Managed Care Program Annual Report (MCPAR) for Rhode Island: Medicaid Managed Care Program

Due Date	Last edited	Edited By	Status
12/27/2022	12/29/2022	Michelle Lizotte	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR	
Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A.1	**State name** Auto-populated from your account profile.	Rhode Island
A.2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Mark Kraics

Number	Indicator	Response
A.2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	Mark.Kraics@ohhs.ri.gov
A.3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Michelle Lizotte
A.3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	Michelle.Lizotte@ohhs.ri.gov
A.4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/29/2022

Reporting Period

Number	Indicator	Response
A.5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2021
A.5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2022
A.6	**Program name** Auto-populated from report dashboard.	Medicaid Managed Care Program

Add plans (A.7)

Indicator	Response
Plan name	Neighborhood Health Plan of Rhode Island
	Tufts Health Public Plan
	UnitedHealthcare of New England
	UnitedHealthcare Insurance Company (RIte Smiles)

Add BSS entities (A.8)

Indicator	Response
BSS entity name	Rhode Island Parent Information (RIPIN)
	The Point
	HealthSource Rhode Island

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
	Statewide Medicaid enrollment	
B.I.1	Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	353,106
	Statewide Medicaid managed care enrollment	
B.I.2	Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only	312,832

Number	Indicator	Response
	once, even if they are enrolled in more than one managed care program or more than one managed care plan.	

Topic III. Encounter Data Report

Number	Indicator	Response
B.III.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	EQRO State actuaries State Medicaid agency staff

Topic X: Program Integrity

Number	Indicator	Response
B.X.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to	State has developed active contract management oversight activities for plans related to preventative services with specific reviews for colonoscopies, mammograms and prostate examinations. The state reviews utilization activities to provide oversight.

Number	Indicator	Response
	identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	
	Contract standard for overpayments	
B.X.2	Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
	Location of contract provision stating overpayment standard	
B.X.3	Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	The standard is located in section: 2.13.08.01 Recovery Reporting
	Description of overpayment contract standard	
B.X.4	Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return	In accordance with 42 C.F.R. Part 433, Subpart F, the Contractor and all subcontractors must establish a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment. The report of total recoveries will be provided to EOHHS on an annual basis and will separate out recoveries made for these types of overpayments in addition to any recoveries

Number	Indicator	Response
	overpayments, or administers a hybrid system) selected in indicator B.X.2.	made related to fraud, waste and abuse activities. The Contractor, and subcontractors, must report to EOHHS within sixty (60) calendar days any capitation payments that has been identified as exceeding the contracted capitation payments.
	State overpayment reporting monitoring	
B.X.5	Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	In accordance with 42 CFR 438.608xxxii, the Contractor or subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under the contract between the State and the Contractor, will have administrative and management arrangements, including a mandatory written compliance plan, which are designed to guard against fraud and abuse. An electronic copy of the Contractor's written compliance plan, including all relevant operating policies, procedures, workflows, and relevant chart of organization must be submitted to the EOHHS for review and approval within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter
	Changes in beneficiary circumstances	
B.X.6	Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change	State has a reconciliation process in place with many functions that are automated.

Number	Indicator	Response
	in status (e.g., incarcerated, deceased, switching plans).	
	Changes in provider circumstances: Monitoring plans	Yes
B.X.7a	Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	**Changes in provider circumstances: Metrics** No
	Federal database checks: Excluded person or entities	
B.X.8a	During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP,	Yes **Federal database checks: Summarize instances of exclusion** N/A

Number	Indicator	Response
	PCCM or PCCM entity through routine checks of Federal databases.	
	Website posting of 5 percent or more ownership control	
B.X.9a	Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to B'455.104 and required by 42 CFR 438.602(g)(3).	No
	Periodic audits	
B.X.10	If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	State has established a hybrid system

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1.I.1	**Program contract** Enter the title and date of the contract between the state and plans participating in the managed care program.	Medicaid Managed Care Services and Medicaid RIte Smiles Program 07/01/2020
C1.I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://eohhs.ri.gov/providers-partners/medicaid-managed-care
C1.I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Other, specify MCO and PAHP (Dental)
C1.I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Dental Transportation
C1.I.4b	**Variation in special benefits** What are any variations in the availability of special	N/A

