



# **Rhode Island Medicaid Managed Care Program UnitedHealthcare Community Plan of Rhode Island (UHCP-RI)**

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

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

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# I. Executive Summary

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## 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 UnitedHealthcare Community Plan of Rhode Island (UCHP-RI) under Rite Care, a Rhode Island Medicaid managed care program.

UnitedHealthcare Community Plan of Rhode Island is a for-profit Health Plan that serves Medicaid, Medicare, and Commercial populations.

## Rhode Island Medicaid Managed Care Program

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

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<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) **CMS Optional Protocol 6. Administration or Validation of Quality of Care Surveys** – UHCP-RI contracted with SPH Analytics (SPH), a National Committee for Quality Assurance (NCQA) certified HEDIS Survey Vendor to administer the 2020 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the adult and child Medicaid populations to measure consumer satisfaction.

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

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

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

## Findings

### Validation of Quality Improvement Projects

IPRO’s validation of UHCP-RI’s 2019 QIPs confirmed the State’s compliance with the standards of *Title 42 CFR § 438.330(a)(1)*. The results of the validation activity determined that UHCP-RI was compliant with the standards of *Title 42 CFR § 438.330(d)(2)* for three (3) of four (4) QIPs. QIP summaries and detailed validation results are in **Section IV** of this report.

UCHP-RI did not demonstrate improvement in three (3) of the four (4) QIPs. Improvement could not be evaluated as the re-measurement rate for 2019 was not included in the QIA form.

### **Validation of Performance Measures**

IPRO's validation of UHCP-RI's performance measures confirmed the State's compliance with the standards of *Title 42 CFR § 438.330(a)(1)*. The results of the validation activity determined that UHCP-RI 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 UHCP-RI met all of the requirements to successfully report HEDIS data to EOHHS and to NCQA.

### **HEDIS**

UHCP-RI's 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. UHCP-RI's rate for each of these three (3) measures exceeded the *Quality Compass* 2019 national Medicaid mean. Additionally, all rates benchmarked at the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile.

The HEDIS Effectiveness of Care domain includes eight (8) measures related to preventive care and care for chronic conditions. UHCP-RI's rate for each of these eight measures exceeded the *Quality Compass* 2019 national Medicaid mean. Rates for four (4) measures achieved the *Quality Compass* national Medicaid 75<sup>th</sup> percentile and three (3) rates benchmarked at the *Quality Compass* 2019 national Medicaid 90<sup>th</sup> percentile.

The HEDIS Access and Availability includes nine (9) measures related to member access to primary care and prenatal care. UHCP-RI's rate for eight (8) of these measures met the *Quality Compass* 2019 national Medicaid mean, while the rate for two (2) measures benchmarked at the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile. Rates for the remaining measures benchmarked below the 2019 national Medicaid 75<sup>th</sup> percentile.

### **Performance Goal Program**

The 2019 Performance Goal Program includes twenty (20) measures, of which nineteen (19) derive from HEDIS and one (1) is State-specific. These measures are categorized into the following domains of care: utilization, access to care, prevention and screening, women's health, chronic care and behavioral health. MCOs qualify for an incentive, full or partial, for a performance rate that meets the *Quality Compass* 2018 national Medicaid 75<sup>th</sup> percentile or the 90<sup>th</sup> percentile, respectively. A rate that does not meet the national Medicaid 75<sup>th</sup> does not qualify the MCO for an incentive.

UHCP-RI's rate for the State-specific measure, *HIV Viral Load Suppression*, qualified the MCO for a partial incentive award. UHCP-RI performance on twelve (12) of the nineteen (19) HEDIS measures qualified the MCO for an incentive. UCHP rates for *Childhood Immunization Status–Combination 10*, *Adolescent Immunizations–Combination 2*, and *Controlling High Blood Pressure (18-85 Years)* each achieved the *Quality Compass* 2018 national Medicaid 90<sup>th</sup> percentile, qualifying the MCO for full incentives. Rates for the following nine (9) measures achieved the *Quality Compass* 2018 national Medicaid 75<sup>th</sup> percentile, qualifying UHCP-RI for partial incentives: *Adolescent Well-Care Visits*; *Postpartum Care*; *Engagement of Alcohol and Other Drug Dependence Treatment*; *Chlamydia Screening in Women (16-20 Years)* *Comprehensive Diabetes Care–HbA1c Control (<8.0%)*; *Follow-up After Hospitalization for Mental Illness–7 Days*; *Follow-up Care for Children Prescribed ADHD*

*Medication–Initiation Phase; Follow-up after Emergency Department Visits for Alcohol and Other Drug Dependence; and Adherences to Antipsychotic Medications for Individuals with Schizophrenia.*

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

IPRO's review of the results of UHCP-RI's most recent accreditation review confirmed the State's compliance with evaluating MCO adherence to the standards in *Title 42 CFR Part 438 Subpart D* and *Title 42 CFR § 438.330*. The review also confirmed that UHCP-RI is compliant with these standards. Detailed results of the MCO's compliance review in **Section IV** of this report.

### **Validation of Network Adequacy**

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

As required by EOHHS, UHCP-RI monitored appointment availability during 2019 using the EOHHS-prescribed secret shopper methodology and reporting template. Surveyed providers across thirteen (13) specialties reported appointment rates below 80% for routine and urgent care. Further, all appointments were untimely when compared to the State's appointment standards.

UHCP-RI established and exceeded the goal of ninety percent (90%) of its' Medicaid membership having access to primary care providers, high-volume specialists (HVS) and high-impact specialists (HIS), and dermatologists within the established distance standards. UHCP-RI also established and exceeded provider-to-member ratio standards for PCPs and HVS/HIS specialists.

Lastly, UHCP-RI earned an "Excellent" rating for two (2) domains of the NCQA Accreditation Survey that include evaluations of provider network and access to care.

### **Administration or Validation of Quality of Care Surveys**

UHCP-RI conducted the CAHPS 5.0H Medicaid survey for the adult and child membership in 2020.

Rates for all nine (9) adult satisfaction measures exceeded the *Quality Compass* 2019 national Medicaid mean. Additionally, five (5) measures achieved the *Quality Compass* 2019 national Medicaid 90<sup>th</sup> percentile and three (3) rates benchmarked at or above the 2019 national Medicaid 75<sup>th</sup> percentile. A rate for one (1) measure ranked below the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile for 2019.

Rates for all eight (8) child satisfaction measures met the *Quality Compass* 2019 national Medicaid mean. Rates for (6) measures achieved the *Quality Compass* 2019 national Medicaid 90<sup>th</sup> percentile. Rates for two (2) measures ranked below the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile.

## **Conclusion**

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

UHCP-RI continued to earn the "Excellent" NCQA Accreditation status for its' Medicaid product line and four point five (4.5) out of five (5) for its 2019 "Overall Rating." Additionally, UHCP-RI continued to demonstrate above average performance (rates benchmarking at or above the national Medicaid 75<sup>th</sup> percentiles) for many of

the quality of care and access to care HEDIS and PGP measures included in this report. Further, UHCP-RI members continue to be highly satisfied with the experience of receiving care under UHCP-RI.

Despite continued strong performance in some areas, a number of opportunities for improvement persist.

## Recommendations

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

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

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

IPRO recommends the following to EOHHS:

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

### Recommendations to UHCP-RI

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

## II. Background

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### 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 UHCP-RI in 2019. For comparative purposes, results for 2017 and 2018 are also displayed when available and appropriate. The framework for IPRO’s assessment is based on the guidelines and protocols established by CMS, as well as State requirements.

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

#### 2019 State Medicaid Quality Strategy

For over 25 years, Rhode Island 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,
- 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.

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

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

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

### **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>8</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
  - Accountable Entity-specific reports.

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<sup>8</sup> RI Medicaid Accountable Entity Roadmap

- **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>9</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>9</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 4** of this report for a description of the State’s approach to quality and evaluation for the Rite Care and Rhody Health programs.

## UnitedHealthcare Community Plan of Rhode Island

UHCP-RI is a for-profit h that serves Medicaid, Medicare, and Commercial populations.

**Table 2** displays UHCP-RI’s Medicaid enrollment for year-end 2017 through year-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 Rite Care	53,579	52,601	47,975
Children with Special Health Care Needs <sup>1</sup>	2,014	1,828	1,845
Rhody Health Partners <sup>2</sup>	7,528	6,883	6,536
Rhody Health Expansion <sup>3</sup>	31,809	29,511	26,742
DSNP <sup>4</sup>	1,778	NR	NR
Extended Family Planning (EFP) <sup>5</sup>	No Data	344	417
<b>Medicaid Total</b>	<b>96,708</b>	<b>91,167</b>	<b>83,515</b>
<b>Percent Change from Previous Year</b>	<b>8%</b>	<b>-6%</b>	<b>-9%</b>

NR: Not reported

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

<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> Enrollment in the DSNP population began on 01/01/2018.

<sup>5</sup> The EFP population includes women who lose Medicaid coverage at 60 days postpartum who do not have access to creditable health insurance.

### **UHCP-RI 2019 Quality Improvement Program**

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

The QA/QM plan shall include:

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

The Quality Assurance Plan also shall:

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

UHCP-RI's Quality Improvement (QI) Program is designed to objectively monitor, systematically evaluate, and effectively improve the quality and safety of clinical care and quality of services provided to all members. The Health Plan strives to continuously improve the care and service provided by the health care delivery system, both from clinical and non-clinical perspectives. The QI Program established the following goals and objectives that encompassed all QI activities within the Health Plan:

- Promote and incorporate quality into the Health Plan's organizational structure and processes;
- Provide effective monitoring and evaluation of patient care and services provided by practitioners and providers for compatibility with evidence-based medicine guidelines;
- Identify and analyze opportunities for improvement and implement actions and follow-up;
- Coordinate quality improvement, risk management, patient safety, and operational activities;
- Maintain compliance with local, state, and federal regulatory requirements and accreditation standards;
- Serve culturally and linguistically diverse populations;
- Monitor and improve quality indicators; and
- Serve members with complex health needs.

The QI Program is structured as follows:

- Executive Vice President (EVP): The Executive Vice President and Chief Medical Officer are responsible for the clinical advancement of members, including enrollees in Commercial, Medicare, Medicaid, and Military health plans. The EVP is the clinical executive specifically responsible for the execution of the QI, medical management, care delivery transformation, performance measures, transparency, and health care affordability programs through UnitedHealthcare and is also active in helping lead the value-based benefits and value-based provider payment programs.

- Chief Medical Officer (CMO): The MCO is a licensed physician and senior member of the UnitedHealth Group Executive Clinical Core Management Team. The CMO provides clinical leadership for the Medical Management and Affordability Agenda; clinical oversight of and collaboration with the ideation and operational execution representatives within UnitedHealth Networks and the clinical leadership in the UnitedHealthcare organization; formal representation and interaction externally; leading the enterprise in Population Health strategy and planning; leading the enterprise's Triple Aim initiatives focused on improving the experience in care, improving the health of the population, and reducing the per capita cost of health care; leadership in QI initiatives, performance assessment, design, and deployment; and support for enterprise strategy, design, and execution for simplifying member experience and new product development.
- Regional Chief Medical Director/Officer: The Regional CMO is the designated senior physician responsible for the implementation of the QI Program and providing leadership within the Program. The Regional CMO is required to maintain a current, unrestricted medical license and has the following responsibilities: providing management with information for strategic decision-making and planning; monitoring and providing oversight for the maintenance of quality health care delivery systems, programs, policies, procedures, and measurements; providing advice to senior management regarding quality and clinical management programs, forecasts, cost/benefit analysis, and utilization trends; promoting collaboration using a multidisciplinary approach to act on identified opportunities for improvement; and monitoring the integrity of functional areas for compliance with state and federal requirements, accreditation standards, and company policies.
- Regional Health Plan Chief Executive Officer (CEO): The Regional CEO is responsible for participating in and providing input to the QI Program and ensuring that fiscal and administrative management decisions do not compromise the quality of care and service provided by the Health Plan.
- Quality Improvement (QI) Senior Director: The QI Senior Director is responsible for oversight of the implementation and evaluation of QI initiatives related to the QI Program. The QI Senior Director is also responsible for oversight of the annual QI Program documents and activities including, but not limited to, HEDIS improvement activities, submission of quality regulatory reports, QI studies and patient safety initiatives, member experience metrics, grievances and appeals, and delegated relationships.
- Board of Directors (BOD): The BOD is the governing body of the organization and is responsible for the oversight of QI functions; annual review and approval of the QI Program Description and QI Work Plan; review of the annual QI Program Evaluation and other reports and information as required or requested; and providing feedback and recommendations to the Quality Management Committee (QMC) related to reports, documents, and any issues or concerns.
- Quality Management Committee (QMC): The QMC is the decision-making body that is ultimately responsible for the implementation, coordination, and integration of all QI activities. The responsibilities of the QMC include: providing program direction and regular oversight of QI Activities as related to the unique needs of members and providers in the areas of clinical care, service, patient safety, administrative processes, compliance, and network credentialing and re-credentialing; oversight and approval of the annual QI Program Description, QI Work Plan, and QI Annual Evaluation; review of the Work Plan at least semi-annually; annual evaluation of the impact and effectiveness of Medicaid-specific

Performance Improvement Projects/Quality Improvement Activities (PIPs/QIAs) and recommending changes as necessary; annual reporting on health plan quality activities to the BOD; reviewing and accepting the decisions of the National Quality Oversight Committee (NQOC), offering feedback as appropriate; reviewing reports and recommendations from other national and Health Plan QI subcommittees, act upon those recommendations as appropriate, and provide feedback, follow-up, and direction to committees; monitoring compliance with regulatory requirements and accrediting organizations; providing local delegation oversight as specified by State regulatory requirements; recommending appropriate resources in support of prioritized activities; reviewing member and practitioner satisfaction results and ongoing improvement activities; monitoring trends related to member complaints, grievances, appeals, and member and provider call center activities; monitoring access and availability results and trends; reviewing, approving, and monitoring member and provider service PIPs/QIAs and activities; monitoring provider service measures; reviewing and approving Health Plan service-related operational policies and procedures; provider oversight and coordination with behavioral health services; and overseeing the Provider Advisory Committee, Healthcare Quality and Utilization Management Committee, and Member Advisory Committee. QMC membership includes the Health Plan President/CEO or designee (chair), the CMO, the Director of Health Services, Quality Management Leadership, Director of Network Programs, Compliance Officer, Chief Operating Officer, and other representation as identified by the Health Plan President/CEO. The Committee meets a minimum of four (4) times per year and reports to the BOD at least annually.

- Provider Advisory Committee (PAC): The PAC monitors peer review activities, reviews credentialing and re-credentialing, and reviews the disposition of concerns about the quality of clinical care provided to members. The PAC also evaluates and monitors the quality, continuity, accessibility, availability, utilization, and cost of care rendered within the network. The responsibilities of the PAC include: monitoring of performance on clinical indicators, conducting or reviewing barrier analyses, and recommendation actions as appropriate; reviewing and accepting nationally-endorsed Clinical Practice Guidelines (CPGs), providing input as appropriate; reviewing summary data regarding quality of care complaints, appeals, and grievances and identifying trends, conducting barrier analysis, and recommending corrective actions; reviewing reports on mortality and inpatient quality issues and recommending actions; reviewing and accepting the National Credentialing Plan and regulatory requirements; providing oversight of final decisions by the Credentialing Committee for the credentialing and re-credentialing process; monitoring the credentialing process for compliance with regulatory and accreditation compliance; reviewing, tracking, and identifying opportunities for improvement and making recommendations relating to medical record issues and potential quality of care concerns; and reviewing member and provider satisfaction survey results and making recommendations for improvement. Membership includes the CMO (chair), network primary care and specialty care physicians, Health Plan Quality Management representation, and ad-hoc Health Plan staff and specialty physicians as needed. The PAC meets a minimum of four (4) times per year and reports to the QMC at least four (4) times per year.
- Regional Peer Review Committee (RPRC): The RPRC provides a forum for qualified physicians to investigate, discuss, and take action on member cases involving potential and actual quality of care concerns. The RPRC has decision-making authority, delegated by the National Peer Review Committee (NPRC), to make decisions relating to quality of care and service. Recommendations for restrictions,

suspensions, or terminations of providers are referred to the NPRC for final disposition. Cases requiring investigation may involve components of care delivered by an individual practitioner or a health delivery organization. Functions of the RPRC include, but are not limited to: obtaining information from QI activities and investigations from various sources required for the review process; investigating providers and health delivery organizations by obtaining documentation and information from all relevant sources; counseling and educating providers, implementing improvement action plans, and instituting concurrent monitoring or retrospective review; reviewing identified system trends and opportunities for improvement and making recommendations for strategies to prevent adverse outcomes; and recommending continued medical education and training for providers. The RPRC includes the Regional CMO or his/her designee, physicians employed as Medical Directors, and physicians who participate in one (1) or more UnitedHealthcare plan as network physicians and meets quarterly.

