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Rhode Island Medicaid Managed Care Program

Tufts Health Public Plan

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 Tufts Health Public Plan, 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 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%

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, 20221 to June 30, 2022 measurement period. Tufts Health Public Plan did not meet the goal. Tufts Health Public Plan does not participate in the Rhode Island Accountable Entity program due to its overall volume of membership.

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
Tufts Health Public Plan	14.5%	65%	Not 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. Tufts Health Public Plan did not meet the goal due to failure to report.

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
Tufts Health Public Plan	Not Reported	60%	Not 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

Tufts Health Public Plan is a not-for-profit health maintenance organization. Table 9 displays Tufts Health Public Plan's enrollment for year-end 2019 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. Tufts Health Public Plan's enrollment increased by 15% from 17,363 members in 2021 to 20,007 members in 2022.

Table 9: Tufts Health Public Plan's Enrollment, 2019 to 2022

Eligibility Group	2019	2020	2021	2022
RIte Care Core	4,520	6,703	8,184	9,871
RIte Care for Children with Special Health Care Needs	69	87	87	100
Rhody Health Partners	566	658	725	740
Rhody Health Expansion	3,765	6,571	8,325	9,261
Extended Family Planning	53	56	42	35
Medicaid Total	8,973	14,075	17,363	20,007
Percent Change from Previous Year	-5.6%	+57%	+23%	+15%

Tufts Health Public Plan'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. Tufts Health Public Plan's *2022 Quality Improvement Workplan for RI Medicaid* (revised December 2021) met these requirements.

Goals and Objectives

Tufts Health Public Plan's quality improvement program aims is to continuously improve the quality and safety of clinical care and services members receive, including physical and behavioral health and substance abuse care; assure adequate access to and availability of clinical care and services; increase member and provider satisfaction; improve the quality of service providers and members receive from the managed care plan; and improve the health and wellness of members while managing health care costs. Table 10 displays Tufts Health Public Plan's quality improvement goals and objectives as reported in the *2022 Quality Improvement Workplan for RI Medicaid*.

Table 10: Tufts Health Public Plan's Quality Improvement Goals and Objectives, 2022

Tufts Health Public Plan's Quality Improvement Program Goals and Objectives, 2022
▪ Implement Quality Improvement Committee structure as planned. ▪ Develop and implement specific goals, objectives, and activities for all product lines in the 2022 Quality Improvement Workplan. ▪ Evaluate 2021 Quality Improvement Workplan projects for all product lines. ▪ Encourage practitioner participation and leadership involvement in the Quality Improvement Program. ▪ Complete the annual evaluation of the 2022 Program Plan and review it with the Tufts Health Plan Board of Directors. ▪ Assess the 2022 Quality Improvement Workplan product composition to ensure adequate representation of projects across products and member populations. ▪ Continuously monitor the quality of member care through various mechanisms to improve member health outcomes. ▪ Continue member and provider education through 2022 and ongoing.

Tufts Health Public Plan's Quality Improvement Program Goals and Objectives, 2022
▪ Continue credentialing/recredentialing processes and act on identified opportunities for improvement. ▪ Review and approve the Utilization Management program separately through the Utilization Management Compliance and Customer Satisfaction Committee, incorporating quality activities into the program. ▪ Meet external reporting requirements. ▪ Analyze adverse patient occurrences to identify potential areas of risk and act on opportunities for improvement. ▪ Continue patient safety efforts with an emphasis on collaborative efforts for greater impact and better provider acceptance. ▪ Actively participate in implementing programs, both individually and through industry-wide collaboration, to improve the health of the member community at Point32Health.

Quality Improvement Program Activities

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

- Ongoing Monitoring and Evaluation
- Continuous Quality Improvement
- Customer Satisfaction
- Practitioner and Organizational Provider Credentialing
- Member Risk Management
- Utilization Management
- Patient Safety

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 each managed care plan'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 auditors assessed Tufts Health Public Plan's compliance with NCQA's seven information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that Tufts Health Public 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 Tufts Health Public 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 each managed care plan's Final Audit Report that was produced by the HEDIS compliance auditor. The Final Audit Report included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental data sources (e.g., immunization registries, care management files, laboratory result files), descriptions of system queries used by the auditor to validate the accuracy of the data, results of the medical record reviews, results of the information systems capabilities assessment, and rate status. Rates were determined to be reportable or not reportable (small denominator, benefit not offered, not reported, not required, biased, or unaudited; Table 25).

Comparative Results

Tufts Health Public Plan'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 Tufts Health Public Plan.

Table 12: Tufts Public Health Plan's NCQA Information Systems Capabilities Standards Audit Results, Measurement Year 2022

Information Systems Capabilities Standards	Tufts Health Public Plan'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 four quality improvement projects led by Tufts Health Public Plan in measurement year 2022.

Table 13: Tufts Health Public Plan's Quality Improvement Project Topics, 2022

Tufts Health Public Plan's Quality Improvement Project Topics, 2022
1. Promote Doula Program for Maternal and Child Health
2. Member Experience and Retention
3. Flu Vaccine
4. Behavioral Health Telehealth

Technical Methods of Data Collection and Analysis

The Office of Health and Human Services requires that quality improvement projects are documented using NCQA's *Quality Improvement Activity Form*. A copy of the *Quality Improvement Activity Form* is in Appendix A of this report. However, Tufts Health Public Plan utilized a homegrown reporting tool for the quality improvement projects that were underway for measurement year 2022.

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 status reports completed by Tufts Health Public Plan for each quality improvement project against the review elements listed above, determinations of "met" and "not met" were used for each element under review. Definitions of these review determinations are presented in Table 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 Tufts Health Public Plan's quarterly quality improvement project reports. These reports included project topics, interventions conducted within the reporting period, barriers to improvement, and quarterly performance indicator rates.

Comparative Results

The results of the validation activity determined that Tufts Health Public Plan was not fully compliant with the standards of *42 Code of Federal Regulations 438.330 Quality assessment and performance improvement program (d)(2) Performance improvement projects* for the four quality improvement projects conducted. IPRO's assessment of Tufts Health Public Plan's methodology found that Tufts Health Public Plan did not conduct the quality improvement projects using the appropriate framework or the state required *Quality Improvement Activity Form*.

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

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

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

Quality Improvement Project 2 – Member Experience and Retention

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

- The quality improvement project topic was not selected through a comprehensive analysis of enrollee needs, care, and services.
- The project indicator did not inform the selection and evaluation of quality improvement activities.
- The data collection plan did not specify the data sources, nor did it link to the data analysis plan to ensure that the appropriate data would be available for quality improvement project reporting. Additionally, the data collection instrument did not allow for consistent and accurate data collection over the period studied.
- The quality improvement project results were not presented in a concise and easily understood manner.
- The improvement strategies were not designed to address root causes or barriers identified through data analysis and quality improvement process, and the quality improvement project did not assess the extent to which the improvement strategy was successful.

Quality Improvement Project 3 – Flu Vaccine

Tufts Health Public Plan's conduct of the Flu Vaccine quality improvement project 2 did not meet all standards related to data collection. Through the validation process, IPRO determined that for Tufts Health Public Plan's quality improvement project 3:

- The data collection plan did not specify the data sources, nor did it link to the data analysis plan to ensure that the appropriate data would be available for quality improvement project reporting. Additionally, the data collection instrument did not allow for consistent and accurate data collection over the period studied.
- The quality improvement project results were not presented in a concise and easily understood manner.

Quality Improvement Project 4 – Behavioral Health Telehealth

Tufts Health Public Plan's conduct of the Behavioral Health Telehealth Services quality improvement project 4 did not meet all standards related to topic selection, data collection, and interpretation of study results. Through the validation process, IPRO determined that for Tufts Health Public Plan's quality improvement project 4:

- The project indicator did not align with the aim of quality improvement project.

- The data collection plan did not specify the data sources, nor did it link to the data analysis plan to ensure that the appropriate data would be available for quality improvement project reporting.
- The improvement strategies were not designed to address root causes or barriers identified through data analysis and quality improvement process, and the quality improvement project did not assess the extent to which the improvement strategy was successful.

