthcare Providers and Systems (CAHPS).

### Technical Methods of Data Collection and Analysis

SPH administered 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 a mail and phone methodology.

The survey sample size was 2,700. Tufts achieved a response rate of 5.3%, or 144 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

I PRO received a copy of the final CAHPS report produced by SPH and utilized the results to assess Tufts' performance compared to the national Medicaid benchmarks.

## Findings

### Member Satisfaction: Adult Medicaid CAHPS 5.0H<sup>16</sup>

Tufts' 2019 rates are also compared to the *Quality Compass* 2019 national Medicaid benchmarks. In 2019, the **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H** survey was conducted on behalf of Tufts by the NCQA-certified survey vendor SPH Analytics, Inc. for the adult population. **Table 13** shows Tufts' rates for the satisfaction measures and composite scores for 2019 for the adult survey. The Health Plan's 2019 rates are also compared to the *Quality Compass*® national Medicaid benchmarks. In 2014, the NCQA introduced the *Flu Vaccinations for Adults (18-64 Years)* measure to the adult CAHPS® 5.0H survey.

Rates for one (1) of the nine (9) CAHPS measures were reported as exceeding the 2019 *Quality Compass*® national Medicaid mean. Rates for the *Rating of Specialist* measure benchmarked at the 2019 *Quality Compass*® 95<sup>th</sup> percentile. The remaining eight (8) measures fell below the 75<sup>th</sup> percentile, thereby not qualifying for an incentive award for the year 2019.

**Table 13: Adult CAHPS® 5.0H Rates—2019**

Measures	CAHPS 2019	Quality Compass® 2019 National Medicaid Benchmark	Quality Compass® 2019 National Medicaid Mean
<b>Flu Vaccinations for Adults (18-64 Years)</b>	35.2%	10 <sup>th</sup>	41.8%
<b>Rating of Health Plan<sup>1</sup></b>	61.3%	<5 <sup>th</sup>	77.6%
<b>Customer Service<sup>2</sup></b>	85.1%	10 <sup>th</sup>	88.8%
<b>Getting Care Quickly<sup>2</sup></b>	81.9%	33.33 <sup>rd</sup>	82.0%
<b>Getting Needed Care<sup>2</sup></b>	78.6%	10 <sup>th</sup>	82.5%
<b>How Well Doctors Communicate<sup>2</sup></b>	91.2%	33.33 <sup>rd</sup>	92.0%
<b>Rating of All Health Care<sup>1</sup></b>	65.1%	<5 <sup>th</sup>	75.4%
<b>Rating of Personal Doctor<sup>1</sup></b>	78.8%	10 <sup>th</sup>	82.1%
<b>Rating of Specialist<sup>1</sup></b>	88.1%	95 <sup>th</sup>	82.3%

<sup>1</sup> "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".

<sup>2</sup> These indicators are composite measures.

<sup>3</sup> 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.

<sup>16</sup> The rates for CAHPS® measures included 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 population was included in the child CAHPS® sample.

## IX. Strengths, Opportunities and Recommendations

---

IPRO's external quality review concludes that, in the measurement year 2019, Tufts program has had a positive impact on the quality of services provided to Medicaid recipients, which is supported by the performance rates in the HEDIS® Effectiveness of Care Measures. Tufts also demonstrates an opportunity for improvement in regards to members accessing preventative care services.

### Strengths

Concerning **quality** and **member satisfaction**, Tufts demonstrated the following strengths:

- Tufts' rate for five (5) of six (6) measures in the HEDIS® Effectiveness of Care domain was above the *Quality Compass* 2019 national Medicaid average.
- Tufts achieved a satisfaction score for *Rating of Specialist* that benchmarked at the *Quality Compass* 2019 national Medicaid 95<sup>th</sup> percentile.

Concerning **quality**, **timeliness**, and **access**, Tufts demonstrated the following strengths:

- Tufts' rate for the *Postpartum Care* measure exceeded the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile.
- Tufts exceeded established distance standards with one hundred percent (100%) of its Medicaid members having adequate access to primary care providers.

