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Rhode Island Medicaid Managed Care Program

Neighborhood Health Plan of Rhode Island

2022 External Quality Review

Annual Technical Report

April 2024

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

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Reference to Medicaid managed care programs and members also includes Children's Health Insurance Program members served under the same managed care programs and contracts.

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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 2022. This report summarizes the 2022 external quality review results for Neighborhood Health Plan of Rhode Island (hereafter referred to as Neighborhood), a Rhode Island Medicaid managed care plan.

2022 External Quality Review

This external quality review technical report focuses on four federally required activities (validation of performance improvement projects[5], validation of performance measures, review of compliance with Medicaid standards, and validation of network adequacy) and two optional activities (validation of encounter data and quality-of-care survey) that were conducted for measurement year 2022. IPRO's external quality review

[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.

methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*[6] published in February 2023. 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	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 standards under *Code of Federal Regulations Part 438 – Managed Care*.
Activity 4. Validation of Network Adequacy (Required)	Protocol 4 (Published in 2023)	IPRO evaluated the managed care plan data collection methodologies and results to determine managed care plan adherence to the network standards outlined in the *Medicaid Managed Care Services Agreement*, as well as managed care plan ability to provide an adequate provider network to its Medicaid population.
Activity 5. Validation of Encounter Data (Optional)	Protocol 5	IPRO evaluated the accuracy and completeness of encounter data that is considered critical o effective managed care plan operation and oversight.
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/2023-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

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 2022.

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

The provision of health care services to each of the applicable eligibility groups (RIte Care Core, 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, 2022-2025

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 2022-2025 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 and objectives for the Rhode Island Medicaid program outlined in the 2022-2025 quality strategy evolved from the guiding principles established by *Working Group to Reinvent Medicaid*. 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. Goals and objectives of the 2022-2025 Medicaid quality strategy are in Table 3.

Table 3: Rhode Island Medicaid Quality Strategy Goals and Objectives, 2022-2025

Rhode Island Medicaid Managed Care Quality Strategy Goals and Objectives
Goal 1: Members receive quality care within all managed care delivery systems.
▪ 1.1 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. ▪ 1.2 Collaborate with managed care organizations, accountable entities, Office of the Health Insurance Commissioner, and other stakeholders to review and modify measures used in Medicaid managed care quality oversight. ▪ 1.3 Monitor managed care organization performance for dual-eligible Medicare Medicaid population.
Goal 2: Focus on quality performance and improvement in the following key areas: chronic disease management, maternal/infant health, preventive care for children, preventive care for adults, and behavioral health.
▪ 2.1 Continue oversight of managed care organizations and accountable entities to increase timely preventive care, screening, and follow-up for adult and child health. ▪ 2.2 Monitor and assess managed care organization and accountable entity performance improvement on quality measures related to chronic conditions. ▪ 2.3 Increase the use of prenatal and postpartum services. ▪ 2.4 Increase the number and percentage of well-child visits. ▪ 2.5 Monitor child immunization rates to maintain high performance.

[11] Rhode Island Medicaid Managed Care Quality Strategy Website: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2023-03/RI%20Managed%20Care%20Quality%20Strategy%20CMS%20Initial%20Submission%202022-08-31.pdf.

Rhode Island Medicaid Managed Care Quality Strategy Goals and Objectives
▪ 2.6 Increase engagement, treatment, and follow-up care for substance abuse.
Goal 3: Improve care and service coordination and management, with focus on coordination of services among medical, behavioral, dental and specialty services providers.
▪ 3.1 Increase availability of coordinated primary care and behavioral health services. ▪ 3.2 Improve integration with medical managed care organizations and RIte Smiles (UnitedHealthcare Dental).
Goal 4: Enhance financial and data analytic oversight of managed care organizations.
▪ 4.1 Ensure timely, complete, and correct encounter data within the 98% acceptance threshold. ▪ 4.2 Migrate to value-based payment programs based on quality measures and managed care organization quality improvement projects.
Goal 5: Increase health equity by improving capabilities to collect and analyze data related to social determinants of health, including race, ethnicity, and language data.
▪ 5.1 Implementation of race, ethnicity, and language data collection process to identify gaps in care. ▪ 5.2 Require managed care organizations to provide strategic plans to address social determinants of health, including organizational strategy and stakeholder strategy to improve care delivery model. ▪ 5.3 Assess quality measures that could be stratified by race, ethnicity, and language.
Goal 6: Empower members to make informed choices about their health plans and care.
▪ 6.1 Continue to require managed care organizations to conduct CAHPS surveys and share survey results with stakeholders. ▪ 6.2 Develop person-centered goals for managed care entities. Consider ways to increase development and implementation of individual care plans for members.

The Office of Health and Human Services has further identified measures to track progress towards the six goals listed above. These measures were selected from the Centers for Medicare & Medicaid Services' Child and Adult Core Set Measures and CAHPS. Table 4 presents a summary of the state's Medicaid quality strategy measurement plan, including measure names, populations included in the calculation of the rates, and baseline data. Unless indicated otherwise, baseline measurements are from measurement year 2020 (January 1, 2020 through December 31, 2020).

Table 4: Rhode Island Medicaid Quality Strategy Goals and Measures, 2022-2025

Goal	Measure (Population)	Baseline Measurement Year 2020
Goal 1: Members receive quality care within all managed care delivery systems.	Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers (Medicaid)	8.6%
	Care for Older Adults: Functional Status Assessment (Medicaid)	58.8%
Goal 2: Focus on quality performance and improvement in the following key areas: Chronic Disease Management, Maternal/Infant Health, Preventive Care for Children, Preventive Care for Adults, and Behavioral Health	Breast Cancer Screening (Medicaid)	65.0%
	Cervical Cancer Screening (Medicaid)	59.6%
	Screening for Depression and Follow-Up Plan: 12 to 17 Years (Children's Health Insurance Program)	To Be Determined
	Comprehensive Diabetes Care: Hemoglobin A1c Testing[1] (Medicaid)	82.2%
	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control[1] (Medicaid)	33.2%
	Controlling High Blood Pressure (Medicaid)	70.7%
	Asthma Medication Ratio: 5 to 18 Years (Children's Health Insurance Program)	65.6%
	Asthma Medication Ratio: 19 to 64 Years (Medicaid)	53.7%
	Prenatal and Postpartum Care – Timeliness of Prenatal Care (Medicaid, Children's Health Insurance Program)	To Be Determined
	Child and Adolescent Well-Care Visits (Children's Health Insurance Program)	To Be Determined
	Childhood Immunization Status – Combination 10 (Children's Health Insurance Program)	61.0%[2]
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation Total (Medicaid, Children's Health Insurance Program)	44.8%
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement Total (Medicaid, Children's Health Insurance Program)	17.9%
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days: 13 to 17 Years (Children's Health Insurance Program)	To Be Determined
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days: 13 17 to Years (Children's Health Insurance Program)	To Be Determined
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days (Medicaid)	12.7%

Goal	Measure (Population)	Baseline Measurement Year 2020
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days (Medicaid)	23.8%
Goal 3: Improve care and service coordination and management, with focus on coordination of services among medical, behavioral, dental and specialty services providers.	Follow-Up After Hospitalization for Mental Illness – 7 Days: 6 to 17 Years (Children's Health Insurance Program)	56.8%
	Follow-Up After Hospitalization for Mental Illness – 30 Days: 6 to 17 Years (Children's Health Insurance Program)	76.6%
	Follow-Up After Hospitalization for Mental Illness – 7 Days: 18 Years and Older (Medicaid)	57.2%
	Follow-Up After Hospitalization for Mental Illness – 30 Days: 18 Years and (Medicaid)	71.7%
	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days: 6 to 17 Years (Children's Health Insurance Program)	To Be Determined
	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days: 6 to 17 Years (Children's Health Insurance Program)	To Be Determined
	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days: 18 Years and Older (Medicaid)	64.6%
	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days: 18 Years and Older (Medicaid)	74.8%
	Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit (Medicaid)	80.7%
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Medications (Medicaid)	67.0%
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Strategies (Medicaid)	59.9%
	Percentage Diagnosed with Major Depression Who Were Treated with and Remained on Antidepressant Medication – Acute Phase: 18 to 64 (Medicaid)	58.9%
	Percentage Diagnosed with Major Depression Who Were Treated with and Remained on Antidepressant Medication – Continuation Phase: 18 to 64 Years (Medicaid)	44.0%
	Topical Fluoride for Children (Children's Health Insurance Program)	To Be Determined

Goal	Measure (Population)	Baseline Measurement Year 2020
Goal 4: Enhance financial & data analytic oversight of managed care organizations.		
Goal 5: Increase health equity by improving capabilities to collect and analyze data related to social determinants of health, including race, ethnicity, and language data.		
Goal 6: Empower members to make informed choices about their health plans and care.	Adult CAHPS 5.1H (Medicaid)	Not Applicable

[1] NCQA retired components of the HEDIS Comprehensive Diabetes Care measure set and implemented new technical specifications for the continuing components beginning with measurement year 2022.

[2] Rates represents measurement year 2021.

Gray shading indicates that a measure for the goal was not available in the 2022-2025 Medicaid Quality Strategy.

Descriptions of the improvement strategies led by the Office of Health and Human Services to achieve the goals of its 2022-2025 Medicaid Managed Care Quality Strategy are described below.

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 2022, as well as the measure steward and reporting category.

Table 5: Medicaid Comprehensive Accountable Entity Common Measure Slate, Performance Year 2022

Measure	Steward	Category
Breast Cancer Screening	NCQA	P4P
Child and Adolescent Well-Care Visits, 3 to 11 Years	NCQA	Reporting Only
Child and Adolescent Well-Care Visits, 12 to 17 Years	NCQA	P4P
Child and Adolescent Well-Care Visits, 18 to 21 Years	NCQA	P4P
Child and Adolescent Well-Care Visits, Total	NCQA	Reporting-only
Eye Exam for Patients With Diabetes	NCQA	P4P
Hemoglobin A1c Control for Patients With Diabetes: HbA1c Control (<8.0%)	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
Lead Screening in Children	NCQA	P4R
Developmental Screening in the First Three Years of Life	Oregon Health & Science University	P4P
Screening for Depression and Follow-up Plan	Centers for Medicare & Medicaid Services	P4P
Tobacco Use: Screening and Cessation Intervention	NCQA	Reporting-only
Social Determinants of Health Screening	Rhode Island Executive Office of Health and Human Services	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. P4R status means that whether or not an accountable entity reports the measure will influence the distribution of any shared savings.

For performance year 2022, 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 2022 using accountable entity performance data for 2019 to 2020 and 2020 to 2021, national and New England Medicaid health maintenance organization data from NCQA's *Quality Compass 2020* (measurement year 2019), 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*, and Rhode Island practice reported data from the Office of The Health Insurance Commissioner PCMH Quality Measures Survey for the period of October 1, 2018 to September 30, 2019. Table 6 displays the performance year 2022 measures and achievement targets.

Table 6: Accountable Entity 'P4P' Measure Targets, Performance Year 2022

Measure	Threshold Target	High-Performance Target
Breast Cancer Screening	55.1%	69.2%
Child and Adolescent Well-Care Visits, 12-21 Years	34.2%	56.5%
Eye Exam for Patients With Diabetes	54.6%	64.5%
Hemoglobin A1c Control for Patients With Diabetes: HbA1c Control (<8.0%)	47.7%	60.8%
Controlling High Blood Pressure	58.2%	67.6%
Follow-Up After Hospitalization for Mental Illness – 7 Days	49.7%	64.9%
Developmental Screening in the First Three Years of Life	63.0%	79.0%
Screening for Depression and Follow-up Plan	45.0%	75.0%
Social Determinants of Health Screening	42.4%	59.2%

Accountable entity rates for 'P4P' measures are presented in the Validation of Performance Measures – Technical Summary 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 30, 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.

Table 7 displays the Alternative Payment Results for the July 1, 2021 to June 30, 2022 measurement period. Neighborhood Health Plan of Rhode Island exceeded the 65% goal.

Table 7: Alternative Payment Results, Measurement Year July 1, 2021-June 30, 2022

Managed Care Plan	July 2021-June 2022 Measurement Period	Goal	Goal Met or Not Met
Neighborhood Health Plan of Rhode Island	66.5%	65%	Met

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.

Table 8 displays the percentage of patient-centered medical home assignments as of June 30, 2022. Neighborhood Health Plan of Rhode Island exceeded the 60% goal.

Table 8: Patient-Centered Medical Home Assignments, as of June 30, 2022

Managed Care Plan	July 2021-June 2022 Measurement Period	Goal	Goal Met or Not Met
Neighborhood Health Plan of Rhode Island	61.7%	60%	Met

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 Accreditation – Technical Summary section of this report.

Health Information Technology

The Office of Health and Human Services, in cooperation with stakeholders across state agencies and community partners, developed the *Health Information Technology Roadmap and Implementation Plan*[12] (released July 2020) to promote alignment among existing efforts and guide future investments in health information technology. The *Health Information Technology Roadmap and Implementation Plan* reflects needs and opportunities to improve the quality of Rhode Island healthcare services, lower costs, reduce provider burden, and better serve the people of Rhode Island. The goals, objectives, and approved interventions of the *Health Information Technology Roadmap and Implementation Plan* were determined by the Steering Committee with consideration of the following core values:

1. health information technology is an enabler of broader health transformation efforts;
2. a race equity lens must be applied to efforts in order to reduce health disparities; and
3. patients are key and must be considered with all initiatives.

Current initiatives of the *Health Information Technology Roadmap and Implementation Plan* are:

- Developing a new governance and coordination process to ensure statewide alignment.
- Adopting an e-referral system to help address social determinants of health.
- Improving and enhancing CurrentCare®[13], including a new opt-out consent policy to increase use.
- Accessing and increasing data availability and sharing, including key demographic data such as race and ethnicity needed to address health disparities.
- Enhancing behavioral health records-sharing through aligned interpretation of regulations and stakeholder convening.
- Continuing work to improve information sharing during transitions of care, such as between hospitals, primary care practices, and skilled nursing facilities.
- Continuing the development of the Quality Reporting System.

[12] Rhode Island Health Information Technology website: https://eohhs.ri.gov/initiatives/health-information-technology.

[13] CurrentCare is a registered trademark of the Rhode Island Quality Institute. CurrentCare is a free service that gives medical professionals and patients access to protected health information, such as prescriptions, lab tests and hospital visits, from multiple sources in one secure place.

Quality Reporting System

The Office of Health and Human Services implemented the Quality Reporting System, a centralized data system, to encourage the automation of electronic clinical quality measurement and reporting. Data are collected directly from electronic health records or claims systems, aggregated and matched at the patient-level, and used to calculate quality measures and share improvement data among participants. The Office of Health and Human Services successfully connected over 40 Medicaid primary care providers' electronic health system to the Quality Reporting System in September 2021 and achieved Data Aggregator Validation NCQA-certification in February 2022 for the majority of data submitters. The Office of Health and Human Services is considering the feasibility of utilizing the Quality Reporting System as a tool for value-based payment performance metrics beginning in 2023.

IPRO's Assessment of the Rhode Island Medicaid Quality Strategy

Rhode Island's 2022-2025 quality strategy aligns with the federal regulations in *Title 42 CFR 438.340(b) Managed Care State Quality Strategy*. The quality strategy 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 entity-level activities that expand upon the tracking, monitoring, and reporting of performance as it relates to the Medicaid service delivery system.

The Rhode Island quality strategy establishes defined goals and objectives that align with the Centers for Medicare & Medicaid Services' National Quality Strategy. The Office of Health and Human Services designed a quality strategy that aims to promote equity and member engagement, improve quality and health outcomes, facilitate statewide alignment and care coordination across programs and systems, and transformation to a health care system that is electronic and data driven.

Additionally, quality improvement initiatives in the 2022-2025 quality strategy reinforce the Office of Health and Human Services' commitment to implementing a standardized process for identifying and addressing social determinants of health needs; increasing the reporting of Core Set Measures and expanding reliance on these measures for performance based incentives and payments; and leveraging partnerships to advance the implementation of the quality strategy.

At this time statewide performance data are not available for the period under review. Remeasurement data for the quality strategy measures (Table 4) are not yet available. An evaluation on the effectiveness of the 2022-2025 quality strategy will include statewide performance in future external quality review technical reports when remeasurement data are available.