Table 15 displays a summary of the validation results of Tufts Health Public Plan's quality improvement projects that were conducted for measurement year 2022. Summaries of each quality improvement project immediately follow.

Table 15: Tufts Health Public Plan's Quality Improvement Project Validation Results, Measurement Year 2022

Tufts Health Public Plan's Quality Improvement Project (QIP) Validation Results				
Validation Element	QIP 1 – Doula Program for Maternal and Child Health	QIP 2 – Member Experience and Retention	QIP 3 – Flu Vaccine	QIP 4 – Behavioral Health Telehealth
Selected Topic	Met	Not Met	Met	Met
Study Question	Insufficient Data	Not Met	Met	Met
Indicators	Insufficient Data	Insufficient Data	Met	Not Met
Population	Insufficient Data	Met	Met	Met
Sampling Methods	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Data collection Procedures	Insufficient Data	Not Met	Not Met	Met
Interpretation of Study Results	Insufficient Data	Not Met	Met	Met
Improvement Strategies	Insufficient Data	Not Met	Met	Not Met

Table 16: Tufts Health Public Plan's Quality Improvement Project 1 Summary – Promotion of Doula Program, Measurement Year 2022

Quality Improvement Project 1 Summary
Title: Promote Doula Program for Maternal and Child Health **Validation Summary:** There were one or more validation findings that indicate a bias in the quality improvement project results. The concerns that put the conclusion at-risk were enumerated above.
Aim Tufts Health Public Plan aimed to promote its doula program for maternal and child health. Indicator of Performance The number of unique members who are pregnant and initiated engagement with a doula service during the quarter. Member-Focused 2022 Interventions ▪ Hosted a community baby shower for current and prospective members and leveraged the opportunity to promote the doula program available to Tufts Health Public Plan members. Managed Care Plan-Focused 2022 Interventions ▪ Continued efforts to contract with individual multilingual/multicultural doulas.

Table 17: Tufts Health Public Plan's Quality Improvement Project 1 Indicator Summary – Promotion of Doula Program

Number of Members Enrolled in the Doula Program		
Measurement Period	Number of Members	Goal
2020 First Quarter	1	Not Established
2020 Second Quarter	0	Not Established
2020 Third Quarter	3	Not Established
2020 Fourth Quarter	4	Not Established
2021 First Quarter	5	Not Established
2021 Second Quarter	3	Not Established
2021 Third Quarter	1	Not Established
2021 Fourth Quarter	3	Not Established
2022 First Quarter	0	Not Established
2022 Second Quarter	No Data Reported	Not Established
2022 Third Quarter	No Data Reported	Not Established
2022 Fourth Quarter	No Data Reported	Not Established

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

Table 18: Tufts Health Public Plan's Quality Improvement Project 2 Summary – Member Experience and Retention, Measurement Year 2022

Quality Improvement Project 2 Summary
Title: Member Experience and Retention **Validation Summary:** It is unclear how performance in this area impacted the health outcomes of Tufts Health Public Plan's Medicaid membership. There were one or more validation findings that indicate a bias in the quality improvement project results. The concerns that put the conclusion at-risk were enumerated above.
Aim Tufts Health Public Plan aimed to improve its average monthly member attrition rate, from 8% to 6%. (A lower rate is desired.) Indicator of Performance The difference in total Medicaid enrollment from the previous measurement period and the current measurement period. Member-Focused 2022 Interventions ▪ Revised new member onboarding content delivered by short message service text. ▪ Distributed HealthSource RI contact information to members. ▪ Continued collaboration with Jenks Park Pediatrics to offer COVID-19 testing and vaccines, and to promote Tufts Health Public Plan. Managed Care Plan-Focused 2022 Interventions ▪ Continued partnership with ASG to engage potential enrollees, build positive brand awareness, and strengthen community relations.

Table 19: Tufts Health Public Plan's Quality Improvement Project 2 Indicator Summary – Member Experience and Retention

Member Retention Rate					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
January 2019	Baseline	Not Provided	Not Provided	8%	Not Applicable
February 2019	Remeasurement 1	Not Provided	Not Provided	5%	6%
March 2019	Remeasurement 2	Not Provided	Not Provided	7%	6%
April 2019	Remeasurement 3	Not Provided	Not Provided	7%	6%
May 2019	Remeasurement 4	Not Provided	Not Provided	5%	6%
June 2019	Remeasurement 5	Not Provided	Not Provided	5%	6%
July 2019	Remeasurement 6	Not Provided	Not Provided	5%	6%
August 2019	Remeasurement 7	Not Provided	Not Provided	7%	6%
September 2019	Remeasurement 8	Not Provided	Not Provided	5%	6%
October 2019	Remeasurement 9	Not Provided	Not Provided	11%	6%
November 2019	Remeasurement 10	Not Provided	Not Provided	9%	6%
December 2019	Remeasurement 11	Not Provided	Not Provided	5%	6%
2020 First Quarter	Remeasurement 12	Not Provided	Not Provided	6%	6%
2020 Second Quarter	Remeasurement 13	Not Provided	Not Provided	2%	6%
2020 Third Quarter	Remeasurement 14	Not Provided	Not Provided	2%	6%
2020 Fourth Quarter	Remeasurement 15	Not Provided	Not Provided	3%	6%
2021 First Quarter	Remeasurement 16	Not Provided	Not Provided	3%	6%
2021 Second Quarter	Remeasurement 17	Not Provided	Not Provided	3%	6%
2021 Third Quarter	Remeasurement 18	Not Provided	Not Provided	3%	6%
2021 Fourth Quarter	Remeasurement 19	Not Provided	Not Provided	3%	6%
2022 First Quarter	Remeasurement 20	Not Provided	Not Provided	2%	6%
2022 Second Quarter	Remeasurement 21	Not Provided	Not Provided	1%	6%
2022 Third Quarter	Remeasurement 22	Not Provided	Not Provided	Not Provided	Not Provided
2022 Fourth Quarter	Remeasurement 23	Not Provided	Not Provided	Not Provided	Not Provided

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

Table 20: Tufts Health Public Plan's Quality Improvement Project 3 Summary – Flu Vaccine, Measurement Year 2022

Quality Improvement Project 3 Summary
Title: Increase Flu Vaccination Rate **Validation Summary:** There were one or more validation findings that indicate a bias in the quality improvement project results. The concerns that put the conclusion at-risk were enumerated above.
Aim Tufts Health Public Plan aimed to increase the influenza vaccination utilization rate by addressing health disparities that impact the target population: the goal was to increase utilization by three percentage points for the RITogether population. Indicator of Performance The percentage of Medicaid members who were continuously enrolled from April 1 to March 31 of the measurement period and had a flu vaccine between September 1 and March 31 of the measurement period. Member-Focused 2022 Interventions ▪ Continued to offer transportation benefit to flu vaccine appointments. ▪ Published articles in the member newsletter on flu and COVID vaccinations. Provider-Focused 2022 Interventions ▪ Hosted webinars to deliver flu vaccine-specific education, including clinical guidelines, cultural competency, and tracking member flu vaccines. Managed Care Plan-Focused 2022 Interventions ▪ Maintained the flu vaccine assessment in care management systems.

