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Rhode Island Medicaid Managed Care Program
Tufts Health Public Plan
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 Tufts Health Public Plan, 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.

Medicaid Managed Care Plan Profile

Tufts Health Public Plan is a not-for-profit health maintenance organization. Table 7 displays Tufts Health Public Plan's enrollment for year-end 2018 through year-end 2021, as well as the percent change in enrollment each year, according to data reported to the Office of Health and Human Services. The data presented here may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. Tufts Health Public Plan's enrollment increased by 23% from 14,075 members in 2020 to 17,363 members in 2021.

Table 7: Tufts Health Public Plan's Enrollment, 2018 to 2021

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

Tufts Health Public Plan Quality Improvement Program, 2021

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. Tufts Health Public Plan's *Tufts Health Quality Improvement Plan* (revised October 2020) met these requirements.

Objectives

Tufts Health Public Plan's quality improvement program aims is to continuously improve the quality and safety of clinical care and services members receive, including physical and behavioral health and substance abuse care; assure adequate access to and availability of clinical care and services; increase member and provider satisfaction; improve the quality of service providers and members receive from the managed care plan; and improve the health and wellness of members while managing health care costs. Table 8 displays Tufts Health Public Plan's quality improvement objectives as reported in the *Tufts Health Quality Improvement Plan* (revised October 2020).

Table 8: Tufts Health Public Plan Quality Improvement Objectives, 2021

Tufts Health Public Plan Quality Improvement Program Objectives, 2021
▪ Continuously and systematically monitor the quality of member care, through various mechanisms, to improve member health outcomes, access to care, evaluate the quality of care through the application of objective criteria, identify problems and opportunities to improve quality of care, implement appropriate and coordinated member and provider-directed actions to improve the quality and safety of member care, and evaluate the impact of corrective interventions. ▪ Ensure that quality improvement activities, interventions and decision making are supported by quantitative and qualitative data collections as appropriate, and as directed by the Centers for Medicare & Medicaid Services and/or the Office of Health and Human Services (including, but not limited to HEDIS, CAHPS, QHP CAHPS (ESS) data, Health Outcomes Survey (HOS), and Part D metrics. ▪ Foster a supportive environment to help practitioners and providers improve the safety of their practices, through member and provider education, and to link technology solutions to patient safety and quality improvements.

Tufts Health Public Plan Quality Improvement Program Objectives, 2021
▪ Arrange for the provision of cost-effective health care by qualified physicians, other designated licensed independent practitioners, and organizational providers. ▪ Monitor the use and ongoing evaluation of up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals, or where evidence-based practice guidelines do not exist, consensus of health care professionals or professionals with expertise in the assessment and delivery of long-term services and supports. ▪ Identify potential areas of corporate risk due to adverse patient occurrences associated with care or service, to intervene, to prevent and reduce the occurrences that lead to liability; and to manage risk and minimize losses. ▪ Outline Tufts Health Public Plan's approach to address the cultural and linguistic needs of membership. ▪ Ensure that quality improvement activities are conducted in a culturally competent manner. ▪ Incorporate experience from members and providers with respect to clinical quality, access and availability, cultural competence of care and services, and continuity and coordination of care in the design, planning, and implementation of quality improvement activities, including but not limited to member and provider satisfaction surveys and member advisory councils or boards. ▪ Coordinate quality activities with the Utilization Management Program. ▪ Assess, participate in, and/or implement programs and initiatives that improve the health and wellness of identified segments of the member community in accordance with the Centers for Medicare & Medicaid Services and the Office of Health and Human Services quality improvement goals and requirements and public health needs and goals, including programs to impact members with complex health needs (physical/developmental disabilities, chronic conditions and severe mental illness) and to increase preventive health services; ▪ Monitor, assess and develop quality improvement activities to assure appropriate access and availability of quality clinical care and services. ▪ Provide seamless continuity and coordination of care and transitions of care across the health care continuum. ▪ Ensure that policies and procedures and processes are in place through which clinical quality, access and availability of health care and services and coordination of care are assured. Processes include but are not limited to appeals and grievances and utilization management.

Quality Improvement Activities

Tufts Health Public Plan's quality improvement program is intended to comprehensively address access and availability, quality and safety of clinical care and the quality of service, including primary and specialty care services, behavioral health and substance use services, community based services and long term services and supports providers and services available to members through contracted providers in all settings in which care is delivered to members. There are seven primary components:

1. Ongoing Monitoring and Evaluation
2. Continuous Quality Improvement
3. Customer Satisfaction
4. Practitioner/Provider Credentialing
5. Member Risk Management: Fraud Prevention and Recovery Unit Drug Utilization Program
6. Utilization Management
7. Patient Safety

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

Tufts Health Public Plan's HEDIS compliance auditor determined that the HEDIS rates reported by the managed care plan for measurement year 2021 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. Further, there were no data collection or reporting issues identified by the HEDIS compliance auditor. Table 10 displays the results of the NCQA Information System Capabilities review for Tufts Health Public Plan.