Recommendations to the Executive Office of Health and Human Services

In working towards the goals of the 2022-2025 strategy, IPRO recommends that the Office of Health and Human Services consider:

- Establishing target goals for the quality strategy performance measures.
- Establishing a process for managed care plans to request technical assistance from the external quality review organization.
- Requiring managed care plans to submit methodologies used to evaluate network adequacy and provider satisfaction to ensure the external quality review organization has sufficient information for validation activities.
- Enforcing standardized data collection and analysis requirements for managed care plan provider satisfaction surveys to enable performance comparisons across managed care plans.
- Enforcing managed care plan use of the *NCQA Quality Improvement Activity Form* to document quality improvement projects.
- Determining secret shopper timely appointment thresholds to encourage managed care plans to aggressively address barriers to accessing care that is adequate and timely.
- Expanding reporting requirements for managed care plan administered secret shopper surveys to include failure reasons like wrong telephone number, no answer, provider no longer at site, etc.
- Developing a quality strategy template for the managed care plans to use and submit.
- Identify opportunities to support the expansion of telehealth capabilities and member access to telehealth services across the state.

Medicaid Managed Care Plan Profile

Neighborhood is a not-for-profit health maintenance organization. Table 9 displays Neighborhood's enrollment for year-end 2018 through year-end 2022, as well as the percent change in enrollment each year, according to data reported to the Office of Health and Human Services. The data presented here may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. Neighborhood's enrollment increased by 6% from 189,923 members in 2021 to 201,305 members in 2022.

Table 9: Neighborhood's Medicaid Enrollment, 2018 to 2022

Eligibility Group	2018	2019	2020	2021	2022
RIte Care Core	100,923	93,611	100,594	104,886	110,003
RIte Care for Children in Substitute Care	2,715	2,616	2,879	2,590	2,474
RIte Care for Children with Special Health Care Needs	5,066	5,119	5,237	5,241	5,482
Rhody Health Expansion	38,135	36,640	48,688	55,652	61,663
Rhody Health Partners	7,465	7,446	7,497	7,621	7,376
Rhody Health Options	15,698	13,875	12,914	12,942	13,479
Extended Family Planning	829	1,265	1,240	991	828
Medicaid Total	170,831	160,572	179,049	189,923	201,305
Percent Change from Previous Year	-7%	-6%	+12%	+6%	+6%

Neighborhood's Quality Improvement Program, 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. Neighborhood's *2022 Quality Improvement Program Description* (approved May 2022) met these requirements.

Goals and Objectives

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

Table 10 displays Neighborhood's quality improvement goals and objectives as reported in the *2022 Quality Improvement Program Description*.

Table 10: Neighborhood's Quality Improvement Goals and Objectives, 2022

Neighborhood's Quality Improvement Goals and Objectives, 2022
▪ Provide a population health structure crossing all departments encompassing the clinical care provided to Neighborhood's members ▪ Assure access to high quality medical and behavioral healthcare ▪ Support members with acute and long-term health care needs ▪ Monitor and improve coordination of care across settings ▪ Improve member and provider experience ▪ Ensure the safety of members in all health care settings ▪ Monitor quality of care in nursing facilities through Minimum Data Set data and other data sources

Neighborhood's Quality Improvement Goals and Objectives, 2022
▪ Engage members in their own care ▪ Improve HEDIS and CAHPS performance ▪ Improve Medicare Health Outcomes Survey performance ▪ Attain maximum NCQA Star Rating and accreditation status ▪ Support the Medicaid accountable entities in achieving maximum performance on their annual quality multipliers ▪ Achieve optimum performance for quality withhold under the INTEGRITY Medicare-Medicaid plan product line ▪ Achieve maximum performance in the quality improvement projects required by contracts for Medicaid, INTEGRITY Medicare-Medicaid plan, and the exchange products ▪ Maintain grievance and appeal procedures and mechanisms and assure that members can achieve resolution to problems or perceived problems relating to access and other quality issues ▪ Maintain collaborative relationships with network providers and state agencies ▪ Improve operational efficiency in the work performed across the organization ▪ Ensure Neighborhood's quality improvement structure and processes adhere to NCQA standards and state and federal requirements ▪ Assess the quality improvement program annually and make changes as necessary to improve program effectiveness

Quality Improvement Program Activities

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

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

Information Systems Capabilities Assessment – Technical Summary

Objectives

The *CMS External Quality Review (EQR) Protocols* published in February 2023 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, 4, 5 and 7.

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 Neighborhood's NCQA HEDIS compliance audit licensed organization in the Final Audit Report for measurement year 2022.

Technical Methods of Data Collection and Analysis

As part of the NCQA HEDIS Compliance Audit, the HEDIS compliance auditor assessed Neighborhood'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 11 displays these standards as well as the elements audited for the standard.

Table 11: 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 2022 external quality review, IPRO obtained Neighborhood'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 38).

Comparative Results

Neighborhood's HEDIS compliance auditor determined that the HEDIS rates reported by the managed care plan for measurement year 2022 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. Further, there were no data collection or reporting issues identified by the HEDIS compliance auditor. Table 12 displays the results of the NCQA Information System Capabilities review for Neighborhood.

Table 12: Neighborhood's NCQA Information Systems Capabilities Standards Audit Results, Measurement Year 2022

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

External Quality Review Activity 1. Validation of Performance Improvement Projects – Technical Summary

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. IPRO conducted this activity on behalf of the Office of Health and Human Services for measurement year 2022.

Table 13 displays the titles of the six quality improvement projects led by Neighborhood in measurement year 2022.

Table 13: Neighborhood's Quality Improvement Project Topics, 2022

Neighborhood's Quality Improvement Project Topics, 2022
1. Child and Adolescent Well Care Visits, Ages 3 to 21 Years
2. Developmental Screening in the First Three Years of Life
3. Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication
4. Lead Screening in Children
5. Care for Older Adults
6. Transitions from the Nursing Home to the Community

Technical Methods of Data Collection and Analysis

All quality improvement projects were documented by Neighborhood 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 2022 *Quality Improvement Activity Form* completed by Neighborhood 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 14.

Table 14: Review Determination Definitions

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

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

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

Description of Data Obtained

For the 2022 external quality review, IPRO reviewed Neighborhood's quality improvement project reports. These reports included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

Comparative Results

IPRO's assessment of Neighborhood's methodology found that there were no validation findings that indicated that the credibility of the six quality improvement projects was at risk. Table 15 displays a summary of the validation results of Neighborhood's quality improvement projects that were conducted for measurement year 2022. Summaries of each quality improvement project immediately follow.

Table 15: Neighborhood's Quality Improvement Project Validation Results, Measurement Year 2022

Neighborhood's Quality Improvement Project (QIP) Validation Results						
Validation Element	QIP 1 – Child and Adolescent Well Care Visits, Ages 3 to 21 Years	QIP 2 – Developmental Screening in the First Three Years of Life	QIP 3 – Follow-up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication	QIP 4 – Lead Screening in Children	QIP 5 – Care for Older Adults	QIP 6 – Transitions from the Nursing Home to the Community
Selected Topic	Met	Met	Met	Met	Met	Met
Study Question	Met	Met	Met	Met	Met	Met
Indicators	Met	Met	Met	Met	Met	Met
Population	Met	Met	Met	Met	Met	Met
Sampling Methods	Met	Met	Met	Met	Met	Met
Data collection Procedures	Met	Met	Met	Met	Met	Met
Interpretation of Study Results	Met	Met	Met	Met	Met	Met
Improvement Strategies	Met	Met	Met	Met	Met	Met

Table 16: Neighborhood's Quality Improvement Project 1 Summary – Well-Care Visits, Measurement Year 2022

Quality Improvement Project 1 Summary
Title: Improve Child and Adolescents' Well-Care Visits, Ages 3 to 21 Years **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aims to improve access to well child visits for child and adolescent members aged 3 to 21 years. Indicator of Performance HEDIS *Child and Adolescent Well-Care Visits*: The percentage of members ages 3 to 21 years who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. Member-Focused 2022 Interventions ▪ Continued to offer a $25 incentive gift card to children and adolescent members for completing an annual well visit. ▪ Promoted the importance of well-child visits and immunizations through automated voice calls to non-compliant members. ▪ Created and posted social media content on the importance of well-child visits. ▪ Distributed flyers at school events across the state to highlight the importance of well visits and staying up-to-date on screenings and immunizations. Provider-Focused 2022 Interventions ▪ Continued provider incentive for accountable entities. ▪ Shared best practices and well-child visits requirements with low performing providers. ▪ Distributed gaps in care reports to providers. ▪ Published an article on the importance of lead screening during well visits.

Table 17: Neighborhood's Quality Improvement Project 1 Indicator Summary –Well-Care Visits 3 to 11 Years

HEDIS Child and Adolescent Well-Care Visits – 3 to 11 Years					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2020	Baseline	18,862	31,375	60.12%	66.06%
Measurement Year 2021	Remeasurement 1	21,671	31,644	68.48%	68.89%
Measurement Year 2022	Remeasurement 2	19,732	31,450	62.74%	68.89%

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

Table 18: Neighborhood's Quality Improvement Project 1 Indicator Summary –Well-Care Visits 12 to 17 Years

HEDIS Child and Adolescent Well-Care Visits – 12 to 17 Years					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2020	Baseline	10,849	20,627	52.60%	62.45%
Measurement Year 2021	Remeasurement 1	13,655	21,632	63.12%	64.17%
Measurement Year 2022	Remeasurement 2	12,271	22,011	55.75%	64.17%

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

Table 19: Neighborhood's Quality Improvement Project 1 Indicator Summary –Well-Care Visits 18 to 21 Years

HEDIS Child and Adolescent Well-Care Visits – 18 to 21 Years					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2020	Baseline	3,549	10,212	34.75%	41.23%
Measurement Year 2021	Remeasurement 1	4,708	12,071	39.00%	41.38%
Measurement Year 2022	Remeasurement 2	4,519	12,868	35.12%	41.38%

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

Table 20: Neighborhood's Quality Improvement Project 1 Indicator Summary –Well-Care Visits 3 to 21 Years

HEDIS Child and Adolescent Well-Care Visits – 3 to 21 Years					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2020	Baseline	33,260	62,214	53.46%	62.19%
Measurement Year 2021	Remeasurement 1	40,034	65,347	61.26%	62.74%
Measurement Year 2022	Remeasurement 2	36,522	66,329	55.06%	62.74%

Indicator Description: The percentage of children 3 to 21 years of age who received one or more well-care visit with a primary care practitioner or an obstetrician/gynecologist practitioner during the measurement year.

Table 21: Neighborhood's Quality Improvement Project 2 Summary – Developmental Screening, Measurement Year 2022

Quality Improvement Project 2 Summary
Title: Improving Developmental Screening Rates in the First Three Years of Life **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aims 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 2022 Interventions ▪ Continued to offer a $25 incentive gift card to children and adolescent members for completing an annual well visit. ▪ Created and posted social media content on the importance of well-child visits. ▪ Continued to provide information regarding the importance of well visits and annual developmental screenings at marketing events. ▪ Conducted automated voice calls to promote the importance of well visits and immunizations to non-compliant members. Provider-Focused 2022 Interventions ▪ Continued to host monthly meetings with accountable entities to review rates for developmental screening, understand specific barriers, and provide best practices. ▪ Continued to include developmental screening as an accountable entity incentive measure.

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

Developmental Screening – By Age 1					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014[1]	Baseline	68	137	49.64%	60.00%
Measurement Year 2015[1]	Remeasurement 1	54	137	39.42%	60.00%
Measurement Year 2016[1]	Remeasurement 2	76	137	55.47%	60.00%
Measurement Year 2017[1]	Remeasurement 3	86	137	62.77%	65.00%
Measurement Year 2018[1]	Remeasurement 4	90	137	65.69%	65.00%
Measurement Year 2019[2]	Remeasurement 5	2,267	3,264	69.45%	65.00%
Measurement Year 2020[2]	Remeasurement 6	2,318	3,253	71.26%	65.00%
Measurement Year 2021[2]	Remeasurement 7	1,945	2,490	78.11%	65.00%
Measurement Year 2022[2]	Remeasurement 8	2,293	3,261	70.32%	65.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

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

Table 23: Neighborhood's Quality Improvement Project 2 Indicator Summary – Second Year Developmental Screening

Developmental Screening – By Age 2					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014[1]	Baseline	79	137	57.66%	60.00%
Measurement Year 2015[1]	Remeasurement 1	87	137	63.50%	60.00%
Measurement Year 2016[1]	Remeasurement 2	99	137	72.26%	60.00%
Measurement Year 2017[1]	Remeasurement 3	95	137	69.34%	65.00%
Measurement Year 2018[1]	Remeasurement 4	103	137	74.45%	65.00%
Measurement Year 2019[2]	Remeasurement 5	2,141	3,119	68.64%	65.00%
Measurement Year 2020[2]	Remeasurement 6	2,223	2,963	75.03%	65.00%
Measurement Year 2021[2]	Remeasurement 7	1,885	2,343	80.45%	65.00%
Measurement Year 2022[2]	Remeasurement 8	2,373	3,288	72.17%	65.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

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

Table 24: Neighborhood's Quality Improvement Project 2 Indicator Summary – Third Year Developmental Screening

Developmental Screening – By Age 3					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014[1]	Baseline	85	137	62.04%	60.00%
Measurement Year 2015[1]	Remeasurement 1	84	137	61.31%	60.00%
Measurement Year 2016[1]	Remeasurement 2	88	137	64.23%	60.00%
Measurement Year 2017[1]	Remeasurement 3	88	137	64.23%	65.00%
Measurement Year 2018[1]	Remeasurement 4	89	137	64.96%	65.00%
Measurement Year 2019[2]	Remeasurement 5	2,160	3,472	62.21%	65.00%
Measurement Year 2020[2]	Remeasurement 6	2,129	3,145	67.69%	65.00%
Measurement Year 2021[2]	Remeasurement 7	1,579	2,234	70.68%	65.00%
Measurement Year 2022[2]	Remeasurement 8	2,230	3,345	66.67%	65.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

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

Table 25: Neighborhood's Quality Improvement Project 3 Summary – Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication, Measurement Year 2022

Quality Improvement Project 3 Summary
Title: Improve the HEDIS *Follow-Up Care for Children Prescribed ADHD Medication* Rate **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aims to improve the follow-up care for children prescribed attention deficit/hyperactivity disorder medication. Indicators of Performance ▪ The percentage of children between 6 and 12 years of age who were diagnosed with attention deficit/hyperactivity disorder and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of attention deficit/hyperactivity disorder medication. ▪ The percentage of children between 6 and 12 years of age who had a prescription for attention deficit/hyperactivity disorder medication and remained on the medication for at least 210 days, and had at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase. Member-Focused 2022 Interventions ▪ Continued to educate parents of enrollees about attention deficit/hyperactivity disorder symptom management, medication compliance, and the importance of timely follow-up with their practitioners. ▪ Created and posted social media content informing members about attention deficit/hyperactivity disorder and how to deal with social isolation. Provider-Focused 2022 Interventions ▪ Continued to disseminate current clinical practice guidelines to network providers. ▪ Continued to deliver education through email blasts to providers identified as treating one or more members diagnosed with attention deficit/hyperactivity disorder within the past we months. ▪ Continued to conduct telephonic outreach to providers of members with a new attention deficit/hyperactivity disorder diagnosis to confirm with the provider that a follow-up appointment has been scheduled. ▪ Continued to offer free continuing education credits for practitioners via an on-demand webcast titled, "Behavioral Health Treatment for Children and Adolescents," which focuses on the screening, diagnosis, treatment, and follow-up care for children and adolescents on ADHD or antipsychotic medication. ▪ Published an article in the provider newsletter outlining Neighborhood's performance, how providers can help, and resources available to providers.