Table 21: Tufts Health Public Plan's Quality Improvement Project 3 Indicator Summary – Flu Vaccine

Flu Vaccine Utilization Rate					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
September 2019-March 2020	Baseline	Not Provided	Not Provided	31.88%	34.88%
September 2020-March 2021	Remeasurement 1	1,872	8,934	20.95%	30.95%
September 2021-March 2022	Remeasurement 2	2,306	15,830	14.57%	19.46%

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

Table 22: Tufts Health Public Plan's Quality Improvement Project 4 Summary – Behavioral Health Telehealth, Measurement Year 2022

Quality Improvement Project 4 Summary
Title: Behavioral Health Telehealth **Validation Summary:** There were one or more validation findings that indicate a bias in the quality improvement project results. The concerns that put the conclusion at-risk were enumerated above.
Aim Tufts Health Public Plan aimed to improve access to behavioral health telehealth services via reduction of known barriers: the goal was to increase the baseline by three percentage points for the RITogether population. Indicator of Performance HEDIS *Mental Health Utilization*: The number and percentage of members receiving the following mental health services during the measurement year: inpatient, intensive outpatient or partial hospitalization, outpatient, emergency department, telehealth, or any service. Member-Focused 2022 Interventions ▪ Continued to refer eligible members to Entouch, a federal phone program, or the loaner phone program through the managed care plan. ▪ Published articles in the member newsletter on the availability of telehealth services. ▪ Offered telehealth counseling for mental health and substance abuse through Gateway Behavioral Health. Provider-Focused 2022 Interventions ▪ Hosted an educational webinar on telehealth. ▪ Continued to incorporate behavioral health telehealth information in provider trainings and publications. Managed Care Plan-Focused 2022 Interventions ▪ Continued efforts to expand the behavioral health provider network, including active recruitment of behavioral health providers that offer telehealth. ▪ Worked with Healthsparq, the centralized provider listing system, to ensure members can identify providers who offer telehealth services.

Table 23: Tufts Health Public Plan's Quality Improvement Project 4 Indicator Summary – Behavioral Health Telehealth

Behavioral Health Telehealth Utilization					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2020	Baseline	Not Provided	Not Provided	68%	71%
Measurement Year 2021	Remeasurement 1	953	1,615	59.01%	64.01%
Measurement Year 2022	Remeasurement 2	Not Available	Not Available	Not Available	Not Available

Indicator Description: The number and percentage of members receiving the following mental health services during the measurement year: inpatient, intensive outpatient or partial hospitalization, outpatient, emergency department, telehealth, or any service.

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 *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, Tufts Health Public Plan was required to submit HEDIS performance measure data to the Office of Health and Human Services. To ensure compliance with reporting requirements, each managed care plan contracted with an NCQA-certified HEDIS vendor and an NCQA-certified HEDIS compliance auditor.

The HEDIS vendor collected data and calculated performance measure rates on behalf of Tufts Health Public Plan 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 Tufts Health Public Plan's adherence to the technical specifications and reporting requirements. The HEDIS compliance auditor evaluated Tufts Health Public Plan's information practices and control procedures, sampling methods and procedures, compliance with technical specifications, analytic file production, and reporting and documentation in two parts:

1. Information System Capabilities
2. HEDIS Specification Standards

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

Information System Capabilities

As part of the NCQA HEDIS Compliance Audit, the HEDIS compliance auditors assessed Tufts Health Public Plan's compliance with NCQA's seven information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that Tufts Health Public Plan has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. Table 24 displays these standards as well as the elements audited for the standard.

Table 24: Information System Capabilities Standards

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

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

HEDIS Specification Standards

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

Performance Measure Validation

Each managed care plan's calculated rates for the NCQA HEDIS Measurement Year 2022 measure set were validated as part of the NCQA HEDIS Compliance Audit and assigned one of NCQA's outcome designations. Table 25 presents these outcome designations and their definitions. Performance measure validation activities included, but were not limited to:

- Confirmation that rates were produced with certified code or Automated Source Code Review approved logic
- Medical record review validation
- Review of supplemental data sources
- Review of system conversions/upgrades, if applicable
- Review of vendor data, if applicable
- Follow-up on issues identified during documentation review or previous audits

Table 25: Performance Measure Outcome Designations

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

NCQA: National Committee for Quality Assurance.

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

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

- Compared performance measure rates reported by Tufts Health Public Plan 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 Tufts Health Public Plan's Final Audit Report and a locked copy of the Audit Review Table that were produced by the HEDIS compliance auditor.

The Final Audit Report included key audit dates, product lines audited, audit procedures, vendors, data sources including supplemental data sources (e.g., immunization registries, care management files, laboratory result files), descriptions of system queries used by the auditor to validate the accuracy of the data, results of the medical record reviews, results of the information systems capabilities assessment, and rate status. Rates were determined to be reportable or not reportable (small denominator, benefit not offered, not reported, not required, biased, or unaudited; Table 25).

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

Comparative Results

Validation of Performance Measures

Tufts Health Public Plan's HEDIS compliance auditor determined that the HEDIS rates reported by Tufts Health Public 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 for Tufts Health Public Plan.

Performance Measure Results

This section of the report explores the utilization of Tufts Health Public Plan's services by examining select measures under the following domains:

- Use of Services – Two measures (three rates) examine the percentage of Medicaid child and adolescent access routine care.
- Effectiveness of Care – Five measures (seven rates) examine how well a managed care plan provides preventive screenings and care for members with acute and chronic illness.
- Access and Availability – 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 26 displays Tufts Health Public Plan's HEDIS rates for measurement years 2020, 2021, and 2022, as well as the national Medicaid benchmarks achieved by Tufts Health Public Plan, and the national Medicaid means.

Table 26: Tufts Health Public Plan's HEDIS Rates, Measurement Years 2020 to 2022

Domain/Measures	Tufts Health Public Plan Measurement Year 2020	Tufts Health Public Plan Measurement Year 2021	Tufts Health Public Plan 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	48.13%	44.55%	59.25%	50th	56.76%
Well-Child Visits in the First 30 Months of Life – First 15 to 30 Months	69.43%	69.39%	68.77%	50th	66.74%
Child and Adolescent Well-Care Visits (Total)	42.75%	46.85%	46.24%	33.33rd	48.61%
Effectiveness of Care					
Cervical Cancer Screening for Women	38.93%	40.88%	42.09%	<10th	55.92%
Chlamydia Screening for Women (Total)	46.98%	56.51%	51.61%	33.33rd	55.80%
Childhood Immunization Status – Combination 3	72.08%	70.89%	73.96%	75th	63.16%
Childhood Immunization Status – Combination 10	49.81%	55.04%	48.89%	90th	31.86%
Follow-Up After Hospitalization for Mental Illness – 7 Days (Total)	53.75%	63.78%	52.54%	75th	36.61%
Follow-Up After Hospitalization for Mental Illness – 30 Days (Total)	67.50%	43.78%	63.28%	50th	57.05%
Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control (<8%)	New Measure in 2022	New Measure in 2022	37.96%	<10th	50.87%
Access and Availability					
Adults' Access to Preventive/Ambulatory Health Services – 20-44 Years	57.92%	56.91%	53.26%	<10th	69.26%
Adults' Access to Preventive/Ambulatory Health Services – 45-64 Years	66.53%	67.24%	63.67%	<10th	79.31%
Adults' Access to Preventive/Ambulatory Health Services – 65+ Years	Small Sample	63.37%	67.37%	10th	79.31%
Prenatal and Postpartum Care – Timeliness of Prenatal Care	66.67%	76.44%	75.68%	10th	82.95%
Prenatal and Postpartum Care – Postpartum Care	60.14%	73.78%	74.32%	25th	76.96%

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

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 plans' NCQA Accreditation Survey to verify managed care plan compliance with state and federal standards. Section *2.02 Licensure and Accreditation* of the *Medicaid Managed Care Services Agreement* requires that each Rhode Island health maintenance organization seek and maintain NCQA Accreditation.

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

Technical Methods of Data Collection and Analysis

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

Comparative Results

Tufts Health Public Plan's accreditation was granted by NCQA on April 29, 2020. Table 27 displays Tufts Health Public Plan's compliance with federal Medicaid standards captured during the most recent NCQA Accreditation Survey. It was determined that Tufts Health Public Plan was fully compliant with the standards reviewed under *42 Code of Federal Regulations Part 438 Managed Care*.

