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Rhode Island Medicaid Managed Care Program
All Medicaid Managed Care Plans
2021 External Quality Review
Annual Technical Report
April 2023

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

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About This Report

External Quality Review and Annual Technical Report Requirements

The Balanced Budget Act of 1997 established that state Medicaid agencies contracting with Medicaid managed care plans 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 managed care plan. *Title 42 Code of Federal Regulations Section 438.350 External quality review (a)* through *(f)* sets forth the requirements for the annual external quality review of contracted managed care plans. States are required to contract with an external quality review organization to perform an annual external quality review for each contracted Medicaid managed care plan. The states must further ensure that the external quality review organization has sufficient information to conduct this review, that the information be obtained from external-quality-review–related activities and that the information provided to the external quality review organization be obtained through methods consistent with the protocols established by the Centers for Medicare and Medicaid Services.[1] Quality, as it pertains to an external quality review, is defined in *42 Code of Federal Regulations 438.320 Definitions* as "the degree to which a managed care plan, PIHP[2], PAHP[3], or PCCM[4] entity increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement."

Title 42 Code of Federal Regulations 438.364 External quality review results (a) through *(d)* requires that the annual external quality review be summarized in a detailed technical report that aggregates, analyzes, and evaluates information on the quality of, timeliness of, and access to health care services that managed care plans furnish to Medicaid recipients. The report must also contain an assessment of the strengths and weaknesses of the managed care plans with respect to health care quality, timeliness, and access, as well as recommendations for improvement.

To comply with 42 Code of Federal Regulations Section 438.364 External quality review results (a) through (d) and 42 Code of Federal Regulations 438.358 Activities related to external quality review, the Rhode Island Executive Office of Health and Human Services contracted Island Peer Review Organization, Inc. (doing business as IPRO), an external quality review organization, to conduct the external quality review of the managed care plans that were part of Rhode Island's Medicaid managed care program in 2021. This report summarizes the 2021 external quality review results for Neighborhood Health Plan of Rhode Island, Tufts Public Health Plan and UnitedHealthcare Community Plan of Rhode Island.

It is important to note that the provision of health care services to each of the applicable Medicaid eligibility groups (Core RIte Care, RIte Care for Children in Substitute Care, RIte Care for Children with Special Health Care Needs, Rhody Health Expansion, and Rhody Health Partners) are evaluated in this report.

2021 External Quality Review

This external quality review technical report focuses on four federally required activities (validation of performance improvement projects[5], validation of performance measures, review of compliance with Medicaid

[1] The Centers for Medicare & Medicaid Services website: https://www.cms.gov/.
[2] Prepaid inpatient health plan.
[3] Prepaid ambulatory health plan.
[4] Primary care case management.
[5] Rhode Island refers to performance improvement projects as quality improvement projects, and the term quality improvement project will be used in the remainder of this report.

standards, and validation of network adequacy) and one optional activity (quality-of-care survey) that were conducted for measurement year 2021. IPRO's external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[6] published in October 2019. The external quality review activities and corresponding protocols are described in Table 1.

Table 1: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	Applicable External Quality Review Protocol	Activity Description
Activity 1. Validation of Performance Improvement Projects (Required)	Protocol 1	IPRO reviewed the managed care plans' quality improvement projects to validate that the design, implementation, and reporting aligned with Protocol 1, promoted improvements in care and services, and provided evidence to support the validity and reliability of reported improvements.
Activity 2. Validation of Performance Measures (Required)	Protocol 2	IPRO reviewed the Healthcare Effectiveness Data and Information Set (HEDIS®[7]) audit results provided by the managed care plans' National Committee for Quality Assurance (NCQA)-certified HEDIS compliance auditors and reported rates to validate that performance measures were calculated according to the Office of Health and Human Services' specifications.
Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards (Required)	Protocol 3	IPRO reviewed the results of evaluations performed by NCQA, as part of the Accreditation Survey, of Medicaid managed care plan compliance with Medicaid standards. Specifically, IPRO's review assessed managed care plan compliance with the standards of *Code of Federal Regulations Part 438 Subpart D* and *Code of Federal Regulations 438.330*.
Activity 4. Validation of Network Adequacy (Required)	Protocol 4 (Published in 2023)	IPRO evaluated the managed care plans' data collection methodologies and results to determine managed care plan adhere to the network standards outlined in the *Medicaid Managed Care Services Agreement*, as well as the managed care plans' ability to provide an adequate provider network to its Medicaid population.
Activity 6. Validation of Quality-of-Care Surveys (Optional)	Protocol 6	IPRO reviewed the managed care plans' member satisfaction survey reports to validate that the methodology aligned with the Office of Health and Human Services' requirement to utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS®[8]) tool. IPRO also reviewed the managed care plans' provider satisfaction reports to verify the validity and reliability of the results.

[6] The Centers for Medicare & Medicaid Services External Quality Review Protocols website: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.
[7] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).
[8] CAHPS is a registered trademark of the Agency for Healthcare Quality and Research (AHRQ).

The results of IPRO's external quality review are reported under each activity section.

Rhode Island Medicaid Managed Care Program and Medicaid Quality Strategy

The Rhode Island Medicaid Managed Care Program

The State of Rhode Island was granted a Section 1115 Demonstration Waiver[9] from the Centers for Medicare & Medicaid Services in 1993 to develop and implement a mandatory Medicaid managed care program. Rite Care, Rhode Island's Medicaid managed care program began enrollment in 1994. Since 1994, the Rhode Island Medicaid managed care program has evolved and expanded to meet the health care needs of Rhode Islanders.

In 2015, the *Working Group to Reinvent Medicaid* was established because of an executive order issued by the Governor of Rhode Island and later codified by the Reinventing Medicaid Act of 2015[10]. The Reinventing Medicaid Act required the *Working Group to Reinvent Medicaid* to identify progressive, sustainable savings initiatives to transform Rhode Island's Medicaid program to pay for better outcomes, better coordination, and higher-quality care, instead of more volume. The *Working Group to Reinvent Medicaid* established these four guiding principles the Rhode Island Medicaid managed care program:

1. Pay for value, not volume.
2. Coordinate physical, behavioral, and long-term health care.
3. Rebalance the delivery system away from high-cost settings.
4. Promote efficiency, transparency, and flexibility.

Further, Rhode Island's vision for its Medicaid managed care program as expressed by the *Working Group to Reinvent Medicaid, "*calls for a reinvented Medicaid in which managed care plans contract with integrated provider organizations called accountable entities that will be responsible for the total cost of care and health care quality and outcomes of the attributed population." Accountable entities represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services.

The Office of Health and Human Services currently offers a variety of managed care plans to coordinate the provision, quality, and payment of care for its enrolled members. The Rhode Island Medicaid managed care program covers acute care, primary and specialty care, pharmacy, and behavioral health services through contracts with three managed care plans: Neighborhood Health Plan of Rhode Island, Tufts Health Public Plan and United Healthcare Community Plan of Rhode Island; and one managed dental health plan: United Healthcare Dental. Table 2 displays a summary of the Medicaid managed care programs and participating managed care plans that were available to Rhode Islanders in 2021.

[9] Section 1115 of the Social Security Act allows for "demonstration projects" to be implemented in states to effect changes beyond routine medical care and focus on evidence-based interventions to improve the quality of care and health outcomes for members. Medicaid.gov About 1115 Demonstrations website: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html.

[10] Title 42 State Affairs and Government Chapter 7.2 Office of Health and Human Services 16.1 Reinventing Medicaid Act of 2015 website: http://webserver.rilin.state.ri.us/Statutes/TITLE42/42-7.2/42-7.2-16.1.htm.

Table 2: Rhode Island Medicaid Managed Care Programs

Program	Program Description	Participating Managed Care Plans
RIte Care Core	Children and families	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
RIte Care Substitute Care	Children in legal custody of the State Department of Children, Youth and Families	▪ Neighborhood Health Plan of Rhode Island
RIte Care for Children with Special Health Care Needs	A Medicaid managed care plan for children with a disability or chronic condition who qualify for supplemental security income, Katie Beckett or adoption subsidy through the Department of Children, Youth, and Families.	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rhody Health Expansion	A Medicaid managed care plan for low-income adults aged 19-64 years with no dependent children.	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rhody Health Partners	A Medicaid managed care plan for eligible adults with disabilities who are 21 years or older.	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rite Smiles	A dental managed care plan for children enrolled in Medicaid and born on or after May 1, 2000.	▪ United Healthcare Dental

The provision of health care services to each of the applicable eligibility groups (Core RIte Care, RIte Care for Children in Substitute Care, RIte Care for Children with Special Health Care Needs, Rhody Health Expansion, and Rhody Health Partners) are evaluated in this report.

Rhode Island Medicaid Quality Strategy, 2019-2022

The Rhode Island Medicaid quality strategy is a framework for managed care plans on how to improve quality, timeliness, and access to care for Medicaid managed care enrollees; and is utilized by the Office of Health and Human Services as a tool to support the alignment of state and managed care plan Medicaid initiatives, identification of opportunities for improvement, and cost reduction. The Office of Health and Human Services performs periodic reviews of the Medicaid quality strategy to determine the need for revision and to ensure managed care plans are compliant with regulatory standards and have committed adequate resources to perform internal monitoring and ongoing quality improvement. The Office of Health and Human Services updates the Medicaid quality strategy as needed, but no less than once every three years.

Rhode Island's 2019-2022 Medicaid Managed Care Quality Strategy[11] aligns with the Office of Health and Human Services' commitment to facilitating the creation of partnerships using accountable delivery models that integrate medical care, mental health, substance abuse disorders, community health, social services and long-term services, supported by innovative payment and care delivery models that establish shared financial accountability across all partners, with a demonstrated approach to continue to grow and develop the model of integration and accountability.

Goals for the Rhode Island Medicaid program outlined in the 2019-2022 quality strategy evolved from the guiding principles established by *Working Group to Reinvent Medicaid* and are displayed in Table 3.

Table 3: Rhode Island Medicaid Quality Strategy Goals, 2019-2022

Rhode Island Medicaid Managed Care Quality Strategy Goals
1. Maintain high level managed care performance on priority clinical quality measures.
2. Improve managed care performance on priority measures that still have room for improvement.
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

To support achievement of the Medicaid managed care quality strategy goals and to ensure Rhode Island Medicaid recipients have access to the highest quality of health care, the Office of Health and Human Services adopts objectives and initiatives to help all parties focus on interventions most likely to result in progress towards the goals of the quality strategy. Table 4 displays these objectives along with the attached goal(s), while descriptions of key initiatives follow.

[11] Rhode Island Medicaid Managed Care Quality Strategy Website: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/Reports/QUALITY-STRATEGY.DRAFT.5.3.19.pdf.

Table 4: Rhode Island Medicaid Quality Strategy Objectives and Goals, 2019-2022

Medicaid Quality Strategy Objectives	Linked Medicaid Quality Strategy Goals
Continue to work with managed care entities and the external quality review organization to collect, analyze, compare, and share clinical performance and member experience across plans and programs.	All Goals
Work collaboratively with managed care plans, accountable entities, Office of the Health Insurance Commissioner, 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 managed care entity performance.	Goal 1
Create non-financial incentives such as increasing transparency of managed care entity performance through public reporting of quality metrics and outcomes – both online and in person.	Goals 1 and 2
Review and potentially modify financial incentives (rewards and/or penalties) for managed care plan performance to benchmarks and improvements over time.	Goals 1 through 5
Work with managed care plans and accountable entities to better track and increase timely, appropriate preventive care, screening, and follow up for maternal and child health.	Goals 3, 6, and 8
Incorporate measures related to screening in managed care and increase the use of screening to inform appropriate services.	Goals 3,4,5,6,8
Monitor and assess managed care plan and accountable entity 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 primary care providers.	Goals 4,5,8
Develop a chronic disease management workgroup and include state partners, managed care entities, and accountable entities, to promote more effective management of chronic disease, including behavioral health and co-morbid conditions.	Goals 4,5,8
Review trend for disparity-sensitive measures and design interventions to improve health equity, including working with managed care plans and accountable entities to screen members related to social determinants of health and make referrals based on the screens.	Goals 5,8
Share and aggregate data across all Rhode Island Health and Human Services agencies to better address determinants of health. Develop a statewide workgroup to resolve barriers to data-sharing.	Goal 6
Continue to require plans to conduct CAHPS 5.0 surveys and annually share managed care plan CAHPS survey results with the MCAC.	Goal 6
Explore future use of a statewide survey to assess member satisfaction related to accountable entities, such as the Clinician Group (CG-CAHPS) survey for adults and children receiving primary care services from accountable entities.	Goal 7
Explore use of focus groups to solicit additional member input on their experiences and opportunities for improvement.	Goal 7

Accountable Entity Program

Rhode Island contends that a core part of the Medicaid quality strategy is the integration of accountable entities into the Medicaid managed care delivery system. Accountable entities represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services. Rhode Island's Accountable Entity Program seeks to achieve the following goals for Medicaid managed care: transition Medicaid from fee-for-service to value-based purchasing at the provider level; focus on total cost of care; 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.

Rhode Island accountable entity certification standards ensure that qualified accountable entities either have or are developing the capacity and authority to integrate and manage the full continuum of physical and behavioral health care, from preventive services to hospital-based services and to long term services and supports and nursing home care. These entities must also demonstrate their capacity and authority to address members' social determinants of health in a way that is acceptable to the Centers for Medicare and Medicaid Services and the Office of Health and Human Services.

Accountable entity quality performance is measured and reported by the managed care plans to the Office of Health and Human Services according to the "Medicaid Comprehensive Accountable Entity Common Measure Slate." Measures in the "Medicaid Comprehensive Accountable Entity Common Measure Slate" are used to inform the distribution of shared savings. Table 5 displays the measures included in the "Medicaid Comprehensive Accountable Entity Common Measure Slate" for 2021, as well as the measure steward and reporting category.

Table 5: Medicaid Comprehensive Accountable Entity Common Measure Slate, Performance Year 2021

Measure	Steward	Category
Breast Cancer Screening	NCQA	P4P
Child and Adolescent Well-Care Visits, 12 to 17 Years	NCQA	Reporting-only
Child and Adolescent Well-Care Visits, 18 to 21 Years	NCQA	Reporting-only
Child and Adolescent Well-Care Visits, Total	NCQA	Reporting-only
Comprehensive Diabetes Care – Eye Exam	NCQA	P4P
Comprehensive Diabetes Care – HbA1c Control	NCQA	P4P
Controlling High Blood Pressure	NCQA	P4P
Follow-Up After Hospitalization for Mental Illness – 7 Days	NCQA	P4P
Follow-Up After Hospitalization for Mental Illness – 30 Days	NCQA	Reporting-only
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	NCQA	P4P
Developmental Screening in the First Three Years of Life	Oregon Health & Science University	P4P
Screening for Depression and Follow-up Plan	State	P4P
Tobacco Use: Screening and Cessation Intervention	PCPI® Foundation	Reporting-only
Social Determinants of Health Screening	State	P4P

P4P status indicates that an accountable entity's performance on the measure will influence the distribution of any shared savings. Reporting-only indicates that measure performance must be reported to Office of Health and Human Services for state monitoring purposes, but that there are no shared savings distribution consequences for reporting of or performance on the measure.

For performance year 2021, the Office of Health and Human Services employed a combination of internal and external sources to set achievement targets. The Office of Health and Human Services set targets for performance year 2021 using accountable entity performance year 2019 data, national and New England Medicaid health maintenance organization data from NCQA's *Quality Compass 2020* (measurement year 2019) and national and Rhode Island state fiscal year 2019 data from the Centers for Medicare & Medicaid Services' *2019 Child and Adult Health Care Quality Measures Report*. Table 6 displays the performance year 2021 measures and achievement targets.

Table 6: Accountable Entity 'P4P' Measure Targets, Performance Year 2021

Measure	Threshold Target	High-Performance Target
Breast Cancer Screening	55.8%	63.2%
Comprehensive Diabetes Care – Eye Exam	51.8%	60.8%
Comprehensive Diabetes Care – HbA1c Control	49.3%	58.7%
Controlling High Blood Pressure	53.8%	64.2%
Follow-Up After Hospitalization for Mental Illness – 7 Days	42.5%	62.2%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Composite Score	62.9%	67.9%
Developmental Screening in the First Three Years of Life	53.2%	65.0%
Screening for Depression and Follow-up Plan	6.6%	24.8%
Social Determinants of Health Screening	25.0%	50.0%

Accountable entity rates for 'P4P' measures are presented in the Technical Summary – Validation of Performance Measures section of this report.

Alternative Payment Models

Transformation to a value-based health care delivery system is a fundamental policy goal for the State of Rhode Island. A fundamental element of the transition to alternative payment models, is a focus on quality-of-care processes and outcomes. Rhode Island Medicaid managed care plans enter alternative payment model arrangements with certified accountable entities, as required by the *Medicaid Managed Care Services Agreement*, and follow the agreement terms of setting targets for payments to providers. Payments are made utilizing an Office of Health and Human Services-approved Alternative Payment Methodology.

An Alternative Payment Methodology means a payment methodology structured such that it provides economic incentives, rather than focusing on volume of services provided, focus upon such key areas as:

- Improving quality of care;
- Improving population health;
- Impacting cost of care and/or cost of care growth;
- Improving patient experience and engagement; and/or
- Improving access to care.

The Rhode Island Medicaid agreement includes defined targets for managed care plan implementation of contracts with alternative payment arrangements. Targets for alternative payment arrangements are:

- July 1, 2019-June 30, 2020 – At least 50% of managed care plan payments to providers are made through an Alternative Payment Methodology, or the percent of managed care payments to providers made through an Alternative Payment Methodology is 5% higher than the percent required for the previous period.

- July 1, 2020-June 30, 2021 – At least 60% of managed care plan payments to providers are made through an Alternative Payment Methodology, or the percent of managed care payments to providers made through an Alternative Payment Methodology is 5% higher than the percent required for the previous period.
- July 1, 2021-June 3, 2022 – At least 65% of managed care plan payments to providers are made through an Alternative Payment Methodology, or the percent of managed care payments to providers made through an Alternative Payment Methodology is 10% higher than the percent required for the previous period.

Early Periodic Screening, Diagnosis and Treatment

Early periodic screening, diagnosis and treatment is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. As part of its oversight program of managed care plans, the Office of Health and Human Services monitors provision of early periodic screening, diagnosis and treatment to Medicaid managed care members. Medicaid beneficiaries under age 21 are entitled to early periodic screening, diagnosis and treatment services, whether they are enrolled in a Medicaid managed care plan or receive services in a fee-for-service delivery system. The Rhode Island-specific *Annual EPSDT Participation Report,* produced by the Centers for Medicare & Medicaid Services, is used by the Office of Health and Human Services to monitor trends over time, differences across managed care plans, and to compare Rhode Island to other states. The Office of Health and Human Services shares the *Annual EPSDT Participation Report* with the managed care plans to discuss opportunities for improvement and modifications to existing early periodic screening, diagnosis and treatment approaches, as necessary.

Patient Centered Medical Homes

A patient-centered medical home provides and coordinates the provision of comprehensive and continuous medical care and required support services to patients with the goals of improving access to needed care and maximizing outcomes. To be recognized as a patient-centered medical home, a practice must meet the three-part definition established by the Office of the Health Insurance Commissioner, which requires demonstration of practice transformation, implementation of cost management initiatives, and clinical improvement.

The *Medicaid Managed Care Services Agreement* includes defined performance targets for managed care plan assignment of members to patient-centered medical homes. Targets for member linkage to a patient-centered medical home are:

- June 30, 2020 – At least 55% of the managed care plan's membership is linked to a patient-centered medical home.
- June 30, 2021 – At least 60% of the managed care plan's membership is linked to a patient-centered medical home.
- June 30, 2022 – At least 60% of the managed care plan's membership is linked to a patient-centered medical home.

NCQA Accreditation

Rhode Island health maintenance organizations are required to obtain and maintain NCQA accreditation and to promptly share accreditation review results and notify the state of any changes in accreditation status. The Office of Health and Human Services reviews and acts on changes in managed care plan accreditation status and has set a performance "floor" to ensure that any denial of accreditation by NCQA is considered cause for termination of the *Medicaid Managed Care Services Agreement*. In addition, managed care plan achievement of no greater than a provisional accreditation status by NCQA requires the managed care plan to submit a corrective action plan within 30 days of the managed care plan's receipt of its final report from the NCQA.

NCQA accreditation results and plan ratings are presented in the Technical Summary – NCQA Accreditation section of this report.

IPRO's Assessment of the Rhode Island Medicaid Quality Strategy

The Rhode Island Medicaid quality strategy aligns with the Centers for Medicare & Medicaid Services' requirements and provides a framework for managed care plans to follow while aiming to achieve improvements in the quality of, timeliness of and access to care. In addition to conducting the required external quality review activities, the Medicaid quality strategy includes state- and managed care plan-level activities that expand upon the tracking, monitoring, and reporting of performance as it relates to the Medicaid service delivery system.

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

In working towards the goals of the 2019-2022 strategy, IPRO recommends that the Office of Health and Human Services consider:

- Establishing appointment availability thresholds for the Medicaid managed care program to hold the managed care plans accountable for increasing the availability of timely appointments.
- Updating the Medicaid quality strategy to explicitly state how performance towards the goals will be evaluated. Each goal should be attached to an outcome measure along with baseline and target rates. Interim reporting of rate performance should be provided to the external quality review organization as part of the annual external quality review assessment.
- Developing a separate quality strategy for the dental Medicaid managed care program or dedicate a section in the overall Medicaid quality strategy to Rite Smiles.
- Identify opportunities to support the expansion of telehealth capabilities and member access to telehealth services across the state.
- Providing technical assistance to the managed care plans during the conduct of the quality improvement project.
- Consider enforcing minimum sample size requirements for appointment availability and provider satisfaction surveys conducted by the managed care plans.

Neighborhood Health Plan of Rhode Island

Neighborhood is a not-for-profit health maintenance organization. Table 7 displays Neighborhood's enrollment for year-end 2018 through year-end 2021, as well as the percent change in enrollment each year, according to data reported to the Office of Health and Human Services. The data presented here may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. Neighborhood's enrollment increased by 6% from 179,049 members in 2020 to 189,923 members in 2021.

Table 7: Neighborhood's Medicaid Enrollment, 2018 to 2021

Eligibility Group	2018	2019	2020	2021
Core RIte Care	100,923	93,611	100,594	104,886
Children with Special Health Care Needs	5,066	5,119	5,237	5,241
Children in Substitute Care	2,715	2,616	2,879	2,590
Rhody Health Partners	7,465	7,446	7,497	7,621
Rhody Health Options	15,698	13,875	12,914	12,942
Rhody Health Expansion	38,135	36,640	48,688	55,652
Extended Family Planning	829	1,265	1,240	991
Medicaid Total	170,831	160,572	179,049	189,923
Percent Change from Previous Year	-7%	-6%	+12%	+6%

Tufts Health Public Plan

Tufts Health Public Plan is a not-for-profit health maintenance organization. Table 8 displays Tufts Health Public Plan's enrollment for year-end 2018 through year-end 2021, as well as the percent change in enrollment each year, according to data reported to the Office of Health and Human Services. The data presented here may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. Tufts Health Public Plan's enrollment increased by 23% from 14,075 members in 2020 to 17,363 members in 2021.

Table 8: Tufts Health Public Plan's Enrollment, 2018 to 2021

Eligibility Group	2018	2019	2020	2021
Core RIte Care	4,281	4,520	6,703	8,184
Children with Special Health Care Needs	52	69	87	87
Rhody Health Partners	505	566	658	725
Rhody Health Expansion	4,600	3,765	6,571	8,325
Extended Family Planning	34	53	56	42
Medicaid Total	9,472	8,973	14,075	17,363
Percent Change from Previous Year	112%	-5.6%	+56.9%	+23%

UnitedHealthcare Community Plan of Rhode Island

UnitedHealthcare Community Plan of Rhode Island is a for-profit health maintenance organization. Table 9 displays UHCCP-RI enrollment for year-end 2018 through year-end 2021, as well as the percent change in enrollment each year, according to data reported to Rhode Island Medicaid. 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. UHCCP-RI's enrollment increased by 6% from 92,899 members in 2020 to 98,367 members in 2021.

Table 9: UHCCP-RI's Medicaid Enrollment, 2018 to 2021

Eligibility Group	2018	2019	2020	2021
Core RIte Care	52,601	47,975	51,539	53,406
Children with Special Health Care Needs	1,828	1,845	1,896	1,884
Rhody Health Partners	6,883	6,536	6,463	6,327
Rhody Health Expansion	29,511	26,742	32,622	36,448
Dual Special Needs Plan	No Enrollment	Not Reported	Not Reported	Not Reported
Extended Family Planning	344	417	379	302
Medicaid Total	**91,167**	**83,515**	**92,899**	**98,367**
Percent Change from Previous Year	**-6%**	**-9%**	**+11%**	**+6%**

Technical Summary – Information Systems Capabilities Assessment

Objectives

The *CMS External Quality Review (EQR) Protocols* published in October 2019 by the Centers for Medicare & Medicaid Services state that an Information Systems Capabilities Assessment is a mandatory component of the external quality review as part of Protocols 1, 2, 3, and 4.

The Centers for Medicare & Medicaid Services later clarified that the systems reviews that are conducted as part of the NCQA HEDIS® Compliance Audit™ for External Quality Review Activity 2. Validation of Performance Measures may be substituted for an Information Systems Capabilities Assessment. IPRO's validation methodology included an evaluation of the systems reviews summarized by each managed care plan's NCQA HEDIS Compliance Audit Licensed Organization in the Final Audit Report for measurement year 2021.

Technical Methods of Data Collection and Analysis

As part of the NCQA HEDIS Compliance Audit, HEDIS compliance auditors assessed the managed care plan's compliance with NCQA's seven information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that the managed care plan has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. Table 10 displays these standards as well as the elements audited for the standard.

Table 10: Information System Capabilities Standards

Information System Capabilities Categories	Elements Audited
1.0 Medicaid Services Data	Sound Coding Methods and Data Capture, Transfer and Entry
2.0 Enrollment Data	Data Capture, Transfer and Entry
3.0 Practitioner Data	Data Capture, Transfer and Entry
4.0 Medical Record Review Processes	Training, Sampling, Abstraction and Oversight
5.0 Supplemental Data	Capture, Transfer and Entry
6.0 Data Preproduction Processing	Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity
7.0 Data Integration and Reporting	Accurate Reporting, Control Procedures that Support Measure Reporting Integrity

The information system capabilities evaluation included the computer and software environment, data collection procedures, abstraction of medical records for hybrid measures, as well as the review of any manual processes used for HEDIS reporting. The HEDIS compliance auditor determined the extent to which the managed care plan had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

Description of Data Obtained

For the 2021 external quality review, IPRO obtained each managed care plan's Final Audit Report that was produced by the HEDIS compliance auditor. The Final Audit Report included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental data sources (e.g., immunization

registries, care management files, laboratory result files), 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; Table 56).

Comparative Results

Each managed care plan's HEDIS compliance auditor determined that the HEDIS rates reported by the managed care plan for measurement year 2021 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. Further, there were no data collection or reporting issues identified by the HEDIS compliance auditors for any managed care plan. Table 11 displays the results of the managed care plan's information systems capabilities review conducted as part of the HEDIS Compliance Audit for measurement year 2021.

Table 11: NCQA Information Systems Capabilities Standards, Measurement Year 2021

Information Systems Capabilities Standards	Neighborhood's Audit Results	Tufts Health Public Plan's Audit Results	UHCCP-RI Audit Results
1.0 Medical Services Data	Met	Met	Met
2.0 Enrollment Data	Met	Met	Met
3.0 Practitioner Data	Met	Met	Met
4.0 Medical Record Review Processes	Met	Met	Met
5.0 Supplemental Data	Met	Met	Met
6.0 Data Preproduction Processing	Met	Met	Met
7.0 Data Integration and Reporting	Met	Met	Met

Technical Summary – Validation of Performance Improvement Projects

Objectives

Title 42 Code of Federal Regulations 438.330(d) Performance improvement projects establishes that the state must require contracted Medicaid managed care plans to conduct performance improvement projects that focus on both clinical and non-clinical areas. According to the Centers for Medicare & Medicaid Services, the purpose of a performance improvement project is to assess and improve the processes and outcomes of health care provided by a managed care plan. Further, managed care plans are required to design performance improvement projects to achieve significant, sustained improvement in health outcomes, and that include the following elements:

- measurement of performance using objective quality indicators,
- implementation of interventions to achieve improvement in access to and quality of care,
- evaluation of the effectiveness of interventions based on the performance measures, and
- planning and initiation of activities for increasing or sustaining improvement.

As required by section *2.12.03.03 Quality Assurance* of the *Medicaid Managed Care Services Agreement*, Rhode Island managed care plans must conduct at least four quality improvement projects in priority topic areas of its choosing with the mutual agreement of the Office of Health and Human Services, and consistent with federal requirements.

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review mandates that the state or an external quality review organization must validate the performance improvement projects that were underway during the preceding 12 months. The Office of Health and Human Services Department conducted this activity for the quality improvement projects that were underway in 2021.

Table 12 displays the titles of the quality improvement projects led by the managed care plans for measurement year 2021.