Table 26: Neighborhood's Quality Improvement Project 3 Indicator Summary – Initiation Phase

HEDIS Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	418	885	47.23%	55.91%
Measurement Year 2018	Remeasurement 1	423	889	47.58%	55.91%
Measurement Year 2019	Remeasurement 2	418	891	46.91%	55.91%
Measurement Year 2020	Remeasurement 3	431	848	50.83%	55.91%
Measurement Year 2021	Remeasurement 4	391	808	48.39%	55.91%
Measurement Year 2022	Remeasurement 5	392	826	47.46%	55.91%

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

Table 27: Neighborhood's Quality Improvement Project 3 Indicator Summary – Continuation and Maintenance Phase

HEDIS Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	130	223	58.30%	69.14%
Measurement Year 2018	Remeasurement 1	134	219	61.19%	69.14%
Measurement Year 2019	Remeasurement 2	127	226	56.19%	69.14%
Measurement Year 2020	Remeasurement 3	131	212	61.79%	69.14%
Measurement Year 2021	Remeasurement 4	97	164	59.15%	69.14%
Measurement Year 2022	Remeasurement 5	99	183	54.10%	69.14%

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

Table 28: Neighborhood's Quality Improvement Project 4 Summary – Lead Screening, Measurement Year 2022

Quality Improvement Project 4 Summary
Title: Social Determinant of Health Measure – Improve the Rate of Lead Screening in Children **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aims to increase the percentage of children screened for lead by their second birthday. Indicator of Performance The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. Member-Focused 2022 Interventions ▪ Continued to mail post card reminders for lead testing to children turning one year old. ▪ Continued to offer a $25 incentive gift card to parents of children who had a lead screening by the age of two years. ▪ Created and posted social media content on the importance of lead screening. ▪ Continued to distribute Rhode Island Department of Health-developed lead screening educational materials at marketing events targeted to parents with children. Provider-Focused 2022 Interventions ▪ Continued to disseminate best practices and clinical requirements for primary care visits with low performing providers. ▪ Continued to distribute gaps in care reports to providers along with education materials on the importance of lead screening and how the provider can support Neighborhood's goal of improving the lead screening rate. ▪ Published an article in the provider newsletter on the importance of lead screening, well visits, and follow-up care for patients with blood lead levels greater than 5 mcg/dl. ▪ Added lead screening as an accountable entity incentive measure. Managed Care Plan-Focused 2022 Interventions ▪ Continued collaboration efforts with the Rhode Island Department of Health to address lead poisoning prevention, promoting screening, rescreening for high blood lead levels, lead screening guidelines and laws, exchange of data, sharing of best practices, and collaborative efforts around member and provider education.

Table 29: Neighborhood's Quality Improvement Project 4 Indicator Summary – Lead Screening

Lead Screening					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2015	Baseline	2,502	3,018	82.90%	84.77%
Measurement Year 2016	Remeasurement 1	2,884	3,688	78.20%	86.37%
Measurement Year 2017	Remeasurement 2	2,699	3,416	79.01%	85.64%
Measurement Year 2018	Remeasurement 3	2,786	3,536	78.79%	85.90%
Measurement Year 2019	Remeasurement 4	2,475	3,119	79.35%	86.62%
Measurement Year 2020	Remeasurement 5	2,267	2,938	77.16%	83.94%
Measurement Year 2021	Remeasurement 6	2,510	3,342	76.80%	79.57%
Measurement Year 2022	Remeasurement 7	2,531	3,280	77.16%	79.57%

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 30: Neighborhood's Quality Improvement Project 5 Summary – Care for Older Adults, Measurement Year 2022

Quality Improvement Project 5 Summary
Title: Improve *HEDIS Care for Older Adults* Performance **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim Neighborhood aims to improve performance for care of older adults. Indicators of Performance The percentage of adults 66 years and older who had each of the following during the measurement year: ▪ medication review, ▪ functional status assessment, and ▪ pain assessment. Provider-Focused 2022 Interventions ▪ Continued to disseminate best practices and technical specifications for the HEDIS *Care for Older Adults* measure to providers. ▪ Continued nursing home collaboration to improving documentation of care. ▪ Updated the provider reference guide to include all Current Procedural Terminology (CPT®) II codes for the HEDIS *Care for Older Adults* measure and made the guide available to providers on the Neighborhood website. Managed Care Plan-Focused 2022 Interventions ▪ Implemented enhancements to the health risk assessment and care management system to capture pain assessment and functional status.

Table 31: Neighborhood's Quality Improvement Project 5 Indicator Summary – Medication Review

HEDIS Care for Older Adults – Medication Review					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017[1]	Baseline	281	411	68.37%	79.00%
Measurement Year 2018[1]	Remeasurement 1	352	411	85.64%	79.00%
Measurement Year 2019[1]	Remeasurement 2	366	411	89.05%	80.00%
Measurement Year 2020[1]	Remeasurement 3	316	388	81.44%	81.00%
Measurement Year 2021[2]	Remeasurement 4	4,566	5,116	89.25%	86.00%
Measurement Year 2022[2]	Remeasurement 5	4,474	5,048	88.63%	87.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

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

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

HEDIS Care for Older Adults – Functional Status Assessment					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017[1]	Baseline	207	411	50.36%	67.00%
Measurement Year 2018[1]	Remeasurement 1	295	411	71.78%	67.00%
Measurement Year 2019[1]	Remeasurement 2	302	411	73.48%	68.00%
Measurement Year 2020[1]	Remeasurement 3	235	388	60.57%	69.00%
Measurement Year 2021[2]	Remeasurement 4	4,208	5,116	82.25%	72.00%
Measurement Year 2022[2]	Remeasurement 5	4,265	5,048	84.49%	73.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

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

Table 33: Neighborhood's Quality Improvement Project 5 Indicator Summary – Pain Assessment

HEDIS Care for Older Adults – Pain Assessment					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017[1]	Baseline	268	411	65.21%	62.00%
Measurement Year 2018[1]	Remeasurement 1	366	411	89.05%	62.00%
Measurement Year 2019[1]	Remeasurement 2	378	411	91.97%	63.00%
Measurement Year 2020[1]	Remeasurement 3	4,199	5,457	77.43%	64.00%
Measurement Year 2021[2]	Remeasurement 4	4,681	5,116	91.50%	90.00%
Measurement Year 2022[2]	Remeasurement 5	4,641	5,048	91.94%	91.00%

[1] Rate calculated using the hybrid methodology.

[2] Rate calculated using the administrative methodology.

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

Table 34: Neighborhood's Quality Improvement Project 6 Summary – Transitions of Care, Measurement Year 2022

Quality Improvement Project 6 Summary
Title: Increase the Percentage of Transitions from the Nursing Home to the Community **Validation Summary:** There were no validation findings that indicate that the credibility was at risk for the performance improvement project results.
Aim: Neighborhood aims to increase the percentage of transitions from the nursing home to the community. Indicators of Performance 1. The number of INTEGRITY Medicare-Medicaid program members who transitioned from a nursing facility to the community under the Rhode to Home Program. 2. The number of INTEGRITY Medicare-Medicaid program members who transitioned from a nursing facility to the community. Member-Focused 2022 Interventions ▪ Continued to facilitate telehealth visits. ▪ Continued to distribute an enrollee educational flyer on the availability of services. ▪ Continued outreached to members prescribed antipsychotic medication and identified with gaps in care. Provider-Focused 2022 Interventions ▪ Continued the Nursing Home Quality Incentive Program. Managed Care Plan-Focused 2022 Interventions ▪ Continued to conduct reassessments after the first 60 days as opposed to the first 90 days for members who opted to remain in the nursing facility and leveraged the contact to encourage the member to transition back to the community. ▪ Continued to accessed nursing home-based electronic medical record systems to assist in identifying opportunities for transition. ▪ Continued use of the nursing home dashboard to display real-time member data for timely response to member needs. ▪ Continued collaboration efforts with the state and community to identify and increase Section 8 Housing Vouchers. ▪ Collaborated with facility nurses to complete "Section Q" from the Minimal Data Set for Neighborhood members to increase identification of potential transfers.

Table 35: Neighborhood's Quality Improvement Project 6 Indicator Summary – Transitions for Rhode to Home Eligible Members

Transitions From the Nursing Home to the Community – INTEGRITY Medicare-Members Who Are Eligible for the Rhode to Home Program					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline	14	55	14 Members	20 Members
Measurement Year 2018	Remeasurement 1	20	58	20 Members	20 Members
Measurement Year 2019	Remeasurement 2	17	31	17 Members	20 Members
Measurement Year 2020	Remeasurement 3	19	30	19 Members	20 Members
Measurement Year 2021	Remeasurement 4	14	21	14 Members	20 Members
Measurement Year 2022	Remeasurement 5	13	22	13 Members	20 Members

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

Table 36: Neighborhood's Quality Improvement Project 6 Indicator Summary – Transitions for All Members

Transitions from the Nursing Home to the Community – All INTEGRITY Medicare-Members					
Measurement Period	Measurement Type	Numerator	Denominator	Results	Goal
Measurement Year 2018	Baseline	391	982	39.82%	35.00%
Measurement Year 2019	Remeasurement 1	647	862	75.06%	35.00%
Measurement Year 2020	Remeasurement 2	390	636	61.32%	35.00%
Measurement Year 2021	Remeasurement 3	416	682	61.00%	35.00%
Measurement Year 2022	Remeasurement 5	469	797	58.85%	35.00%

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

External Quality Review Activity 2. Validation of Performance Measures – Technical Summary

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 2022.

Technical Methods of Data Collection and Analysis

For measurement year 2022, Neighborhood was required to submit HEDIS performance measure data to the Office of Health and Human Services. To ensure compliance with reporting requirements, Neighborhood contracted with an NCQA-certified HEDIS vendor and an NCQA-certified HEDIS compliance auditor.

The HEDIS vendor collected data and calculated performance measure rates on behalf of Neighborhood for measurement year 2022. The HEDIS vendor calculated rates using NCQA's *HEDIS Measurement Year 2022 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 Neighborhood's adherence to the technical specifications and reporting requirements. The HEDIS compliance auditor evaluated Neighborhood'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, the HEDIS compliance auditor assessed Neighborhood'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 Neighborhood has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. Table 37 displays these standards as well as the elements audited for the standard.

Table 37: 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 Neighborhood 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

The HEDIS compliance auditor used the HEDIS specification standards to assess Neighborhood'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

Neighborhood's calculated rates for the NCQA HEDIS Measurement Year 2022 measure set were validated as part of the NCQA HEDIS Compliance Audit and assigned one of NCQA's outcome designations. Table 38 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 38: NCQA 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.

Neighborhood'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. Neighborhood submitted these documents to the Office of Health and Human Services and IPRO.

IPRO reviewed Neighborhood'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 Neighborhood 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 2022 external quality review, IPRO obtained Neighborhood'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 38).

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

Comparative Results

Validation of Performance Measures

Neighborhood's HEDIS compliance auditor determined that the HEDIS rates reported by Neighborhood for measurement year 2022 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. Further, there were no data collection or reporting issues identified by the HEDIS compliance auditor for Neighborhood.

Performance Measure Results

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

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

Table 39 displays Neighborhood's HEDIS rates for measurement years 2019, 2020, 2021, and 2022, as well as the national Medicaid benchmarks achieved by the managed care plan, and the national Medicaid means.

Table 39: Neighborhood's HEDIS Rates, Measurement Years 2019 to 2022

Domain/Measures	Neighborhood Measurement Year 2019	Neighborhood Measurement Year 2020	Neighborhood Measurement Year 2021	Neighborhood Measurement Year 2022	*Quality Compass* Measurement Year 2022 National Medicaid Benchmark (Met/Exceeded)	*Quality Compass* Measurement Year 2022 National Medicaid Mean
Use of Services						
Well-Child Visits in the First 30 Months of Life – First 15 Months	First Year Measure	76.45%	73.43%	77.95%	95th	56.76%
Well-Child Visits in the First 30 Months of Life – First 15 to 30 Months	First Year Measure	85.63%	79.74%	81.88%	95th	66.74%
Child and Adolescent Well-Care Visits (Total)	First Year Measure	53.46%	61.26%	62.57%	90th	48.61%
Effectiveness of Care						
Cervical Cancer Screening for Women	74.21%	73.83%	71.95%	67.54%	90th	55.92%
Chlamydia Screening for Women (Total)	68.85%	63.19%	65.23%	65.29%	75th	55.80%
Childhood Immunization Status – Combination 3	78.66%	80.15%	76.59%	80.61%	95th	63.16%
Childhood Immunization Status – Combination 10	59.95%	62.31%	61.33%	59.95%	95th	31.86%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	54.33%	55.92%	54.20%	52.85%	75th	36.61%
Follow-Up After Hospitalization for Mental Illness – 30 Days (Total)	72.77%	73.82%	74.55%	71.92%	75th	57.05%
Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control (<8%)	New Measure in 2022	New Measure in 2022	New Measure in 2022	59.37%	75th	50.87%
Access and Availability						
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	81.43%	78.96%	78.01%	76.67%	75th	69.26%
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	89.97%	87.92%	87.50%	86.68%	90th	79.31%
Adults' Access to Preventive/Ambulatory Health Services – 65+ Years	95.77%	93.47%	92.74%	91.57%	75th	79.31%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	96.11%	95.86%	92.25%	94.89%	95th	82.95%
Prenatal and Postpartum Care – Postpartum Care	87.59%	88.08%	87.79%	88.56%	95th	76.96%

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 2022, 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 2022, Neighborhood held contracts with seven accountable entities:

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

When available, rates for performance years 2019, 2020, 2021, and 2022 for Neighborhood's accountable entities are displayed in figures that follow.

