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Rhode Island Medicaid Managed Care Program
Neighborhood Health Plan of Rhode Island
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 (hereafter referred to as Neighborhood), a Rhode Island Medicaid managed care plan.

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 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

[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.

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 managed care plan 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, this 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 managed care plan data to determine adherence 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 managed care plan 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 managed care plan provider satisfaction reports to verify the validity and reliability of the results.

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

[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).

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, United Healthcare Community Plan of Rhode Island, and Tufts Health Public Plan; 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 ▪ UnitedHealthcare Community Plan ▪ Tufts Public Health Plan
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 ▪ UnitedHealthcare Community Plan ▪ Tufts Public Health Plan
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 ▪ UnitedHealthcare Community Plan ▪ Tufts Public Health Plan
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 ▪ UnitedHealthcare Community Plan ▪ Tufts Public Health Plan
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 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%

Neighborhood's Quality Assurance and Improvement Program

The Office of Health and Human Services requires that contracted health plans have a written quality assurance or quality management plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas, including all subcontractors. Neighborhood's *2021 Quality Improvement Program Description* (May 2021) met these requirements.

Objectives

Neighborhood's quality improvement program strives to ensure that members have access to high quality health care services that are responsive to their needs and result in positive health outcomes. To meet this high-level goal, Neighborhood's quality improvement program targets clinical quality of care, member, and provider experience and internal operations.

Table 8 displays Neighborhood's quality improvement goals as reported in the *2021 Quality Improvement Plan*.

Table 8: Neighborhood's Quality Improvement Objectives, 2021

Neighborhood's Quality Improvement Objectives, 2021
▪ Provide a population health structure crossing all departments encompassing the clinical care provided to Neighborhood's members ▪ Assure access to high quality medical and behavioral healthcare ▪ Support members with acute and long-term health care needs ▪ Monitor and improve coordination of care across settings ▪ Improve member and provider experience ▪ Ensure the safety of members in all health care settings ▪ Monitor quality of care in nursing facilities through Minimum Data Set data and other data sources ▪ Engage members in their own care ▪ Improve HEDIS and CAHPS performance ▪ Improve Medicare Health Outcomes Survey performance ▪ Attain maximum NCQA Star Rating and accreditation status

Neighborhood's Quality Improvement Objectives, 2021
▪ Support the Medicaid accountable entities in achieving maximum performance on their annual quality multipliers ▪ Achieve optimum performance for quality withhold under the INTEGRITY Medicare-Medicaid plan product line ▪ Achieve maximum performance in the quality improvement projects required by contracts for Medicaid, INTEGRITY Medicare-Medicaid plan, and the exchange products ▪ Maintain grievance and appeal procedures and mechanisms and assure that members can achieve resolution to problems or perceived problems relating to access and other quality issues ▪ Maintain collaborative relationships with network providers and state agencies ▪ Improve operational efficiency in the work performed across the organization ▪ Ensure Neighborhood's quality improvement structure and processes adhere to NCQA standards and state and federal requirements ▪ Assess the quality improvement program annually and make changes as necessary to improve program effectiveness

Quality Improvement Program Activities

Neighborhood's quality improvement program activities involve a variety of mechanisms to measure and evaluate the total scope of services provided to enrollees. The framework for program activities may vary and may include but is not limited to, the following functions:

- Clinical Quality Performance Indicators: HEDIS
- Member Satisfaction: CAHPS and Qualified Health Plan Enrollee Experience Survey
- Member Satisfaction: Care Management Member Satisfaction Survey
- Provider Satisfaction Survey
- Clinical Practice Guidelines
- Disease Management and Wellness
- Peer Review Activity
- Actions to Address Quality of Care Complaints
- Quality Improvement Projects
- Chronic Care Improvement Programs – INTEGRITY Medicare-Medicaid plan
- Activities to Improve Patient Safety
- Objectives to Enhance Service to a Culturally Diverse Membership
- Objectives to Enhance Services to Members with Complex Health Needs
- Population Health Management Strategy
- Annual Evaluation and Work Plan Development

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 9 displays these standards as well as the elements audited for the standard.

Table 9: 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 36).

Comparative Results

Neighborhood'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 auditor. Table 10 displays the results of the NCQA Information System Capabilities review for Neighborhood.

