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Rhode Island Medicaid Managed Care Program
UnitedHealthcare Community Plan of Rhode Island
2021 External Quality Review
Annual Technical Report
April 2023

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

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About This Report

External Quality Review and Annual Technical Report Requirements

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

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

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

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

2021 External Quality Review

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

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

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

Table 1: External Quality Review Activity Descriptions and Applicable Protocols

External Quality Review Activity	Applicable External Quality Review Protocol	Activity Description
Activity 1. Validation of Performance Improvement Projects (Required)	Protocol 1	IPRO reviewed 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 ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
RIte Care Substitute Care	Children in legal custody of the State Department of Children, Youth and Families	▪ Neighborhood Health Plan of Rhode Island
RIte Care for Children with Special Health Care Needs	A Medicaid managed care plan for children with a disability or chronic condition who qualify for supplemental security income, Katie Beckett or adoption subsidy through the Department of Children, Youth, and Families.	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rhody Health Expansion	A Medicaid managed care plan for low-income adults aged 19-64 years with no dependent children.	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rhody Health Partners	A Medicaid managed care plan for eligible adults with disabilities who are 21 years or older.	▪ Neighborhood Health Plan of Rhode Island ▪ Tufts Public Health Plan ▪ UnitedHealthcare Community Plan of Rhode Island
Rite Smiles	A dental managed care plan for children enrolled in Medicaid and born on or after May 1, 2000.	▪ United Healthcare Dental

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

Rhode Island Medicaid Quality Strategy, 2019-2022

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

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

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

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

Rhode Island Medicaid Managed Care Quality Strategy Goals
1. Maintain high level managed care performance on priority clinical quality measures.
2. Improve managed care performance on priority measures that still have room for improvement.
3. Improve perinatal outcomes.
4. Increase coordination of services among medical, behavioral, and specialty services and providers
5. Promote effective management of chronic disease, including behavioral health and comorbid conditions.
6. Analyze trends in health disparities and design interventions to promote health equity.
7. Empower members in their healthcare by allowing more opportunities to demonstrate a voice and choice.
8. Reduce inappropriate utilization of high-cost settings

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

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

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

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

Accountable Entity Program

Rhode Island contends that a core part of the Medicaid quality strategy is the integration of accountable entities into the Medicaid managed care delivery system. Accountable entities represent interdisciplinary partnerships between providers with strong foundations in primary care that also work to address services outside of the traditional medical model which includes behavioral health and social support services. Rhode Island's Accountable Entity Program seeks to achieve the following goals for Medicaid managed care: transition Medicaid from fee-for-service to value-based purchasing at the provider level; focus on total cost of care; create population-based accountability for an attributed population; build interdisciplinary care capacity that extends beyond traditional health care providers; deploy new forms of organization to create shared incentives across a common enterprise; and apply emerging data capabilities to refine and enhance care management, pathways, coordination, and timely responsiveness to emergent needs.

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

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

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

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

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

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

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

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

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

Alternative Payment Models

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

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

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

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

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

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

Early Periodic Screening, Diagnosis and Treatment

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

Patient Centered Medical Homes

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

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

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

NCQA Accreditation

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

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

IPRO's Assessment of the Rhode Island Medicaid Quality Strategy

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

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

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

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

Medicaid Managed Care Plan Profile

UnitedHealthcare Community Plan of Rhode Island is a for-profit health maintenance organization. Table 7 displays UHCCP-RI enrollment for year-end 2018 through year-end 2021, as well as the percent change in enrollment each year, according to data reported to Rhode Island Medicaid. The data presented may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. UHCCP-RI's enrollment increased by 6% from 92,899 members in 2020 to 98,367 members in 2021.

Table 7: UHCCP-RI's Medicaid Enrollment, 2018 to 2021

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

UHCCP-RI's Quality Strategy, 2021-2022

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. UHCCP-RI's *2021-2022 Population Health Management Strategy* (March 2021) and *2021 Quality Management Work Plan Activities,* together, met these requirements.

The overarching goal of UHCCP-RI's strategy is to provide members with preventive services and tools needed to promote wellness and to assist at risk individuals and those with complex conditions to better manage their conditions with a resultant decrease in morbidity and mortality. The strategy covers these four major areas:

1. keeping members healthy,
2. managing members with emerging risk,
3. addressing patient safety or outcomes across settings, and
4. managing members with multiple complex illnesses.

For each of these identified areas, UHCCP-RI has developed specific programs or interventions that address the unique needs of our membership.

Table 8 displays UHCCP-RI's quality improvement objectives as reported in the *2021 Quality Improvement Work Plan Activities*.

Table 8: UHCCP-RI's Quality Improvement Objectives, 2021

UHCCP-RI Quality Improvement Objectives, 2021-2022
▪ Continue to strengthen partnerships with accountable care organizations to help improve quality outcomes. ▪ Continue to build upon the UHCCP-RI Quality and Optum Behavioral Health Quality and Network Management teams as it relates to analysis, barrier identification and opportunities for improvement related to behavioral health measures. ▪ Continue to build upon the HEDIS UHCCP-RI National Quality Solutions Delivery Medical Record Review strategy. ▪ Continue to increase data capture through pre-HEDIS medical record review and supplemental data sources to reduce the disruption to practitioners during the medical record review season. ▪ Continue to work toward achievement of *Quality Compass* Medicaid 90th percentile for the Medicaid All Lines of Business *Quality Compass* HEDIS quality measures deemed critical. ▪ Continue to strive toward meeting at least the 67th percentile for the Medicaid All Lines of Business Quality Compass for the Adult and Child CAHPS surveys. ▪ Continue to achieve improvement in provider satisfaction survey results over previous years. ▪ Continue analysis work on the four quality improvement projects agreed upon with the Office of Health and Human Services not meeting benchmark and determine barriers and opportunities for improvement.

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 25).

Comparative Results

UHCCP-RI'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 UHCCP-RI. Table 10 displays the results of the UHCCP-RI's information systems capabilities review conducted as part of the HEDIS Compliance Audit for measurement year 2021.

Table 10: UHCCP-RI's NCQA Information Systems Capabilities Standards, Measurement Year 2021

Information Systems Capabilities Standards	UHCCP-RI 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 UHCCP-RI for its Medicaid membership in measurement year 2021.