Number	Indicator	Response
	benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	
	Program enrollment	
C1.I.5	Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	353,106
	Changes to enrollment or benefits	
C1.I.6	Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	Enrollment was impacted by the Public Health Emergency (PHE) as related to COVID-19

Topic III: Encounter Data Report

Number	Indicator	Response
		Rate setting
	Uses of encounter data	Quality/performance measurement
C1.III.1	For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Monitoring and reporting Contract oversight Program integrity Policy making and decision support
	Criteria/measures to evaluate MCP performance	Overall data accuracy (as determined through data validation)
C1.III.2	What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more.	Timeliness of data certifications

Number	Indicator	Response
	Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of data corrections Timeliness of initial data submissions
	Encounter data performance criteria contract language	
C1.III.3	Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Section 2.13.02 Encounter Data Reporting
	Financial penalties contract language	
C1.III.4	Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-11/rhodei1.pdf
	Incentives for encounter data quality	
C1.III.5	Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
	Barriers to collecting/validating encounter data	The plans continue to work towards 100% accuracy. The State meets with each Health Plan bi-weekly to address any barriers.
C1.III.6	Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
	State's definition of "critical incident," as used for reporting purposes in its MLTSS program	
C1.IV.1	If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	Expedited appeals must be resolved within seventy-two (72) hours of receipt of the appeal. The member may submit a verbal request for an expedited resolution of appeal. The member does not need to follow an oral request for an expedited resolution of appeal with a written request. The Contractor must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of an expedited resolution.
C1.IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely	The Contractor must resolve each grievance and provide written notice of the resolution as expeditiously as the member's health condition requires but not to exceed ninety (90) calendar days from the date that the Contractor received the grievance. For resolution of each standard appeal, the Contractor must provide written notice of the disposition within thirty (30) calendar days from the time the Contractor receives the appeal. The timeframes for both grievances and appeals resolution may be extended by up to fourteen (14) calendar days if the member requests an extension or if the Contractor shows (to the satisfaction of EOHHS upon request) that there is need for additional

Number	Indicator	Response
	resolution for standard appeals in the managed care program. Per 42 CFR B'438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	information and how the delay is in the member's best interest. If the Contractor extends the timeframes not at the request of the member, it must complete all the following: b" Make reasonable efforts to give the member prompt oral notice of the delay; b" Within two (2) calendar days, give members written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; b" Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.
C1.IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR B'438.408(b)(3), states must establish a timeframe for timely	Expedited appeals must be resolved within seventy-two (72) hours of receipt of the appeal. The member may submit a verbal request for an expedited resolution of appeal. The member does not need to follow an oral request for an expedited resolution of appeal with a written request. The Contractor must inform the member of the limited time available for the member to present evidence and allegations of fact or law, in person and in writing, in the case of an expedited resolution.

Number	Indicator	Response
	resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	
C1.IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR B'438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	Provide members with an acknowledgment of receipt of each grievance and appeal within five (5) calendar days. The timeframe for resolution is ninety (90) calendar days from receipt of the grievance as provided in Rhode Island Medicaid Managed Care Grievance and Appeals Process.

Topic V. Availability, Accessibility and Network Adequacy

Number	Indicator	Response
C1.V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	Any gaps or challenges in network adequacy are generally attributed to provider reimbursement and workforce challenges.
C1.V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The state works with health plans to ensure their networks meet the needs of the membership, review member plan change requests and EQRO annual reporting.

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook

C2_Program_State

1 / 1

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

EQRO or MCO report

C2.V.1 General category

Ease of getting a timely appointment

C2.V.4 Provider

Primary care

C2.V.5 Region

RI is a small state and the expectation is that the plans provide coverage statewide in accordance with the population they serve.

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Monitoring Methods includes, quarterly review of network

adequacy via a template created by EOHHS. This includes appointment availability and open provider panels.

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
	BSS website	
C1.IX.1	List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.unitedwayri.org/get-help/point/; https://ripin.org/healthcare-advocate-contact-form/; https://healthsourceri.com/contact/; https://alliancebltc.org/ombudsman-program/overview/
	BSS auxiliary aids and services	
C1.IX.2	How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when	United Way of RI's Point Aging and Disability Resource Center provides support by phone, email, and face-to-face at six offices across the state. The Rhode Island Parent Information Network's (RIPIN) Call Center provides support by phone and email. HealthSource RI has Navigiators and Certified Application Counselors that provide assistance via phone, video conference, live web chat, and in-person (by appointment). All BSS entities can be accessed through auxiliary aids and services or through an interpreter.