- National Quality Oversight Committee (NQOC): The NQOC directs the quality programs for UnitedHealthcare Community and State plans at the national level and interfaces with other national and regional committees as needed. The Committee provides oversight of state, national, and regional programs for patient safety, quality improvement, and accreditation and handles the quality of care and service complaints. The NQOC is accountable for review and approval of national quality policies and procedures applicable to accreditation and clinical quality activities.
- Other Group Participants: The following national groups also play a role in the QI Program: National Credentialing Committee, National Peer Review Committee, National Provider Sanctions Committee, Executive Medical Policy Committee, National Medical Technology Assessment Committee, National Pharmacy and Therapeutics Committee, Medicaid Delegate Oversight Committee, National Health Disparities Committee, National Medical Care Committee, and National Joint Operating Committee.
- Behavioral Health Quality Management: The UHC Community Plan provides mental health and substance abuse services to members. Optum Behavioral Health Solutions (OBHS) and the UHC Community Plan collaborate to improve quality of care and services to the Health Plan's members. United Behavioral Health (UBH) performs certain functions for the behavioral health program on behalf of the UHC Community Plan, including quality improvement, utilization management, credentialing, and member rights and responsibilities. The OBHS Medical Director is involved in the implementation of the behavioral health aspects of the quality program.
- Behavioral Health Joint Operating Committee: The Behavioral Health Joint Operating Committee is responsible for the coordination of care and services and oversight of accreditation between United Behavioral Health, UnitedHealthcare, UHC Community Plan, and the State. The functions of the Committee include: reviewing UBH quarterly reports, reviewing and approving annual quality program documents, evaluation of behavioral health-related HEDIS measures, and designing and implementing interventions related to continuity and coordination of care.
- National Integrated Behavioral Health Steering Committee: This Committee's functions include developing and overseeing an overall strategy to improve continuity and coordination of care between physical and behavioral health, as well as performing oversight of strategies to improve outcomes for behavioral health measures.

- Unique Features of the Program: Provider Profiling: Annual Primary Care Provider utilization and quality profiles are designed by the National Quality Management Department. Profiles provide summary information on five (5) utilization and nine (9) quality indicators for PCPs with sufficient data to generate statistically significant profiles. Individual provider scores are compared to network peer scores. Utilization indicators include encounters and visits to the ER and hospitals. Quality indicators include completed well-child visits for adolescents, children ages three (3) to six (6) years old, children seven (7) to eleven (11) years old, and children fifteen (15) months old; childhood and adolescent immunizations; cervical cancer screenings; and mammograms. To identify potential over-utilization or under-utilization, profile data are further analyzed to identify scores greater than one (1) standard deviation from the mean. Providers in the lowest quartile are targeted for quality improvement initiatives.
- Practitioner/Practice Manager Satisfaction: Surveys that measure provider and practice manager satisfaction are conducted annually and reviewed by the PAC, and QMC. Surveys assess which services are important to Health Plan practitioners, satisfaction with UM processes, and satisfaction with coordination and continuity of care.

### NCQA Health Plan Accreditation and Health Plan Ranking

NCQA's Health Plan Accreditation program is considered the industry's gold standard for assuring and improving quality care and patient experience. It reflects a commitment to quality that yields tangible, bottom-line value. It also ensures essential consumer protections, including fair marketing, sound coverage decisions, access to care, and timely appeals. The accreditation process is a rigorous, comprehensive, and transparent evaluation process through which the quality of key systems and processes that define a health plan are assessed. Additionally, accreditation includes an evaluation of the actual results the health plan achieved on key dimensions of care, service, and efficacy. Specifically, NCQA reviews the health plan's quality management and improvement, utilization management, provider credentialing and re-credentialing, members' rights and responsibilities, standards for member connections, and HEDIS and CAHPS performance measures.

Although the on-site Accreditation Survey occurs once every three (3) years, star ratings are re-calculated annually by NCQA based on the most recent Accreditation Survey findings and the latest HEDIS and CAHPS results. The star rating performance levels are described in **Table 3**.

**Table 3: NCQA Accreditation Survey Levels**

Number of Stars	Accreditation Levels	Accreditation Requirement
★★★★	<b>Excellent</b>	Organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS results are in the highest range of national performance.
★★★	<b>Commendable</b>	Organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.
★★	<b>Accredited</b>	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take further action to achieve a higher accreditation status.
★	<b>Provisional</b>	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take significant action to achieve a higher accreditation status.
No stars	<b>Denied</b>	Organizations whose programs for service and clinical quality did not meet NCQA requirements during the Accreditation Survey.

Health plans are scored along the following five (5) dimensions using these star ratings (1-lowest; 4-highest)<sup>10</sup>:

- Access and Service: An evaluation of Health Plan members' access to needed care and good customer service. Are there enough primary care doctors and specialists to serve all plan members? Do members report problems getting needed care? How well does the Health Plan follow up on grievances?
- Qualified Providers: An evaluation of Health Plan efforts to ensure that each doctor is licensed and trained to practice medicine, and that Health Plan members are happy with their doctors. Does the Health Plan check whether physicians have had sanctions or lawsuits against them? How do members rate their personal doctor?
- Staying Healthy: An evaluation of Health Plan activities that help people maintain good health and avoid illness. Does the Health Plan give its doctors guidelines about how to provide appropriate preventive health services? Do members receive appropriate tests and screenings?
- Getting Better: An evaluation of Health Plan activities that help people recover from illness. How does the Health Plan evaluate new medical procedures, drugs, and devices to ensure that patients have access to the most up-to-date care? Do doctors in the Health Plan advise patients to quit smoking?
- Living with Illness: An evaluation of Health Plan activities that help people manage chronic illness. Does the Health Plan have programs in place to help patients manage chronic conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?

<sup>10</sup> [www.ncqa.org](http://www.ncqa.org)

UHCP-RI maintains its national accreditation as required by EOHHS. UHCP-RI achieved NCQA's "Excellent" accreditation status in 2017, 2018 and 2019. In 2019, UHCP-RI scored four (4) stars for two (2) of the five (5) Accreditation dimensions. **Table 4** displays the results of UHCP-RI's Accreditation Survey for 2019.

**Table 4: Accreditation Survey Findings—2019**

Product Line	Access and Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Accreditation Outcome
Medicaid	★★★★	★★★★	★★★	★★	★★★	Excellent

NCQA's *Health Insurance Plan Rating* evaluates health plans based on clinical performance (HEDIS results), member satisfaction (CAHPS scores), and NCQA Accreditation Standards scores. To be eligible for a rating, health plans must authorize public release of their performance data and submit enough data for statistically valid analysis.

The *Health Insurance Plan Ratings* 2019-2020 methodology used to calculate an overall score, comprised of dozens of measures related to consumer satisfaction measures (*Consumer Satisfaction*), preventive and treatment measures (*Rates of Clinical Measures*), and the Accreditation score. These three (3) categories are defined below. Health plans received a score for each of these three (3) categories from one (1) to five (5) in half-point increments, with five (5) being the highest score. NCQA defines these

1. Consumer Satisfaction: Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Consumer Satisfaction category).
2. Rates for Clinical Measures: The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).
3. NCQA Accreditation Standards Score: Partial and proportionally adjusted results of NCQA Accreditation surveys (actual NCQA Accreditation standards score divided by the maximum possible NCQA Accreditation standards score). Since 2010, the NCQA used a five-point numerical scale rating system, which compares the health plan's scores to the national average. The scale and definitions for each level are displayed in **Table 5**.

**Table 5: NCQA Health Plan Rating Scale**

Rating	Rating Definition
5	The top 10% of health plans, which are also statistically different from the mean.
4	Health plans in the top one-third of health plans that are not in the top 10% and are statistically different from the mean.
3	The middle one-third of health plans and health plans that are not statistically different from the mean.
2	Health plans in the bottom one-third of health plans that are not in the bottom 10% and are statistically different from the mean.
1	The bottom 10% of health plans, which are also statistically different from the mean.

UHCP-RI achieved an “overall rating” of four point five (4.5) out of five (5) for the *2019-2020 Health Insurance Plan Ratings*. **Table 6** displays UHCP-RI’s “overall rating,” as well as its’ ratings for the three (3) categories under review.

**Table 6: NCQA Rating by Category—2019**

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

### III. EQRO Evaluation Methodology

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

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

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

- A. **Quality** is the extent to which an MCO increases the likelihood of desired health outcomes for enrollees through its structural and operational characteristics and through health care services provided, which are consistent with current professional knowledge.
- B. **Access** is the timely use of personal health services to achieve the best possible health outcomes.<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 UHCP-RI by EOHHS for follow up, as well as a brief description of UHCP-RI's progress related to the *UnitedHealthcare Community Plan Annual External Quality Review Technical Report, Reporting Year 2018*.

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<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/> Annual EQR Technical Report 2019—UnitedHealthcare Community Plan of Rhode Island

## IV. Validation of Performance Improvement Projects

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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:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the MCO's enrollment.
2. Review of the study question(s) for clarity of statement.
3. Review of the identified study population to ensure it is representative of the MCO's enrollment and generalizable to the MCO's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous and meaningful to the focus of the QIP.
5. Review of sampling methods (if sampling used) for validity and proper technique.
6. Review of the data collection procedures to ensure complete and accurate data were collected.
7. Review of the data analysis and interpretation of study results.
8. Assessment of the improvement strategies for appropriateness.
9. Assessment of the likelihood that reported improvement is "real" improvement.
10. 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:

1. There are no validation findings that indicate that the credibility is at risk for the QIP results.
2. 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.

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<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.

3. 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

UHCP-RI conducted the following QIPs in 2019:

- QIP 1 – *Improving Effective Acute Phase Treatment for Major Depression*, State-Directed
- QIP 2 – *Developmental Screening in the 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> Years of Life*, State-Directed
- QIP 3 – *Improving Lead Screening in Children*, State-Directed
- QIP 4 – *Improving Breast Cancer Screening*, MCO-Selected

IPRO's assessment of UHCP-RI's methodology found that there were no validation findings that indicated that the credibility of the QIP 1, QIP 3 and QIP 4 results was at risk. However, improvement could not be assessed for QIP 2 because re-measurement data was not report by UHCP-RI for 2019. **Table 7** displays a summary of UHCP-RI's QIP assessments. Summaries of each QIP immediately follow.

**Table 7: 2019 UHCP-RI QIP Validation Findings**

Validation Element	QIP 1	QIP 2	QIP 3	QIP 4
<b>Selected Topic</b>	Met	Met	Met	Met
<b>Study Question</b>	Met	Met	Met	Met
<b>Indicators</b>	Met	Met	Met	Met
<b>Population</b>	Met	Met	Met	Met
<b>Sampling Methods</b>	Met	Met	Met	Met
<b>Data collection Procedures</b>	Met	Met	Met	Met
<b>Interpretation of Study Results</b>	Met	Not Met	Met	Met
<b>Improvement Strategies</b>	Met	Met	Met	Met

### State-Directed QIP #1: Improving Effective Acute Phase Treatment for Major Depression

Aim: UHCP-RI aimed to increase the percentage of members aged 18 years and older who remain on antidepressant medication during the acute phase of treatment.

Indicator(s)/Goal(s): The performance indicator is the HEDIS *Antidepressant Medication Management– Effective Acute Phase* measure. The goal for the indicator was to achieve the national Medicaid 75<sup>th</sup> percentile.

#### Member-Focused Intervention:

- Related articles were published in the member newsletter.

#### Provider-Focused Intervention(s):

- Related articles were published in the provider newsletter.

- Conducted educational email blast to 1,382 outpatient prescribing practitioners who were identified as having treated five (5) or more adult enrollees within the past twelve (12) months. The email content included depression best treatment practices, measure specifications and suggested tips on medication adherence.
- Clinical Practice Consultants (CPCs) conducted provider education at a Federally Qualified Health Center (FQHC) town hall meeting facilitated by UHCCP-RI. CPCs emphasized screening and coding, as data revealed that members who failed the measure are not members with clinical depression and counseling may be more appropriate.

**Results:** UHCP-RI's reported a re-measurement rate of 55.15% for the HEDIS 2019 period, which was below the QIP's goal rate of 58.01%. **Table 8** displays the results of the QIP including measurement periods, numerators, denominators and overall project goal.

**Table 8: QIP 1 – Improving Effective Acute Phase Treatment for Major Depression**

Time Period	Measurement	Numerator	Denominator	Results	Goal
<b>HEDIS 2010</b>	Baseline	134	274	52.63%	52.63%
<b>HEDIS 2011</b>	Re-measurement 1	218	371	58.76%	53.18%
<b>HEDIS 2012</b>	Re-measurement 2	156	345	45.22%	53.57%
<b>HEDIS 2013</b>	Re-measurement 3	289	556	51.98%	52.74%
<b>HEDIS 2014</b>	Re-measurement 4	529	1,031	51.31%	56.27%
<b>HEDIS 2015</b>	Re-measurement 5	588	1,113	52.83%	54.48%
<b>HEDIS 2016</b>	Re-measurement 6	1,188	2,173	54.67%	56.28%
<b>HEDIS 2017</b>	Re-measurement 7	1,252	2,319	53.99%	59.56%
<b>HEDIS 2018</b>	Re-measurement 8	1,242	2,424	51.24%	57.47%
<b>HEDIS 2019</b>	Re-measurement 9	1,254	2,274	55.15%	58.01%

## **State-Directed QIP #2: HEDIS Developmental Screening in the 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup> Years of Life**

**Aim:** UHCP-RI aimed to increase the percentage of children who were screened for risks of developmental, behavioral and social delays using standardized screening tools in the twelve (12) months preceding their first, second and third birthdays.

**Indicator(s)/Goal(s):** These are the three (3) indicators for this QIP:

1. The percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first birthday;
2. The percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their second birthday; and
3. The percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their third birthday.

The goal for this QIP is to increase each indicator rate to 50.0%

#### Member-Focused Intervention(s):

- Parents and guardians were targeted for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) interactive voice recordings (IVR) with a reminder to complete a routine check-up for children ages two (2) to twenty-one (21) years of age.
- Monthly birthday card and child preventive health letter mailings to members included reminders to seek age appropriate services.
- Live outreach calls were placed to remind heads of households to seek age appropriate care for their children.
- Related articles were published in the member newsletter.

#### Provider-Focused Intervention(s):

- CPCs targeted FQHCs, high-volume practices, and practices with low adherence for developmental screening for onsite outreach.

Results: UHCP-RI did not report re-measurement data for CY 2019 and therefore improvement could not be assessed. **Table 9** displays the results of the QIP including measurement periods, numerators, denominators and overall project goals.