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

Information Systems Capabilities Standards	Tufts Health Public Plan 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 four quality improvement projects led by Tufts Health Public Plan for its Medicaid membership in measurement year 2021.

Table 11: Tufts Health Public Plan's Quality Improvement Project Topics, 2021

Tufts Health Public Plan's Quality Improvement Project Topics, 2021
1. Promote Doula Program for Maternal and Child Health
2. Member Experience and Retention
3. Flu Vaccine
4. Behavioral Health Telehealth

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

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

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

Description of Data Obtained

For the 2021 external quality review, IPRO reviewed managed care plan quality improvement project reports. These reports included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

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

Quality Improvement Project 1 – Promote Doula Program for Maternal and Child Health

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

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

Quality Improvement Project 2 – Member Experience and Retention

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

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

Table 13 displays a summary of the validation results of Tufts Health Public Plan's quality improvement projects that were conducted for measurement year 2021. Summaries of each quality improvement project immediately follow.

Table 13: Tufts Health Public Plan's Quality Improvement Project Validation Results, Measurement Year 2021

Quality Improvement Project Topic	Selected Topic	Study Question	Indicators	Population	Sampling Methods	Data Collection Procedures	Interpretation of Results	Improvement Strategies
Doula Program for Maternal and Child Health	Met	Insufficient Data	Insufficient Data	Insufficient Data	Not Applicable	Insufficient Data	Insufficient Data	Insufficient Data
Member Experience and Retention	Not Met	Not Met	Insufficient Data	Met	Not Applicable	Not Met	Met	Met
Flu Vaccine	Met	Met	Met	Met	Not Applicable	Met	Met	Met
Behavioral Health Telehealth	Met	Met	Met	Met	Met	Met	Met	Met

Table 14: Quality Improvement Project 1 Summary – Promotion of Doula Program, Measurement Year 2021

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

Table 15: Quality Improvement Project 1 Indicator Summary – Promotion of Doula Program

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

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

Table 16: Quality Improvement Project 2 Summary – Member Experience and Retention, Measurement Year 2021

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

Table 17: Quality Improvement Project 2 Indicator Summary – Member Experience and Retention

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

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

Table 18: Quality Improvement Project 3 Summary – Flu Vaccine, Measurement Year 2021

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

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

Table 19: Quality Improvement Project 3 Indicator Summary – Flu Vaccine

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

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

Table 20: Quality Improvement Project 4 Summary – Behavioral Health Telehealth, Measurement Year 2021

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

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

Table 21: Quality Improvement Project 4 Indicator Summary – Behavioral Health Telehealth

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

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

Technical Summary – Validation of Performance Measures

Objectives

Title 42 Code of Federal Regulations 438.330(c) Performance measurement establishes that the state must *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. Tufts Health Public Plan 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 22 displays these standards as well as the elements audited for the standard.

Table 22: 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 23 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 23: 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 23).

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

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

Performance Measure Results

This section of the report explores the utilization of Tufts Health Public Plan'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 24 displays Tufts Health Public Plan's HEDIS rates for measurement years 22020 and 2021, as well as the national Medicaid benchmarks achieved by the managed care plan, and the national Medicaid means.

Table 24: Tufts Health Public Plan's HEDIS Rates, Measurement Years 2020 and 2021

Domain/Measures	Tufts Health Public Plan Measurement Year 2020	Tufts Health Public Plan 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	48.13%	44.55%	10th	54.04%
Well-Child Visits in the First 30 Months of Life – First 15 to 30 Months	69.43%	69.39%	50th	66.04%
Child and Adolescent Well-Care Visits (Total)	42.75%	46.85%	33.33rd	49.55%
Effectiveness of Care				
Cervical Cancer Screening for Women	38.93%	40.88%	<10th	56.26%
Chlamydia Screening for Women (Total)	46.98%	56.51%	50th	55.15%
Childhood Immunization Status – Combination 3	72.08%	70.89%	75th	63.08%
Childhood Immunization Status – Combination 10	49.81%	55.04%	95th	35.94%
Comprehensive Diabetes Care – HbA1c Testing	74.80%	78.10%	<10th	85.28%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	53.75%	63.78%	95th	38.53%
Follow-Up After Hospitalization for Mental Illness – 30 Days (Total)	67.50%	43.78%	10th	58.86%
Access and Availability				
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	57.92%	56.91%	<10th	72.60%
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	66.53%	67.24%	<10th	81.24%
Adults' Access to Preventive/Ambulatory Health Services – 65+ Years	Small Sample	63.37%	<10th	82.26%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	66.67%	76.44%	10th	83.53%
Prenatal and Postpartum Care – Postpartum Care	60.14%	73.78%	25th	76.18%

Small sample means that the denominator was less than 30 members.