Number	Indicator	Response
	requested.	
	BSS LTSS program data	
C1.IX.3	How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	The state has established data reporting requirements with the BSS entities.
	State evaluation of BSS entity performance	
C1.IX.4	What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The state has established data reporting requirements and has regular contract oversight meetings with the BSS entities.

Topic X: Program Integrity

Number	Indicator	Response
	Prohibited affiliation disclosure	
C1.X.3	Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1.I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Neighborhood Health Plan of Rhode Island** 181,069 **Tufts Health Public Plan** 19,459 **UnitedHealthcare of New England** 98,963 **UnitedHealthcare Insurance Company (RIte Smiles)** 130,652
D1.I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Neighborhood Health Plan of Rhode Island** 51.3% **Tufts Health Public Plan** 5.5% **UnitedHealthcare of New England** 28% **UnitedHealthcare Insurance Company**

Number	Indicator	Response
		(RIte Smiles) 100% **Neighborhood Health Plan of Rhode Island** 57.9% **Tufts Health Public Plan** 6.2% **UnitedHealthcare of New England** 31.6% **UnitedHealthcare Insurance Company (RIte Smiles)** 100%
D1.I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	

Topic II. Financial Performance

Number	Indicator	Response
D1.II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Neighborhood Health Plan of Rhode Island** 91.3% **Tufts Health Public Plan** 86.6% **UnitedHealthcare of New England** 90.2%

Number	Indicator	Response
		UnitedHealthcare Insurance Company (RIte Smiles) 85.3% **Neighborhood Health Plan of Rhode Island** Program-specific regional **Tufts Health Public Plan** Statewide all programs & populations
D1.II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**UnitedHealthcare of New England** Statewide all programs & populations **UnitedHealthcare Insurance Company (RIte Smiles)** Statewide all programs & populations
D1.II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable.	**Neighborhood Health Plan of Rhode Island** No **Tufts Health**

Number	Indicator	Response
		Public Plan No **UnitedHealthcare of New England** No **UnitedHealthcare Insurance Company (RIte Smiles)** N/A **Neighborhood Health Plan of Rhode Island** Yes 07/01/2020 06/30/ 2021 **Tufts Health Public Plan** Yes 07/01/2020 06/30/ 2021 **UnitedHealthcare of New England** Yes 07/01/2020 06/30/ 2021 **UnitedHealthcare Insurance Company (RIte Smiles)**
	See glossary for the regulatory definition of MLR.	
D1.II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	

Number	Indicator	Response
		Yes 07/01/2020 06/30/2021

Topic III. Encounter Data

Number	Indicator	Response
D1.III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Neighborhood Health Plan of Rhode Island** Timely Submissions: Initial submission within thirty (30) business days of paid claim date. Rejected claims are re-submitted within thirty (30) business days of notice of the rejection. **Tufts Health Public Plan** Timely Submissions: Initial submission within thirty (30) business days of paid claim date. Rejected claims are re-submitted within thirty (30) business days of notice of the rejection. **UnitedHealthcare of New England** Timely Submissions: Initial submission within thirty (30) business days of paid claim date. Rejected claims are re-submitted within thirty (30) business days of notice of the rejection.

Number	Indicator	Response
		UnitedHealthcare Insurance Company (RIte Smiles) Timely Submissions: Initial submission within thirty (30) business days of paid claim date. Rejected claims are re-submitted within thirty (30) business days of notice of the rejection.
D1.III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Neighborhood Health Plan of Rhode Island** 97% **Tufts Health Public Plan** 95% **UnitedHealthcare of New England** 99% **UnitedHealthcare Insurance Company (RIte Smiles)** 98%
D1.III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions	**Neighborhood Health Plan of Rhode Island** 97% **Tufts Health Public Plan** 95% **UnitedHealthcare of**

Number	Indicator	Response
		New England
	that were compliant out of the proportion received from the managed care plan for the reporting period.	99%
		UnitedHealthcare Insurance Company (RIte Smiles)
		98%