Table 11: UHCCP-RI's Quality Improvement Project Topics, 2021

UHCCP-RI's Quality Improvement Project Topics, 2021
1. Improving Effective Acute Phase Treatment for Major Depression
2. Developmental Screening in the 1st, 2nd, 3rd Years of Life
3. Improving Lead Screening in Children
4. Improving Breast Cancer Screening

Technical Methods of Data Collection and Analysis

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

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

1. Review of the selected study topic(s) for relevance of focus and for relevance to the managed care plan's enrollment.

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

Following IPRO's evaluation of the 2021 *Quality Improvement Activity Form* completed by the managed care plan for each quality improvement project against the review elements listed above, determinations of "met" and "not met" were used for each element under review. Definitions of these review determinations are presented in Table 12.

Table 12: Review Determination Definitions

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

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

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

Description of Data Obtained

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

Comparative Results

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

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

Table 13: UHCCP-RI's Quality Improvement Project Validation Results, Measurement Year 2021

UHCCP-RI's Quality Improvement Project (QIP) Validation Results				
Validation Element	QIP 1	QIP 2	QIP 3	QIP 4
Selected Topic	Met	Met	Met	Met
Study Question	Met	Met	Met	Met
Indicators	Met	Met	Met	Met
Population	Met	Met	Met	Met
Sampling Methods	Met	Met	Met	Met
Data Collection Procedures	Met	Met	Met	Met
Interpretation of Study Results	Met	Met	Met	Met
Improvement Strategies	Met	Met	Met	Met

Table 14: Quality Improvement Project 1 Summary – Treatment for Depression, Measurement Year 2021

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

Aim

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

Indicator of Performance

HEDIS *Antidepressant Medication Management – Effective Acute Phase*: The percentage of members 18 years of age and older who remain on their antidepressant medications during the 12-week effective acute phase treatment after being diagnosed with a new episode of depression and treated with antidepressant medications.

Member-Focused 2021 Interventions

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

Provider-Focused 2021 Interventions

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

Quality Improvement Project 1 Summary
Title: Improving Effective Acute Phase Treatment for Major Depression **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Managed Care Plan-Focused 2021 Interventions ▪ Implemented a 90-day supply of antidepressants to be filled at a pharmacy or through mail-order. ▪ Held monthly meetings throughout the entire year and focused on behavioral health quality measures. The meetings include UnitedHealthcare quality representatives, clinical services representatives, Optum behavioral health associates, as well as the health plan's pharmacist. Data was requested and analyzed to determine trends, including practitioners with poor performance on this measure. ▪ Created the Behavioral Health Link flyer on available resources to be utilized by clinical practice consultants, case managers, community health workers and marketing representatives as hand-outs and for community events.

Table 15: Quality Improvement Project 1 Indicator Summary – Treatment for Depression, Measurement Years 2009 to 2021

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

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

Table 16: Quality Improvement Project 2 Summary – Developmental Screening, Measurement Year 2021

Quality Improvement Project 2 Summary
Title: Developmental Screening in the 1st, 2nd, 3rd Years of Life **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHCCP-RI aimed to increase the percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first, second, and third birthdays. Indicators of Performance 1. Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first birthday. 2. Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their second birthday. 3. Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their third birthday. Member-Focused 2021 Interventions ▪ Targeted parents and guardians for Early and Periodic Screening, Diagnostic, and Treatment interactive voice recordings with a reminder to complete a routine check-up for children ages 2-21 years. In 2021, 27,997 calls were conducted. ▪ Distributed a developmental screening educational flyer to members who attended multiple community events. ▪ Conducted live outreach calls to remind heads of households to seek age-appropriate routine care for their children. In 2021 a total of 19,364 calls were conducted. ▪ Published articles on related topics in the member newsletter. Provider-Focused 2021 Interventions ▪ Added developmental screening as a pay-for-performance measure for all accountable entities. ▪ Met with accountable entities and high-volume sites (at least 100 members) to discuss current rates, opportunities for improvement with noncompliant members and share best practices from high performing provider sites. Managed Care Plan-Focused 2021 Interventions ▪ Executed a contract with a community-based organization to provide funds for a health worker to assist with expanding education and improving the health of community members within Central Falls. The education will encompass education regarding preventive measures, such as developmental screenings, as well as chronic care.

Table 17: Quality Improvement Project 2 Indicator Summary – First Year Developmental Screening, Measurement Years 2014 to 2021

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

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first birthday.

Table 18: Quality Improvement Project 2 Indicator Summary – Second Year Developmental Screening, Measurement Years 2014 to 2021

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

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their second birthday.

Table 19: Quality Improvement Project 2 Indicator Summary – Third Year Developmental Screening, Measurement Years 2014 to 2021

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

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

Indicator Description: Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their third birthday.

Table 20: Quality Improvement Project 3 Summary – Lead Screening, Measurement Year 2021

Quality Improvement Project 3 Summary
Title: Improving Lead Screening in Children **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHCCP-RI aimed to increase the percentage of members two years of age who received one or more capillary or venous blood tests for lead poising on or before their second birthday. Member-Focused 2021 Interventions ▪ Targeted parents and guardians for Early and Periodic Screening, Diagnostic, and Treatment interactive voice recordings with a reminder to complete a routine check-up for children ages 2-21 years. In 2021, 27,997 calls were conducted. ▪ Continued member incentive of a $25 gift card for completing lead testing. ▪ Published articles on related topics in the member newsletter. ▪ Distributed a lead screening educational flyer to members who attended multiple community events. Provider-Focused 2021 Interventions ▪ Discussed barriers and lessons learned with external participating practitioners who are committee members of the Provider Advisory Committee for the UnitedHealthcare Community Plan of Rhode Island. ▪ Distributed lists of members due for lead screening to providers. ▪ Initiated a pilot program with two accountable entities to improve housing environments of underserved population in Providence, Rhode Island. Managed Care Plan-Focused 2021 Interventions ▪ Executed a contract with a community-based organization to provide funds for a health worker to assist with expanding education and improving the health of community members within Central Falls. The education will encompass education regarding preventive measures, such as lead screenings, as well as chronic care.

Quality Improvement Project 3 Summary
Title: Improving Lead Screening in Children **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
▪ Continued to collaborate with the Rhode Island Department of Health's Lead Screening Evaluator and Neighborhood Health Plan of Rhode Island to identify barriers and opportunities for improvement. The group encouraged providers to conduct in-office capillary screenings or in-office blood tests and send samples via a currier to the State lab. ▪ Provided the Rhode Island Department of Health with member incentive information to share at the Rhode Island Department of Health's Lead Poisoning Prevention Coordination Group meetings in Central Falls, Pawtucket, Providence, and Woonsocket.