**Table 9: QIP 2 – Screenings for Risks of Developmental, Behavioral, and Social Delays**

Time Period	Measurement Covers	Measurement	Numerator	Denominator	Results	Goal
<b>Preceding 1<sup>st</sup> Birthday</b>						
CY 2014 <sup>1</sup>	Baseline		57	137	41.61%	60.0%
CY 2015 <sup>2</sup>	Re-measurement 1		505	1,517	33.29%	60.0%
CY 2016 <sup>1</sup>	Re-measurement 2		74	137	54.01%	60.0%
CY 2017 <sup>1</sup>	Re-measurement 3		79	137	57.66%	50.0%
CY 2018 <sup>1</sup>	Re-measurement 4		88	137	64.23%	50.0%
CY 2019	Re-measurement 5	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
<b>Preceding 2<sup>nd</sup> Birthday</b>						
CY 2014 <sup>1</sup>	Baseline		67	137	48.91%	60.0%
CY 2015 <sup>2</sup>	Re-measurement 1		549	1,237	44.38%	60.0%
CY 2016 <sup>1</sup>	Re-measurement 2		79	137	57.66%	60.0%
CY 2017 <sup>1</sup>	Re-measurement 3		79	137	57.66%	50.0%
CY 2018 <sup>1</sup>	Re-measurement 4		90	137	65.69%	50.0%
CY 2019	Re-measurement 5	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
<b>Preceding 3<sup>rd</sup> Birthday</b>						
CY 2014 <sup>1</sup>	Baseline		60	137	43.80%	60.0%
CY 2015 <sup>1</sup>	Re-measurement 1		570	1,313	43.41%	60.0%
CY 2016 <sup>1</sup>	Re-measurement 2		81	137	59.12%	60.0%
CY 2017 <sup>1</sup>	Re-measurement 3		78	137	56.93%	50.0%
CY 2018 <sup>1</sup>	Re-measurement 4		82	137	59.85%	50.0%
CY 2019	Re-measurement 5	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported

<sup>1</sup> Rate calculated using the hybrid methodology.

<sup>2</sup> Rate calculated using the administrative methodology.

### State-Directed QIP #3: Improving Lead Screening in Children

**Aim:** UHCP-RI aimed to increase the percentage of members two (2) years of age who received one (1) or more capillary or venous blood tests for lead poisoning on or before their second birthday.

**Indicator(s)/Goal(s):** The goal of this QIP is improve rate of the HEDIS *Lead Screening in Children* measure 85.64%.

#### Member-Focused Intervention(s):

- Sent an informational flyer to the parents and guardians of children residing in Washington County and identified as needed a lead screening.
- Parents and guardians were targeted for EPSDT IVRs with a reminder to complete a routine check-up for children ages two (2) to twenty-one (21) years of age.
- Live outreach calls were made to members identified as being eighteen (18) months of age and in need of a lead screening.
- Related articles were published in the member newsletter.

#### Provider-Focused Intervention(s):

- Related articles were published in the provider newsletter.
- Targeted providers in Washington County for education on the importance of lead screening, especially in areas with high rates of lead poisoning

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

- Collaborated with the Rhode Island Department of Health (RIDOH) Lead Screening Evaluator to develop an intervention strategy.

**Results:** UHCP-RI's HEDIS MY 2019 *Lead Screening in Children* rate of 74.24% did not meet the goal rate of 85.64%. **Table 10** displays the results of the QIP including measurement periods, numerators, denominators and overall project goals.

**Table 10: QIP 3 – Improving Lead Screening in Children**

Time Period	Measurement	Numerator	Denominator	Results	Goal
<b>HEDIS 2017</b>	Baseline 1	1,174	1,547	75.89%	84.77%
<b>HEDIS 2018</b>	Re-measurement 1	315	411	76.64%	86.37%
<b>HEDIS 2019</b>	Re-measurement 2	1,320	1,778	74.24%	85.64%

### MCO-Selected QIP #4: Improving Breast Cancer Screening

**Aim:** UHCP-RI aimed to increase the percentage of women aged 50-74 years who had a mammogram.

**Indicator(s)/Goal(s):** The goal of this QIP is to improve the rate of the HEDIS *Breast Cancer Screening* measure to 68.94%.

#### Member-Focused Intervention(s):

- Live outreach calls were made to members residing in Washington County and identified as being in need of breast cancer screening.

- An informational flyer encouraging members to get an a mammogram was mailed to 209 members residing in Washington County
- Live outreach calls were made to members reminding them complete preventive screenings, to stay up to date with immunizations and to complete well-child visits.
- Completed monthly birthday card mailings to members reminding them to seek age appropriate services.
- Related articles were published in the member newsletter.

Provider-Focused Intervention(s):

- Related articles were published in the provider newsletter.
- Conducted provider education through the UHCP-RI on-air program “Working Together to Improve Breast Cancer Screening.”

Health Plan-Focused Intervention(s):

- Organized the Health Disparities Work Group developed a health disparities action plan.

Results: UHCP-RI HEDIS *Breast Cancer Screening* rate of 61.45% did not the goal rate of 68.94%.

**Table 11: QIP 4 – Improving Breast Cancer Screening**

Time Period	Measurement	Numerator	Denominator	Results	Goal
<b>HEDIS 2018</b>	Baseline 1	2,834	4,551	62.27%	70.29%
<b>HEDIS 2019</b>	Re-measurement 1	2,882	4,690	61.45%	68.94%

## V. Validation of Performance Measures

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This subpart of the report presents the results of the evaluation of UHCP-RI 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.

UHCP-RI 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 UHCP-RI met all of the requirements to successfully report HEDIS data to EOHHS and to NCQA. **Table 12** displays the results of the IS audit.

**Table 12: UHCP-RI 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.

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

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

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

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

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

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

### Findings

This section of the report explores the utilization of UHCP-RI's services by examining select measures under the following domains:

- Use of Services – Measures examine the percentage of Medicaid child and adolescent access routine care.

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<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.

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

### **Use of Services Measures<sup>14</sup>**

UHCP-RI's performance in this domain was strong. UHCP-RI's rates for all three (3) measures exceeded the *Quality Compass* 2019 national Medicaid mean. Additionally, the rate for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* benchmarked at the *Quality Compass* 2019 national Medicaid 90<sup>th</sup> percentile and the rates for *Adolescent Well-Care Visits* and *Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, & 6<sup>th</sup> Years of Life* ranked at the national Medicaid 75<sup>th</sup> percentile. **Table 13** displays UHCP-RI's rates for these measures, as well as the national Medicaid benchmarks achieved by the MCO.

**Table 13: HEDIS Use of Services Rates—2017-2019**

Use of Services Measures	HEDIS 2017	HEDIS 2018	HEDIS 2019	<i>Quality Compass</i> 2019 National Medicaid Benchmark	<i>Quality Compass</i> 2019 National Medicaid Mean
Well-Child Visits in the First 15 Months of Life (6+ Visits)	81.0%	77.9%	74.2%	90 <sup>th</sup>	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	82.0%	83.2%	80.0%	75 <sup>th</sup>	72.1%
Adolescent Well-Care Visits	74.2%	65.0%	67.4%	75 <sup>th</sup>	53.2%

### **HEDIS Effectiveness of Care Measures**

UHCP-RI's performance in this domain was strong. UHCP-RI's rates for all eight (8) measures exceeded the *Quality Compass* 2019 national Medicaid mean, with seven (7) of these measures meeting or exceeding the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile.

*Childhood Immunization Status—Combination 10* exceeded the *Quality Compass* 2019 national Medicaid 90<sup>th</sup> percentile, while the rate for *Childhood Immunization Status—Combination 3* benchmarked at the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile. UHCP-RI's rate for *Chlamydia Screening for Women (16-24 Years)* benchmarked below the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile while *Cervical Cancer Screening for Women* benchmarked at the 2019 national Medicaid 75<sup>th</sup> percentile. Lastly, UHCP-RI's rates for *Follow-up After Hospitalization for Mental Illness—7 Days* and *Follow-up After Hospitalization for Mental Illness—30 Days* met the *Quality Compass* 2019 national Medicaid 90<sup>th</sup> percentile.

**Table 14** 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 14: HEDIS Effectiveness of Care Rates—2017-2019**

Effectiveness of Care Measures	HEDIS 2017	HEDIS 2018	HEDIS 2019	<i>Quality Compass</i> 2019 National Medicaid Benchmark	<i>Quality Compass</i> 2019 National Medicaid Mean
Medication Management for People with Asthma 75% (5-64 Years)	39.5%	43.1%	46.2%	75 <sup>th</sup>	37.8%
Cervical Cancer Screening for Women	68.1%	69.3%	66.9%	75 <sup>th</sup>	59.3%
Chlamydia Screening for Women (16-24 Years)	66.4%	66.0%	65.9%	66.67 <sup>th</sup>	58.1%
Childhood Immunization Status—Combination 3	73.5%	79.3%	77.9%	75 <sup>th</sup>	68.1%
Childhood Immunization Status—Combination 10	51.8%	58.9%	59.4%	95 <sup>th</sup>	35.2%
Comprehensive Diabetes Care—HbA1c Testing	90.0%	90.5%	90.5%	75 <sup>th</sup>	87.8%
Follow-Up After Hospitalization for Mental Illness—30 Days	86.1%	74.8%	73.9%	90 <sup>th</sup>	56.8%
Follow-Up After Hospitalization for Mental Illness—7 Days	77.2%	55.1%	54.4%	90 <sup>th</sup>	35.8%

**HEDIS Access and Availability Measures**

UHCP-RI's performance in this domain varied. Rates for eight (8) of the nine (9) measures exceeded the *Quality Compass 2019* national Medicaid mean, with only two (2) of these rates benchmarking at the *Quality Compass 2019* national Medicaid 75<sup>th</sup> percentile.

UHCP-RI rates for *Timeliness of Prenatal Care* and *Postpartum Care* benchmarked at the *Quality Compass 2019* national Medicaid 75<sup>th</sup> percentile. Rates for all age groups of the *Children and Adolescents' Access to Primary Care Practitioners* measure performed below the *Quality Compass 2019* national Medicaid 75<sup>th</sup> percentile. Rates for all age groups of the *Adults' Access to Preventive/Ambulatory Health Services* performed at or below the *Quality Compass 2019* national Medicaid 50<sup>th</sup> percentile.

**Table 15** displays UHCP-RI Access and Availability rates for MY 2019 compared to the *Quality Compass 2019* national Medicaid benchmarks.

**Table 15: HEDIS Access and Availability Rates—2017-2019**

Effectiveness of Care Measures	HEDIS 2017	HEDIS 2018	HEDIS 2019	Quality Compass 2019 National Medicaid Benchmark	Quality Compass 2019 National Medicaid Mean
<b>Children and Adolescents' Access to PCP</b>					
12-24 Months	93.1%	91.6%	92.5%	10 <sup>th</sup>	94.8%
25 Months – 6 Years	90.2%	87.9%	86.8%	33.33 <sup>rd</sup>	86.3%
7-11 Years	95.2%	93.6%	93.2%	66.67 <sup>th</sup>	90.0%
12-19 Years	94.9%	93.1%	89.9%	33.33 <sup>rd</sup>	88.8%
<b>Adults' Access to Preventive/Ambulatory Health Services</b>					
20-44 Years	77.9%	77.2%	78.4%	33.33 <sup>rd</sup>	76.5%
45-64 Years	87.4%	87.2%	87.0%	50 <sup>th</sup>	84.8%
65+ Years	84.9%	88.4%	88.4%	50 <sup>th</sup>	86.6%
<b>Timeliness of Prenatal Care</b>	92.5%	91.0%	90.3%	75 <sup>th</sup>	81.5%
<b>Postpartum Care</b>	72.5%	76.2%	71.5%	75 <sup>th</sup>	63.6%

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

### Objectives

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

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

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

### Technical Methods of Data Collection and Analysis

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

### Description of Data Obtained.

<sup>15</sup> The rates for all PGP measures include all Medicaid members, where eligible population criteria were met.  
Annual EQR Technical Report 2019—UnitedHealthcare Community Plan of Rhode Island

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

## Findings

This section of the report evaluates UHCP-RI's performance on the PGP measures for 2017 through 2019 for all Medicaid populations.

**Table 16** presents the rates for the PGP metrics. The HEDIS percentiles displayed were derived from the 2019 Performance Goal Program results, in which rates were benchmarked against the NCQA's *Quality Compass* 2018 for Medicaid.

The **Utilization** domain included one (1) measure for Reporting Year 2019, HEDIS *Adolescent Well-Care Visits*. UHCP-RI reported a rate that exceeded the 2018 *Quality Compass* 75<sup>th</sup> percentile and qualified for a partial incentive award for this measure.

Of the five (5) measures included in the **Access to Care** domain, UHCP-RI reported rates qualifying for incentive awards for two (2) of the measures. UHCP-RI achieved the 2018 *Quality Compass* 75<sup>th</sup> percentile for the HEDIS *Engagement of Alcohol and Other Drug Dependence Treatment measure* and the HEDIS *Postpartum Care measure*. Unfortunately, UHCP-RI's rates did not meet a *Quality Compass* benchmark to qualify for an incentive award for HEDIS *Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)*, *Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)* and HEDIS *Initiation of Alcohol and Other Drug Dependence Treatment*.

The **Prevention and Screening** domain was comprised of four (4) HEDIS measures. UHCP-RI reported rates qualifying for incentive awards for two (2) of the measures. UHCP-RI reported rates for two (2) of the HEDIS measures and twelve (12) of the state-specific measures in reporting year 2019. UHCP-RI achieved the 2018 *Quality Compass* 90<sup>th</sup> percentile for HEDIS *Childhood Immunization Status—Combination 10* and *Adolescent Immunizations—Combination 2*. UHCP-RI's rates did not meet a *Quality Compass* benchmark to qualify for an incentive award for the *Lead Screening* measure or the *Children and Breast Cancer Screening* measure.

In the **Women's Health** domain, UHCP-RI 's rate exceeded the 2018 *Quality Compass* 75<sup>th</sup> percentile and qualified for a partial incentive award for the HEDIS *Chlamydia Screening in Women (16-20 Years)*. UHCP-RI 's rate for HEDIS *Cervical Cancer Screening* did not meet a *Quality Compass* benchmark to qualify for an incentive award in 2019.

For Reporting Year 2019, the **Chronic Care** domain included two (2) HEDIS measures and one (1) State-specified measure. For the State-specified measure *HIV Viral Load Suppression*, UHCP-RI reported a rate that exceeded the State-selected *Contract* goal to qualify for a partial incentive award. Regarding the three (3) HEDIS measures, UHCP-RI's rate for *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* benchmarked at the 2018 *Quality Compass* 75<sup>th</sup> percentile and qualified for a partial incentive award, while the *Controlling High Blood Pressure (18-85 Years)* measure met the 90<sup>th</sup> *Quality Compass* benchmark to qualify for a full incentive award in 2019.

The **Behavioral Health** domain included five (5) HEDIS measures. UHCP-RI's rates for the HEDIS *Follow-up After Hospitalization for Mental Illness—7 Days* measure exceeded the 75<sup>th</sup> percentile benchmark. The following four

(4) measures benchmarked at the 2018 *Quality Compass* 75<sup>th</sup> percentile: *Follow-Up After Hospitalization for Mental Illness—7 Days*, *Follow-up After Emergency Department Visits for Alcohol and Other Drug Dependence*, *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*. The *Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications* measure did not meet a *Quality Compass* benchmark to qualify for an incentive award in 2019.

