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# **Rhode Island Medicaid Managed Care Program Tufts Health Public Plans 2024 External Quality Review Annual Technical Report April 2026**

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

[ipro.org](https://ipro.org)

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.

Per *Title 42 CFR 438.364(a)(7)*, no managed care plan was exempt from the external quality review activities conducted in 2024.

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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 & Medicaid Services. Quality, as it pertains to an external quality review, is defined in *Title 42 Code of Federal Regulations 438.320 Definitions* as “the degree to which a managed care plan, PIHP<sup>1</sup>, PAHP<sup>2</sup>, or PCCM<sup>3</sup> 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 *Title 42 Code of Federal Regulations Section 438.364 External quality review results (a) through (d)* and *Title 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 2024. This report summarizes the 2024 external quality review results for **Tufts Public Health Plan**.

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

### 2024 External Quality Review

This external quality review technical report focuses on four federally required activities (validation of performance improvement projects<sup>4</sup>, validation of performance measures, review of compliance Medicaid and Children’s Health Insurance Program standards, and validation of network adequacy) and one optional activity (validation of quality-of-care survey) that were conducted for measurement year 2024 (January 1, 2024-December 31, 2024). IPRO’s

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<sup>1</sup> Prepaid inpatient health plan.

<sup>2</sup> Prepaid ambulatory health plan.

<sup>3</sup> Primary care case management.

<sup>4</sup> 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.

external quality review methodologies for these activities follow the *CMS External Quality Review (EQR) Protocols*<sup>5</sup> 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 <sup>®6</sup> ) 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 Rhode Island Executive 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 and Children's Health Insurance Program standards. Specifically, this review assessed managed care plan compliance with standards under <i>Code of Federal Regulations Part 438 – Managed Care</i> .
Activity 4. Validation of Network Adequacy (Required)	Protocol 4	IPRO evaluated the managed care plan data collection methodologies and results to determine managed care plan adherence to the network standards outlined in the <i>Medicaid Managed Care Services Agreement</i> , as well as managed care plan ability to provide an adequate provider network to its Medicaid and Children's Health Insurance Program populations.
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 Rhode Island Executive Office of Health and Human Services' requirement to utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS <sup>®7</sup> ) tool. IPRO also reviewed managed care plan provider satisfaction survey reports to verify the validity and reliability of the results and to ensure that the survey was conducted in alignment with the <i>Medicaid Managed Care Services Agreement</i> .

The results of IPRO's external quality review are reported under each activity section.

<sup>5</sup> The Centers for Medicare & Medicaid Services External Quality Review Protocols website: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>.

<sup>6</sup> HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

<sup>7</sup> 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<sup>8</sup> 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<sup>9</sup>. 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 Rhode Island Executive 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, UnitedHealthcare Community Plan of Rhode Island, and **Tufts Health Public Plans**; and one managed dental health plan: UnitedHealthcare Dental. **Table 2** displays a summary of the Medicaid managed care programs and participating managed care plans that were available to Rhode Islanders in 2024.

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<sup>8</sup> 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>.

<sup>9</sup> 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
Rlte Care Core	A Medicaid managed care plan for children and families.	<ul style="list-style-type: none"> <li>▪ Neighborhood Health Plan of Rhode Island</li> <li>▪ <b>Tufts Public Health Plan</b></li> <li>▪ UnitedHealthcare Community Plan of Rhode Island</li> </ul>
Rlte 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.	<ul style="list-style-type: none"> <li>▪ Neighborhood Health Plan of Rhode Island</li> </ul>
Rlte 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.	<ul style="list-style-type: none"> <li>▪ Neighborhood Health Plan of Rhode Island</li> <li>▪ <b>Tufts Public Health Plan</b></li> <li>▪ UnitedHealthcare Community Plan of Rhode Island</li> </ul>
Rhody Health Expansion	A Medicaid managed care plan for low-income adults aged 19-64 years with no dependent children.	<ul style="list-style-type: none"> <li>▪ Neighborhood Health Plan of Rhode Island</li> <li>▪ <b>Tufts Public Health Plan</b></li> <li>▪ UnitedHealthcare Community Plan of Rhode Island</li> </ul>
Rhody Health Partners	A Medicaid managed care plan for eligible adults with disabilities who are 21 years or older.	<ul style="list-style-type: none"> <li>▪ Neighborhood Health Plan of Rhode Island</li> <li>▪ <b>Tufts Public Health Plan</b></li> <li>▪ UnitedHealthcare Community Plan of Rhode Island</li> </ul>
Rite Smiles	A dental managed care plan for children enrolled in Medicaid and born on or after May 1, 2000.	<ul style="list-style-type: none"> <li>▪ UnitedHealthcare Dental</li> </ul>

The provision of health care services to each of the applicable eligibility groups (Rlte Care Core, Rlte Care for Children in Substitute Care, Rlte 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 Rhode Island Executive 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 Rhode Island Executive 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 Rhode Island Executive 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<sup>10</sup> aligns with the Rhode Island Executive 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 Rhode Island Executive 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**