### Opportunities for Improvement

Concerning **quality**, Tufts demonstrates the following opportunities for improvement:

- Although Tufts' QIP regarding member experience and retention demonstrated an improvement of the monthly member attrition rate from the baseline rate of 8% to 6.8%, Tufts did not achieve the QIP goal of 6%.
- Tufts' rates for two (2) of three (3) HEDIS® Use of Services measures and rates for two (2) of six (6) HEDIS® Effectiveness of Care measures did not achieve *Quality Compass* 2019 national Medicaid average.

Concerning **timeliness** and **access**, Tufts demonstrates the following opportunity for improvement:

- Tufts' rates for child/adolescent access to primary care, adult access to ambulatory care, and prenatal care performed below *Quality Compass* 2019 national Medicaid 5<sup>th</sup> percentile.

Concerning member satisfaction with **quality**, **timeliness**, **access** and **member satisfaction**, Tufts demonstrates the following opportunity for improvement:

- Tufts' scores for seven (7) of eight (8) satisfaction measures benchmarking at or below the *Quality Compass* 2019 national Medicaid 33.33<sup>rd</sup> percentile coupled with a high average monthly member attrition rate suggest that members are highly dissatisfied with the Tufts Medicaid managed care program.

## Recommendations

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

## X. 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 addressed effectively the recommendations for QI made by the EQRO during the previous year’s EQR.”

As Tufts began enrollment for its Medicaid product line in 2017, data were not available for many of the elements included in the annual 2018 EQR Technical Report. Therefore, there were no recommendations made for Tufts to address from the 2018 EQR Technical Report.

## XI. REFERENCES

---

### Introduction

- Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Federal Register, Part II, CFR Parts 433 and 438, Medicaid Program, External Quality Review of Medicaid Managed Care Organizations, Final Rule*, §438.320.
- Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Rhode Island Global Consumer Choice Compact Section 1115 Demonstration (Project No. 11-W-00242/1) Special Terms and Conditions*, December 2018.
- Rhode Island Executive Office of Health and Human Services, *Code of Rules, Medical Assistance, §0300 Medical Assistance Program Overview, §0348 Rite Care Program, §0374 Managed Care Program Options for Adults*, available at: <http://www.ohhs.ri.gov/documents/documents13/0300.pdf>; <http://www.ohhs.ri.gov/documents/documents13/0348.pdf>; [http://www.ohhs.ri.gov/documents/documents12/0374\\_CoC.pdf](http://www.ohhs.ri.gov/documents/documents12/0374_CoC.pdf) (accessed May 22, 2019).
- Rhode Island Executive Office of Health and Human Services, *Medicaid Managed Care Services Contract*, July 2018.
- Rhode Island Department of Human Services, *Rhode Island's Strategy for Quality Assurance and Performance Improvement*, April 2005.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island Strategy for Assessing and Improving the Quality of Managed Care Services*, October 2012.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island Comprehensive Quality Strategy*, December 2014.

### Corporate Profile

- Tufts Enrollment as of December 31, 2018, provided by RI EOHHS October 10, 2019.

### Accreditation Summary and Health Plan Rating

- NCQA, *Health Insurance Plan Ratings 2018-2019, Methodology Overview*, July 2018, available at: [www.ncqa.org](http://www.ncqa.org) (accessed May 22, 2019).
- Rhode Island Executive Office of Health and Human Services, *Medicaid Managed Care Services Contract*, July 2018.
- Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Federal Register, Part II, CFR Parts 433 and 438, Medicaid Program, External Quality Review of Medicaid Managed Care Organizations, Final Rule*, §438.360.

### Enrollment and Provider Network

- Tufts Enrollment as of December 31, 2018, provided by RI EOHHS May 23, 2019.
- Rhode Island Executive Office of Health and Human Services, *Medicaid Managed Care Services Contract*, July 2018.

### Utilization

*No references available.*

### HEDIS® and CAHPS® Performance Measures

*No references available.*

## Rhode Island Medicaid Managed Care Performance Goal Program

*No references available.*

## Quality Improvement Program

- Tufts Health Plan, *Tufts Health Plan Quality Improvement Program Description 2018*.
- Rhode Island Executive Office of Health and Human Services, *Medicaid Managed Care Services Contract*, July 2018.