Figure 1. Breast Cancer Screening

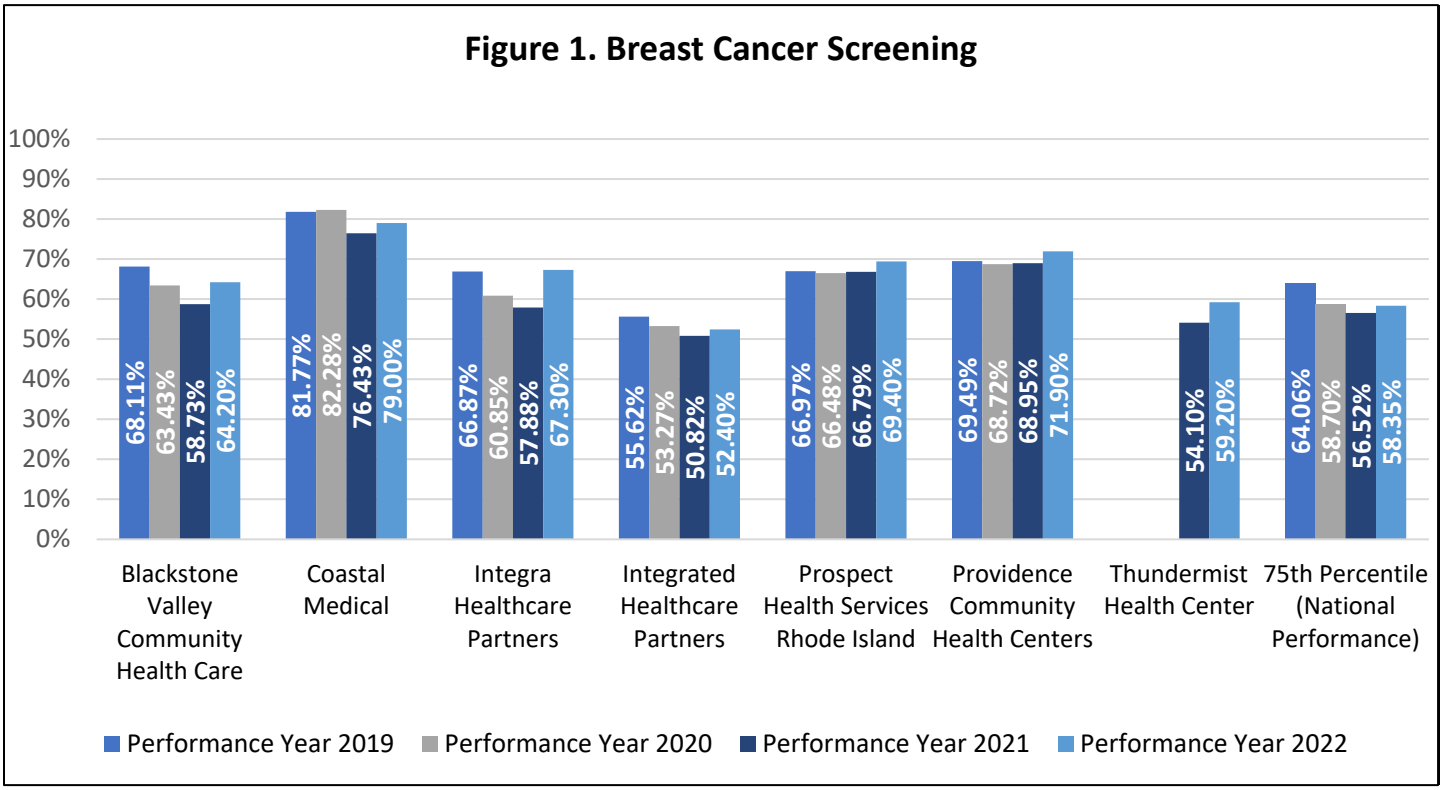


Figure 2. Eye Exam for Patients With Diabetes

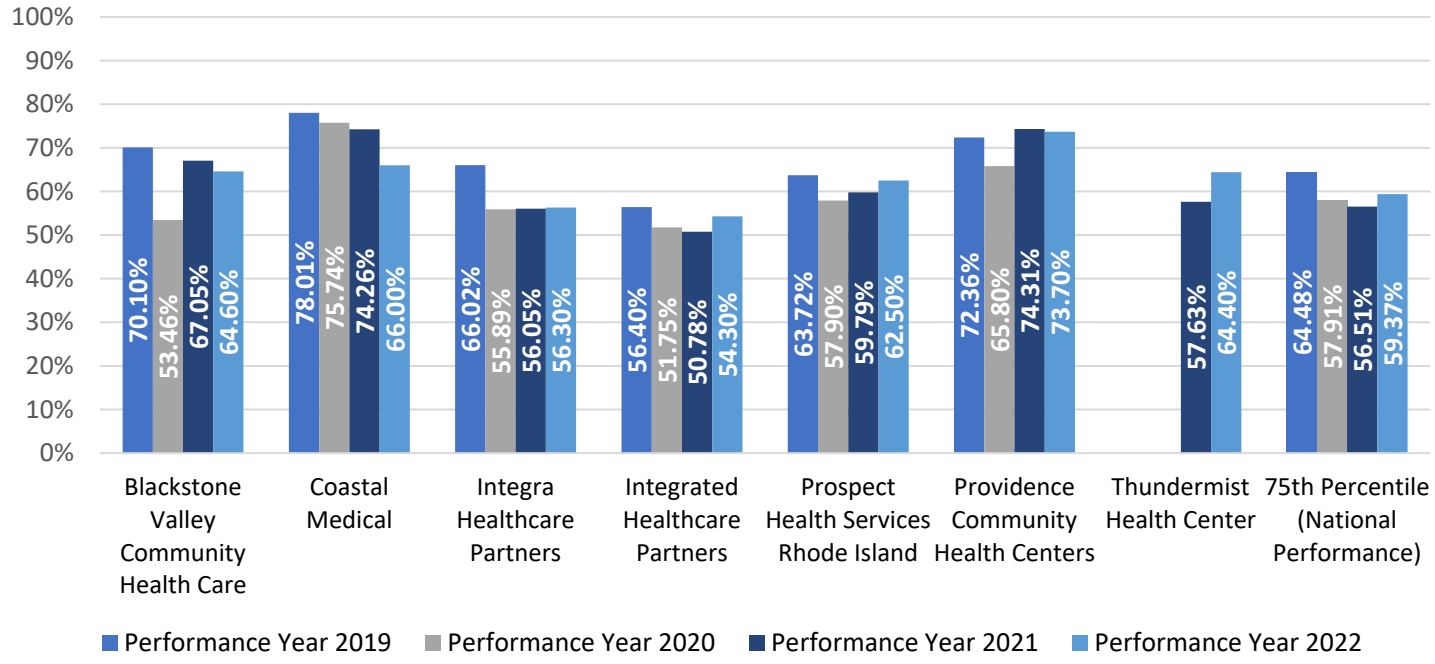


Figure 3. Hemoglobin A1c Control for Patients with Diabetes - HbA1c Good Control (<8.0)

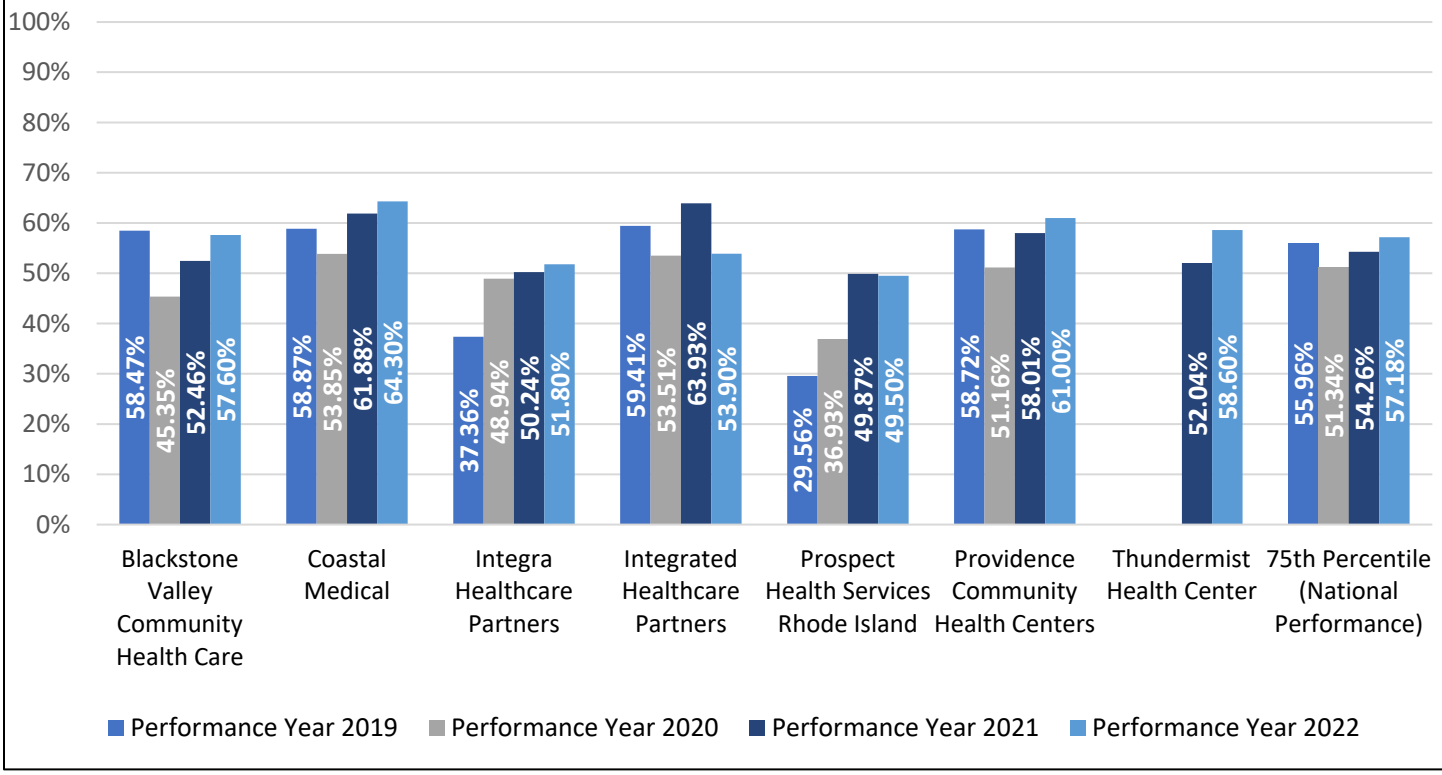


Figure 4. Controlling High Blood Pressure

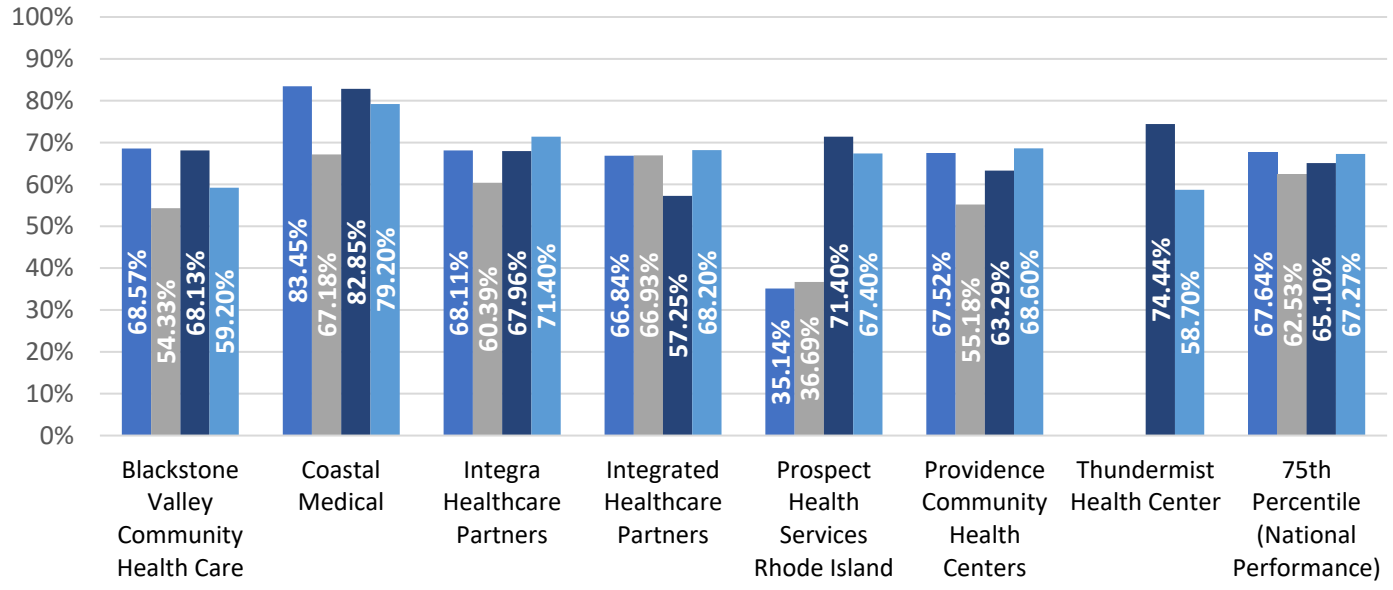


Figure 5. Follow-up After Hospitalization for Mental Illness (7-Day)