Table 10: Neighborhood's NCQA Information Systems Capabilities Standards Audit Results, Measurement Year 2021

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

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 11 displays the titles of the six quality improvement projects led by Neighborhood for its Medicaid membership in measurement year 2021.

Table 11: Neighborhood's Quality Improvement Project Topics, 2021

Neighborhood's Quality Improvement Project Topics, 2021
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

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 12.

Table 12: Review Determination Definitions

Review Determination	Definition
Met	The MCO has met or exceeded the standard.
Not Met	The MCO 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

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 13 displays a summary of the validation results of Neighborhood's quality improvement projects that were conducted for measurement year 2021. Summaries of each quality improvement projects immediately follow.

Table 13: Neighborhood's Quality Improvement Project Validation Results, Measurement Year 2021

Neighborhood's Quality Improvement Project (QIP) Validation Results						
Validation Element	QIP 1	QIP 2	QIP 3	QIP 4	QIP 5	QIP 6
Selected Topic	Met	Met	Met	Met	Met	Met
Study Question	Met	Met	Met	Met	Met	Met
Indicators	Met	Met	Met	Met	Met	Met
Population	Met	Met	Met	Met	Met	Met
Sampling Methods	Met	Met	Met	Met	Met	Met
Data collection Procedures	Met	Met	Met	Met	Met	Met
Interpretation of Study Results	Met	Met	Met	Met	Met	Met
Improvement Strategies	Met	Met	Met	Met	Met	Met

Table 14: Quality Improvement Project 1 Summary – Well-Care Visits, Measurement Year 2021

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 15: 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 16: 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 17: 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 18: Quality Improvement Project 2 Summary – Developmental Screening, Measurement Year 2021

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 1. Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first birthday. 2. 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. 3. 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 19: 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 20: 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 21: 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 22: Quality Improvement Project 3 Summary – Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication, Measurement Year 2021

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 23: 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 24: 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 25: Quality Improvement Project 4 Summary – Lead Screening, Measurement Year 2021

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.

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.
▪ Distributed Rhode Island Department of Health-developed lead screening educational materials at marketing events targeted to parents with children. 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 26: 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 27: Quality Improvement Project 5 Summary – Care for Older Adults, Measurement Year 2021

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

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.

4. Pain assessment

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 28: 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 29: 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 30: 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 31: 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 32: Quality Improvement Project 6 Summary – Transitions of Care, Measurement Year 2021

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.

Managed Care Plan-Focused 2021 Interventions

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.
▪ 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 33: 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 34: 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.

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. Neighborhood contracted with Symphony Performance Health to serve as its HEDIS vendor and Attest Health Care Advisors to serve as its HEDIS Compliance Auditor.

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 35 displays these standards as well as the elements audited for the standard.

Table 35: 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 36 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 36: 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 24).

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

Neighborhood'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 auditor for Neighborhood.

Performance Measure Results

This section of the report explores the utilization of Neighborhood's 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 37 displays Neighborhood's HEDIS rates for measurement years 2019, 2020 and 2021, as well as the national Medicaid benchmarks achieved by the managed care plan, and the national Medicaid means.

Table 37: Neighborhood's HEDIS Rates, Measurement Years 2019 to 2021

Domain/Measures	Neighborhood Measurement Year 2019	Neighborhood Measurement Year 2020	Neighborhood 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	First Year Measure	76.45%	73.43%	95th	54.04%
Well-Child Visits in the First 30 Months of Life – First 15 to 30 Months	First Year Measure	85.63%	79.74%	90th	66.04%
Child and Adolescent Well-Care Visits (Total)	First Year Measure	53.46%	61.26%	75th	49.55%
Effectiveness of Care					
Cervical Cancer Screening for Women	74.21%	73.83%	71.95%	95th	56.26%
Chlamydia Screening for Women (Total)	68.85%	63.19%	65.23%	66.67th	55.15%
Childhood Immunization Status – Combination 3	78.66%	80.15%	76.59%	90th	63.08%
Childhood Immunization Status – Combination 10	59.95%	62.31%	61.33%	95th	35.94%
Comprehensive Diabetes Care – HbA1c Testing	90.38%	81.05%	89.02%	75th	85.28%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	54.33%	55.92%	54.20%	75th	38.53%
Follow-Up After Hospitalization for Mental Illness – 30 Days (Total)	72.77%	73.82%	74.55%	90th	58.86%
Access and Availability					
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	81.43%	78.96%	78.01%	75th	72.60%
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	89.97%	87.92%	87.50%	75th	81.24%
Adults' Access to Preventive/Ambulatory Health Services – 65+ Years	95.77%	93.47%	92.74%	90th	82.26%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	96.11%	95.86%	92.25%	90th	83.53%
Prenatal and Postpartum Care – Postpartum Care	87.59%	88.08%	87.79%	95th	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 held contracts with seven accountable entities:

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

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

Figure 1. Breast Cancer Screening

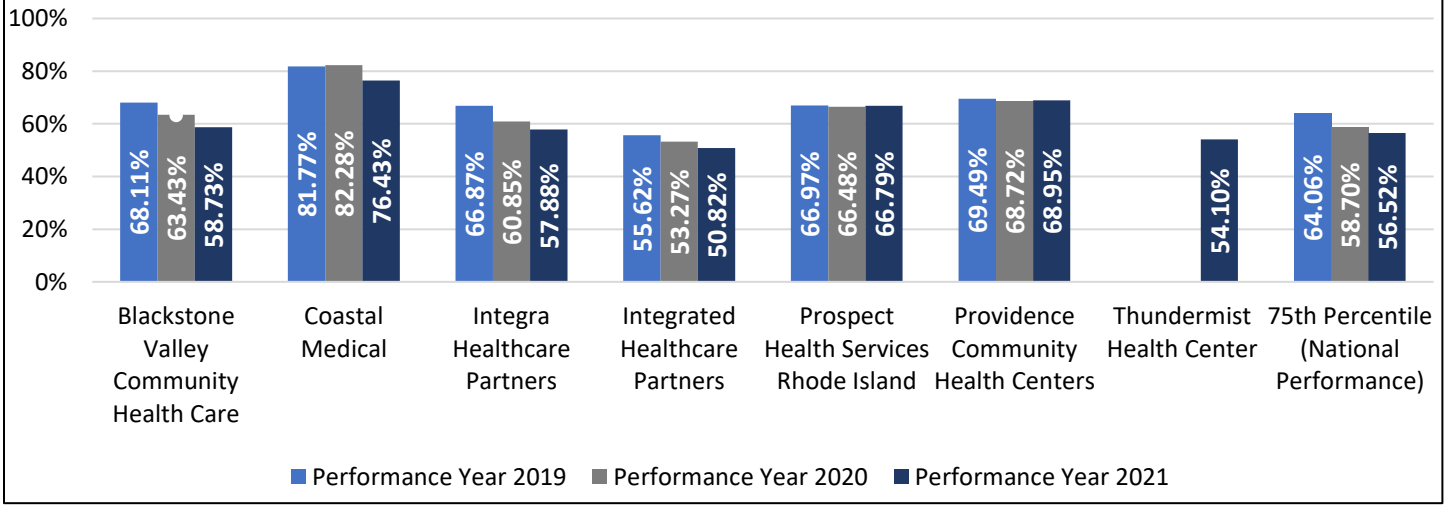


Figure 2. Comprehensive Diabetes Care - Eye Exam

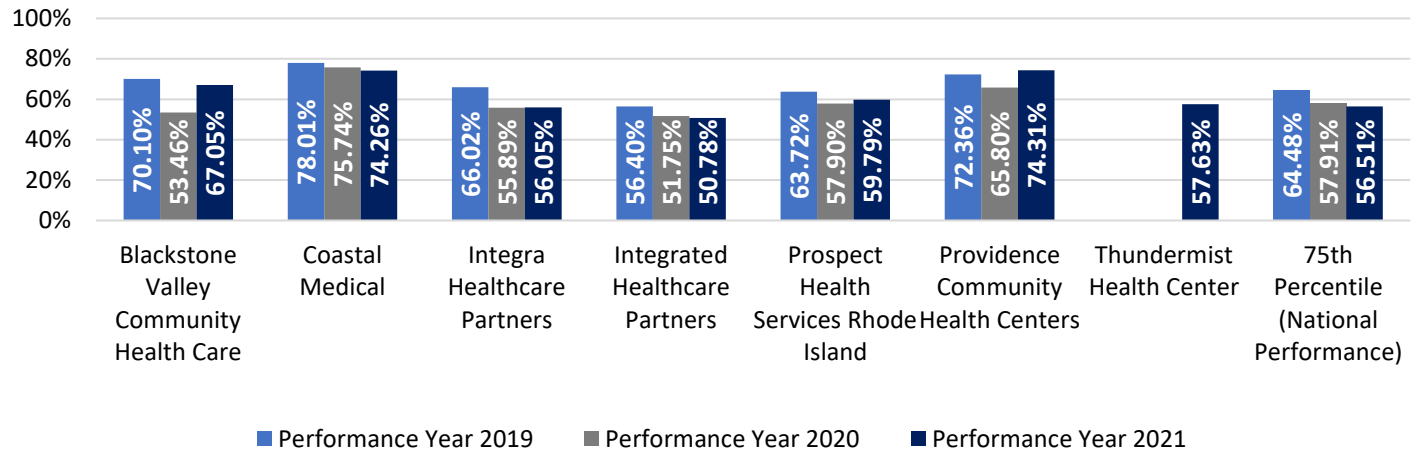


Figure 3. Comprehensive Diabetes Care - HbA1c Control (<8.0)