<b>Rhode Island Medicaid Managed Care Quality Strategy Goals and Objectives</b>
<b>Goal 1: Members receive quality care within all managed care delivery systems.</b>
<ul style="list-style-type: none"><li>▪ <b>1.1</b> 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.</li><li>▪ <b>1.2</b> 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.</li><li>▪ <b>1.3</b> Monitor managed care organization performance for dual-eligible Medicare-Medicaid population.</li></ul>
<b>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.</b>
<ul style="list-style-type: none"><li>▪ <b>2.1</b> Continue oversight of managed care organizations and accountable entities to increase timely preventive care, screening, and follow-up for adult and child health.</li><li>▪ <b>2.2</b> Monitor and assess managed care organization and accountable entity performance improvement on quality measures related to chronic conditions.</li><li>▪ <b>2.3</b> Increase the use of prenatal and postpartum services.</li><li>▪ <b>2.4</b> Increase the number and percentage of well-child visits.</li></ul>

<sup>10</sup> 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

- **2.5** Monitor child immunization rates to maintain high performance.
- **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 Rhode Island Executive 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, baseline data, remeasurement data, and an assessment of performance between measurement year 2023 and measurement year 2024. Unless indicated otherwise, baseline measurements are from measurement year 2020 (January 1, 2020 through December 31, 2020).

#### Symbol Key For Table 4

Symbol	Meaning
▲ (Green Upward Triangle)	Performance Improved
▼ (Red Downward Triangle)	Performance Declined
● (Blue Circle)	No Change
— (Black Dash)	Cannot Compare

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

Goal	Measure (Population)	Baseline Measurement Year 2020	Measurement Year 2023	Measurement Year 2024	2023 to 2024 Performance Assessment
<b>Goal 1: Members receive quality care within all managed care delivery systems.</b>	Long-Stay, High-Risk Nursing Facility Residents with Pressure Ulcers ( <i>Lower rate indicates better performance.</i> ) (Medicaid)	8.6%	8.5%	Removed in 2024	—
	Care for Older Adults: Functional Status Assessment (Medicaid)	58.8%	88.8%	92.4%	▲
<b>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</b>	Breast Cancer Screening (Medicaid)	65.0%	64.38%	63.99%	▼
	Cervical Cancer Screening (Medicaid)	59.6%	66.09%	63.41%	▼
	Screening for Depression and Follow-Up Plan, Ages 12-17 Years (Medicaid and Children’s Health Insurance Program)	Not Available	8.24%	7.60%	▼
	Comprehensive Diabetes Care: Hemoglobin A1c Testing <sup>1</sup> (Medicaid)	82.2%	Not Available	Not Available	—
	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control <sup>1</sup> ( <i>Lower rate indicates better performance.</i> ) (Medicaid)	33.2%	27.03%	28.85%	▼
	Controlling High Blood Pressure (Medicaid)	70.7%	73.86%	74.06%	▲
	Asthma Medication Ratio, Ages 5-18 Years (Medicaid and Children’s Health Insurance Program)	65.6%	57.59%	Not Available	—
	Asthma Medication Ratio, Ages 19-64 Years (Medicaid)	53.7%	52.95%	Not Available	—
	Prenatal and Postpartum Care – Timeliness of Prenatal Care, Ages 21 Years and Older (Medicaid)	Not Available	93.4%	85.6%	▼
	Prenatal and Postpartum Care – Timeliness of Prenatal Care, Ages Under 21 Years (Medicaid and Children’s Health Insurance Program)	Not Available	83.6%	83.3%	▼
	Child and Adolescent Well-Care Visits, Ages 3-21 Years	Not Available	61.20%	62.85%	▲

Goal	Measure (Population)	Baseline Measurement Year 2020	Measurement Year 2023	Measurement Year 2024	2023 to 2024 Performance Assessment
	(Medicaid and Children’s Health Insurance Program)				
	Childhood Immunization Status – Combination 10 (Medicaid and Children’s Health Insurance Program)	61.0% <sup>2</sup>	52.29%	49.82%	▼
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Initiation, Ages 18 Years and Older (Medicaid and Children’s Health Insurance Program)	44.8%	40.70%	39.99%	▼
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment – Engagement, Ages 18 Years and Older (Medicaid and Children’s Health Insurance Program)	17.9%	14.92%	15.83%	▲
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days, Ages 13-17 Years (Medicaid and Children’s Health Insurance Program)	Not Available	25.33%	36.00%	▲
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days, Ages 13-17 to Years (Medicaid and Children’s Health Insurance Program)	Not Available	49.33%	52.00%	▲
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 7 Days, Ages 18 Years and Older (Medicaid and Children’s Health Insurance Program)	12.7%	32.61%	32.90%	▲
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence – 30 Days, Ages 18 Years and Older (Medicaid and Children’s Health Insurance Program)	23.8%	48.25%	48.86%	▲
<b>Goal 3: Improve care and service coordination and management, with focus on coordination of services among medical, behavioral, dental and specialty services providers.</b>	Follow-Up After Hospitalization for Mental Illness – 7 Days, Ages 6-17 Years (Medicaid and Children’s Health Insurance Program)	56.8%	59.73%	63.29%	▲
	Follow-Up After Hospitalization for Mental Illness – 30 Days, Ages 6-17 Years (Medicaid and Children’s Health Insurance Program)	76.6%	77.51%	82.28%	▲
	Follow-Up After Hospitalization for Mental Illness – 7 Days, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	57.2%	59.73%	48.94%	▼