Table 21: Quality Improvement Project 3 Indicator Summary – Lead Screening, Measurement Years 2016 to 2021

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

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

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

Table 22: Quality Improvement Project 4 Summary – Breast Cancer Screening, Measurement Year 2021

Quality Improvement Project 4 Summary
Title: Improving Breast Cancer Screening **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim UHCCP-RI aimed to increase the percentage of women aged 50-74 years who had a mammogram. Member-Focused 2021 Interventions ▪ Continued member incentive of a $25 gift card for a timely mammogram. ▪ Conducted live outreach calls to members encouraging them to complete a well visit. ▪ Conducted targeted live outreach calls to members ages 45 to 64 years identified as needing an annual exam. A total of 1,508 calls were conducted between November 2021 and December 2021. ▪ Continued the monthly mailing to members with an upcoming birthday encouraging members to complete a well visit. ▪ Issued a women's health email encouraging members to get screened for breast cancer. ▪ Distributed a breast cancer screening educational flyer to members who attended multiple community events.

Quality Improvement Project 4 Summary
Title: Improving Breast Cancer Screening **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.

- Initiated the House Call Program for in-person appointments for members ages 26 years and older, who are not pregnant and need an annual exam. During the appointment, the importance of breast cancer screenings is discussed.
- Published articles on related topics in the member newsletter.

Provider-Focused 2021 Interventions

- Collaborated with an accountable entity on a health equity project to improve the rate of breast cancer screenings.
- Issued gaps in care lists to network obstetricians/gynecologists.

Managed Care Plan-Focused 2021 Intervention

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

Table 23: Quality Improvement Project 4 Indicator Summary – Breast Cancer Screening, Measurement Years 2017 to 2021

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

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

Technical Summary – Validation of Performance Measures

Objectives

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

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

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

Technical Methods of Data Collection and Analysis

For measurement year 2021, the Rhode Island Medicaid managed care plans were required to submit HEDIS performance measure data to the Office of Health and Human Services. To ensure compliance with reporting requirements, each managed care plan contracted with an NCQA-certified HEDIS vendor and an NCQA-certified HEDIS compliance auditor. UHCCP-RI 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 24 displays these standards as well as the elements audited for the standard.

Table 24: 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 25 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 25: Performance Measure Outcome Designations

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

NCQA: National Committee for Quality Assurance.

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

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

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

Description of Data Obtained

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

The Final Audit Report included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental data sources (e.g., immunization registries, care management files, laboratory result files), descriptions of system queries used by the auditor to validate the accuracy of the data, results of the medical record reviews, results of the information systems capabilities assessment, and rate status. Rates were determined to be reportable or not reportable (small denominator, benefit not offered, not reported, not required, biased, or unaudited; Table 24).

The Audit Review Table displayed performance-measure–level detail including data collection methodology (administrative or hybrid), eligible population count, exclusion count, numerator event count by data source (administrative, medical record, supplemental), and reported rate. When applicable, the following information was also displayed in the Audit Review Table: administrative rate before exclusions; minimum required sample size, and minimum required sample size numerator events and rate; oversample rate and oversample record count; exclusions by data source; count of oversample records added; denominator; numerator events by data source (administrative, medical records, supplemental); and reported rate.

Comparative Results

Validation of Performance Measures

UHCCP-RI'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 UHCCP-RI.

Performance Measure Results

This section of the report explores the utilization of UHCCP-RI'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 26 displays UHCCP-RI's HEDIS rates for measurement years 2019, 2020 and 2021, as well as the national Medicaid benchmarks achieved by the managed care plan, and the national Medicaid means.

Table 26: UHCCP-RI's HEDIS Rates, Measurement Years 2019 to 2021

Domain/Measures	UHCCP-RI Measurement Year 2019	UHCCP-RI Measurement Year 2020	UHCCP-RI Measurement Year 2021	*Quality Compass* Measurement Year 2021 National Medicaid Benchmark (Met/Exceeded)	*Quality Compass* Measurement Year 2021 National Medicaid Mean
Use of Services					
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure	64.98%	64.22%	75th	54.04%
Well-Child Visits in the First 30 Months of Life – First 15 to 30 Months	First Year Measure	78.34%	74.71%	75th	66.04%
Child and Adolescent Well-Care Visits (Total)	First Year Measure	53.83%	60.24%	75th	49.55%
Effectiveness of Care					
Cervical Cancer Screening for Women	66.91%	65.21%	65.21%	75th	56.26%
Chlamydia Screening for Women (Total)	65.88%	60.69%	60.24%	66.67th	55.15%
Childhood Immunization Status – Combination 3	77.86%	81.27%	76.89%	90th	63.08%
Childhood Immunization Status – Combination 10	59.37%	63.50%	63.26%	95th	35.94%
Comprehensive Diabetes Care – HbA1c Testing	90.51%	80.29%	89.05%	75th	85.28%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	54.38%	58.58%	56.29%	90th	38.53%
Follow-Up After Hospitalization for Mental Illness – 30 Days (Total)	73.85%	75.21%	76.31%	90th	58.86%
Access and Availability					
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	78.37%	75.42%	75.23%	50th	72.60%
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	87.03%	84.24%	84.52%	66.67th	81.24%
Adults' Access to Preventive/Ambulatory Health Services – 65+ Years	88.37%	82.70%	81.79%	33.33rd	82.26%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	90.27%	89.05%	84.67%	33.33rd	83.53%
Prenatal and Postpartum Care – Postpartum Care	71.53%	85.16%	82.73%	75th	76.18%

First Year Measure is not publicly reported.