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

Tufts Health Public Plan's accreditation was granted by NCQA on April 29, 2020. Table 25 displays Tufts Health Public Plan's compliance with federal Medicaid standards captured during the most recent NCQA Accreditation Survey. It was determined that Tufts Health Public Plan was fully compliant with the standards *42 Code of Federal Regulations Part 438 Subpart D* and *Subpart E 438.330*.

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

Table 25: Evaluation of Tufts Health Public Plan's Compliance with Federal Medicaid Standards, 2020

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

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 26.

Table 26: 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

Rhode Island Medicaid Managed Care Access Standards
▪ Physical Exam Within 180 Calendar Days
▪ 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

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

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

Description of Data Obtained

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

Comparative Results

Table 27 displays aggregate results of the secret shopper appointment availability surveys conducted by Tufts Health Public Plan in January 2021 and July 2021. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 27: Tufts Health Public Plan's Appointment Availability Survey Results, January 2021 and July 2021

Provider Type/Appointment Type	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]
Primary Care Routine Appointments				
Family/General/Internal	85	36	42.35%	61.11%
Pediatricians	71	9	12.68%	55.56%
Obstetrics/Gynecology	3	3	100.00%	33.33%
Primary Care Urgent Appointments				
Family/General/Internal	105	41	39.05%	19.51%
Pediatricians	63	9	14.29%	77.78%
Obstetrics/Gynecology	1	1	100.00%	0.00%
Adult Specialty Care Routine Appointments				
Cardiology	22	7	31.82%	42.86%
Dermatology	15	9	60.00%	44.44%
Endocrinology	3	2	66.67%	0.00%
Gastroenterology	7	4	57.14%	25.00%
Pulmonary	10	3	30.00%	66.67%
Adult Specialty Care Urgent Appointments				
Cardiology	24	5	20.83%	0.00%
Dermatology	7	5	71.43%	20.00%
Endocrinology	5	2	40.00%	0.00%
Gastroenterology	11	4	36.36%	0.00%
Pulmonary	12	2	16.67%	0.00%
Pediatric Specialty Care Routine Appointments				
Allergy/Immunology	1	1	100.00%	0.00%
Gastroenterology	3	2	66.67%	0.00%
Neurology	13	3	23.08%	100.00%
Orthopedics	12	6	50.00%	100.00%
Otolaryngology/Ear, Nose and Throat	5	1	20.00%	100.00%
Pediatric Specialty Care Urgent Appointments				
Allergy/Immunology	Not Surveyed	Not Applicable	Not Applicable	Not Applicable
Gastroenterology	1	1	100.00%	0.00%
Neurology	12	0	0.00%	Not Applicable
Orthopedics	18	13	72.22%	46.15%
Otolaryngology/Ear, Nose and Throat	4	3	75.00%	0.00%
Behavioral Health Care Routine Appointments				
Adult Behavioral Health	101	22	21.78%	86.36%
Pediatric/Adolescent Behavioral Health	15	0	0.00%	Not Applicable

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

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

Objectives

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

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

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

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

Technical Methods of Data Collection and Analysis

The standardized survey instrument selected for measurement year 2021 was the CAHPS 5.1H Adult Medicaid Health Plan Survey.

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 28 provides a summary of the technical methods of data collection.

Table 28: CAHPS Technical Methods of Data Collection, Measurement Year 2021

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

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

Table 29: 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 30 displays the results of the 2022 CAHPS Adult 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 30: Tufts Health Public Plan's Adult CAHPS Results, MY 2018-MY 2020

Measures	Tufts Health Public Plan CAHPS Measurement Year 2019	Tufts Health Public Plan CAHPS Measurement Year 2020	Tufts Health Public Plan CAHPS 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]	72.3%	72.1%	75.8%	25th	77.98%
Rating of All Health Care	Small Sample	76.0%	Small Sample	Not Applicable	75.41%
Rating of Personal Doctor[1]	89.7%	82.3%	81.8%	33.33rd	82.38%
Rating of Specialist[1]	Small Sample	Small Sample	Small Sample	Not Applicable	83.52%
Getting Care Quickly[2]	Small Sample	Small Sample	Small Sample	Not Applicable	80.22%
Getting Needed Care[2]	Small Sample	Small Sample	Small Sample	Not Applicable	81.86%
Customer Service[2]	Small Sample	Small Sample	Small Sample	Not Applicable	88.91%
How Well Doctors Communicate[2]	Small Sample	Small Sample	Small Sample	Not Applicable	92.51%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	Not Applicable	83.96%

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

[2] Rates reflect responses of "always" or "usually."