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
		Neighborhood Health Plan of Rhode Island
	Appeals resolved (at the plan level)	1,182
	Enter the total number of appeals resolved as of the first day of the last month of the reporting year.	**Tufts Health Public Plan**
D1.IV.1	An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	31
		UnitedHealthcare of New England
		669
		UnitedHealthcare Insurance Company (RIte Smiles)
		157
	Active appeals	**Neighborhood Health Plan of Rhode Island**
D1.IV.2	Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	N/A
		Tufts Health Public Plan

Number	Indicator	Response
		N/A
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
D1.IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Tufts Health Public Plan**
		N/A
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
D1.IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter	**Neighborhood Health Plan of Rhode Island**
		N/A
		Tufts Health Public Plan
		N/A

Number	Indicator	Response
	"N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	**UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A
		Neighborhood Health Plan of Rhode Island
D1.IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR B'438.408(b)(2) for requirements related to timely resolution of standard appeals.	1,182 **Tufts Health Public Plan** 10 **UnitedHealthcare of New England** 669 **UnitedHealthcare**

Number	Indicator	Response
		Insurance Company (RIte Smiles)
		43
		Neighborhood Health Plan of Rhode Island
		108
	Expedited appeals for which timely resolution was provided	**Tufts Health Public Plan**
D1.IV.5b	Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR B'438.408(b)(3) for requirements related to timely resolution of standard appeals.	21
		UnitedHealthcare of New England
		43
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
	Resolved appeals related to denial of authorization or limited authorization of a service	**Neighborhood Health Plan of Rhode Island**
		N/A
D1.IV.6a	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Tufts Health Public Plan**
		N/A
		UnitedHealthcare of New England
		N/A

Number	Indicator	Response
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
	Resolved appeals related to reduction, suspension, or termination of a previously authorized service	**Tufts Health Public Plan**
		N/A
D1.IV.6b	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**UnitedHealthcare of New England**
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
	Resolved appeals related to payment denial	N/A
D1.IV.6c	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Tufts Health Public Plan**
		N/A
		UnitedHealthcare of New England
		N/A

Number	Indicator	Response
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
		Tufts Health Public Plan
	Resolved appeals related to service timeliness	N/A
D1.IV.6d	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**UnitedHealthcare of New England**
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
	Resolved appeals related to lack of timely plan response to an appeal or grievance	N/A
D1.IV.6e	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR B'438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Tufts Health Public Plan**
		N/A
		UnitedHealthcare of New England
		N/A

Number	Indicator	Response
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care	**Tufts Health Public Plan**
D1.IV.6f	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR B'438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	N/A
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
	Resolved appeals related to denial of an enrollee's request to dispute financial liability	N/A
D1.IV.6g	Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Tufts Health Public Plan**
		N/A
		UnitedHealthcare of New England
		N/A

Number	Indicator	Response
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
		Neighborhood Health Plan of Rhode Island
D1.IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services - those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	N/A **Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A
D1.IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services - those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Neighborhood Health Plan of Rhode Island** N/A **Tufts Health Public Plan** N/A

Number	Indicator	Response
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
		Tufts Health Public Plan
		N/A
D1.IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**UnitedHealthcare of New England**
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
D1.IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	N/A
		Tufts Health Public Plan
		N/A

Number	Indicator	Response
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
	Resolved appeals related to covered outpatient prescription drugs	**Tufts Health Public Plan**
D1.IV.7e	Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	N/A
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
	Resolved appeals related to skilled nursing facility (SNF) services	N/A
D1.IV.7f	Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Tufts Health Public Plan**
		N/A

Number	Indicator	Response
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
D1.IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Tufts Health Public Plan**
		N/A
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
D1.IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	N/A
		Tufts Health Public Plan
		N/A

Number	Indicator	Response
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
		Tufts Health Public Plan
		N/A
D1.IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**UnitedHealthcare of New England**
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
		Tufts Health Public Plan
		N/A
D1.IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	

Number	Indicator	Response
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
		Neighborhood Health Plan of Rhode Island
		192
		Tufts Health Public Plan
	State Fair Hearing requests	0
D1.IV.8a	Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**UnitedHealthcare of New England**
		4
		UnitedHealthcare Insurance Company (RIte Smiles)
		21
	State Fair Hearings resulting in a favorable decision for the enrollee	**Neighborhood Health Plan of Rhode Island**
D1.IV.8b	Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	148