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

For performance year 2021, UHCCP-RI held contracts with six accountable entities:

1. Coastal Medical
2. Integra Community Care Network
3. Integrated Healthcare Partners
4. Prospect Health Services Rhode Island
5. Providence Community Health Centers
6. Thundermist Health Center

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

Figure 1. Breast Cancer Screening

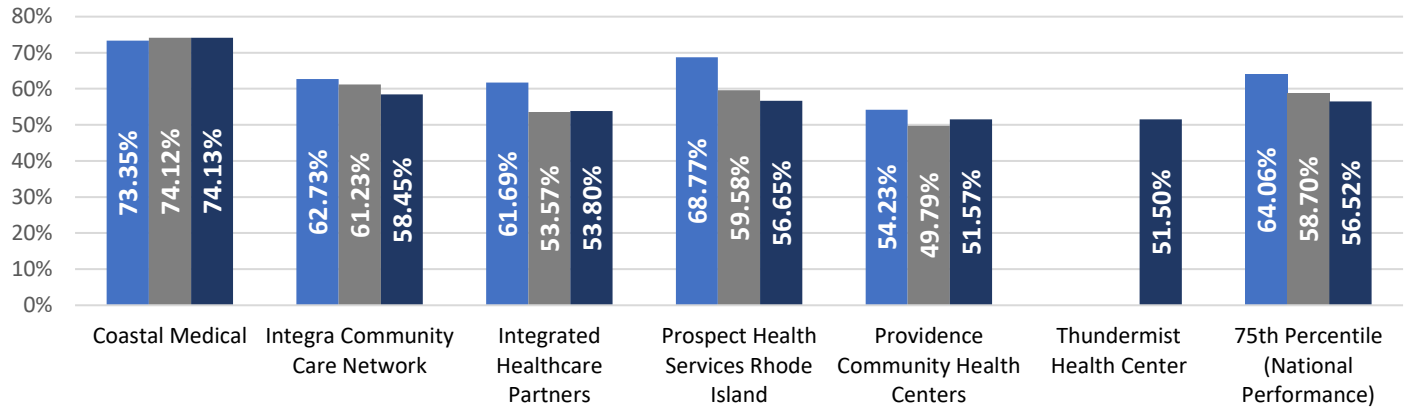


Figure 2. Comprehensive Diabetes Care - Eye Exam

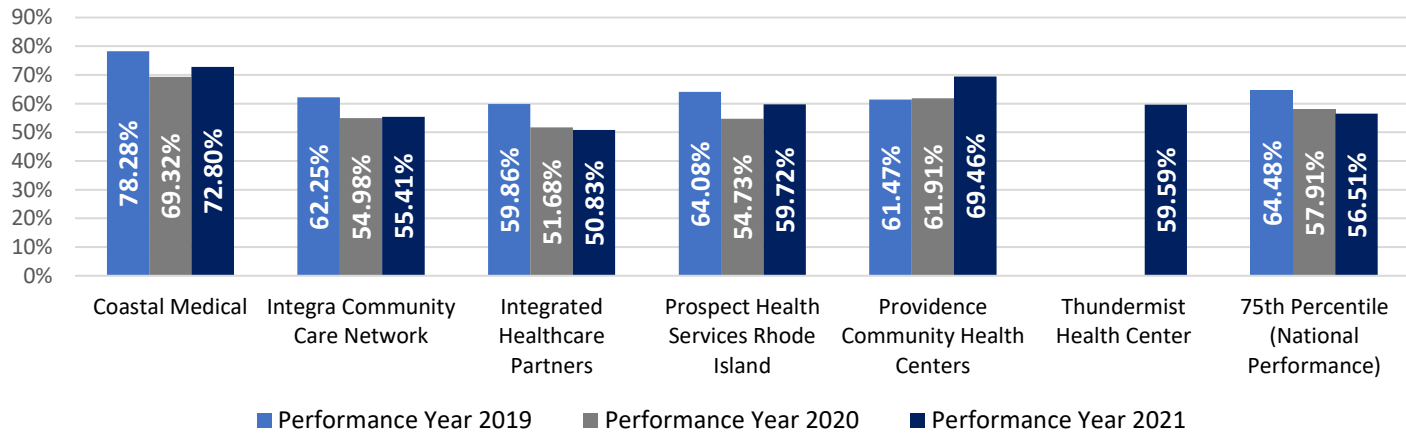


Figure 3. Comprehensive Diabetes Care - HbA1c Control (<8.0)