Goal	Measure (Population)	Baseline Measurement Year 2020	Measurement Year 2023	Measurement Year 2024	2023 to 2024 Performance Assessment
	Follow-Up After Hospitalization for Mental Illness – 30 Days, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	71.7%	77.51%	69.26%	▼
	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days, Ages 6-17 Years (Medicaid and Children’s Health Insurance Program)	Not Available	57.89%	47.23%	▼
	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days, Ages 6-17 Years (Medicaid and Children’s Health Insurance Program)	Not Available	74.58%	68.34%	▼
	Follow-Up After Emergency Department Visit for Mental Illness – 7 Days, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	64.6%	57.89%	48.57%	▼
	Follow-Up After Emergency Department Visit for Mental Illness – 30 Days, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	74.8%	74.58%	64.38%	▼
	Medical Assistance with Smoking and Tobacco Use Cessation – Advised to Quit (Medicaid)	80.7%	Not Available <sup>3</sup>	Not Available <sup>3</sup>	—
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Medications (Medicaid)	67.0%	Not Available <sup>3</sup>	Not Available <sup>3</sup>	—
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Strategies (Medicaid)	59.9%	Not Available <sup>3</sup>	Not Available <sup>3</sup>	—
	Percentage Diagnosed with Major Depression Who Were Treated with and Remained on Antidepressant Medication – Acute Phase, Ages 18-64 Years (Medicaid and Children’s Health Insurance Program)	58.9%	61.32%	60.40%	▼
	Percentage Diagnosed with Major Depression Who Were Treated with and Remained on Antidepressant Medication – Continuation Phase, Ages 18-64 Years	44.0%	43.66%	44.05%	▲

Goal	Measure (Population)	Baseline Measurement Year 2020	Measurement Year 2023	Measurement Year 2024	2023 to 2024 Performance Assessment
	(Medicaid and Children’s Health Insurance Program)				
	Topical Fluoride for Children – Dental Services or Oral Health Services (Medicaid and Children’s Health Insurance Program)	Not Available	8.81%	18.71%	▲
	Topical Fluoride for Children – Dental Services (Medicaid and Children’s Health Insurance Program)	Not Available	17.53%	18.71%	▲
	Topical Fluoride for Children – Oral Health Services (Medicaid and Children’s Health Insurance Program)	Not Available	0.00%	0.00%	●
<b>Goal 4: Enhance financial &amp; data analytic oversight of managed care organizations.</b>					
<b>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.</b>					
<b>Goal 6: Empower members to make informed choices about their health plans and care.</b>	Adult CAHPS 5.1H (Medicaid)	Not Applicable	Not Applicable	Not Applicable	—

<sup>1</sup> 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.

<sup>2</sup> Rates represents measurement year 2021.

<sup>3</sup> Statewide measurement year 2023 performance for the Medical Assistance with Smoking and Tobacco Use Cessation measures will be calculated by the Centers for Medicare & Medicaid Services using CAHPS data submitted by Rhode Island managed care plans to the Agency for Healthcare Research and Quality’s CAHPS Health Plan Survey Database. At the time of this report, statewide results were not available for inclusion.

Descriptions of the improvement strategies led by the Rhode Island Executive 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 & Medicaid Services and the Rhode Island Executive Office of Health and Human Services.

Accountable entity quality performance is measured and reported by the managed care plans to the Rhode Island Executive 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 2024, as well as the measure steward and reporting category.

**Table 5: Medicaid Comprehensive Accountable Entity Common Measure Slate, Performance Year 2024**

Measure	Steward	Category
Breast Cancer Screening	NCQA	P4P
Child and Adolescent Well-Care Visits, Total	NCQA	P4P
Chlamydia Screening	NCQA	Reporting-only
Colorectal Cancer Screening	NCQA	Reporting-only
Controlling High Blood Pressure	NCQA	P4P
Eye Exam for Patients With Diabetes	NCQA	P4P
Follow-Up After Hospitalization for Mental Illness – 7 Days	NCQA	P4P
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	NCQA	P4P
Immunizations for Adolescents (Combination 2)	NCQA	Reporting-only
Lead Screening in Children	NCQA	P4P
Developmental Screening in the First Three Years of Life	Oregon Health & Science University	Reporting-only
Screening for Depression and Follow-up Plan	Centers for Medicare & Medicaid Services	P4P
Patient Engagement With an Accountable Entity Primary Care Provider	Rhode Island Executive Office of Health and Human Services	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 the Rhode Island Executive Office of Health and Human Services for state monitoring purposes, but that there are no shared savings distribution consequences for reporting of or performance on the measure.

For performance year 2024, the Rhode Island Executive Office of Health and Human Services employed a combination of internal and external sources to set achievement targets. The Rhode Island Executive Office of Health and Human Services set targets for performance year 2024 using accountable entity performance data for 2021, national and New England Medicaid health maintenance organization data from NCQA’s *Quality Compass 2022* (measurement year 2021), and national and Rhode Island data from the Centers for Medicare & Medicaid Services’ *2021 Child and Adult Health Care Quality Measures Report*. **Table 6** displays the performance year 2024 measures and achievement targets.

**Table 6: Accountable Entity ‘P4P’ Measure Targets, Performance Year 2024**

Measure	Threshold Target	High-Performance Target
Breast Cancer Screening	58%	65%
Child and Adolescent Well-Care Visits, Total	52%	61%
Controlling High Blood Pressure	65%	72%
Eye Exam for Patients With Diabetes	56%	71%
Follow-Up After Hospitalization for Mental Illness – 7 Days	49%	53%
Glycemic Status Assessment for Patients with Diabetes (<8.0%)	52%	60%
Lead Screening in Children	67%	79%
Screening for Depression and Follow-up Plan	50%	61%
Social Determinants of Health Screening	42%	59%

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

### **Alternative Payment Models**

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

- July 1, 2022-June 30, 2023 – 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.
- July 1, 2023-June 30, 2024 – 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, 2023 to June 30, 2024 measurement period. Neighborhood Health Plan of Rhode Island and UnitedHealthcare Community Plan of Rhode Island exceeded the 65% goal. **Tufts Health Public Plans** did not meet the goal.