Table 27: Evaluation of Tufts Health Public Plan's Compliance with Federal Medicaid Standards, 2020

Federal Medicaid Standard	Tufts Health Public Plan'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	Met
438.207 Assurances of adequate capacity and services	Met
438.208 Coordination and continuity of care	Met
438.210 Coverage and authorization of services	Met
438.214 Provider selection	Met
438.224 Confidentiality	Met
438.228 Grievance and appeal system	Met
438.230 Sub-contractual relationships and delegation	Met
438.236 Practice guidelines	Met
438.242 Health information systems	Met
438.330 Quality assessment and performance improvement program	Met

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 28.

Table 28: Rhode Island Medicaid Managed Care Network Standards

Rhode Island Medicaid Managed Care Access Standards
Time and Distance Standards
▪ Primary Care, Adult and Pediatric Within 20 Minutes or 20 Miles
▪ OB/GYN Within 45 Minutes or 30 Miles
▪ Top 5 Adult Specialties Within 30 Minutes or 30 Miles
▪ Top 5 Pediatric Specialties Within 45 Minutes or 45 Miles
▪ Hospital Within 45 Minutes or 30 Miles
▪ Pharmacy Within 10 Minutes or 10 Miles
▪ Imaging Within 45 Minutes or 30 Miles
▪ Ambulatory Surgery Centers Within 45 Minutes or 30 Miles
▪ Dialysis Within 30 Minutes or 30 Miles
▪ 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 Tufts Health Public Plan.

Technical Methods of Data Collection and Analysis

Tufts Health Public Plan 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.

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

Tufts Health Public Plan's access standard for primary care providers is one provider within 20 miles and one provider within 30 miles for obstetricians/gynecologists. Tufts Health Public Plan's goal is to have 90% 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 Tufts Health Public Plan in the *Tufts Health Public Plan Network Analysis Report* (October 19, 2022) and Tufts Health Public Plan's quarterly *Access Survey Reports* for 2022.

Comparative Results

Table 29 shows the percentage of members for whom the geographic access standards were met. The results of this analysis show that Tufts Health Public Plan exceeded the 90% goal for member geographic access for all primary care and behavioral health provider types reported. Tufts Health Public Plan did not meet the 90% goal member geographic access pediatric allergy/immunology specialists.

Table 29: Tufts Health Public Plan's Geo Access Analysis, October 2022

Provider Specialty	Access to Provider Standard[1]	% of Members With Access	Goal = 90% Met/Not Met
Primary Care			
Internal Medicine	1 in 20 Miles	99.9%	Met
Family Medicine	1 in 20 Miles	99.9%	Met
Pediatrics	1 in 20 Miles	99.9%	Met
Obstetrics/Gynecology	1 in 30 Miles	100.0%	Met
Specialty Care			
Adult Cardiology	1 in 30 Miles	100.0%	Met
Adult Dermatology	1 in 30 Miles	100.0%	Met
Adult Endocrinology	1 in 30 Miles	100.0%	Met
Adult Gastroenterology	1 in 30 Miles	100.0%	Met
Adult Pulmonary	1 in 30 Miles	100.0%	Met
Pediatric Allergy/Immunology	1 in 45 Miles	61.0%	Not Met
Pediatric Gastroenterology	1 in 45 Miles	100.0%	Met
Pediatric Neurology	1 in 45 Miles	100.0%	Met
Pediatric Otolaryngology	1 in 45 Miles	100.0%	Met
Behavioral Health Care			
Adult Behavioral Health Substance Use	1 in 30 Miles	100.0%	Met
Adult Behavioral Health Outpatient Mental Health	1 in 30 Miles	100.0%	Met
Pediatric Behavioral Health Outpatient Mental Health	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 30 displays aggregate results of the secret shopper appointment availability surveys conducted by Tufts Health Public Plan in January 2022 and July 2022. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 30: Tufts Health Public Plan'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	287	173	60.3%	19.2%
Pediatricians	112	22	19.6%	14.3%
Obstetrics/Gynecology	1	0	0.0%	0.0%
Primary Care Urgent Appointments				
Family/General/Internal	374	228	61.0%	9.9%
Pediatricians	101	3	3.0%	2.0%
Obstetrics/Gynecology	24	24	100.0%	0.0%
Adult Specialty Care Routine Appointments				
Cardiology	64	13	20.3%	1.6%
Dermatology	10	9	90.0%	50.0%
Endocrinology	16	5	31.3%	12.5%
Gastroenterology	23	10	43.5%	4.3%
Pulmonary	24	4	16.7%	0.0%
Adult Specialty Care Urgent Appointments				
Cardiology	65	33	50.8%	4.6%
Dermatology	21	15	71.4%	9.5%
Endocrinology	18	3	16.7%	0.0%
Gastroenterology	26	11	42.3%	3.8%
Pulmonary	24	7	29.2%	0.0%
Pediatric Specialty Care Routine Appointments				
Allergy/Immunology	4	1	25.0%	0.0%
Gastroenterology	6	2	33.3%	0.0%
Neurology	22	4	18.2%	9.1%
Orthopedics	51	20	39.2%	35.3%
Otolaryngology/Ear, Nose and Throat	17	10	58.8%	0.0%
Pediatric Specialty Care Urgent Appointments				
Allergy/Immunology	8	3	37.5%	0.0%
Gastroenterology	15	3	20.0%	0.0%
Neurology	26	6	23.1%	0.0%
Orthopedics	49	23	46.9%	18.4%
Otolaryngology/Ear, Nose and Throat	11	6	54.5%	0.0%
Behavioral Health Care Routine Appointments				
Adult Behavioral Health	559	108	19.3%	14.8%
Pediatric/Adolescent Behavioral Health	22	4	18.2%	13.6%

[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 Tufts Health Public Plan 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 the managed care plan 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. Tufts Health Public Plan 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 study was conducted utilizing the following methodology:

1. Tufts Health Public Plan 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 Tufts Health Public Plan 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 Tufts Health Public Plan's files and generated separate data tables per encounter type per managed care plan. Analyses were conducted using SAS®.
3. To identify discrepancies, IPRO compared the values of each data element from Tufts Health Public Plan'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 Tufts Health Public Plan. 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 Tufts Health Public Plan, IPRO identified omitted and surplus internal control numbers. The omitted internal control numbers were identified as the encounters in Tufts Health Public Plan'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 Tufts Health Public Plan's claims files.

A teleconference was held to discuss preliminary findings and conduct staff interviews. The Tufts Health Public Plan encounter data validation audit call was conducted on June 13, 2023. Tufts Health Public Plan'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 study call included the Office of Health and Human Services, Tufts Health Public Plan, and IPRO. Data elements with less than a 90% match rate were reviewed.

Following the teleconference with Tufts Health Public Plan, IPRO worked with Gainwell Technologies to identify any inconsistencies between the values and/or information provided by Tufts Health Public Plan 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, "Tufts Health Public Plan 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 Tufts Health Public Plan'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 Tufts Health Public Plan, and discussions with Tufts Health Public Plan and the Office of Health and Human Services during and following the teleconference, there are areas that require further research by encounter type by Tufts Health Public Plan, 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 Tufts Health Public Plan'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 Tufts Health Public Plan's encounter extract data file. Table 31 shows the total number of discrepant surplus and omitted internal control numbers identified by IPRO.

Table 31: Tufts Health Public Plan's Count of Surplus and Omitted Internal Control Numbers

Encounter Type	Surplus Internal Control Numbers Count[1]	Omitted Internal Control Numbers Count[2]
Professional	28,247	6
Institutional inpatient	443	357
Institutional outpatient	8,844	3,952
Pharmacy	105	2

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

[2] Omitted internal control numbers are encounters in Tufts Health Public Plan'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 32, Table 33, Table 34, and Table 35.