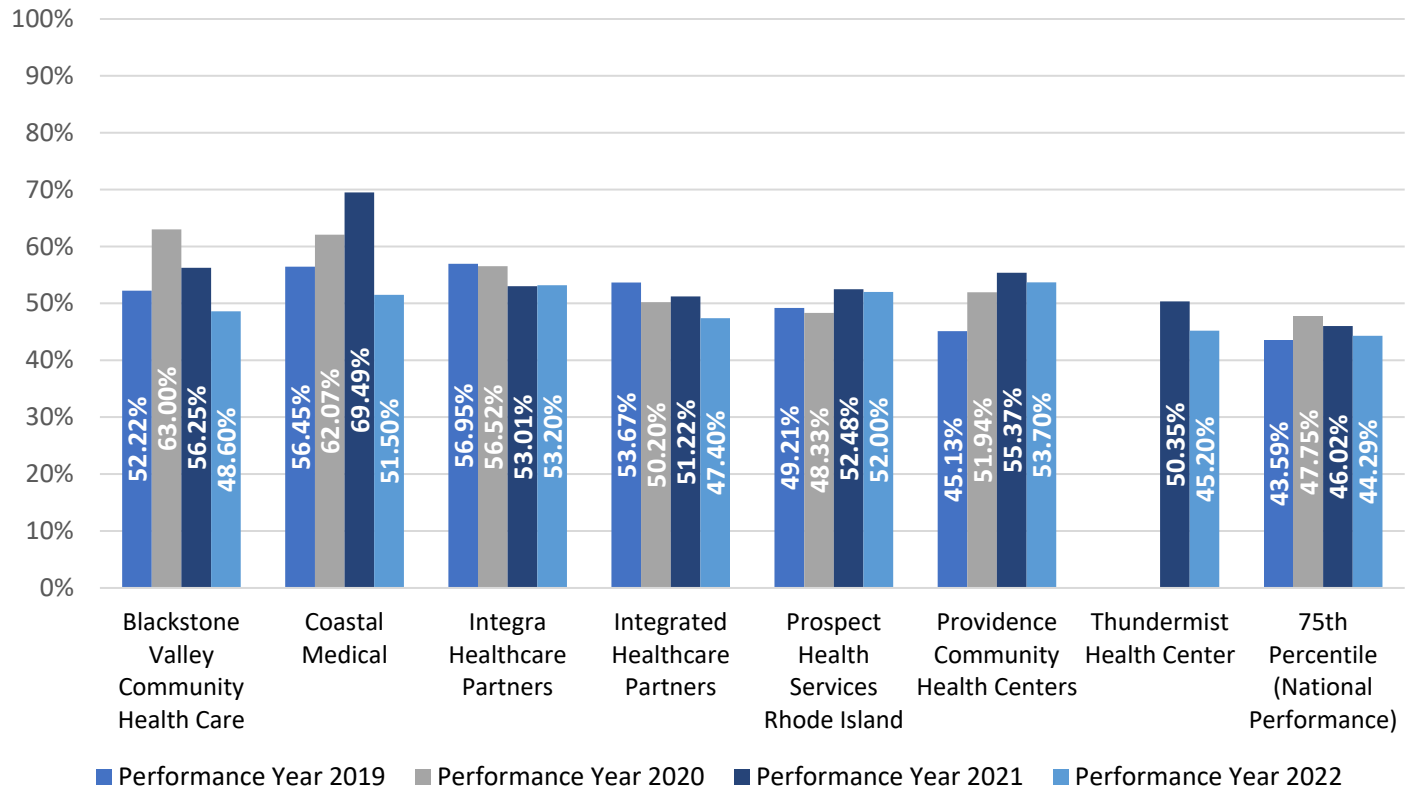


Figure 6. Developmental Screening in the First Three Years of Life

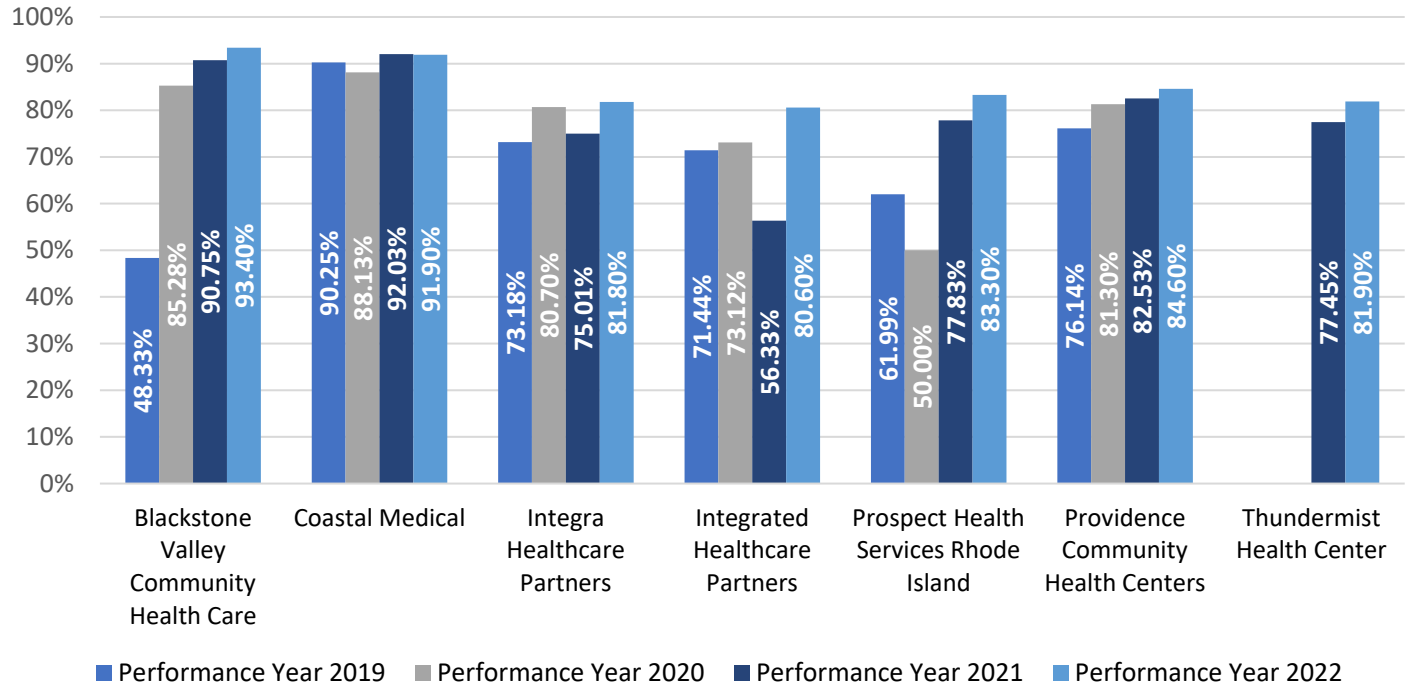


Figure 7. Screening for Depression and Follow-up Plan

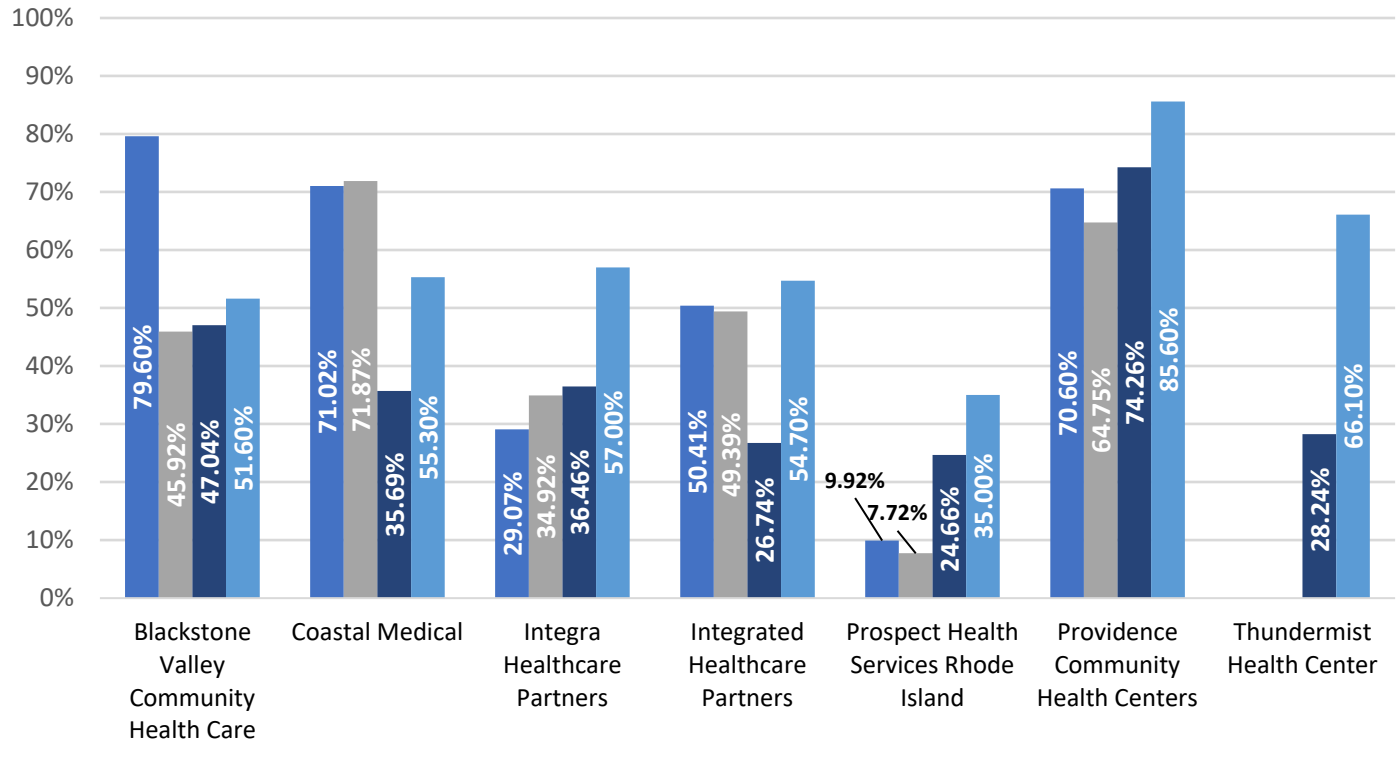
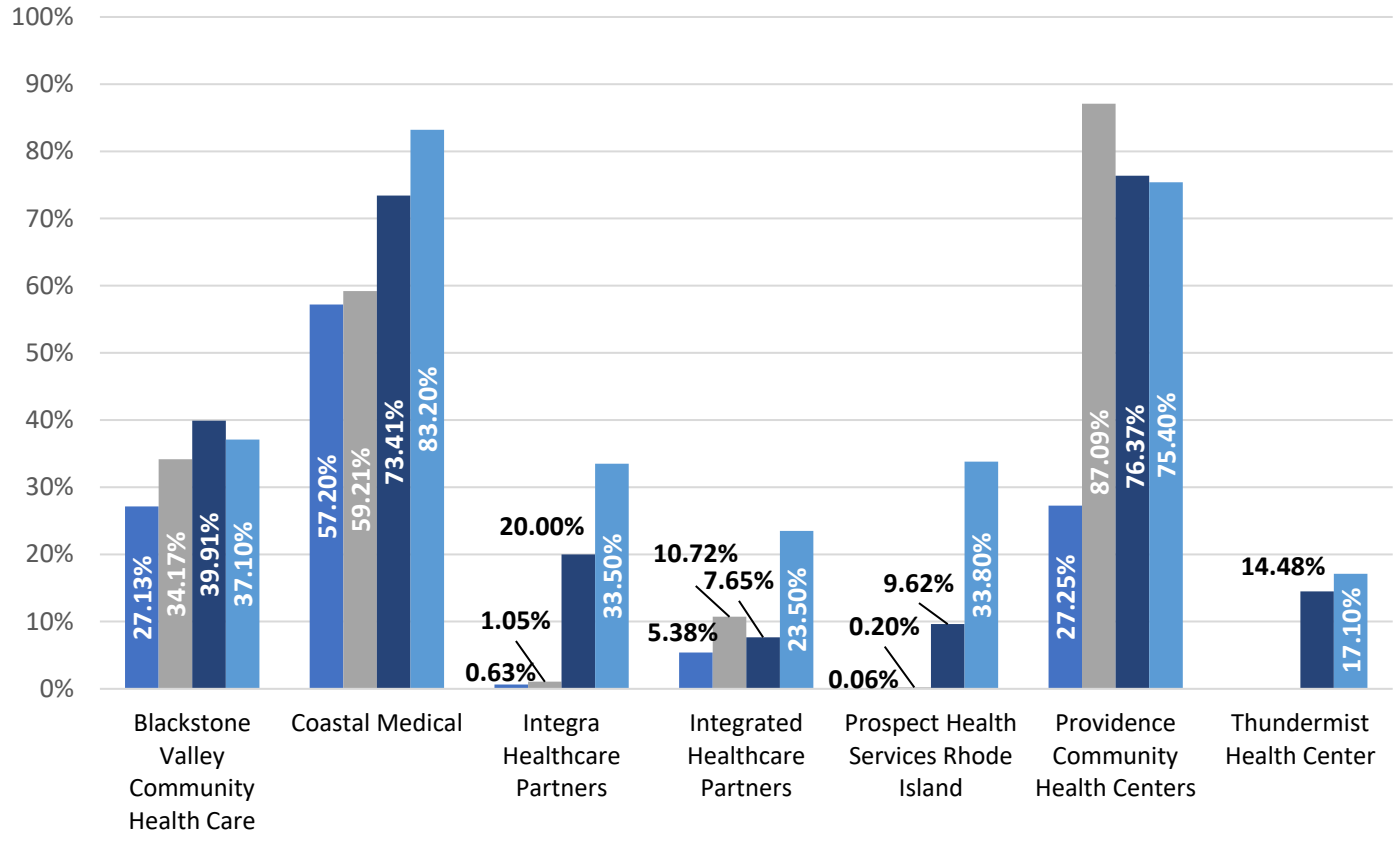


Figure 8. Social Determinants of Health Screening



External Quality Review Activity 3. Review of Compliance with Medicaid and Children's Health Insurance Program Standards – Technical Summary

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 set forth in *42 Code of Federal Regulations Part 438 Managed Care Subpart D MCO, PIHP and PAHP Standards*, the disenrollment requirements and limitations described in *42 Code of Federal Regulations 438.56*, the enrollee rights requirements described in *42 Code of Federal Regulations 438.100*, the emergency and post-stabilization services requirements described in *42 Code of Federal Regulations 438.114*, and the quality assessment and performance improvement requirements described in *42 Code of Federal Regulations 438.330* is a mandatory external quality review 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 Managed Care*.

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 plan's 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 Neighborhood's most recent NCQA Accreditation Survey to verify managed care compliance with state and federal Medicaid requirements.

Technical Methods of Data Collection and Analysis

IPRO received NCQA Accreditation Survey results from Neighborhood and reviewed these results to verify managed care plan compliance with federal Medicaid standards of *42 Code of Federal Regulations Part 438 Managed Care*.

Description of Data Obtained

The *NCQA 2020 Renewal Survey Medicaid Score Summary* presented Accreditation Survey results by category code, standard code, review category title, self-assessed score, current score, issues not met, points received and possible points. The crosswalk provided to IPRO by the Office of Health and Human Services included instructions on how to use the crosswalk, a glossary, and detailed explanations on how the NCQA accreditation standards support federal Medicaid standards.

Comparative Results

Neighborhood's accreditation was granted by NCQA on October 29, 2020. Table 40 displays Neighborhood's compliance with federal Medicaid standards captured during the most recent NCQA Accreditation Survey.

Table 40: Evaluation of Neighborhood's Compliance with Federal Medicaid Standards, 2020

Federal Medicaid Standard	Neighborhood's Results
438.56 Disenrollment requirements and limitations	Met
438.100 Enrollee rights and requirements	Met
438.114 Emergency and poststabilization services	Met
438.206 Availability of services	1 Element Partially Met
438.207 Assurances of adequate capacity and services	Met
438.208 Coordination and continuity of care	Met
438.210 Coverage and authorization of services	Met
438.214 Provider selection	Met
438.224 Confidentiality	Met
438.228 Grievance and appeal system	Met
438.230 Sub-contractual relationships and delegation	1 Element Not Met
438.236 Practice guidelines	Met
438.242 Health information systems	Met
438.330 Quality assessment and performance improvement program	Met

External Quality Review Activity 4. Validation of Network Adequacy – Technical Summary

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. The Office of Health and Human Services-established access standards are presented in Table 41.

Table 41: 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
▪ Outpatient Behavioral/Mental Health Adult Prescribers Within 30 Minutes or 30 Miles
▪ Outpatient Behavioral/Mental Health Pediatric Prescribers Within 45 Minutes or 45 Miles
▪ Outpatient Behavioral/Mental Health Adult Non-Prescribers Within 20 Minutes or 20 Miles
▪ Outpatient Behavioral/Mental Health Pediatric Non-Prescribers Within 20 Minutes or 20 Miles
▪ Outpatient Behavioral Health Substance Use Prescribers Within 30 Minutes or 30 Miles
▪ Outpatient Behavioral Health Substance Use Non-Prescribers Within 20 Minutes or 20 Miles
Appointment Standards
▪ After-Hours Care (telephone) Available 24 Hours a Day, 7 Days a Week
▪ Emergency Care Available Immediately
▪ Urgent Care Within 24 Hours
▪ Routine Care Within 30 Calendar Days
▪ Physical Exam Within 180 Calendar Days
▪ 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

Rhode Island Medicaid Managed Care Access Standards
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

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 2022 validation of network adequacy for Neighborhood.

Technical Methods of Data Collection and Analysis

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

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

Neighborhood's access standard for primary care providers is one provider within 20 miles and one provider within 30 miles for obstetricians/gynecologists. Neighborhood's goal is to have 95% of its network of providers meet the established distance requirements. The distance requirements differ by provider type and county designation.

Description of Data Obtained

IPRO's evaluation was performed using network data submitted by Neighborhood in the *Network Adequacy Analysis Report* (November 2022) and in Neighborhood's quarterly *Access Survey Reports* for 2022.

Comparative Results

Table 42 shows the percentage of members for whom the geographic access standards were met. The results of this analysis show that Neighborhood exceeded the 95% goal for member geographic access for all provider types reported.

Table 42: Neighborhood's Geo Access Analysis, 2022 Quarter 4

Provider Specialty	Access to Provider Standard[1]	% of Members With Access 2022 Quarter 4	Goal = 95% Met/Not Met
Primary Care			
Pediatrics	1 in 20 Miles	100.0%	Met
Family Medicine	1 in 20 Miles	100.0%	Met
Internal Medicine	1 in 20 Miles	99.9%	Met
Obstetrics/Gynecology	1 in 30 Miles	100.0%	Met
Specialty Care			
Cardiology	1 in 30 Miles	100.0%	Met
Gastroenterology	1 in 30 Miles	100.0%	Met
Neurology	1 in 30 Miles	100.0%	Met
Oncology	1 in 30 Miles	100.0%	Met
Optometry	1 in 30 Miles	99.9%	Met
Optometry, Pediatrics	1 in 45 Miles	98.0%	Met
Orthopedic Surgery	1 in 30 Miles	100.0%	Met
Orthopedic Surgery, Pediatrics	1 in 45 Miles	99.9%	Met
Otolaryngology, Pediatrics	1 in 45 Miles	100.0%	Met
Physical Therapy, Pediatrics	1 in 45 Miles	100.0%	Met

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

Table 43 displays aggregate results of the secret shopper appointment availability surveys conducted by Neighborhood in January 2022 and July 2022. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 43: Neighborhood's Appointment Availability Survey Results, January 2022 and July 2022

Appointment Type/Provider Specialty	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made[1]
Primary Care Routine Appointments				
Family/General/Internal	20	17	85.0%	85.0%
Pediatricians	20	16	80.0%	80.0%
Obstetrics/Gynecology	12	10	83.3%	83.3%
Primary Care Urgent Appointments				
Family/General/Internal	20	18	90.0%	60.0%
Pediatricians	20	18	90.0%	80.0%
Obstetrics/Gynecology	12	7	58.3%	33.3%
Adult Specialty Care Routine Appointments				
Cardiology	12	2	16.7%	16.7%
Dermatology	12	8	66.7%	58.3%
Endocrinology	12	4	33.3%	25.0%
Gastroenterology	12	6	50.0%	50.0%
Pulmonary	12	2	16.7%	16.7%
Adult Specialty Care Urgent Appointments				
Cardiology	12	5	41.7%	25.0%
Dermatology	12	5	41.7%	16.7%
Endocrinology	12	3	25.0%	8.3%
Gastroenterology	12	6	50.0%	33.3%
Pulmonary	12	8	66.7%	16.7%
Pediatric Specialty Care Routine Appointments				
Allergy/Immunology	12	10	83.3%	75.0%
Gastroenterology	12	2	16.7%	16.7%
Neurology	7	4	57.1%	42.9%
Orthopedics	12	5	41.7%	41.7%
Otolaryngology/Ear, Nose and Throat	12	2	16.7%	16.7%
Pediatric Specialty Care Urgent Appointments				
Allergy/Immunology	12	7	58.3%	41.7%
Gastroenterology	12	4	33.3%	16.7%
Neurology	7	4	57.1%	14.3%
Orthopedics	12	9	75.0%	33.3%
Otolaryngology/Ear, Nose and Throat	12	6	50.0%	16.7%
Behavioral Health Care Routine Appointments				
Adult Behavioral Health	30	6	20.0%	3.3%
Pediatric/Adolescent Behavioral Health	30	6	20.0%	10.0%

[1] The Number of Providers Surveyed is the denominator for Rate of Timely Appointments Made.

External Quality Review Activity 5. Validation of Encounter Data Reported by the Medicaid and Children's Health Insurance Program Managed Care Plan – Technical Summary

Objectives

Title 42 Code of Federal Regulations Section 438.242 Health Information Systems (c) Enrollee encounter data requires that states hold managed care plans contractually responsible for the collection, maintenance, and reporting of encounter data in a manner that meets state and federal standards. These standards are intended to ensure that the encounter data provides a complete and accurate representation of services provided to enrollees.

As required by section *2.13.02 Encounter Data Reporting* of the *Medicaid Managed Care Services Agreement*, and the *Rhode Island Medicaid Managed Care Encounter Data Methodology, Thresholds and Penalties for Non-Compliance* guidance document, Rhode Island managed care plans must submit encounter data, monthly, to the state that is accurate and complete. Managed care plan encounter submissions must include all paid (original, corrected and adjusted/voided, paid at $0 dollars) encounter data and partial payments denied at the line level and paid at the header level. All data reported to the Office of Health and Human Services are housed within the state's Medicaid Management Information System and maintained by fiscal intermediary, Gainwell Technologies, LLC.

Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review (c)(1) encourages states to validate encounter data reported by managed care plans during the preceding 12 months. In 2022, IPRO conducted this activity on behalf of the Office of Health and Human Services. IPRO aimed to verify the completeness and accuracy of encounters with service dates from January 1, 2021 to December 31, 2021 and submitted by Neighborhood to the state between January 1, 2021, and March 31, 2022.

Technical Methods of Data Collection and Analysis

During calendar year 2022, IPRO initiated a review of encounters submitted with service dates from January 1, 2021 to December 31, 2021 and submitted to the state between January 1, 2021, and March 31, 2022. Specifically, a comparison of data housed by Neighborhood to data housed in the state's Medicaid Management Information System was performed. For each data element compared, IPRO aimed to calculate a match rate between the two data sources.

At the request of the Office of Health and Human Services, Gainwell Technologies provided IPRO with the data extracts from the state's Medicaid Management Information System that were needed to carry out this activity. Neighborhood submitted data using the layouts developed by IPRO. File layouts were provided for the following encounter types:

- professional claims,
- institutional inpatient claims,
- institutional outpatient claims,
- dental claims, and
- pharmacy claims.