**Table 7: Alternative Payment Results, Measurement Year July 1, 2023-June 30, 2024**

Managed Care Plan	July 2023-June 2024 Measurement Period	Goal	Goal Met or Not Met
Neighborhood Health Plan of Rhode Island	87.50%	65%	Met
Tufts Health Public Plans	20.81%		Not Met
UnitedHealthcare Community Plan of Rhode Island	73.08%		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 Rhode Island Executive 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 Rhode Island Executive 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 Rhode Island Executive 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.
- June 30, 2023 – At least 60% of the managed care plan’s membership is linked to a patient-centered medical home.
- June 30, 2024 – At least 60% of the managed care plan’s membership is linked to a patient-centered medical home.

**Table 8** displays the percentage of the managed care plans’ patient-centered medical home assignments as of June 30, 2024 Neighborhood Health Plan of Rhode Island, **Tufts Health Public Plans**, and UnitedHealthcare Community Plan of Rhode Island exceeded the 60% goal.

**Table 8: Patient-Centered Medical Home Assignments, as of June 30, 2024**

Managed Care Plan	July 2023-June 2024 Measurement Period	Goal	Goal Met or Not Met
Neighborhood Health Plan of Rhode Island	87.35%	60%	Met
Tufts Health Public Plans	60.17%		Met
UnitedHealthcare Community Plan of Rhode Island	89.71%		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 Rhode Island Executive 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 Rhode Island Executive 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*<sup>11</sup> (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.

<sup>11</sup> Rhode Island Health Information Technology website: <https://eohhs.ri.gov/initiatives/health-information-technology>.

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<sup>®12</sup>, 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.

### **Quality Reporting System**

The Rhode Island Executive 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 Rhode Island Executive 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 Rhode Island Executive Office of Health and Human Services in coordination with Project Governance will determine which data feeds will undergo data aggregator validation, starting with the accountable entity providers in 2025 and expanding year to year.

### **IPRO's Assessment of the Rhode Island Medicaid Quality Strategy**

Rhode Island's Medicaid Managed Care Quality Strategy provides a comprehensive framework to guide managed care entities in improving the quality of care, timeliness of care, and access to care for Medicaid members. In addition to required external quality review activities, the quality strategy incorporates state- and managed care entity-level initiatives that strengthen monitoring, reporting, and accountability across the Medicaid delivery system.

The Rhode Island Executive Office of Health and Human Services designed the quality strategy to align with the National Quality Strategy established by the Centers for Medicare and Medicaid Services. The strategy emphasizes promoting equity and member engagement, improving quality and health outcomes, facilitating statewide alignment and care coordination, and advancing a health care system that is increasingly electronic and data-driven. Key initiatives reinforce standardized approaches to identifying and addressing social determinants of health, expanding the use of Child and Adult Core Set quality measures, and leveraging partnerships to advance quality improvement activities.

This assessment evaluates Rhode Island Medicaid's progress between measurement year 2023 and measurement year 2024 across three of the six quality strategy goals. Overall, performance during this period reflects incremental improvement in several care coordination, behavioral health, and chronic disease management measures, alongside continued challenges in preventive care, pediatric measures, and medication adherence. While some

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<sup>12</sup> 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.

indicators demonstrate positive momentum, declines in key preventive and pediatric metrics highlight ongoing opportunities for targeted intervention.

### **Goal 1: Members receive quality care within all managed care delivery systems.**

The largest improvement was seen in functional status assessments for older adults. Completion rates increased from 58.8% in 2020 to 92.4% in 2024—an increase of 33.6 percentage points. This suggests that care facilities are more consistently evaluating residents’ functional abilities.

### **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.**

Rhode Island Medicaid demonstrated varied performance across Goal 2 measures, with notable improvements in several chronic disease and substance use–related metrics, alongside declines in preventive and pediatric care.

#### **Strengths and Improvements**

- Chronic disease management:
  - Controlling high blood pressure increased modestly.
  - Poor blood sugar control among adults with diabetes continued to decline, indicating improved diabetes management.
- Maternal health:
  - Timeliness of prenatal care remained high, indicating effective access to early prenatal services.
- Substance use treatment and follow-up:
  - Follow-up after emergency department visits for alcohol or other drug abuse or dependence improved for adults and adolescents.
  - Improvements were observed for both seven-day and thirty-day follow-up.

#### **Opportunities for Improvement**

- Preventive care:
  - Breast cancer screening declined slightly.
  - Cervical cancer screening declined more notably.
- Pediatric care:
  - Childhood immunization rates continued to decline.
  - Screening for depression and follow-up planning among adolescents decreased slightly.
- Asthma medication management:
  - Declines observed across pediatric and adult populations.

### **Goal 3: Improve care and service coordination and management, with a focus on coordination of services among medical, behavioral, dental, and specialty services providers.**

#### **Strengths and Improvements**

- Follow-up after hospitalization for mental illness:
  - Improved for children, adolescents, and adults.
  - Thirty-day (30) follow-up rates exceeded 82 percent for pediatric populations and 77 percent for adults.
- Depression treatment:
  - Acute-phase antidepressant treatment adherence improved.