Table 12: Managed Care Plans' Quality Improvement Project Topics, 2021

Managed Care Plan Quality Improvement Project Topics, 2021	
Neighborhood	1. Child and Adolescent Well Care Visits 2. Developmental Screening in the First Three Years of Life 3. Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication 4. Lead Screening in Children 5. Care for Older Adults 6. Transitions from the Nursing Home to the Community Technical Methods of Data Collection and Analysis
Tufts Health Public Plan	1. Promote Doula Program for Maternal and Child Health 2. Member Experience and Retention 3. Flu Vaccine 4. Behavioral Health Telehealth
UHCCP-RI	1. Improving Effective Acute Phase Treatment for Major Depression 2. Developmental Screening in the 1st, 2nd, 3rd Years of Life 3. Improving Lead Screening in Children 4. Improving Breast Cancer Screening

Technical Methods of Data Collection and Analysis

All quality improvement projects were documented using NCQA's *Quality Improvement Activity Form*. All data needed to conduct the validation were obtained through these report submissions. A copy of the *Quality Improvement Activity Form* is in Appendix A of this report.

The quality improvement project assessments were conducted using an evaluation approach developed by IPRO and consistent with the Centers for Medicare & Medicaid Services' *Protocol 1 – Validation of Performance Improvement Projects*. IPRO's evaluation involves the following elements:

1. Review of the selected study topic(s) for relevance of focus and for relevance to the managed care plan'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 managed care plan's enrollment and generalizable to the managed care plan's total population.
4. Review of selected study indicator(s), which should be objective, clear, unambiguous, and meaningful to the focus of the performance improvement project.
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 managed care plan achieved sustained improvement.

Following IPRO's evaluation of the 2021 *Quality Improvement Activity Form* completed by the managed care plan for each quality improvement project against the review elements listed above, determinations of "met" and "not met" were used for each element under review. Definitions of these review determinations are presented in Table 13.

Table 13: Review Determination Definitions

Review Determination	Definition
Met	The managed care plan has met or exceeded the standard.
Not Met	The managed care plan has not met the standard.

The review findings were considered to determine whether the quality improvement project outcomes should be accepted as valid and reliable. A determination was made as to the overall credibility of the results of each quality improvement project, with assignment of one of three categories:

- There were no validation findings that indicate that the credibility was at risk for the quality improvement project results.
- The validation findings generally indicate that the credibility for the quality improvement project results was not at risk; however, results must be interpreted with some caution. Processes that put the conclusions at risk are enumerated.
- There are one or more validation findings that indicate a bias in the quality improvement project results. The concerns that put the conclusion at risk are enumerated.

Description of Data Obtained

For the 2021 external quality review, IPRO reviewed managed care plan quality improvement project reports. These reports included project rationale, aims and goals, target population, performance indicator descriptions,

performance indicator rates (baseline, interim, 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.

Comparative Results

Table 14 displays a summary of the validation results of each managed care plan's quality improvement projects that were conducted for measurement year 2021. Summaries of each quality improvement project immediately follow.

Table 14: Managed Care Plan Quality Improvement Project Validation Results, Measurement Year 2021

Quality Improvement Project Topic	Selected Topic	Study Question	Indicators	Population	Sampling Methods	Data Collection Procedures	Interpretation of Results	Improvement Strategies
Neighborhood								
Child and Adolescent Well Care Visits	Met	Met	Met	Met	Met	Met	Met	Met
Developmental Screening in the First Three Years of Life	Met	Met	Met	Met	Met	Met	Met	Met
Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication	Met	Met	Met	Met	Met	Met	Met	Met
Lead Screening in Children	Met	Met	Met	Met	Met	Met	Met	Met
Care for Older Adults	Met	Met	Met	Met	Met	Met	Met	Met
Transitions from the Nursing Home to the Community Technical Methods of Data Collection and Analysis	Met	Met	Met	Met	Met	Met	Met	Met
Child and Adolescent Well Care Visits	Met	Met	Met	Met	Met	Met	Met	Met
Developmental Screening in the First Three Years of Life	Met	Met	Met	Met	Met	Met	Met	Met
Tufts Health Public Plan								
Promote Doula Program for Maternal and Child Health	Met	Insufficient Data	Insufficient Data	Insufficient Data	Not Applicable	Insufficient Data	Insufficient Data	Insufficient Data
Member Experience and Retention	Not Met	Not Met	Insufficient Data	Met	Not Applicable	Not Met	Met	Met
Flu Vaccine	Met	Met	Met	Met	Not Applicable	Met	Met	Met
Behavioral Health Telehealth	Met	Met	Met	Met	Met	Met	Met	Met
UHCCP-RI								
Improving Effective Acute Phase Treatment for Major Depression	Met	Met	Met	Met	Met	Met	Met	Met
Developmental Screening in the 1st, 2nd, 3rd Years of Life	Met	Met	Met	Met	Met	Met	Met	Met
Improving Lead Screening in Children	Met	Met	Met	Met	Met	Met	Met	Met
Improving Breast Cancer Screening	Met	Met	Met	Met	Met	Met	Met	Met

Neighborhood Health Plan

IPRO's assessment of Neighborhood's methodology found that there were no validation findings that indicated that the credibility of the six quality improvement projects was at risk.

Table 15: Neighborhood's Quality Improvement Project 1 Summary – Well-Care Visits, Measurement Year 2021

Neighborhood's Quality Improvement Project 1 Summary
Title: Improve Child and Adolescents' Well-Care Visits, Ages 3 to 21 Years **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aimed to improve access to well child visits for child and adolescent members aged 3 to 21 years. Indicator of Performance HEDIS *Child and Adolescent Well-Care Visits*: The percentage of members 3 to 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Member-Focused 2021 Interventions ▪ Continued to offer a $25 incentive gift card to children and adolescent members for completing an annual well visit. ▪ Promoted the importance of well-child visits and immunizations through automated voice calls. ▪ Created social media posts on the importance of well-child visits. Provider-Focused 2021 Interventions ▪ Continued provider incentive for accountable entities. ▪ Shared best practices and well-child visits requirements with low performing providers. ▪ Distributed gaps in care reports to providers. ▪ Published an article on the importance of lead screening during well visits.

Table 16: Neighborhood's Quality Improvement Project 1 Indicator Summary –Well-Care Visits 3 to 11 Years

HEDIS Child and Adolescent Well-Care Visits – 3 to 11 Years					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2020	Baseline	18,862	31,375	60.12%	66.06%
Measurement Year 2021	Remeasurement 1	20,343	31,662	64.25%	66.06%

Indicator Description: The percentage of children 3 to 11 years of age who received one or more well-care visit with a primary care practitioner or an obstetrician/gynecologist practitioner during the measurement year.

Table 17: Neighborhood's Quality Improvement Project 1 Indicator Summary –Well-Care Visits 12 to 17 Years

HEDIS Child and Adolescent Well-Care Visits – 12 to 17 Years					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2020	Baseline	10,849	20,627	52.60%	62.45%
Measurement Year 2021	Remeasurement 1	12,631	21,632	58.39%	62.45%

Indicator Description: The percentage of children 12 to 17 years of age who received one or more well-care visit with a primary care practitioner or an obstetrician/gynecologist practitioner during the measurement year.

Table 18: Neighborhood's Quality Improvement Project 1 Indicator Summary –Well-Care Visits 18 to 21 Years

HEDIS Child and Adolescent Well-Care Visits – 18 to 21 Years					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2020	Baseline	3,549	10,212	34.75%	41.23%
Measurement Year 2021	Remeasurement 1	4,360	12,083	36.08%	41.23%

Indicator Description: The percentage of children 18 to 21 years of age who received one or more well-care visit with a primary care practitioner or an obstetrician/gynecologist practitioner during the measurement year.

Table 19: Neighborhood's Quality Improvement Project 2 Summary – Developmental Screening, Measurement Year 2021

Neighborhood's Quality Improvement Project 2 Summary
Title: Improving Developmental Screening Rates in the First Three Years of Life **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aimed to increase 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, second and third birthdays. Indicators of Performance ▪ 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. ▪ 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. ▪ 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. Member-Focused 2021 Interventions ▪ Continued to offer a $25 incentive gift card to children and adolescent members for completing an annual well visit. ▪ Continued social media postings on the importance of well-child visits. ▪ Provided information regarding the importance of well visits and annual developmental screenings at marketing events. Provider-Focused 2021 Interventions ▪ Conducted monthly meetings with accountable entities to review rates for developmental screening, understand specific barriers, and provide best practices. ▪ Continued to include developmental screening as an accountable entity incentive measure.

Table 20: Neighborhood's Quality Improvement Project 2 Indicator Summary – First Year Developmental Screening

Developmental Screening – By Age 1					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014[1]	Baseline	68	137	49.64%	60.00%
Measurement Year 2015[1]	Remeasurement 1	54	137	39.42%	60.00%
Measurement Year 2016[1]	Remeasurement 2	76	137	55.47%	60.00%
Measurement Year 2017[1]	Remeasurement 3	86	137	62.77%	65.00%
Measurement Year 2018[1]	Remeasurement 4	90	137	65.69%	65.00%
Measurement Year 2019[2]	Remeasurement 5	2,267	3,264	69.45%	65.00%
Measurement Year 2020[2]	Remeasurement 6	2,287	3,251	70.35%	65.00%
Measurement Year 2021[2]	Remeasurement 7	1,989	2,577	77.18%	65.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: 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.

Table 21: Neighborhood's Quality Improvement Project 2 Indicator Summary – Second Year Developmental Screening

Developmental Screening – By Age 2					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014[1]	Baseline	79	137	57.66%	60.00%
Measurement Year 2015[1]	Remeasurement 1	87	137	63.50%	60.00%
Measurement Year 2016[1]	Remeasurement 2	99	137	72.26%	60.00%
Measurement Year 2017[1]	Remeasurement 3	95	137	69.34%	65.00%
Measurement Year 2018[1]	Remeasurement 4	103	137	74.45%	65.00%
Measurement Year 2019[2]	Remeasurement 5	2,141	3,119	68.64%	65.00%
Measurement Year 2020[2]	Remeasurement 6	2,208	2,958	74.65%	65.00%
Measurement Year 2021[2]	Remeasurement 7	2,005	2,405	83.37%	65.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: 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.

Table 22: Neighborhood's Quality Improvement Project 2 Indicator Summary – Third Year Developmental Screening

Developmental Screening - By Age 3					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014[1]	Baseline	85	137	62.04%	60.00%
Measurement Year 2015[1]	Remeasurement 1	84	137	61.31%	60.00%
Measurement Year 2016[1]	Remeasurement 2	88	137	64.23%	60.00%
Measurement Year 2017[1]	Remeasurement 3	88	137	64.23%	65.00%
Measurement Year 2018[1]	Remeasurement 4	89	137	64.96%	65.00%
Measurement Year 2019[2]	Remeasurement 5	2,160	3,472	62.21%	65.00%
Measurement Year 2020[2]	Remeasurement 6	2,117	3,143	67.36%	65.00%
Measurement Year 2021[2]	Remeasurement 7	1,590	2,144	74.16%	65.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: 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.

Table 23: Neighborhood's Quality Improvement Project 3 Summary – Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication, Measurement Year 2021

Neighborhood's Quality Improvement Project 3 Summary
Title: Improve the HEDIS *Follow-Up Care for Children Prescribed ADHD Medication* Rate **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aimed to improve the follow-up care for children prescribed attention deficit/hyperactivity disorder medication. Indicator of Performance The percentage of children newly prescribed attention-deficit/hyperactivity disorder medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first attention-deficit/hyperactivity medication was dispensed. Member-Focused 2021 Interventions ▪ Educated parents of enrollees about attention deficit/hyperactivity disorder symptom management, medication compliance, and the importance of timely follow-up with their practitioners. ▪ Published social media content informing members about attention deficit/hyperactivity disorder and how to deal with social isolation. Provider-Focused 2021 Interventions ▪ Updated and disseminated clinical practice guidelines. ▪ Issued an education email blast to providers identified as treating one or more members diagnosed with attention deficit/hyperactivity disorder within the past we months. ▪ Conducted telephonic outreach to providers of members with a new attention deficit/hyperactivity disorder diagnosis to confirm with the provider that a follow-up appointment has been scheduled.

Table 24: Neighborhood's Quality Improvement Project 3 Indicator Summary – Initiation Phase

HEDIS Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	418	885	47.23%	55.91%
Measurement Year 2018	Remeasurement 1	423	889	47.58%	55.91%
Measurement Year 2019	Remeasurement 2	418	891	46.91%	55.91%
Measurement Year 2020	Remeasurement 3	434	851	51.00%	55.91%
Measurement Year 2021	Remeasurement 4	390	809	48.21%	55.99%

Indicator Description: The percentage of children between 6 and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication.

Table 25: Quality Improvement Project 3 Indicator Summary – Continuation and Maintenance Phase

HEDIS Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	130	223	58.30%	69.14%
Measurement Year 2018	Remeasurement 1	134	219	61.19%	69.14%
Measurement Year 2019	Remeasurement 2	127	226	56.19%	69.14%
Measurement Year 2020	Remeasurement 3	134	221	60.63%	69.14%
Measurement Year 2021	Remeasurement 4	131	212	61.79%	67.61%

Indicator Description: The percentage of children between 6 and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase.

Table 26: Neighborhood's Quality Improvement Project 4 Summary – Lead Screening, Measurement Year 2021

Neighborhood's Quality Improvement Project 4 Summary
Title: Social Determinant of Health Measure – Improve the Rate of Lead Screening in Children **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aimed to increase the percentage of children screened for lead by their second birthday. Indicator of Performance The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. Member-Focused 2021 Interventions ▪ Continued to mail post card reminders for lead testing to children turning one year old. ▪ Continued to offer a $25 incentive gift card to parents of children who had a lead screening by the age of two years. ▪ Published an article in the member newsletter on the importance of lead screenings. ▪ Educated members on lead screening and created goals for members that met the screening age criteria. ▪ Created social media posts on the importance of well-child visits. ▪ Distributed Rhode Island Department of Health-developed lead screening educational materials at marketing events targeted to parents with children.

Neighborhood's Quality Improvement Project 4 Summary
Title: Social Determinant of Health Measure – Improve the Rate of Lead Screening in Children **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Provider-Focused 2021 Interventions ▪ Continued to share best practices and requirements for primary care visits with low performing providers. ▪ Distributed gaps in care reports to providers along with education materials on the importance of lead screening and how the provider can support Neighborhood's goal of improving the lead screening rate. ▪ Published articles in the provider newsletter on the importance of lead screening, well visits, and follow-p care for patients with blood lead levels greater than 5 mcg/dl. Managed Care Plan-Focused 2021 Interventions ▪ Continued collaboration efforts with the Rhode Island Department of Health to address lead poisoning prevention, promoting screening, rescreening for high blood lead levels, lead screening guidelines and laws, exchange of data, sharing of best practices, and collaborative efforts around member and provider education.

Table 27: Neighborhood's Quality Improvement Project 4 Indicator Summary – Lead Screening

Lead Screening					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2015	Baseline	2,502	3,018	82.90%	84.77%
Measurement Year 2016	Remeasurement 1	2,884	3,688	78.20%	86.37%
Measurement Year 2017	Remeasurement 2	2,699	3,416	79.01%	85.64%
Measurement Year 2018	Remeasurement 3	2,786	3,536	78.79%	85.90%
Measurement Year 2019	Remeasurement 4	2,475	3,119	79.35%	86.62%
Measurement Year 2020	Remeasurement 5	2,282	2,958	77.15%	86.62%
Measurement Year 2021	Remeasurement 6	2,509	3,347	74.96%	83.94%

Indicator Description: The percentage of members 2 years of age who received one or more capillary or venous blood tests for lead poisoning on or before their second birthday.

Table 28: Neighborhood's Quality Improvement Project 5 Summary – Care for Older Adults, Measurement Year 2021

Neighborhood's Quality Improvement Project 5 Summary
Title: Improve *HEDIS Care for Older Adults* Performance **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aimed to improve performance for care of older adults. Indicators of Performance The percentage of adults 66 years and older who had each of the following during the measurement year: 1. Advance care planning 2. Medication review 3. Functional status assessment 4. Pain assessment

Neighborhood's Quality Improvement Project 5 Summary
Title: Improve *HEDIS Care for Older Adults* Performance **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Provider-Focused 2021 Interventions ▪ Continued to share best practices and technical specifications for the HEDIS *Care for Older Adults* measure with providers. ▪ Collaborated with nursing homes to improving documentation of care. ▪ Developed a CPT II code reference guide for providers, inclusive of all components of the HEDIS *Care for Older Adults* measure. The guide was distributed via the provider newsletter and posted on Neighborhood's website. Managed Care Plan-Focused 2021 Interventions ▪ Continued data collection improvements for the advanced care plan, functional status assessment, and pain assessment measures through Acuity, a care management software.

Table 29: Neighborhood's Quality Improvement Project 5 Indicator Summary – Advance Care Planning

HEDIS Care for Older Adults – Advance Care Planning					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	163	411	39.66%	40%
Measurement Year 2018	Re-measurement 1	257	411	62.53%	40%
Measurement Year 2019	Re-measurement 2	255	411	62.04%	45%
Measurement Year 2020	Re-measurement 3	3,773	5,457	69.14%	50%
Measurement Year 2021	Re-measurement 4	3,676	5,144	71.46%	66%

Indicator Description: The percentage of adults 66 years and older who had advance care planning during the measurement year.

Table 30: Neighborhood's Quality Improvement Project 5 Indicator Summary – Medication Review

HEDIS Care for Older Adults – Medication Review					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	281	411	68.37%	79%
Measurement Year 2018	Remeasurement 1	352	411	85.64%	79%
Measurement Year 2019	Remeasurement 2	366	411	89.05%	80%
Measurement Year 2020	Remeasurement 3	3,980	5,457	72.93%	81%
Measurement Year 2021	Remeasurement 4	4,583	5,144	89.09%	86%

Indicator Description: The percentage of adults 66 years and older who had a medication review during the measurement year.

Table 31: Neighborhood's Quality Improvement Project 5 Indicator Summary – Functional Status Assessment

HEDIS Care for Older Adults – Functional Status Assessment					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	207	411	50.36%	67%
Measurement Year 2018	Remeasurement 1	295	411	71.78%	67%
Measurement Year 2019	Remeasurement 2	302	411	73.48%	68%
Measurement Year 2020	Remeasurement 3	3,208	5,457	58.79%	69%
Measurement Year 2021	Remeasurement 4	4,167	5,144	81.01%	72%

Indicator Description: The percentage of adults 66 years and older who had a functional status assessment during the measurement year.

Table 32: Neighborhood's Quality Improvement Project 5 Indicator Summary – Pain Assessment

HEDIS Care for Older Adults – Pain Assessment					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	268	411	65.21%	62%
Measurement Year 2018	Remeasurement 1	366	411	89.05%	62%
Measurement Year 2019	Remeasurement 2	378	411	91.97%	63%
Measurement Year 2020	Remeasurement 3	4,209	5,457	77.13%	64%
Measurement Year 2021	Remeasurement 4	4,700	5,144	91.37%	90%

Indicator Description: The percentage of adults 66 years and older who had a pain assessment during the measurement year.

Table 33: Neighborhood's Quality Improvement Project 6 Summary – Transitions of Care, Measurement Year 2021

Neighborhood's Quality Improvement Project 6 Summary
Title: Increase the Percentage of Transitions from the Nursing Home to the Community **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim: Neighborhood aimed to increase the percentage of transitions from the nursing home to the community. Indicators of Performance 1. The number of INTEGRITY Medicare-Medicaid program members who transitioned from a nursing facility to the community under the Rhode to Home Program. 2. The number of INTEGRITY Medicare-Medicaid program members who transitioned from a nursing facility to the community. Member-Focused 2021 Interventions ▪ Facilitated telehealth visits. ▪ Continued distribution of an enrollee educational flyer on the availability of services. ▪ Continued outreached to members prescribed antipsychotic medication and identified with gaps in care. Provider-Focused 2021 Interventions ▪ Continued the Nursing Home Quality Incentive Program.

Neighborhood's Quality Improvement Project 6 Summary
Title: Increase the Percentage of Transitions from the Nursing Home to the Community **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Managed Care Plan-Focused 2021 Interventions ▪ Continued to conduct reassessments after the first 60 days as opposed to the first 90 days for members who opted to remain in the nursing facility. ▪ Accessed nursing home-based electronic medical record systems to assist in identifying opportunities for transition. ▪ Implemented a process for nursing staff to support reassessments every six months as opposed to annually. ▪ Continued collaboration efforts with the state and community to identify and increase Section 8 Housing Vouchers. ▪ Continued use of the nursing home dashboard to display real-time member data for timely response to member needs. ▪ Continued to utilize welcome calls to help identify members for transition. ▪ Continued an intensive case management program within nursing home facilities to identify potential candidates for transition.

Table 34: Neighborhood's Quality Improvement Project 6 Indicator Summary – Transitions for Rhode to Home Eligible Members

Transitions From the Nursing Home to the Community – INTEGRITY Medicare-Members Who Are Eligible for the Rhode to Home Program					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	14	55	14 Members	20 Members
Measurement Year 2018	Remeasurement 1	20	58	20 Members	20 Members
Measurement Year 2019	Remeasurement 2	17	31	17 Members	20 Members
Measurement Year 2020	Remeasurement 3	19	30	19 Members	20 Members
Measurement Year 2021	Remeasurement 4	14	21	14 Members	20 Members

Indicator Description: The number of INTEGRITY Medicare-Medicaid program members who transitioned from a nursing facility to the community under the Rhode to Home Program.

Table 35: Neighborhood's Quality Improvement Project 6 Indicator Summary – Transitions for All Members

Transitions from the Nursing Home to the Community – All INTEGRITY Medicare-Members					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2018	Baseline	391	982	39.8%	35%
Measurement Year 2019	Remeasurement 1	647	862	75.1%	35%
Measurement Year 2020	Remeasurement 2	390	636	61.3%	35%
Measurement Year 2021	Remeasurement 3	416	682	61.0%	35%

Indicator Description: The number of INTEGRITY Medicare-Medicaid program members who transitioned from a nursing facility to the community.

Tufts Health Public Plan

The results of the validation activity determined that Tufts Health Public Plan was compliant with the standards of *42 CFR § 438.330(d)(2)* for the two of the four quality improvement projects conducted. IPRO's assessment of Tufts Health Public Plan's methodology found that Tufts Health Public Plan did not conduct the quality improvement projects using the appropriate framework, nor the state required *Quality Improvement Activity Form*. The concerns that put the conclusion of the Tufts Public Health Plan's quality improvement activities at-risk are enumerated below.

Tufts Public Health Plan's Quality Improvement Project 1 – Promote Doula Program for Maternal and Child Health

Tufts Health Public Plan's conduct of Doula Program for Maternal and Child Health quality improvement project did not meet all standards related to topic selection, data collection, and interpretation of study results. Through the validation process, IPRO determined that for Tufts Health Public Plan's quality improvement project 1:

- The project indicator did not monitor Tufts Health Public Plan's performance at a point in time or over time and did not inform the selection and evaluation of quality improvement activities.
- The data collection plan did not specify the data sources, nor did it link to the data analysis plan to ensure that the appropriate data would be available for quality improvement project reporting. Additionally, the data collection instrument did not allow for consistent and accurate data collection over the period studied.
- The analysis did not include baseline and repeat measures of project outcomes; and the quality improvement project results were not presented in a concise and easily understood manner.
- The improvement strategies were not designed to address root causes or barriers identified through data analysis and quality improvement process, and the quality improvement project did not assess the extent to which the improvement strategy was successful.

Tufts Public Health Plan's Quality Improvement Project 2 – Member Experience and Retention

Tufts Health Public Plan's conduct of the Member Experience and Retention quality improvement project 2 did not meet all standards related to topic selection, data collection, and interpretation of study results. Through the validation process, IPRO determined that for Tufts Health Public Plan's quality improvement project 2:

- The quality improvement project topic was not selected through a comprehensive analysis of enrollee needs, care, and services.
- The project indicator did not inform the selection and evaluation of quality improvement activities.
- The data collection instrument did not allow for consistent data collection and reporting over the period studied.
- The quality improvement project results were not presented in a concise and easily understood manner.
- The improvement strategies were not designed to address root causes or barriers identified through data analysis and quality improvement process, and the quality improvement project did not assess the extent to which the improvement strategy was successful.

Table 36: Tufts Health Public Plan's Quality Improvement Project 1 Summary – Promotion of Doula Program, Measurement Year 2021

Tufts Health Public Plan's Quality Improvement Project 1 Summary
Title: Promote Doula Program for Maternal and Child Health **Validation Summary:** There were one or more validation findings that indicate a bias in the quality improvement project results. The concerns that put the conclusion at-risk were enumerated above.
Aim Tufts Health Public Plan aimed to promote its doula program for maternal and child health. Indicator of Performance The number of unique members who are pregnant and initiated engagement with a doula service during the quarter. Member-Focused 2021 Interventions ▪ Distributed member materials in multiple languages electronically to increase knowledge of doula program. ▪ Established a new contract with multilingual/multicultural doula provider to provide members with care and support in their native language. Managed Care Plan-Focused 2021 Interventions ▪ Continued conducting primary research (in conjunction with doula provider) with both members and prospective members including having in-depth interviews with members who have participated in the doula program to identify value drivers and how to better market this benefit to existing members. ▪ Continued engaging current and prospective members through events such as virtual baby showers and meeting with community-based organizations to brainstorm collaboration opportunities. ▪ Trained Community Relations staff to be able to speak about the doula program more comprehensively during events. ▪ Updated website to include doula services, with links to flyers, educational resources, basic referral information, and adding an events page.

Table 37: Tufts Health Public Plan's Quality Improvement Project 1 Indicator Summary – Promotion of Doula Program

Number of Members Enrolled in the Doula Program		
Measurement Period	**Number of Members**	**Goal**
2020 First Quarter	1	Not Established
2020 Second Quarter	0	Not Established
2020 Third Quarter	3	Not Established
2020 Fourth Quarter	4	Not Established
2021 First Quarter	5	Not Established
2021 Second Quarter	3	Not Established
2021 Third Quarter	1	Not Established
2021 Fourth Quarter	3	Not Established

Indicator Description: The number of unique members who are pregnant and initiated engagement with a doula service during the quarter.

Table 38: Tufts Health Public Plan's Quality Improvement Project 2 Summary – Member Experience and Retention, Measurement Year 2021

Tufts Health Public Plan's Quality Improvement Project 2 Summary
Title: Member Experience and Retention **Validation Summary:** It is unclear how performance in this area impacted the health outcomes of Tufts Health Public Plan's Medicaid membership. There were one or more validation findings that indicate a bias in the quality improvement project results. The concerns that put the conclusion at-risk were enumerated above.
Aim Tufts Health Public Plan aimed to improve its average monthly member attrition rate, from 8% to 6%. (A lower rate is desired.) Indicator of Performance The difference in total Medicaid enrollment from the previous measurement period and the current measurement period. Member-Focused 2021 Interventions ▪ Revised new member onboarding content delivered by short message service text. ▪ Distributed essential supplies and groceries to families during member appreciation events, collaborating with various community-based organizations in Providence, Woonsocket, and Central Falls/Pawtucket. ▪ Collaborated with Jenks Park Pediatrics to kick off a transportation pilot offering no-cost transportation for patients to travel to and from appointments. ▪ Implemented a youth health & wellness program, Healthy Heroes, with third graders in two Central Falls schools in collaboration with the American Heart Association, YMCA, and University of Rhode Island's SNAP Nutrition Education Program. The objective of the Healthy Heroes program is to improve healthy behaviors related to nutrition and physical activity. Managed Care Plan-Focused 2021 Interventions ▪ Pivoted in-person awareness and acquisition campaigns to virtual outreach of approximately 73,000 prospective members. ▪ Developed 2021 PCO campaign strategy to focus more on member retention messaging to engage enrolled families. ▪ Leveraged Healthsource RI Support to increase awareness of managed care plan offerings, collaborating with navigators to share product/benefit information and incorporating the navigators into PCO strategy. ▪ Established community commitment by developing and constructing two soccer fields in Central Falls.

Table 39: Tufts Health Public Plan's Quality Improvement Project 2 Indicator Summary – Member Experience and Retention

Member Retention Rate					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
January 2019	Baseline	Not Provided	Not Provided	8%	Not Applicable
February 2019	Remeasurement 1	Not Provided	Not Provided	5%	6%
March 2019	Remeasurement 2	Not Provided	Not Provided	7%	6%
April 2019	Remeasurement 3	Not Provided	Not Provided	7%	6%
May 2019	Remeasurement 4	Not Provided	Not Provided	5%	6%
June 2019	Remeasurement 5	Not Provided	Not Provided	5%	6%
July 2019	Remeasurement 6	Not Provided	Not Provided	5%	6%
August 2019	Remeasurement 7	Not Provided	Not Provided	7%	6%
September 2019	Remeasurement 8	Not Provided	Not Provided	5%	6%
October 2019	Remeasurement 9	Not Provided	Not Provided	11%	6%
November 2019	Remeasurement 10	Not Provided	Not Provided	9%	6%
December 2019	Remeasurement 11	Not Provided	Not Provided	5%	6%
2020 First Quarter	Remeasurement 12	Not Provided	Not Provided	6%	6%
2020 Second Quarter	Remeasurement 13	Not Provided	Not Provided	2%	6%
2020 Third Quarter	Remeasurement 14	Not Provided	Not Provided	2%	6%
2020 Fourth Quarter	Remeasurement 15	Not Provided	Not Provided	3%	6%
2021 First Quarter	Remeasurement 16	Not Provided	Not Provided	3%	6%
2021 Second Quarter	Remeasurement 17	Not Provided	Not Provided	3%	6%
2021 Third Quarter	Remeasurement 18	Not Provided	Not Provided	3%	6%
2021 Fourth Quarter	Remeasurement 19	Not Provided	Not Provided	3%	6%

Indicator Description: The difference in total Medicaid enrollment from the previous measurement period and the current measurement period.