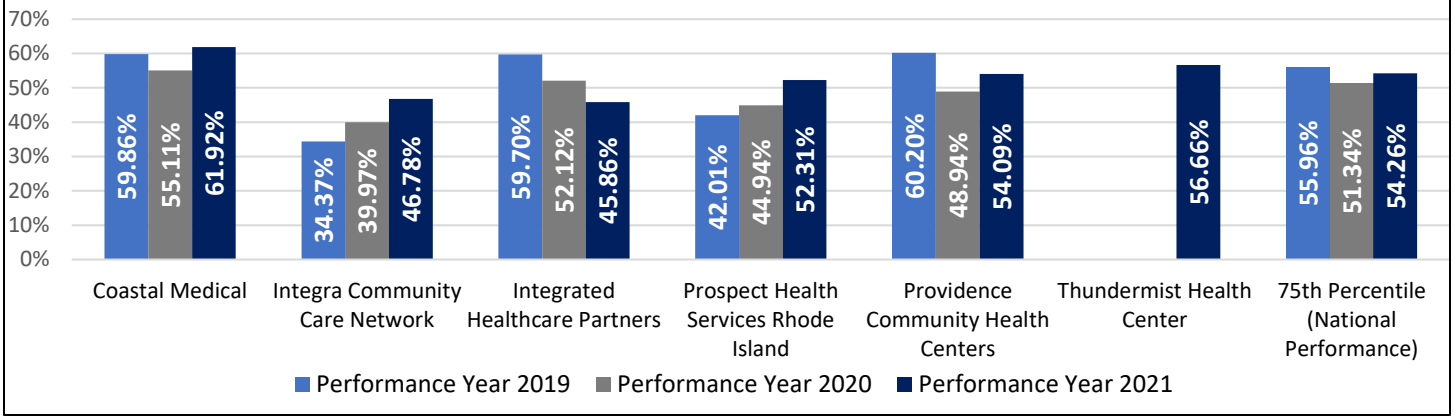


Figure 4. Controlling High Blood Pressure

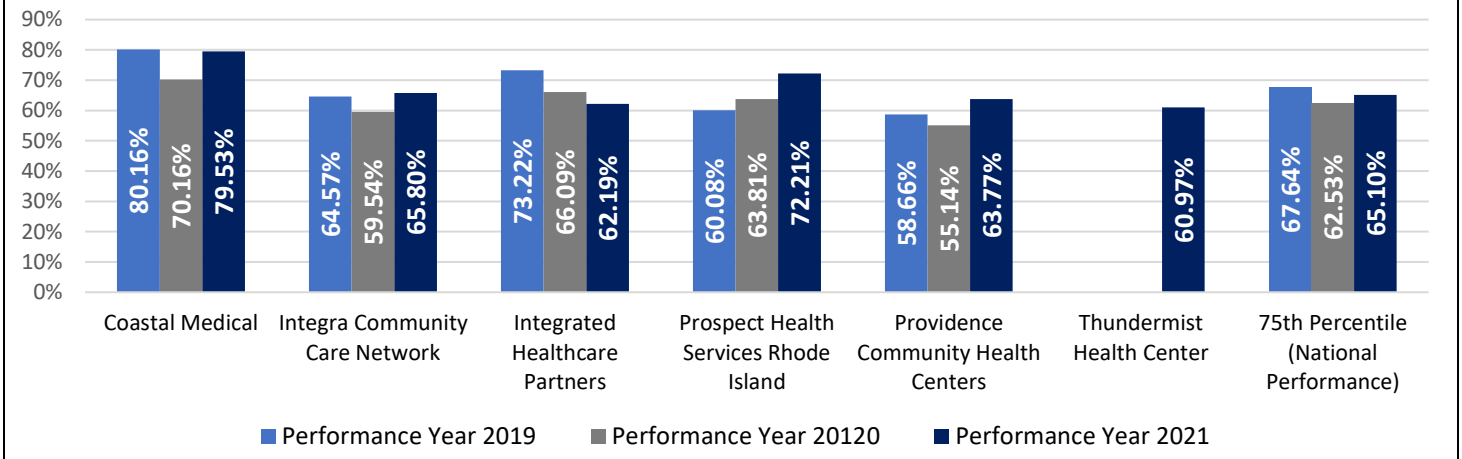


Figure 5. Follow-Up After Hospitalization for Mental Illness - 7 Days

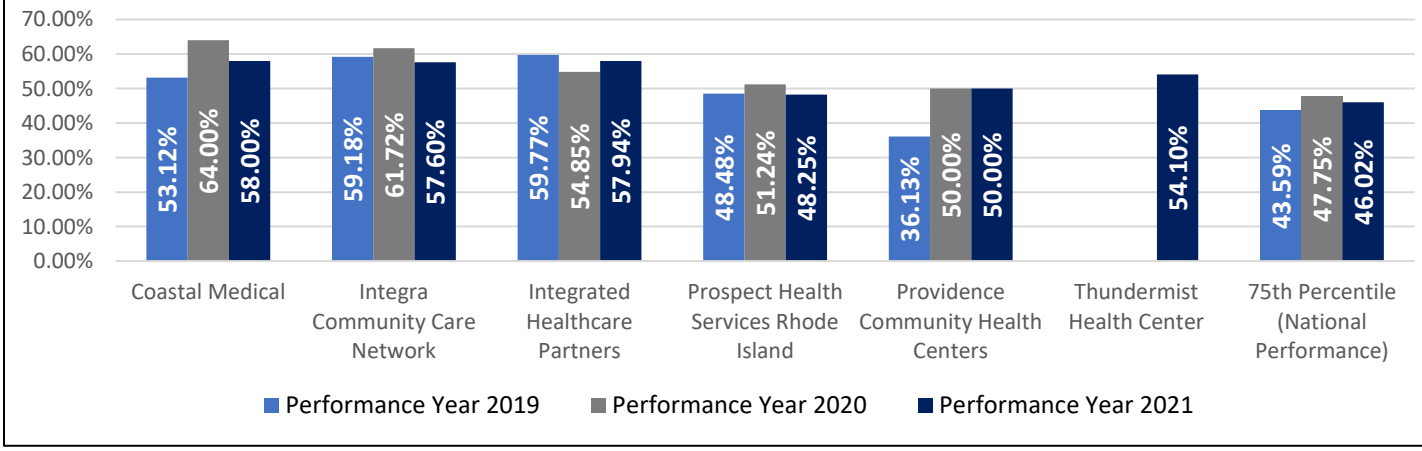


Figure 6. Developmental Screening in the First Three Years of Life

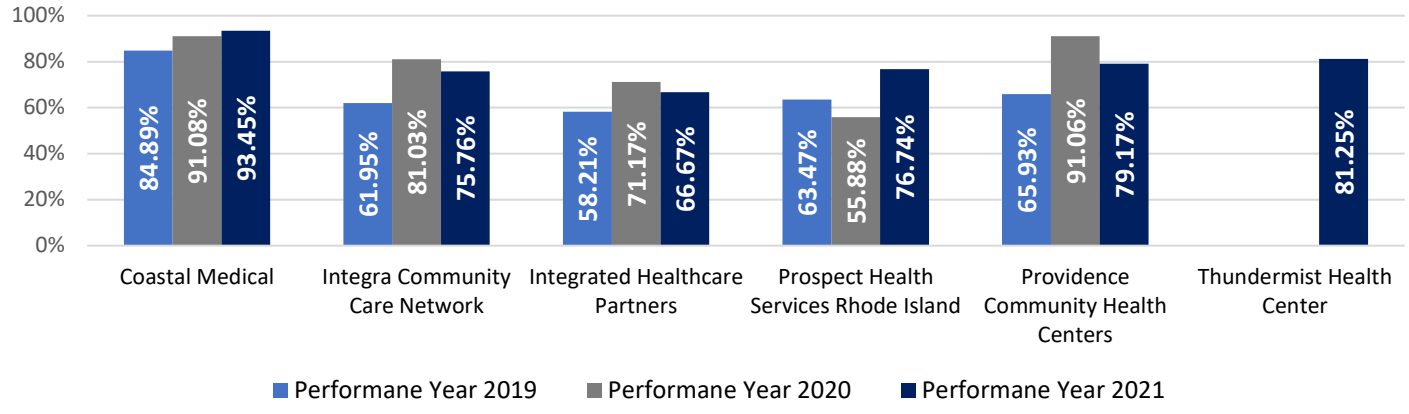


Figure 7. Screening for Depression and Follow-up Plan

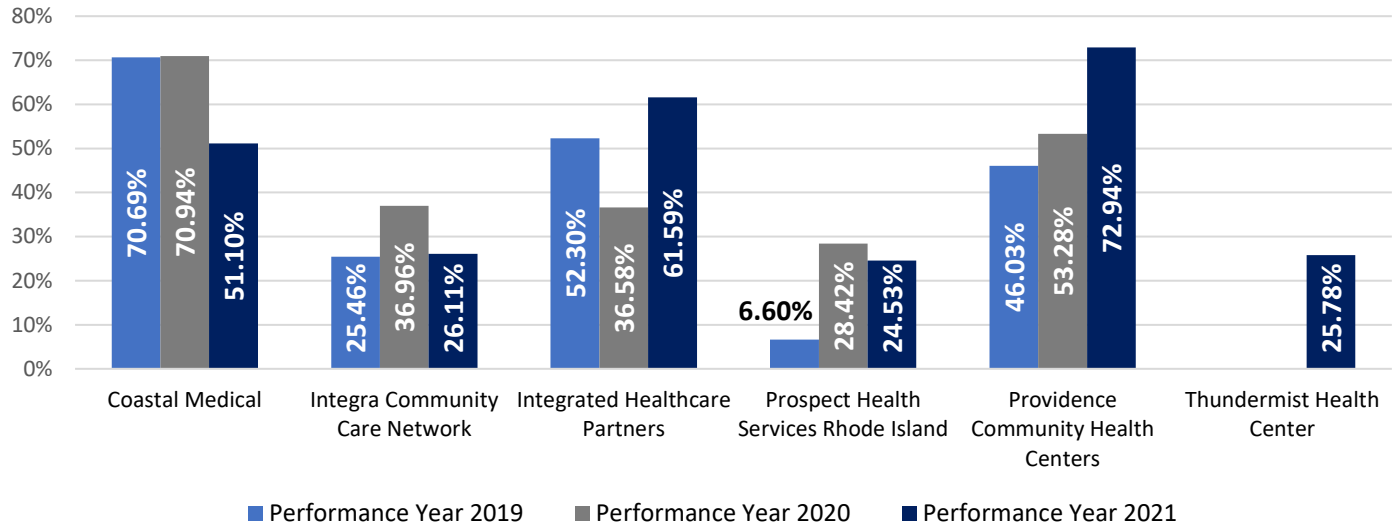
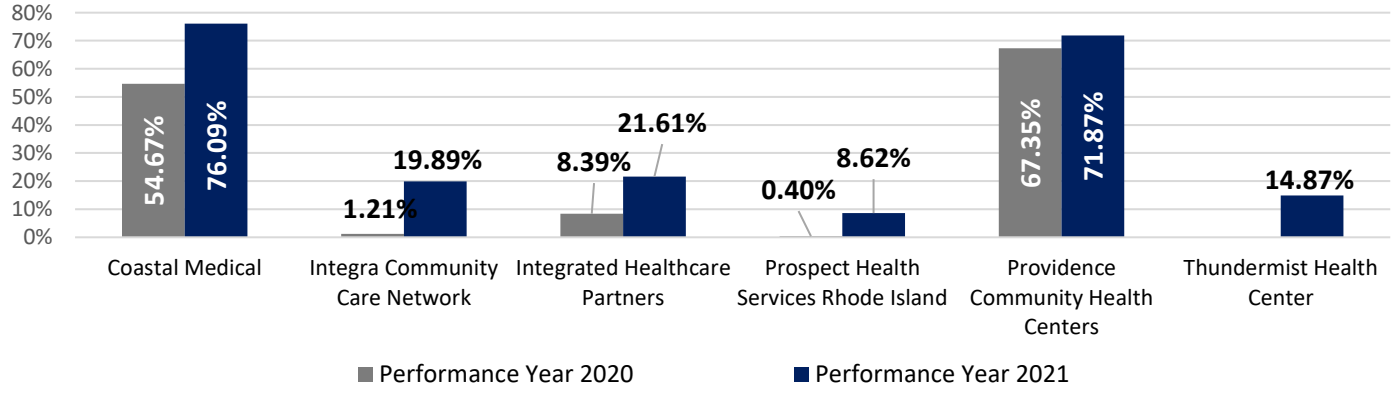


Figure 8. Social Determinants of Health Screening



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

Objectives

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

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

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

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

Technical Methods of Data Collection and Analysis

IPRO received NCQA Accreditation Survey results from each managed care plan and reviewed these results to verify managed care plan compliance with federal Medicaid standards of *42 Code of Federal Regulations Part 438 Subpart D* and *Subpart E 438.330*.

Description of Data Obtained

The *Score Summary Overall Results* presented Accreditation Survey results by category code, standard code, review category title, self-assessed score, current score, issues not met, points received and possible points. The crosswalk provided to IPRO by the Office of Health and Human Services included instructions on how to use the crosswalk, a glossary, and detailed explanations on how the NCQA accreditation standards support federal Medicaid standards.

Comparative Results

UHCCP-RI's accreditation was granted by NCQA on December 3, 2020. Table 27 displays UHCCP-RI's compliance with federal Medicaid standards captured during the most recent NCQA Accreditation Survey. It was determined that UHCCP-RI 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 27: Evaluation of UHCCP-RI's Compliance with Federal Medicaid Standards, 2020

Part 438 Subpart D and Subpart E 438.330	UHCCP-RI 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 28.

Table 28: 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

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

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

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