**Table 16: Performance Goal Program Results—2017-2019<sup>1</sup>**

				RI Medicaid Contract Goal	
				State-Specified Contract Goal <sup>2</sup>	Quality Compass 2018 Percentile Met <sup>3</sup>
RI Medicaid Managed Care Performance Goal Program Measures	2017	2018	2019		
Utilization					
HEDIS Adolescent Well-Care Visits	74.2%	65.0%	64.0%		PM
Access to Care					
HEDIS Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)	93.1%	91.6%	93.3%		NM
HEDIS Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	90.2%	87.9%	85.9%		NM
HEDIS Postpartum Care	72.5%	76.2%	71.5%		PM
HEDIS Initiation of Alcohol and Other Drug Dependence Treatment	53.6%	45.1%	40.8%		NM
HEDIS Engagement of Alcohol and Other Drug Dependence Treatment	25.5%	18.8%	18.5%		PM
Prevention and Screening					
HEDIS Childhood Immunization Status—Combination 10	51.8%	58.9%	55.0%		M/E
HEDIS Lead Screening in Children	75.9%	76.6%	74.2%		NM
HEDIS Adolescent Immunizations—Combination 2	34.6%	45.5%	47.9%		M/E
HEDIS Breast Cancer Screening	64.2%	62.3%	61.4%		NM
Women's Health					
HEDIS Chlamydia Screening in Women (16-20 Years)	63.7%	65.2%	65.4%		PM
HEDIS Cervical Cancer Screening <sup>4</sup>			61.8%		NM
Chronic Care					
HEDIS Comprehensive Diabetes Care—HbA1c Control (<8.0%)	56.5%	60.1%	55.5%		PM
HEDIS Controlling High Blood Pressure (18-85 Years)	66.7%	69.6%	71.3%		M/E
HIV Viral Load Suppression <sup>5</sup>	56.0%	72.4%	76.8%	PM	
Behavioral Health					
HEDIS Follow-Up After Hospitalization for Mental Illness—7 Days	77.2%	55.1%	53.8%		PM
HEDIS Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	53.1%	47.6%	51.7%		PM
HEDIS Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic Medications <sup>4</sup>			80.1%		NM

				RI Medicaid <i>Contract</i> Goal	
				State-Specified <i>Contract</i> Goal <sup>2</sup>	<i>Quality Compass</i> 2018 Percentile Met <sup>3</sup>
RI Medicaid Managed Care Performance Goal Program Measures	2017	2018	2019		
HEDIS Follow-Up After Emergency Department Visits for Alcohol and Other Drug Dependence <sup>4</sup>			25.0%		PM
HEDIS Adherence to Antipsychotic Medications for Individuals with Schizophrenia <sup>4</sup>			67.2%		PM

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

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

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

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

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

<sup>5</sup> State-specified measure.

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

### Objectives

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

### Technical Methods of Data Collection and Analysis

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

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 met, 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.

### Findings

UHCPR's accreditation was granted by NCQA on December 3, 2020. **Table 17** displays the results of UHCPR's most recent NCQA Accreditation survey. It was determined that UHCPR was fully compliant with the standards *Title 42 CFR Part 438 Subpart D and Subpart E 438.330*.

**Table 17: Evaluation 42 CFR Part 438 Subpart D and QAPI Standards**

Part 438 Subpart D and Subpart E 438.330	UHCPR-RI Results
<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

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

### Objectives

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

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 UHCP-RI in the *Annual Assessment of Network Adequacy Report*, June 2020. IPRO's evaluation included a comparison of UHCP-RI access data to the MCO-determined standards for distance and provider-to-member ratios, and a comparison of UHCP-RI's appointment availability rates to the State's appointment standards.

UHCP-RI's distance standards vary by practitioner type and by county type, 'large metro' and 'metro'. **Table 18** presents UHCP-RI's distance standards.

**Table 18: UHCP-RI Distance Standards**

Practitioner Type	Large Metro	Metro
<b>Primary Care Providers</b> (Family/General Practice, Internal Medicine, Pediatrics)	1 in 5 Miles	1 in 10 Miles
<b>High-Volume Specialists and High-Impact Specialists</b> (Cardiology, OB/GYN, Orthopedics)	1 in 5 Miles	1 in 20 Miles
<b>High-Volume Specialists and High-Impact Specialists</b> (Oncology)	1 in 10 Miles	1 in 30 Miles
<b>Dermatology</b>	1 in 15 Miles	1 in 30 Miles

Appointment timeliness standards included in the State's *Medicaid Managed Care Contract* are displayed in **Table 19**.

**Table 19: RI Medicaid Managed Care Contract Appointment Standards**

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

UHCP-RI established its provider-to-member ratio standards based on a literature review and UHCP-RI's historical performance in this area. **Table 21** presents the most current provider-to-member ratios, and indicates if the ratio standard was met for the provider types reported. UHCP-RI met the established ratio standards for all reported provider types.

## Description of Data

UHCP-RI 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. UHCP-RI's GeoAccess standards derive from CMS' Medicare Advantage network adequacy

criteria, which assesses geographic accessibility by county type<sup>16</sup>. All counties in Rhode Island fall under the large metro and metro county designations.

UHCP-RI 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

UHCP-RI's goal is to have ninety percent (90%) of its network of primary care, high-volume<sup>17</sup>, and high-impact<sup>18</sup> providers meet the established distance requirements, as well as to meet provider-to-member ratios. The distance requirements and ratios differ by provider type and county designation.

**Table 20** shows the percentage of providers who met UHCP-RI's geographic access standards in the large metro and metro counties. UHCP-RI exceeded its goal of ninety percent (90%) of its members having access to for all provider types in the large metro counties and all provider types.

**Table 20: GeoAccess Provider Network Accessibility—2019**

Provider Type	Access Standard (Large Metro)	% of Providers (Large Metro)	Access Standard (Metro)	% of Providers (Metro)
<b>Primary Care Providers</b>				
Family/General Practice	1 within 5 miles	99%	1 within 10 miles	100%
Internal Medicine	1 within 5 miles	97%	1 within 10 miles	100%
Pediatricians	1 within 5 miles	99%	1 within 10 miles	99%
Total Adult PCPs	1 within 5 miles	99%	1 within 10 miles	100%
<b>High-Volume Specialists (HVS)<sup>1</sup> and High-Impact Specialists (HIS)<sup>2</sup></b>				
Cardiology – HIS/HVS	1 within 5 miles	99%	1 within 20 miles	100%
OB/GYN - HVS	1 within 5 miles	100%	1 within 20 miles	100%
Orthopedics -HVS	1 within 5 miles	98%	1 within 20 miles	100%
Dermatology	1 within 15 miles	97%	1 within 30 miles	100%
Oncology – HIS/HVS	1 within 10 miles	98%	1 within 30 miles	100%

<sup>1</sup> Only the top high-volume specialty providers are reported based on the volume of visits/1,000 members. As such, the provider types displayed may differ from prior years' reports, as the volume of visits/1,000 members is reassessed annually. If OB/GYNs are not identified as a high-volume specialty, this provider type is included regardless.

<sup>2</sup> Only the top high-impact specialists are reported based on the top [www.cdc.gov](http://www.cdc.gov) mortality and morbidity statistics. As such, the provider types may differ from prior years' reports, as they are reassessed annually. At minimum, high-impact specialists will include Oncology.

<sup>16</sup> The county types include large metro, metro, micro, rural, and counties with extreme access consideration (CEAC). County types are defined by population and population density, based on the most recently available census data. Detailed information can be found at [www.cms.gov](http://www.cms.gov).

<sup>17</sup> High-volume specialists are defined as specialists that treat a significant portion of the Health Plan's membership. Annually, the Health Plan identifies the top three high-volume specialists based on visits per 1,000 members. If OB/GYNs are not identified in the top three, this specialty is added as a fourth type.

<sup>18</sup> High-impact specialists are defined as specialists that treat specific conditions that have serious consequences for members and require significant resources. Annually, the Health Plan identifies the top high-impact specialists based on the top three [www.cdc.gov](http://www.cdc.gov) mortality and morbidity statistics. At a minimum, high-impact specialists include Oncologists.

In addition to displaying the provider-to-member ration standards by provider type and specialty, **Table 13** also presents UHCP-RI 2019 ratios and a determination of whether or not the standard was met. UHCP-RI met the established ratio standards for all reported provider types.

**Table 21: Provider-to-Member Ratios—2019**

Provider Type	Ratio Standard	Number of Members per Single Provider	Met / Not Met
<b>Primary Care Providers</b>			
Family and General Practice	1:1,000	86	Met
Internal Medicine	1:1,000	82	Met
Pediatricians	1:1,000	81	Met
Total Adult PCPs	1:1,000	43	Met
<b>High-Volume Specialists (HVS) and High-Impact Specialists (HIS)</b>			
Orthopedics-HVS	1:2,000	125	Met
Dermatology-HVS	1:8,000	237	Met
OB/GYN-HVS	1:2,000	68	Met
Cardiology-HIS	1:2,000	117	Met
Oncology-HIS	1:4,000	157	Met

**Table 22** presents the results of the UHCP-RI 2019 Access and Availability Survey. Timeliness and Availability of both routine and urgent care appointments was assessed for a variety of provider types.

**Table 22: 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	9	0	-	-	-
Family/General Practice—Urgent	10	1	10.0%	0.0%	Not Reported
Pediatricians—Routine	6	2	33.3%	0.0%	Not Reported
Pediatricians—Urgent	4	1	25.0%	0.0%	16.5
OB/GYNs—Routine	5	1	20.0%	0.0%	5
OB/GYNs—Urgent	6	2	33.3%	0.0%	39.5
Cardiology—Routine	6	4	66.7%	0.0%	26.75
Cardiology—Urgent	3	2	66.7%	0.0%	9
Dermatology—Routine	4	3	75.0%	0.0%	28
Dermatology—Urgent	5	3	60.0%	0.0%	84.3
Endocrinology—Routine	5	2	40.0%	0.0%	Not Reported
Endocrinology—Urgent	5	0	-	-	-
Gastroenterology—Routine	8	6	75.0%	0.0%	27
Gastroenterology—Urgent	4	2	50.0%	0.0%	46.2
Pulmonary—Routine	5	0	-	-	-
Pulmonary—Urgent	6	3	50.0%	0.0%	1.3
Pediatric Allergy—Routine	6	3	50.0%	0.0%	21

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
Pediatric Allergy—Urgent	6	2	33.3%	0.0%	6
Pediatric Neurology—Routine	3	0	-	-	-
Pediatric Neurology—Urgent	6	0	-	-	-
Pediatric Orthopedics—Routine	4	0	-	-	-
Pediatric Orthopedics—Urgent	4	3	75.0%	-	3.3
Pediatric Otolaryngology—Routine	5	0	-	-	-
Pediatric Otolaryngology—Urgent	6	0	-	-	-
Adult Behavioral Health—Routine	2	0	-	-	-
Pediatric/Adolescent Behavioral Health—Routine	1	0	-	-	-

N/A: Not available.

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

## VIII. Validation or Administration of a Quality of Care Survey

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### 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.

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

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

### Technical Methods of Data Collection and Analysis

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

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

The survey sample size for the Adult CAHPS was 1,620. UHCP-RI achieved a response rate of 13.7%, or 219 completed surveys.

The survey sample size for the Child CAHPS was 2,310. UHCP-RI achieved a response rate of 10.7%, or 246 completed surveys.

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

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

- *Rating of Health Plan*

## Description of Data

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

## Findings

### Member Satisfaction: Adult and Child Medicaid CAHPS 5.0H<sup>19</sup>

#### Adult CAHPS

UHCP-RI rates for six (6) of the nine (9) satisfaction measures exceeded the *Quality Compass* 2019 national Medicaid mean. Three (3) of these rates performed at or above the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile. UHCP-RI's rate for *Getting Care Quickly* benchmarked at the *Quality Compass* 2019 national Medicaid 90<sup>th</sup> percentile, while the rate for *Rating of All Health Care* and the rate for *Rating of Specialist* benchmarked at the 2019 national Medicaid 75<sup>th</sup> percentile.

Rates for six (6) satisfaction measures performed below the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile. The rate for *Getting Needed Care* benchmarked at the 2019 national Medicaid 66.67<sup>th</sup> percentile; the rates for *Flu Vaccinations for Adults* and *Rating of Personal Doctor* benchmarked at the 2019 national Medicaid 50<sup>th</sup> percentiles; the rates for *Customer Service How Well Doctors Communicate* benchmarked at the 2019 national Medicaid 10<sup>th</sup> percentiles; and lastly, the rate for *Rating of Health Plan* performed below the 2019 national Medicaid 5<sup>th</sup> percentile.

**Table 23** displays the 2017, 2018 and 2019 results of UCHP-RI's Adult CAHPS. The table also displays the *Quality Compass* 2019 national Medicaid percentile achieved by each rate and the 2019 national Medicaid means.

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<sup>19</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.

**Table 23: Adult CAHPS 5.0H Rates—2017-2019**

Measures	CAHPS 2017	CAHPS 2018	CAHPS 2019	<i>Quality Compass</i> 2019 National Medicaid Benchmark	
				<i>Quality Compass</i> 2019 National Medicaid Mean	
Flu Vaccinations for Adults (18-64 Years)	44.6%	44.3%	42.5%	50 <sup>th</sup>	41.8%
Rating of Health Plan <sup>1</sup>	78.9%	78.9%	66.4%	<5 <sup>th</sup>	77.6%
Customer Service <sup>2</sup>	SS <sup>3</sup>	SS <sup>3</sup>	86.8%	10 <sup>th</sup>	88.8%
Getting Care Quickly <sup>2</sup>	85.5%	85.8%	87.1%	90 <sup>th</sup>	82.0%
Getting Needed Care <sup>2</sup>	85.8%	84.7%	84.6%	66.67 <sup>th</sup>	82.5%
How Well Doctors Communicate <sup>2</sup>	93.9%	93.0%	90.2%	10 <sup>th</sup>	92.0%
Rating of All Health Care <sup>1</sup>	78.9%	84.0%	79.1%	75 <sup>th</sup>	75.4%
Rating of Personal Doctor <sup>1</sup>	82.8%	83.9%	82.4%	50 <sup>th</sup>	82.1%
Rating of Specialist <sup>1</sup>	84.5%	77.9%	86.0%	75 <sup>th</sup>	82.3%

SS: Sample size too small to report.

<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 “SS” designation was given for the *Customer Service* composite in 2018 and 2019 and to the Shared Decision Making composite in 2019 because the denominator was less than 100 members.

### **Child CAHPS**

UHCP-RI’s rate for four (4) of the eight (8) satisfaction measures exceeded the *Quality Compass* 2019 national Medicaid mean, while rates for two (2) measures met the 2019 national Medicaid mean. Rates for two (2) measures benchmarked at the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile, while the remaining six (6) rates performed below the 75<sup>th</sup> percentile.

UHCP-RI’s rates for *Rating of All Health Care* and *Getting Care Quickly* achieved the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile. The rate for *Getting Needed Care* benchmarked at the 2019 national Medicaid 66.67<sup>th</sup> percentile; the rates for *Rating of Health Plan*, *How Well Doctors Communicate*, and *Rating of Personal Doctor* benchmarked at the 2019 national Medicaid 33.33<sup>rd</sup> benchmark; and *Customer Service* and *Rating of Specialist* performed below the 2019 national Medicaid 5<sup>th</sup> percentile.

**Table 24** displays the 2017, 2018 and 2019 results of UHCP-RI’s Child CAHPS. The table also displays the *Quality Compass* 2019 national Medicaid percentile achieved by each rate and the 2019 national Medicaid means.

**Table 24: Child CAHPS 5.0 Rates—2017-2019**

Measures	CAHPS 2017	CAHPS 2018	CAHPS 2019	Quality Compass	Quality Compass
				2019 National Medicaid Benchmark	2019 National Medicaid Mean
Rating of Health Plan <sup>1</sup>	86.2%	86.7%	87.1%	33.33 <sup>rd</sup>	86.5%
Customer Service <sup>2</sup>	SS <sup>3</sup>	SS <sup>3</sup>	82.7%	<5 <sup>th</sup>	88.4%
Getting Care Quickly <sup>2</sup>	91.8%	96.1%	93.0%	75 <sup>th</sup>	89.4%
Getting Needed Care <sup>2</sup>	90.3%	87.4%	87.1%	66.67 <sup>th</sup>	84.5%
How Well Doctors Communicate <sup>2</sup>	94.8%	95.9%	94.0%	33.33 <sup>rd</sup>	94.0%
Rating of All Health Care <sup>1</sup>	87.8%	87.4%	90.2%	75 <sup>th</sup>	87.5%
Rating of Personal Doctor <sup>1</sup>	89.7%	89.1%	90.0%	33.33 <sup>rd</sup>	90.0%
Rating of Specialist <sup>1</sup>	SS <sup>3</sup>	SS <sup>3</sup>	80.6%	<5 <sup>th</sup>	87.5%

<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 “SS” designation was given for the *Customer Service* and *Shared Decision Making* composites in 2017, 2018 and 2019 because the denominators were less than 100 members. The “SS” designation was also given to *Rating of Specialist* in 2018 and 2019.