Table 40: Tufts Health Public Plan's Quality Improvement Project 3 Summary – Flu Vaccine, Measurement Year 2021

Tufts Health Public Plan's Quality Improvement Project 3 Summary
Title: Increase Flu Vaccination Rate **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the quality improvement project results.
Aim Tufts Health Public Plan aimed to increase the influenza vaccination utilization rate by addressing health disparities that impact the target population: the goal was to increase utilization by three percentage points for the RITogether population. Indicator of Performance The percentage of Medicaid members who were continuously enrolled from April 1 to March 31 of the measurement period and had a flu vaccine between September 1 and March 31 of the measurement period. Member-Focused 2021 Interventions ▪ Established a transportation benefit offering transport to and from vaccine appointments. This benefit was marketed on a newsletter to members about flu vaccinations. ▪ Published articles on flu and COVID vaccinations in the member newsletter.

Tufts Health Public Plan's Quality Improvement Project 3 Summary
Title: Increase Flu Vaccination Rate **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the quality improvement project results.
Provider-Focused 2021 Interventions ▪ Included flu vaccine reminders on provider webinars. Managed Care Plan-Focused 2021 Interventions ▪ Incorporated flu vaccine information into the care management assessment – care managers are to identify barriers to vaccination and help members mitigate any identified issues. Zip code analysis was conducted: areas identified with lower vaccination rates are targeted for care managers to conduct outreach for members in those zip codes.

Table 41: Tufts Health Public Plan's Quality Improvement Project 3 Indicator Summary – Flu Vaccine

Flu Vaccine Utilization Rate					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year September 2019-March 2020	Baseline	Not Provided	Not Provided	31.88%	34.88%
Measurement Year September 2020-March 2021	Remeasurement 1	1,872	8,934	20.95%	30.95%

Indicator Description: The percentage of Medicaid members who were continuously enrolled from April 1 to March 31 of the measurement period and had a flu vaccine between September 1 and March 31 of the measurement period.

Table 42: Tufts Health Public Plan's Quality Improvement Project 4 Summary – Behavioral Health Telehealth, Measurement Year 2021

Tufts Health Public Plan's Quality Improvement Project 4 Summary
Title: Behavioral Health Telehealth **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the quality improvement project results.
Aim Tufts Health Public Plan aimed to improve access to behavioral health telehealth services via reduction of known barriers: the goal was to increase the baseline by three percentage points for the RITogether population. Indicator of Performance *HEDIS Mental Health Utilization* – The percentage of members receiving a telehealth mental health service during the measurement year. Member-Focused 2021 Interventions ▪ Referred members without phones who met the criteria to Entouch, a federal phone program, or the loaner phone program through the managed care plan. ▪ Published articles in the member newsletter. Provider-Focused 2021 Interventions ▪ Added behavioral health telehealth information to provider publications.

Tufts Health Public Plan's Quality Improvement Project 4 Summary
Title: Behavioral Health Telehealth **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the quality improvement project results.
▪ Discussed telehealth on bi-monthly provider webinars. Managed Care Plan-Focused 2021 Interventions ▪ Expanded the behavioral health provider network, including active recruitment of behavioral health providers that offer telehealth. ▪ Updated Healthsparq, the centralized provider listing system which allows Rhode Island members to see active providers in their network and area, including specific labels designating behavioral health telehealth providers. ▪ Gathered member experience data regarding telehealth through Member Advisory Council meetings.

Table 43: Tufts Health Public Plan's Quality Improvement Project 4 Indicator Summary – Behavioral Health Telehealth

Behavioral Health Telehealth Utilization					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2020	Baseline	Not Provided	Not Provided	68%	71%
Measurement Year 2021	Remeasurement 1	953	1,615	59.01%	64.01%

Indicator Description: The percentage of members receiving a telehealth mental health service during the measurement year.

UnitedHealthcare Community Plan of Rhode Island

IPRO's assessment of UHCCP-RI's methodology found that there were no validation findings that indicated that the credibility of the four quality improvement projects was at risk.

Table 44: UHCCP-RI's Quality Improvement Project 1 Summary – Treatment for Depression, Measurement Year 2021

UHCCP-RI's Quality Improvement Project 1 Summary
Title: Improving Effective Acute Phase Treatment for Major Depression **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHCCP-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 of Performance HEDIS *Antidepressant Medication Management – Effective Acute Phase*: The percentage of members 18 years of age and older who remain on their antidepressant medications during the 12-week effective acute phase treatment after being diagnosed with a new episode of depression and treated with antidepressant medications. Member-Focused 2021 Interventions

UHCCP-RI's Quality Improvement Project 1 Summary
Title: Improving Effective Acute Phase Treatment for Major Depression **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.

- Conducted live outreach calls to high-risk members to help identify, prevent, and resolve prescription drug related problems, while improving compliance with patient adherence related to behavioral health prescription medications.
- Published articles on related topics in the member newsletter.

Provider-Focused 2021 Interventions

- Launched online continuing education unit seminars for providers related to depression and follow-up care after higher levels of care.
- Offered and facilitated open calls for providers on how to use the Live and Work Well website, how to identify providers, and answer any questions providers had regarding behavioral health access, behavioral health in general and to address any concerns.
- Met with accountable entities and high-volume sites (at least 100 members) to discuss current rates, opportunities for improvement with noncompliant members and share best practices from high performing provider sites. Due to COVID-19, both virtual and in-person meetings were conducted.
- Distributed a Behavioral Health Guide to help providers find behavioral health providers who have agreed to provide an appointment within 5 business days.
- Conducted a training on behavioral health measures during the Accountable Entities Quality Circle meetings.

Managed Care Plan-Focused 2021 Interventions

- Implemented a 90-day supply of antidepressants to be filled at a pharmacy or through mail-order.
- Held monthly meetings throughout the entire year and focused on behavioral health quality measures. The meetings include UnitedHealthcare quality representatives, clinical services representatives, Optum behavioral health associates, as well as the health plan's pharmacist. Data was requested and analyzed to determine trends, including practitioners with poor performance on this measure.
- Created the Behavioral Health Link flyer on available resources to be utilized by clinical practice consultants, case managers, community health workers and marketing representatives as hand-outs and for community events.

Table 45: UHCCP-RI's Quality Improvement Project 1 Indicator Summary – Treatment for Depression, Measurement Years 2009 to 2021

HEDIS Antidepressant Medication Management – Acute Phase					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2009	Baseline	134	274	48.91%	52.63%
Measurement Year 2010	Remeasurement 1	218	371	58.76%	53.18%
Measurement Year 2011	Remeasurement 2	156	345	45.22%	53.57%
Measurement Year 2012	Remeasurement 3	289	556	51.98%	52.74%
Measurement Year 2013	Remeasurement 4	529	1,031	51.31%	56.27%
Measurement Year 2014	Remeasurement 5	588	1,113	52.83%	54.48%
Measurement Year 2015	Remeasurement 6	1,188	2,173	54.67%	56.28%
Measurement Year 2016	Remeasurement 7	1,252	2,319	53.99%	59.56%
Measurement Year 2017	Remeasurement 8	1,242	2,424	51.24%	57.47%
Measurement Year 2018	Remeasurement 9	1,254	2,274	55.15%	58.01%
Measurement Year 2019	Remeasurement 10	1,361	2,236	60.87%	56.57%
Measurement Year 2020	Remeasurement 11	1,471	2,281	64.49%	64.29%
Measurement Year 2021	Remeasurement 12	1,793	2,557	70.12%	67.74%

Indicator Description: The percentage of members 18 years of age and older who remain on their antidepressant medications during the 12-week effective acute phase treatment after being diagnosed with a new episode of depression and treated with antidepressant medications.

Table 46: UHCCP-RI's Quality Improvement Project 2 Summary – Developmental Screening, Measurement Year 2021

UHCCP-RI's Quality Improvement Project 2 Summary
Title: Developmental Screening in the 1st, 2nd, 3rd Years of Life **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHCCP-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 12 months preceding their first, second, and third birthdays. Indicators of Performance ▪ 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. ▪ 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. ▪ 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. Member-Focused 2021 Interventions ▪ Targeted parents and guardians for Early and Periodic Screening, Diagnostic, and Treatment interactive voice recordings with a reminder to complete a routine check-up for children ages 2-21 years. In 2021, 27,997 calls were conducted. ▪ Distributed a developmental screening educational flyer to members who attended multiple community events.

UHCCP-RI's Quality Improvement Project 2 Summary
Title: Developmental Screening in the 1st, 2nd, 3rd Years of Life **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.

- Conducted live outreach calls to remind heads of households to seek age-appropriate routine care for their children. In 2021 a total of 19,364 calls were conducted.
- Published articles on related topics in the member newsletter.

Provider-Focused 2021 Interventions

- Added developmental screening as a pay-for-performance measure for all accountable entities.
- Met with accountable entities and high-volume sites (at least 100 members) to discuss current rates, opportunities for improvement with noncompliant members and share best practices from high performing provider sites.

Managed Care Plan-Focused 2021 Interventions

- Executed a contract with a community-based organization to provide funds for a health worker to assist with expanding education and improving the health of community members within Central Falls. The education will encompass education regarding preventive measures, such as developmental screenings, as well as chronic care.

Table 47: UHCCP-RI's Quality Improvement Project 2 Indicator Summary – First Year Developmental Screening, Measurement Years 2014 to 2021

Developmental Screening – By Age 1					
Measurement Period	**Measurement Phase**	**Numerator**	**Denominator**	**Results**	**Goal**
Measurement Year 2014[1]	Baseline	57	137	41.61%	60.00%
Measurement Year 2015[2]	Remeasurement 1	505	1,517	33.29%	60.00%
Measurement Year 2016[1]	Remeasurement 2	74	137	54.01%	60.00%
Measurement Year 2017[1]	Remeasurement 3	79	137	57.66%	50.00%
Measurement Year 2018[1]	Remeasurement 4	88	137	64.23%	50.00%
Measurement Year 2019[1]	Remeasurement 5	92	137	67.15%	50.00%
Measurement Year 2020[1]	Remeasurement 6	107	134	79.85%	50.00%
Measurement Year 2021[1]	Remeasurement 7	111	137	81.02%	50.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: 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.

Table 48: UHCCP-RI's Quality Improvement Project 2 Indicator Summary – Second Year Developmental Screening, Measurement Years 2014 to 2021

Developmental Screening – By Age 2					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014[1]	Baseline	67	137	48.91%	60.00%
Measurement Year 2015[2]	Remeasurement 1	549	1,237	44.38%	60.00%
Measurement Year 2016[1]	Remeasurement 2	79	137	57.66%	60.00%
Measurement Year 2017[1]	Remeasurement 3	79	137	57.66%	50.00%
Measurement Year 2018[1]	Remeasurement 4	90	137	65.69%	50.00%
Measurement Year 2019[1]	Remeasurement 5	101	137	73.72%	50.00%
Measurement Year 2020[1]	Remeasurement 6	109	135	80.74%	50.00%
Measurement Year 2021[1]	Remeasurement 7	108	137	78.83%	50.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: 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.

Table 49: UHCCP-RI's Quality Improvement Project 2 Indicator Summary – Third Year Developmental Screening, Measurement Years 2014 to 2021

Developmental Screening - By Age 3					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014[1]	Baseline	60	137	43.80%	60.00%
Measurement Year 2015[2]	Remeasurement 1	570	1,313	43.41%	60.00%
Measurement Year 2016[1]	Remeasurement 2	81	137	59.12%	60.00%
Measurement Year 2017[1]	Remeasurement 3	78	137	56.93%	50.00%
Measurement Year 2018[1]	Remeasurement 4	82	137	59.85%	50.00%
Measurement Year 2019[1]	Remeasurement 5	86	137	62.77%	50.00%
Measurement Year 2020[1]	Remeasurement 6	115	142	80.99%	50.00%
Measurement Year 2021[1]	Remeasurement 7	106	137	77.37%	50.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: 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.

Table 50: UHCCP-RI's Quality Improvement Project 3 Summary – Lead Screening, Measurement Year 2021

UHCCP-RI's Quality Improvement Project 3 Summary
Title: Improving Lead Screening in Children **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHCCP-RI aimed to increase the percentage of members two years of age who received one or more capillary or venous blood tests for lead poising on or before their second birthday.

UHCCP-RI's Quality Improvement Project 3 Summary
Title: Improving Lead Screening in Children **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Member-Focused 2021 Interventions ▪ Targeted parents and guardians for Early and Periodic Screening, Diagnostic, and Treatment interactive voice recordings with a reminder to complete a routine check-up for children ages 2-21 years. In 2021, 27,997 calls were conducted. ▪ Continued member incentive of a $25 gift card for completing lead testing. ▪ Published articles on related topics in the member newsletter. ▪ Distributed a lead screening educational flyer to members who attended multiple community events. Provider-Focused 2021 Interventions ▪ Discussed barriers and lessons learned with external participating practitioners who are committee members of the Provider Advisory Committee for the UnitedHealthcare Community Plan of Rhode Island. ▪ Distributed lists of members due for lead screening to providers. ▪ Initiated a pilot program with two accountable entities to improve housing environments of underserved population in Providence, Rhode Island. Managed Care Plan-Focused 2021 Interventions ▪ Executed a contract with a community-based organization to provide funds for a health worker to assist with expanding education and improving the health of community members within Central Falls. The education will encompass education regarding preventive measures, such as lead screenings, as well as chronic care. ▪ Continued to collaborate with the Rhode Island Department of Health's Lead Screening Evaluator and Neighborhood Health Plan of Rhode Island to identify barriers and opportunities for improvement. The group encouraged providers to conduct in-office capillary screenings or in-office blood tests and send samples via a currier to the State lab. ▪ Provided the Rhode Island Department of Health with member incentive information to share at the Rhode Island Department of Health's Lead Poisoning Prevention Coordination Group meetings in Central Falls, Pawtucket, Providence, and Woonsocket.

Table 51: UHCCP-RI's Quality Improvement Project 3 Indicator Summary – Lead Screening, Measurement Years 2016 to 2021

HEDIS Lead Screening in Children					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2016[2]	Baseline 1	1,174	1,547	75.89%	84.77%
Measurement Year 2017[1]	Remeasurement 1	315	411	76.64%	86.37%
Measurement Year 2018[2]	Remeasurement 2	1,320	1,778	74.24%	85.64%
Measurement Year 2019[1]	Remeasurement 3	316	411	76.89%	85.90%
Measurement Year 2020[2]	Remeasurement 4	1,027	1,436	71.52%	86.62%
Measurement Year 2021[1]	Remeasurement 5	288	411	70.07%	83.94%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: The percentage of members 2 years of age who received one or more capillary or venous blood tests for lead poisoning on or before their second birthday.

Table 52: UHCCP-RI's Quality Improvement Project 4 Summary – Breast Cancer Screening, Measurement Year 2021

UHCCP-RI's Quality Improvement Project 4 Summary
Title: Improving Breast Cancer Screening **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHCCP-RI aimed to increase the percentage of women aged 50-74 years who had a mammogram. Member-Focused 2021 Interventions ▪ Continued member incentive of a $25 gift card for a timely mammogram. ▪ Conducted live outreach calls to members encouraging them to complete a well visit. ▪ Conducted targeted live outreach calls to members ages 45 to 64 years identified as needing an annual exam. A total of 1,508 calls were conducted between November 2021 and December 2021. ▪ Continued the monthly mailing to members with an upcoming birthday encouraging members to complete a well visit. ▪ Issued a women's health email encouraging members to get screened for breast cancer. ▪ Distributed a breast cancer screening educational flyer to members who attended multiple community events. ▪ Initiated the House Call Program for in-person appointments for members ages 26 years and older, who are not pregnant and need an annual exam. During the appointment, the importance of breast cancer screenings is discussed. ▪ Published articles on related topics in the member newsletter. Provider-Focused 2021 Interventions ▪ Collaborated with an accountable entity on a health equity project to improve the rate of breast cancer screenings. ▪ Issued gaps in care lists to network obstetricians/gynecologists. Managed Care Plan-Focused 2021 Intervention ▪ Executed a contract with a community-based organization to provide funds for a health worker to assist with expanding education and improving the health of community members within Central Falls. The education will encompass education regarding preventive measures, such as breast cancer screenings, as well as chronic care.

Table 53: UHCCP-RI's Quality Improvement Project 4 Indicator Summary – Breast Cancer Screening, Measurement Years 2017 to 2021

HEDIS Breast Cancer Screening					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline 1	2,834	4,551	62.27%	70.29%
Measurement Year 2018	Remeasurement 1	2,882	4,690	61.45%	68.94%
Measurement Year 2019	Remeasurement 2	2,826	4,480	63.33%	69.23%
Measurement Year 2020	Remeasurement 3	2,973	5,004	59.41%	69.22%
Measurement Year 2021	Remeasurement 4	3,330	5,669	58.74%	63.77%

Indicator Description: Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.

Technical Summary – Validation of Performance Measures

Objectives

Title 42 Code of Federal Regulations 438.330(c) Performance measurement establishes that the state must identify standard performance measures relating to the performance of managed care plans and that the state requires each managed care plan to annually measure and report to the state on its performance using the standard measures required by the state.

As required by section *2.12.03.03 Quality Assurance* of the *Medicaid Managed Care Services Agreement*, Rhode Island managed care plans must provide performance measure data, specifically HEDIS, to the Office of Health and Human Services within 30 days following the presentation of these results to the managed care plan's quality improvement committee. The Office of Health and Human Services utilizes performance measures to evaluate the quality and accessibility of services furnished to Medicaid beneficiaries and to promote positive health outcomes. Further, the Office of Health and Human Services incorporates select HEDIS results into its methodology for the accountable entity shared savings distribution.

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (2)(b)(1)(ii) mandates that the state or an external quality review organization must validate the performance measures that were calculated during the preceding 12 months. IPRO conducted this activity on behalf of the Office of Health and Human Services for measurement year 2021.

Technical Methods of Data Collection and Analysis

For measurement year 2021, the Rhode Island Medicaid managed care plans were required to submit HEDIS performance measure data to the Office of Health and Human Services. To ensure compliance with reporting requirements, each managed care plan contracted with an NCQA-certified HEDIS vendor and an NCQA-certified HEDIS compliance auditor.

Table 54 displays vendors and compliance audit licensed organizations by managed care plan.

Table 54: HEDIS Vendors and HEDIS Compliance Audit Licensed Organizations, Measurement Year 2021

Managed Care Plan	NCQA-Certified HEDIS Vendor	NCQA-Certified HEDIS Compliance Audit Licensed Organization
Neighborhood	Symphony Performance Health	Attest Health Care Advisors
Tufts Health Public Plan	Symphony Performance Health	Attest Health Care Advisors
UHCCP-RI	Symphony Performance Health	Attest Health Care Advisors

The HEDIS vendor collected data and calculated performance measure rates on behalf of the managed care plan for measurement year 2021. The HEDIS vendor calculated rates using NCQA's *HEDIS Measurement Year 2021 Volume 2 Technical Specifications for Health Plans*.

The HEDIS compliance auditor determined if the appropriate information processing capabilities were in place to support accurate and automated performance measurement, and they also validated the managed care plan's adherence to the technical specifications and reporting requirements. The HEDIS compliance auditor evaluated the managed care plan's information practices and control procedures, sampling methods and procedures, compliance with technical specifications, analytic file production, and reporting and documentation in two parts:

1. Information System Capabilities
2. HEDIS Specification Standards

HEDIS compliance auditors consider managed care plan compliance with the information system capabilities and HEDIS specification standards to fully assess the organization's HEDIS reporting capabilities.

Information System Capabilities

As part of the NCQA HEDIS Compliance Audit, HEDIS compliance auditors assessed the managed care plan's compliance with NCQA's seven information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that the managed care plan has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. Table 55 displays these standards as well as the elements audited for the standard.

Table 55: Information System Capabilities Standards

Information System Capabilities Categories	Elements Audited
2.0 Medicaid Services Data	Sound Coding Methods and Data Capture, Transfer and Entry
2.0 Enrollment Data	Data Capture, Transfer and Entry
3.0 Practitioner Data	Data Capture, Transfer and Entry
4.0 Medical Record Review Processes	Training, Sampling, Abstraction and Oversight
5.0 Supplemental Data	Capture, Transfer and Entry
6.0 Data Preproduction Processing	Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity
7.0 Data Integration and Reporting	Accurate Reporting, Control Procedures that Support Measure Reporting Integrity

The information system capabilities evaluation included the computer and software environment, data collection procedures, abstraction of medical records for hybrid measures, as well as the review of any manual processes used for HEDIS reporting. The HEDIS compliance auditor determined the extent to which the managed care plan had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

HEDIS Specification Standards

HEDIS compliance auditors use the HEDIS specification standards to assess the managed care plan's compliance with conventional reporting practices and HEDIS technical specifications. These standards describe the required procedures for specific information, such as proper identification of denominators and numerators, and verification of algorithms and rate calculations.

Performance Measure Validation

Each managed care plan's calculated rates for the NCQA HEDIS Measurement Year 2021 measure set were validated as part of the NCQA HEDIS Compliance Audit and assigned one of NCQA's outcome designations. Table 56 presents these outcome designations and their definitions. Performance measure validation activities included, but were not limited to:

- Confirmation that rates were produced with certified code or Automated Source Code Review approved logic
- Medical record review validation
- Review of supplemental data sources
- Review of system conversions/upgrades, if applicable
- Review of vendor data, if applicable

- Follow-up on issues identified during documentation review or previous audits

Table 56: Performance Measure Outcome Designations

NCQA Performance Measure Outcome Designation	Outcome Designation Definition
R	**Reportable**. A reportable rate was submitted for the measure.
NA	**Small Denominator.** The organization followed the specifications, but the denominator was too small (e.g., < 30) to report a valid rate. a. For Effectiveness of Care and Effectiveness of Care-like measures when the denominator is fewer than 30. b. For utilization measures that count member months when the denominator is fewer than 360 member months. c. For all risk-adjusted utilization measures when the denominator is fewer than 150. d. For electronic clinical data systems measures when the denominator is fewer than 30.
NB	**No Benefit.** The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	**Not Reported.** The organization chose not to report the measure.
NQ	**Not Required.** The organization was not required to report the measure.
BR	**Biased Rate.** The calculated rate was materially biased.
UN	**Unaudited.** The organization chose to report a measure that is not required to be audited. This result only applies when permitted by NCQA.

NCQA: National Committee for Quality Assurance.

Each managed care plan's HEDIS compliance auditor produced a Final Audit Report and Audit Review Table at the conclusion of the audit. Together, these documents present a comprehensive summary of the audit activities and performance measure validation results. Each managed care plan submitted these documents to the Office of Health and Human Services and IPRO.

IPRO reviewed each managed care plan's Final Audit Report and Audit Review Table to confirm that all performance measures were deemed reportable by the HEDIS auditor, and that calculation of these performance measures aligned with Office of Health and Human Services requirements. To assess the accuracy of the reported rates, IPRO:

- Compared performance measure rates reported by the managed care plans to NCQA's Quality Compass regional Medicaid benchmarks; and
- Analyzed performance-measure-rate–level trends to identify drastic changes in performance.

Description of Data Obtained

For the 2021 external quality review, IPRO obtained each managed care plan's Final Audit Report and a locked copy of the Audit Review Table that were produced by the HEDIS compliance auditor.

The Final Audit Report included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental data sources (e.g., immunization registries, care management files, laboratory result files), 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; Table 56).

The Audit Review Table 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 Audit Review Table: administrative rate before exclusions; minimum required sample size, and minimum required sample size 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.

Comparative Results

Validation of Performance Measures

Each managed care plan's HEDIS compliance auditor determined that the HEDIS rates reported by the managed care plan for measurement year 2021 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. Further, there were no data collection or reporting issues identified by the HEDIS compliance auditors for any managed care plan.

Performance Measure Results

This section of the report explores the utilization of managed care plan services by examining select measures under the following domains:

- Use of Services – Two measures (three rates) examine the percentage of Medicaid child and adolescent access routine care.
- Effectiveness of Care – Five measures (seven rates) examine how well a managed care plan provides preventive screenings and care for members with acute and chronic illness.
- Access and Availability – Three measures (five rates) examine the percentage of Medicaid children, adolescents, child-bearing women, and adults who received primary care provider or preventive care services, ambulatory care (adults only), or timely prenatal and postpartum care.

Table 57 displays the managed care plans' HEDIS rates for measurement year 2021, as well as the measurement year 2021 national Medicaid benchmarks achieved by the managed care plan, and the national Medicaid means.

Table 57: Managed Care Plan HEDIS Rates, Measurement Year 2021

Domain/Measures	Neighborhood Measurement Year 2021	*Quality Compass* Measurement Year 2021 National Medicaid Benchmark (Met/Exceeded)	Tufts Health Public Plan Measurement Year 2021	*Quality Compass* Measurement Year 2021 National Medicaid Benchmark (Met/Exceeded)	UHCCP-RI Measurement Year 2021	*Quality Compass* Measurement Year 2021 National Medicaid Benchmark (Met/Exceeded)	*Quality Compass* Measurement Year 2021 National Medicaid Mean
Use of Services							
Well-Child Visits in the First 30 Months of Life – First 15 Months	73.43%	95th	44.55%	10th	64.22%	75th	54.04%
Well-Child Visits in the First 30 Months of Life – First 15 to 30 Months	79.74%	90th	69.39%	50th	74.71%	75th	66.04%
Child and Adolescent Well-Care Visits (Total)	61.26%	75th	46.85%	33.33rd	60.24%	75th	49.55%
Effectiveness of Care							
Cervical Cancer Screening for Women	71.95%	95th	40.88%	<10th	65.21%	75th	56.26%
Chlamydia Screening for Women (Total)	65.23%	66.67th	56.51%	50th	60.24%	66.67th	55.15%
Childhood Immunization Status – Combination 3	76.59%	90th	70.89%	75th	76.89%	90th	63.08%
Childhood Immunization Status – Combination 10	61.33%	95th	55.04%	95th	63.26%	95th	35.94%
Comprehensive Diabetes Care – HbA1c Testing	89.02%	75th	78.10%	<10th	89.05%	75th	85.28%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	54.20%	75th	63.78%	95th	56.29%	90th	38.53%
Follow-Up After Hospitalization for Mental Illness – 30 Days (Total)	74.55%	90th	43.78%	10th	76.31%	90th	58.86%
Access and Availability							
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	78.01%	75th	56.91%	<10th	75.23%	50th	72.60%
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	87.50%	75th	67.24%	<10th	84.52%	66.67th	81.24%
Adults' Access to Preventive/Ambulatory Health Services – 65+ Years	92.74%	90th	63.37%	<10th	81.79%	33.33rd	82.26%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	92.25%	90th	76.44%	10th	84.67%	33.33rd	83.53%
Prenatal and Postpartum Care – Postpartum Care	87.79%	95th	73.78%	25th	82.73%	75th	76.18%

First Year Measure is not publicly reported.

In accordance with *42 Code of Federal Regulations 438.6(c)(2)(ii)(B)*, accountable entity quality performance must be measured and reported to the Office of Health and Human Services. For performance year 2021, rates of eight measures from the 'Medicaid Comprehensive Accountable Entity Common Measure Slate' were categorized as 'P4P' and included in the Office of Health Human Services' calculation of shared savings distribution to the accountable entities.

For performance year 2021, Neighborhood and UHCCP-RI maintained contracts with accountable entities. Table 58 displays the accountable care entities that were contracted by each managed care plan for performance year 2021.

Table 58: Accountable Entities, 2021

Managed Care Plan	Accountable Entity
Neighborhood	1. Blackstone Valley Community Health Care 2. Coastal Medical 3. Integra Community Care Network 4. Integrated Healthcare Partners 5. Prospect Health Services Rhode Island 6. Providence Community Health Centers 7. Thundermist Health Center
UHCCP-RI	1. Coastal Medical 2. Integra Community Care Network 3. Integrated Healthcare Partners 4. Prospect Health Services Rhode Island 5. Providence Community Health Centers 6. Thundermist Health Center

When available, rates for performance years 2019, 2020, and 2021 for Neighborhood's and UHCCP-RI's accountable entities are displayed in figures that follow.