Professional Encounters and Claims

Table 32: Tufts Health Public Plan'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	99.94	
ICN	NV	ICN and LINE_NUMBER were utilized to match the EDV study records and the EOHHS data.
MCO_ICN	97.77	
NUM_ADJ_ICN	5.91	During the remote meeting, it was indicated that for certain adjustments, the adjudication ICN is submitted, but the discrepancy could be because of a timing issue. The 837P extract was shared on the call and compared to Gainwell's values. It was found that Gainwell did not have the latest adjudication ICNs. As a follow-up, Point32Health provided screen prints with examples showing that, as per the standards shared by Rhode Island EOHHS, the REF*F8 segment included the original claim IDs, which were adjusting/voiding. IPRO followed up with EOHHS's Gainwell to understand if this element will be populated for all adjusted/voided ICNs.
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_FIRST_SVC_DTL	89.92	During the remote meeting, it was indicated that the discrepancy is due to an issue with Point32Health's TIBCO claims processing system reordering the sequential line number. IPRO followed up with Point32Health after the remote meeting. IPRO requested the 837P and claim print screen for a couple of records that confirmed the reordering sequential line number issue. Point32Health confirmed that the fix for outbound claim line mapping will be on a going-forward basis starting July 9, 2023, for the June paid month encounter data submission.
DTE_LAST_SVC_DTL	99.73	
PLACESVC	99.73	
DIAGCD1	97.78	
DIAGCD2	99.47	
DIAGCD3	99.96	
DIAGCD4	99.99	
DIAGCD5	100	
DIAGCD6	100	
DIAGCD7	100	
DIAGCD8	100	
DIAGCD9	100	
DIAGCD10	100	
DIAGCD11	98.76	
DIAGCD12	100	
PTMT_ADJ_DATE	0	Point32Health 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	97.81	
AMT_OTH_INS_PD_HDR	0.23	During the remote meeting, it was indicated that Point32Health is escalating fixes to submit the coordination of benefits (COB) amount when the paid amount from other insurers is available. IPRO followed up with Point32Health after the remote meeting. IPRO requested that Point32Health provide the estimated production live date for the fix. Point32Health responded that the production live date for this fix is July 9, 2023.
AMT_MCO_PAID_DTL	71.41	Point32Health indicated that outbound claim lines are in different order due to not submitting denied claims, which leads to the reordering of the lines. During the remote meeting, Point32Health shared the 837P and claim screens to confirm that the line numbers were rearranged to maintain the

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
		sequential ordering when submitting in 837P. This was a known issue to Point32Health, who is working towards fixing it. IPRO followed up with Point32Health after the remote meeting. IPRO requested that Point32Health provide the estimated production live date for the fix. Point32Health responded that the production live date for this fix is July 9, 2023.
AMT_OTH_INS_PD_DTL	100	
PROCCODE	67.18	Point32Health indicated that outbound claim lines are in different order (between the Point32Health data warehouse and the Point32Health outbound 837) due to not submitting denied claims, which leads to the reordering of the lines. During the remote meeting, Point32Health shared the claim screens, which confirmed the issue.
QTY_UNITS_BILLED	91.93	
MODIFIER1	92.12	
MODIFIER2	98.70	
MODIFIER3	99.68	
MODIFIER4	99.98	
NDC_CODE	99.26	
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	
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	70.88	Point32Health indicated that this is a known issue, where the old legacy claims admin did not have provider hierarchy. Point32Health confirmed that this issue will get fixed in the upcoming database migration. IPRO followed up with Point32Health after the remote meeting. IPRO requested that Point32Health provide Rendering Provider NPI submission logic as a follow-up. Point32Health followed up with Rendering Provider submission logic, stating that Rendering Provider NPI is not submitted on the 837 when it is same as the Billing Provider.
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	98.44	

Gray shading: < 90% match with MCO discrepancy; 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.

Institutional Inpatient Encounters and Claims

Table 33: Tufts Health Public Plan'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	84.77	Point32Health indicated referencing the original claim and a new claim number with an updated version (i.e., 02,04), which is correctly submitted with frequency code of 7. During the remote meeting, it was confirmed that the last two digits were for adjustment. Therefore, it is a non-issue, since these would reflect adjustments.
NUM_ADJ_ICN	15.17	Point32Health indicated that the original ICN claim number is used as the referencing claim, which was approved by Rhode Island EOHHS and Gainwell. 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_ADMISSION	100	
DTE_DISCHARGE	100	
DTE_FIRST_SVC_HDR	100	
DTE_LAST_SVC_HDR	100	
DTE_FIRST_SVC_DTL	90.18	
DTE_LAST_SVC_DTL	86.21	Point32Health is sending DTP*472*D8*SERVICE DATE on the outbound 837. However, EOHHS's Gainwell did not have matching values. During the remote meeting, it was indicated that this could be an EDV study data extraction issue. IPRO followed up with Point32Health after the remote meeting. IPRO requested claim print screens, the 837 string, and an explanation on the date that was populating. Point32Health responded that the data sent on the EDV study were using 'SOURCE DATE TO', while the current encounter submission uses date of service (DOS). Point32Health can update to the code and submit 'SOURCE DATE TO' on a going-forward basis starting July 9, 2023.
ADMITTYP	100	
DIS_STAT	100	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
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.
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 will follow up with Gainwell after the remote meeting.
DIAGCD1	100	
DIAGCD2	100	
DIAGCD3	100	
DIAGCD4	22.82	Point32Health 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	28.29	Point32Health 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	33.84	Point32Health 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	100	
DIAGCD8	42.94	Point32Health 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.
DIAGCD9	100	
DIAGCD10	100	
DIAGCD11	100	
DIAGCD12	100	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
DIAGCD13	100	
DIAGCD14	100	
DIAGCD15	100	
DIAGCD16	100	
DIAGCD17	100	
DIAGCD18	100	
DIAGCD19	100	
DIAGCD20	100	
DIAGCD21	100	
DIAGCD22	100	
DIAGCD23	100	
DIAGCD24	100	
DIAGCD25	100	
SURG1	99.60	
SURG2	70.63	Point32Health is not submitting SURG2–SUGR6 and followed up with a fix date of July 9, 2023. Point32Health will resubmit three years of claims by July 28, 2023.
SURG3	79.53	Point32Health is not submitting SURG2–SURG6 and followed up with a fix date of July 9, 2023. Point32Health will resubmit three years of claims by July 28, 2023.
SURG4	83.94	Point32Health is not submitting SURG2–SUGR6 and followed up with a fix date of July 9, 2023. Point32Health will resubmit three years of claims by July 28, 2023.
SURG5	88.09	Point32Health is not submitting SURG2–SUGR6 and followed up with a fix date of July 9, 2023. Point32Health will resubmit three years of claims by July 28, 2023.
SURG6	90.85	
SURGDTE1	75.10	Point32Health indicated that the data element is mapped to DOS, and an update will be needed to update the surgical procedure code date.
SURGDTE2	70.63	Point32Health is not submitting SURGDTE2–SUGRDTE5 and had followed up with a resolution date of July 9, 2023. For a resolution plan, Point32Health will resubmit three years of claims by July 28, 2023.
SURGDTE3	79.53	Point32Health is not submitting SURGDTE2–SUGRDTE5 and had followed up with a resolution date of July 9, 2023. For a resolution plan, Point32Health will resubmit three years of claims by July 28, 2023.
SURGDTE4	83.94	Point32Health is not submitting SURGDTE2–SUGRDTE5 and had followed up with a resolution date of July 9, 2023. For a resolution plan, Point32Health will resubmit three years of claims by July 28, 2023.
SURGDTE5	88.09	Point32Health is not submitting SURGDTE2–SUGRDTE5 and had followed up with a resolution date of July 9, 2023. For a

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
		resolution plan, Point32Health will resubmit three years of claims by July 28, 2023.
SURGDTE6	90.85	
PTMT_ADJ_DATE	0	Point32Health does not submit PTMT_ADJ_DATE. Only the paid date 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	0	Point32Health does not submit the paid date in the claim header. 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	0.61	Point32Health submits the MCO paid amount on 837 at the header level. During the remote meeting, Point32Health shared 837I screens to review a few examples. IPRO followed up with Point32Health after the remote meeting and requested print screens that would be provided to Gainwell. IPRO followed up with Gainwell after the remote meeting to inquire 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	0.61	During the remote meeting, it was indicated that Point32Health is escalating fixes to submit the COB amount when the paid amount from other insurers is available. IPRO followed up with Point32Health after the remote meeting. IPRO requested that Point32Health provide the estimated production live date for the fix. Point32Health responded that the production live date for this fix is July 9, 2023.
PAIDDATE_DTL	100	
AMT_MCO_PAID_DTL	86.95	Point32Health indicated that the line number reordering issue is due to the TIBCO claims processing system. During the remote meeting, Point32Health shared the 837I and claim screens to confirm that the line numbers were rearranged to maintain the sequential ordering when submitting in 837I. This was a known issue to Point32Health, who is working towards fixing it. IPRO followed up with Point32Health after the remote meeting. IPRO requested that Point32Health provide the estimated production live date for the fix. Point32Health