## IX. Strengths, Opportunities and Recommendations

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

### Strengths

Concerning **quality**, UHCP-RI demonstrated the following strengths:

- UHCP-RI's rates for all three (3) measures in the HEDIS Use of Services domain exceeded the *Quality Compass* 2019 national Medicaid average. One (1) measure met the *Quality Compass* 2019 national Medicaid 90<sup>th</sup> percentile and two (2) measures met the 2019 national Medicaid 75<sup>th</sup> percentile.
- UHCP-RI's rate for all eight (8) measures in the HEDIS Effectiveness of Care domain exceeded the *Quality Compass* 2019 national Medicaid average. A rate for one (1) measure met the *Quality Compass* 2019 national Medicaid 95<sup>th</sup> percentile; rates for two (2) measures met the *Quality Compass* national Medicaid 90<sup>th</sup> percentile; rates for four (4) measures met the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile; and a rate for one (1) measure met the *Quality Compass* 2019 national Medicaid 66.67<sup>th</sup> percentile.
- UHCP-RI received a full incentive award for three (3) measures and a partial incentive award for ten (10) measures in the 2019 Performance Goal Program.
- UHCP-RI scores for six (6) of the nine (9) adult satisfaction measures exceeded the *Quality Compass* 2019 national Medicaid averages.
- UHCP-RI scores for six (6) of the eight (8) child satisfaction measures exceeded the *Quality Compass* 2019 national Medicaid averages.

Concerning **timeliness** and **access**, UHCP-RI demonstrated the following strengths:

- UHCP-RI's rates for eight (8) of the nine (9) measures in the HEDIS Access and Availability domain exceeded the *Quality Compass* 2019 national Medicaid average. Rates for two (2) of the measures met the *Quality Compass* 2019 national Medicaid 75<sup>th</sup> percentile.
- UHCP-RI exceeded its provider network adequacy goal of ninety percent (90%) for all provider types in the large metro counties.

### Opportunities for Improvement

Concerning **quality**, UHCP-RI demonstrates an opportunity for improvement in the following areas:

- Although UHCP-RI's QIP, Improving Effective Acute Phase Treatment for Major Depression, demonstrated an improvement in rates, UHCP-RI did not achieve the goal of 58.1%.
- In regards to UHCP-RI's Improving Lead Screening in Children QIP, UHCP-RI did not meet the goal of 85.64%.
- In regards to UHCP-RI's Improving Breast Cancer Screening QIP, UHCP-RI did not meet the goal of 68.94%.
- Regarding the 2019 Adult CAHPS survey, UHCP-RI had reported rates for three (3) of the nine (9) measures below the *Quality Compass* 2019 national Medicaid averages.

- Regarding the 2019 Child CAHPS survey, UHCP-RI had reported rates below the *Quality Compass* 2019 national Medicaid averages for two (2) of the eight (8) measures.

Concerning **timeliness** and **access**, UHCP-RI demonstrates an opportunity for improvement in the following areas:

- UHCP-RI had reported rates below the *Quality Compass* 2019 national Medicaid average for one (1) of the nine (9) reported measures in the HEDIS Access and Availability domain.

## Recommendations

- As UHCP-RI demonstrated improvement in the Living with Illness domain of the NCQA Accreditation survey, UHCP-RI should continue with the improvement strategy described in the Health Plan's response to the previous year's recommendation. The Health Plan should continue to include strategies that target the Getting Better domain. *(repeat recommendation)*
- To improve timeliness and access, UHCP-RI should continue monitoring the access and availability of routine and urgent care appointments. With ten (10) of the 26 provider types surveyed having an appointment rate at or below 50%, UHCP-RI should re-educate network providers of appointment standards and request providers submit a plan of correction should standards continue to not be met.
- The four (4) contractually mandated Quality Improvement Projects (QIPs) comprised multi-faceted intervention strategies that targeted members, providers, and Health Plan systems and processes. Opportunities for improvement remain for all of the four (4) QIPs, as the Health Plan did not achieve the established project goals.

## 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

Identified Opportunity for Improvement	EQRO / IPRO Recommendations	MCO Response
<p>A. Quality of Care Domain: National Committee for Quality Assurance (NCQA) Accreditation Status</p> <p><b>Page 46:</b> Even though the Health Plan received an “Excellent” accreditation from the NCQA, there remain opportunities for improvement regarding the NCQA Accreditation Survey. The Health Plan earned two (2) star ratings for both the Getting Better and Living with Illness domains of the Survey.</p>	<p><u>Page 46:</u> As the Health Plan demonstrated improvement in the Getting Better domain of the NCQA Accreditation survey, the Health Plan should continue with the improvement strategy described in the Health Plan’s response to the previous year’s recommendation. The Health Plan should expand its improvement strategy to include the Living with Illness domain as performance in this area declined.</p>	<ul style="list-style-type: none"> <li>• The Health Plan improved its rating for the Living with Illness domain and earned three stars with the 2019 National Committee for Quality Assurance (NCQA) Accreditation Summary. The Health Plan continued to earn an Excellent Accreditation status from the NCQA for its Medicaid product line. Based on the accreditation standards score, and the HEDIS and CAHPS1 5.0H results, the Health Plan continued to receive an NCQA rating of four and a half out of five.</li> <li>• The Health Plan continues to implement interventions that are targeted to improving members’ getting better and living with illness. Interventions include: <ul style="list-style-type: none"> <li>○ Accountable Care Organizations (ACOs)/ Accountable Entities (AEs): The Health Plan continues to contract with AEs allowing for shared savings if specific quality metrics are met. Measures considered for the contracts are determined from a variety of sources and include HEDIS and State identified custom measures. As of January 1, 2020, the Health Plan is contracted with five AEs; representing approximately 70% percent of the Health Plan’s Medicaid membership.</li> <li>○ <u>The Whole Person Care Plus (WPC) Program:</u> Effective January 1, 2020, the WPC Program’s reporting alignment transitioned from Optum to UnitedHealthcare. This transition allows for a more local approach for addressing the needs of the Health Plan’s membership. The purpose of the program is to facilitate appropriate health care services across the continuum of care as well as to monitor and evaluate options and services to meet an individual’s needs to promote quality, cost effective outcomes. WPC focuses on medical, behavioral and social determinants of health in a multidisciplinary and integrated structure. WPC Management targets individuals who have a higher persistency of health care utilization with complex care</li> </ul> </li> </ul>

		<p>needs and who have chronic and complex risk factors. Additional emphasis is placed on transitions of care.</p> <ul style="list-style-type: none"> <li>○ <u>Preventive Care Program:</u> Health Plans cover and manage services defined as Preventive. These services are now covered under the Preventive Care Program and are administered by the Home Assessment Team. Preventive services are non-skilled home-based services that are intended to maintain members' health and help members' stay independently in their homes in an effort to avoid admission to long term care. These services include homemaking, attendant care services and minor home modifications. A care manager meets members at risk in their home to conduct an extensive functional assessment and develop an individualized plan of care and services. After gaining agreement from the member to the elements of the plan, the care manager coordinates access to these services. The care manager routinely monitors the member's status and assists the member/family with any state long term support applications that may benefit the member's condition. The goals of the interventions include: preventing unnecessary exacerbation and medical expense, keeping members in the community setting for as long as possible, promoting independence, selfreliance and personal esteem, addressing holistic needs, improving quality of life and ensuring safety.</li> <li>○ <u>Continuum Rounds:</u> The Health Plan conducts bi-weekly Continuum Rounds meetings in which the most complex care management cases are discussed with a multidisciplinary team. This includes the following teams and participants: Utilization Management, Discharge Planning, WPC, Home Assessment Team, 3 Identified Opportunity for Improvement EQRO / IPRO Recommendations MCO Response Chief Medical Officer, Skilled Nursing Facility Care Management and Pharmacy. The team reviews member status, problem solves together and develop care plans and interventions.</li> <li>○ <u>HotSpotting Tool:</u> The Health Plan has a hotspotting tool that identifies highest risk members by utilization and social determinants of health elements and assigns each of those individuals identified to an intensive Community Health Worker assessment and intervention process. Special targeted training has</li> </ul>
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		<p>been provided to the team on such topics trauma informed care, safety, motivational interviewing and more.</p> <ul style="list-style-type: none"> <li>○ <u>Pain Management:</u> Effective January 2020, the Health Plan hired a Care Manager dedicated to members in need of pain management. The Care Manager contacted members and worked with them on non-pharmacological approaches; such as physical therapy for lower back pain, stress reduction, exercise, diet and chiropractic services. The Care Manager will coordinate with the members' primary care physician to confirm the treatment plan. To determine the effectiveness of this program, the Health Plan will analyze claims that represent emergency department data. The goal of the program is to reduce emergency room visits. The program was presented at the Health Plan Provider Advisory Committee for input and committee members agreed that the approach seemed reasonable and had no further recommendations regarding the program.</li> <li>○ <u>Housing Pilot:</u> In April 2018, the Rhode Island model incorporated a pilot program which focused on members with housing insecurity who were also persistent super-utilizers of frequent Emergency Room (ER) visits, inpatient utilization and serious persistent mental illness. A team was assigned to assist in obtaining stable housing and closing health care gaps for the members. The program was a pilot program and included care managers, nurses, social workers and a housing authority navigator. The nurse and social workers completed care plans. In the original pilot of forty members, 63% secured stable housing and the Health Plan saw a significant drop in inpatient and ER utilization. Additional plans for expansion of the program are underway.</li> <li>○ <u>Additional Housing Pilot:</u> In June 2020, the Health Plan launched a pilot program with Crossroads RI to build and fund a transitional housing program. In this program, the Health Plan will pay Crossroads for rent and residential care management services for up to ten members who are identified as having housing 4 Identified Opportunity for Improvement EQRO / IPRO Recommendations MCO Response insecurity that significantly impacts their total cost of medical care. In this program, Crossroads has renovated ten apartments in a victorian home for our members. Members are also</li> </ul>
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		<p>provided with a bus pass and telephone. Care management supports will include assistance with other social determinants of health, coordination of health care, vocational support and access to community resources. Each member's goal is to improve their acute health care needs and move into long term stable living situations to improve health and optimize medical expense within 12 months.</p> <ul style="list-style-type: none"> <li>○ <u>Multiple Member and Provider Interventions:</u> The Health Plan continues to implement interventions that are targeted to specific members for specific services with the goal of improving the quality of life of our members. Interventions implemented include: member incentive programs, member mailings, member emails, member Interactive Voice Response (IVR) and live agent calls, Member Advisory Committee, provider mailings, provider calls, Provider Advisory Committee, provider site visits, monthly meetings with AEs, educational Town Hall meetings with our FQHCs, State and MCO partnerships; as well as data analysis from a social determinant of health perspective.</li> </ul>
<p>B. <u>Quality of Care Domain: HEDIS Effectiveness of Care</u></p> <p><u>Page 46:</u> In regard to the HEDIS Effectiveness of Care domain, the Health Plan's rate for Medication Management for People with Asthma 75% (5-64 Years) benchmarked in the 2018 Quality Compass 66th percentile.</p>	<p><u>Page 46:</u> The Health Plan continues to demonstrate an opportunity for improvement in regard to specific HEDIS measures: Medication Management for People with Asthma 75% (5-64 Years). Despite not achieving the Quality Compass 75th percentile, the Health Plan rates has demonstrated improvement. As such, it is recommended the Health Plan continue the initiatives described in the Health Plan's response to the previous year's recommendation.</p>	<ul style="list-style-type: none"> <li>• The Health Plan's performance in 2019 improved for the third year in a row to 45.55%, from 43.06% and 39.50% in the past two years, and met the 2018 Medicaid QC 75th percentile. Even though the Health Plan's rates have demonstrated improvement, opportunity continues to exist. The Health Plan will continue the initiatives described in the previous year's response. <ul style="list-style-type: none"> <li>○ <u>Member IVR Calls:</u> The Health Plan contracts with a vendor for telephonic IVR calls. During RY 2019, a total of 551 IVR calls were conducted for members with asthma. The call script emphasized concepts such as the importance of having regular visits with one's healthcare provider and differentiates between controller and rescue medications.</li> <li>○ <u>Provider Visits:</u> In April of each year, Clinical Practice Consultants (CPCs) identify high volume providers who have at least 100 Medicaid members in their patient panel. This translates on average to 100 provider practices. Provider visits are then scheduled from May through November and the Patient Care Opportunity Reports (PCORs) (e.g., gap in care reports that list non-compliant members, low performing providers and etc.) are</li> </ul> </li> </ul>

		reviewed and discussed for 5 Identified Opportunity for Improvement EQRO / IPRO Recommendations MCO Response specific priority measures. AWC is discussed. Conversations include barriers, opportunities for improvement, interventions, lessons learned and/ or etc.
<p>C. Quality of Care Domain: State Performance Goal Program</p> <p><u>Page 46:</u> Despite the Health Plan's overall strong performance on the Performance Goal Program (PGP), there are opportunities for improvement in certain areas. The Health Plan did not report rates to qualify for incentive awards for the following five (5) HEDIS measures within the Prevention and Screening and Behavioral Health domains:</p> <ul style="list-style-type: none"> <li>• Lead Screening in Children (LSC),</li> <li>• Breast Cancer Screening (BCS),</li> <li>• Follow-Up After Hospitalization for Mental Illness—7 Days (FUH),</li> <li>• Antidepressant Medication Management—Effective Acute Phase Treatment (AMM), and</li> <li>• Follow-Up for Children Prescribed ADHD Medication—Initiation Phase (ADD).</li> </ul>	<p><u>Pages 46-47:</u> The Health Plan continues to demonstrate an opportunity for improvement in regard to specific HEDIS measures:</p> <ul style="list-style-type: none"> <li>• Lead Screening in Children – The Health Plan should determine if there are significant differences in rates between PCP locations with an onsite lab and locations with no onsite lab.</li> <li>• Breast Cancer Screening member outreach initiatives, in addition to tracking the number of mailings and telephone calls to members, the Health Plan should also track the number of unsuccessful mailings due to incorrect addresses, as well as unanswered and unsuccessful live agent calls. These data will allow the Health Plan to calculate the percentage of members who are positively impacted by the initiatives and ultimately determine the effectiveness of the initiatives. The Health Plan should also broaden its provider education outreach strategy to include all innetwork PCPs and OB/GYNs.</li> <li>• Follow-Up After Hospitalization for Mental Illness—7 Days,</li> </ul>	<p>• Even though the Health Plan's overall performance was strong for the 2018 PGP, opportunities continue to exist.</p> <ul style="list-style-type: none"> <li>• LSC <ul style="list-style-type: none"> <li>○ The Health Plan did determine through a sample of providers that rates for provider locations with an onsite lab were higher than provider locations with no onsite lab. The Health Plan continues to partner with the Rhode Island Department of Health (RIDOH) and Neighborhood Health Plan to encourage providers during on-site or virtual visits with no onsite lab to try using capillary screenings to help improve lead screening rates.</li> </ul> </li> <li>• BCS <ul style="list-style-type: none"> <li>○ The health plan does track the number of unsuccessful mailings and unanswered/ unsuccessful live agent calls for many of its initiatives; including initiatives related to BCS. Beginning with the programs implemented in RY 2020, undeliverable mailings and unanswered live agent calls will be included in the effectiveness analysis of the programs.</li> <li>○ The Health Plan does provide in-person and/ or virtual education outreach to high volume provider practices (e.g., more than 100 Medicaid members in the practice patient panel). This translates to about 100 provider practices that receive at least one visit, but up to a few visits a year. The Health Plan agrees that we should include OB/GYNs in the education outreach and will do so in RY 2020 by identifying high volume and low performing sites so that CPCs can outreach.</li> </ul> </li> <li>• FUH and AMM <ul style="list-style-type: none"> <li>○ The Health Plan is working with a vendor to provide Medication Management Solutions (MMS) to our Medicaid members. We are currently in the process of identifying eligible members. The MMS program is similar, but not parallel to, an MTM program. The</li> </ul> </li> </ul>