Figure 1. Neighborhood's Accountable Entity Rates for Breast Cancer Screening

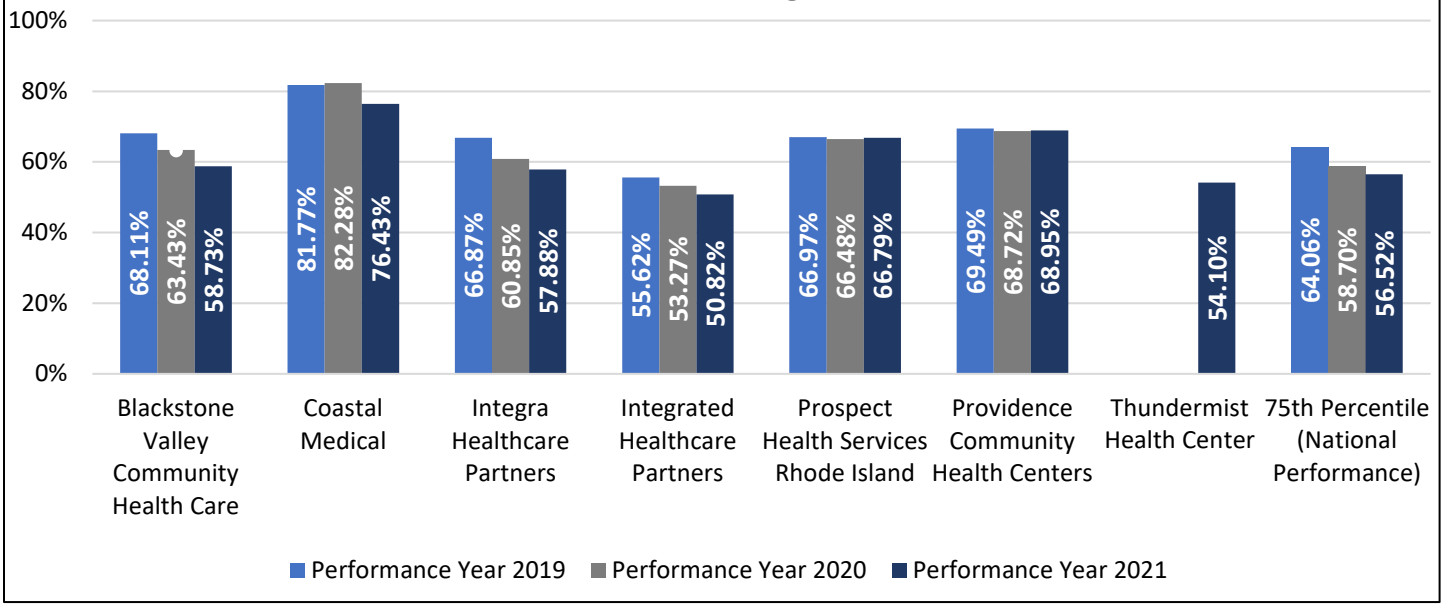


Figure 2. UHCCP-RI's Accountable Entity Rates for Breast Cancer Screening

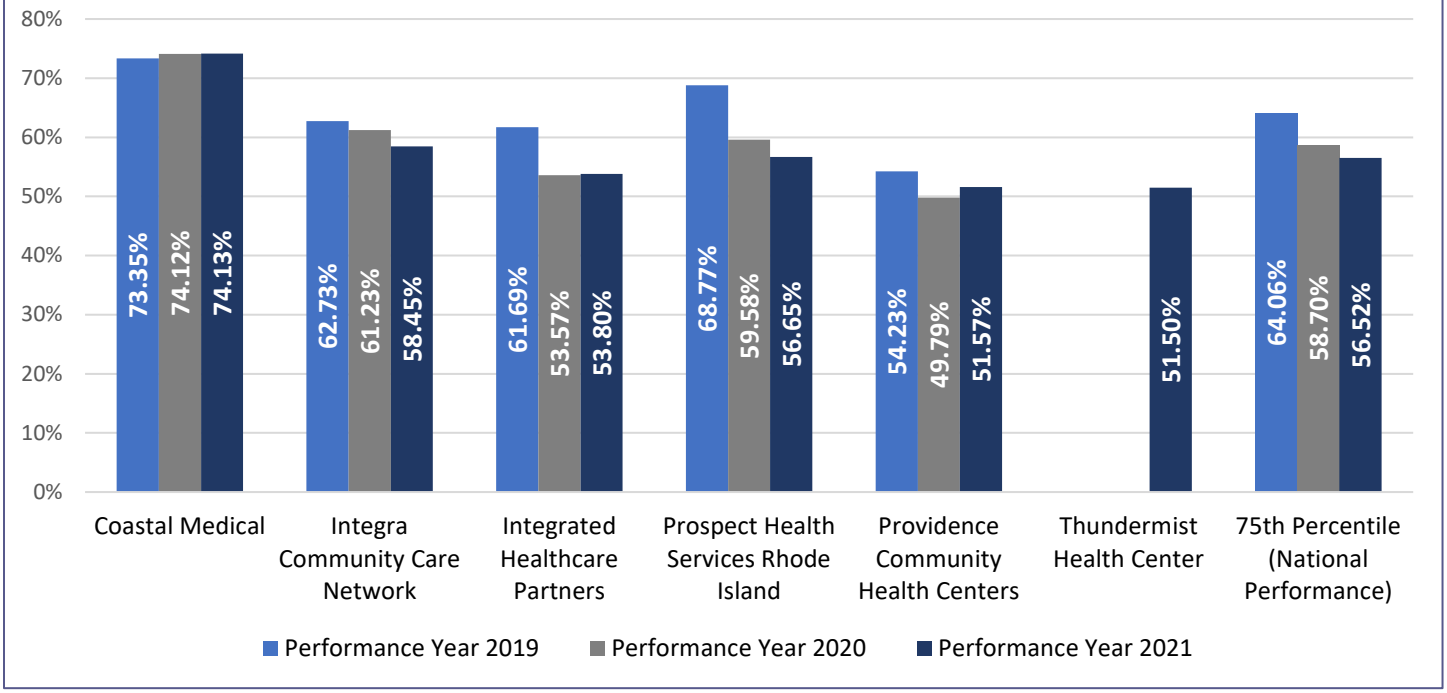


Figure 3. Neighborhood's Accountable Entity Rates for Comprehensive Diabetes Care - Eye Exam

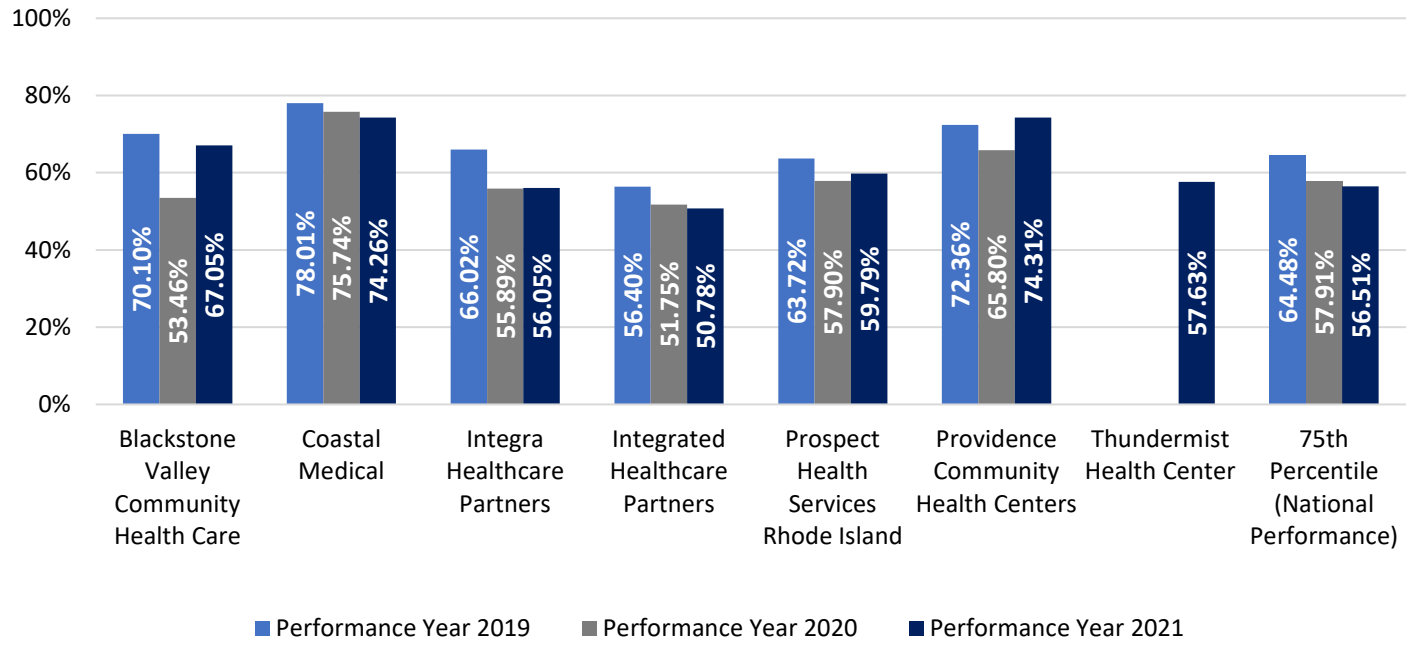


Figure 4. UHCCP-RI's Accountable Entity Rates for Comprehensive Diabetes Care - Eye Exam

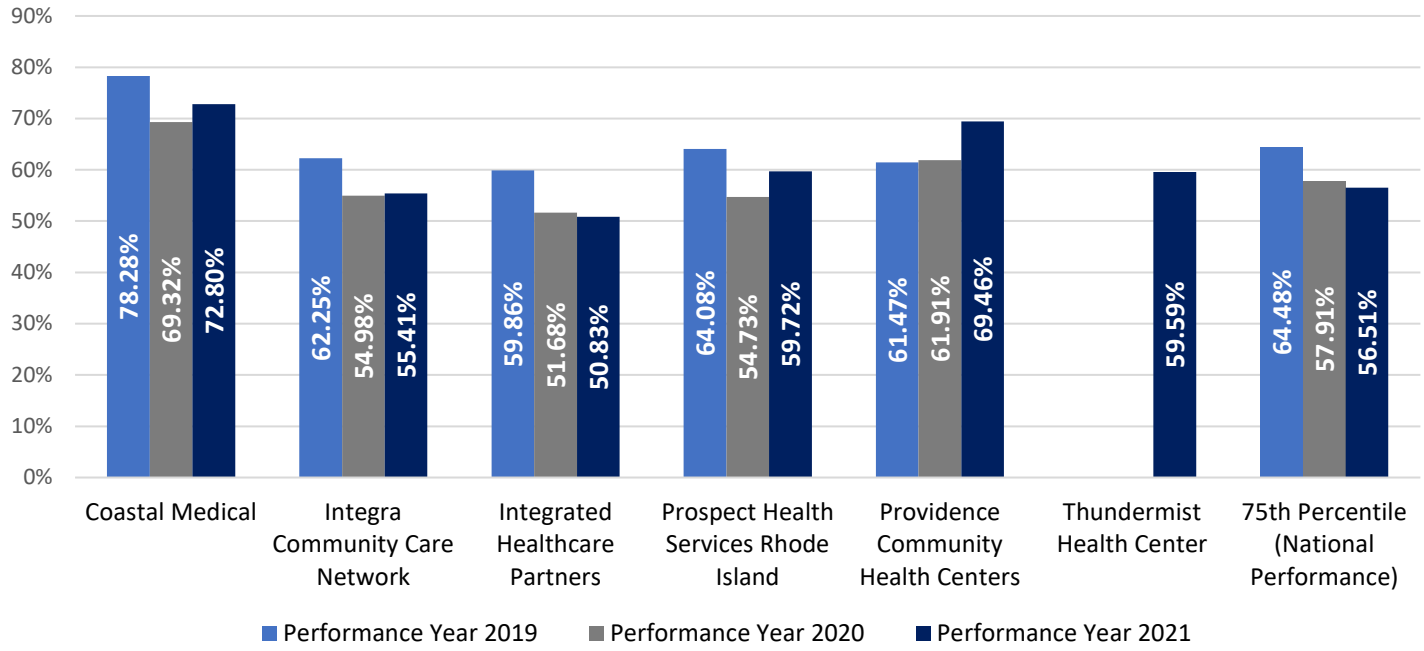


Figure 5. Neighborhood's Accountable Entity Rates for Comprehensive Diabetes Care - HbA1c Control (<8.0)

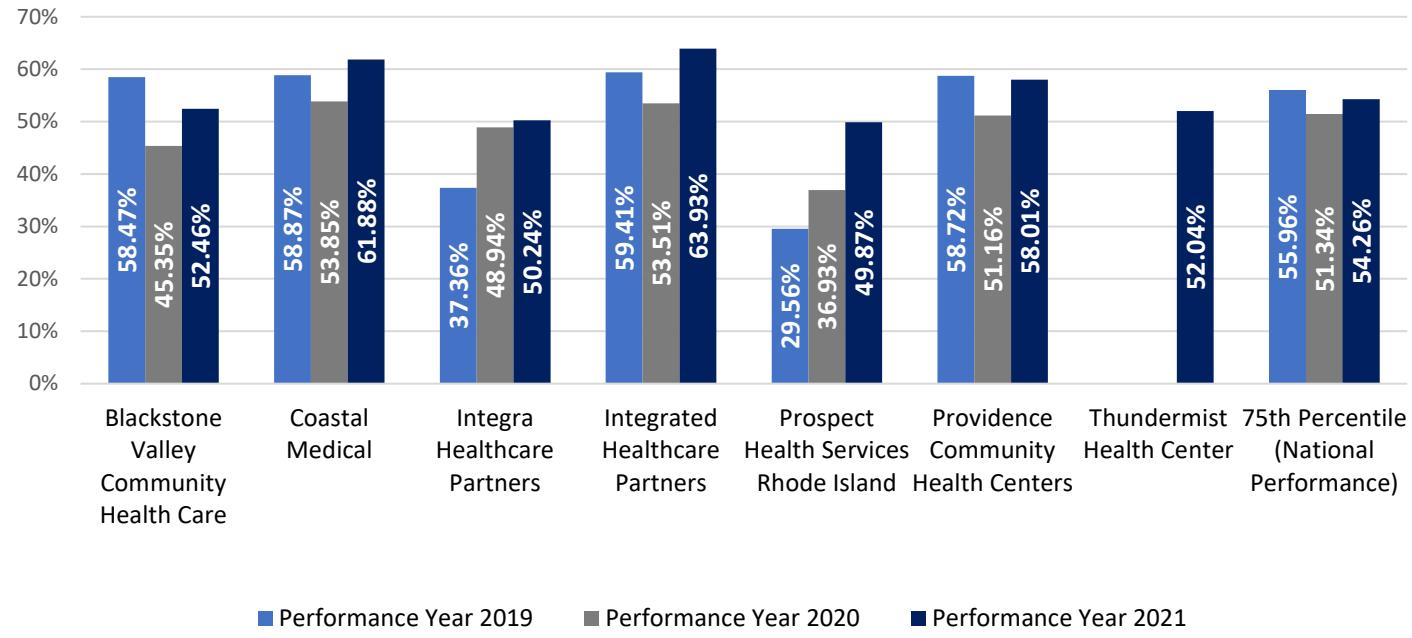


Figure 6. UHCCP-RI's Accountable Entity Rates for Comprehensive Diabetes Care - HbA1c Control (<8.0)

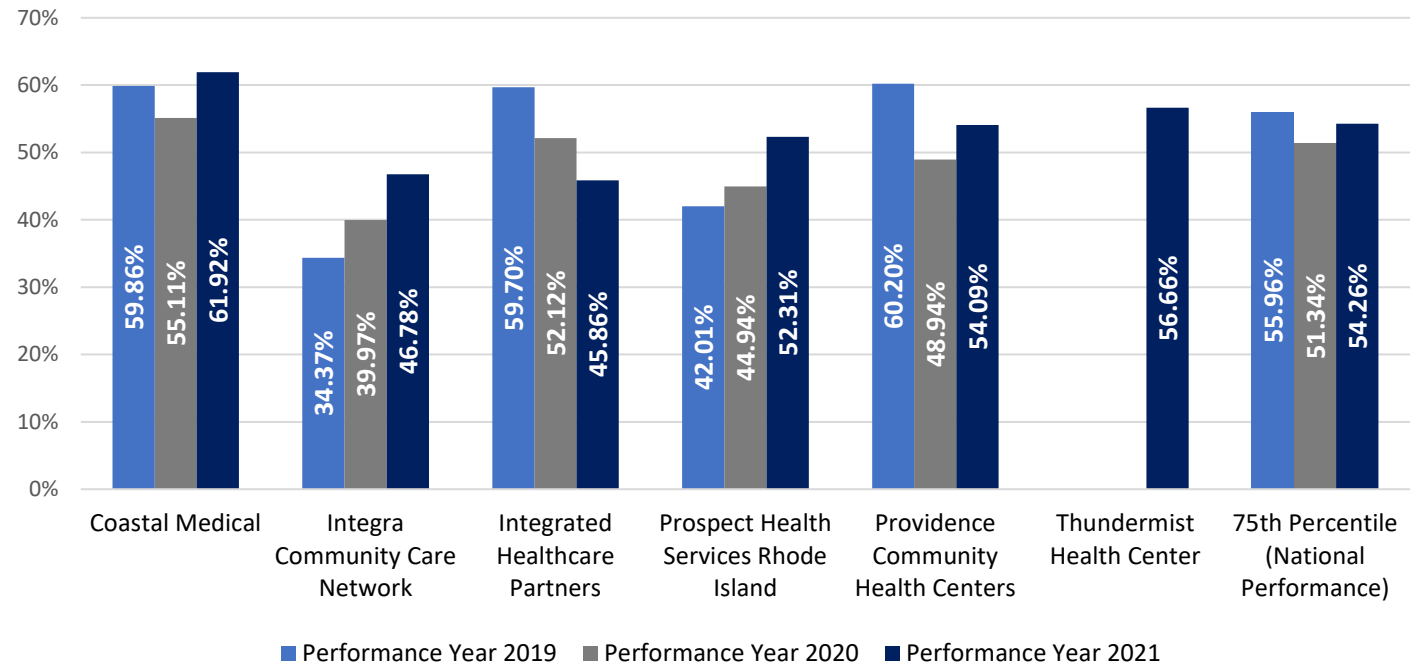


Figure 7. Neighborhood's Accountable Entity Rates for Controlling High Blood Pressure

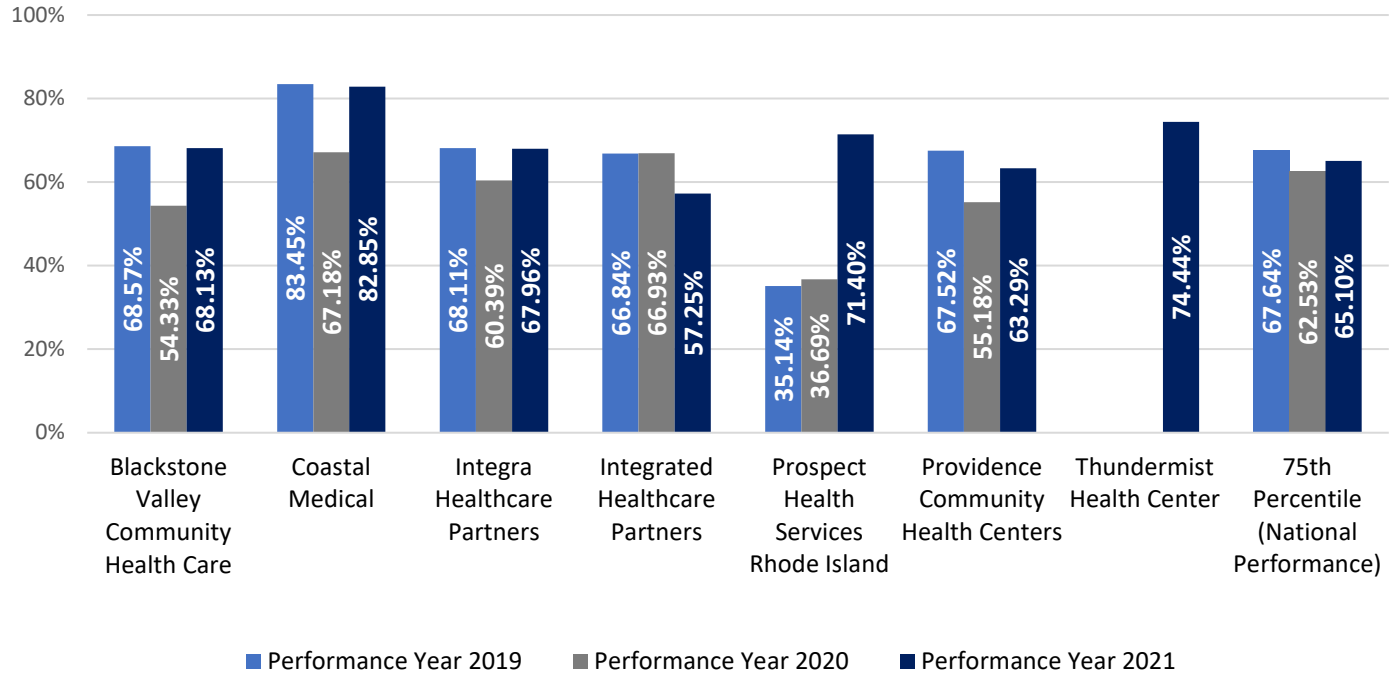


Figure 8. UHCCP-RI's Accountable Entity Rates for Controlling High Blood Pressure

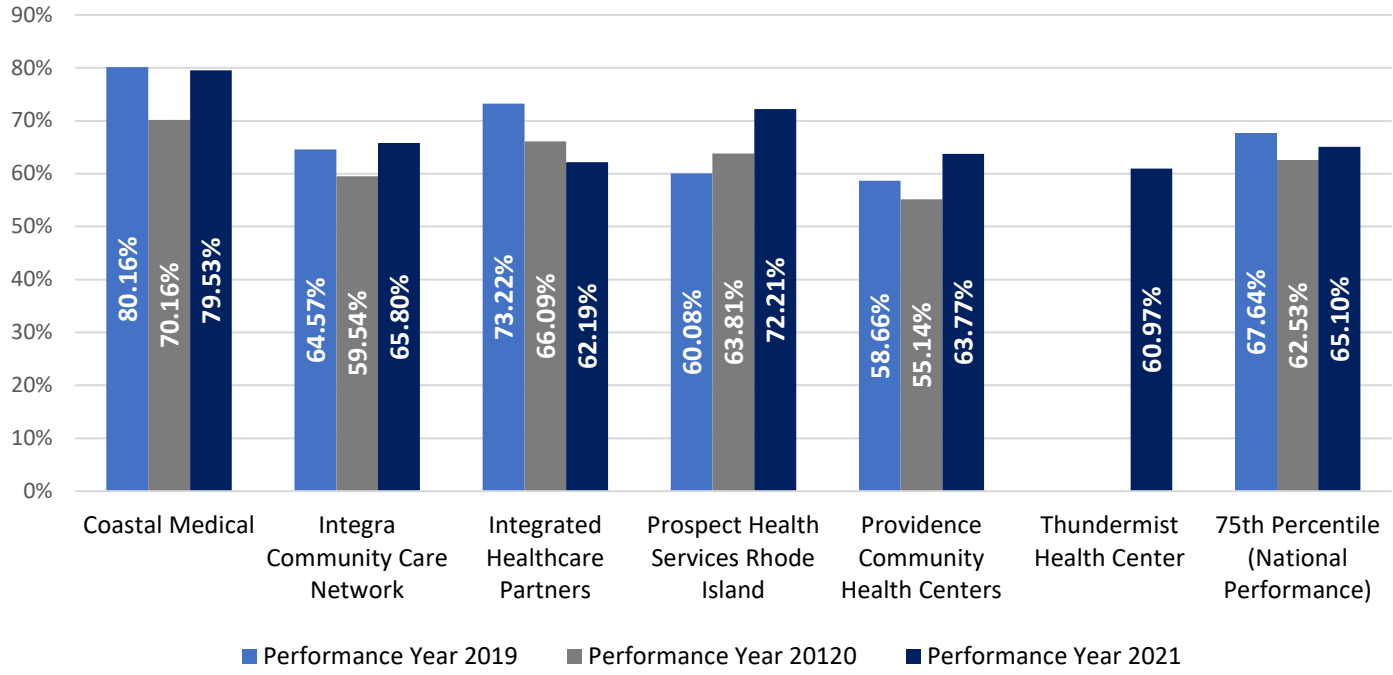


Figure 9. Neighborhood's Accountable Entity Rates for Follow-Up After Hospitalization for Mental Illness - 7 Days

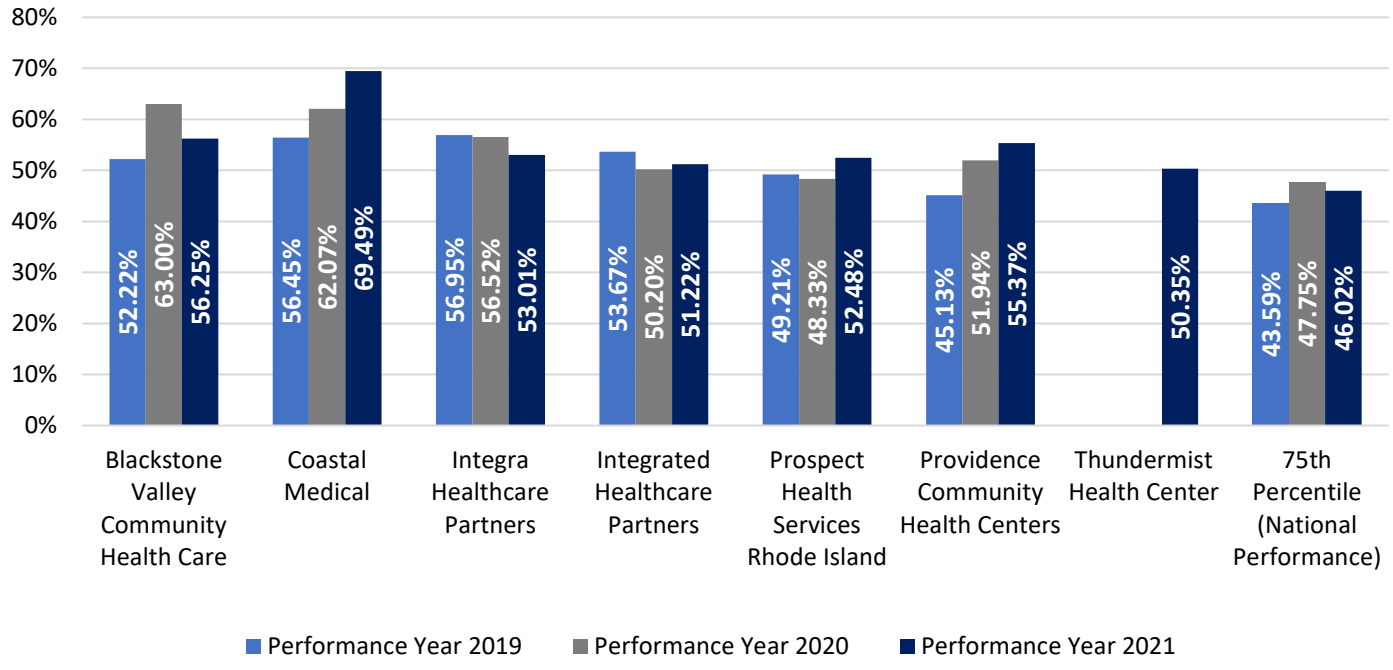


Figure 10. UHCCP-RI's Accountable Entity Rates for Follow-Up After Hospitalization for Mental Illness - 7 Days

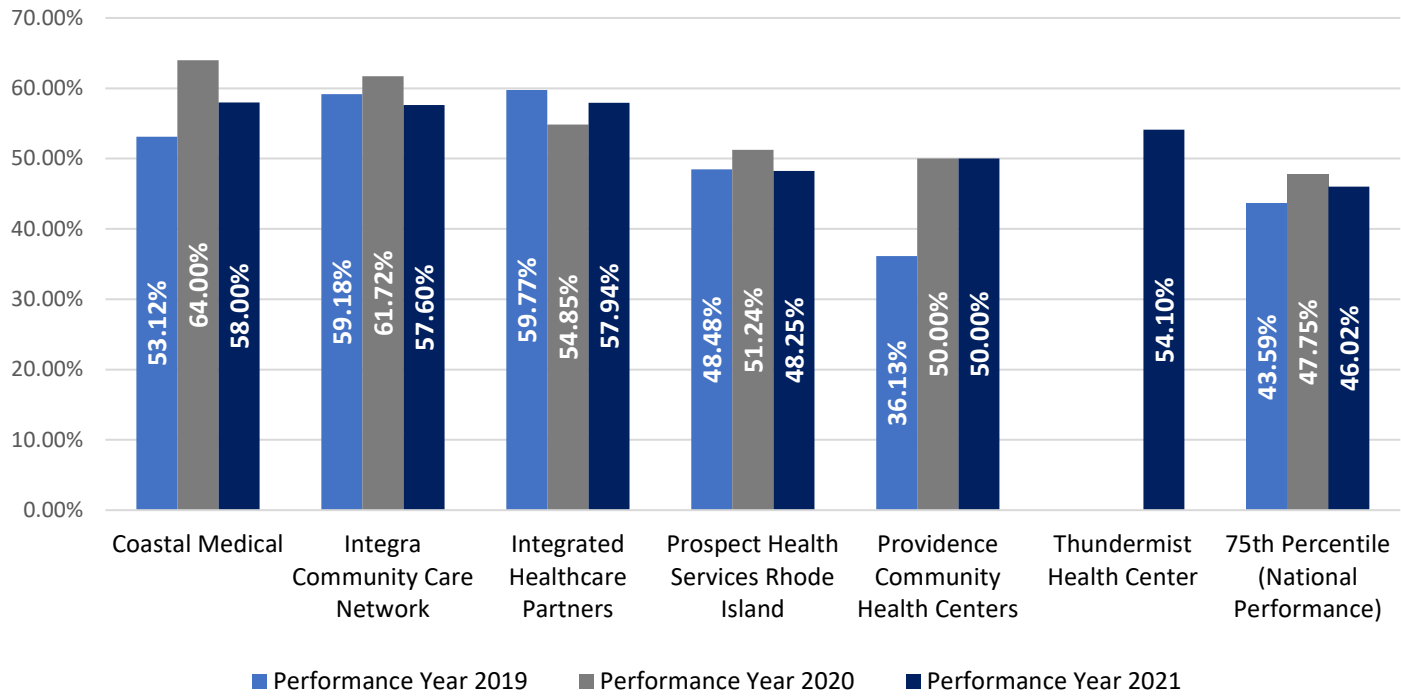


Figure 11. Neighborhood's Accountable Entity Rates for Developmental Screening in the First Three Years of Life