UHCCP-RI's goal is to have 90% of its network of primary care, high-volume, and high-impact providers meet the established distance requirements, as well as to meet provider-to-member ratios. The distance requirements and ratios differ by provider type and county designation.

Description of Data Obtained

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

Comparative Results

Table 29 shows the percentage of members for whom the geographic access standards were met. The results of this analysis show that UHCCP-RI met its geographic accessibility standards for all provider types reported.

Table 29: Geo Access Provider Network Accessibility, July 2019-June 2020, and July 2020 – June 2021

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

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

Table 30 displays aggregate results of the secret shopper appointment availability surveys conducted by UHCCP-RI in January 2021 and July 2021. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 30: Appointment Availability for Network Providers, January 2021, and July 2021

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

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

Objectives

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Methodology Element	Adult CAHPS Survey	Child CAHPS Survey
Survey Vendor	Symphony Performance Health, Inc.	Symphony Performance Health, Inc.
Survey Tool	5.1H Medicaid Adult	5.1H Medicaid Child
Survey Timeframe	2/22/2022-5/09/2022	2/22/2022-5/05/2022
Method of Collection	Mail, Telephone, Internet	Mail, Telephone, Internet
Sample Size	1,620	2,310
Response Rate	9.2%	6.8%

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

For the global ratings, composite measures, composite items, and individual item measures the scores were calculated using a 100-point scale. Responses were classified into response categories. Table 32 displays these categories and the measures which these response categories are used.

Table 32: 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 33 displays the results of the 2022 CAHPS Adult Medicaid Survey for measurement year 2021 while Table 34 displays the results of the 2022 CAHPS Child Medicaid Survey for measurement year 2021. The national Medicaid benchmarks displayed in these tables come from *NCQA's 2022 Quality Compass* for measurement year 2021.