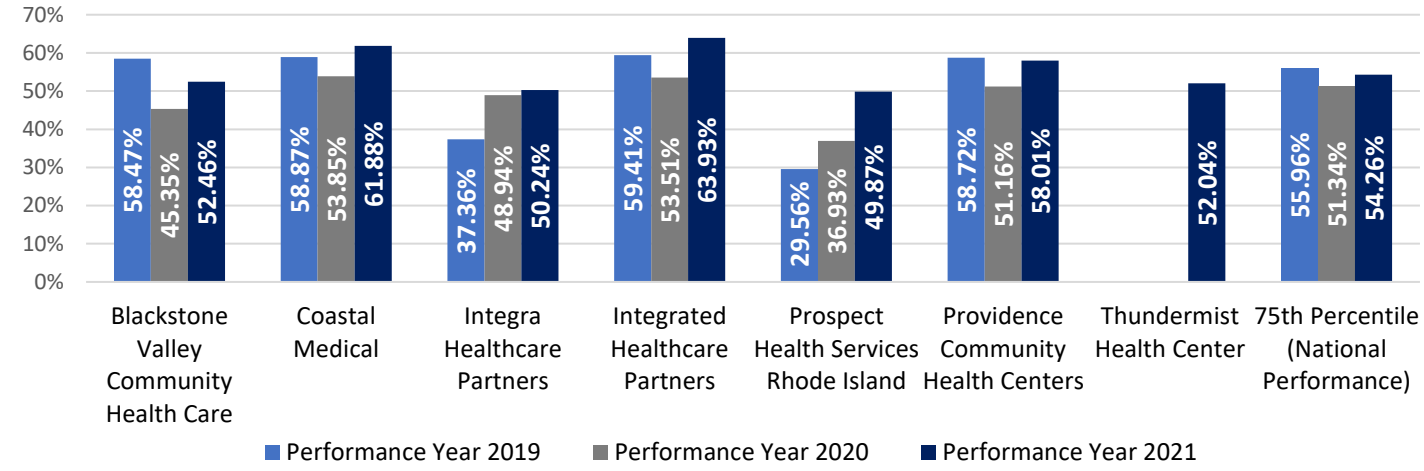


Figure 4. Controlling High Blood Pressure

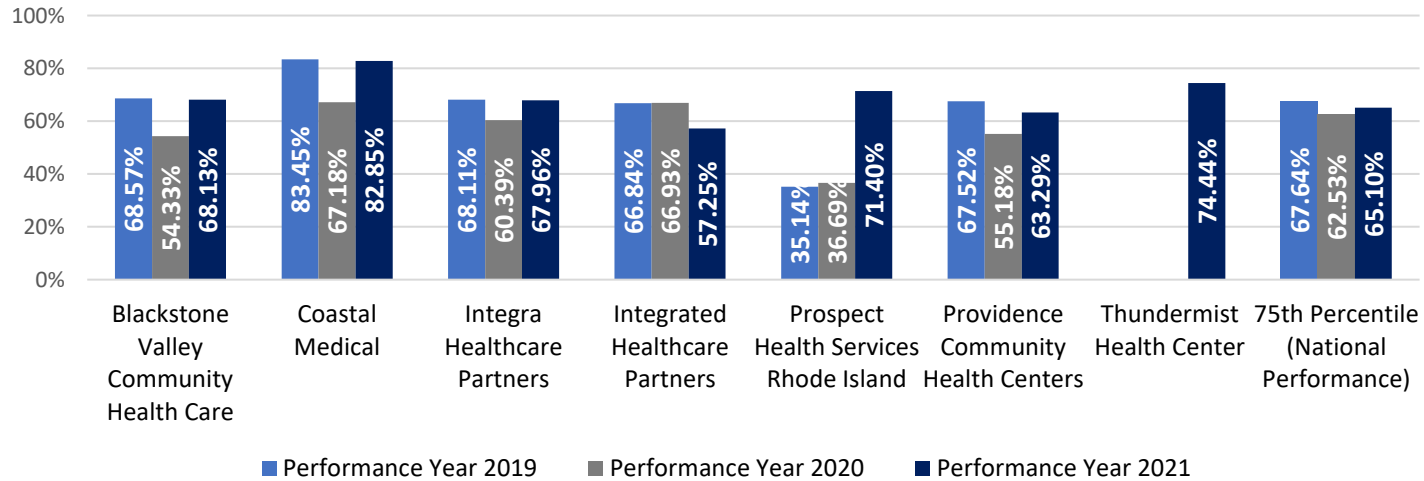


Figure 5. Follow-Up After Hospitalization for Mental Illness - 7 Days

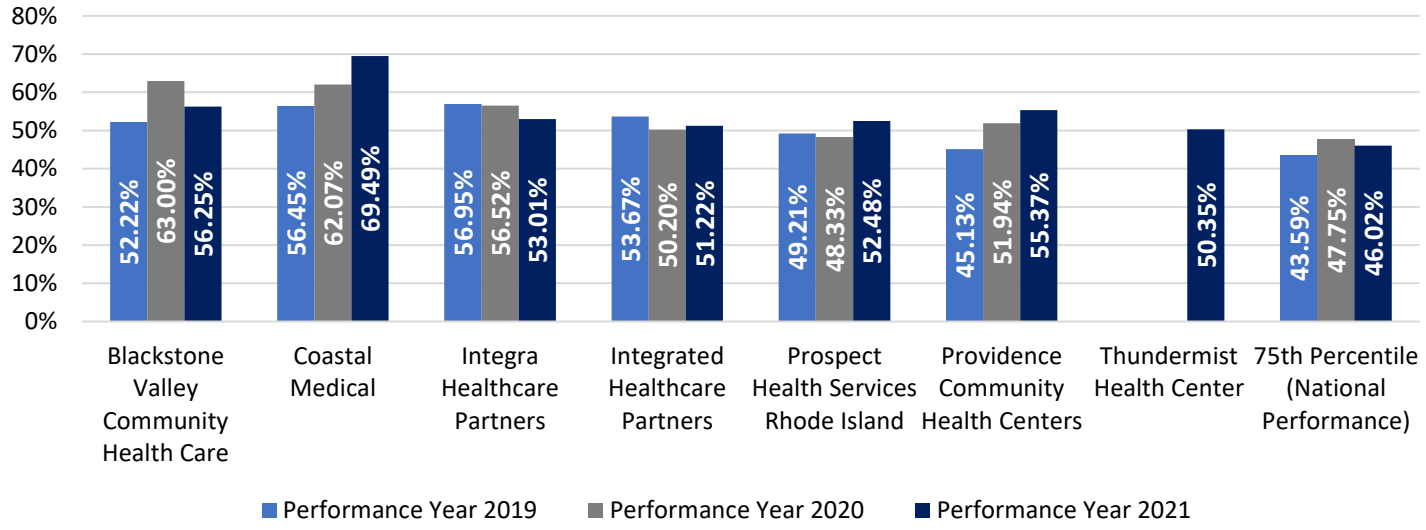


Figure 6. Developmental Screening in the First Three Years of Life

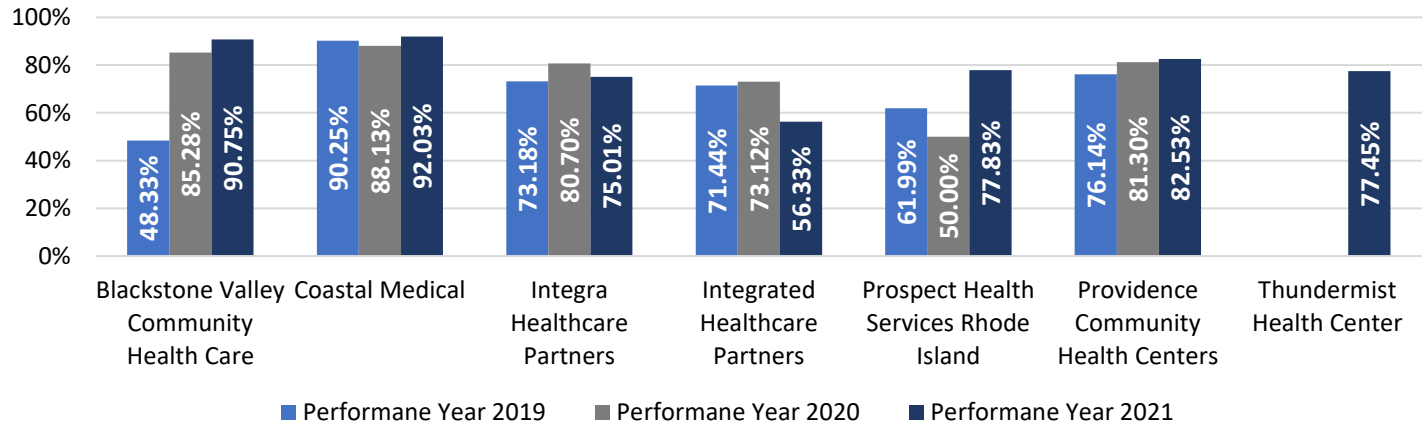


Figure 7. Screening for Depression and Follow-up Plan

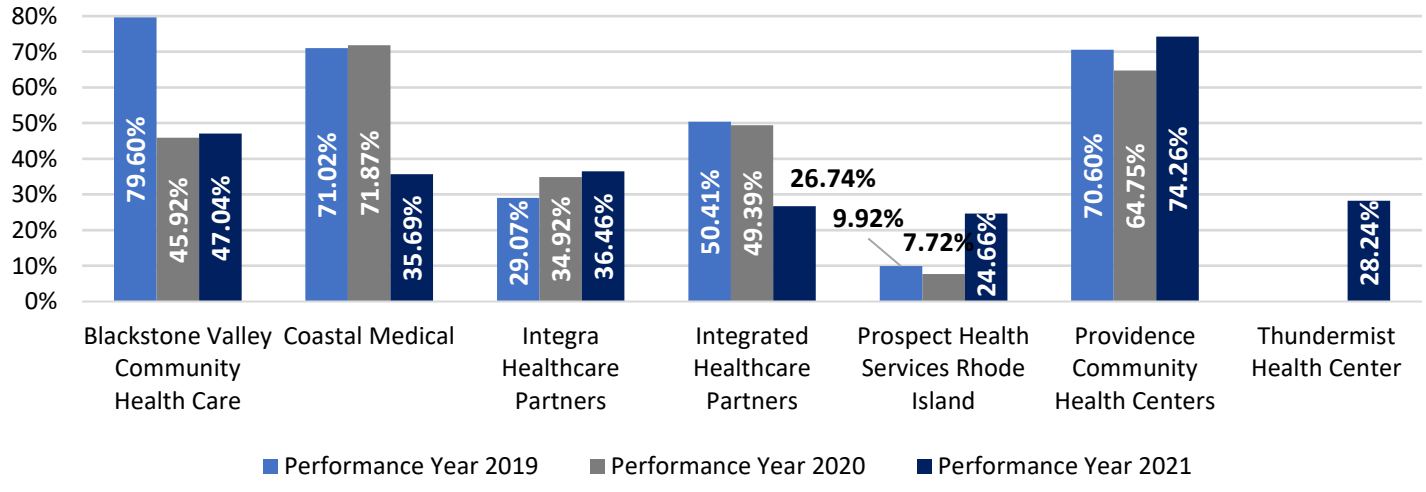
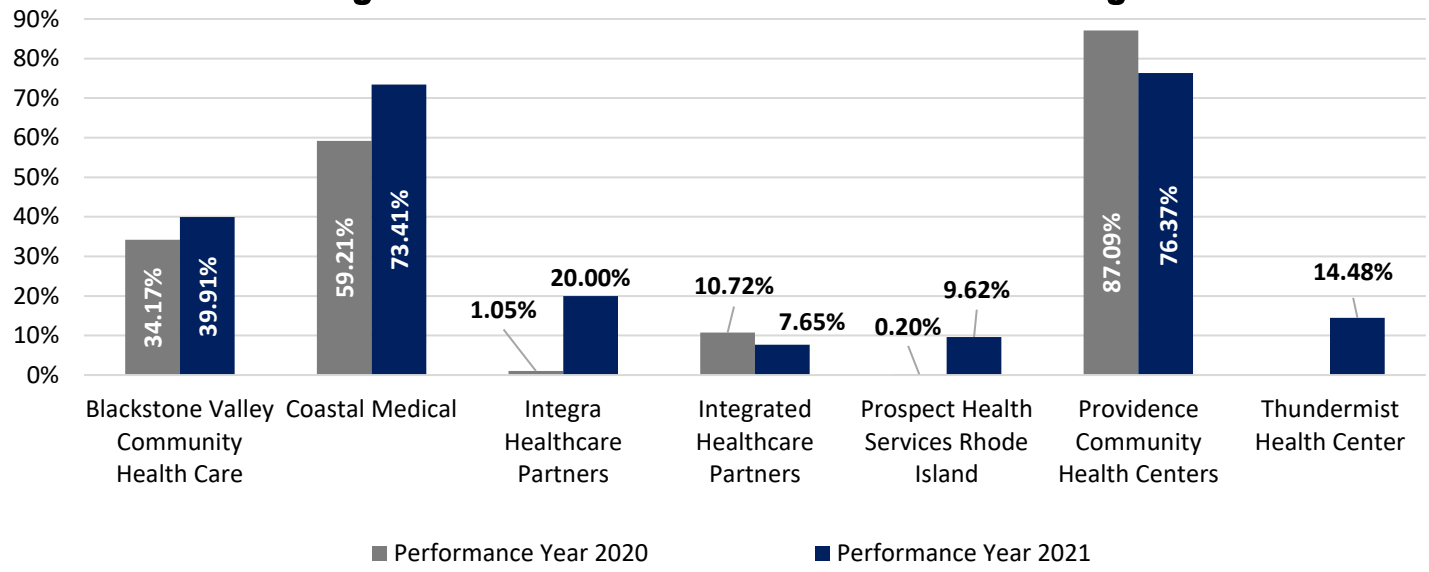


Figure 8. Social Determinants of Health Screening



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

Neighborhood's accreditation was granted by NCQA on October 29, 2020. Table 38 displays Neighborhood's compliance with federal Medicaid standards captured during the most recent NCQA Accreditation Survey.

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

Table 38: Evaluation of Neighborhood's Compliance with Federal Medicaid Standards, 2020

Part 438 Subpart D and Subpart E 438.330	Neighborhood Results
438.206: Availability of services	1 Element Partially Met
438.207: Assurances of adequate capacity and services	Met
438.208: Coordination and continuity of care	Met
438.210: Coverage and authorization of services	Met
438.214: Provider selection	Met
438.224: Confidentiality	Met
438.228: Grievance and appeal system	Met
438.230: Sub-contractual relationships and delegation	1 Element Not Met
438.236: Practice guidelines	Met
438.242: Health information systems	Met
438.330: Quality assessment and performance improvement program	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 39.

Table 39: 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 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.

Description of Data Obtained

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

Comparative Results

Table 40 shows the percentage of members for whom the geographic access standards were met. The results of this analysis show that Neighborhood exceeded its geographic accessibility standards for all provider types reported.

Table 40: 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%
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 41 displays 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 41: 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%

Provider Type/Appointment Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]
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%
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%

Technical Summary – Validation of Member 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 *2.13.05 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 Medicaid Health Plan Survey (with the chronic conditions measurement set). 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 42 provides a summary of the technical methods of data collection.