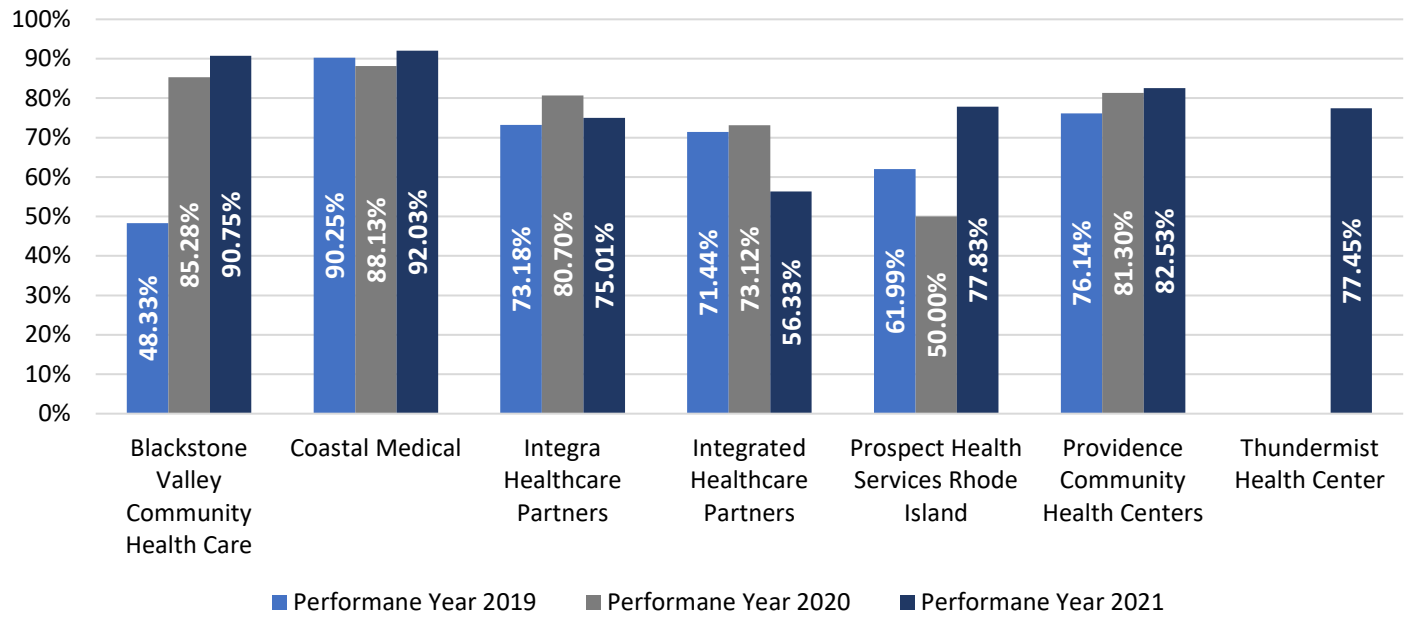


Figure 12. UHCCP-RI's Accountable Entity Rates for Developmental Screening in the First Three Years of Life

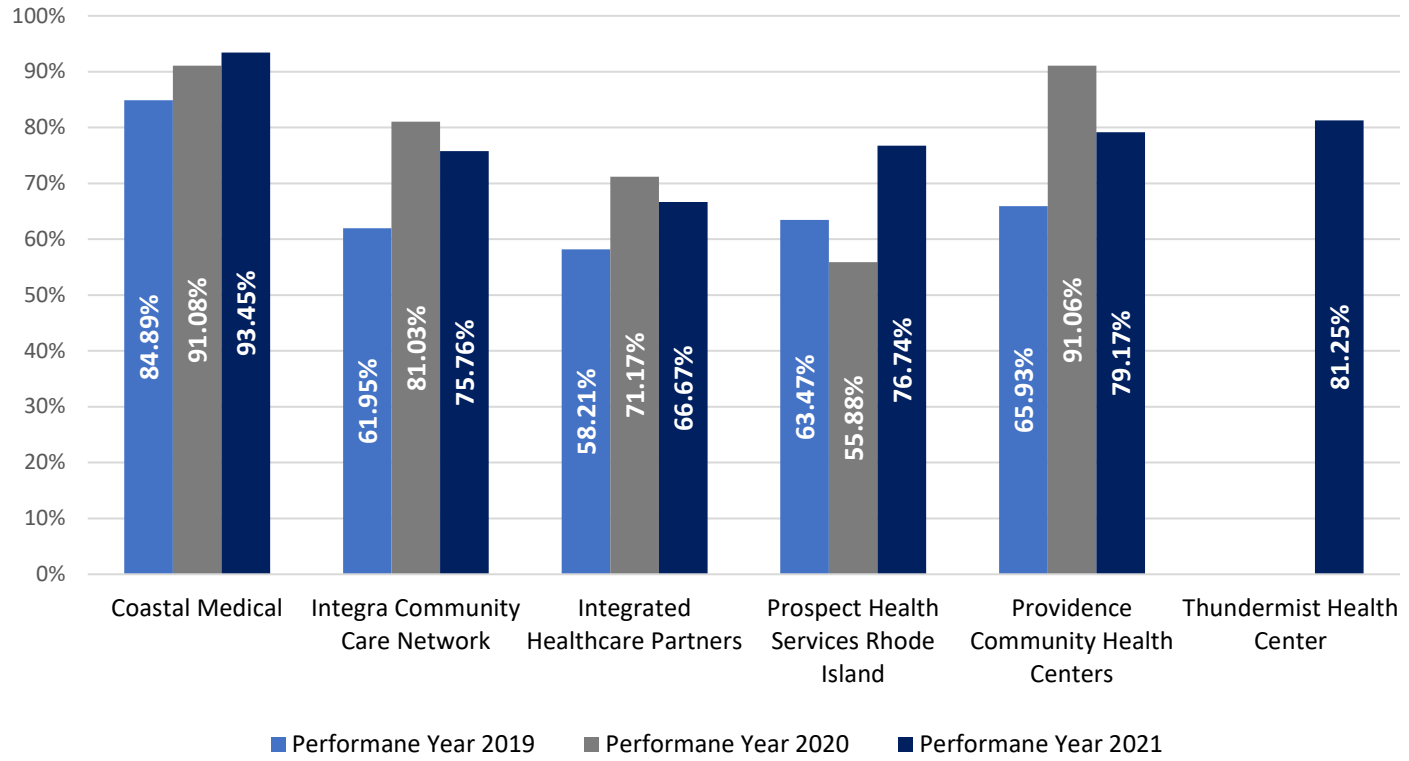


Figure 13. Neighborhood's Accountable Entity Rates for Screening for Depression and Follow-up Plan

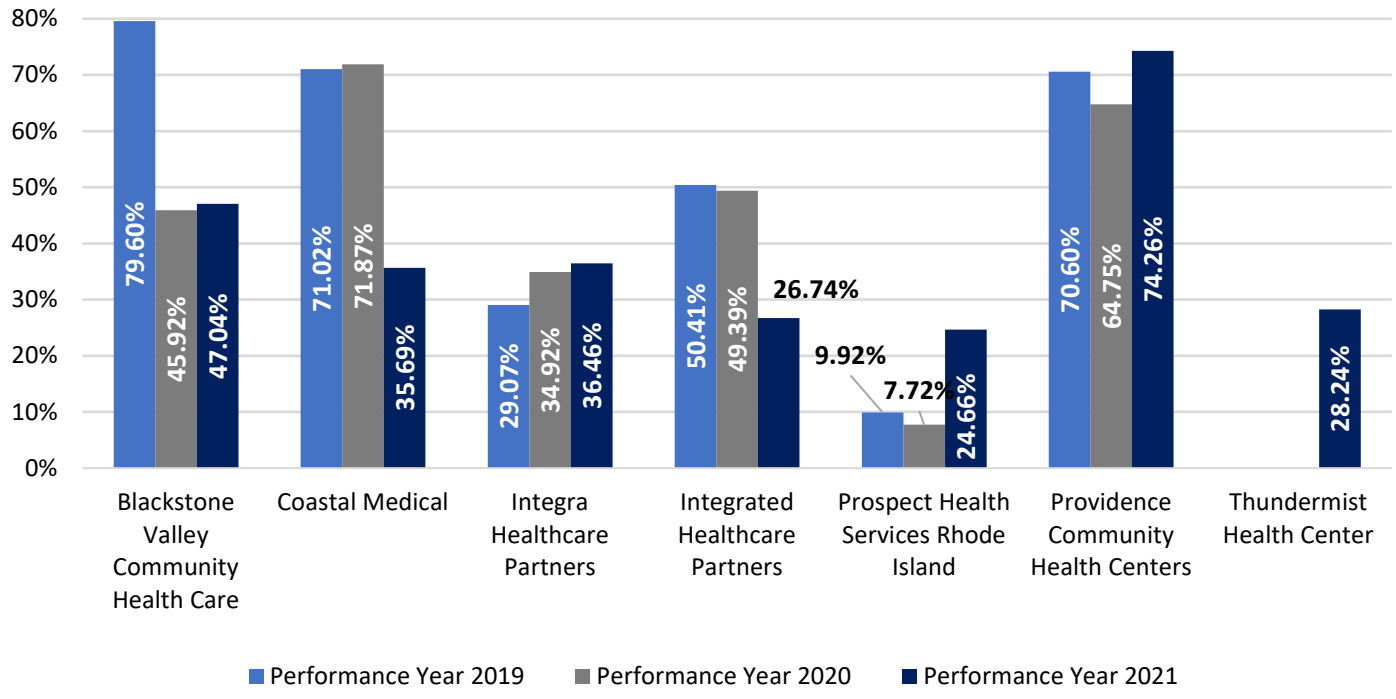


Figure 14. UHCCP-RI's Accountable Entity Rates for Screening for Depression and Follow-up Plan

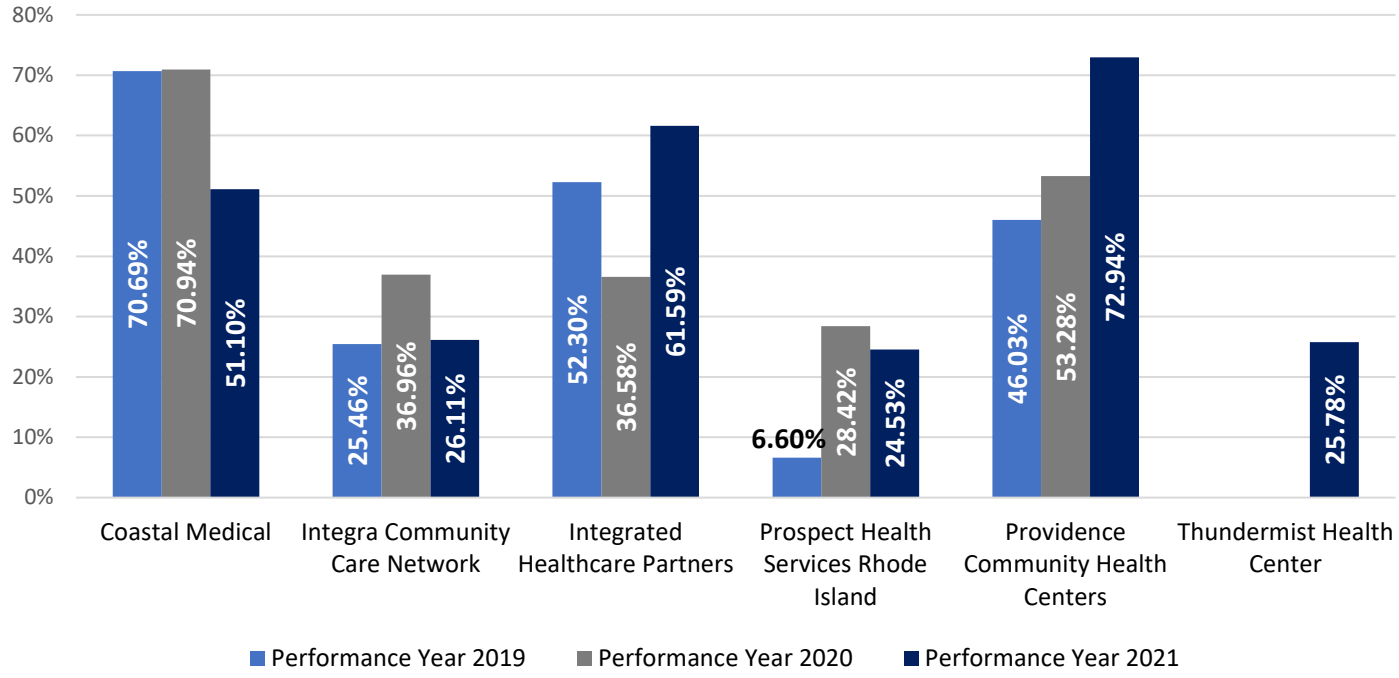


Figure 15. Neighborhood's Accountable Entity Rates for Social Determinants of Health Screening

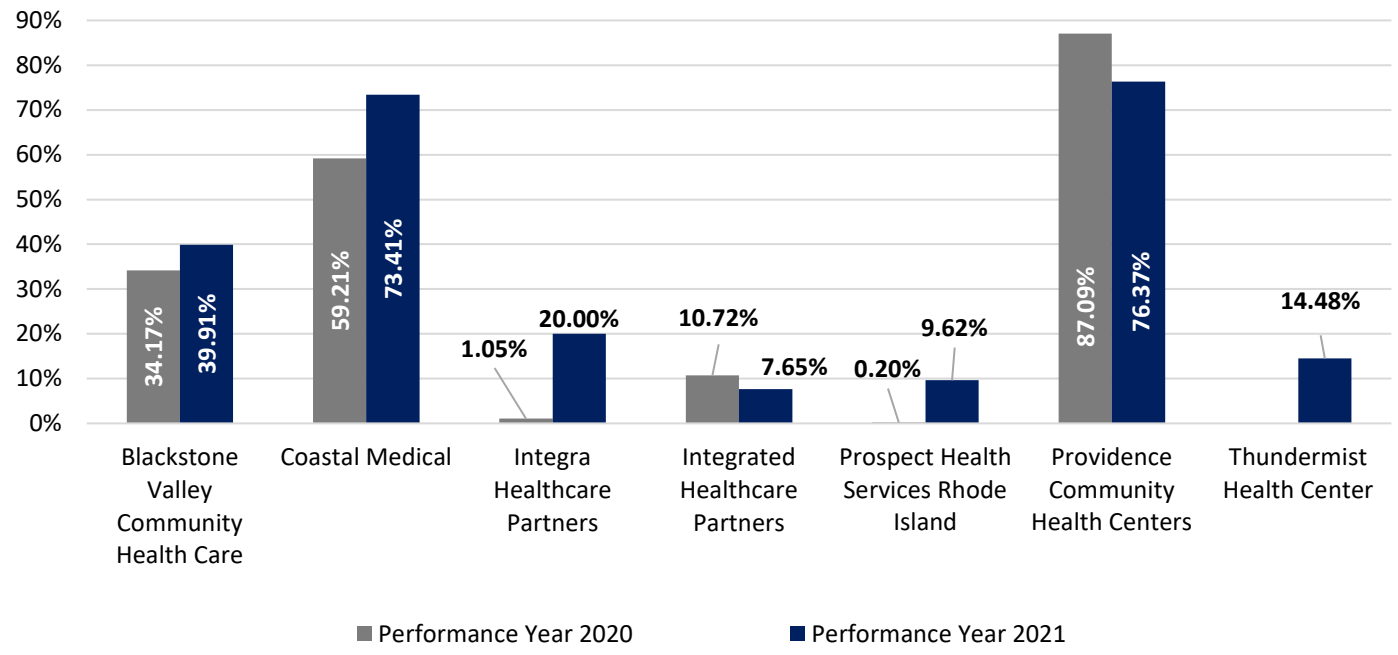
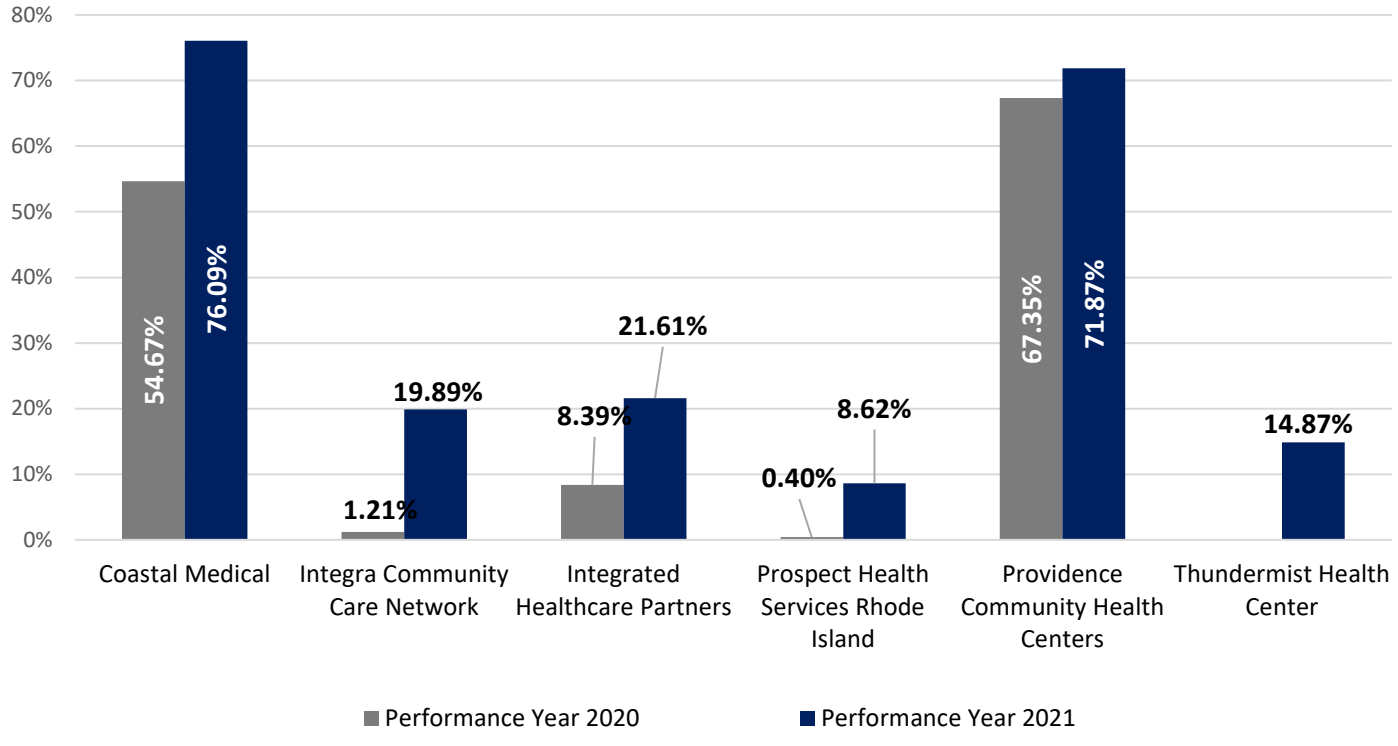


Figure 16. UHCCP-RI's Accountable Entity Rates for Social Determinants of Health Screening



Technical Summary – Review of Compliance with Medicaid and Children's Health Insurance Program Standards

Objectives

Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (b)(1)(iii) establishes that a review of a managed care plan's compliance with the standards of *42 Part 438 Managed Care Subpart D MCO*[12]*, PIHP*[13] *and PAHP*[14] *Standards* and the standards of *42 Code of Federal Regulations 438.330 Quality assessment and performance improvement program* is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

As required by section *3.02.01 Conformance with State and Federal Regulations* of the *Medicaid Managed Care Services Agreement*, Rhode Island managed care plans are required to meet all regulations specified in *42 Code of Federal Regulations Part 438*.

Per *42 Code of Federal Regulations 438.360 Nonduplication of mandatory activities with Medicare or accreditation review,* in place of a review by the state, its agent or external quality review organization, states can use information obtained from a national accrediting organization review for the external quality review activities. Through this authority, the Office of Health and Human Services uses the results of each managed care plans' NCQA Accreditation Survey to verify managed care plan compliance with state and federal standards. Section *2.02 Licensure and Accreditation* of the *Medicaid Managed Care Services Agreement* requires that each Rhode Island health maintenance organization seek and maintain NCQA Accreditation.

On behalf of the Office of Health and Human Services, IPRO reviewed the results of each managed care plan's most recent NCQA Accreditation Survey to verify managed are compliance with state and federal Medicaid requirements.

Technical Methods of Data Collection and Analysis

IPRO received NCQA Accreditation Survey results from each managed care plan and reviewed these results to verify managed care plan compliance with federal Medicaid standards of *42 Code of Federal Regulations 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 by the Office of Health and Human Services included instructions on how to use the crosswalk, a glossary, and detailed explanations on how the NCQA accreditation standards support federal Medicaid standards.

Comparative Results

Table 59 displays managed care plan compliance with federal Medicaid standards captured during the most recent NCQA Accreditation Survey. Neighborhood's accreditation was granted by NCQA on October 29, 2020. Tufts Health Public Plan's accreditation was granted by NCQA on April 29, 2020. UHCCP-RI's accreditation was granted by NCQA on December 3, 2020.

[12] Managed Care Organization.
[13] Prepaid Inpatient Health Plan.
[14] Prepaid Ambulatory Health Plan.

Table 59: Evaluation of Managed Care Plan Compliance with Federal Medicaid Standards, 2020

Part 438 Subpart D and Subpart E 438.330	Neighborhood	Tufts Health Public Plan	UHCCP-RI
438.206: Availability of services	1 Element Partially Met	Met	Met
438.207: Assurances of adequate capacity and services	Met	Met	Met
438.208: Coordination and continuity of care	Met	Met	Met
438.210: Coverage and authorization of services	Met	Met	Met
438.214: Provider selection	Met	Met	Met
438.224: Confidentiality	Met	Met	Met
438.228: Grievance and appeal system	Met	Met	Met
438.230: Sub-contractual relationships and delegation	1 Element Not Met	Met	Met
438.236: Practice guidelines	Met	Met	Met
438.242: Health information systems	Met	Met	Met
438.330: Quality assessment and performance improvement program	Met	Met	Met

Technical Summary – Validation of Network Adequacy

Objectives

Title 42 Code of Federal Regulations 438.68 Network adequacy standards requires states that contract with a managed care plan to develop and enforce time and distance standards for the following provider types: adult and pediatric primary care, obstetrics/gynecology, adult and pediatric behavioral health (for mental health and substance use disorder), adult and pediatric specialists, hospitals, pediatric dentists, and long-term services and support. The Office of Health and Human Services enforces managed care adoption of the Rhode Island time and distance standards through the *Medicaid Managed Care Services Agreement*.

Section 2.*09 Service Accessibility Standards* of the *Medicaid Managed Care Services Agreement* requires Rhode Island managed care plans to ensure that network providers comply with access and timely appointment availability requirements, and to monitor access and availability standards of the network to determine compliance and take corrective action if there is a failure to comply.

Title 42 Code of Federal Regulations 438.356 State contract options for external quality review and *42 Code of Federal Regulations 438.358 Activities related to external quality review* establish that state agencies must contract with an external quality review organization to perform the annual validation of network adequacy. To meet these federal regulations, the Office of Health and Human Services contracted IPRO to perform the 2021 validation of network adequacy for the Rhode Island Medicaid managed care plans.

Technical Methods of Data Collection and Analysis

The Office of Health and Human Services-established access standards are presented in Table 60.

Table 60: Rhode Island Medicaid Managed Care Network Standards

Rhode Island Medicaid Managed Care Access Standards
Time and Distance Standards
▪ Primary Care, Adult and Pediatric Within 20 Minutes or 20 Miles
▪ OB/GYN Within 45 Minutes or 30 Miles
▪ Top 5 Adult Specialties Within 30 Minutes or 30 Miles
▪ Top 5 Pediatric Specialties Within 45 Minutes or 45 Miles
▪ Hospital Within 45 Minutes or 30 Miles
▪ Pharmacy Within 10 Minutes or 10 Miles
▪ Imaging Within 45 Minutes or 30 Miles
▪ Ambulatory Surgery Centers Within 45 Minutes or 30 Miles
▪ Dialysis Within 30 Minutes or 30 Miles
▪ Adult Prescribers Within 30 Minutes or 30 Miles
▪ Pediatric Prescribers Within 45 Minutes or 45 Miles
▪ Adult Non-Prescribers Within 20 Minutes or 20 Miles
▪ Pediatric Non-Prescribers Within 20 Minutes or 20 Miles
▪ Substance Use Prescribers Within 30 Minutes or 30 Miles
▪ Substance Use Non-Prescribers Within 20 Minutes or 20 Miles
Appointment Standards
▪ After-Hours Care (telephone) Available 24 Hours a Day, 7 Days a Week
▪ Emergency Care Available Immediately
▪ Urgent Care Within 24 Hours
▪ Routine Care Within 30 Calendar Days
▪ Physical Exam Within 180 Calendar Days

Rhode Island Medicaid Managed Care Access Standards
▪ EPSDT Within 6 Weeks
▪ New Member Within 30 Calendar Days
▪ Non-Emergent or Non-Urgent Mental Health or Substance Use Services Within 10 Calendar Days
Member-to-Primary Care Provider Ratio Standards
▪ No more than 1,500 members to any single primary care provider
▪ No more than 1,000 members per single primary care provider within a primary care provider team
24 Hour Coverage Standard
▪ On a 24 hours a day, 7 days a week basis access to medical and behavioral health services must be available to members either directly through the managed care plan or primary care provider
Other Standards
▪ Each Medicaid network should include Patient Centered Medical Homes that serve as primary care providers

Neighborhood Health Plan of Rhode Island

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

Neighborhood monitors its network's 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.

Neighborhood's access standards for PCPs are one provider within 20 miles and one provider within 30 miles for OB/GYNs. Neighborhood's goal is to have 95% of its network of primary care, high-volume, and high-impact 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.

Tufts Health Public Plan

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

Tufts Health Public Plan monitors its network's 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.

UnitedHealthcare Community Plan of Rhode Island

UHCCP-RI monitors its provider network for accessibility and network adequacy using the Geo Access 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.

UHCCP-RI monitors its network's 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.

UHCCP-RI primary care access standards are one provider in 10 miles for metro regions and 1 in 30 miles for rural regions; and for OB/GYN providers, the access standards are one provider in in 10 miles for metro regions and 1 in 60 miles for rural regions. UHCCP-RI reports access data for metro and rural regions to NCQA on annual basis. However, as Rhode Island's Medicaid managed care membership is confined to metropolitan areas, UHCCP-RI reports metro access data only, to the Office of Health and Human Services on a quarterly basis.

UHCCP-RI's goal is to have 90% of its network of primary care, high-volume, and high-impact 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.

Description of Data Obtained

IPRO's evaluation of Neighborhood was performed using network data submitted by the managed care plan in the *Network Adequacy Analysis Report, December 2021* and *Access Survey Report* for the July 1, 2019 – June 30, 2020, timeframe.

IPRO's evaluation of Tufts Health Public Plan was performed using network data submitted by the managed care plan in the *Tufts Health Public Plan Access Survey Report* for January 2021 and July 2021.

IPRO's evaluation of UHCCP-RI was performed using network data submitted by the managed care plan in the second and fourth quarter 2021 *Access Survey Reports.* These reports presented the results of secret shopper appointment availability surveys, as well as the total number of providers surveyed, and total number of appointments made.

Comparative Results

Due to variation in data collection and analysis across the managed care plans, performance comparisons could not be made, and results are reported separately for each managed care plan.

Neighborhood Health Plan of Rhode Island

Table 61 shows the percentage of Neighborhood's members for whom the geographic access standards were met. The results of this analysis show that Neighborhood exceeded its geographic accessibility standards for all provider types reported.