## Findings and Recommendations

- Rhode Island Executive Office of Health and Human Services, *Medicaid Managed Care Services Contract*, July 2018.



# APPENDIX 1: RHODE ISLAND MEDICAID MANAGED CARE 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).<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> 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).<sup>4</sup>

**Section 1.3 History of Medicaid Managed Care Programs**

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

Table 1 Rhode Island Medicaid Managed Care Program Additions

Year	Managed Care Program Additions
1994	<ul style="list-style-type: none"> <li>• Rite Care</li> <li>• SCHIP</li> </ul>
2000	<ul style="list-style-type: none"> <li>▪ Children in Substitute Care</li> <li>▪ Rite Share</li> </ul>
2003	<ul style="list-style-type: none"> <li>• Children with Special Needs</li> <li>• Rite Smiles</li> </ul>
2008	a. Rhody Health Partners
2014	<ol style="list-style-type: none"> <li>1. Medicaid Expansion</li> <li>2. Behavioral Health carved in to managed care</li> </ol>
2015	1. 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;<sup>5</sup> 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
<b>Grand Total MCO Members</b>	<b>264,841</b>	
<b>Dental PAHP Members</b> 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 Annual EQR Technical Report 2019—Tufts Public Health Plan

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:<sup>6</sup>

- 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.

<b>Table 3: Managed Care Quality Strategy Goals</b>	
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<sup>®7</sup> 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)<sup>8</sup> 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**.

<b>Table 3: Managed Care Quality Objectives</b>	<b>Aligned with Goal</b>
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

### 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 not 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 (NQL) 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.<sup>9</sup> 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<sup>®</sup>. Historically, the MCO PGP has provided financial incentives to the health plans for performing in the 90<sup>th</sup> and 75<sup>th</sup> 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 438.352 Activities- 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.”<sup>10</sup> 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:

<b>TABLE 4: MCO ACCESS TO CARE STANDARDS</b>	
<b>Provider Type</b>	<b>Time and Distance Standard</b> <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
<b>Outpatient behavioral health-mental health</b>	
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.
<b>Outpatient behavioral health-substance use</b>	
Prescribers	Thirty (30) minutes or thirty (30) miles from the member’s home.

<b>TABLE 4: MCO ACCESS TO CARE STANDARDS</b>	
<b>Provider Type</b>	<b>Time and Distance Standard</b> <i>Provider office is located within the lesser of</i>
Non-prescribers	Twenty (20) minutes or twenty (20) miles from the member's home.
<b>Specialist</b>	
The Contractor to identify top five adult specialties by volume	Thirty (30) minutes or thirty (30) miles from the member's home.
The Contractor to identify top five pediatric specialties by volume	Forty-five (45) minutes or forty-five (45) miles from the member's home.
Hospital	Forty-five (45) minutes or thirty (30) miles from the member's home
Pharmacy	Ten (10) minutes or ten (10) miles from the member's home
Imaging	Forty-five (45) minutes or thirty (30) miles from the member's home
Ambulatory Surgery Centers	Forty-five (45) minutes or thirty (30) miles from the member's home
Dialysis	Thirty (30) minutes or thirty (30) miles from the member's home.

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

<b>Table 5: MCO Timeliness of Care Standards</b>	
<b>Appointment</b>	<b>Access Standard</b>
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 and are specific to members who are dually eligible for Medicare and Medicaid and enrolled in this managed care plan. Network requirements, including network adequacy and availability of services under the State's MMP contract are similar to those for managed medical and behavioral health care but also take into account Medicare managed care standards and related federal requirements for plans serving dual-eligibles. Although methods and tools may vary, each long-term service and supports (LTSS) delivery model is expected to ensure that, for example:

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 Annual EQR Technical Report 2019—Tufts Public Health Plan