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
		responded that the estimated production live date for the fix is July 9, 2023.
AMT_OTH_INS_PD_DTL	100	
PROCCODE	98.72	
UNITS_BILLED	44.62	Point32Health indicated that the line number reordering issue is due to the TIBCO claims processing system. During the remote meeting, Point32Health shared the 837I and claim screens that confirmed this is a line numbering issue.
MODIFIER1	99.94	
MODIFIER2	100	
MODIFIER3	100	
MODIFIER4	100	
REVENUE_CODE	31.50	Point32Health indicated that revenue codes were not being submitted on the outbound 837 with a leading zero, causing the discrepancy. During the remote meeting, it was found that the issue on REVENUE_CODE is two-fold: ▪ Point32Health was not submitting with a leading zero for certain claims that had a leading zero. ▪ A line number reordering issue was also found, which was a clear mismatch even when IPRO's program was updated to consider the leading zero discrepancy.
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.
BILLING_PROV_NPI	99.48	
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	9.43	Point32Health submits ATTENDING_PROV_NPI in the *71 segment. However, Gainwell did not have any values. IPRO followed up with Gainwell after the remote meeting, requesting that Gainwell provide the logic by encounter type for NPIs that need to be submitted by the MCOs on the encounter data extracts. This information will assist in future EDV studies.
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	NV	Point32Health submitted the BILLING_PROV_NPI on encounter data files in the REFERRING _PROV_NPI data element. IPRO

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
		followed up with Gainwell after the remote meeting, requesting that Gainwell provide the logic by encounter type for NPIs that need to be submitted by the MCOs on the encounter data extracts. This information will assist in future EDV studies.

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; DRG: diagnosis-related group; NPI: National Provider Identifier; ICN: internal control number.

Institutional Outpatient Encounters and Claims

Table 34: Tufts Health Public Plan'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	84.10	Point32Health indicated referencing the original claim and a new claim number with updated version (i.e., 02,04), which is correctly submitted with frequency code of 7. During the remote meeting, it was confirmed that the last two digits were for adjustment. Therefore, it is a non-issue, since these would reflect adjustments.
NUM_ADJ_ICN	4.13	During the remote meeting, it was indicated that Gainwell should have had the original ICN, as Point32Health includes the original claim number as the ICN, which was approved by Rhode Island EOHHS and Gainwell. However, Gainwell had no values for this data element. 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	94.86	
DTE_LAST_SVC_DTL	94.86	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
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	100	
DIAGCD3	100	
DIAGCD4	75.59	Point32Health 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	83.94	Point32Health 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	89.19	Point32Health 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	100	
DIAGCD8	94.40	
DIAGCD9	100	
DIAGCD10	100	
DIAGCD11	100	
DIAGCD12	100	
DIAGCD13	100	
DIAGCD14	100	
DIAGCD15	100	
DIAGCD16	100	
DIAGCD17	100	
DIAGCD18	100	
DIAGCD19	100	
DIAGCD20	100	
DIAGCD21	100	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
DIAGCD22	100	
DIAGCD23	100	
DIAGCD24	100	
DIAGCD25	100	
SURG1	100	
SURG2	100	
SURG3	100	
SURG4	100	
SURG5	100	
SURG6	100	
SURGDTE1	100	
SURGDTE2	100	
SURGDTE3	100	
SURGDTE4	100	
SURGDTE5	100	
SURGDTE6	100	
PTMT_ADJ_DATE	0	Point32Health does not submit the adjudication date 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	0	Point32Health does not submit the paid date at the header level. It is only submitted at the detail level. 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	0.09	Point32Health did submit the claim paid amount at the header level. During the remote meeting, Point32Health shared the 837I extract and claim screens. Gainwell had zeros populated for this element. IPRO reached out to Gainwell 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.

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
AMT_OTH_INS_PD_HDR	0.09	During the remote meeting, it was indicated that Point32Health is escalating fixes to submit the coordination of benefits (COB) amount when the paid amount from other insurers is available. IPRO followed up with Point32Health after the remote meeting. IPRO requested that Point32Health provide the estimated production live date for the fix. Point32Health responded that the production live date for this fix is July 9, 2023.
PAIDDATE_DTL	100	
AMT_MCO_PAID_DTL	40.64	Point32Health indicated that the line number reordering issue is due to the TIBCO claims processing system. During the remote meeting, Point32Health shared the 837I and claim screens to confirm that the line numbers were rearranged to maintain the sequential ordering when submitting in 837I. This was a known issue to Point32Health, who is working towards fixing it. IPRO followed up with Point32Health after the remote meeting. IPRO requested that Point32Health provide the estimated production live date for the fix. Point32Health responded that the estimated production live date for the fix is July 9, 2023.
AMT_OTH_INS_PD_DTL	100	
PROCEDURE_CODE	37.89	Point32Health indicated that the line number reordering issue is due to the TIBCO claims processing system and denied lines not submitted.
UNITS_BILLED	95.33	
MODIFIER1	95.32	
MODIFIER2	99.51	
MODIFIER3	99.99	
MODIFIER4	100	
REVENUE_CODE	77.08	Point32Health indicated that revenue codes were not being submitted on outbound 837 with a leading zero, causing the discrepancy. During the remote meeting, it was found that the issue on REVENUE_CODE is two-fold: ▪ Point32Health was not submitting with a leading zero for certain claims that had a leading zero. ▪ A line number reordering issue was also found, which was a clear mismatch even when IPRO's program was updated to consider the leading zero discrepancy.
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.
BILLING_PROV_NPI	100	
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.

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
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	98.64	
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; 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.

Pharmacy Encounters and Claims

Table 35: Tufts Health Public Plan'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	Point32Health does not submit MCO_ICN on NCPDP file. The ICN that is submitted is an ICN that 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	

Data Element/Field Name	% Match	Findings for Fields with < 90% Match
DTE_LAST_SVC	100	
PAIDDATE_HDR	99.98	
AMT_PAID_MCO_HDR	4.52	During the remote meeting, it was observed that an incorrect data point was pulled, indicating an EDV study data extraction issue. The Point32Health pharmacy vendor shared screens to show the discrepancy and the fixed records. IPRO did not request a revision data file, but the Point32Health pharmacy vendor was ready to provide one should there be a request from IPRO.
AMT_TPL_SUBM_HDR	99.97	
AMT_NDC_PROFEE	10.85	During the remote meeting, it was observed that an incorrect data point was pulled, indicating an EDV study data extraction issue. The Point32Health pharmacy vendor shared screens to show the discrepancy and the fixed records. IPRO did not request a revision data file, but the Point32Health pharmacy vendor was ready to provide one should there be a request from IPRO.
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	99.96	
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	94.41	
NUM_PRESCRIPTION_ID	100	
DISPENSE_DATE	100	
NDC_CODE	99.04	
QTY_DISPENSE_DTL	98.59	
QTY_DISPENSE_HDR	0	Point32Health indicated that QTY_DISPENSE_HDR and QTY_DISPENSE_DTL are the same value, but IPRO requested it twice. For future EDV studies, IPRO will request only the QTY_DISPENSE_DTL data element. 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; yellow shading: < 90% match with MCO reporting study data extraction issue; NV: not validated; MCO: managed care organization; EDV: encounter data validation; ID: identifier; EOHHS: Executive Office of Health and Human Services; NCPDP: National Council for Prescription Drug Program; ICN: internal control number.