Table 62 displays Neighborhood's aggregate results of the secret shopper appointment availability surveys conducted by Neighborhood in January 2021 and July 2021. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 61: Neighborhood's Geo Access Analysis, December 2021

Provider Specialty	Access to Provider Standard[1]	% of English-Speaking Members With Access	% of Spanish-Speaking Members With Access
Primary Care			
Pediatrics	1 in 20 Miles	99.9%	99.9%
Family Medicine	1 in 20 Miles	99.9%	99.9%
Internal Medicine	1 in 20 Miles	99.9%	99.9%
Obstetrics/Gynecology	1 in 30 Miles	100.0%	100.0%
Specialty Care			
Cardiology	1 in 30 Miles	100.0%	100.0%
Dermatology	1 in 30 Miles	100.0%	No Data to Report
Endocrinology	1 in 30 Miles	100.0%	No Data to Report
Gastroenterology	1 in 30 Miles	100.0%	99.8%
Neurology	1 in 30 Miles	100.0%	99.8%

Provider Specialty	Access to Provider Standard[1]	% of English-Speaking Members With Access	% of Spanish-Speaking Members With Access
Oncology	1 in 30 Miles	100.0%	100.0%
Optometry	1 in 30 Miles	100.0%	100.0%
Optometry, Pediatrics	1 in 45 Miles	100.0%	100.0%
Orthopedic Surgery	1 in 30 Miles	100.0%	100.0%
Orthopedic Surgery, Pediatrics	1 in 45 Miles	100.0%	100.0%
Otolaryngology, Pediatrics	1 in 45 Miles	100.0%	100.0%
Pulmonary	1 in 30 Miles	100.0%	No Data to Report
Physical Therapy, Pediatrics	1 in 45 Miles	100.0%	100.0%
Speech Therapy, Pediatrics	1 in 45 Miles	100.0%	100.0%

[1] The Access Standard is measured in travel time from a member's home to provider offices.

Table 62: Neighborhood's Appointment Availability Survey Results, January 2021 and July 2021

Provider Type/Appointment Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]
Primary Care Routine Appointments				
Family/General/Internal	20	15	75.00%	93.33%
Pediatricians	20	8	40.00%	75.00%
Obstetrics/Gynecology	20	11	55.00%	100.00%
Primary Care Urgent Appointments				
Family/General/Internal	20	19	95.00%	47.37%
Pediatricians	20	9	45.00%	88.89%
Obstetrics/Gynecology	20	18	90.00%	38.89%
Adult Specialty Care Routine Appointments				
Cardiology	12	7	58.33%	85.71%
Dermatology	12	8	66.67%	50.00%
Endocrinology	12	5	41.67%	80.00%
Gastroenterology	12	6	50.00%	100.00%
Pulmonary	12	2	16.67%	0.00%
Adult Specialty Care Urgent Appointments				
Cardiology	12	4	33.33%	25.00%
Dermatology	12	5	41.67%	20.00%
Endocrinology	12	4	33.33%	25.00%
Gastroenterology	12	5	41.67%	20.00%
Pulmonary	12	0	0.00%	Not Applicable
Pediatric Specialty Care Routine Appointments				
Allergy/Immunology	12	9	75.00%	77.78%
Gastroenterology	12	3	25.00%	100.00%
Neurology	12	3	25.00%	66.67%
Orthopedics	12	7	58.33%	100.00%
Otolaryngology/Ear, Nose and Throat	12	7	58.33%	85.71%
Pediatric Specialty Care Urgent Appointments				
Allergy/Immunology	12	8	66.67%	25.00%

Provider Type/Appointment Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]
Gastroenterology	12	3	25.00%	66.67%
Neurology	12	2	16.67%	50.00%
Orthopedics	12	4	33.33%	25.00%
Otolaryngology/Ear, Nose and Throat	12	6	50.00%	50.00%
Behavioral Health Care Routine Appointments				
Adult Behavioral Health	30	12	40.00%	33.33%
Pediatric/Adolescent Behavioral Health	30	10	33.33%	60.00%

Tufts Health Public Plan

Table 63 displays Tufts Health Public Plan's aggregate results of the secret shopper appointment availability surveys conducted by Tufts Health Public Plan in January 2021 and July 2021. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 63: Tufts Health Public Plan's Appointment Availability Survey Results, January 2021 and July 2021

Provider Type/Appointment Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]
Primary Care Routine Appointments				
Family/General/Internal	85	36	42.35%	61.11%
Pediatricians	71	9	12.68%	55.56%
Obstetrics/Gynecology	3	3	100.00%	33.33%
Primary Care Urgent Appointments				
Family/General/Internal	105	41	39.05%	19.51%
Pediatricians	63	9	14.29%	77.78%
Obstetrics/Gynecology	1	1	100.00%	0.00%
Adult Specialty Care Routine Appointments				
Cardiology	22	7	31.82%	42.86%
Dermatology	15	9	60.00%	44.44%
Endocrinology	3	2	66.67%	0.00%
Gastroenterology	7	4	57.14%	25.00%
Pulmonary	10	3	30.00%	66.67%
Adult Specialty Care Urgent Appointments				
Cardiology	24	5	20.83%	0.00%
Dermatology	7	5	71.43%	20.00%
Endocrinology	5	2	40.00%	0.00%
Gastroenterology	11	4	36.36%	0.00%
Pulmonary	12	2	16.67%	0.00%
Pediatric Specialty Care Routine Appointments				
Allergy/Immunology	1	1	100.00%	0.00%
Gastroenterology	3	2	66.67%	0.00%
Neurology	13	3	23.08%	100.00%
Orthopedics	12	6	50.00%	100.00%

Provider Type/Appointment Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]
Otolaryngology/Ear, Nose and Throat	5	1	20.00%	100.00%
Pediatric Specialty Care Urgent Appointments				
Allergy/Immunology	Not Surveyed	Not Applicable	Not Applicable	Not Applicable
Gastroenterology	1	1	100.00%	0.00%
Neurology	12	0	0.00%	Not Applicable
Orthopedics	18	13	72.22%	46.15%
Otolaryngology/Ear, Nose and Throat	4	3	75.00%	0.00%
Behavioral Health Care Routine Appointments				
Adult Behavioral Health	101	22	21.78%	86.36%
Pediatric/Adolescent Behavioral Health	15	0	0.00%	Not Applicable

[1] Rate of timely appointments reflects a percentage of the total number of appointments made that met the access standard.

UnitedHealthcare Community Plan of Rhode Island

Table 64 shows the percentage of UHCCP-RI's members for whom the geographic access standards were met. The results of this analysis show that UHCCP-RI met its geographic accessibility standards for all provider types reported.

Table 65 displays UHCCP-RI's aggregate results of the secret shopper appointment availability surveys conducted by UHCCP-RI in January 2021 and July 2021. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 64: Geo Access Provider Network Accessibility, July 2019-June 2020, and July 2020 – June 2021

Provider Type	Access Standard[1]	% of Members with Access July 2019-June 2020	% of Members with Access July 2020-June 2021
Metro			
Adult Primary Care Providers (Total)	1 in 10 Miles	100%	100%
Family/General Practice	1 in 10 Miles	100%	100%
Internal Medicine	1 in 10 Miles	100%	100%
Pediatrics	1 in 10 Miles	99%	100%
Cardiology High Volume, High Impact Specialist	1 in 10 Miles	100%	100%
Ophthalmology	1 in 10 Miles	100%	100%
Oncology / Hematology High Impact Specialist	1 in 10 Miles	100%	100%
OB/GYN High Volume Specialist	1 in 10 Miles	100%	100%

[1] The Access Standard is measured in travel time from a member's home to provider offices.

Table 65: Appointment Availability for Network Providers, January 2021, and July 2021

Provider Type/Appointment Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]
Primary Care Urgent Appointments				
Family/General/Internal	96	27	28.13%	0.00%
Pediatricians	13	2	15.38%	0.00%
Obstetrics/Gynecology	9	4	44.44%	0.00%
Adult Specialty Care Urgent Appointments				
Cardiology	2	2	100.00%	0.00%
Dermatology	1	0	0.00%	Not Applicable
Endocrinology	2	0	0.00%	Not Applicable
Gastroenterology	1	1	100.00%	0.00%
Pulmonary	1	0	0.00%	Not Applicable
Pediatric Specialty Care Urgent Appointments				
Allergy/Immunology	4	4	100.00%	0.00%
Neurology	4	0	0.00%	Not Applicable
Orthopedics	5	2	40.00%	0.00%
Otolaryngology/Ear, Nose and Throat	5	1	20.00%	0.00%
Behavioral Health Care Routine Appointments				
Adult Behavioral Health	12	4	33.33%	0.00%
Pediatric/Adolescent Behavioral Health	10	3	30.00%	0.00%

Technical Summary – Validation of Quality-of-Care Surveys, Member Satisfaction

Objectives

Title 42 Code of Federal Regulations 438.358(c)(2) establishes that for each managed care plan, the administration or validation of consumer or provider surveys of quality of care may be performed by using information derived during the preceding 12 months. Further, *42 Code of Federal Regulations* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual external quality review.

Section *2.13.05 Member Satisfaction Report* of the *Medicaid Managed Care Services Agreement* requires the Medicaid managed care plan to sponsor a member satisfaction survey for all Medicaid product lines annually. The goal of the survey is to get feedback from these members about how they view the health care services they receive. The Office of Health and Human Services uses results from the survey to determine variation in member satisfaction among the managed care plans. Further, section *2.13.04 EOHHS Quality Assurance* of the *Medicaid Managed Care Services Agreement* requires that the CAHPS survey tool be administered.

The overall objective of the CAHPS study 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 can aid plans in increasing the quality of provided care.

Each managed care plan independently contracted with a certified CAHPS vendor to administer the adult and child surveys for measurement year 2021. On behalf of the Office of Health and Human Services, IPRO validated satisfaction surveys sponsored by the managed care plans for measurement year 2021.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected for measurement year 2021 were the CAHPS 5.1H Adult Medicaid Health Plan Survey and the CAHPS 5.1H Child General Population Medicaid Health Plan Survey. The CAHPS Medicaid questionnaire set includes separate versions for the adult and child populations.

HEDIS specifications require that the managed care plan provide a list of all eligible members for the sampling frame. Following HEDIS requirements, the managed care plan included members in the sample frame who were 18 years of age or older for adult members or 17 years of age or younger for child members as of December 31, 2021, continuously enrolled for at least five of the last six months of 2021, and currently enrolled in the managed care plan.

Table 66 provides a summary of the technical methods of data collection by managed care plan.

Table 66: CAHPS Technical Methods of Data Collection, Measurement Year 2021

Managed Care Plan/Methodology Element	Adult CAHPS Survey	Child CAHPS Survey
Neighborhood		
Survey Vendor	Symphony Performance Health, Inc.	Symphony Performance Health, Inc.
Survey Tool	5.1H Medicaid Adult	5.1H Medicaid Child
Survey Timeframe	03/01/2022-5/16/2022	03/01/2022-5/6/2022
Method of Collection	Mail, Telephone, Internet	Mail, Telephone, Internet
Sample Size	3,375	2,475
Response Rate	14.16%	10.21%

Managed Care Plan/Methodology Element	Adult CAHPS Survey	Child CAHPS Survey
Tufts Health Public Plan		
Survey Vendor	Symphony Performance Health, Inc.	Not Applicable
Survey Tool	5.1H Medicaid Adult	Not Applicable
Survey Timeframe	03/01/2022-5/16/2022	Not Applicable
Method of Collection	Mail, Telephone, Internet	Not Applicable
Sample Size	3,375	Not Applicable
Response Rate	14.16%	Not Applicable
UHCCP-RI		
Survey Vendor	Symphony Performance Health, Inc.	Symphony Performance Health, Inc.
Survey Tool	5.1H Medicaid Adult	5.1H Medicaid Child
Survey Timeframe	2/22/2022-5/09/2022	2/22/2022-5/05/2022
Method of Collection	Mail, Telephone, Internet	Mail, Telephone, Internet
Sample Size	1,620	2,310
Response Rate	9.2%	6.8%

Results were calculated in accordance with HEDIS specifications for survey measures. According to HEDIS specifications, results for the adult and child populations were reported separately, and no weighting or case-mix adjustment was performed on the results.

For the global ratings, composite measures, composite items, and individual item measures the scores were calculated using a 100-point scale. Responses were classified into response categories. Table 67 displays these categories and the measures which these response categories are used.

Table 67: CAHPS Categories and Response Options

Category/Measure	Response Options
Composite Measures	
▪ Getting Needed Care ▪ Getting Care Quickly ▪ How Well Doctors Communicate ▪ Customer Service	Never, Sometimes, Usually, Always *(Top-level performance is considered responses of "usually" or "always.")*
Global Rating Measures	
▪ Rating of All Health Care ▪ Rating of Personal Doctor ▪ Rating of Specialist Talked to Most Often ▪ Rating of Health Plan ▪ Rating of Treatment or Counseling	0-10 Scale *(Top-level performance is considered scores of "8" or "9" or "10.")*

To assess managed care plan performance, IPRO compared managed care plan scores to national Medicaid performance reported in the *2022 Quality Compass* (measurement year 2021) for all lines of business that reported measurement year 2021 CAHPS data to NCQA.

Description of Data Obtained

For each managed care plan, IPRO received a copy of the final measurement year 2021 study reports produced by the certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as managed care plan-level results and analyses.

Comparative Results

Table 68 displays the managed care plans' results of the 2022 CAHPS Adult Medicaid Survey for measurement year 2021 while Table 67 displays the managed care plans' results of the 2022 CAHPS Child Medicaid Survey for measurement year 2021. Tufts Health Public Plan did not conduct a child satisfaction survey for measurement year 2021. The national Medicaid benchmarks displayed in these tables come from *NCQA's 2022 Quality Compass* for measurement year 2021.

Table 68: Managed Care Plan Adult CAHPS Results, Measurement Years 2019 to 2021

Measures	Neighborhood Measurement Year 2021	*Quality Compass* Measurement Year 2021 National Medicaid Benchmark (Met/Exceeded)	Tufts Health Public Plan Measurement Year 2021	*Quality Compass* Measurement Year 2021 National Medicaid Benchmark (Met/Exceeded)	UHCCP-RI Measurement Year 2021	*Quality Compass* Measurement Year 2021 National Medicaid Benchmark (Met/Exceeded)	*Quality Compass* Measurement Year 2021 National Medicaid Mean
Rating of Health Plan[1]	87.31%	95th	75.8%	25th	84.5%	90th	77.98%
Rating of All Health Care	75.74%	33.33rd	Small Sample	Not Applicable	80.4%	90th	75.41%
Rating of Personal Doctor[1]	85.34%	66.67th	81.8%	33.33rd	82.4%	33.33rd	82.38%
Rating of Specialist[1]	87.16%	75th	Small Sample	Not Applicable	Small Sample	Not Applicable	83.52%
Getting Care Quickly[2]	83.43%	50th	Small Sample	Not Applicable	Small Sample	Not Applicable	80.22%
Getting Needed Care[2]	84.71%	66.67th	Small Sample	Not Applicable	Small Sample	Not Applicable	81.86%
Customer Service[2]	88.92%	33.33rd	Small Sample	Not Applicable	Small Sample	Not Applicable	88.91%
How Well Doctors Communicate[2]	92.72%	33.33rd	Small Sample	Not Applicable	94.6%	75th	92.51%
Coordination of Care[2]	86.21%	50th	Small Sample	Not Applicable	Small Sample	Not Applicable	83.96%

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible"). [2] Rates reflect responses of "always" or "usually."

Small Sample means that the denominator is less than 100 members.

Table 69: Managed Care Plan Child CAHPS Results, Measurement Years 2019 to 2021

Measures	Neighborhood Measurement Year 2021	*Quality Compass* Measurement Year 2021 National Medicaid Benchmark (Met/Exceeded)	UHCCP-RI 2022 Measurement Year 2021	*Quality Compass* Measurement Year 2021 National Medicaid Benchmark (Met/Exceeded)	*Quality Compass* Measurement Year 2021 National Medicaid Mean
Rating of Health Plan[1]	89.80%	75th	86.8%	50th	86.48%
Rating of All Health Care	88.27%	50th	Small Sample	Not Applicable	87.34%
Rating of Personal Doctor[1]	90.79%	50th	94.3%	95th	90.18%
Rating of Specialist[1]	Small Sample	Not Applicable	Small Sample	Not Applicable	86.54%
Getting Care Quickly[2]	85.74%	33.33rd	Small Sample	Not Applicable	86.74%
Getting Needed Care[2]	88.19%	75th	Small Sample	Not Applicable	84.19%
Customer Service[2]	Small Sample	Not Applicable	Small Sample	Not Applicable	88.06%
How Well Doctors Communicate[2]	93.21%	33.33rd	94.1%	33.33rd	94.18%
Coordination of Care[2]	86.21%	50th	Small Sample	Not Applicable	84.71%

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible"). [2] Rates reflect responses of "always" or "usually."

Small Sample means that the denominator is less than 100 members.

Technical Summary – Validation of Provider Quality-of-Care Surveys

Objectives

Title 42 Code of Federal Regulations 438.358(c)(2) establishes that for each managed care plan, the administration or validation of consumer or provider surveys of quality of care may be performed by using information derived during the preceding 12 months. Further, *42 Code of Federal Regulations* 438.*358(a)(2)* requires that the data obtained from the quality-of-care survey(s) be used for the annual external quality review.

Section *2.13.06 Provider Satisfaction Report* of the *Medicaid Managed Care Services Agreement* requires the Medicaid managed care plan to sponsor a satisfaction survey for all Medicaid network providers. The goal of the survey is to get feedback from these providers about how they view the Medicaid program and the managed care plan. The Office of Health and Human Services uses results from the survey to determine variation in provider satisfaction among the managed care plans.

To meet the requirements of the *Medicaid Managed Care Services Agreement*, the managed care plans administer the provider satisfaction surveys annually. The general objective of these surveys is to assess provider perception of the managed care plan's Medicaid operations and services to better understand strengths, pain points, and opportunities.

On behalf of the Office of Health and Human Services, IPRO validated satisfaction surveys sponsored by the managed care plans for measurement year 2021.

Technical Methods of Data Collection and Analysis

Neighborhood Health Plan

Neighborhood collaborated with the survey vendor Symphony Performance Health, Inc. to conduct the measurement year 2021 provider satisfaction survey. To be eligible for this survey, providers needed visits with at least 100 or more unique members between March 2020 and September 2020.

Table 46 provides a summary of the technical methods of data collection.

Table 70: Provider Satisfaction Technical Methods of Data Collection, Measurement Year 2021

Methodology Element	Provider Satisfaction Survey
Survey Administrator	Symphony Performance Health, Inc.
Survey Tool	Non-standard
Survey Timeframe	10/2021 – 12/2021
Method of Collection	Mail, Telephone, Internet
Eligible Provider Types	Primary Care Providers and Specialists
Sample Size	837
Response Rate	12.5%

The 52-question 2021 survey instrument was similar to the 2020 instrument, with two exceptions: the addition of two provider demographic questions requesting information about the provider's racial/ethnic background and the languages used to communicate with patients by providers, nurses, or office staff.

Table 71 displays the measures and the response options that were used.

Table 71: Provider Satisfaction Survey Categories and Response Options

Measures	Response Options
▪ All Other Plans (Comparative Rating) ▪ Finance Issues ▪ Utilization and Quality Management ▪ Network/Coordination of Care ▪ Pharmacy ▪ Health Plan Call Center Service Staff ▪ Provider Relations	▪ Well Below Average ▪ Somewhat Below Average ▪ Average ▪ Somewhat Above Average ▪ Well Above Average
▪ Overall Satisfaction	▪ Completely Dissatisfied ▪ Someone Dissatisfied ▪ Neither ▪ Somewhat Satisfied ▪ Completely Satisfied

Summary rates generally represent the most favorable response percentages. For comparison purposes, results are presented by summary rates. Composite scores are calculated by taking the average summary rates of the attributes in the specified section. Summary rates include the following categories: Well Below Average, Somewhat Below Average, Average, Somewhat Above Average, Well Above Average.

Where possible, the survey vendor compared Neighborhood's performance to Symphony Performance Health, Inc.'s *2020 Medicaid Book of Business* benchmarks.

Tufts Health Public Plan

Tufts Health Public Plan collaborated with the survey vendor Symphony Performance Health, Inc. to conduct the measurement year 2021 provider satisfaction survey. To be eligible for this survey, providers needed one claim for a 'RITogether' member.

Table 72 provides a summary of the technical methods of data collection.

Table 72: Provider Satisfaction Technical Methods of Data Collection, Measurement Year 2021

Methodology Element	Provider Satisfaction Survey
Survey Administrator	Symphony Performance Health, Inc.
Survey Tool	Non-standard
Survey Timeframe	09/2021 – 10/2021
Method of Collection	Mail
Eligible Provider Types	Primary Care Providers and Specialists
Sample Size	3,341
Response Rate	2.3%

The 36-question 2021 survey instrument was similar to the 2020 instrument. Table 73 displays these categories and the measures which these response categories are used.

Table 73: Provider Satisfaction Survey Categories and Response Options

Category/Measure	Response Options
▪ Overall Satisfaction with Tufts Health 'RITogether'	1 – 6 Scale 1=Completely Dissatisfied 2=Very Dissatisfied 3=Somewhat Dissatisfied 4=Somewhat Satisfied 5=Very Satisfied 6=Complete Satisfied *(Top-level performance is considered scores of "4" or "5" or "6".)*
▪ Provider Communication, Education & Support ▪ Utilization Management Programs ▪ Tufts Health 'RITogether's' Provider Payment Dispute Process ▪ Member Education and Materials ▪ Financial Reimbursement ▪ Information/Technology ▪ Relationship with Tufts Health 'RITogether'	1 – 4 Scale 1=Strongly Disagree 2=Disagree 3=Agree 4=Strongly Agree *(Top-level performance is considered scores of "3" or "4".)*
▪ Likelihood to Recommend Medicaid Health Plan	0 – 10 Scale 0=Not At All 10=Extremely Likely *(Top-level performance is considered scores of "8" or "9" or "10.")*
▪ Comparison with Other Medicaid Health Plans	1 – 5 Scale 1=Much Worse 2=Somewhat Worse 3=About the Same 4=Somewhat Better 5=Much Better *(Top-level performance is considered scores of "3" or "4".)*

The survey vendor trended Tufts Health Public Plan's performance over a three-year period and applied statistical analysis to determine statistical differences in performance.

UnitedHealthcare Community Plan

UHCCP-RI utilized a homegrown survey tool for measurement year 2021. Key metrics were maintained to allow UHCCP-RI to trend performance year-over-year.

Table 74 provides a summary of the technical methods of data collection.

Table 74: Provider Satisfaction Technical Methods of Data Collection, Measurement Year 2021

Methodology Element	Provider Satisfaction Survey
Survey Administrator	UHCCP-RI
Survey Tool	Non-standard
Number of UnitedHealthcare Entities Surveyed	20
Survey Timeframe	Mid-September 2022 to Mid-November 2022
Method of Collection	Mail, Email
Sample Size	43
Response Rate	Not Reported

Survey responses were captured using a Likert scale of 0 (not satisfied) to 10 (very satisfied). Responses of '9' and '10' were evaluated as top box performance. Statistical significance testing was conducted between measurement year 2021 performance and measurement year 2022 performance at a 95% confidence interval.

Description of Data Obtained

IPRO received a copy of Neighborhood's final study report produced by Symphony Performance Health, Inc. for Neighborhood and utilized the reported results to evaluate the administration of the 2021 provider satisfaction survey. The report included detailed descriptions of the survey objectives, methodology, and results.

IPRO received a copy of Tufts Health Public Plan's final study report produced by Symphony Performance Health, Inc. for Tufts Health Public Plan and utilized the reported results to evaluate the administration of the 2021 provider satisfaction survey. The report included detailed descriptions of the survey objectives, methodology, and results.

IPRO received a copy of UHCCP-RI's 2021 Provider Satisfaction Summary. This document presented the metrics evaluated and performance rates at the state and national levels.

Comparative Results

Due to variation in survey methodology across the managed care plans, performance comparisons could not be made, and results are reported separately for each managed care plan.

Neighborhood Health Plan

Table 75 displays Neighborhood's survey questions and results for measurement years 2019, 2020, and 2021.

Table 75: Neighborhood's Provider Satisfaction Performance Summary, Measurement Years 2019 to 2021

Measures	Neighborhood Measurement Year 2019	Neighborhood Measurement Year 2020	Neighborhood Measurement Year 2021	2020 SPHA Medicaid Book of Business Average
Overall Satisfaction [1]	52%	73%	70%	71%
Finance Issues [2]	19%	32%	34%	33%
Utilization and Quality Management [2]	25%	38%	40%	34%
Network/Coordination of Care [2]	21%	28%	33%	30%
Pharmacy [2]	11%	24%	26%	25%
Health Plan Call Center Staff [2,3]	35%	51%	46%	38%
Provider Relations [2]	16%	24%	43%▲	37%

[1] Proportion represent percentage of "completely" or "somewhat satisfied" responses.
[2] Proportion represent percentage of "well above average" or "somewhat above average" responses.
[3] Neighborhood's call center staff represent provider services.
▲ Rate is statistically significantly better than the previous measurement year's rate.

Tufts Health Public Plan

Table 76 displays Tufts Health Public Plan's survey questions and results for the 'overall measures' for measurement years 2019, 2020, and 2021.

Table 76: Tufts Health Public Plan's Provider Satisfaction Performance Summary, Measurement Years 2019 to 2021

Measures	Tufts Health Public Plan Summary Rate Measurement Year 2019	Tufts Health Public Plan Summary Rate Measurement Year 2020	Tufts Health Public Plan Summary Rate Measurement Year 2021
Overall Satisfaction With 'RITogether'			
All Providers	61.1%	75.6% ▲	75.3%
Primary Care Providers/ Primary Care Provider Specialists	60.0%	82.9%▲	81.6%
Specialists	62.8%	71.7%	68.4%
Tufts Health Public Plan is a Strong Collaborator in Providing Quality Patient Care			
All Providers	69.2%	74.4%	77.7%
Primary Care Providers/ Primary Care Provider Specialists	73.4%	84.4%	84.8%
Specialists	64.7%	68.2%	70.0%
Tufts Health Public Plan is a Valuable Partner in a Crisis			
All Providers	New Measure in 2020	78.4%	81.3%
Primary Care Providers/ Primary Care Provider Specialists	New Measure in 2020	87.9%	92.6%
Specialists	New Measure in 2020	70.9%	66.6%

▲ Rate is statistically significantly better than the previous measurement year's rate.

UnitedHealthcare Community Plan

Table 77 displays UHCCP-RI's provider survey measures and results for measurement years 2020 and 2021.

Table 77: UHCCP-RI's Provider Satisfaction Survey Results, Measurement Years 2020 and 2021

Measure	UHCCP-RI Measurement Year 2020 (N=34)	UHCCP-RI Measurement Year 2021 (N=43)	UnitedHealthcare National Measurement Year 2021 (N=1,823)
Ease of Credentialing	28%	20%	37%
Ease of Contracting	21%	21%	37%
Quality of the Network	48%	31%	41%
Availability of Specialists to Accommodate Referrals	41%	26%	40%
Ease of Prior Authorization for Pharmacy	6%	10%	24%
Quality of Incentive-Based Programs	11%	6%	30%
Accuracy of Claims Processing on First Submission	17%	14%	33%
Ease of Appeals	39%	9%	27%
Overall Satisfaction with Customer Service	12%	5%	33%
Ease of Accessing Information	19%	11%	29%
Timeliness of Information Provided by Primary Care Physicians	38%	33%	39%
Timeliness of Information Provided by Specialists	25%	20%	33%
Timeliness of Information Provided by Behavioral Health Practitioners	13%	12%	27%
Overall Satisfaction with UnitedHealthcare	12%	12%	38%
Easy to Get Answers to Questions	15%	10%	32%
Policies are Aligned with the Latest Evidence Based Best Practices	16%	8%	31%

N=Denominator.

Technical Summary – NCQA Accreditation

Objectives

Section *2.02 Licensure and Accreditation* of the *Medicaid Managed Care Services Agreement* requires that each health maintenance organization seek and maintain NCQA Accreditation. Health maintenance organizations participating in the Rhode Island Medicaid managed care program must provide the Office of Health and Human Services evidence of full accreditation. Failure to obtain and maintain accreditation would result in the suspension of enrollment and/or termination of the *Medicaid Managed Care Services Agreement*.

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.

Technical Methods of Data Collection and Analysis

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.

Beginning with Health Plan Accreditation 2020 and the 2020 HEDIS reporting year, the health plan ratings and accreditation were aligned to improve consistency between the two activities and to simplify the scoring methodology for accreditation. An aggregate summary of managed care plan performance on these two activities is summarized in the NCQA Health Plan Report Cards.

To earn NCQA accreditation, each managed care plan must meet at least 80% of applicable points in each standards category, submit HEDIS and CAHPS data during the reporting year after the first full year of accreditation, and submit HEDIS and CAHPS data annually thereafter. The standards categories include quality management, population health management, network management, utilization management, credentialing and re-credentialing, and member experience.

To earn points in each standards category, managed care plans are evaluated on the factors satisfied in each applicable element and earn designation of "met," "partially met," or "not met" for each element. Elements are worth 1 or 2 points and are awarded based on the following:

- Met = Earns all applicable points (either 1 or 2)
- Partially Met = Earns half of applicable points (either 0.5 or 1)
- Not Met = Earns no points (0)

Within each standards category, the total number of points is added. The managed care plans can achieve 1 of 3 accreditation levels based on how they score on each standards category. Table 78 displays the accreditation determination levels and points needed to achieve each level.