	<p>Antidepressant Medication Management—Effective Acute Phase Treatment – The Health Plan should consider utilizing in-network pharmacists to conduct Medication Therapy Management (MTM).</p> <ul style="list-style-type: none"> <li>• In regard to the HEDIS Follow-Up for Children Prescribed ADHD Medication—Initiation Phase measure, the Health Plan should identify reasons for the decline in performance through root cause analysis and leverage the success of current behavioral health initiatives to address this measure.</li> </ul>	<p>targeting criteria is different, the overlap of members eligible for MTM service is not significant, and we are not submitting any MTM electronic “paperwork” to be reimbursed or counted for MTM service for these members. However, MTM is an easy way to conceptualize the initial encounter with these members, as that process is very similar. The vendor is reaching out to targeted members, performing a Comprehensive Medication Review (CMR), coordinating care and follow up with the member, their caregivers, and their prescribers, and sending out summaries to the providers and members after the encounter. By comparison to the MTM service, the vendor does not stop there. They schedule follow ups with members based on the care level needed in each situation. At a minimum the follow up is scheduled quarterly. Sometimes they end up engaging patients weekly until they are stable/comfortable on their medication regimen before the vendor start backing the calls out to a longer cadence. If the member ends up back in the hospital, the vendor is pushing them back to the top of the call list priority and performing the discharge reconciliation and coordination process as soon as possible. They also have a call back line the members can reach the vendor through if any questions come up between encounters.</p> <ul style="list-style-type: none"> <li>• ADD <ul style="list-style-type: none"> <li>○ The Health Plan improved in performance from RY 2017 (47.61%) to RY 2018 (51.69%); however, there is still room for improvement. An analysis was completed with preliminary RY 2019 data. Findings revealed some members receiving medication for ADHD were not appearing on a list for member education. The program logic has been since updated.</li> <li>○ The Health Plan will continue to leverage the success of current behavioral health initiatives which include: <ul style="list-style-type: none"> <li>▪ Member Mailing: A weekly letter mailed to parents/ guardians of children where a prescription for ADD was initially filled the previous week. The letter encourages the parent / guardian to have a follow-up appointment within thirty calendar days of the initial fill and two more appointments between six and nine months. In RY 2019, 784 letters were mailed to members after</li> </ul> </li> </ul> </li> </ul>
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		<p>the initial prescription fill.</p> <ul style="list-style-type: none"> <li>▪ Member Website Resource: Provided education materials to enrollees via the behavioral health Liveandworkwell.com website on topics related to major depressive disorder including causes of depression, symptoms, treatment, medications, suicide warnings, living with depression, and finding and selecting mental health providers and ADD.</li> <li>▪ Provider Visits: In April of each year, Clinical Practice Consultants (CPCs) identify high volume providers who have at least 100 Medicaid members. This translates on average to 100 provider practices. Provider visits are then scheduled from May through November and the Patient Care Opportunity Reports (PCORs) (e.g., gap in care reports that list non-compliant members, low performing providers and etc.) are reviewed and discussed for specific priority measures. ADD is discussed. Conversations include barriers, opportunities for improvement, interventions, lessons learned and/ or etc.</li> <li>▪ Provider Outreach: In Q3 of 2019, CPCs identified low performing provider practices and outreached to the practices to discuss barriers. Optum outreached to the low performing behavioral health practices during this same time period.</li> <li>▪ Provider Educational Materials: Optum flyers related to ADD were distributed during the provider visits and behavioral health educational materials are available at <a href="http://www.uhcprovider.com">www.uhcprovider.com</a>.</li> <li>▪ Provider Website Resource: Educated providers on the Liveandworkwell.com website that has information and resources for mental and physical health conditions.</li> <li>▪ Behavioral Health Collaborative: Health Plan quality staff and Optum Behavioral Health quality staff meet monthly to review behavioral health measures' barriers and opportunities.</li> </ul>
<p>D. Quality of Care Domain: Member Satisfaction - CAHPS Survey</p> <p><u>Page 46:</u> UnitedHealthcare continues to demonstrate an opportunity for improvement in</p>	<p>Page 47: Despite having a robust strategy for addressing member satisfaction, the Health Plan continues to demonstrate opportunities for improvement as member satisfaction varies across</p>	<ul style="list-style-type: none"> <li>• Each year, the health plan conducts a thorough analysis of the results from the CAHPS survey. The analysis includes a year-over-year comparison, as well as a comparison to the UHC National Average. The Health Plan historically meets and exceeds the UHC National Average. The Health Plan determines opportunities and implements strategies with the goal of improving identified opportunities. The Health Plan continues to conduct both the</li> </ul>

<p>regard to member satisfaction. In regard to the adult CAHPS survey, the Health Plan reported rates below the 2018 Quality Compass 75th percentile for the following measures:</p> <ul style="list-style-type: none"> <li>• Rating of Health Plan,</li> <li>• Getting Needed Care,</li> <li>• How Well Doctors Communicate and</li> <li>• Rating of Specialist. Additionally for the child CAHPS survey, the following measure rates benchmarked below the 75th percentile:</li> <li>• Rating of Health Plan,</li> <li>• Getting Needed Care,</li> <li>• Rating of All Health Care and</li> <li>• Rating of Personal Doctor.</li> </ul>	<p>the adult and child populations. The Health Plan should continue with its strategy of analyzing CAHPS data on an annual basis, identifying opportunities for improvement and addressing these opportunities. However, the Health Plan should consider collaborating with other Medicaid health plans in Rhode Island to address shared provider network issues.</p>	<p>Adult Medicaid and the Child Medicaid CAHPS survey results.</p> <ul style="list-style-type: none"> <li>• Beginning with the 2018 CAHPS results, the Health Plan performance was compared against the 2017 National Quality Compass Medicaid All Lines of Business (QC) 50th percentile (update to 75th percentile with the 2019 CAHPS). The 2019 CAHPS results were mixed and activities implemented to improve the CAHPS rates included the following: <ul style="list-style-type: none"> <li>o Member Newsletter: In the Spring 2019 Health Talk member newsletter, a CAHPS article was included called “What do you think (CAHPS Survey)”.</li> <li>o Member Education/ Outreach: <ul style="list-style-type: none"> <li>▪ The Health Plan continued to educate the membership regarding the provider network and how to access care with emphasis on the member’s role to create a partnership with their provider and specialist, as well as how to make the most of one’s appointment.</li> <li>▪ The Health Plan continued to educate members on appropriate points of services depending on their condition and the appropriate appointment scheduling based upon need.</li> </ul> </li> <li>o Provider Education/ Outreach: <ul style="list-style-type: none"> <li>▪ Continued to educate and reinforce mainstreaming expectations with the Health Plan provider network.</li> <li>▪ Educated providers about the CAHPS survey and questions asked related to the relationship the member has with the physician and physician’s staff through materials available to: Provider Advisory Committee meetings, Network Provider Advocate outreach, FQHC Town Hall meetings, provider newsletters and educational resources and bulletins on the provider portal.</li> <li>▪ Provider Educational Material: A CAHPS Reference Sheet is distributed to about 100 high volume providers (at least 100 Medicaid members) and AEs. The CAHPS reference sheet is also available at <a href="http://www.uhcprovider.com">www.uhcprovider.com</a>. The CAHPS reference sheet provides providers with an overview of the CAHPS survey process and the questions asked that rate the physician/ member experience. The CAHPS reference sheet gives providers recommendations on how to improve their interactions with members in order to improve the member experience.</li> </ul> </li> </ul> </li> </ul>
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		<p>partners and members.</p> <ul style="list-style-type: none"> <li>Beginning in the Summer of 2019, the Health Plan met monthly with Neighborhood Health Plan of RI to discuss quality items, including CAHPS. The purpose of the meetings was to not only address shared provider network issues, but also to ensure consistent messaging to members and providers. Where Neighborhood tends to perform better in the Adult CAHPS Survey, UHCCP RI tends to perform better in the Child CAHPS Survey.</li> </ul>
<p>E. Access to / Timeliness of Care Domain: Access and Availability Survey</p> <p><b>Pages 47:</b></p> <p><b>o The Health Plan demonstrates an opportunity for improvement regarding the Access and Availability Survey. The Health Plan's rates for timely appointments were low across many of the providers and appointment types</b></p>	<p><u>Page 48:</u> The results of the Access and Availability survey coupled with continuously low primary care rates among children and adults suggests that there are potential network issues that are preventing members from accessing care within appropriate timeframes. The Health Plan should assess adequacy of its provider network to identify the existence of gaps in quality and size that may act as barriers for members who want to access primary care.</p>	<ul style="list-style-type: none"> <li>The Health Plan in coordination with Optum Health offers one of the most comprehensive Medicaid networks statewide with 11 hospitals, 9 Ambulatory Surgery Centers, over 2,200 Primary Care Physicians and over 5,000 Specialists. The Health Plan has been in the marketplace for more than twenty-five years and is committed to continuously maintain, evaluate, monitor and recruit to ensure a robust disciplinary provider network, so members have access to the full range of covered health services. We have a Network Management Team structure that supports ongoing review and analysis of the network, ensuring access as well as identifying opportunities to continue to enhance our network. As part of network development, maintenance and monitoring, we conduct quarterly geographic access reporting, quarterly provider capacity reports to ensure appropriate access for our members, Access Surveys – announced and secret shopper (alternating quarters), ongoing monitoring and trending of quality of care / quality of service concerns / complaints from members and trending of feedback from medical directors, nurse case managers and front line staff.</li> <li>The results from the quarterly surveys are evaluated by a cross functional team including representation from Quality, Provider Network Management, Behavioral Health and Provider Relations Advocates meet to analyze the results and drill down to root causes and opportunities. Provider Relations Advocates contact each practice/ provider that was not able to make an appointment in accordance with the standards and they educate the provider office on the standard requirements. For some cases, the reasoning is justified such as the provide office is requesting the member's insurance card or medical records to make the appointment but not truly available in a secret shopper scenario. For areas identified as opportunities, provider relations advocates mitigate issues such as working with the provider/ practice to update demographic data within the Health Plan systems, and the Provider Directory to ensure providers are aligned with the correct</li> </ul>

		<p>practice location, if the provider has moved or retired, if they've added new providers, if their practice panel is closed to new patients or if they need a reminder as to the standards and purpose of the survey and how they can best support the existing practice providers by covering for each other to meet the patient needs and access standards. In addition, when the survey results do not match what the Provider Advocates find when they follow up with a practice/ provider, the actual survey call recording is requested to drill down even further as what the underlining issue is and the Provider Advocate is better able to help mitigate.</p> <ul style="list-style-type: none"> <li>• The Health Plan continues to accept applications from new providers and continues to credential and contract with new providers to support an accessible and robust network.</li> <li>• Our 2018 CAHPS results revealed improvements in both the Getting Needed Care and Getting Care Quickly composites for both the adult and child surveys and met the 2017 National QC Medicaid All Lines of Business 50th percentile (75th percentile with 2019 CAHPS results). After each CAHPS season, the results are presented and discussed at the Provider Advisory Committee meeting. The discussion from the 2019 CAHPS survey results focused on routine and urgent care appointment accessibility. The providers advised us that the majority of their patients prefer early morning appointments before work or school; with open appointments available throughout the day</li> </ul>
<p>F. Access to / Timeliness of Care Domain: HEDIS Access to / Availability of Care</p> <p><b>Pages 47-48:</b></p> <ul style="list-style-type: none"> <li>○ <b>UHCP-RI continues to demonstrate an opportunity for improvement regarding the HEDIS Access and Availability domain.</b></li> <li>○ <b>The Health Plan's rates for the 12-24 Months and 25 Months-6 Years age</b></li> </ul>	<p><u>Page 48:</u> The results of the Access and Availability survey coupled with continuously low primary care rates among children and adults suggests that there are potential network issues that are preventing members from accessing care within appropriate timeframes. The Health Plan should assess adequacy of its provider network to identify the existence of gaps in quality and size that may act as barriers for members who want to access primary care.</p>	<ul style="list-style-type: none"> <li>• CAP 12-24 Months and 25 Months to 6 Years Interventions to Improve Performance: <ul style="list-style-type: none"> <li>○ <u>Member Healthy First Steps and Baby Blocks:</u> Ongoing incentive programs that encourage pregnant members to make and keep doctor appointments during pregnancy through the baby's first 15 months, including the postpartum visit. Members use the app to schedule doctor appointments, prepare for what to expect and learn how to take care of themselves and their baby; mybabyblocks.com.</li> <li>○ <u>Member Monthly Preventive Health Mailings:</u> Mailing encouraging a PCP visit. There were 33,222 members in calendar year (CY) 2019 who received a mailing. The letter is designed to educate and encourage members to call and schedule an appointment with their primary care physician in order to receive their preventative health screenings and Early and Periodic Screening, Diagnostic and</li> </ul> </li> </ul>

<p><b>groups of the Children and Adolescents' Access to Primary Care Providers (CAP) measures were benchmarked in the 2018 Quality Compass 10th and 50th percentiles, respectively.</b></p> <ul style="list-style-type: none"> <li>○ <b>Additionally, the Health Plan's rate for the 20-44 Years age group of the Adults' Access to Preventive/Ambulatory Health Services (AAP) measure benchmarked in the 33rd percentile, while the 45-64 Years and 65+ Years age groups benchmarked in the 50th percentile.</b></li> </ul>		<p>Treatment (EPSDT) services according to their upcoming birthday. The letter is available in English and Spanish.</p> <ul style="list-style-type: none"> <li>○ <u>Member Monthly Birthday Card Mailing:</u> This mailing was another avenue to educate, remind and encourage the Health Plan membership of the importance of scheduling an appointment with their primary care physician and receive necessary health screenings. The birthday cards impart age appropriate preventive health messaging and are available in English and Spanish. Approximately 7,000 birthday cards were mailed each month for a total of 88,492 birthday cards mailed to members in RY 2019.</li> <li>○ <u>Member Newsletter:</u> In the Summer 2019 Heath Talk member newsletter, an article was included called "Charting health and Time for a checkup" and "Getting the right care. Where to go for the care you need".</li> <li>○ <u>Member EPSDT IVR Calls:</u> The call script emphasizes the importance of having child appointments with the PCP so that health, speech, hearing, eyesight, and growth can be monitored. The call also reminds to parent / guardian that the child may be due for certain shots or a test to check for lead poisoning. In RY 2019, 29,124 calls were completed.</li> <li>○ <u>Member Live Outreach Calls:</u> The Health Plan also contracts with vendors to conduct live outreach calls to the Health Plan members. As part of this process, the vendor conducts an initial outreach call, a reminder call and if a call after the appointment to confirm appointment was conducted. There was a total of 4,824 calls conducted in RY 2019 for both CAP age groups.</li> <li>○ <u>Provider Visits:</u> The Health Plan CPCs meet with large volume Provider Practices (e.g., more than 100 Medicaid members in the practice patient panel) 1-2 times per year to discuss current rates, opportunities for improvement with noncompliant members and share best practices from high performing provider practices.</li> <li>○ <u>Operational Data Clean Up:</u> <ul style="list-style-type: none"> <li>● The Health Plan staff reviews baby identification numbers with child membership to identify matches and eliminate duplicates.</li> <li>● On a monthly basis, the Health Plan provides information to the State that has been received by the Health Plan case managers or field</li> </ul> </li> </ul>
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		<p>workers on members identified as having moved out of state.</p> <ul style="list-style-type: none"> <li>• AAP Interventions to Help Improve Performance: <ul style="list-style-type: none"> <li>○ <u>Member Annual Preventive Health Mailing</u>: encouraged a PCP visit and in May 2010, 31,962 adult members were sent the mailing. The letter is designed to educate and encourage members to call and schedule an appointment with their primary care physician in order to receive their preventative health care and other recommended screenings. The letter is available in English / Spanish.</li> <li>○ <u>Member Monthly Birthday Card</u>: The Health Plan continued the birthday card campaign in 2019 as another avenue to educate, remind and encourage the Health Plan membership of the importance of scheduling an appointment with their primary care physician and receive necessary health screenings. The birthday cards are available in English / Spanish. Approximately 7,000 birthday cards were mailed each month for a total of 88,492 birthday cards mailed to members in RY 2019.</li> <li>○ <u>Member Newsletter</u>: In the Summer 2019 Health Talk member newsletter, an article was included called “Charting health and Time for a checkup” and “Getting the right care. Where to go for the care you need”.</li> </ul> </li> </ul>
<p>G. <u>Access to / Timeliness of Care</u> <u>Domain: State Performance</u> <u>Goal Program</u></p> <p><b>Page 48:</b> <b>Regarding the Access to Care domain of the Performance Goal Program, the Health Plan’s reported rates did not benchmark in a 2017 Quality Compass percentile to qualify for an incentive award for the following HEDIS measures:</b></p> <ul style="list-style-type: none"> <li>• <b>Children and Adolescents’ Access to Primary Care Providers (CAP) (12-24 Months),</b></li> </ul>	<p><b>Page 48:</b> The results of the Access and Availability survey coupled with continuously low primary care rates among children and adults suggests that there are potential network issues that are preventing members from accessing care within appropriate timeframes. The Health Plan should assess adequacy of its provider network to identify the existence of gaps in quality and size that may act as barriers for members who want to access primary care.</p>	<ul style="list-style-type: none"> <li>• CAP 12-24 Months and 25 Months to 6 Years Interventions to Help Improve Performance: <ul style="list-style-type: none"> <li>○ Please refer to above for MCO CAP response.</li> </ul> </li> <li>• IET Interventions to Improve Performance: <ul style="list-style-type: none"> <li>○ <u>Provider Educational Materials</u>: Behavioral health education materials are available on the UHC provider website and also provided during provider visits.</li> <li>○ <u>Provider Mailing</u>: In October 2019, the Health Plan educated 52 RI behavioral health providers who saw 5 or more members and had an IET compliance rate of &lt; 50%, via a mailing that included information on IET specifications and best practices in treating members with a Substance Use Disorder.</li> <li>○ <u>Provider Newsletter</u>: In Fall 2019, the Practice Matters Provider Newsletter included an article for IET and a Behavioral Health Toolkit for providers.</li> </ul> </li> </ul> <p>UHCCP RI quality staff and Optum Behavioral Health quality staff meet</p>