Number	Indicator	Response
		Tufts Health Public Plan N/A **UnitedHealthcare of New England** 2 **UnitedHealthcare Insurance Company (RIte Smiles)** N/A **Neighborhood Health Plan of Rhode Island** 44
D1.IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A
D1.IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the	**Neighborhood Health Plan of Rhode Island** N/A

Number	Indicator	Response
		Tufts Health Public Plan N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A **Neighborhood Health Plan of Rhode Island** N/A
	representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	
D1.IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR B'438.402(c)(i)(B).	**Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A
D1.IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical	**Neighborhood Health Plan of Rhode Island** N/A

Number	Indicator	Response
		Tufts Health Public Plan
		N/A
	review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A".	**UnitedHealthcare of New England**
		N/A
	External medical review is defined and described at 42 CFR B'438.402(c)(i)(B).	**UnitedHealthcare Insurance Company (RIte Smiles)**
		N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
		Neighborhood Health Plan of Rhode Island
		302
	Grievances resolved	**Tufts Health Public Plan**
D1.IV.10	Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	7
		UnitedHealthcare of New England
		112
		UnitedHealthcare Insurance Company (RIte Smiles)
		4
D1.IV.11	**Active grievances**	**Neighborhood**

Number	Indicator	Response
		Health Plan of Rhode Island N/A **Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A **Neighborhood Health Plan of Rhode Island** N/A
	Grievances filed on behalf of LTSS users Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users.	**Tufts Health Public Plan** N/A
D1.IV.12	An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A

Number	Indicator	Response
D1.IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	**Neighborhood Health Plan of Rhode Island** N/A **Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A
D1.IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR B'438.408(b)(1) for requirements	**Neighborhood Health Plan of Rhode Island** N/A **Tufts Health Public Plan**

Number	Indicator	Response
		N/A
		UnitedHealthcare of New England
		N/A
	related to the timely resolution of grievances.	**UnitedHealthcare Insurance Company (RIte Smiles)**
		N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
		Neighborhood Health Plan of Rhode Island
		N/A
D1.IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services - those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** 4
D1.IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were	**Neighborhood Health Plan of Rhode Island** N/A

Number	Indicator	Response
		Tufts Health Public Plan N/A
	related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**UnitedHealthcare of New England** N/A
		UnitedHealthcare Insurance Company (RIte Smiles) N/A
		Neighborhood Health Plan of Rhode Island N/A
D1.IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Tufts Health Public Plan** N/A
		UnitedHealthcare of New England N/A
		UnitedHealthcare Insurance Company (RIte Smiles) N/A
D1.IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were	**Neighborhood Health Plan of Rhode Island** N/A

Number	Indicator	Response
		Tufts Health Public Plan N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A **Neighborhood Health Plan of Rhode Island** N/A
	related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	
D1.IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A **Neighborhood Health Plan of Rhode Island** N/A
D1.IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were	

Number	Indicator	Response
		Tufts Health Public Plan N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A **Neighborhood Health Plan of Rhode Island** N/A
D1.IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A
D1.IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care	**Neighborhood Health Plan of Rhode Island** N/A

Number	Indicator	Response
		Tufts Health Public Plan N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A **Neighborhood Health Plan of Rhode Island** N/A
	plan does not cover this type of service, enter "N/A".	
D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A **Neighborhood Health Plan of Rhode Island** N/A
D1.IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were	

Number	Indicator	Response
		Tufts Health Public Plan
		N/A
	related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**UnitedHealthcare of New England**
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
		Neighborhood Health Plan of Rhode Island
	Resolved grievances related to plan or provider customer service	302
		Tufts Health Public Plan
D1.IV.16a	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	7
		UnitedHealthcare of New England
		112
		UnitedHealthcare Insurance Company (RIte Smiles)
		4
D1.IV.16b	**Resolved grievances related to plan or**	**Neighborhood**

Number	Indicator	Response
		Health Plan of Rhode Island
		N/A
	provider care management/case management	**Tufts Health Public Plan**
	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management.	N/A
		UnitedHealthcare of New England
	Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
	Resolved grievances related to access to care/ services from plan or provider	**Tufts Health Public Plan**
D1.IV.16c	Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.	N/A
		UnitedHealthcare of New England
	Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A