Table 33: UHCCP-RI's Adult CAHPS Results, Measurement Years 2019 to 2021

Measures	UHCCP-RI 2020 CAHPS Measurement Year 2019	UHCCP-RI 2021 CAHPS Measurement Year 2020	UHCCP-RI 2022 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]	86.4%	80.6%	84.5%	90th	77.98%
Rating of All Health Care	79.6%	78.6%	80.4%	90th	75.41%
Rating of Personal Doctor[1]	79.9%	82.4%	82.4%	33.33rd	82.38%
Rating of Specialist[1]	Small Sample	Small Sample	Small Sample	Not Applicable	83.52%
Getting Care Quickly[2]	87.1%	82.0%	Small Sample	Not Applicable	80.22%
Getting Needed Care[2]	86.9%	81.4%	Small Sample	Not Applicable	81.86%
Customer Service[2]	Small Sample	Small Sample	Small Sample	Not Applicable	88.91%
How Well Doctors Communicate[2]	94.4%	90.6%	94.6%	75th	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.

Table 34: UHCCP-RI's Child CAHPS Results, Measurement Years 2019 to 2021

Measures	UHCCP-RI 2020 CAHPS Measurement Year 2019	UHCCP-RI 2021 CAHPS Measurement Year 2020	UHCCP-RI 2022 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]	86.6%	92.4%	86.8%	50th	86.48%
Rating of All Health Care	95.0%	88.4%	Small Sample	Not Applicable	87.34%
Rating of Personal Doctor[1]	92.7%	95.1%	94.3%	95th	90.18%
Rating of Specialist[1]	Small Sample	Small Sample	Small Sample	Not Applicable	86.54%
Getting Care Quickly[2]	94.2%	Small Sample	Small Sample	Not Applicable	86.74%
Getting Needed Care[2]	86.0%	Small Sample	Small Sample	Not Applicable	84.19%
Customer Service[2]	Small Sample	Small Sample	Small Sample	Not Applicable	88.06%
How Well Doctors Communicate[2]	96.9%	95.6%	94.1%	33.33rd	94.18%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	Not Applicable	84.71%

[1] Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the "best possible"). [2] Rates reflect responses of "always" or "usually."
Small Sample means that the denominator is less than 100 members.

Technical Summary – Validation of 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*, UHCCP-RI administers the Provider Satisfaction Survey annually. The objective of this survey is to assess provider perception of UHCCP-RI's Medicaid operations and services to better understand strengths, pain points, and opportunities.

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

Technical Methods of Data Collection and Analysis

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

Table 35 provides a summary of the technical methods of data collection.

Table 35: Provider Satisfaction Technical Methods of Data Collection, Measurement Year 2021

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

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

Description of Data Obtained

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

Comparative Results

Table 36 displays the provider survey measures and results for measurement years 2020 and 2021.

Table 36: Provider Satisfaction Survey Results, Measurement Years 2020 and 2021

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

N=Denominator.

Technical Summary – NCQA Accreditation

Objectives

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

NCQA's Health Plan Accreditation program is considered the industry's gold standard for assuring and improving quality care and patient experience. It reflects a commitment to quality that yields tangible, bottom-line value. It also ensures essential consumer protections, including fair marketing, sound coverage decisions, access to care, and timely appeals.

Technical Methods of Data Collection and Analysis

The accreditation process is a rigorous, comprehensive, and transparent evaluation process through which the quality of key systems and processes that define a health plan are assessed. Additionally, accreditation includes an evaluation of the actual results the health plan achieved on key dimensions of care, service, and efficacy. Specifically, NCQA reviews the health plan's quality management and improvement, utilization management, provider credentialing and re-credentialing, members' rights and responsibilities, standards for member connections, and HEDIS and CAHPS performance measures.

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

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

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

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

Within each standards category, the total number of points is added. The managed care plans can achieve 1 of 3 accreditation levels based on how they score on each standards category. Table 37 displays the accreditation determination levels and points needed to achieve each level.

Table 37: 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 38.

Table 38: NCQA Health Plan Star Rating Scale

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

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

Description of Data Obtained

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

IPRO also received from UHCCP-RI, the accreditation survey decision letter issued by NCQA, the certificate of accreditation issued by NCQA, and the NCQA 2020 Renewal Survey Summary for Medicaid. The accreditation decision survey decision letter included information about UHCCP-RI's accreditation status and level achieved, the effective dates of the accreditation, and tentative dates of future accreditation surveys. The certificate of

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

accreditation issued by NCQA displayed UHCCP-RI's accreditation status and level achieved, as well as the effective dates of the accreditation. The NCQA 2020 Renewal Survey Summary for Medicaid listed all the elements reviewed by NCQA during UHCCP-RI's accreditation survey and determinations of 'Met' or 'Not Met' issued to UHCCP-RI by element.

Comparative Results

UHCCP-RI was compliant with the state's requirement to achieve and maintain NCQA Accreditation. The managed care plan's 'Accredited' status is effective December 30, 2020 to December 30, 2023.

UHCCP-RI achieved overall health plan star ratings of 4 out of 5 for the *Health Plan Ratings 2022.* Table 39 displays UHCCP-RI'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 39: UHCCP-RI's NCQA Rating by Category, 2020

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

UHCCP-RI'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 40 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2020 external quality review recommendations. Table 41 displays UHCCP-RI'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 40: 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 41: UHCCP-RI's Response to the 2020 External Quality Review Recommendations

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

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

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

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

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

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

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

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

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

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

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

External Quality Review Activity	2020 External Quality Review Recommendation	UHCCP-RI's Response to the 2020 External Quality Review Recommendation	IPRO's Assessment of UHCCP-RI's Response
		care / quality of service concerns / complaints from members and trending of feedback from medical directors, nurse case managers and front-line staff. This ongoing monitoring has not detected any deficiencies in our network or access or availability issues for our members. • The results from the quarterly surveys are evaluated by a cross functional team which includes representation from Quality, Provider Network Management, Provider Programs, Optum Behavioral Health, and Provider Relations Advocates who meet to analyze the results and determine root causes and opportunities. Provider Relations Advocates contact each practice/ provider that was not able to make an appointment in accordance with the standards and they educate the provider office on the standard requirements and purpose of the survey. For some cases, the reasoning is justified such as the provide office is requesting the member's insurance card or medical records to make the appointment but not truly available in a secret shopper scenario. For areas identified as opportunities, Provider Relations Advocates mitigate issues such as working with the provider/ practice to update demographic data within the Health Plan systems, to ensure providers are aligned with the correct practice location, if the provider has moved or retired, if they've added new providers, or if their practice panel is closed to new patients. This discussion and assistance assure our Provider Directory provides an accurate assessment of our provider network. The Provider Relations Advocates also discuss how the existing practice providers can assist one another by covering for each other to meet the patient needs and access standards. In addition, when the survey results do not match what the Provider Advocates find when they discuss the findings with a practice/ provider, the actual survey call recording is requested to review and determine the underlining issue. This way the Provider Advocate is better able to assist the practice/ provider	