Table 78: NCQA Accreditation Status Levels and Points

Accreditation Status	Points Needed
Accredited	At least 80% of applicable points
Accredited with Provisional Status	Less than 80% but no less than 55% of applicable points
Denied	Less than 55% of applicable points

To distinguish quality among the accredited managed care plans, NCQA calculates an overall rating for each managed care plan as part of its Health Plan Ratings program. The overall rating is the weighted average of a managed care plan's HEDIS and CAHPS measure ratings, plus accreditation bonus points (if the plan is accredited by NCQA), rounded to the nearest half point and displayed as stars.

Overall ratings are recalculated annually and presented in the *Health Plan Ratings* report that is released every September. The *Health Insurance Plan Ratings 2022* methodology used to calculate an overall rating is based on managed care plan performance on dozens of measures of care and is calculated on a 0–5 scale in half points, with five being the highest. Performance includes these three subcategories (also scored 0–5 in half points):

1. Patient Experience: Patient-reported experience of care, including experience with doctors, services, and customer service (measures in the Patient Experience 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 Health Plan Accreditation: For a plan with an accredited or provisional status, 0.5 bonus points are added to the overall rating before being rounded to the nearest half point and displayed as stars. A plan with an Interim status receives 0.15 bonus points added to the overall rating before being rounded to the nearest half point and displayed as stars.

The rating scale and definitions for each are displayed in Table 79.

Table 79: NCQA Health Plan Star Rating Scale

Ratings	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.

Due to the continued impact of COVID-19, NCQA used the same measurement year percentiles as plan data for scoring in *Health Plan Ratings 2022.*

Description of Data Obtained

IPRO accessed the NCQA Health Plan Reports website[15] to review the *Health Plan Report Cards 2022* for the Rhode Island Medicaid managed care plans. For each managed care plan, star ratings, accreditation status, plan type, and distinctions were displayed. At the managed care plan-specific pages, information displayed was related to membership size, accreditation status, survey type and schedule, and star ratings for each measure and overall. The data presented here were current as of March 2023.

IPRO also received from each managed care plan, the accreditation survey decision letter issued by NCQA, the certificate of accreditation issued by NCQA, and the NCQA 2020 Renewal Survey Summary for Medicaid. The accreditation decision survey decision letter included information about the managed care plan's accreditation

[15] NCQA Health Plan Report Cards Website: https://reportcards.ncqa.org/health-plans.

status and level achieved, the effective dates of the accreditation, and tentative dates of future accreditation surveys. The certificate of accreditation issued by NCQA displayed the managed care plan's accreditation status and level achieved, as well as the effective dates of the accreditation. The NCQA 2020 Renewal Survey Summary for Medicaid listed all the elements reviewed by NCQA during the managed care plan's accreditation survey and determinations of 'Met' or 'Not Met' issued to the managed care plan by element.

Comparative Results

Neighborhood was compliant with the state's requirement to achieve and maintain NCQA Accreditation. The managed care plan's 'Accredited' status is effective October 29, 2020 to October 29, 2023. Neighborhood achieved overall health plan star ratings of 4.5 out of 5 for the *Health Plan Ratings 2022.*

Tufts Health Public Plan was compliant with the state's requirement to achieve and maintain NCQA Accreditation. The managed care plan's 'Accredited' status is effective April 29, 2020 to April 29, 2023. Tufts Health Public Plan achieved overall health plan star ratings of 3.5 out of 5 for the *Health Plan Ratings 2022.*

UHCCP-RI was compliant with the state's requirement to achieve and maintain NCQA Accreditation. The managed care plan's 'Accredited' status is effective December 30, 2020 to December 30, 2023. UHCCP-RI achieved overall health plan star ratings of 4 out of 5 for the *Health Plan Ratings 2022.*

Table 80 displays each managed care plans' overall health plan star ratings, as well as the ratings for the three overarching categories (patient experience, prevention, and treatment) and their subcategories under review.

Table 80: Managed Care Plan NCQA Rating by Category, 2020

Overarching and Subcategories *(Number of Measures Included in Subcategory)*	Neighborhood Star Rating Achieved 4.5 Stars Overall *(out of 5 stars)*	Tufts Health Public Plan Star Rating Achieved 3.5 Stars Overall *(out of 5 stars)*	UHCCP-RI Star Rating Achieved 4.0 Stars Overall *(out of 5 stars)*
Patient Experience	**4.0 Stars**	**Insufficient Data**	**Insufficient Data**
Getting Care *(2)*	3.5 Stars	Insufficient Data	Insufficient Data
Satisfaction with Plan Physicians *(1)*	4.0 Stars	3.0 Stars	5.0 Stars
Satisfaction with Plan and Plan Services *(2)*	4.5 Stars	2.0 Stars	3.0 Stars
Prevention	**4.5 Stars**	**3.5 Stars**	**4.0 Stars**
Children and Adolescent Well Care *(4)*	4.5 Stars	4.5 Stars	4.5 Stars
Women's Reproductive Health *(3)*	5.0 Stars	2.5 Stars	3.0 Stars
Cancer Screening *(2)*	5.0 Stars	1.0 Star	4.0 Stars
Other Preventive Services *(3)*	4.0 Stars	3.0 Stars	Insufficient Data
Treatment	**4.0 Stars**	**3.0 Stars**	**3.5 Stars**
Respiratory *(6)*	3.5 Stars	3.5 Stars	3.0 Stars
Diabetes *(5)*	4.5 Stars	2.0 Stars	4.0 Stars
Heart Disease *(3)*	4.5 Stars	3.0 Stars	4.0 Stars
Behavioral Health-Care Coordination *(4)*	4.0 Stars	4.0 Stars	4.0 Stars
Behavioral Health-Medication Adherence *(3)*	3.5 Stars	4.0 Stars	3.5 Stars
Behavioral Health-Access, Monitoring and Safety *(5)*	3.0 Stars	Insufficient Data	3.0 Stars
Risk-Adjusted Utilization *(1)*	1.0 Stars	3.0 Stars	3.0 Stars
Overuse of Opioids *(3)*	3.5 Stars	2.5 Stars	3.0 Stars
Other Treatment Measures *(1)*	4.0 Stars	2.0 Stars	3.0 Stars

Managed Care Plan Responses to the 2020 External Quality Review Recommendations

Title 42 Code of Federal Regulations 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 effectively addressed the recommendations for quality improvement made by the external quality review organization during the previous year's external quality review." Table 81 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2020 external quality review recommendations. Table 82, Table 83, and Table 84 display the managed care plans' progress related to the recommendations made in the *2020 External Quality Review Aggregate Annual Technical Report* as well as IPRO's assessment of the managed care plan's response.

Table 81: Managed Care Plan Response to Recommendation Assessment Levels

Assessment Determinations and Definitions
Addressed
Managed care plan's quality improvement response resulted in demonstrated improvement.
Partially Addressed
Managed care plan's quality improvement response was appropriate; however, improvement is still needed.
Remains an Opportunity for Improvement
Managed care plan's quality improvement response did not address the recommendation; improvement was not observed, or performance declined.

Table 82: Neighborhood's Response to the 2020 External Quality Review Recommendations

External Quality Review Activity	2020 External Quality Review Recommendation	Neighborhood's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
Quality Improvement Projects	Neighborhood should investigate opportunities to improve the current interventions as five of the six quality improvement projects s did not achieve the goal rates. Neighborhood should continue to monitor the effectiveness of their multi-faceted intervention strategies, including member-focused, provider-focused, and managed care plan-focused interventions.	Neighborhood will continue to monitor the effectiveness of the interventions implemented for all the QIPs and adjust where appropriate. The COVID-19 public health emergency continues to be a systemic barrier impacting performance on nearly all QIP measures, including those relating to access, Care for Older Adults, and nursing home transitions. Of note, since this reporting period (Measurement Year 2020), the Plan has implemented several new interventions for the following QPIs: Lead Screening in Children (LSC) The Plan's performance for LSC decreased slightly from measurement year 2020 (77.16) to measurement year 2021 (76.80). The Plan continued several member education interventions in 2021 and prioritized new interventions in 2022 including a letter to low performing Community Health Centers and lunch and learns to the RIDOH Family Visiting Program about member rewards for children who get a lead screening. In addition, lead screening was added as a measure to the Rhode Island's Accountable Entity Program with payfor performance beginning in 2023. In preparation, the Accountable Entities were provided an introductory presentation to the measure by a guest speaker from the Rhode Island Department of Health at a monthly Quality Circle meeting. In addition, the Plan reviews quarterly Lead Screening rates and gap reports with the individual Accountable Entities and discusses barriers to performance as well as best practices. Neighborhood will continue to collaborate with RIDOH on efforts to increase lead screening and prevention. Child and Adolescent Well Care Visit (WCV) - formerly Children and Adolescents' Access to Primary Care Practitioners The Plan's performance for WCV for ages 3-21 significantly improved in measurement year 2021 (61.26) compared to measurement year 2020 (53.46). In addition to our ongoing member and provider interventions	Partially addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	Neighborhood's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
		such as promoting member rewards, encouraging well visits through social media, automated voice calls and gap in care reports. Neighborhood has planned several interventions for 2022 including collaboration with school-based health centers and automated voice call reminders about the importance of well visits. Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication (ADD) The Plan's Quality staff conducts outreach calls to providers to ensure that members with newly prescribed ADHD medication have a follow-up scheduled within 30 days. If there is no follow-up scheduled or if the follow-up occurred outside of 30 days, the Quality staff makes recommendation to the provider's office to reach out to the member to schedule an appointment within 30 days. The Plan's ADD rates increased in measurement year 2020 but declined in measurement year 2021. The ADD rate for the Initiation phase decreased from measurement year 2020 (50.83) to measurement year 2021 (48.39) and the rate for the Continuation and Maintenance phase decreased from 61.79 to 59.15. Improving Performance for Care for Older Adults (COA) HEDIS Measure In CY 2021, Neighborhood implemented several interventions to improve performance on the COA QIP. Some of these interventions included a detailed provider analysis to determine low and high performers for targeted outreach, developed and implement the COA informational document inclusive of CPT II code instructions and distributed to providers via the Provider Newsletter and Provider Website and leveraged Acuity Care Management system to capture COA data. The measurement year 2021 rates for all four COA measure components improved significantly from the baseline - the Medication Review rate improved from 68.37 to 89.25, the Functional Status Assessment rate improved from 50.36 to 82.25, the Pain Screening rate improved from 65.21 to 91.5 and the Advance Care Planning rate improved from 39.66 to 71.46.	

External Quality Review Activity	2020 External Quality Review Recommendation	Neighborhood's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
		Percentage of Transitions from the Nursing Home to the Community In CY 2021, Neighborhood implemented a number of interventions in an effort to increase transitions from nursing home to the community. Some of these interventions include ongoing effort to obtain access to nursing homes' electronic medical record systems to help identify opportunities for transition and the Nursing Home Incentive Program. The measurement year 2021 rate surpassed the QIP goal (35%) as 61% of members transitioned from the nursing home into the community. Note that this measure was particularly heavily affected by the ravages of COVID-19 among nursing home patients.	
Performance Measures	Neighborhood should investigate opportunities to improve the health of members with diabetes.	Neighborhood has the following interventions in place with the goal of improving the health of its members with diabetes: Control for Life which is a Diabetes Disease Management program where all members identified as having diabetes receive a welcome letter introducing the program to them and informing them of the services and educational materials they can expect to receive. Members identified for the program are stratified into one of two risk levels. Assignment of risk level determines the level of intervention they receive to support condition monitoring, adherence, lifestyle, and other health issues. ▪ Low Risk (Well Controlled) - These members receive a welcome packet as well as quarterly educational mailings addressing standards of diabetes care. ▪ High Risk: (Poorly Controlled) - A Medicaid or Exchange member is considered high risk if they have an inpatient admission for diabetes as one of the first three diagnoses. These members receive the same educational mailing as those at low risk but also receive telephonic outreach attempts from a Care Manager to offer High Risk disease management (health coaching) and assistance in meeting service milestones such as PCP/endocrinologist visits, HbA1c testing, diabetic foot exam and nephrology testing.	Addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	Neighborhood's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
		The Plan also launched a new program in 2021 for Rhody Health Expansion members who are missing care milestones. The program consists of adult members with poorly controlled diabetes who meet the following criteria: ▪ Two or more inpatient stays with three or more ER visits; HbA1c level greater than 9; enrolled with Neighborhood for more than 6 months. In addition to the Control for Life mailings and telephonic outreach, home visits by Care Managers are completed as applicable. The following HEDIS Measures for Diabetes are assessed to evaluate the effectiveness of the program. Three of the four diabetes measures rate at the Medicaid Quality Compass 90th percentile in measurement year 2020. ▪ Comprehensive Diabetes Care – HbA1c Poor Control >9 Eye Exam Blood Pressure Control (BP<140/90) A new program just being initiated that targets at-risk members with diabetes focuses on members for whom Neighborhood receives lab results showing their HbA1c levels to be out of control. These members are referred from the HEDIS Team to Neighborhood's Health@Home nurse practitioner teams for outreach and home visits to address their HbA1c levels and other predictors of poor outcomes. HEDIS measures for Diabetes are monitored by the Treatment and Utilization Work Group. In 2022, the Plan identified Accountable Entity (AE) members with a high HbA1c and shared this information with AE case managers for outreach. Members who receive outreach will be evaluated in 2023 to assess effectiveness of the outreach.	
Network Adequacy	Neighborhood should investigate opportunities to improve adult access to	The Plan completes quarterly surveys to measure adult access to routine and urgent care. Urgent care declined from 2020 to 2021 for nearly all specialties, believed due to the COVID-19 pandemic driving limited	Partially addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	Neighborhood's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
	urgent care as none of the specialties reported met the 24-hour standard.	availability. In addition to COVID-19, an ongoing barrier to successfully measuring urgent care specialty appointments is that appointments are based on acuity, symptoms, and referrals from the primary care provider. Therefore, the urgent care appointments do not always align with Neighborhood standards of 24-hours. To supplement survey data, the Plan investigates member complaints related to access. Of the nine complaints received in 2021, all were investigated by the Grievance and Appeals Unit which found all complaints had a reasonable explanation or accommodation for the member at the time of issue. The Plan will continue to assess provider accessibility quarterly and any provider not meeting the standards will be contacted and educated on Plan standards.	
Quality of Care Surveys – Member Satisfaction	Neighborhood should evaluate the adult and child CAHPS scores to identify opportunities to improve member experience with the managed care plan.	In terms of the Medicaid Adult CAHPS, Rating of Health Plan (8+9+10) improved significantly ($p < 0.05$) to its highest recorded level from 85.46% in 2020 to 90.15% in 2021. Neighborhood's performance on this measure rates 1st among the 139 Medicaid health plans publicly reporting results in the 2021 Medicaid Quality Compass. Ratings of Specialist and Health Care (8+9+10) also improved, to the 90th and 75th percentiles, respectively. Customer Service remains a key driver of Rating of Health Plan, however, satisfaction with getting help and information and being treated with courtesy and respect declined to below average levels and now rate in the 33rd percentile. A new Customer Experience (CX) Work Group was implemented in 2021 and recommended the automated Member Services after call SMS text message survey to members continue. In addition, CX Team designed and launched an organization-wide program to share and seed Neighborhood's CX brand promises to ensure we make our customers' day better than expected. The CX Team designed a plan to triage and act on member feedback collected by the "always on"	Partially addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	Neighborhood's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
		persistent feedback collector on the www.nhpri.org website. Customer Experience work will continue in 2022. Medicaid CAHPS (Child) – The Rating of Health Plan among responding parents and caregivers of Medicaid child members remained high in 2021 and rated in the 95th percentile. In addition, Neighborhood achieved a "World Class" Net Promoter Score of +78 among survey respondents. The Plan recognized the need to improve satisfaction levels among parents and caregivers of Medicaid children with access to quality health care. In response, the Plan launched a new Member Customer Experience (CX) Work Group in September 2021 to identify and prioritize interventions to improve the members' experience throughout the health care journey.	
Quality of Care Surveys – Provider Satisfaction	Neighborhood should monitor the effectiveness of the planned interventions outlined in the 2020 Provider Satisfaction Survey Summary and modify interventions as needed.	Neighborhood will monitor these interventions and modify them as needed through the regular work of the Customer Experience Work Group.	Addressed.

Table 83: Tufts Health Public Plan's Response to the 2020 External Quality Review Recommendations

External Quality Review Activity	2020 External Quality Review Recommendation	Tufts Health Public Plan's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of Tufts Health Public Plan's Response
Annual Quality Strategy/Annual Evaluation	Consider enhancing the annual quality strategy with linking objectives to goals and goals to quantifiable indicators.	The 2021 Quality Strategy uses a separate document (the "2021 Workplan") to track data on performance towards goals. The 2021 workplan outlines project titles, project descriptions, activities for the project, and measurement/benchmarks.	Addressed.
Quality Improvement Projects	To ensure future quality improvement project methodologies are effectively designed and managed, Tufts Health Public Plan staff should complete quality improvement project trainings, consult the Centers for Medicare & Medicaid Services protocol to ensure quality improvement projects meet all validation requirements, and fully address issues identified by the external quality review organization.	No response submitted.	Remains an opportunity for improvement.
Performance Measures	The managed care plan should investigate opportunities to improve the HEDIS measures that performed below the national Medicaid mean.	HEDIS data are used to drive quality activities aimed at improving the care of members. HEDIS performance data is routinely monitored and reviewed against NCQA national and regional benchmarks. In addition to monthly performance reports, an annual dashboard is used to identify targeted improvement opportunities. Root cause analyses are conducted on measures where the variances are deemed significant and improvement initiatives are developed in response to the findings. The focus of quality improvement efforts is on HEDIS measures that most significantly impact quality of care and member health outcomes. Goals for performance are defined and activities incorporated into	Partially addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	Tufts Health Public Plan's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of Tufts Health Public Plan's Response
		relevant clinical and non-clinical programs and projects aimed at members and/or contracted providers.	
Network Adequacy	The managed care plan should investigate opportunities to improve members access to urgent care, primary care, and behavioral health providers.	Tufts Health Public Plan contracted with Providence Community Health Center, a federally qualified health center, in October 2020 to improve access to urgent care services at two of the health centers in the Providence City, Rhode Island. Providence City, Rhode Island contains our highest membership concentration. Tufts Health Public Plan is in the process of contracting with an urgent care center in North Kingstown (South County) – planned for May 2023. Tufts Health Public Plan tracks membership density by city/town for comparison to provider location/site to ensure adequate ratio of providers to member applying NCQA guidelines. The data is shared with our contracting outreach team(s) to identify and recruit providers in the areas to close any gaps. Tufts Health Public Plan initiated a provider partnership project to identify providers that have met the Medicaid state agency screening requirement for recruitment into the Tufts Health RITogether network. Through this initiative, we have been prioritizing expansion of Tufts Health Public Plan's primary care and behavioral health networks, with more than 200 providers identified for recruitment.	Partially addressed.
Quality of Care Survey – Member Satisfaction	The managed care plan should evaluate the adult CAHPS scores to identify opportunities to improve member experience with the managed care plan.	Due to nationwide declines in CAHPS scores and response rates, Tufts Health Public Plan has implemented efforts to increase awareness of CAHPS internally and externally. CAHPS communication explains the purpose and importance of the survey. Additionally, in partnership with Tufts Health Public Plan's CAHPS vendor, analysis is completed to determine areas/measures the organization needs to improve upon. The analysis also informs oversample and methodology of future surveys. The strategies are intended to increase CAHPS response rates and ratings.	Partially addressed.

Table 84: UHCCP-RI's Response to the 2020 External Quality Review Recommendations