## Opportunities for Improvement

- Follow-up after emergency department visits for mental illness:
  - Declines observed, particularly among adolescents, for both seven-day and thirty-day follow-up.
- Long-term antidepressant treatment:
  - Slight decline in continuation-phase adherence.
- Data limitations:
  - Incomplete data for dental services and tobacco cessation limited comprehensive assessment.
- Overall finding:
  - Strong inpatient-to-outpatient coordination, with weaker linkage following emergency department encounters.

Rhode Island Medicaid demonstrated modest progress in selected priority areas, including chronic disease management, follow-up after hospitalization for mental illness, and follow-up after emergency department visits related to substance use. These gains indicate strengthening care coordination and targeted improvement efforts. At the same time, continued declines in preventive care, childhood immunizations, asthma medication management, and follow-up after emergency department visits for mental illness highlight persistent gaps. Overall, performance reflects maintenance of prior gains with incremental improvement in some areas, while underscoring the need for focused interventions, improved care transitions following emergency department use, and sustained attention to preventive and pediatric services to advance the effectiveness of the quality strategy.

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

- Reinforce quality improvement project requirements to the managed care plans.
- Enforce standardized data collection and analysis requirements for managed care plan provider experience surveys to enable performance comparisons across managed care plans.
- Require managed care plans to submit methodologies used to evaluate network adequacy and provider experience to ensure the external quality review organization has sufficient information for validation activities.
- Determine secret shopper timely appointment thresholds to encourage managed care plans to aggressively address barriers to accessing care that is adequate and timely.
- Expand 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.
- 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 Plans

Tufts Health Public Plans is a not-for-profit health maintenance organization. **Table 9** displays **Tufts Health Public Plans'** enrollment for year-end 2019 through year-end 2024, as well as the percent change in enrollment each year, according to data reported to the Rhode Island Executive 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 Plans'** enrollment decreased by 16% from 17,906 members in 2023 to 15,101 members in 2024.

**Table 9: Tufts Health Public Plans' Enrollment, 2019 to 2024**

Eligibility Group	2019	2020	2021	2022	2023	2024
Rlte Care Core	4,520	6,703	8,184	9,871	10,476	9,141
Rlte Care for Children with Special Health Care Needs	69	87	87	100	336	340
Rhody Health Partners	566	658	725	740	645	624
Rhody Health Expansion	3,765	6,571	8,325	9,261	6,419	4,886
Extended Family Planning	53	56	42	35	30	110
<b>Medicaid Total</b>	<b>8,973</b>	<b>14,075</b>	<b>17,363</b>	<b>20,007</b>	<b>17,906</b>	<b>15,101</b>
<b>Percent Change from Previous Year</b>	<b>-5.6%</b>	<b>+57%</b>	<b>+23%</b>	<b>+15%</b>	<b>-11%</b>	<b>-16%</b>

Note: Enrollment counts for 2019–2023 reflect totals as of December 31, while 2024 enrollment counts are as of October 31.

## Tufts Health Public Plans' Quality Improvement Program, 2024

The Rhode Island Executive 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 Plans' 2023 Quality Improvement Program Plan** met these requirements.

### Program Description

The Quality Assurance and Performance Improvement Program for Tufts Health Plan and **Tufts Health Public Plans** operates under the enterprise-wide quality framework of Point32Health. The program is designed to promote continuous, systematic improvement in the quality, safety, and accessibility of clinical care and services provided to members across all lines of business, including commercial, Medicaid, Medicare, and Medicare-Medicaid products.

The program applies to all members served by Point32Health entities and encompasses medical management, behavioral health, pharmacy services, population health management, care management, utilization management, provider network oversight, and member experience activities. Quality improvement efforts are integrated across departments and delegated entities, with oversight provided through a formal quality committee governance structure and the Board of Directors.

The program framework is grounded in the Quintuple Aim, focusing on improving member experience, improving population health outcomes, improving provider experience, addressing health disparities, and promoting cost-effective care. The program uses a continuous improvement methodology that includes data collection,

performance measurement, root cause analysis, implementation of targeted interventions, and re-measurement to assess effectiveness.

An annual evaluation is conducted to assess the effectiveness of the Quality Assurance and Performance Improvement Program, determine whether established goals and objectives were met, identify barriers to success, and inform the development of the subsequent year's quality improvement work plan.

### **Program Goals**

- Promote high-quality, safe, and appropriate clinical care and services for members
- Improve health outcomes and reduce preventable adverse events
- Enhance member experience with health plan services and care delivery
- Support continuity and coordination of care across providers and care settings
- Address health disparities and advance health equity across member populations
- Ensure compliance with state, federal, and accreditation requirements
- Maintain and strengthen health plan and health equity accreditation status

### **Program Objectives**

- Monitor and improve performance on nationally recognized clinical and service quality measures
- Implement and evaluate quality improvement projects aligned with identified performance priorities
- Ensure effective oversight of medical management, behavioral health, pharmacy, and care management programs
- Strengthen patient safety initiatives, including efforts to reduce hospital readmissions
- Assess and improve access to care, provider availability, and network adequacy
- Evaluate member and provider satisfaction and implement improvement actions as needed
- Conduct a comprehensive annual evaluation to inform future quality improvement priorities

### **Quality Improvement Program Activities**

#### Clinical Quality Improvement Activities

- Monitoring and analysis of clinical quality performance measures
- Implementation of clinical quality improvement projects addressing preventive care, chronic disease management, and behavioral health services
- Development, review, and dissemination of evidence-based clinical practice guidelines
- Medical and behavioral health continuity and coordination of care activities
- Quality of care reviews and investigation of potential adverse clinical events