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.

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

Technical Methods of Data Collection and Analysis

The standardized survey instrument selected for measurement year 2022 was the CAHPS 5.1H Adult Medicaid Health Plan Survey.

HEDIS specifications require that Tufts Health Public Plan provide a list of all eligible members for the sampling frame. Following HEDIS requirements, Tufts Health Public Plan included members in the sample frame who were 18 years of age or older as of December 31, 2022, continuously enrolled for at least five of the last six months of 2022, and currently enrolled in the managed care plan.

Table 36 provides a summary of the technical methods of data collection.

Table 36: Tufts Health Public Plan's CAHPS Technical Methods of Data Collection, Measurement Year 2022

Methodology Element	Adult CAHPS Survey
Survey Vendor	Symphony Performance Health, Inc.
Survey Tool	5.1H Medicaid Adult
Survey Timeframe	2/28/2023-5/17/2023
Method of Collection	Mail, Telephone
Sample Size	5,670
Response Rate	6.8%

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

For the global ratings, composite measures, composite items, and individual item measures the scores were calculated using a 100-point scale. Responses were classified into response categories. Table 37 displays these categories and the measures which these response categories are used.

Table 37: 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 Tufts Health Public Plan'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 Tufts Health Public Plan's certified CAHPS vendor. The report included comprehensive descriptions of the project objectives and methodology, as well as results and analyses.

Comparative Results

Table 38 displays the results of Tufts Health Public Plan's 2023 CAHPS Adult 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 38: Tufts Health Public Plan's Adult CAHPS Results, Measurement Years 2019, 2020, 2021, and 2022

Measures	Tufts Health Public Plan CAHPS Measurement Year 2019	Tufts Health Public Plan CAHPS Measurement Year 2020	Tufts Health Public Plan CAHPS Measurement Year 2021	Tufts Health Public Plan CAHPS 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]	72.3%	72.1%	75.8%	75.1%	25th	77.69%
Rating of All Health Care[1]	Small Sample	76.0%	Small Sample	76.7%	66.67th	74.55%
Rating of Personal Doctor[1]	89.7%	82.3%	81.8%	87.0%	90th	82.40%
Rating of Specialist[1]	Small Sample	Small Sample	Small Sample	85.5%	75th	81.40%
Getting Care Quickly[2]	Small Sample	Small Sample	Small Sample	83.8%	66.67th	80.36%
Getting Needed Care[2]	Small Sample	Small Sample	Small Sample	81.1%	33.33rd	80.99%
Customer Service[2]	Small Sample	Small Sample	Small Sample	89.0%	33.33rd	89.18%
How Well Doctors Communicate[2]	Small Sample	Small Sample	Small Sample	93.4%	50th	92.49%
Coordination of Care[2]	Small Sample	Small Sample	Small Sample	83.2%	33.33rd	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."

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

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

Technical Methods of Data Collection and Analysis

Tufts Health Public Plan contracted a vendor to conduct the measurement year 2022 provider satisfaction survey. Table 39 provides a summary of the technical methods of data collection.

Table 39: Tufts Health Public Plan's Provider Satisfaction Survey Technical Methods of Data Collection, Measurement Year 2022

Methodology Element	Provider Satisfaction Survey
Survey Administrator	InMoment, Inc.
Survey Tool	Homegrown *(Provider Relationship Survey)*
Survey Timeframe	10/2022 – 12/2022
Method of Collection	Telephone
Eligible Provider Types	Primary Care Providers and Specialists
Sample Size	283
Response Rate	Not Reported

Due to the methodology changes that occurred in 2022, results contained in this report are considered baseline. Table 40 displays the survey's measure categories and possible response options.

Table 40: Provider Satisfaction Survey Categories and Response Options

Measure Category	Response Options
▪ Satisfaction with…[policy/service]	0 – 10 Scale 0=Not At All Satisfied 10=Completely Satisfied *(Top-level performance is considered scores of "8," "9," or "10".)*
▪ Ease of…[process]	0 – 10 Scale 0=Not At All Easy 10=Extremely Easy *(Top-level performance is considered scores of "8," "9," or "10".)*

Survey responses were captured using a Likert scale of 0 (not satisfied) to 10 (very satisfied). Responses of "8," "9," and '10' were evaluated as top box performance.

Description of Data Obtained

For the period under review, IPRO received a copy of the final study report and utilized the reported results to evaluate the administration of the 2022 provider satisfaction survey. The report included an executive summary, high-level summary of methodology and objectives, key take aways, results, and a copy of the survey tool.

Comparative Results

Table 41 displays the survey questions and results for the 'overall measures' for measurement year 2022. Results in this table reflect response scores of "8," "9", or "10."

Table 41: Tufts Health Public Plan's Provider Satisfaction Survey Results, Measurement Year 2022

Measures	Tufts Health Public Plan Score Summary Measurement Year 2022
Overall Satisfaction	**65%**
Claims	**62%**
Accuracy of claims payments	74%
Timeliness of claims payments	72%
Clarity of payment documents	71%
Clarity of payment explanations	60%
Claims appeals procedures	49%
Ability to resolve problems or disputes	49%
Call Center Representative	**64%**
Professionalism	82%
Effectiveness in responding	71%
Ability to resolve during same call	66%
Ease of reaching	60%
Timeliness of callbacks	58%
Ease of reaching supervisor	46%
Communications	**68%**
Through secure provider portal	73%
Of product/benefit information	70%
Through provider public website	70%
Of authorization policies	68%

Measures	Tufts Health Public Plan Score Summary Measurement Year 2022
Throughout the enrollment process	68%
Regarding claims payments and appeals	56%
Referral/Authorization	69%
Ease of obtaining referrals	75%
Company's overall process/procedures	72%
Clarity of referral policies	71%
Ease of obtaining authorizations	71%
Clarity of authorization policies	70%
Ease of review process	67%
Ease of completing online transactions	65%
Ease of appeals process	58%

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

Table 42: NCQA Accreditation Status Levels and Points[11]

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 2023* 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 43.

Table 43: 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 2023* 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 Tufts Health Public Plan, the NCQA *2020 Score Summary Report*. The NCQA *2020 Score Summary Report* listed all the elements reviewed by NCQA during Tufts Health Public Plan's accreditation survey and determinations of 'Met' or 'Not Met' issued to Tufts Health Public Plan by element.

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

Comparative Results

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

Tufts Health Public Plan achieved overall health plan star ratings of 3.5 out of 5 for the *Health Plan Ratings 2023.* Table 44 displays Tufts Health Public Plan's overall health plan star ratings, as well as the ratings for the three overarching categories (patient experience, prevention and equity, and treatment) and their subcategories under review.

Table 44: Tufts Health Public Plan's 2023 NCQA Rating by Category, Measurement Year 2022

Overarching and Subcategories *(Number of Measures Included in Subcategory)*	Tufts Health Public Plan Star Rating Achieved 3.5 Stars Overall *(out of 5 stars)*
Patient Experience	**3.5 Stars**
Getting Care *(2)*	3.5 Stars
Satisfaction with Plan Physicians *(1)*	3.0 Stars
Satisfaction with Plan and Plan Services *(2)*	3.5 Stars
Prevention and Equity	**3.5 Stars**
Children and Adolescent Well-Care *(4)*	4.5 Stars
Women's Reproductive Health *(3)*	2.5 Stars
Cancer Screening *(2)*	1.0 Star
Equity *(1)*	5.0 Stars
Other Preventive Services *(3)*	
Chlamydia Screening	3.0 Stars
Flu Shots	4.0 Stars
Smoking Advice	2.0 Stars
Treatment	**2.5 Stars**
Respiratory *(6)*	4.0 Stars
Diabetes *(6)*	1.5 Stars
Heart Disease *(3)*	2.5 Stars
Behavioral Health-Care Coordination *(4)*	3.5 Stars
Behavioral Health-Medication Adherence *(3)*	4.5 Stars
Behavioral Health-Access, Monitoring and Safety *(5)*	Insufficient Data
Risk-Adjusted Utilization *(1)*	3.0 Stars
Overuse of Opioids *(3)*	3.5 Stars
Other Treatment Measures *(1)*	4.0 Stars

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

Tufts Health Public Plan'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 45 displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2021 external quality review recommendations. Table 46 displays Tufts Health Public Plan's progress related to the recommendations made in the *2021 External Quality Review Aggregate Annual Technical Report* as well as IPRO's assessment of Tufts Health Public Plan's response.