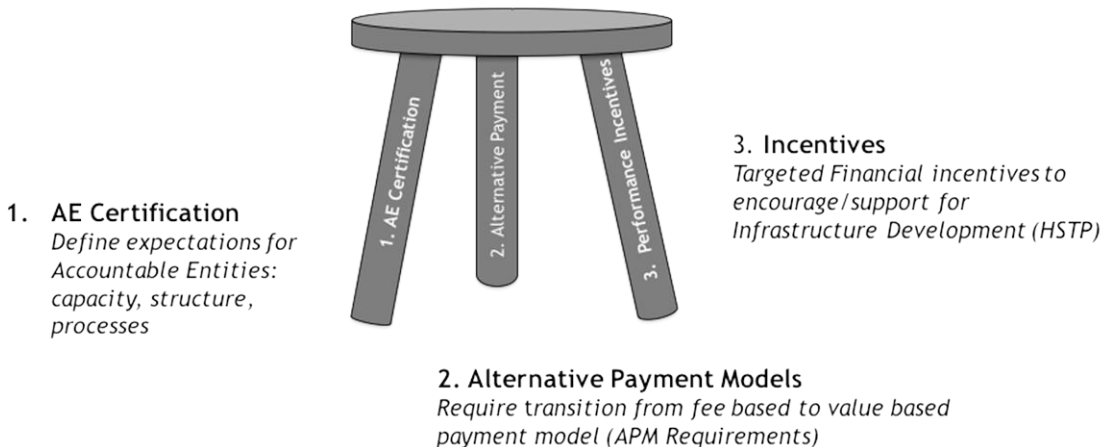
Department of Health manages several key HIT initiatives to support data-focused public health and the EHR Incentive Program. These include:

- 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 EOHS

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

**Section 8: Conclusions and Opportunities**

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

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

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

## 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:				
<b>C. Baseline Methodology.</b>				
<b>C.1 Data Sources.</b>				
<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) <input type="checkbox"/> Other (list and describe):  The Plan also uses a local access database to track all pregnant members as part of our Healthy First Steps Program. Although this database was not used as an administrative database from NCOA perspective, it was used by local Plan team members to identify and outreach to pregnant members. In addition, we used this database to track number of members who participated in our Diaper Reward Program.				
<b>C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.</b>				
If medical/treatment records, check below: <input type="checkbox"/> Medical/treatment record abstraction  If survey, check all that apply: <input type="checkbox"/> Personal interview <input type="checkbox"/> Mail <input type="checkbox"/> Phone with CATI script <input type="checkbox"/> Phone with IVR <input type="checkbox"/> Internet <input type="checkbox"/> Incentive provided <input type="checkbox"/> Other (list and describe):  <hr/>	If administrative, check all that apply: <input type="checkbox"/> Programmed pull from claims/encounter files of all eligible members <input type="checkbox"/> Programmed pull from claims/encounter files of a sample of members <input type="checkbox"/> Complaint/appeal data by reason codes <input type="checkbox"/> Pharmacy data <input type="checkbox"/> Delegated entity data <input type="checkbox"/> Vendor file <input type="checkbox"/> Automated response time file from call center <input type="checkbox"/> Appointment/access data <input type="checkbox"/> Other (list and describe):  <hr/>			
<b>C.3 Sampling. If sampling was used, provide the following information.</b>				
Measure	Sample Size	Population	Method for Determining Size ( <i>describe</i> )	Sampling Method ( <i>describe</i> )

<b>C.4 Data Collection Cycle.</b>			<b>Data Analysis Cycle.</b>	
<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/>	
<b>C.5 Other Pertinent Methodological Features.</b> Complete only if needed.				
<b>D. Changes to Baseline Methodology.</b> Describe any changes in methodology from measurement to measurement.				
Include, as appropriate: <ul style="list-style-type: none"> <li>▪ Measure and time period covered</li> <li>I. Type of change</li> <li>II. Rationale for change</li> <li>III. Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method</li> <li>IV. Any introduction of bias that could affect the results</li> </ul>				

**Section II: Data/Results Table**  
 Complete for each quantifiable measure; add additional sections as needed.

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

--