#### Service and Operational Quality Improvement Activities

- Evaluation of member satisfaction through surveys and complaint and appeal analysis
- Monitoring administrative access to services, including call center performance and claims processing
- Provider satisfaction assessments and feedback analysis
- Oversight of credentialing and recredentialing processes
- Monitoring provider availability, accessibility, and network adequacy

#### Patient Safety Activities

- Enterprise-wide initiatives to reduce hospital readmissions
- Medication safety monitoring and pharmacy utilization oversight
- Critical incident tracking and analysis
- Peer review activities conducted through the Quality of Care Committee

### Population Health and Care Management Activities

- Population health management programs supporting healthy, at-risk, and high-risk members
- Medical, behavioral health, and specialty care management programs
- Monitoring and support for transitions of care
- Integration of care management activities with quality improvement initiatives

### Health Equity and Culturally and Linguistically Appropriate Services Activities

- Analysis of quality performance and outcomes by race, ethnicity, and preferred language
- Implementation of cultural and linguistic appropriate services initiatives
- Provision of language assistance services for members with limited English proficiency
- Cultural competency education and training for staff and providers

## **Summary of Tufts Health Plan Public Plan's Evaluation of the 2024 Quality Assurance and Performance Improvement Program**

The 2024 Quality Assurance and Performance Improvement Program Evaluation concluded that the program was effective overall in supporting quality improvement, patient safety, member experience, and regulatory compliance across Tufts Health Plan and **Tufts Health Public Plans**.

### Key Evaluation Findings

- The quality committee structure operated as intended, with enhancements implemented in 2024 to strengthen oversight and interdisciplinary collaboration.
- Quality improvement projects were implemented across all applicable product lines and member populations, addressing both clinical and service priorities.
- Patient safety efforts continued through enterprise-wide hospital readmission reduction initiatives, supporting improved transitions of care.
- Resources supporting quality management, utilization management, pharmacy services, population health management, care management, member experience, and network adequacy were determined to be sufficient to meet program objectives.
- Behavioral health programs demonstrated effectiveness in improving access, care coordination, and member outcomes following the transition to an insourced behavioral health delivery model.
- External reporting requirements were met, and the organization maintained compliance with applicable accreditation and regulatory standards, with corrective actions identified where necessary.

The evaluation also identified challenges related to regulatory complexity, documentation consistency, and opportunities to further strengthen member engagement. Based on these findings, the organization identified opportunities for continued improvement, including enhanced accreditation training, expanded member engagement strategies, and refinement of governance structures to support sustained quality improvement.

# 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, 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 2024.

## Technical Methods of Data Collection and Analysis

As part of the NCQA HEDIS Compliance Audit™, HEDIS compliance auditors assessed the managed care plan’s compliance with NCQA’s four information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that the managed care plan has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. **Table 23** and **Table 24** display these standards as well as the elements audited for the standard.

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

A managed care plan meeting all Information System standards required for successful HEDIS reporting and submitting HEDIS data to the Rhode Island Executive Office of Health and Human Services according to contractual requirements were considered strengths during IPRO’s external quality review. A managed care plan not meeting an Information System standard was considered an opportunity for improvement during IPRO’s review.

## Description of Data Obtained

For the 2024 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 Plans'** HEDIS compliance auditor determined that the HEDIS rates reported by the managed care plan for measurement year 2024 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 auditors for the managed care plan. **Table 26** displays the results of **Tufts Health Public Plans'** information systems capabilities review conducted as part of the HEDIS Compliance Audit for measurement year 2024.

# 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 Rhode Island Executive 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 Rhode Island Executive Office of Health and Human Services for measurement year 2024.

**Table 10** displays the titles of the quality improvement projects led by **Tufts Health Public Plans** for measurement year 2024.

**Table 10: Managed Care Plan Quality Improvement Project Topics, 2024**

Managed Care Plan Quality Improvement Project Topics, 2024	
Tufts Health Public Plans	<ol style="list-style-type: none"><li>1. Improve Prenatal/Postpartum Care</li><li>2. Increase Flu Vaccination Rate</li><li>3. Follow-up After Hospitalization for Mental Illness – 7 Day</li><li>4. Member Experience and Retention</li></ol>

## Technical Methods of Data Collection and Analysis

The Rhode Island Executive Office of Health and Human Services requires that quality improvement projects be documented using NCQA’s *Quality Improvement Activity Form*. A copy of the *Quality Improvement Activity Form* is in **Appendix A** of this report.

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

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

Following IPRO’s evaluation of the *2024 Quality Improvement Activity Forms* completed by the managed care plan 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 11**.

**Table 11: 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 indicating that the credibility of the performance improvement project results was at risk.
- 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 2024 external quality review, IPRO reviewed the *2024 Quality Improvement Activity Forms* submitted by **Tufts Health Public Plans**. These reports included project rationale, aims and goals, target population, performance indicator descriptions, performance indicator rates (baseline, interim, final), methods for performance measure calculations, targets, benchmarks, interventions (planned and executed), tracking measures and rates, barriers, limitations, and next steps for continuous quality improvement.

## Comparative Results

IPRO's assessment of the methodologies used by **Tufts Health Public Plans** determined that the managed care plan was not fully compliant with the standards of *Title 42 Code of Federal Regulations 438.330(d)(2) Performance Improvement Projects*. The four quality improvement projects did not meet all elements reviewed to validate improvement strategies.