The validation was conducted using an approach developed by IPRO and consistent with the Centers for Medicare & Medicaid Services' *Protocol 5 – Validation of Encounter Data*. The encounter data validation audit was conducted utilizing the following methodology:

1. Neighborhood submitted specified data elements obtained from their adjudicated source claims that correspond to the selected audit period. To verify the source claims data, IPRO requested that Neighborhood include the internal control number when available. The internal control number is obtained when the encounter is adjudicated in the state's Medicaid Management Information System.
2. IPRO imported Neighborhood's files and generated separate data tables per encounter type. Analyses were conducted using SAS®.
3. To identify discrepancies, IPRO compared the values of each data element from Neighborhood's source data to values of the corresponding data element from the Office of Health and Human Services' source data.
4. The percentage of records with discrepant values were calculated for each data element, and those with less than a 90% match rate were investigated.
5. IPRO reviewed discrepancies and categorized the data element discrepancies for each encounter type, where applicable.
6. Among data elements with less than a 90% match rate, IPRO selected a random sample of 1,000 discrepant records for each encounter type and discrepancy category for Neighborhood. IPRO provided counts of all discrepant records by discrepancy category to the Office of Health and Human Services. The sample size was determined based on the number of discrepancies.
7. For Neighborhood, IPRO identified omitted and surplus internal control numbers. The omitted internal control numbers were identified as the encounters in Neighborhood's claims files that were not present in IPRO's data warehouse. The surplus internal control numbers were identified in IPRO's data warehouse that were included in Neighborhood's claims files.

A teleconference was held to discuss preliminary findings and conduct staff interviews. The Neighborhood encounter data validation audit call was conducted on May 31, 2023. Neighborhood's system was reviewed for discrepancies of data elements present in the encounter types between the submitted encounter data validation data file and the data submitted to the Office of Health and Human Services. The attendees of the encounter data validation audit call included the Office of Health and Human Services, Neighborhood, CVS Caremark, and IPRO. Data elements with less than a 90% match rate were reviewed.

Following the teleconference with Neighborhood, IPRO worked with Gainwell Technologies to identify any inconsistencies between the values and/or information provided by Neighborhood and confirmed the information the Office of Health and Human Services received for each data element by encounter type.

Description of Data Obtained

For this review period, the data source was the IPRO-produced report, "Neighborhood Encounter Data Validation-2021 Claims." The report included comprehensive descriptions of the objectives, methodology, detailed findings, and recommendations for improvement.

Comparative Results

Based upon IPRO's review of Neighborhood's encounter data audit file values for the sampled records, identification and research of the discrepant values, review of the discrepant reason codes received from Neighborhood, and discussions with Neighborhood and the Office of Health and Human Services during and following the teleconference, there are areas that require further research by encounter type by Neighborhood, CVS Caremark, the Office of Health and Human Services, Gainwell, and IPRO.

Surplus and Omitted Internal Control Numbers

The omitted internal control numbers were identified as the encounters in Neighborhood's encounter extract data file that were not present in the Office of Health and Human Services/Gainwell Technologies encounter data file. The surplus internal control numbers were identified in the Office of Health and Human Services/Gainwell

Technologies' encounter data for the audit period that were not present or included on Neighborhood's encounter extract data file. Table 44 shows Neighborhood's total number of discrepant surplus and omitted internal control numbers identified by IPRO.

Table 44: Neighborhood's Count of Surplus and Omitted Internal Control Numbers

Encounter Type	Surplus Internal Control Numbers Count[1]	Omitted Internal Control Numbers Count[2]
Professional	0	1,017
Institutional inpatient	32,554	3,913
Institutional outpatient	74,947	49,504
Pharmacy	139,759	5,300

[1] Surplus internal control numbers are encounters present in the Office of Health and Human Services' Medicaid Management Information System but not submitted in Neighborhood's claim/encounter data validation audit file.

[2] Omitted internal control numbers are encounters in Neighborhood's claim/encounter data validation audit file but not present in the Office of Health and Human Services' Medicaid Management Information System

Data elements with less than a 90% match rate were reviewed. IPRO reviewed discrepancies and categorized them for each encounter type. Findings are summarized in Table 45, Table 46, Table 47, and Table 48.

Professional Encounters and Claims

Table 45: Neighborhood's Professional Data Element Discrepancies and Findings

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
MCO_NAME	NV	The MCO name was not validated and will be removed from future EDV studies.
PLAN_CODE	NV	Gainwell data included the trading partner ID. For future studies, IPRO will indicate that MCOs should submit the trading partner ID.
MEDICAID_MEMBER_ID	99.99	
ICN	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the EOHHS data.
MCO_ICN	99.92	For future EDV studies, IPRO will clarify the scope of work requirement for the MCO_ICN, advising the MCOs how to submit.
NUM_ADJ_ICN	100	
LINE_NUMBER	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the EOHHS data.
DTE_FIRST_SVC_DTL	99.99	
DTE_LAST_SVC_DTL	99.99	
PLACESVC	100	
DIAGCD1	99.38	
DIAGCD2	99.77	
DIAGCD3	99.89	
DIAGCD4	99.95	
DIAGCD5	100	
DIAGCD6	100	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
DIAGCD7	100	
DIAGCD8	100	
DIAGCD9	100	
DIAGCD10	100	
DIAGCD11	99.95	
DIAGCD12	99.96	
PTMT_ADJ_DATE	84.02	NHPRI indicated that only the paid date is provided on 837P, rather than the adjudication date. IPRO followed up with Gainwell after the remote meeting. Gainwell advised that the header paid date is only required when the MCO is reporting header only paid claims If reporting detail service line is a paid claim, the MCO should not report header paid date, as reporting both dates will cause a compliance issue. For future EDV studies, IPRO will modify the scope of work requirement for the payment adjudication date.
AMT_MCO_PAID_HDR	99.99	
AMT_OTH_INS_PD_HDR	84.02	NHPRI indicated that other insurance paid amount is typically reported at the detail level, not at the header level. It appeared that Gainwell summed up paid and other insurance amounts. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that the value on the Gainwell data extract includes what is provided by the MCOs and not a calculated/summarized value. IPRO further followed up with Gainwell and provided MCO examples for review.
AMT_MCO_PAID_DTL	99.99	
AMT_OTH_INS_PD_DTL	84.69	NHPRI populated value for the header and detail data elements. NHPRI indicated that this data element should match with AMT_OTH_INS_PD_HDR on the Gainwell populated values. Gainwell contained a 0 for the AMT_OTH_INS_PD_DTL. This is an EDV reporting study data extraction issue, as NHPRI should have only provided a value for the AMT_OTH_INS_PD_HDR. IPRO will clarify the scope of work requirement for the other insurance paid amounts.
PROCCODE	99.99	
QTY_UNITS_BILLED	99.99	
MODIFIER1	99.98	
MODIFIER2	96.51	
MODIFIER3	99.98	
MODIFIER4	99.99	
NDC_CODE	100	
BILLING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
BILLING_PROV_NPI	99.70	
RENDERING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
RENDERING_PROV_NPI	93.91	
REFERRING _PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
REFERRING _PROV_NPI	97.75	

Yellow shading: < 90% match with MCO reporting study data extraction issue; light green shading: < 90% match and IPRO to follow up with Gainwell; no shading and < 90% match is IPRO/Rhode Island EOHHS/vendor data issue; NV: not validated; MCO: managed care organization; EDV: encounter data validation; ID: identifier; EOHHS: Executive Office of Health and Human Services; NPI: National Provider Identifier; ICN: internal control number; NHPRI: Neighborhood Health Plan of Rhode Island.

Institutional Inpatient Encounters and Claims

Table 46: Neighborhood's Institutional Inpatient Data Element Discrepancies and Findings

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
MCO_NAME	NV	The MCO name was not validated and will be removed from future EDV studies.
PLAN_CODE	NV	Gainwell data included the trading partner ID. For future studies, IPRO will indicate that MCOs should submit the trading partner ID.
MEDICAID_MEMBER_ID	NV	MEDICAID_MEMBER_ID was not validated and will be reviewed in future EDV studies.
ICN	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the EOHHS data.
MCO_ICN	88.09	During the remote meeting, it was indicated that the adjusted claim numbers ended with 01. There was a version difference between the behavioral health organization's original claim versus the adjusted claim. For future EDV studies, IPRO will modify the scope of work requirement for the MCO_ICN, advising the MCOs how to submit.
NUM_ADJ_ICN	76.33	During the remote meeting, it was indicated that the data element was provided as the original ICN value and should have been populated on the Gainwell data. IPRO followed up with Gainwell regarding the missing values, and Gainwell confirmed that a new ICN would be assigned to the data element provided to IPRO. Since the new ICN is not available to the MCOs, IPRO recommends this field be removed from future EDV studies.
LINE_NUMBER	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the EOHHS data.

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
DTE_ADMISSION	100	
DTE_DISCHARGE	NV	Date of discharge was not validated and will be reviewed in future EDV studies.
DTE_FIRST_SVC_HDR	87.01	During the remote meeting, it was indicated that the discrepancy was on behavioral claims, and Gainwell was displaying the last service date instead of the first service date. This was confirmed by the claim screens and the 837I string that was shared. As a follow-up item, IPRO requested the date of transition for the new encounter management. The date of transition was given as 4/1/2022.
DTE_LAST_SVC_HDR	99.99	
DTE_FIRST_SVC_DTL	98.92	
DTE_LAST_SVC_DTL	65.03	During the remote meeting, it was indicated that it was an identification of service line discrepancy. There are decimal line numbers in the core system. The decimal concept was explained, and examples for line splits were shared. The service line splits occur when some service is paid, and some are denied (an example would be due to preauthorization). It was also indicated that only integers need to be submitted. It was indicated that this issue can be considered as an EDV study pull issue, since the line numbers cannot match if certain previous line numbers had split lines. Reconciliation is done by the value that is in the core system and the values that were submitted in the encounters. As a follow-up item, NHPRI provided screen prints to understand the decimal line number concept. NHPRI indicated in the examples shared that the decimal numbers are translated to sequential line numbers on the 837 file. NHPRI also indicated including the corresponding decimal line number on the 837 file in the REF*6R segment.
ADMITTYP	100	
DIS_STAT	NV	Discharge status code discrepancies were not provided to the MCO for review prior to the remote meeting. The discharge status code discrepancies will be reviewed in future EDV studies.
TYPEBILL	100	IPRO reran the percent discrepancy matching only on the first two digits. The companion guide indicates MCOs should only submit a frequency code of 1 (original), 7 (replacement), or 8 (void). Due to the discrepancy of the frequency code (the third digit), IPRO proposes only the first two digits be submitted for future EDV studies.

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
DRG	NV	Gainwell data included a data element labeled RUG_CDE, but the value was missing. IPRO was not able to match any values to the MCO's submitted DRG codes. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that values are being pulled correctly from the database where they are loaded. IPRO further followed up with Gainwell to confirm the correct data field that contains the values for the DRG code.
DIAGCD1	99.96	
DIAGCD2	99.99	
DIAGCD3	99.96	
DIAGCD4	39.63	NHPRI submits values for DIAGCD4–DIAGCD6 and DIAGCD8 in EDV study file. Gainwell data file contains blanks. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that values are being pulled from the MCO extracts, but they are not present on the Gainwell data file. IPRO further followed up with Gainwell with examples of discrepancies to review.
DIAGCD5	47.30	NHPRI submits values for DIAGCD4–DIAGCD6 and DIAGCD8 in EDV study file. Gainwell data file contains blanks. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that values are being pulled from the MCO extracts, but they are not present on the Gainwell data file. IPRO further followed up with Gainwell with examples of discrepancies to review.
DIAGCD6	55.08	NHPRI submits values for DIAGCD4–DIAGCD6 and DIAGCD8 in EDV study file. Gainwell data file contains blanks. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that values are being pulled from the MCO extracts, but they are not present on the Gainwell data file. IPRO further followed up with Gainwell with examples of discrepancies to review.
DIAGCD7	99.96	
DIAGCD8	67.44	NHPRI submits values for DIAGCD4–DIAGCD6 and DIAGCD8 in EDV study file. Gainwell data file contains blanks. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that values are being pulled from the MCO extracts, but since they are not present on the Gainwell data file. IPRO further followed up with Gainwell with examples of discrepancies to review.
DIAGCD9	99.96	
DIAGCD10	99.96	
DIAGCD11	94.74	
DIAGCD12	97.92	
DIAGCD13	97.92	
DIAGCD14	94.54	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
DIAGCD15	95.08	
DIAGCD16	95.67	
DIAGCD17	96.13	
DIAGCD18	96.64	
DIAGCD19	97.30	
DIAGCD20	97.68	
DIAGCD21	97.92	
DIAGCD22	98.17	
DIAGCD23	98.48	
DIAGCD24	98.73	
DIAGCD25	99.12	
SURG1	99.99	
SURG2	99.99	
SURG3	99.99	
SURG4	99.99	
SURG5	99.99	
SURG6	99.99	
SURGDTE1	99.99	
SURGDTE2	100	
SURGDTE3	99.99	
SURGDTE4	99.99	
SURGDTE5	100	
SURGDTE6	99.99	
PTMT_ADJ_DATE	0	NHPRI does not submit this data element on 837I. Only the paid date at the detail level is submitted. IPRO followed up with Gainwell after the remote meeting. Gainwell advised that the header paid date is only required when the MCO is reporting header only paid claims. If reporting detail service line is a paid claim, the MCO should not report header paid date, as reporting both dates will cause a compliance issue. For future EDV studies, IPRO will modify the scope of work requirement for the payment adjudication date
PAIDDATE_HDR	7.20	NHPRI indicated that if global reimbursement claim (bundled claim) is submitted, then the sum of all lines is populated in the PAIDDATE_HDR data element. However, in other cases this data element is not submitted on 837I; only the paid date at the detail level is submitted. For future EDV studies, IPRO will modify the scope of work requirement for the paid date header, advising the MCOs how to submit.

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
AMT_MCO_PAID_HDR	8.43	There were two findings related with the discrepancy: 1. NHPRI submitted the sum of the paid amount of all lines. During the remote meeting, it was confirmed that this is an EDV extraction pull issue, since this was summing up all the detail level lines to populate the header. 2. IPRO reached out to Gainwell also as a follow-up item to understand if Gainwell receives and retains values for this data element. Gainwell confirmed that the values will be 0 if the claim is paid at the detail level for AMT_MCO_PAID_HDR and greater than 0 if the claim is paid at the header level. IPRO will modify the scope of work requirement for the amount MCO paid header.
AMT_OTH_INS_PD_HDR	0.01	NHPRI submitted the sum of other insurance paid amounts across all details. However, Gainwell submitted the sum of both NHPRI paid amounts and other insurance paid amounts. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that the value on the Gainwell data extract includes what is provided by the MCOs and not a calculated/summarized value. IPRO further followed up with Gainwell and provided MCO examples for review.
PAIDDATE_DTL	90.44	
AMT_MCO_PAID_DTL	90.41	
AMT_OTH_INS_PD_DTL	0.41	NHPRI populated value for the header and detail data elements. NHPRI indicated that this data element should match with AMT_OTH_INS_PD_HDR on Gainwell populated values. Gainwell contained a 0 for the AMT_OTH_INS_PD_DTL. IPRO will clarify the scope of work requirement for the other insurance paid amounts.
PROCCODE	99.96	
UNITS_BILLED	97.83	
MODIFIER1	99.99	
MODIFIER2	100	
MODIFIER3	100	
MODIFIER4	100	
REVENUE_CODE	97.40	
NDC_CODE	100	
BILLING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
BILLING_PROV_NPI	85.57	NHPRI indicated that primary cause could be merger/acquisition of provider group. IPRO followed up with NHPRI after the remote meeting. NHPRI confirmed that the discrepancy is due to system re-architecture. The transition was made on 10/31/2021 with an effective date of 9/1/2020 for the provider.
ATTENDING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
ATTENDING_PROV_NPI	0.35	NHPRI indicated that this data element is submitted for every record. IPRO followed up with Gainwell after the remote meeting to understand the logic behind populating NPIs by encounter type. Gainwell initially advised that the information in the file is from the claim information Gainwell receives from the MCOs on the encounter extract file. IPRO has further followed up with Gainwell and provided Gainwell with examples of discrepancies. IPRO also has requested Gainwell to provide the logic by encounter type for NPIs that need to be submitted by the MCOs on the encounter data extracts.
RENDERING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
RENDERING_PROV_NPI	NV	Rendering Provider NPI was not validated and will be reviewed in future EDV studies.
REFERRING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
REFERRING_PROV_NPI	100	

Gray shading: < 90% match with MCO discrepancy; yellow shading: < 90% match with MCO reporting study data extraction issue; light green shading: < 90% match and IPRO to follow up with Gainwell; no shading and < 90% match is IPRO/Rhode Island EOHHS/vendor data issue; NV: not validated; MCO: managed care organization; EDV: encounter data validation; EOHHS: Executive Office of Health and Human Services; ID: identifier; DRG: diagnosis-related group; NPI: National Provider Identifier; ICN: internal control number; NHPRI: Neighborhood Health Plan of Rhode Island.