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
Quality Improvement Projects	Opportunities of improvement remain for two (2) of the four (4) quality improvement projects, as UHCCP- RI did not achieve the established project goals for these quality improvement projects. UHCCP-RI should continue to monitor the effectiveness of their multi-faceted intervention strategies, including member-focused, provider- focused, and plan-focused interventions. UnitedHealthcare should consider developing and initiating more active interventions.	UHCCP-RI continuously monitors compliance with several priority measures throughout the year and works with practitioners and Accountable Entities on those measures to determine barriers, opportunities, and next steps. In addition, updates are provided to the Rhode Island Executive Office of Health and Human Service quarterly on new and ongoing interventions completed for each quality improvement project. The four quality improvement projects conducted in MY 2020 were continued throughout MY 2021. The national COVID-19 pandemic impacted compliance with several measures as practitioner offices were required to close during 1Q 2020; with reopening allowed 2Q 2020. Once practitioner offices were allowed to reopen, COVID-19 guidelines were implemented and included: social distancing requirements and rescheduling of previously scheduled appointments. Many practitioner offices only allowed the patient and one parent/guardian if the patient was a minor. In some instances, this caused baby-sitter issues for members and the inability to fulfill the appointment. This limited appointment access and availability for patients. The use of telemedicine was also implemented and utilized. Telemedicine is not an effective or viable option for some services, including lead and mammography screenings. In some instances, patients were hesitant to enter offices and/or facilities as they were fearful of contracting COVID-19. Lead Screening in Children The HEDIS *Lead Screening in Children* measure continues to be an opportunity for UHCCP-RI. Existing and new targeted provider and member focused interventions with the goal of improving performance and compliance with lead screening continue and include the following: ▪ Managed Care Plan and State Collaboration (2019 and ongoing): Since the Summer of 2019, the UHCCP-RI has met with Neighborhood Health Plan and the Rhode Island Department of	Partially addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		Health on a quarterly basis to discuss barriers, opportunities for improvement, interventions and lessons learned to close gaps in care. We also ensure consistent messaging/ interventions across organizations to better align our efforts for both the provider and member. ▪ Supplemental Data Retrieval: State Immunization Registry (Ongoing): Four times annually, UHCCP-RI sends a file to the Rhode Island Department of Health to access supplemental information on enrolled members. The Rhode Island Department of Health returns all relevant information for the members on the list. The file that is returned is loaded to the HEDIS software engine as an auditor-approved supplemental data source. ▪ Community Based Organization Contract (Fourth Quarter of 2021 and Ongoing): UHCCP-RI finalized a contract with a community-based organization, to provide funds for a health worker to assist with expanding education and improving the health of community members within Central Falls. The education encompasses education regarding preventive measures such as lead screening in children. ▪ Community-Based Organization Collaboration (Calendar Year 2021 and Ongoing): UHCCP-RI has distributed the lead screening member flyer to approximately 50 community-based organizations and satellite offices for distribution as warranted. The flyer is available in English, Spanish, European Portuguese, Laotian, and Cambodian. ▪ Primary Care Provider Incentives (New Calendar Year 2022): UHCCP-RI will be implementing a provider incentive program for primary care providers. The HEDIS *Lead Screening in Children* measure is included within the incentive program. ▪ Health Equity Program Primary Care Provider Incentive (New Calendar Year 2022): UHCCP-RI is also implementing an additional provider incentive related to health equity. The HEDIS *Lead Screening in Children* measure is included within this incentive	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		program. ▪ Accountable Entities Pay for Reporting Program (New Calendar Year 2022): Lead screening in children has become a pay for reporting measure. Approximately 70% of the UHCCP-RI membership is aligned with a primary care provider associated with an accountable entity. ▪ Accountable Entities Housing Pilot Program (Fourth Quarter of 2021 and Ongoing): UHCCP-RI is working with two accountable entities on a pilot program to improve the housing environments of underserved populations in Providence, Rhode Island. ▪ Accountable Entity Health Equity Grant Support (Calendar Year 2021): UnitedHealthcare supported accountable entities and practitioners by providing actionable data to accountable entities and practitioners interested in the Health Equity Grant for Health Equity Zones to work on lead screening in children in Providence, Rhode Island (02907). ▪ Provider Advisory Committee (October 2021): Discussion occurred regarding barriers related to lead screening. Practitioners communicated patients were fearful of entering practitioner offices and facilities as the patients feared contracting COVID-19. ▪ Patient Care Opportunity Reports (November 2021): Clinical practice consultants distributed to practitioner offices members due for lead screening in advance of the children turning 2 years of age to assist practitioners with closing this gap in care. This initiative will be conducted in calendar year 2022. ▪ Member Rewards Program (Second Quarter of 2022 – Fourth Quarter of 2022): The member rewards program for lead screening will continue. Parents/guardians of members one year of age will be eligible for the $25.00 merchant gift card. For calendar year 2021, 1,475 members were identified as eligible to receive the incentive opportunity. ▪ Member Advisory Committee (March 2022): Discussion occurred	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		regarding barriers to lead screening. No barriers identified. ▪ Member Events (Calendar Year 2022): The member events continue throughout calendar year 2022. Events conducted through April 2022 include Warwick Mall Great Toothbrush Exchange event, We Heart Lives Faith- Based organization backpack event, Community event in partnership with Rhode Island Housing, Rhode Island Department of Health and Health Equity Zone at Juanita Sanchez Educational Complex for Rent Relief assistance, COVID-19 vaccines/boosters, and home test kits distribution. The member flyer continued to be available in English and Spanish and in the first quarter of 2022 has also been translated into European Portuguese, Laotian and Cambodian. ▪ Member Events (Calendar Year 2021): UHCCP-RI attended several events in 2021 and had member flyers available at the events: Tri-County Community Action Plan COVID-19 Celebration Pride event, Warwick Mall Event, International Overdose Awareness Day at Lippitt Memorial Park, Providence Career and Technical Academy meal site back to school event coordinated by the Providence School department, COVID-19 testing site for the underserved population at the Cambodian Society of Rhode Island, and COVID-19 Vaccine event where the Cambodian Society of Rhode Island partnered with Providence Community Health Center. The member flyer was available in English and Spanish. ▪ Baby Shower Event (Second Quarter of 2021): The lead screening educational flyer was distributed to members at a baby shower conducted at Thundermist Health Center. Fifty (50) members attended the baby shower. ▪ Member Live Telephonic Outreach (Ongoing): Live telephonic outreach continues to members identified at 18 months of age and in need of lead screening. The outreach is to educate the parent/guardian of the importance of the lead screening and to assist with scheduling an appointment. For calendar year 2021,	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		6,912 calls were conducted. ▪ Member Healthy First Steps and Baby Blocks Reward (Ongoing): Members who enroll in the program and complete a lead screening are eligible for a child proof kit or a children's lead screening book. ▪ Member Monthly Preventive Health Mailings (Ongoing): Members receive an annual letter based on birthday to remind and encourage members to receive their annual visit, immunizations, and lead screening as applicable. For calendar yar 2021, 33,620 letters mailed to ages 0-20 years. ▪ Member Newsletter Articles (Ongoing): The quarterly member newsletter communicates information regarding lead screening and encourages members to receive annual appointments from practitioners. ▪ Health Disparity Work Plan (Ongoing): HEDIS *Lead Screening in Children* continues to be one of the targeted measures. For calendar year 2022, the focus will be race and ethnicity disparities, instead of geographic location. ▪ Member Demographic Updates (Ongoing): UHCCP-RI staff reviews baby identification numbers with child membership to identify matches and eliminate duplicates. On a monthly basis, UHCCP-RI provides information to the State that has been received by UHCCP-RI case managers or field workers on members identified as having moved out of state. Additionally, UHCCP-RI's clinical practice consultants advise the UHCCP-RI finance liaison of a child's real name from provider visits to also eliminate duplicates. The UHCCP-RI finance liaison provides the Office of Health and Human Services with the child's real name so that membership files can be updated. ▪ Patient Centered Medical Home-Kids Provider Incentive (Ongoing): UHCCP-RI pays providers an incentive through Patient Centered Medical Home-Kids if they meet the *Lead Screening in Children* benchmark. Breast Cancer Screening	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		Breast cancer screening continues to be an opportunity for UHCCP-RI. Existing and new targeted provider and member focused interventions with the goal of improving performance and compliance with breast cancer screenings continue and include the following: ▪ Community Based Organization Contract (4Q 2021 and Ongoing): The health plan finalized a contract with a community-based organization, to provide funds for a health worker to assist with expanding education and improving the health of community members within Central Falls. The education encompasses education regarding preventive measures such as breast cancer screening. ▪ Community-Based Organization (CBO) Collaboration (CY 2021 and Ongoing): UHCCP-RI has distributed the BCS member flyer to approximately 50 CBOs and satellite offices for distribution as warranted. The flyer is available in English, Spanish, European Portuguese, Laotian, and Cambodian. ▪ Primary Care Provider Incentives (New CY 2022): UHCCP-RI will be implementing a provider incentive program for primary care providers. BCS is a measure included within the incentive program. ▪ Health Equity Program Primary Care Provider Incentive (New CY 2022): UHCCP-RI is also implementing an additional provider incentive related to health equity. The BCS measure is included within this incentive program. ▪ Accountable Entities (AEs) Pay for Performance Program (Ongoing): Breast cancer screening is a Pay for Performance measure. Approximately 70% of the UHCCP-RI membership is aligned with a PCP associated with an AE. In addition, a CPC worked directly with one of the AEs on a healthy equity project to try and improve BCS performance. In March 2021, a discussion regarding BCS barriers occurred at an AE Quality Circle meeting. ▪ Patient Care Opportunity Reports (PCORs) (Ongoing): Clinical Practice Consultants (CPCs) outreach to high volume OB/GYNs and	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		provide lists of patients due for mammograms. ▪ Member Rewards Program (Q2 2022 – Q4 2022): The member rewards program for BCS will continue. Members will be eligible for the $25.00 merchant gift card. For CY 2021, 2,670 members were identified as eligible to receive the member incentive opportunity. ▪ Member Advisory Committee (March 2022): Discussion occurred regarding barriers to BCS. No barriers identified. ▪ Member Events (CY 2022): The member events continue throughout CY 2022. Events conducted through April 2022 include Community event in partnership with Rhode Island Housing, Rhode Island Department of Health and Health Equity Zone at Juanita Sanchez Educational Complex for Rent Relief assistance, COVID-19 vaccines/boosters and home test kits distribution and Community event in partnership with the Cambodian Society of Rhode Island COVID-19 vaccination and booster clinic for all ages 5 and older. The member flyer continued to be available in English and Spanish and in Q1 2022 has also been translated into European Portuguese, Laotian and Cambodian. ▪ Member Events (CY 2021): UHCCP-RI attended several events in 2021 and had member flyers available at the events: Tri-County Community Action Plan COVID-19 Celebration Pride event, Warwick Mall Event, International Overdose Awareness Day at Lippitt Memorial Park, Providence Career and Technical Academy (PTCA) meal site back to school event coordinated by the Providence School department, COVID-19 testing site for the underserved population at the Cambodian Society of Rhode Island, and COVID-19 Vaccine event where the Cambodian Society of Rhode Island partnered with Providence Community Health Center. The member flyer was available in English and Spanish. ▪ House Calls Program (September 2021 and Ongoing): This is an in-person member annual visit program. The program outreaches to adult members aged 26 and older, who are not pregnant and need	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		an annual exam. The appointment will also review and discuss gaps in care, including mammography screening. 1,039 members were contacted in calendar year 2021. Baby Shower Event (2Q 2021): The breast cancer screening educational flyer was distributed to members at a baby shower conducted at Thundermist Health Center. 50 members attended the baby shower. ▪ Member Email (2Q 2021): A women's health email was sent to members encouraging members to get screened. 4,150 emails were sent. This initiative will be conducted in calendar year 2022. ▪ Member Live Telephonic Outreach Annual Exam (November 2021 and Ongoing): Live telephonic outreach was conducted to members aged 45-64 and who needed an annual exam (as determined by the HEDIS® measure Adult Access to Preventive Ambulatory Health Services (AAP)). Live agents called members to remind them to receive an annual appointment. For calendar year 2021, 1,508 calls conducted. Effective January 1, 2022, the live telephonic outreach has been expanded to include members aged 20 and older with a race or ethnicity of Black or African American, Asian, American Indian, and Native, Hispanic or Latino and may indirectly assist with the improvement in compliance with breast cancer screening because members are more likely to complete screenings if they complete wellness visits with their primary care provider. ▪ Member Live Telephonic Outreach Breast Cancer Screening (Ongoing): UHCCP RI contracts with a vendor to conduct live outreach calls. Live agents call to remind members to receive BCS services. For calendar year 2021, 5,566 calls conducted. ▪ Member Monthly Preventive Health Mailings (Ongoing): Members receive an annual letter based on birthday to remind and encourage members to receive their annual visit and other screenings as applicable. For CY 2021, 48,095 letters mailed. ▪ Member Newsletter Articles (Ongoing): The quarterly member newsletter communicates information regarding breast cancer	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		screening and encourages members to receive annual appointments from practitioners. ▪ Health Disparity Work Plan (Ongoing): BCS continues to be one of the targeted measures. For CY 2022, the focus will be race and ethnicity disparities, instead of geographic location.	
Performance Measures	The managed care plan should investigate opportunities to improve the health of members with diabetes.	Comprehensive Diabetes Care HbA1c Testing (CDC HbA1c Testing) continues to be an opportunity for UHCCP-RI and is a measure that UHCCP-RI monitors for compliance throughout the year, determines areas of opportunity and implements member and practitioner interventions with the goal of improving compliance. As stated above, the national COVID-19 pandemic impacted MY 2020 compliance with several measures, including CDC HbA1c Testing. Existing and new targeted provider and member focused interventions with the goal of improving performance and compliance with CDC HbA1c Testing and include the following: ▪ Community Based Organization Contract (4Q 2021 and Ongoing): The health plan finalized a contract with a community-based organization, to provide funds for a health worker to assist with expanding education and improving the health of community members within Central Falls. The education encompasses education regarding preventive and chronic care measures such as comprehensive diabetes care. ▪ Community Based Organization (CBO) Collaboration (CY 2021 and Ongoing): UHCCP-RI has distributed flyers related to diabetes care to approximately 50 CBOs and satellite offices for distribution as warranted. The flyer is available in English, Spanish, European Portuguese, Laotian, and Cambodian. ▪ Accountable Entities (AEs) Pay for Performance Program (Ongoing): CDC HbA1c is a Pay for Performance measure. Approximately 70% of the UHCCP-RI membership is aligned with a PCP associated with an AE. ▪ Patient Care Opportunity Reports (PCORs) (Ongoing): Clinical	Addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		Practice Consultants (CPCs) outreach to high volume FQHCs and practitioner offices and provide lists of patients due for services. ▪ Provider Collaboration (Summer 2021): UHCCP-RI supplied diabetes kits which included a scale, exercise band, and pedometer to the East Bay Community Action Plan to help support the road to equity diabetes pilot. ▪ Member Events (CY 2021): UHCCP-RI attended several events in 2021 and had member flyers available at the events: Tri-County Community Action Plan COVID-19 Celebration Pride event, Warwick Mall Event, International Overdose Awareness Day at Lippitt Memorial Park, Providence Career and Technical Academy (PTCA) meal site back to school event coordinated by the Providence School department, COVID-19 testing site for the underserved population at the Cambodian Society of Rhode Island, and COVID-19 Vaccine event where the Cambodian Society of Rhode Island partnered with Providence Community Health Center. The member flyer was available in English and Spanish. The flyer will be available at member events throughout calendar year 2022 as deemed appropriate. The member flyer is now available in European Portuguese, Laotian, Cambodian, in addition to English and Spanish. ▪ House Calls Program (September 2021 and Ongoing): This is an in-person member annual visit program. The program outreaches to adult members aged 26 and older, who are not pregnant and comprehensive diabetes care. 1,039 members were contacted in calendar year 2021. ▪ Medication Adherence Member Email (August 2021 and December 2021): Two separate member email campaigns related to medication adherence were deployed. Both campaigns focused on reminding members to take medications as prescribed to stay healthy. Members identified with diabetes were included in the email campaigns. 1,541 emails were sent. The member email campaigns will be conducted in calendar year 2022.	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		▪ Member Live Telephonic Outreach (Ongoing): Live telephonic outreach is conducted to members aged 18 and older and in need of CDC HbA1c Testing. Live agents call members to remind them to receive appropriate care and to assist with scheduling of appointments. For calendar year 2021, 28,494 calls conducted. ▪ Member Monthly Preventive Health Mailings (Ongoing): Members receive an annual letter based on birthday to remind and encourage members to receive their annual visit and other screenings as applicable. For CY 2021, 48,095 letters mailed. ▪ Member Newsletter Articles (Ongoing): The quarterly member newsletter communicates information regarding diabetes care and encourages members to receive annual appointments from practitioners.	
Network Adequacy	The managed care plan should investigate opportunities to improve members timely access to providers.	• The Health Plan in coordination with UHCCP-RI offers one of the most comprehensive Medicaid networks statewide with 11 hospitals, 9 Ambulatory Surgery Centers, more than 2,200 Primary Care Physicians and 5,000 Specialists. 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. The Health Plan has been in the marketplace for more than twenty-five years and continuously evaluates, monitors, and recruits new practitioners to assure a robust disciplinary provider network, so members have access to the full range of covered health services. • UHCCP-RI has a Network Management Team structure that supports ongoing review and analysis of the network. This ensures access, as well as allows us to identify 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	Partially addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		care / quality of service concerns / complaints from members and trending of feedback from medical directors, nurse case managers and front-line staff. This ongoing monitoring has not detected any deficiencies in our network or access or availability issues for our members. • The results from the quarterly surveys are evaluated by a cross functional team which includes representation from Quality, Provider Network Management, Provider Programs, Optum Behavioral Health, and Provider Relations Advocates who meet to analyze the results and determine 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 and purpose of the survey. 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, to ensure providers are aligned with the correct practice location, if the provider has moved or retired, if they've added new providers, or if their practice panel is closed to new patients. This discussion and assistance assure our Provider Directory provides an accurate assessment of our provider network. The Provider Relations Advocates also discuss how the existing practice providers can assist one another 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 discuss the findings with a practice/ provider, the actual survey call recording is requested to review and determine the underlining issue. This way the Provider Advocate is better able to assist the practice/ provider	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		and mitigate the issue. • In addition to the above, UHCCP-RI has conducted a root cause analysis to better understand the underlying issues regarding both timeliness and availability. The analysis resulted in three root causes. The first root cause being that UHCCP-RI is on a data platform with limited capabilities. UHCCP-RI anticipates moving to a new data platform in September 2022. UHCCP-RI has seen improvements in the capabilities of the new data platform in other health plans across UHC with the secret shopper surveys. The second root cause was the vendor was not calling providers in the same offices to avoid provider abrasion, thus resulting in providers not being surveyed. This has since been mitigated for the Q2 2022 secret shopper survey and the vendor will be calling all providers on the sample on different days to avoid provider abrasion. Lastly, the third root cause was the COVID-19 national pandemic. COVID-19 did influence the survey. There were providers who required COVID-19 screenings to make an appointment and due to staffing shortages within the practice/ provider offices, many practice/ provider offices had calls forwarded to an answering machine/ voicemail.	
Quality of Care Survey – Member Satisfaction	The managed care plan should evaluate the Adult CAHPS scores to identify opportunities to improve member experience with the managed care plan.	On an annual basis, CAHPS® survey results are evaluated by a cross functional team including representation from Quality, Marketing, Provider Programs, UnitedHealthcare Clinical Services, and OptumRX to determine strengths and areas of opportunity for possible interventions. Based on the CAHPS® 2021 results, *Rating of Personal Doctor*, *Getting Needed Care* and *How Well Doctors Communicate* were identified as opportunities. The CAHPS® 2021 questions related to getting needed care and getting care quickly continued to be impacted by the COVID-19 pandemic. Reduced satisfaction was seen throughout UHC and nationally, particularly with routine care.	Addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		The COVID-19 pandemic may have had a negative impact on getting an appointment due to COVID-19 office protocols, the need to reschedule previously cancelled appointments and the overall demand for appointments once practitioner offices could reopen. This caused appointment demand to exceed appointment capacity and a back log with appointment availability. Even though we educate members on appointment expectations through the quarterly newsletter *Health Talk* and member welcome materials, members may lack understanding of primary and/or specialty care availability standards causing unrealistic expectations for appointment times. Specialists may not schedule appointments without prior medical records, including immunizations which may cause longer wait times for appointments. Initiatives implemented include the following: ▪ CAHPS® results are presented and discussed annually at multiple UHCCP-RI committee meetings, including the Quality Management and Provider Advisory Committee meetings. ▪ Provider Advocates and Clinical Practice Consultants discuss the CAHPS® survey and results during face-to-face or video conference (due to COVID-19) practitioner visits. ▪ Both secret shopper and announced primary care appointment access and availability survey calls are conducted to confirm practitioners' meeting contractual appointment timeliness requirements. Practitioners not meeting compliance are contacted for education. ▪ Telemedicine appointment option/vehicle was implemented for both primary and specialty care to increase appointment availability and access. ▪ The primary care to specialist referral requirement has been paused indefinitely to further reduce administrative burden to the	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		practitioners and reduce and eliminate a potential barrier to appointment access. ▪ Overall, response rates are small and, in some instances, have declined. UHCCP-RI has implemented strategies with the goal of improving and increasing member response rates. Strategies implemented include discussing the survey and results with practitioner offices, the Provider Advisory Committee meeting, mailing a letter to the UHCCP-RI membership January of 2022, provided updated member demographic information to be shared with the CAHPS® vendor, and included an article regarding the survey in the Winter quarterly newsletter *Health Talk*. UHCCP-RI will continue to discuss and implement strategies with the goal of improving the response rate for the CAHPS® 2023 survey process.	
Quality of Care Survey – Provider Satisfaction	The managed care plan should investigate opportunities to improve the provider experience with the managed care plan.	Annually, UHCCP-RI conducts a Provider Satisfaction survey and evaluates the results of the survey with a cross functional team which includes representation from Marketing and Strategic Insights, Provider Network Management, Provider Programs, Quality, Marketing, UnitedHealthcare Clinical Services, and OptumRX to determine strengths and a workplan with areas of opportunity for possible interventions. UHCCP-RI recognizes opportunities with practitioner satisfaction exist and has implemented the following initiatives: ▪ Medical Prior Authorization: Discussion with the Provider Advisory Committee is ongoing regarding the prior authorization process. UHCCP-RI is researching the ability to implement a program for radiology services where practitioners who have been identified with low denial rates would no longer need to receive prior authorizations. ▪ Pharmacy Prior Authorization: Due to the ongoing discussions with the Provider Advisory Committee, medications are reviewed on an ongoing basis and prior authorizations have been removed and for other medications, prior authorization criteria have been updated;	Partially addressed.

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		reducing the number of services requiring a prior authorization. Also, free text field was recently added to the on-line prior authorization process. This free text allows practitioners to provide additional information; particularly regarding previous medications tried but not effective. UHC is also reviewing decision trees with the goal of decreasing the length of the decision tree which will impact the initial request. UHCCP-RI will continue to discuss prior authorization processes with the practitioners and implement improvements to simplify the process. ▪ Referral Process: Discussion with the Provider Advisory Committee occurred regarding the primary care to specialty care referral process and UHCCP-RI has determined the referral process is a provider satisfaction detractor, particularly during the pandemic. UHCCP-RI paused the primary care to specialist referral process during the pandemic and has elected to discontinue the referral requirement until further notice. The Provider Advisory Committee members were appreciative and grateful of this decision. UHCCP-RI is working on a communication process for both providers and members. ▪ Medical Record Collection: UHCCP-RI has expanded electronic medical record exchange and access which reduces the need to request copies of medical records and/or conduct practitioner office on-site collection. UHC has expanded internal medical record collection, allowing practitioner offices to work with UHC staff they are familiar with and work with throughout the year. UHCCP-RI has also merged requests for lines of business and has had one UHC representative collect medical records for all lines of UHC business when feasible. This reduces the number of UHC outreaches and staff to the practices. UHCCP-RI will continue to review processes and merge and minimize medical record requests from multiple UHC staff when feasible. ▪ Provider Services: UHCCP-RI reviewed the verbatims provided from	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		the survey and did not detect this was a trend. The Provider Network Provider Advocates outreached to their practices to introduce themselves and make sure practices were aware of their local contacts. The Provider Advocates also conduct periodic virtual Town Hall meetings, and a review of the service model was provided. ▪ Customer Service: Provider dissatisfaction was revealed with the inability to resolve issues on the first call. UHC added new information within a pop-up when a provider calls. The pop up now advises the customer service representative if the caller is a repeat caller, meaning has the provider called within the last 30 calendar days. The Provider Advocates may now see this information and can determine the number of times the caller has called. Ongoing surveys have been implemented and there are three questions in total. Two of the three questions are related to satisfaction of the recent call and the third question is related to overall UHC satisfaction and how we can improve our business. Improvement opportunities are determined from the surveys and action is taken as appropriate. ▪ Credentialing Process: UHCCP-RI utilizes the Council for Affordable Quality Healthcare online process/portal for initial and recredentialing of practitioners. UHC monitors initial and recredentialing timeliness standards for both individual practitioners and facilities to ensure credentialing is processed in an effective and efficient manner. For UHCCP-RI the timeliness standard for initial and recredentialing of practitioners and facilities is 45 days. For calendar year 2020, all UHCCP-RI practitioners and facilities who submitted complete/ clean applications were credentialed and recredentialed within the 45-day parameter. ▪ Provider Incentives: During one of the Provider Advisory Committee meetings in 2021, providers requested an incentive program to help close gaps in care. In 2022, UHCCP-RI is	

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		implementing two provider incentive programs: 1) to close the gap in care for specific measures and 2) an additional incentive if the gap is closed for a BIPOC member to help close healthy disparity gaps.	

Strengths, Opportunities and 2021 Recommendations Related to Quality, Timeliness and Access

The managed care plans' strengths and opportunities for improvement identified during IPRO's external quality review of the activities described are enumerated in this section. For areas needing improvement, recommendations to improve the **quality** of, **timeliness** of and **access** to care are presented. These three elements are defined as:

- **Quality** is the degree to which a managed care plan increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*42 Code of Federal Regulations 438.320 Definitions*.)
- **Timeliness** is the managed care plan's capacity to provide care quickly after a need is recognized. (Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services)
- **Access** is the timely use of services to achieve health optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements. (*42 Code of Federal Regulations 438.320 Definitions*.)

The strengths and opportunities for improvement based on the managed care plans' 2021 performance, as well recommendations for improving quality, timeliness, and access to care are presented in **Table 85, Table 86,** and **Table 87** for Neighborhood, Tufts Health Public Plan, and UHCCP-RI, respectively. In this table, links between strengths, opportunities, and recommendations to quality, timeliness and access are made by IPRO (indicated by 'X'). In some cases, IPRO determined that there were no links between these elements (indicated by shading).

Table 85: Neighborhood's Strengths, Opportunities, and Recommendations, Measurement Year 2021

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	Neighborhood maintained NCQA accreditation in 2021.	X	X	X
Quality Improvement Projects – General	Six of six quality improvement projects passed validation.			
Quality Improvement Project – Developmental Screening	Neighborhood's measurement year 2021 rates for the three performance indicators exceeded the goal.	X	X	X
Quality Improvement Project – Improve *HEDIS Care for Older Adults* Performance	Neighborhood's measurement year 2021 rates for the four performance indicators exceeded the goal.	X	X	X
Quality Improvement Project – Increase the Percentage of	Neighborhood's measurement year 2021 rate for one of two performance indicators exceeded the goal.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Transitions from the Nursing Home to the Community				
Performance Measures	Neighborhood met all information systems and validation requirements to successfully report HEDIS data to the Office of Health and Human Services and to NCQA.			
Performance Measures – Use of Services	Neighborhood reported three measurement year 2021 HEDIS rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Performance Measures – Effectiveness of Care	Neighborhood reported six measurement year 2021 rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Performance Measures – Access and Availability	Neighborhood reported five measurement year 2021 rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	Neighborhood is compliant with eight standards of *Code of Federal Regulations Part 438 Subpart D* and *Subpart E 438.330*.	X	X	X
Network Adequacy	In 2021, approximately 100% of Neighborhood's English or Spanish speaking membership had appropriate distance access to primary and specialty care providers.		X	X
	In 2021, Neighborhood's provider network had appointment availability rates at or above the 90% for adult primary care and obstetrics/gynecology.		X	X
Quality of Care Surveys – Member Satisfaction	Neighborhood achieved two scores on the adult survey that met or exceeded the national Medicaid 75th percentile.	X	X	X
	Neighborhood achieved two scores on the child survey that met the national Medicaid 75th percentile.	X	X	X
Quality of Care Surveys – Provider Satisfaction	Neighborhood demonstrated improvement between measurement years 2020 and 2021 on five measures of provider satisfaction.	X	X	X
Opportunities for Improvement				
Quality Improvement Project – Improve	Neighborhood's measurement year 2021 rates for the three performance indicators did not meet the goal rate.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Child and Adolescents' Well-Care Visits				
Quality Improvement Project – Improve the HEDIS *Follow-Up Care for Children Prescribed ADHD Medication* Rate	Neighborhood's measurement year 2021 rates for the two performance indicators did not meet the goal rate.	X		
Quality Improvement Project – Social Determinant of Health Measure – Improve the Rate of Lead Screening in Children	Neighborhood's measurement year 2021 rate for the single performance indicator did not meet the goal rate.	X	X	X
Quality Improvement Project – Increase the Percentage of Transitions from the Nursing Home to the Community	Neighborhood's measurement year 2021 performance for one of two indicators did not meet the goal.	X	X	X
Performance Measures – Effectiveness of Care	Neighborhood reported one measurement year 2021 rate that benchmarked below the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	Neighborhood is not fully compliant with two standards of *Code of Federal Regulations Part 438 Subpart D*.	X	X	X
Network Adequacy	Overall, appointment availability among the surveyed providers was low.		X	X
Quality of Care Surveys – Member Satisfaction	Neighborhood achieved seven measurement year 2021 scores for the adult survey that benchmarked below the national Medicaid 75th percentile.	X	X	X
	Neighborhood achieved five measurement year 2021 scores for the child survey that benchmarked below the national Medicaid 75th percentile.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality of Care Surveys – Provider Satisfaction	Neighborhood demonstrated performance decline between measurement years 2020 and 2021 on two measures of provider satisfaction.	X	X	X
Recommendations				
Quality Improvement Projects	Opportunities of improvement remain for four of the six quality Improvement projects, as Neighborhood did not achieve the established project goals. Neighborhood should continue to study the effectiveness of the intervention strategy and act on opportunities to make enhancements.	X	X	X
Performance Measures	Neighborhood should investigate opportunities to improve chlamydia screening in women.	X	X	X
Compliance with Medicaid Standards	Neighborhood should conduct routine monitoring to ensure areas of noncompliance have been effectively addressed.	X	X	X
Network Adequacy	Neighborhood should investigate opportunities to improve member access to care.		X	X
Quality of Care Surveys – Member Satisfaction	Neighborhood should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid 75th percentile.	X	X	X
Quality of Care Surveys – Provider Satisfaction	Neighborhood should work to improve resolution process for claims issues.	X	X	X

Table 86: Tufts Health Public Plan's Strengths, Opportunities, and Recommendations, Measurement Year 2021

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	Tufts Health Public Plan maintained NCQA accreditation in 2021.	X	X	X
Quality Improvement Projects – General	Two of four quality improvement projects passed validation.			
Performance Measures	Tufts Health Public Plan met all information systems and validation requirements to successfully report HEDIS data to the Office of Health and Human Services and to NCQA.			
Performance Measures – Effectiveness of Care	Tufts Health Public Plan reported three measurement year 2021 rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	Tufts Health Public Plan is compliant with the standards of *Code of Federal Regulations Part 438 Subpart D* and *438.330*.	X	X	X
Network Adequacy	None.			
Quality of Care Survey – Member Satisfaction	None.			
Quality of Care Survey – Provider Satisfaction	Though not statistically significant, Tufts Health Public Plan demonstrated performance improvement in provider perception of the managed care plan being a strong collaborator in quality patient care and a valuable partner for primary care clinicians in a crisis.	X		
Opportunities for Improvement				
Quality Improvement Projects	Two of four quality improvement projects did not pass validation.			
Performance Measures – Use of Services	Tufts Health Public Plan reported three measurement year 2021 rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Performance Measures – Effectiveness of Care	Tufts Health Public Plan reported four measurement year 2021 rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Performance Measures – Access and Availability	Tufts Health Public Plan reported five measurement year 2021 rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy	Appointment availability among the surveyed providers was low.		X	X
Quality of Care Surveys – Member Satisfaction	Tufts Health Public Plan achieved two measurement year 2021 scores for the adult survey that benchmarked below the national Medicaid 75th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	Tufts Health Public Plan demonstrated performance decline in overall provider satisfaction.	X	X	X
Recommendations				
Quality Improvement Projects	To ensure future quality improvement project methodologies are effectively designed and managed, Tufts Health Public Plan staff should utilize the standardized NCQA *Quality Improvement Activity Form*, and fully address issues identified by the external quality review organization.	X	X	X
Compliance with Medicaid Standards	Tufts Health Public Plan should conduct routine monitoring to ensure compliance is maintained.	X	X	X
Performance Measures	Tufts Health Public Plan should continue to utilize HEDIS results in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Tufts Health Public Plan should focus on child and adult primary care utilization rates, women's health, and chronic conditions.	X	X	X
Network Adequacy	Tufts Health Public Plan should investigate opportunities to improve member access to care.		X	X
	For future appointment availability surveys, Tufts Health Public Plan should establish a minimum sample size by specialty to increase the overall validity of the results. In the absence of a state-established threshold for timely appointments, Tufts Health Public Plan should identify a threshold to work toward.		X	X
Quality of Care Survey – Member Satisfaction	Tufts Health Public Plan should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid 75th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	Tufts Health Public Plan should work to improve contract management practices and the timeliness of the dispute process for denied claims.	X		

Table 87: UHCCP-RI's Strengths, Opportunities, and Recommendations, Measurement Year 2021

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	UHCCP-RI maintained NCQA accreditation in 2021.	X	X	X
Quality Improvement Projects – General	Four of four quality improvement projects passed validation.			
Quality Improvement Project – Improving Effective Acute Phase Treatment for Major Depression	UHCCP-RI's measurement year 2021 rate for the single performance indicator exceeded the goal.	X	X	X
Quality Improvement Project – Developmental Screening in the 1st, 2nd, and 3rd Years of Life	UHCCP-RI's measurement year 2021 rates for the three performance indicators exceeded their respective goal.	X	X	X
Performance Measures	UHCCP-RI met all information systems and validation requirements to successfully report HEDIS data to the Office of Health and Human Services and to NCQA.			
Performance Measures – Use of Services	UHCCP-RI reported three measurement year 2021 HEDIS rates that benchmarked at the national Medicaid 75th percentile.	X	X	X
Performance Measures – Effectiveness of Care	UHCCP-RI reported six measurement year 2021 rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Performance Measures – Access and Availability	UHCCP-RI reported one measurement year 2021 rate that benchmarked at the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	UHCCP-RI is compliant with the standards of *Code of Federal Regulations Part 438 Subpart D* and *438.330*.	X	X	X
Network Adequacy	UHCCP-RI met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.		X	X
Quality of Care Survey – Member Satisfaction	UHCCP-RI achieved three scores on the adult survey that met or exceeded the national Medicaid 75th percentile.	X	X	X
	UHCCP-RI achieved one score on the child survey that exceeded the national Medicaid 75th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	None.			
Opportunities for Improvement				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality Improvement Project – Improving Lead Screening in Children	UHCCP-RI's measurement year 2021 rate for the single performance indicator demonstrated a decline in performance from 2020 and did not meet the 2021 goal.	X	X	X
Quality Improvement Project – Improving Breast Cancer Screening	UHCCP-RI's measurement year 2021 rate for the single performance indicator demonstrated a decline in performance from 2020 and did not meet the 2021 goal.		X	X
Performance Measures – Effectiveness of Care	UHCCP-RI reported one measurement year 2021 HEDIS rate that benchmarked below the national Medicaid 75th percentile.	X	X	X
Performance Measures – Access and Availability	UHCCP-RI reported four measurement year 2021 HEDIS rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	Appointment availability among the surveyed providers was low.		X	X
Quality of Care Surveys – Member Satisfaction	UHCCP-RI achieved one measurement year 2021 score for the adult survey that benchmarked below the national Medicaid 75th percentile.	X	X	X
	UHCCP-RI achieved two measurement year 2021 scores for the child survey that benchmarked below the national Medicaid 75th percentile.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UHCCP-RI's 2021 rates for the measures displayed in this report demonstrated no change or a decline in performance between measurement years 2020 and 2021 or did not meet the national UnitedHealthcare 2021 average.	X	X	X
Recommendations				
Quality Improvement Projects	Opportunities of improvement remain for two of the four quality Improvement projects, as UHCCP-RI did not achieve the established project goals. UHCCP-RI should continue to study the effectiveness of the intervention strategy and act on opportunities to make enhancements.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	UHCCP-RI should continue to utilize HEDIS results in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, UHCCP-RI should focus on primary and prenatal care utilization.	X	X	X
Compliance with Medicaid Standards	UHCCP-RI should conduct routine monitoring to ensure compliance is maintained.	X	X	X
Network Adequacy	UHCCP-RI should investigate opportunities to improve member access to care.		X	X
	For future appointment availability surveys, UHCCP-RI should establish a minimum sample size by specialty to increase the overall validity of the results. In the absence of a state-established threshold for timely appointments, UHCCP-RI should identify a threshold to work toward.		X	X
Quality of Care Surveys – Member Satisfaction	UHCCP-RI should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid 75th percentile.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UHCCP-RI should identify best practices used at other UnitedHealthcare organizations that aim to improve provider satisfaction.	X	X	X

Appendix A – 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 *and* why there is an opportunity for improvement.	
B. Quantifiable Measures. List and define *all* 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:	
C. Baseline Methodology.	
C.1 Data Sources.	

[ ] Medical/treatment records
[ ] Administrative data:
[ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] 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.

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:
[ ] Medical/treatment record abstraction

If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):
_____

If administrative, check all that apply:
[ ] Programmed pull from claims/encounter files of all eligible members
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):
_____

C.3 Sampling. If sampling was used, provide the following information.

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*

C.4 Data Collection Cycle.

[ ] Once a year
[ ] Twice a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Once a week
[ ] Once a day
[ ] Continuous
[ ] Other (list and describe):
_Annual HEDIS data collection in Spring, and interim measure in Summer preceding close of the HEDIS 2008 year (Summer 2007

Data Analysis Cycle.

[ ] Once a year
[ ] Once a season
[ ] Once a quarter
[ ] Once a month
[ ] Continuous
[ ] Other (list and describe):
_____
_____

C.5 Other Pertinent Methodological Features. Complete only if needed.

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

Include, as appropriate:

- **I.** Measure and time period covered
- **II.** Type of change
- **III.** Rationale for change
- **IV.** Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method
- **V.** 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*
	Baseline:						

#2 Quantifiable Measure:

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

#3 Quantifiable Measure:

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

***** 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.