Table 45: 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 46: Tufts Health Public Plan's Response to the 2021 External Quality Review Recommendations

External Quality Review Activity	2021 External Quality Review Recommendation	Tufts Health Public Plan's Response to the 2021 External Quality Review Recommendation	IPRO's Assessment of Tufts Health Public Plan's Response
Quality Improvement Projects	To ensure future quality improvement project methodologies are effectively designed and managed, Tufts Health Public Plan staff should utilize the standardized NCQA *Quality Improvement Activity Form*, and fully address issues identified by the external quality review organization.	Tufts Health Public Plan will utilize the standardized NCQA Quality Improvement Activity Form so that issues are fully addressed as identified by the external quality review organization.	Not addressed.
Compliance with Medicaid Standards	Tufts Health Public Plan should conduct routine monitoring to ensure compliance is maintained.	Tufts Health Public Plan conducts routine monitoring to ensure compliance with Medicaid standards is maintained.	Partially addressed.
Performance Measures	Tufts Health Public Plan should continue to utilize HEDIS results in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Tufts Health Public Plan should focus on child and adult primary care utilization rates, women's health, and chronic conditions.	Tufts Health Public Plan utilizes HEDIS results when developing performance improvement projects. Project topics are identified through review of HEDIS results and projects are designed around lower performing measures. Tufts Health Public Plan has RI specific Quality Improvement Projects which cover Prenatal and Postpartum Care (PPC), Flu Immunization, and Follow Up after Hospitalization (FUH 7-day). Additionally, the Population Health Strategy has identified the following topics after completing a population health assessment: Prenatal Immunizations (PRSE), Diabetes Care (HBD), Follow Up after Hospitalization (FUH) and Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-I and IET-E).	Partially addressed.
Network Adequacy	Tufts Health Public Plan should investigate opportunities to improve member access to care.	Tufts Health Public Plan reviews opportunities to improve member access to care by completing analysis of CAHPS and other member experience access surveys. Tufts	Partially addressed.

External Quality Review Activity	2021 External Quality Review Recommendation	Tufts Health Public Plan's Response to the 2021 External Quality Review Recommendation	IPRO's Assessment of Tufts Health Public Plan's Response
		Health Public Plans implemented an access to care quality improvement project/workgroup which completes further investigating of access to care and implements interventions and activities to support improvement with access.	
Network Adequacy	For future appointment availability surveys, Tufts Health Public Plan should establish a minimum sample size by specialty to increase the overall validity of the results. In the absence of a state-established threshold for timely appointments, Tufts Health Public Plan should identify a threshold to work toward.	For future Network Adequacy surveys, Tufts Health Public Plan will establish a minimum sample size by specialty.	Partially addressed.
Quality of Care Survey – Member Satisfaction	Tufts Health Public Plan should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid 75th percentile.	Tufts Health Public Plan completes CAHPS analysis and sets goals for member satisfaction at the 75th percentile.	Partially addressed.
Quality of Care Survey – Provider Satisfaction	Tufts Health Public Plan should work to improve contract management practices and the timeliness of the dispute process for denied claims.	Tufts Health Public Plan will continue to field a provider satisfaction survey which includes contract management practices and timeliness of dispute process for denied claims questions. Annual analysis of survey results will take place.	Partially addressed.

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

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

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

The strengths and opportunities for improvement based on Tufts Health Public Plan's 2022 performance, as well recommendations for improving quality, timeliness, and access to care are presented in Table 47. 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 47: Tufts Health Public Plan's Strengths, Opportunities, and Recommendations, Measurement Year 2022

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths				
NCQA Accreditation	Tufts Health Public Plan maintained NCQA accreditation in 2022.	X	X	X
Performance Measures	Tufts Health Public Plan met all information systems and validation requirements to successfully report HEDIS data to the Office of Health and Human Services and to NCQA.			
Performance Measures – Effectiveness of Care	Tufts Health Public Plan reported three measurement year 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	Tufts Health Public Plan is compliant with the standards of *42 Code of Federal Regulations Part 438 Managed Care*.	X	X	X
Network Adequacy	Tufts Health Public Plan's network analyses for measurement year 2022 were determined to be reliable.			
Encounter Data	IPRO determined that there were no critical findings risking Tufts Health Public Plan's			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	ability to submit claims/encounter data that are accurate and complete.			
Quality of Care Survey – Member Satisfaction	Tufts Health Public Plan achieved two scores on the adult survey that met or exceeded the national Medicaid 75th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	None.			
Opportunities for Improvement				
Quality Improvement Projects	All four quality improvement projects did not pass validation.			
Performance Measures – Use of Services	Tufts Health Public Plan reported three measurement year 2022 rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Performance Measures – Effectiveness of Care	Tufts Health Public Plan reported four measurement year 2022 rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Performance Measures – Access and Availability	Tufts Health Public Plan reported five measurement year 2022 rates that benchmarked below the national Medicaid 75th percentile.	X	X	X
Compliance with Medicaid and Children's Health Insurance Program Standards	None.			
Compliance with State Contract Requirements	Tufts Health Public Plan failed to report patient-centered medical home data according to state contract requirements.			
Network Adequacy	Tufts Health Public Plan did not meet the 90% goal for member geographic access to pediatric allergy/immunology specialists.	X	X	X
	Appointment availability among the surveyed providers was low.		X	X
Encounter Data	Discrepancies and data extraction issues were identified across encounter types.			
Quality of Care Surveys – Member Satisfaction	Tufts Health Public Plan achieved seven scores on the adult survey that benchmarked below the national Medicaid 75th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	Tufts Health Public scored low on ease of reaching a supervisor at the call center, claims	X		

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	appeals procedures, and ability to resolve problems or disputes.			
Recommendations				
Quality Improvement Projects	To ensure future quality improvement project methodologies are effectively designed and managed, Tufts Health Public Plan staff should reference the Centers for Medicare & Medicaid Services' *External Quality Review Protocol 1 – Validation of Performance Improvement Projects*, utilize the NCQA *Quality Improvement Activity Form*, and fully address issues identified by the external quality review organization.	X	X	X
Compliance with Medicaid and Children's Health Insurance Program Standards	Tufts Health Public Plan should conduct routine monitoring to ensure compliance is maintained.	X	X	X
Compliance with State Contract Requirements	Tufts Health Public Plan should determine why current policies and procedures failed to ensure that the managed care plan met state-required reporting requirements, and take action to ensure future compliance with all contract requirements.			
Performance Measures	Tufts Health Public Plan should continue to utilize HEDIS results in the development of its annual quality assurance and performance improvement program. As low performance measure rates generally indicate that members received lower quality care, faced inadequate access to care, and experienced unfavorable health outcomes, Tufts Health Public Plan should focus on child and adult primary care utilization rates, women's health, and chronic conditions.	X	X	X
Network Adequacy	Tufts Health Public Plan should address barriers members face when attempting to access care that is timely and appropriate.	X	X	X
	Tufts Health Public Plan should work to increase the number of in-network pediatric allergy/immunology specialists available to members.	X	X	X
Encounter Data	Tufts Health Public Plan should work to reduce discrepancies and resolve identified data extraction issues.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Quality of Care Survey – Member Satisfaction	Tufts Health Public Plan should work to improve its performance on measures of member satisfaction for which it did not meet the national Medicaid 75th percentile.	X	X	X
Quality of Care Survey – Provider Satisfaction	Tufts Health Public Plan should work to improve ease of reaching supervisors at the call center, claims appeals procedures, and ability to resolve problems or disputes.	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.