Institutional Outpatient Encounters and Claims

Table 47: Neighborhood's Institutional Outpatient Data Element Discrepancies and Findings

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
MCO_NAME	NV	The MCO name was not validated and will be removed from future EDV studies.
PLAN_CODE	NV	Gainwell data included the trading partner ID. For future studies, IPRO will indicate that MCOs should submit the trading partner ID.
MEDICAID_MEMBER_ID	NV	MEDICAID_MEMBER_ID was not validated and will be reviewed in future EDV studies.
ICN	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the EOHHS data.
MCO_ICN	100	
NUM_ADJ_ICN	44.34	During the remote meeting, it was indicated that the data element was provided as the original ICN value and should have been populated on the Gainwell data. IPRO followed up with Gainwell regarding the missing values, and Gainwell confirmed that a new ICN would be assigned to the data element provided to IPRO. Since the new ICN is not available to the MCOs, IPRO recommends this field be removed from future EDV studies.
LINE_NUMBER	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the EOHHS data.
DTE_FIRST_SVC_HDR	100	
DTE_LAST_SVC_HDR	100	
DTE_FIRST_SVC_DTL	98.66	
DTE_LAST_SVC_DTL	98.66	
TYPEBILL	100	IPRO reran the percent discrepancy matching only on the first two digits. The companion guide indicates MCOs should only submit a frequency code of 1 (original), 7 (replacement), or 8 (void). Due to the discrepancy of the frequency code (the third digit), IPRO proposes only the first two digits be submitted for future EDV studies.
DIAGCD1	100	
DIAGCD2	99.96	
DIAGCD3	99.96	
DIAGCD4	70.11	NHPRI submits values for DIAGCD4–DIAGCD6 and DIAGCD8 in EDV study file. Gainwell data file contains blanks. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that values are being pulled from the MCO extracts, but they are not present on the Gainwell data file. IPRO further followed up with Gainwell with examples of discrepancies to review.

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
DIAGCD5	78.82	NHPRI submits values for DIAGCD4–DIAGCD6 and DIAGCD8 in EDV study file. Gainwell data file contains blanks. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that values are being pulled from the MCO extracts, but they are not present on the Gainwell data file. IPRO further followed up with Gainwell with examples of discrepancies to review.
DIAGCD6	85.33	NHPRI submits values for DIAGCD4–DIAGCD6 and DIAGCD8 in EDV study file. Gainwell data file contains blanks. IPRO followed up with Gainwell after the remote meeting. Gainwell initially advised that values are being pulled from the MCO extracts, but since they are not present on the Gainwell data file. IPRO further followed up with Gainwell with examples of discrepancies to review.
DIAGCD7	99.98	
DIAGCD8	92.26	
DIAGCD9	99.99	
DIAGCD10	99.99	
DIAGCD11	100	
DIAGCD12	100	
DIAGCD13	100	
DIAGCD14	98.57	
DIAGCD15	98.89	
DIAGCD16	99.11	
DIAGCD17	99.29	
DIAGCD18	99.47	
DIAGCD19	99.60	
DIAGCD20	99.69	
DIAGCD21	99.75	
DIAGCD22	99.82	
DIAGCD23	99.85	
DIAGCD24	99.91	
DIAGCD25	99.93	
SURG1	100	
SURG2	100	
SURG3	100	
SURG4	100	
SURG5	100	
SURG6	100	
SURGDTE1	100	
SURGDTE2	100	
SURGDTE3	100	
SURGDTE4	100	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
SURGDTE5	100	
SURGDTE6	100	
PTMT_ADJ_DATE	0	NHPRI does not submit this data element on 837I. Only the paid date at the detail level is submitted. As a follow-up item, IPRO reached out to Gainwell to inquire if Gainwell receives and retains this data element or if only the paid date will be considered in future EDV studies. Gainwell advised that the header paid date is only required when the MCO is reporting header only paid claims. If reporting detail service line is a paid claim, the MCO should not report header paid date, as reporting both dates will cause a compliance issue. For future EDV studies, IPRO will modify the scope of work requirement for the payment adjudication date.
PAIDDATE_HDR	4.82	NHPRI indicated that PAIDDATE_HDR is populated only if global reimbursement claim (bundled claim) is submitted. In other cases, this data element is not submitted on 837I; only the paid date at the detail level is submitted. For future EDV studies, IPRO will modify the scope of work requirement for the paid date header, advising the MCOs how to submit.
AMT_MCO_PAID_HDR	5.66	NHPRI submitted the sum of the paid amount of all lines. During the remote meeting, it was confirmed that this is an EDV pull issue, since this was summing up all the detail level lines to populate the header. IPRO reached out to Gainwell also as a follow-up item to understand if Gainwell receives and retains values for this data element. Gainwell confirmed the values will be 0 if the claim is paid at the detail level for AMT_MCO_PAID_HDR and greater than 0 if the claim is paid at the header level. AMT_MCO_PAID_DTL is populated when paid at the detail level. IPRO will modify the scope of work requirement for the amount MCO paid header.
AMT_OTH_INS_PD_HDR	0.04	NHPRI submitted the sum of other insurance paid amounts across all details. However, Gainwell submitted the sum of both NHPRI paid amounts and other insurance paid amounts. As a follow up item, IPRO reached out to Gainwell to get clarification if this data element is derived on Gainwell's end. Gainwell initially advised that the value on the Gainwell data extract includes what is provided by the MCOs and not a calculated/summarized value. IPRO further followed up with Gainwell and provided MCO examples for review.

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
PAIDDATE_DTL	84.50	During the remote meeting, NHPRI indicated that the discrepancy is due to timing of adjustments.
AMT_MCO_PAID_DTL	84.35	During the remote meeting, NHPRI indicated that the mismatch is due to the denied lines not getting reported and residing in the core system. This creates a discrepancy between what is in the core system and what Gainwell would have reported.
AMT_OTH_INS_PD_DTL	0.97	NHPRI populates value for other insurance paid amounts at detail level when available. NHPRI also indicated that this data element should match with AMT_OTH_INS_PD_HDR on the Gainwell populated values. Gainwell contained a 0 for the AMT_OTH_INS_PD_DTL. IPRO will clarify the scope of work requirement for the other insurance paid amounts.
PROCEDURE_CODE	89.33	During the remote meeting, NHPRI indicated that the discrepancy is due to sequential line number reordering. This happens when denied service lines get dropped; there is a shifting of line numbers to ensure they are sequential in 837I.
UNITS_BILLED	98.75	
MODIFIER1	98.85	
MODIFIER2	99.78	
MODIFIER3	99.99	
MODIFIER4	100	
REVENUE_CODE	96.50	
NDC_CODE	98.09	
BILLING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
BILLING_PROV_NPI	96.71	
RENDERING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
RENDERING_PROV_NPI	NV	IPRO compared ATTENDING_PROV_NPI for RENDERING_PROV_NPI for CY 2021.
REFERRING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
REFERRING_PROV_NPI	100	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
OPERATING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies. Operating Provider information would not be available on the institutional outpatient encounter data extract. For future EDV studies, IPRO will remove OPERATING_PROV_ID from institutional outpatient and ensure it is included on the institutional inpatient.
OPERATING_PROV_NPI	NV	Operating Provider information would not be available on the Institutional Outpatient encounter data extract. For future EDV studies, IPRO will remove OPERATING_PROV_NPI from institutional outpatient and ensure it is included on the institutional inpatient.

Gray shading: < 90% match with MCO discrepancy; yellow shading: < 90% match with MCO reporting study data extraction issue; light green shading: < 90% match and IPRO to follow up with Gainwell; no shading and < 90% match is IPRO/Rhode Island EOHHS/vendor data issue; NV: not validated; MCO: managed care organization; EDV: encounter data validation; ID: identifier; EOHHS: Executive Office of Health and Human Services; NPI: National Provider Identifier; ICN: internal control number; NHPRI: Neighborhood Health Plan of Rhode Island.

Pharmacy Encounters and Claims

Table 48: Neighborhood's Pharmacy Data Element Discrepancies and Findings

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
MCO_NAME	NV	The MCO name was not validated and will be removed from future EDV studies.
PLAN_CODE	NV	Gainwell data included the trading partner ID. For future studies, IPRO will indicate that MCOs should submit the trading partner ID.
MEDICAID_MEMBER_ID	NV	MEDICAID_MEMBER_ID was not validated and will be reviewed in future EDV studies.
ICN	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the EOHHS data.
MCO_ICN	0	NHPRI populated MCO_ICN on both encounter and NCPDP files. This data element, however, is not submitted to Gainwell. For future EDV studies, IPRO will modify the scope of work requirement for the MCO_ICN, advising the MCOs how to submit.
NUM_ADJ_ICN	100	
LINE_NUMBER	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the EOHHS data.
DTE_FIRST_SVC	100	
DTE_LAST_SVC	100	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
PAIDDATE_HDR	99.99	
AMT_PAID_MCO_HDR	99.99	
AMT_TPL_SUBM_HDR	98.98	
AMT_NDC_PROFEE	99.99	
PRESC_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
PRESC_PROV_NPI	99.98	
BILLING_PROV_ID	NV	MCOs do not submit provider identification numbers on encounter data files. The provider identification numbers were not validated and will be removed from future EDV studies.
BILLING_PROV_NPI	100	
PRESC_DATE	99.99	
NUM_PRESCRIPTION_ID	100	
DISPENSE_DATE	100	
NDC_CODE	99.18	
QTY_DISPENSE_DTL	98.47	
QTY_DISPENSE_HDR	NV	NHPRI indicated that quantity dispensed is typically reported at the detail level; hence, quantity dispensed at the header is expected to be blank on the IPRO audit and encounter fields. For future EDV studies, IPRO will modify the scope of work requirement for QTY_DISPENSE_HDR.
NUM_DAY_SUPPLY	100	

Gray shading: < 90% match with MCO discrepancy; NV: not validated; MCO: managed care organization; EDV: encounter data validation; ID: identifier; EOHHS: Executive Office of Health and Human Services; NPI: National Provider Identifier; ICN: internal control number; NCPDP: National Council for Prescription Drug Program; NHPRI: Neighborhood Health Plan of Rhode Island.

External Quality Review Activity 6. Validation of Quality-of-Care Surveys, Member Satisfaction – Technical Summary

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.

Neighborhood independently contracted with a certified CAHPS vendor to administer the adult and child surveys for measurement year 2022. On behalf of the Office of Health and Human Services, IPRO validated satisfaction surveys sponsored by Neighborhood for measurement year 2022.

Technical Methods of Data Collection and Analysis

The standardized survey instruments selected for measurement year 2022 were the CAHPS 5.1H Adult Medicaid Health Plan Survey and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the chronic conditions measurement set). The CAHPS Medicaid questionnaire set includes separate versions for the adult and child populations.

HEDIS specifications require that Neighborhood provide a list of all eligible members for the sampling frame. Following HEDIS requirements, Neighborhood 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, 2022, continuously enrolled for at least five of the last six months of 2022, and currently enrolled in Neighborhood.

Table 49 provides a summary of Neighborhood's technical methods of data collection.

Table 49: Neighborhood's Technical Methods of Data Collection for CAHPS, Measurement Year 2022

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	2/25/2022-5/18/2022	2/25/2022-5/18/2022
Method of Collection	Mail Only	Mail Only
Sample Size	3,375	2,475
Response Rate	16.72%	10.08%

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

Table 50: CAHPS Categories and Response Options

Category/Measure	Response Options
Composite Measures	
▪ Getting Needed Care ▪ Getting Care Quickly ▪ How Well Doctors Communicate ▪ Coordination of Care ▪ 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	0-10 Scale *(Top-level performance is considered scores of "8" or "9" or "10.")*

To assess Neighborhood's performance, IPRO compared managed care plan scores to national Medicaid performance reported in the *2023 Quality Compass* (measurement year 2022) for all lines of business that reported measurement year 2022 CAHPS data to NCQA.

Description of Data Obtained

For the period under review, IPRO received a copy of the final measurement year 2022 study report produced by Neighborhood's certified CAHPS vendor. The report included comprehensive descriptions of the project objectives and methodology, as well as results and analyses.

Comparative Results

Table 51 displays the results of Neighborhood's 2023 CAHPS Adult Medicaid Survey for measurement year 2022 while Table 52 displays the results of Neighborhood's 2023 CAHPS Child Medicaid Survey for measurement year 2022. The national Medicaid benchmarks displayed in these tables come from *NCQA's 2023 Quality Compass* for measurement year 2022.

Table 51: Neighborhood's Adult CAHPS Results, Measurement Years 2019, 2020, 2021, and 2022

Measures	Neighborhood Measurement Year 2019	Neighborhood Measurement Year 2020	Neighborhood Measurement Year 2021	Neighborhood Measurement Year 2022	*Quality Compass* Measurement Year 2022 National Medicaid Benchmark (Met/Exceeded)	*Quality Compass* Measurement Year 2022 National Medicaid Mean
Rating of Health Plan[1]	85.46%	90.15%	87.31%	86.81%	95th	77.69%
Rating of All Health Care[1]	77.69%	82.10%	75.74%	80.57%	90th	74.55%
Rating of Personal Doctor[1]	85.34%	83.19%	85.34%	86.17%	75th	82.40%
Rating of Specialist[1]	86.27%	88.36%	87.16%	85.00%	75th	81.40%
Getting Care Quickly[2]	86.16%	85.93%	83.43%	86.48%	75th	80.36%
Getting Needed Care[2]	87.39%	88.14%	84.71%	86.06%	75th	80.99%
Customer Service[2]	91.86%	89.17%	88.92%	91.85%	75th	89.18%
How Well Doctors Communicate[2]	93.79%	92.00%	92.72%	94.11%	75th	92.49%
Coordination of Care[2]	89.45%	84.32%	86.21%	88.26%	75th	84.61%

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

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

Table 52: Neighborhood's Child CAHPS Results, Measurement Years 2019, 2020, 2021, and 2022

Measures	Neighborhood Measurement Year 2019	Neighborhood Measurement Year 2020	Neighborhood Measurement Year 2021	Neighborhood Measurement Year 2022	*Quality Compass* Measurement Year 2022 National Medicaid Benchmark (Met/Exceeded)	*Quality Compass* Measurement Year 2022 National Medicaid Mean
Rating of Health Plan[1]	92.55%	92.21%	89.80%	91.67%	90th	86.21%
Rating of All Health Care[1]	88.84%	89.29%	88.27%	88.89%	75th	86.16%
Rating of Personal Doctor[1]	91.44%	91.59%	90.79%	91.48%	75th	89.33%
Rating of Specialist[1]	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	85.63%
Getting Care Quickly[2]	89.11%	90.81%	85.74%	83.40%	25th	85.46%
Getting Needed Care[2]	88.17%	89.38%	88.19%	81.85%	33.33rd	82.71%
Customer Service[2]	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	87.64%
How Well Doctors Communicate[2]	91.97%	95.51%	93.21%	93.05%	33.33rd	93.62%
Coordination of Care[2]	Small Sample	Small Sample	86.21%	Small Sample	Not Applicable	83.81%

[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.

External Quality Review Activity 6. Validation of Quality-of-Care Surveys, Provider Satisfaction – Technical Summary

Objectives

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

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

To meet the requirements of the *Medicaid Managed Care Services Agreement*, Neighborhood administers a provider satisfaction survey annually. The objective of this survey is to assess provider perception of Neighborhood's Medicaid operations and services to better understand strengths, pain points, and opportunities. In 2022, Neighborhood aimed to meet or exceed overall satisfaction goal of 65%.

On behalf of the Office of Health and Human Services, IPRO validated the provider satisfaction survey sponsored by Neighborhood for measurement year 2022.

Technical Methods of Data Collection and Analysis

Neighborhood contracted a certified CAHPS vendor to conduct the measurement year 2022 provider satisfaction survey. To be eligible for this survey, providers needed visits with at least 100 or more unique members between March 2021 and September 2021.

Table 53 provides a summary of the technical methods of data collection.