<ul style="list-style-type: none"> <li>• <b>Children and Adolescents' Access to Primary Care Providers (25 Months-6 Years), (CAP) and</b></li> <li>• <b>Initiation of Alcohol and Other Drug Dependence Treatment (IET)</b></li> </ul>		monthly to review behavioral health measures, barriers and opportunities.
<p>H. <u>State Performance Goal</u> <u>Program: Quality Improvement Projects (QIPs) Overall</u></p> <p><b>Please refer to the sections below for overviews of each QIP.</b></p>	<p><u>Page 48:</u> The four (4) contractually mandated Quality Improvement Projects (QIPs) comprised multi-faceted intervention strategies that targeted members, providers, and Health Plan systems and processes. Opportunities for improvement remain for three (4) of the four (4) QIPs, as the Health Plan did not achieve the established project goals.</p>	<ul style="list-style-type: none"> <li>• The Health Plan provides an update to the Rhode Island Executive Office of Health and Human Services (EOHHS) each quarter on the activities completed for each QIP.</li> <li>• Please refer to the specific QIP sections below for the responses to each individual QIP.</li> </ul>
<p><u>QIP#1: State Measure Developmental Screening in the First Three Years of Life</u></p> <p><u>Page 38:</u> <b>The Health Plan demonstrated improvement in the rate for one (1) measure, a decrease in the rate for one (1) measure, and the rate for the third measure remained the same from the previous year. All three (3) indicators exceeded the goal of fifty percent (50%).</b></p> <ul style="list-style-type: none"> <li>• <b>Indicator 1 increased from 54.0% to 57.7% and exceeded the QIP goal.</b></li> </ul>	<p><u>Page 39: Opportunities for Improvement:</u></p> <ul style="list-style-type: none"> <li>• The Health Plan decreased its goals for the three (3) indicators by ten (10) percentage points from the previous measurement period for this QIP. While the Health Plan was able to meet the new goal for each indicator, the Health Plan should consider revising the goals and aiming for a higher level of improvement.</li> <li>• Many of the barriers identified by the Health Plan are addressing lack of understanding or awareness of preventive health schedules for children. The Health Plan should conduct a more</li> </ul>	<ul style="list-style-type: none"> <li>• Developmental Screening will continue as a QIP in RY 2020 with an increased goal from 50% to 65%. The Health Plan continued with the hybrid medical record collection strategy for the three sub-measures and achieved improvements in all three sub-measures year over year. <ul style="list-style-type: none"> <li>○ <u>12 months preceding their first birthday:</u> 67.15% in RY 2019; 64.23% in RY 2018; 57.66% in RY 2017; and 54.01% in RY 2016</li> <li>○ <u>12 months preceding their second birthday:</u> 73.72% in RY 2019; 65.69% in RY 2018; 57.66% in RY 2017; and 57.66% in RY 2016</li> <li>○ <u>12 months preceding their third birthday:</u> 62.77% in RY 2019; 59.85% in RY 2018; 56.93% in RY 2017; and 59.12% in RY 2016</li> </ul> </li> <li>• The Health Plan will continue to conduct ongoing barrier analysis in order to implement targeted interventions. <ul style="list-style-type: none"> <li>○ RY 2019 medical record review revealed that members were being screened after their birthday as well as the provider not using an approved screening tool making the member non-compliant for the measure.</li> </ul> </li> <li>• Clinical Practice Consultants (CPC) are providing education regarding the patient needing to be screened before their birthday, the Health Plan's</li> </ul>

<ul style="list-style-type: none"> <li>• <b>Indicator 2 remained the same at 57.7% and exceeded the QIP goal.</b></li> <li>• <b>Indicator 3 decreased from 59.1% to 56.9%, but still exceeded the QIP goal.</b></li> </ul> <p><b>Overall Credibility of Results:</b>  <b>There were no validation findings that call into question the credibility of this QIP.</b></p>	<p>thorough barrier analysis to identify other barriers members and providers may face preventing them from getting appropriate screenings and barriers providers face to conducting these screenings. The Health Plan should then develop proactive interventions to address any identified barriers. Some barriers could include lack of transportation to appointments or availability of timely appointments, among others.</p> <ul style="list-style-type: none"> <li>• The intervention strategy aimed at members, as well as several of the interventions aimed at providers, are passive in nature (i.e., mailings and newsletter articles). Additionally, the interventions are broad, covering well-visits in general, rather than focusing on the QIP topic of developmental screenings. The Health Plan should consider developing more active, focused interventions in order to facilitate improvement in the rates for developmental screenings.</li> </ul>	<p>operational change in being able to provide a well visit within the calendar year and the approved screening tools to all five contracted AEs (~70% of Medicaid membership), as well as the top 100 high volume providers/ FHQCs (at least 100 Medicaid members) during monthly meetings with the AE and annual visits with the high volume provider practices/ FQHCs.</p> <ul style="list-style-type: none"> <li>• The Health Plan has developed more active, focused interventions in order to facilitate improvement in the rates for developmental screenings. Interventions included: <ul style="list-style-type: none"> <li>○ <u>Member IVR Calls:</u> The Health Plan contracts with a vendor to provide IVR calls to noncompliant members for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screenings on a weekly basis. Developmental Screenings is one of the EPSDT screenings. In RY 2019, there were a total of 29,124 calls completed.</li> <li>○ <u>Member Mailing:</u> In RY 2020, the Health Plan developed a Developmental Screening flyer to mail to non-compliant members to educate the members on the importance of developmental screenings. As the State begins to open back up from COVID-19, that flyer will also be distributed at member events.</li> <li>○ <u>FQHC Town Hall Presentation:</u> The Developmental Screening technical specifications and results were presented at the Health Plan FQHC Town Hall meeting in May 2018.</li> <li>○ <u>Patient Care Opportunity Reports (PCORs):</u> During the meetings with the AEs and high-volume provider practices/ FHQCs, CPCs also review PCORs. These reports include members who are non-compliant with developmental screenings and low performing providers. Providers are encouraged to reach out to those members to schedule a visit to complete a developmental screening and educate the providers on the importance of developmental screenings.</li> <li>○ <u>ACO:</u> One of the quality measures AEs and MCOs have included in the ACO contracts is Developmental Screening for RY 2018, 2019 and 2020. This measure is part of the Total Cost of Care shared savings. The Health Plan meets with the ACOs each month, provides a list of non-compliant members and discusses barriers and opportunities for improvement.</li> <li>○ <u>Developmental Screening Data:</u> The Health Plan partners with the</li> </ul> </li> </ul>
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		Rhode Island Department of Health to receive Developmental Screening data in order to feed into our data engines. This allows for more accurate and robust data that is provided in the PCORs.
QIP#2: HEDIS Lead-Screening in Children	<p><u>Page 41:</u> Opportunities for Improvement:</p> <ul style="list-style-type: none"> <li>• The Health Plan’s Health Disparities Work Group identified several barriers to care for lead screening, as well as several opportunities for collaborations with external partners. The Health Plan should develop interventions to address the barriers identified by this work group, as well as follow up with the identified external collaborators in order to help improve lead screening rates.</li> <li>• The Health Plan should consider developing more active, focused interventions for this QIP. Several of the interventions are similar or identical to other projects the Health Plan is conducting, and are generally aimed at “preventive care”, and not at the topic of the project.</li> </ul>	<ul style="list-style-type: none"> <li>• The Health Plan will continue LSC as a QIP in RY 2020 because there is still room for improvement in order to meet the benchmark.</li> <li>• The Health Disparities Work Group identified geographic location as the top disparity. Barriers also included members being screened after their second birthday and members not obtaining a screen because there was no lab onsite. <ul style="list-style-type: none"> <li>○ <u>The Health Disparities Action Plan:</u> Developed in 2018 and includes LSC as one of the targeted measures. The health plan chose to target geographic location as the health disparity. As of December 2019, data revealed that Newport County had the lowest percentage of non-compliant members, so a Clinical Practice Consultant (CPC) reached out to the largest volume practice in Newport County with a list of members who were noncompliant in receiving lead screenings. Data in 2020 is now revealing Providence County is the least compliant county with a statistically significant denominator. CPCs will continue to speak with large pediatric practices in Providence</li> <li>○ <u>Data Analysis:</u> Analysis on non-compliant members revealed Washington County residents had the highest rates of children at risk for lead poisoning; however, this was primarily due to lack of screening. For those children who were screened, blood lead levels were actually lower than their counterparts in other counties.</li> <li>○ <u>Member Event:</u> In Q3 2018, Health Plan staff including the Quality Team, participated in the Westerly Community Event at the Johnnycake Center. LSC educational materials were distributed to participants.</li> <li>○ <u>Member Educational Mailing:</u> In Q3 2019, the Health Plan developed an LSC educational mailing targeted to non-compliant members residing in Washington County. The mailing educated 93 parents on the importance of LSC before a child’s second birthday and a general statement that providers are available within these communities or if assistance is needed to contact</li> </ul> </li> </ul>

		<p>Member Services.</p> <ul style="list-style-type: none"> <li>○ <u>Member Newsletter</u>: In Q3 2019, the Health Plan requested an article on lead screening to be included in the Fall 2019 edition of the Member Newsletter: HealthTalk. The article indicated providers are available to provide lead screening throughout the state and if a member needed assistance with locating a provider or scheduling the lead screening to call Member Services.</li> <li>○ <u>Provider Newsletter</u>: In Q3 2019, the Health Plan included an LSC article in the Fall 2019 edition of the Provider Newsletter: Practice Matters.</li> <li>○ <u>Provider Outreach</u>: In Q4 of 2018, CPCs identified five low performing provider practices and outreached to the practices to discuss barriers. In RY 2020, CPCs identified two ACOs and one hospital that was low performing and outreached to the practices for a combined.</li> </ul> <ul style="list-style-type: none"> <li>● Since the Summer of 2019, the Health Plan has met with Neighborhood Health Plan and RIDOH on a quarterly basis. <ul style="list-style-type: none"> <li>○ Based on discussions from those meetings, we meet on a quarterly basis to discuss barriers, opportunities for improvement, interventions and lessons learned in order to close gaps in care. We also ensure consistent messaging/ interventions across organizations to better align our efforts for both the provider and member. In addition, UnitedHealthcare has identified two AEs and one hospital that are high volume and low performing for lead screening to schedule a combined RIDOH and UnitedHealthcare visit. To date, we have met with one ACO, the other ACO declined the offer, and the hospital is scheduled. <ul style="list-style-type: none"> <li>● The Health Plan has developed more active, focused interventions for this QIP.</li> </ul> </li> <li>○ <u>Member Rewards</u>: A \$25.00 gift card member incentive program is available to members' age one year of age. There were 22 lead screening incentives were fulfilled out of 743 opportunities mailed (3%) in RY 2019.</li> <li>○ <u>Member Monthly Preventive Health Mailings</u>: A mailing which encouraged a lead screening at a PCP visit. The letter was revised in calendar year 2019 to emphasize the importance of lead screening.</li> </ul> </li> </ul>
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		<p>The letter is available in English / Spanish. There were 33,222 members in calendar year (CY) 2019 who received a mailing.</p> <ul style="list-style-type: none"> <li>○ <u>Member Live Calls</u>: Live telephonic calls continue to those members still in need of a lead screening at 18 months of age. The call educates the parent / guardian on the importance of the lead screen and offers to assist the member with scheduling an appointment with the child's PCP. There was a total of 3,259 calls made in RY 2019.</li> <li>○ <u>Member Mailing</u>: Monthly preventive mailer encouraging a lead screening at a PCP visit. The letter was revised in calendar year 2019 to emphasize the importance of lead screening.</li> <li>○ <u>Member Healthy First Steps and Baby Blocks Reward</u>: Members who are enrolled in the program and completed a lead screening are eligible for a child proof kit or a children's lead screening book.</li> <li>○ <u>Provider Educational Material</u>: In Fall of 2019, a lead screening flyer was developed and distributed at about 100 provider offices and is available at community events for distribution.</li> <li>○ <u>FQHC Town Hall Presentation</u>: In May 2018, HEDIS Lead Screening technical specifications; along with our analysis, results and actions taken were presented at the Health Plan FQHC Town Hall meeting.</li> </ul>
<p><u>QIP#3: HEDIS Antidepressant Medication Management</u></p> <p><u>Page 43:</u> The Health Plan's rate continued to demonstrate a slight decline in performance, decreasing from 54.0% to 51.2%, and did not meet the QIP goal.</p> <p>Overall Credibility of Results: There were no validation findings that call into question the credibility of this QIP.</p>	<p><u>Page 43:</u> Opportunities for Improvement:</p> <ul style="list-style-type: none"> <li>• The Health Plan should consider expanding the case management intervention to include more members rather than just those that are hospitalized. The Health Plan should consider triggering case management services</li> <li>• earlier for members diagnosed with depression and dispensed an antidepressant in order to assist members in receiving appropriate</li> </ul>	<ul style="list-style-type: none"> <li>• The Health Plan will continue AMM as a QIP in RY 2020 to ensure the benchmark continues to be met. The Health Plan met the goal for the first time of the 2019 QC 75th percentile rate of 56.57 with a final rate of 60.87 for RY 2019.</li> <li>• Beginning in 2013 and ongoing therefore after, the Health Plan provided case management services for enrollees with complex behavioral health issues and who were hospitalized with major depression. In regard to IPRO's recommendation for the Health Plan to consider expanding the case management intervention to include more members rather than just those that are hospitalized, all members who are enrolled in care management are screened for medications and also are screened for depression as part of a comprehensive assessment. When members are identified as having complex behavioral health needs, they are referred to our specialized behavioral health care managers for ongoing assessment and care planning. The team also works to ensure that members are connected to behavioral health clinicians and/or RI</li> </ul>