Number	Indicator	Response
D1.IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Neighborhood Health Plan of Rhode Island** N/A **Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A
D1.IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Neighborhood Health Plan of Rhode Island** N/A **Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A

Number	Indicator	Response
		Neighborhood Health Plan of Rhode Island
		N/A
		Tufts Health Public Plan
	Resolved grievances related to payment or billing issues	N/A
D1.IV.16f	Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**UnitedHealthcare of New England**
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
	Resolved grievances related to suspected fraud	N/A
	Enter the total number of grievances resolved during the reporting year that were related to suspected fraud.	**Tufts Health Public Plan**
		N/A
D1.IV.16g	Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**UnitedHealthcare of New England**
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A

Number	Indicator	Response
		Neighborhood Health Plan of Rhode Island
		N/A
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Tufts Health Public Plan**
		N/A
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Tufts Health Public Plan**
		N/A
		UnitedHealthcare of New England
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A

Number	Indicator	Response
		Neighborhood Health Plan of Rhode Island
	Resolved grievances related to plan denial of expedited appeal	N/A
	Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.	**Tufts Health Public Plan**
D1.IV.16j		N/A
	Per 42 CFR B'438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**UnitedHealthcare of New England**
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A
		Neighborhood Health Plan of Rhode Island
		N/A
		Tufts Health Public Plan
	Resolved grievances filed for other reasons	N/A
D1.IV.16k	Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**UnitedHealthcare of New England**
		N/A
		UnitedHealthcare Insurance Company (RIte Smiles)
		N/A

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Find in the Excel Workbook

D2_Plan_Measures

1 / 4

Complete

D2.VII.1 Measure Name: Follow up after hospitalizatin for MI-30 day

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

01/01/2020 - 12/31/2020

D2.VII.8 Measure Description

N/A

Measure results

Neighborhood Health Plan of Rhode Island

73.82

Tufts Health Public Plan

76.45

UnitedHealthcare of New England

75.21

UnitedHealthcare Insurance Company (RIte Smiles)

N/A

2 / 4

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care - HbA1c Testing

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

59

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

01/01/2020 - 12/31/2020

D2.VII.8 Measure Description

N/A

Measure results

Neighborhood Health Plan of Rhode Island

81.05

Tufts Health Public Plan

74.08

UnitedHealthcare of New England

80.29

UnitedHealthcare Insurance Company (RIte Smiles)

N/A

3 / 4

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care - Timeliness of Prenatal Care

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

1517

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

01/01/2020 - 12/31/2020

D2.VII.8 Measure Description

N/A

Measure results

Neighborhood Health Plan of Rhode Island

95.86

Tufts Health Public Plan

66.67

UnitedHealthcare of New England

89.05

UnitedHealthcare Insurance Company (RIte Smiles)

N/A

4 / 4

Complete

D2.VII.1 Measure Name: WCC

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1516

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

01/01/2020 - 12/31/2020

D2.VII.8 Measure Description

N/A

Measure results

Neighborhood Health Plan of Rhode Island

76.45

Tufts Health Public Plan

48.13

UnitedHealthcare of New England

64.98

UnitedHealthcare Insurance Company (RIte Smiles)

N/A

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to

improve performance.

Find in the Excel Workbook

D3_Plan_Sanctions

1 / 1

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

D3.VIII.2 Intervention topic

Non-Compliance with Section 3.05.05, Subcontracts and Delegation of Duty

D3.VIII.3 Plan name

Neighborhood Health Plan of Rhode Island

D3.VIII.4 Reason for intervention

NHPRI sent an incorrect termination report of their PBM and then reported non-compliance late

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$ 25,000

D3.VIII.7 Date assessed

07/21/2021

D3.VIII.8 Remediation date non-compliance was corrected

08/21/2021

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1.X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Neighborhood Health Plan of Rhode Island** 2 **Tufts Health Public Plan** 2 **UnitedHealthcare of New England** 2 **UnitedHealthcare Insurance Company (RIte Smiles)** 2
D1.X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Neighborhood Health Plan of Rhode Island** N/A **Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)**