Table 53: Neighborhood's Provider Satisfaction Technical Methods of Data Collection, Measurement Year 2022

Methodology Element	Provider Satisfaction Survey
Survey Administrator	Symphony Performance Health, Inc.
Survey Tool	Non-standard
Survey Timeframe	11/1/2022-1/3/2023
Method of Collection	Mail, Telephone, Internet
Eligible Provider Types	Primary Care Providers, Specialists, and Behavioral Health Clinicians
Sample Size	104
Response Rate	11.1%

The 52-question 2022 survey instrument was similar to the 2021 instrument. Table 54 displays the survey's measure and possible response options.

Table 54: Provider Satisfaction Survey Categories and Response Options

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

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

Where possible, the survey vendor compared Neighborhood's performance to Symphony Performance Health, Inc.'s *2022 Medicaid Book of Business* benchmarks.

Description of Data Obtained

For the period under review, IPRO received a copy of the final study report produced by the survey vendor for Neighborhood and utilized the reported results to evaluate the administration of the 2022 provider satisfaction survey. The report included detailed descriptions of the survey objectives, methodology, and results.

Comparative Results

Table 55 displays Neighborhood's provider satisfaction survey questions and results for measurement years 2019, 2020, 2021, and 2022.

Table 55: Neighborhood's Provider Satisfaction Results, Measurement Years 2019 to 2022

Measures	Neighborhood Measurement Year 2019 (n=unknown)	Neighborhood Measurement Year 2020 (n=108)	Neighborhood Measurement Year 2021 (n=105)	Neighborhood Measurement Year 2022 (m=104)
Overall Satisfaction [1]	52%	73.0%	69.6%	64.7%
Finance Issues [2]	19%	32%	34%	32%
Utilization and Quality Management [2]	25%	38%	40%	38%
Network/Coordination of Care [2]	21%	28%	33%	26%▼
Pharmacy [2]	11%	24%	26%	19%▼
Health Plan Call Center Staff [2,3]	35%	51%	46%	45%
Provider Relations [2]	16%	24%	43%▲	42%

[1] Proportion represent percentage of "completely" or "somewhat satisfied" responses.

[2] Proportion represent percentage of "well above average" or "somewhat above average" responses.

[3] Neighborhood's call center staff represent provider services.

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

▼ Rate is statistically significantly worse than the previous measurement year's rate.

Accreditation – Technical Summary

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

Table 56: NCQA Accreditation Status Levels and Points[1]

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 57.

Table 57: 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 2023.*

Description of Data Obtained

IPRO accessed the NCQA Health Plan Reports website[14] 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 September 2023.

IPRO also received from Neighborhood, the certificate of accreditation issued by NCQA and the NCQA 2020 Renewal Survey Summary for Medicaid. The certificate of accreditation issued by NCQA displayed Neighborhood'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

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

Neighborhood's accreditation survey and determinations of 'Met' or 'Not Met' issued to Neighborhood by element.

Comparative Results

Neighborhood was compliant with the state's requirement to achieve and maintain NCQA Accreditation. The managed care plan's 'Accredited' status is effective October 29, 2020 to October 29, 2023.

Neighborhood achieved overall health plan star ratings of 4.5 out of 5 for the *Health Plan Ratings 2023.* Table 58 displays Neighborhood's overall health plan star ratings, as well as the ratings for the three overarching categories (patient experience, prevention and equity, and treatment) and their subcategories under review.

Table 58: Neighborhood's 2023 NCQA Rating by Category, Measurement Year 2022

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

Gray shading means that an aggregate score for the subcategory is not available.

Neighborhood's Response to the 2021 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 59 displays the assessment categories used by IPRO to describe Neighborhood's progress towards addressing the 2021 external quality review recommendations. Table 60 displays Neighborhood's progress related to the recommendations made in the *2021 External Quality Review Aggregate Annual Technical Report* as well as IPRO's assessment of Neighborhood's response.

Table 59: 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, more time is needed to observe for performance improvement.
Remains an Opportunity for Improvement
Managed care plan's quality improvement response did not address the recommendation; or performance declined.

Table 60: Neighborhood's Response to the 2021 External Quality Review Recommendations

External Quality Review Activity	2021 External Quality Review Recommendation	Neighborhood's Response to the 2021 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
Quality Improvement Projects	Opportunities of improvement remain for four of the six quality Improvement projects, as Neighborhood did not achieve the established project goals. Neighborhood should continue to study the effectiveness of the intervention strategy and act on opportunities to make enhancements.	Neighborhood will continue to monitor the effectiveness of the interventions implemented for all quality improvement projects and adjust where appropriate. Since the reporting period (measurement year 2021), Neighborhood has implemented several new interventions for the following quality improvement projects: Lead Screening in Children Neighborhood's HEDIS rate for Lead Screening in Children increased from measurement year 2021 (75.10) compared to measurement year 2022 (78.06). Neighborhood continued several member education interventions in 2022. Lead screening was added as a quality measure to the Rhode Island's Accountable Entity Program as pay-for-reporting in 2022 with pay-for-performance beginning in 2023. Additionally, we have developed a monthly Lead Screening gap in care reports for individual accountable entities with an earlier age range. Neighborhood discusses barriers to performance as well as best practices with accountable entities during joint quarterly meetings. Neighborhood will continue to collaborate with the Rhode Island Department of Health on efforts to increase lead screening and prevention. Child and Adolescent Well Care Visit Neighborhood's HEDIS rate for Child and Adolescent Well Care Visit for ages 3-21 improved in measurement year 2022 (62.57) compared to measurement year 2021 (61.26). In addition to our ongoing member and provider interventions such as promoting member rewards, encouraging well visits through social media, automated voice calls and gap in care reports, we have planned several interventions for 2023 including collaboration with school-based health centers and automated voice call reminders about the importance of well visits. In 2022, the Well Exam Member Rewards increased across all age groups and our automated voice call campaign had a reach success rate of 49%.	Partially addressed.

External Quality Review Activity	2021 External Quality Review Recommendation	Neighborhood's Response to the 2021 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
		<u>Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication</u> Neighborhood's Quality Improvement staff conducts outreach calls to providers to ensure that members with newly prescribed attention deficit/hyperactivity disorder medication have a follow-up scheduled within 30 days. If there is no follow-up scheduled or if the follow-up occurred outside of 30 days, the Quality Improvement staff makes recommendation to the provider's office to reach out to the member to schedule an appointment within 30 days. Neighborhood has also published articles in our provider newsletter to inform providers on the HEDIS Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication measure specification. We also developed an attention deficit/hyperactivity disorder member checklist that can be used by members to track visits and symptoms post attention deficit/hyperactivity disorder diagnosis. The HEDIS Follow-Up Care for Children Prescribed Attention Deficit/Hyperactivity Disorder Medication rate for the initiation phase decreased from measurement year 2021 (48.39) compared to measurement year 2022 (47.57) and the rate for the continuation and maintenance phase decreased from 59.15 to 54.40. <u>Percentage of Transitions from the Nursing Home to the Community</u> In calendar year 2022, Neighborhood implemented a number of interventions in an effort to increase transitions from nursing home to the community. We continued to leverage access to nursing homes' electronic medical record systems to identify residents with potential discharge opportunities. We continued to collaborate with the State in an effort to use the subsided/waiver housing vouchers targeted for the RTHP. Assessment of housing availability by Neighborhood's housing specialist helps to identify possible suitable community locations for residency. Neighborhood lead case managers collaborate with business office and Minimum Data Set	

External Quality Review Activity	2021 External Quality Review Recommendation	Neighborhood's Response to the 2021 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
		nurses and complete Section Qs from the Minimum Data Set on Neighborhood members at each facility to ensure Neighborhood is identifying as many potential transitions as possible. Since many facilities do not administer Section Q forms, Neighborhood's Case Management staff complete the forms and provides them to the State. Lastly, Neighborhood re-assessed members that had chosen to stay in the nursing facility after the first 60 days rather than the first 90 days to encourage transition back into the community. The measurement year 2022 rate surpassed the quality improvement goal (35%) as 59% of members transitioned from the nursing home into the community. Note that this measure was impacted by high rates COVID-19 among nursing home patients.	
Performance Measures	Neighborhood should investigate opportunities to improve chlamydia screening in women.	The HEDIS Chlamydia Screening in Women measure is monitored by Neighborhood's Prevention and Screening workgroup. Some of the interventions implemented to improve Chlamydia Screening in Women rate include distribution of non-compliant gap in care reports to providers and publishing member and provider newsletter articles in collaboration with Rhode Island Department of Health. In 2023, Neighborhood will design a pamphlet to distribute at marketing events, during in-home visits, and at provider sites in the communities. Neighborhood Quality Improvement staff will also hold quarterly collaboration meetings with Rhode Island Department of Health on sexually transmitted infections, sharing sexually transmitted infection provider guide with provider sites and share best practices during quarterly provider quality meetings.	Partially addressed.
Network Adequacy	Neighborhood should investigate opportunities to improve member access to care.	Neighborhood completes quarterly surveys to measure access to routine and urgent care and supplements survey data with complaint data. When a member outreaches to Neighborhood expressing difficulty accessing services, Neighborhood's Member Services department contacts the provider's office directly to escalate the member's concern	Partially addressed.

External Quality Review Activity	2021 External Quality Review Recommendation	Neighborhood's Response to the 2021 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
		and find an acceptable resolution. Access to routine care continues to be impacted by the pandemic. We will continue to assess provider accessibility quarterly and any provider not meeting the standards are contacted and educated on Neighborhood's standards.	
Quality of Care Surveys – Member Satisfaction	Neighborhood should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid 75th percentile.	Neighborhood continuously works to improve its performance on measures of member satisfaction falling below the Medicaid 75th percentile through its Member Customer Experience Work Group, launched in September 2021. Business owners are responsible for identifying opportunities for improvement based on survey results and interventions are prioritized. In 2021, Neighborhood introduced its Member Call Center After Service survey, which follows up with members the following day of outreach to the call center. The survey allows Neighborhood to measure trends in member feedback as well as deliver service recovery within 24-48 business hours should a member report not receiving needed services. Between January 1 – December 31, 2022 based on 1,237 responses Neighborhood's call center team achieved a +69 Net Promoter Score, driven by 86% overall satisfaction score; 94% was friendly; 92% easy to work with and 91% answered question. Survey feedback informed changes in the recorded message prompts to improve transfers to service providers and improvements in call center staff. In July 2022, Neighborhood introduced the same listening strategy for its Care Management team with surveys sent to members having contact with Care Management within the last 30 days. Between July 2022 and June 2023, a total of 252 responses achieved a +58 Net Promoter Score, driven by 78% overall satisfaction score with care managers; 84% helps me arrange services I need; 86% listens to me; and 84% able to follow instructions from care manager. The Care Management team has aligned its structure to better meet the needs of complex cases and provide integrated services based on geography.	Partially addressed.

External Quality Review Activity	2021 External Quality Review Recommendation	Neighborhood's Response to the 2021 External Quality Review Recommendation	IPRO's Assessment of Neighborhood's Response
Quality of Care Surveys – Provider Satisfaction	Neighborhood should work to improve resolution process for claims issues.	Based on results of the 2021 Provider Satisfaction Survey, Neighborhood implemented several interventions through its Provider Experience Work Group including but not limited to: updating all payment policies, creating a primary care provider change electronic form to simplify the process of changing primary care providers, conducting a CHC listening tour, simplifying pharmacy web pages, and reducing the number of services requiring authorization. Neighborhood also identified key performance metrics impacting provider satisfaction and tracks progress monthly to create awareness and identify ways to improve performance. Neighborhood improved provider communication through the creation of a Provider Communications Committee that governs Neighborhood's Provider Notification Policy and ensures we communicate relevant, timely and accurate information. Neighborhood also developed an improved provider issue resolution process which created a dedicated Claim Resolution team that has resulted in faster resolution to escalated issues.	Partially addressed.

2022 Strengths, Opportunities and Recommendations Related to Quality, Timeliness and Access

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

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

The strengths and opportunities for improvement based on Neighborhood's 2022 performance, as well recommendations for improving quality, timeliness, and access to care are presented in Table 61. 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 gray shading).

Table 61: Neighborhood's Strengths, Opportunities, and Recommendations, Measurement Year 2022

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	Neighborhood maintained NCQA accreditation in 2022.	X	X	X
Quality Improvement Projects	Six of six quality improvement projects passed validation.			
Quality Improvement Project – Developmental Screening	Neighborhood's measurement year 2022 rates for all three performance indicators exceeded the goal.	X	X	X
Quality Improvement Project – Improve *HEDIS Care for Older Adults* Performance	Neighborhood's measurement year 2022 rates for all three performance indicators exceeded the goal.	X	X	X
Quality Improvement Project – Increase the Percentage of Transitions from the Nursing Home to the Community	Neighborhood's measurement year 2022 rate for one of two performance indicators exceeded the goal.	X	X	X
Performance Measures	Neighborhood met all information systems and validation requirements to successfully report HEDIS data to the Office of Health and Human Services and to NCQA.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Performance Measures – Use of Services	Neighborhood reported three measurement year 2022 HEDIS rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Performance Measures – Effectiveness of Care	Neighborhood reported seven measurement year 2022 rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Performance Measures – Access and Availability	Neighborhood reported five measurement year 2022 rates that benchmarked at or above the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid and Children's Health Insurance Program Standards	Neighborhood is compliant with eight of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Network Adequacy	Neighborhood's network analyses for measurement year 2022 were determined to be reliable.			
	In 2022, approximately 100% of Neighborhood's membership had appropriate distance access to primary and specialty care providers.	X	X	X
	Timely routine appointments among surveyed primary care providers ranged between 80% and 85%; and timely urgent appointments among surveyed pediatricians was 80%.	X	X	X
Encounter Data	IPRO determined that there were no critical findings risking Neighborhood's ability to submit claims/encounter data that are accurate and complete.			
Quality of Care Surveys – Member Satisfaction	Neighborhood achieved one score on the adult survey that benchmarked at the national Medicaid 95th percentile, one score that benchmarked at the national Medicaid 90th percentile, and seven scores that benchmarked at the national Medicaid 75th percentile.	X	X	X
	Neighborhood achieved one score on the child survey that benchmarked at the national Medicaid 90th percentile and two scores that benchmarked at the national Medicaid 75th percentile.	X	X	X
Quality of Care Surveys – Provider Satisfaction	None.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Opportunities for Improvement				
Quality Improvement Project – Improve Child and Adolescents' Well-Care Visits	Neighborhood's measurement year 2022 rates for four performance indicators did not meet the goal rate.	X	X	X
Quality Improvement Project – Improve the HEDIS *Follow-Up Care for Children Prescribed ADHD Medication* Rate	Neighborhood's measurement year 2022 rates for the two performance indicators did not meet the goal rate.	X	X	X
Quality Improvement Project – Social Determinant of Health Measure – Improve the Rate of Lead Screening in Children	Neighborhood's measurement year 2022 rate for the single performance indicator did not meet the goal rate.	X	X	X
Quality Improvement Project – Increase the Percentage of Transitions from the Nursing Home to the Community	Neighborhood's measurement year 2022 performance for one of two indicators did not meet the goal.	X	X	X
Performance Measures	None.			
Compliance with Medicaid and Children's Health Insurance Program Standards	Neighborhood is not fully compliant with two of the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Network Adequacy	Overall, appointment availability among the surveyed providers was low.	X	X	X
Encounter Data	Discrepancies and data extraction issues were identified across encounter types.			
Quality of Care Surveys – Member Satisfaction	Neighborhood achieved three measurement year 2022 scores for the child survey that benchmarked below the national Medicaid 75th percentile.	X	X	X
Quality of Care Surveys – Provider Satisfaction	Neighborhood demonstrated performance decline between measurement years 2021 and 2022 on all measures of provider satisfaction.	X	X	X
Recommendations				
Quality Improvement Projects	Opportunities of improvement remain for four of the six quality Improvement projects, as Neighborhood did not achieve the established project goals. Neighborhood	X	X	X

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	should continue to study the effectiveness of the intervention strategy and act on opportunities to make enhancements.			
Performance Measures	None.			
Compliance with Medicaid and Children's Health Insurance Program Standards	Neighborhood should conduct routine monitoring to ensure areas of noncompliance have been effectively addressed.	X	X	X
Network Adequacy	Neighborhood should address barriers members face when attempting to access care that is timely and appropriate.	X	X	X
Encounter Data Validation	Neighborhood should work to reduce discrepancies and resolve identified data extraction issues.			
Quality of Care Surveys – Member Satisfaction	Neighborhood should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid 75th percentile.	X	X	X
Quality of Care Surveys – Provider Satisfaction	Neighborhood should work to improve provider satisfaction in all categories.	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.