### Quality Improvement Project 1 - Prenatal/Postpartum Care

Tufts Health Public Plans' conduct of the Prenatal/Postpartum Care quality improvement project 1 did not meet all standards related to improvement strategies. Through the validation process, IPRO determined that for Tufts Health Public Plans' quality improvement project 1:

- Tufts Health Public Plans' revised goal rates downward to levels below baseline, changing the performance expectations used for monitoring. Goal attainment for the affected measurement periods should be interpreted with caution.

### Quality Improvement Project 2 – Increase Flu Vaccine Rate

Tufts Health Public Plans' conduct of the Increase Flu Vaccine Rate quality improvement project 2 did not meet all standards related to improvement strategies. Through the validation process, IPRO determined that for Tufts Health Public Plans' quality improvement project 2:

- The quality improvement strategy did not include a single targeted intervention for the population identified by Tufts Health Public Plans as having disparate outcomes.
- The data collection plan was not updated to include a comprehensive explanation of the data integrity issues that required the managed care plan to re-run data for the September 2023-March 2024 measurement period, nor did Tufts Health Public Plans describe these issues were remediated.
- Tufts Health Public Plans' revised goal rates downward to levels either below baseline or a recent measurement period, changing the performance expectations used for monitoring. Goal attainment for the affected measurement periods should be interpreted with caution.

### Quality Improvement Project 3 – Follow-up After Hospitalization for Mental Illness – 7 Day

Tufts Health Public Plans' conduct of the Follow-up After Hospitalization for Mental Illness – 7 Day quality improvement project 3 did not meet all standards related to improvement strategies. Through the validation process, IPRO determined that for Tufts Health Public Plans' quality improvement project 3:

- The quality improvement strategy included interventions that have remained unchanged year over year, which suggests that the improvement strategy is not being updated to address current barriers or to implement a distinct test of change.
- Tufts Health Public Plans' revised goal rates downward to levels below baseline, changing the performance expectations used for monitoring. Goal attainment for the affected measurement periods should be interpreted with caution.

#### Quality Improvement Project 4 – Member Experience and Retention

Tufts Health Public Plans' conduct of the Member Experience and Retention 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 Plans' quality improvement project 4:

- 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.
- The quality improvement project results were not presented in a concise and easily understood manner.
- The improvement strategies were not aligned with root causes or barriers identified through data analysis or the quality improvement process, and the quality improvement project did not include an assessment of the effectiveness of the selected interventions. Additionally, although Tufts Health Public Plans reported an initiation date of 2024 for this quality improvement project, the interventions represent a continuation of activities implemented under a prior quality improvement project with the same focus. These interventions were in place during 2023, before the start of the current project year.

**Table 12** displays a summary of the validation results of each quality improvement project that was conducted for measurement year 2024. Summaries of each quality improvement project immediately follow.

**Table 12: Managed Care Plan Quality Improvement Project Validation Results, Measurement Year 2024**

Quality Improvement Project Topics	Selected Topic	Study Question	Indicators	Population	Sampling Methods	Data Collection Procedures	Interpretation of Results	Improvement Strategies
<b>Tufts Health Public Plans</b>								
1) Prenatal/Postpartum Care	Met	Met	Met	Met	Met	Met	Met	Not Met
2) Increase Flu Vaccination Rate	Met	Met	Met	Met	Not Applicable	Not Met	Met	Not Met
3) Follow-up After Hospitalization for Mental Illness – 7 Day	Met	Met	Met	Met	Not Applicable	Met	Met	Not Met
4) Member Experience and Retention	Not Met	Not Met	Insufficient Data	Met	Not Applicable	Not Met	Not Met	Not Met

## Tufts Health Public Plans

The results of the validation activity determined that **Tufts Health Public Plans** was fully compliant with the standards of *Title 42 Code of Federal Regulations 438.330 (d)(2) Performance improvement projects* for one of four quality improvement projects conducted. Summaries of each quality improvement project immediately follow.

**Table 13: Tufts Health Public Plans’ Quality Improvement Project 1 Summary – Prenatal/Postpartum Care, Measurement Year 2024**

Quality Improvement Project 1 Summary	
<p><b>Title:</b> Improve Prenatal/Postpartum Care  <b>Start Year:</b> 2022. <b>End Year:</b> Not yet determined.  <b>Validation Summary:</b> 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.</p>	
<p><u>Aim</u>            Tufts Health Public Plans aimed to increase member access to timely prenatal and postpartum care.</p>	
<p><u>Indicators of Performance</u></p> <ul style="list-style-type: none"> <li>▪ HEDIS <i>Timeliness of Prenatal Care</i> – the percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.</li> <li>▪ HEDIS <i>Postpartum Care</i> – the percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.</li> </ul>	
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> <li>▪ Launched a family health platform, the Ovia app, to provide support to women and families using personalized and data driven solutions for fertility, pregnancy tracking, and parenting.</li> <li>▪ Continued to offered obstetrical complex care management to eligible members.</li> </ul>	
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> <li>▪ Made provider-level educational materials available on the plan’s website.</li> </ul>	

**Table 14: Tufts Health Public Plans’ Quality Improvement Project 1 Indicator Summary – Timeliness of Prenatal Care, Measurement Years 2022 to 2024**

HEDIS Timeliness of Prenatal Care Rate					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2022	Baseline	224	296	75.68%	77.68%
Measurement Year 2023	Remeasurement 1	169	241	70.12%	77.68%
Measurement Year 2024	Remeasurement 2	169	210	80.48%	72.12%