	<p>follow-up care.</p> <ul style="list-style-type: none"> <li>• The Health Plan should continue to conduct thorough barrier analyses to determine barriers members face when seeking care and barriers providers face to providing appropriate care. The majority of the interventions are directed at the barrier surrounding lack of knowledge of measure specifications and treatment guidelines.</li> <li>• The Health Plan should consider addressing the side effects of antidepressants in its intervention strategy. Many individuals stop taking prescribed antidepressants when their depressive symptoms abate or due to other side effects of these types of drugs. Reinforcing education about the side effects of medications may assist in increased adherence to antidepressants.</li> </ul>	<p>contracted health homes when necessary.</p> <ul style="list-style-type: none"> <li>• Beginning in 2016 and ongoing therefore after, as a part of the preventive health program, enrollees are screened for depression when they enroll in the Medicaid plan during the Welcome Call process. Through the Welcome Call process, the Behavioral Health Case Management Department and Hospitality, Assessment and Reminder Center (HARC) focus on getting enrollees proper depression screening and referrals that flow from the HARC team to a Behavioral Health Advocate. Since HARC has the opportunity to assess enrollees shortly after enrollment, this physical health team added questions to their health screening tool to help determine whether enrollees may have depression. By detecting the issues early in their enrollment period, behavioral health advocates can intervene, provide support and get enrollees care they need. In regard to IPRO's recommendation for the Health Plan to consider triggering case management services earlier for members diagnosed with depression and dispensed an antidepressant in order to assist members in receiving appropriate follow-up care, the initiative is conducted at the time of enrollment. The Health Plan would not able trigger case management services unless the member is enrolled with UnitedHealthcare.</li> <li>• The Health Plan conducted a thorough barrier analyses for the AMM measure using RY 2019 results. Results included: <ul style="list-style-type: none"> <li>○ Some members receiving medication for ADHD were not appearing on the list for member education. The program logic has since been updated.</li> <li>○ The Health Plan also analyzed if there was an event that triggered adding members to measure, when prescriptions were initiated, what the drug was, the amount dispensed, and the prescribing provider/ practice/ specialty. It was revealed that psychiatry was the least compliant specialty; therefore, an email blast was sent to those providers.</li> </ul> </li> <li>• The Health Plan did address side effects of antidepressant medication. <ul style="list-style-type: none"> <li>○ In 2018, the CMO mailed providers a letter. In the letter, it stated for providers to visit the Health Plan's website for tools such as talking points. The talking points include talking to members about the side effects of the antidepressants.</li> </ul> </li> </ul>
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		<ul style="list-style-type: none"> <li>○ Clinical Practice consultants also meet each year with about 100 high volume provider sites and monthly with ACOs to discuss opportunities for improvement. One of the measures discussed was AMM and discussions included side effects of antidepressants.</li> </ul>
<p><u>QIP#4: HEDIS Breast Cancer Screening</u></p> <p><b>Page 44:</b>  <b>Results: 59.44%, Q1 rate calculated through December 31, 2018. Overall Credibility of Results: Unable to determine. The QIP report is not available for review. Strengths: Unable to determine. The QIP report is not available for review.</b></p>	<p><b>Page 44:</b>  <b>Opportunities for Improvement:</b></p> <ul style="list-style-type: none"> <li>• The Health Plan should consider enhancing its quality improvement strategy by expanding both provider- and health plan-focused interventions. As UHCP-RI identified provider compliance with recommended guidelines as a barrier, the Health Plan should implement an intervention(s) to address this barrier.</li> </ul> <p>The Health Plan should continuously analyze the effectiveness of each intervention and modify them as needed.</p>	<ul style="list-style-type: none"> <li>• The Health Plan will continue BCS as a QIP in RY 2020 because there is still room for improvement in order to meet the benchmark.</li> <li>• Provider Focused Interventions <ul style="list-style-type: none"> <li>○ <u>ACO</u>: BCS was a Pay for Performance (P4P) measure in RY 2019 and 2020. This impacts the majority of the Medicaid membership (~70%).</li> <li>○ <u>Provider Visits</u>: The CPCs discuss the Breast Cancer Screening guideline during office visits to assigned provider practices. CPC provider outreach is targeted to FQHCs, high volume primary care practices, targeted specialty care offices and low performing offices. The outreach is year-round but after the HEDIS hybrid season the outreach becomes proactive; instead of medical record collection. During provider office visits, the CPCs review and discuss health plan initiatives, member and provider programs and members due for preventive screenings. Emphasis is placed on those measures deemed “critical”, defined as an EOHHS PGP measure, AE measure and/or NCQA accreditation measure.</li> <li>○ <u>Provider Newsletter</u>: In the Fall 2019 iteration of the newsletter, a Breast Cancer Screening – We Need Your Help article was included.</li> </ul> </li> <li>• Health Plan Focused Interventions: <ul style="list-style-type: none"> <li>○ The Health Disparities Action Plan: The Plan was developed at the health plan level in 2018 and includes BCS as one of the targeted measures. The health plan chose to target geographic location as the health disparity. As of December 2019, data revealed that Washington County had the lowest percentage of non-compliant members. Interventions are focused on both provider and member education and include the following:</li> </ul> </li> <li>• <u>Member Live Calls</u>: From October 2019 through March 2020, the</li> </ul>

		<p>Health Plan conducted 360 live agent outreach calls to women in Washington County in need of a mammography.</p> <ul style="list-style-type: none"> <li>• <u>Member Mailing:</u> In October 2019, the health plan related and mailed a breast cancer screening informational flyer to women in Washington County in need of a mammography.</li> <li>• <u>Provider Visits:</u> When CPCs visited Washington County provider practices, CPCs shared that Washington County had the highest rates of non-compliance with breast cancer screening.</li> <li>• <u>Community Outreach:</u> In August 2018, the Health Plan representatives; including Quality staff, participated in a Johnnycake Center event in Westerly. Quality information focused on the importance of breast cancer screening, flyers from the CDC and the American Cancer Society were available.</li> <li>• The Health Plan will continue to analyze the effectiveness of each intervention and modify them as needed. Other interventions include: <ul style="list-style-type: none"> <li>○ Member Rewards: \$25.00 member incentive program available to members' age one year of age. In RY 2019, 51 mammography incentives were fulfilled out of 1,782 opportunities mailed (3.00%).</li> <li>○ Member Live Calls: Live agent calls from a vendor to our members to remind members to receive a mammography. There were 3,838 calls made in RY 2019.</li> <li>○ Member Email: Email to women members educating members on the importance of a mammography. A total of 2,506 emails were sent in RY 2019.</li> <li>○ Member Newsletter: Articles related to breast cancer screening appear in the member quarterly newsletter <i>Health Talk</i>. The most recent articles included: "Mammograms save lives" and "Crush Cancer – Are you due for a screening?" (Fall and Winter 2018)</li> </ul> </li> </ul>
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# Appendix 1: Rhode Island State Quality Strategy, Rhode Island State Quality Strategy – July 2019

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## 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	I. Accountable Entities Pilot
2016	1. Medicare-Medicaid Plan (MMP)
2018	1. MCO-Certified Accountable Entities APMs

Today, RI Medicaid and CHIP beneficiaries enrolled in managed care entities include children and families; children in substitute care;<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***

<b>Managed Care Program</b>	<b>Members Enrolled in Program</b>	<b>Eligible MCEs</b>
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—UnitedHealthcare Community Plan of Rhode Island

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 RItSmiles. 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 (NQTL) to mental health or substance use disorder benefits and ensure that the classifications are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. The Contractor will provide EOHHS with its analysis ensuring parity compliance when: (1) new services are added as an in-plan benefit for members or (2) there are changes to non-qualitative treatments limitations. The Contractor will publish its MHPAEA policy and procedure on its website, including the sources used for documentary evidence. In the event of a suspected parity violation, the Contractor will direct members through its internal complaint, grievance and appeals process as appropriate. If the matter is still not resolved to the member's satisfaction, the member may file an external appeal (medical review) and/or a State Fair Hearing. The Contractor will track and trend parity complaints, grievances and appeals on the EOHHS approved template at a time and frequency as specified in the EOHHS Managed Care Reporting Calendar and Templates.*
- State-level data collection and monitoring – RI Medicaid collects data to compare MCE performance to quality and access standards in the MCE contracts. At least annually, for example, Rhode Island collects HEDIS and other performance measure data from its managed care plans and compares plan performance to national benchmarks, state program performance, and prior plan performance. In addition, the state monitors MCE encounter data to assess trends in service utilization, as well as analyzing a series of quarterly reports, including informal complaints, grievances, and appeals.

RI Medicaid's enhanced Reporting Calendar tool helps MCOs and the state better track, manage, and assess a comprehensive series of standing reports used for oversight and monitoring of the State's

managed care programs. MCO reports are submitted monthly, quarterly and annually depending on the reporting cadence on a variety of topics specified by the state, such as:

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

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

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

- Performance Incentives - Within the contract for Rite Care, Rhody Health Partners and Rhody Health Expansion, the state requires performance measures through a pay-for-performance program called the Performance Goal Program (PGP). MCOs can earn financial incentives for achieving specified benchmarks for measures in the following domains: utilization, access to care, prevention/screening, women's health, and chronic care management, and behavioral health. The contract for the MMP requires performance measures that are tied to withholds. The plan can earn the withhold payment by meeting benchmarks as outlined in the contract. The PAHP has one required performance measure that is calculated using a HEDIS methodology.

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

- Performance improvement projects - Each managed care entity is required to complete at least two performance improvement projects (PIPs) annually in accordance with 42 CFR 438.330(d) and the RI Medicaid managed care contracts. RI Medicaid MCOs are contractually obligated to conduct 4 PIPs annually. The dental plan has two contractually required PIP(s). The MMP is also required to perform one additional PIP specific to that population and their service needs. After analysis and discussion, MCEs are required to act on findings from each contractually required quality improvement project.
- Annual Quality Plan-Each MCE must submit an annual quality plan to RI Medicaid. This plan must align the RI Medicaid's goals and objectives. RI Medicaid contracts with an EQRO to perform an independent annual review of each Medicaid MCE. The state's EQRO is involved in reviewing the MCE quality plans as part of its broader role in performing the external quality review of each managed care entity and program.

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

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

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

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

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

### **Section 4.3 Appropriateness of Care in Managed Care**

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

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

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

Rhode Island uses findings from the CMS 416 Report as part of its Medicaid Quality Strategy to monitor trends over time, differences across managed care contractors, and to compare RI results to data reported by other

states. RI Medicaid will share the 416 report results with the MCEs annually, discuss opportunities for improvement and modifications to existing EPSDT approaches as necessary. For example, the CMS 416 report includes but is not limited to the following measures:

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

## 2. Persons with Special Health Care Needs

A critical part of providing appropriate care is identify Medicaid beneficiaries with special health care needs as defined in the MCE contracts. Each MCE must have mechanisms in place to assess enrollees identified as having **special health care needs**. Rhode Island defines children with special health care needs (CSHCN) as: persons up to the age of twenty-one who are blind and/or have a disability and are eligible for Medical Assistance on the basis of SSI; children eligible under Section 1902(e) (3) of the Social Security Administration up to nineteen years of age (“Katie Beckett”); children up to the age of twenty-one receiving subsidized adoption assistance, and children in substitute care or “Foster Care”. The State defines adults with special health care needs as adults twenty-one years of age and older who are categorically eligible for Medicaid, not covered by a third-party insurer such as Medicare, and residing in an institutional facility.

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

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

## 3. Cultural Competency

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

adhere to the American Disabilities Act and ensure accessible services for members with a visual, hearing, and/or physical disability.

#### 4. Health Disparity Analysis

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

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

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

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

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

#### **Section 4.4 MCE Performance Measures and Targets**

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

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

RI Medicaid has employed use of standard measures that are nationally endorsed, by such entities as the National Quality Forum (NQF). Rhode Island collects and voluntarily reports on most CMS Adult and Child Core Measure Set performance measures.<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 438.352Activities- the EQRO must perform the following activities for each MCO/PAHP:

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

attributed to an AE.

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

31. A description of the way data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to care furnished by the MCEs.
32. For each Mandatory and, if directed by the State, Optional Activity conducted the objectives, technical methods of data collection and analysis, description of data obtained (including validated performance measurement data for each activity conducted), and conclusions drawn from the data.
33. An assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
34. Recommendations for improving the quality of health care services furnished by each MCE including how the State can establish target goals and objective in the quality strategy to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.
35. An assessment of the degree to which each MCE has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.
36. An evaluation of the effectiveness of the State's quality strategy and recommendations for updates based on the results of the EQR.

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

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

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

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

## Section 5.1 RI Managed Care Standards

Rhode Island's Medicaid managed care contracts have been reviewed by CMS for compliance with the Medicaid managed care rule and the 2017 version of the *"State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval."*<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 Rlthe 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 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—UnitedHealthcare Community Plan of Rhode Island

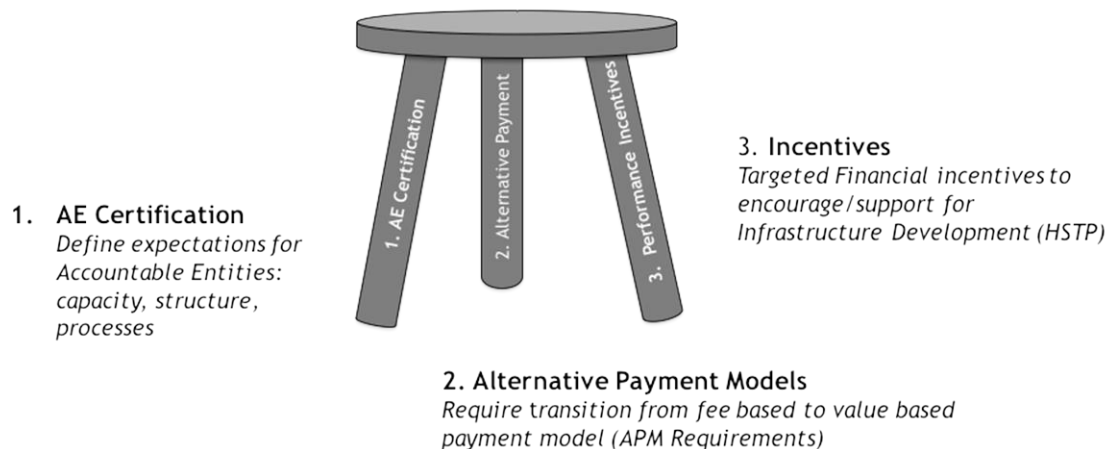
Department of Health manages several key HIT initiatives to support data-focused public health and the EHR Incentive Program. These include:

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

### Section 7: Delivery System Reform

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

#### Accountable Entity Program Approach: Three “Pillars”



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

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

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

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

for identifying performance metrics and targets with the MCOs and the AEs.

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

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

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

## Section 8: Conclusions and Opportunities

Rhode Island is committed to ongoing development, implementation, monitoring and evaluation of a vigorous quality management program that will effectively and efficiently improve and monitor quality of care for its 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.	
Quantifiable Measure #1:	
Numerator:	
Denominator:	
First measurement period dates:	
Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #2:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #3:	
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 NCQA 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>				
<b>Measure</b>	<b>Sample Size</b>	<b>Population</b>	<b>Method for Determining Size (<i>describe</i>)</b>	<b>Sampling Method (<i>describe</i>)</b>

<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> </ul> I. Type of change II. Rationale for change III. Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method IV. Any introduction of bias that could affect the results				

## Section II: Data/Results Table

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

### #1 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	<i>Baseline:</i>						

### #2 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	<i>Baseline:</i>						

### #3 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	<i>Baseline:</i>						

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

## Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

### A. Time Period and Measures That Analysis Covers.

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

#### B.1 For the quantitative analysis:

#### B.2 For the qualitative analysis:

- Opportunities identified through the analysis

#### Impact of interventions

- Next steps

#### Section IV: Interventions Table

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

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

#### Section V: Chart or Graph (Optional)

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