Table 42: CAHPS Technical Methods of Data Collection, Measurement Year 2021

Methodology Element	Adult CAHPS Survey	Child CAHPS Survey
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%

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 43 displays these categories and the measures which these response categories are used.

Table 43: 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 44 displays the results of the 2022 CAHPS Adult Medicaid Survey for measurement year 2021 while Table 45 displays the results of the 2022 CAHPS Child Medicaid 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 44: Neighborhood's Adult CAHPS Results, Measurement Years 2019 to 2021

Measures	Neighborhood Measurement Year 2019	Neighborhood Measurement Year 2020	Neighborhood 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]	85.46%	90.15%	87.31%	95th	77.98%
Rating of All Health Care	77.69%	82.10%	75.74%	33.33rd	75.41%
Rating of Personal Doctor[1]	85.34%	83.19%	85.34%	66.67th	82.38%
Rating of Specialist[1]	86.27%	88.36%	87.16%	75th	83.52%
Getting Care Quickly[2]	86.16%	85.93%	83.43%	50th	80.22%
Getting Needed Care[2]	87.39%	88.14%	84.71%	66.67th	81.86%
Customer Service[2]	91.86%	89.17%	88.92%	33.33rd	88.91%
How Well Doctors Communicate[2]	93.79%	92.00%	92.72%	33.33rd	92.51%
Coordination of Care[2]	89.45%	84.32%	86.21%	50th	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."

Table 45: Neighborhood's Child CAHPS Results, Measurement Years 2019 to 2021

Measures	Neighborhood Measurement Year 2019	Neighborhood Measurement Year 2020	Neighborhood 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]	92.55%	92.21%	89.80%	75th	86.48%
Rating of All Health Care	88.84%	89.29%	88.27%	50th	87.34%
Rating of Personal Doctor[1]	91.44%	91.59%	90.79%	50th	90.18%
Rating of Specialist[1]	Small Sample	Small Sample	Small Sample	Not Applicable	86.54%
Getting Care Quickly[2]	89.11%	90.81%	85.74%	33.33rd	86.74%
Getting Needed Care[2]	88.17%	89.38%	88.19%	75th	84.19%
Customer Service[2]	Small Sample	Small Sample	Small Sample	Not Applicable	88.06%
How Well Doctors Communicate[2]	91.97%	95.51%	93.21%	33.33rd	94.18%
Coordination of Care[2]			86.21%	50th	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*, Neighborhood administers the Provider Satisfaction Survey annually. The objective of this survey is to assess provider perception of Neighborhood's Medicaid operations and services to better understand strengths, pain points, and opportunities. Additionally, Neighborhood aimed to meet or exceed applicable benchmarks, and to achieve an overall satisfaction goal of 62%.

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 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 46: 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 47 displays the measures and the response options that were used.

Table 47: 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.

Description of Data Obtained

IPRO received a copy of the 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.

Comparative Results

Table 48 displays the survey questions and results for measurement years 2019, 2020, and 2021.

Table 48: Provider Satisfaction Performance Summary, Measurement Years 2019 to 2021

Measures	Neighborhood Summary Rate Measurement Year 2019	Neighborhood Summary Rate Measurement Year 2020	Neighborhood Summary Rate Measurement Year 2021	2020 SPHA Medicaid Book of Business Summary Rate
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.

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 49 displays the accreditation determination levels and points needed to achieve each level.

Table 49: 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 50.

Table 50: 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.

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.

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

Neighborhood achieved overall health plan star ratings of 4.5 out of 5 for the *Health Plan Ratings 2022.* Table 51 displays Neighborhood's 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 51: Neighborhood's NCQA Rating by Category, 2022

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

Neighborhood's Response 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 52 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2020 external quality review recommendations. Table 53 displays Neighborhood's 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 52: 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 53: 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.

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

Neighborhood's 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 Neighborhood's 2021 performance, as well recommendations for improving quality, timeliness, and access to care are presented in **Table 54**. 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 54: 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 Transitions from	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
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 Child and	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
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
Quality of Care Surveys – Provider Satisfaction	Neighborhood demonstrated performance decline between measurement years 2020	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	and 2021 on two measures of provider satisfaction.			
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

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.