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

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

Objectives

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

Section *2.13.06 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*, Tufts Health Public Plan administers the 'RITogether' Provider Satisfaction Study annually. The objectives of this survey are to evaluate providers' satisfaction with various aspects of working with Tufts Health Public Plan and to compare provider perception of Tufts Health Public Plan to other Rhode Island Medicaid managed care plans.

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

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

Table 31 provides a summary of the technical methods of data collection.

Table 31: Provider Satisfaction Technical Methods of Data Collection, Measurement Year 2021

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

The 36-question 2021 survey instrument was similar to the 2020 instrument. Table 32 displays these categories and the measures which these response categories are used.

Table 32: Provider Satisfaction Survey Categories and Response Options

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

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

Description of Data Obtained

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

Comparative Results

Table 34 displays the survey questions and results for the 'overall measures' for measurement years 2019, 2020, and 2021.

Table 33: Provider Satisfaction Performance Summary, Measurement Years 2019 to 2021

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

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

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

Table 34: 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 35.

Table 35: 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

Tufts Health Public Plan was compliant with the state's requirement to achieve and maintain NCQA Accreditation. The managed care plan's 'Accredited' status is effective April 29, 2020 to April 29, 2023.

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

Tufts Health Public Plan achieved overall health plan star ratings of 3.5 out of 5 for the *Health Plan Ratings 2022.* Table 36 displays Tufts Health Public Plan'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 36: Tufts Health Public Plan's NCQA Rating by Category, 2022

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

Tufts Health Public Plan'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 37 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2020 external quality review recommendations. Table 38 displays Tufts Health Public Plan'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 37: 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 38: Tufts Health Public Plan's Response to the 2020 External Quality Review Recommendations

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

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

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

Tufts Health Public Plan'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 Tufts Health Public Plan's 2021 performance, as well recommendations for improving quality, timeliness, and access to care are presented in **Table 39**. 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 39: Tufts Health Public Plan's Strengths, Opportunities, and Recommendations, Measurement Year 2021

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	Tufts Health Public Plan maintained NCQA accreditation in 2021.	X	X	X
Quality Improvement Projects – General	Two of four quality improvement projects passed validation.			
Performance Measures	Tufts Health Public Plan met all information systems and validation requirements to successfully report HEDIS data to the Office of Health and Human Services and to NCQA.			
Performance Measures – Effectiveness of Care	Tufts Health Public Plan reported three measurement year 2021 rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	Tufts Health Public Plan is compliant with the standards of *Code of Federal Regulations Part 438 Subpart D* and *438.330*.	X	X	X
Network Adequacy	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality of Care Survey – Member Satisfaction	None.			
Quality of Care Survey – Provider Satisfaction	Though not statistically significant, Tufts Health Public Plan demonstrated performance improvement in provider perception of the managed care plan being a strong collaborator in quality patient care and a valuable partner for primary care clinicians in a crisis.	X		
Opportunities for Improvement				
Quality Improvement Projects	Two of four quality improvement projects did not pass validation.			
Performance Measures – Use of Services	Tufts Health Public Plan reported three measurement year 2021 rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Performance Measures – Effectiveness of Care	Tufts Health Public Plan reported four measurement year 2021 rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Performance Measures – Access and Availability	Tufts Health Public Plan reported five measurement year 2021 rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	Appointment availability among the surveyed providers was low.		X	X
Quality of Care Surveys – Member Satisfaction	Tufts Health Public Plan achieved two measurement year 2021 scores for the adult survey that benchmarked below the national Medicaid 75th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	Tufts Health Public Plan demonstrated performance decline in overall provider satisfaction.	X	X	X
Recommendations				
Quality Improvement Projects	To ensure future quality improvement project methodologies are effectively designed and managed, Tufts Health Public Plan staff should utilize the standardized NCQA *Quality Improvement Activity Form*, and fully address issues identified by the external quality review organization.	X	X	X
Compliance with Medicaid Standards	Tufts Health Public Plan should conduct routine monitoring to ensure compliance is maintained.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures	Tufts Health Public Plan should continue to utilize HEDIS results in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Tufts Health Public Plan should focus on child and adult primary care utilization rates, women's health, and chronic conditions.	X	X	X
Network Adequacy	Tufts Health Public Plan should investigate opportunities to improve member access to care.		X	X
	For future appointment availability surveys, Tufts Health Public Plan should establish a minimum sample size by specialty to increase the overall validity of the results. In the absence of a state-established threshold for timely appointments, Tufts Health Public Plan should identify a threshold to work toward.		X	X
Quality of Care Survey – Member Satisfaction	Tufts Health Public Plan should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid 75th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	Tufts Health Public Plan should work to improve contract management practices and the timeliness of the dispute process for denied claims.	X		

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.