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

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

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

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

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

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

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

UHCCP-RI'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 UHCCP-RI's 2021 performance, as well recommendations for improving quality, timeliness, and access to care are presented in **Table 42**. 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 42: UHCCP-RI's Strengths, Opportunities, and Recommendations, Measurement Year 2021

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	UHCCP-RI maintained NCQA accreditation in 2021.	X	X	X
Quality Improvement Projects – General	Four of four quality improvement projects passed validation.			
Quality Improvement Project – Improving Effective Acute Phase Treatment for Major Depression	UHCCP-RI's measurement year 2021 rate for the single performance indicator exceeded the goal.	X	X	X
Quality Improvement Project – Developmental Screening in the 1st, 2nd, and 3rd Years of Life	UHCCP-RI's measurement year 2021 rates for the three performance indicators exceeded their respective goal.	X	X	X
Performance Measures	UHCCP-RI met all information systems and validation requirements to successfully report HEDIS data to the Office of Health and Human Services and to NCQA.			
Performance Measures – Use of Services	UHCCP-RI reported three measurement year 2021 HEDIS rates that benchmarked at the national Medicaid 75th percentile.	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Effectiveness of Care	UHCCP-RI reported six measurement year 2021 rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Performance Measures – Access and Availability	UHCCP-RI reported one measurement year 2021 rate that benchmarked at the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	UHCCP-RI is compliant with the standards of *Code of Federal Regulations Part 438 Subpart D* and *438.330*.	X	X	X
Network Adequacy	UHCCP-RI met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.		X	X
Quality of Care Survey – Member Satisfaction	UHCCP-RI achieved three scores on the adult survey that met or exceeded the national Medicaid 75th percentile.	X	X	X
	UHCCP-RI achieved one score on the child survey that exceeded the national Medicaid 75th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	None.			
Opportunities for Improvement				
Quality Improvement Project – Improving Lead Screening in Children	UHCCP-RI's measurement year 2021 rate for the single performance indicator demonstrated a decline in performance from 2020 and did not meet the 2021 goal.	X	X	X
Quality Improvement Project – Improving Breast Cancer Screening	UHCCP-RI's measurement year 2021 rate for the single performance indicator demonstrated a decline in performance from 2020 and did not meet the 2021 goal.		X	X
Performance Measures – Effectiveness of Care	UHCCP-RI reported one measurement year 2021 HEDIS rate that benchmarked below the national Medicaid 75th percentile.	X	X	X
Performance Measures – Access and Availability	UHCCP-RI reported four measurement year 2021 HEDIS rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid Standards	None.			
Network Adequacy	Appointment availability among the surveyed providers was low.		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality of Care Surveys – Member Satisfaction	UHCCP-RI achieved one measurement year 2021 score for the adult survey that benchmarked below the national Medicaid 75th percentile.	X	X	X
	UHCCP-RI achieved two measurement year 2021 scores for the child survey that benchmarked below the national Medicaid 75th percentile.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UHCCP-RI's 2021 rates for the measures displayed in this report demonstrated no change or a decline in performance between measurement years 2020 and 2021 or did not meet the national UnitedHealthcare 2021 average.	X	X	X
Recommendations				
Quality Improvement Projects	Opportunities of improvement remain for two of the four quality Improvement projects, as UHCCP-RI did not achieve the established project goals. UHCCP-RI should continue to study the effectiveness of the intervention strategy and act on opportunities to make enhancements.	X	X	X
Performance Measures	UHCCP-RI should continue to utilize HEDIS results in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, UHCCP-RI should focus on primary and prenatal care utilization.	X	X	X
Compliance with Medicaid Standards	UHCCP-RI should conduct routine monitoring to ensure compliance is maintained.	X	X	X
Network Adequacy	UHCCP-RI should investigate opportunities to improve member access to care.		X	X
	For future appointment availability surveys, UHCCP-RI should establish a minimum sample size by specialty to increase the overall validity of the results. In the absence of a state-established threshold for timely appointments,		X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	UHCCP-RI should identify a threshold to work toward.			
Quality of Care Surveys – Member Satisfaction	UHCCP-RI should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid 75th percentile.	X	X	X
Quality of Care Surveys – Provider Satisfaction	UHCCP-RI should identify best practices used at other UnitedHealthcare organizations that aim to improve provider satisfaction.	X	X	X

Appendix A – NCQA Quality Improvement Activity Form

QUALITY IMPROVEMENT FORM

NCQA Quality Improvement Activity Form

Activity Name:	
Section I: Activity Selection and Methodology	
A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.	
B. Quantifiable Measures. List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
Quantifiable Measure #1:	
Numerator:	
Denominator:	
First measurement period dates:	
Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #2:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #3:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
C. Baseline Methodology.	
C.1 Data Sources.	

[ ] Medical/treatment records
[ ] Administrative data:
[ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] Other (list and describe):
_The Plan also uses a local access database to track all pregnant members as part of our Healthy First Steps Program. Although this database was not used as an administrative database from NCQA perspective, it was used by local Plan team members to identify and outreach to pregnant members. In addition, we used this database to track number of members who participated in our Diaper Reward Program.

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

If medical/treatment records, check below:
[ ] Medical/treatment record abstraction
If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):
_____

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

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

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

C.4 Data Collection Cycle.

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

Data Analysis Cycle.

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

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

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

Include, as appropriate:

I. Measure and time period covered
II. Type of change
III. Rationale for change
IV. Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method
V. Any introduction of bias that could affect the results

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

#1 Quantifiable Measure:

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

#2 Quantifiable Measure:

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

#3 Quantifiable Measure:

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

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

Section III: Analysis Cycle
Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That Analysis Covers.

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

B.1 For the quantitative analysis:

B.2 For the qualitative analysis:

- Opportunities identified through the analysis

Impact of interventions

- Next steps

Section IV: Interventions Table

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

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

Section V: Chart or Graph (Optional)

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