Number	Indicator	Response
		N/A
D1.X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Neighborhood Health Plan of Rhode Island** 0:0 **Tufts Health Public Plan** 0:0 **UnitedHealthcare of New England** 0:0 **UnitedHealthcare Insurance Company (RIte Smiles)** 0:0
D1.X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**Neighborhood Health Plan of Rhode Island** N/A **Tufts Health Public Plan** N/A **UnitedHealthcare of New England** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** N/A
D1.X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per	**Neighborhood Health Plan of Rhode Island** 0:0 **Tufts Health Public Plan** 0:0 **UnitedHealthcare of New England** 0:0

Number	Indicator	Response
	1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**UnitedHealthcare Insurance Company (RIte Smiles)** 0:0 **Neighborhood Health Plan of Rhode Island** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** N/A **Tufts Health Public Plan** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1.X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Count of program integrity referrals to the state** N/A **UnitedHealthcare of New England** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** N/A **UnitedHealthcare Insurance Company (RIte Smiles)** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** N/A

Number	Indicator	Response
D1.X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	**Neighborhood Health Plan of Rhode Island** 0:0 **Tufts Health Public Plan** 0:0 **UnitedHealthcare of New England** 0:0 **UnitedHealthcare Insurance Company (RIte Smiles)** 0:0
D1.X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of	**Neighborhood Health Plan of Rhode Island** In accordance with 42 C.F.R. Part 433, Subpart F, the Contractor and all subcontractors must establish a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment. The report of total recoveries will be provided to EOHHS on an annual basis and will separate out recoveries made for these types of overpayments in addition to any recoveries made related to fraud, waste and abuse activities. The Contractor, and subcontractors, must report to EOHHS within sixty (60) calendar days any capitation payments that has been identified as exceeding the contracted capitation payments. **Tufts Health Public Plan** In accordance with 42 C.F.R. Part 433, Subpart F, the Contractor and all subcontractors must establish a mechanism for a network provider to

Number	Indicator	Response
		report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment. The report of total recoveries will be provided to EOHHS on an annual basis and will separate out recoveries made for these types of overpayments in addition to any recoveries made related to fraud, waste and abuse activities. The Contractor, and subcontractors, must report to EOHHS within sixty (60) calendar days any capitation payments that has been identified as exceeding the contracted capitation payments.
		UnitedHealthcare of New England
	overpayments recovered.	In accordance with 42 C.F.R. Part 433, Subpart F, the Contractor and all subcontractors must establish a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment. The report of total recoveries will be provided to EOHHS on an annual basis and will separate out recoveries made for these types of overpayments in addition to any recoveries made related to fraud, waste and abuse activities. The Contractor, and subcontractors, must report to EOHHS within sixty (60) calendar days any capitation payments that has been identified as exceeding the contracted capitation payments.
	• The ratio of the dollar amount of overpayments recovered as a percent of premium revenue, as defined in MLR reporting under 438.8(f)(2).	**UnitedHealthcare Insurance Company (RIte Smiles)** In accordance with 42 C.F.R. Part 433, Subpart F, the Contractor and all subcontractors must establish a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment. The report of total recoveries will

Number	Indicator	Response
		be provided to EOHHS on an annual basis and will separate out recoveries made for these types of overpayments in addition to any recoveries made related to fraud, waste and abuse activities. The Contractor, and subcontractors, must report to EOHHS within sixty (60) calendar days any capitation payments that has been identified as exceeding the contracted capitation payments.
		Neighborhood Health Plan of Rhode Island
		Monthly
	Changes in beneficiary circumstances	**Tufts Health Public Plan**
		Monthly
D1.X.10	Select the frequency the plan reports changes in beneficiary circumstances to the state.	**UnitedHealthcare of New England**
		Monthly
		UnitedHealthcare Insurance Company (RIte Smiles)
		Quarterly

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Number	Indicator	Response
		Rhode Island Parent Information (RIPIN)
	BSS entity type	
E.IX.1	What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	Other Community-Based Organization
		The Point
		Other Community-Based Organization

Number	Indicator	Response
		HealthSource Rhode Island Enrollment Broker Local Government Entity **Rhode Island Parent Information (RIPIN)** Beneficiary Outreach
E.IX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**The Point** Enrollment Broker/ Choice Counseling **HealthSource Rhode Island** Enrollment Broker/ Choice Counseling