**Indicator Description:** The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.

**Table 15: Tufts Health Public Plans’ Quality Improvement Project 1 Indicator Summary – Postpartum Care, Measurement Years 2022 to 2024**

HEDIS Postpartum Care Rate					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2022	Baseline	220	296	74.32%	76.32%
Measurement Year 2023	Remeasurement 1	155	241	64.32%	76.32%
Measurement Year 2024	Remeasurement 2	156	210	74.29%	66.32%

**Indicator Description:** The percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.

**Table 16: Tufts Health Public Plans’ Quality Improvement Project 2 Summary – Flu Vaccine, Measurement Year 2024**

Quality Improvement Project 2 Summary	
<p><b>Title:</b> Increase Flu Vaccination Rate  <b>Start Year:</b> 2020. <b>End Year:</b> Not yet determined.  <b>Validation Summary:</b> 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.</p>	
<p><u>Aim</u>            Tufts Health Public Plans 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.</p>	
<p><u>Indicators of Performance</u></p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ The percentage of Medicaid members who identify as Hispanic and 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.</li> </ul>	
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> <li>▪ Continued to offer transportation benefit to flu vaccine appointments.</li> <li>▪ Published articles in the member newsletter on flu and COVID vaccinations.</li> </ul>	
<p><u>Provider-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> <li>▪ Continued to make available, flu vaccine-specific education and the adult immunization measure specifications on the provider website.</li> </ul>	

**Table 17: Tufts Health Public Plans’ Quality Improvement Project 2 Indicator Summary – Flu Vaccine, All Members, Measurement Years 2019 to 2024**

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%
September 2022-March 2023	Remeasurement 3	1,802	12,315	14.63%	19.63%
September 2023-March 2024	Remeasurement 4	3,281	14,516	22.60%	21.91%
September 2024-March 2025	Remeasurement 5	2,813	10,968	25.65%	14.35%

**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 18: Tufts Health Public Plans’ Quality Improvement Project 2 Indicator Summary – Flu Vaccine, Hispanic Members, Measurement Years 2022 to 2024**

Flu Vaccine Utilization Rate					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
September 2022-March 2023	Baseline	2	16	12.50%	13.50%
September 2023-March 2024	Remeasurement 1	487	1,918	25.39%	15.60%
September 2024-March 2025	Remeasurement 2	484	1,605	30.16%	18.67%

**Indicator Description:** The percentage of Medicaid members who identify as Hispanic and 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 19: Tufts Health Public Plans’ Quality Improvement Project 3 Summary – Follow-up After Hospitalization for Mental Illness – 7 Day, Measurement Year 2024**

<b>Quality Improvement Project 3 Summary</b>	
<p><b>Title:</b> Follow-up After Hospitalization for Mental Illness – 7 Day  <b>Start Year:</b> 2022. <b>End Year:</b> Not yet determined.  <b>Validation Summary:</b> There were no validation findings indicating that the credibility of the performance improvement project results was at risk.</p>	
<p><u>Aim</u>            Tufts Health Public Plans aimed to increase timely follow-up after hospitalization for mental illness within the RITogether population by improving the transition from facility to home process.</p>	
<p><u>Indicator of Performance</u>            HEDIS <i>Follow-Up After Hospitalization for Mental Illness – 7 Day</i>: the percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients age 6 years and older that resulted in follow-up care with a mental health provider within 7 days.</p>	
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> <li>▪ Continued to outreach to members within 48 hours of a hospital discharge to conduct a comprehensive assessment and provide enhanced support such as medication reconciliation, appointment scheduling assistance, and assistance with identified social determinants of health.</li> </ul>	
<p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> <li>▪ Utilized community health workers to support member outreach initiatives.</li> <li>▪ Continued to work on expanding telehealth options within network.</li> </ul>	

**Table 20: Tufts Health Public Plans’ Quality Improvement Project 3 Indicator Summary – Follow-Up After Hospitalization for Mental Illness – 7 Day, Measurement Years 2022 and 2024**

<b>Follow-Up After Hospitalization for Mental Illness – 7 Day</b>					
<b>Measurement Period</b>	<b>Measurement Phase</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Results</b>	<b>Goal</b>
Measurement Year 2022	Baseline	93	177	52.54%	54.54%
Measurement Year 2023	Remeasurement 1	94	188	50.00%	64.01%
Measurement Year 2024	Remeasurement 2	117	221	52.94%	52.00%

**Indicator Description:** The percentage of inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients age 6 years and older that resulted in follow-up care with a mental health provider within 7 days.

**Table 21: Tufts Health Public Plan’s Quality Improvement Project 4 Summary – Member Experience and Retention, Measurement Year 2024**

Quality Improvement Project 4 Summary	
<p><b>Title:</b> Member Experience and Retention  <b>Start Year:</b> 2024. <b>End Year:</b> Not yet determined.  <b>Validation Summary:</b> 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.</p>	
<p><u>Aim</u>            Tufts Health Public Plan aimed to increase Medicaid enrollment by 1% annually.</p>	
<p><u>Indicator of Performance</u>            The yearly average growth rate.</p>	
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> <li>Continued outreach to members using short message service text with information on redetermination and benefit renewals.</li> </ul>	
<p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> <li>Continued participation in community events to distribute food, toys, and resources on how to obtain health coverage.</li> </ul>	

**Table 22: Tufts Health Public Plan’s Quality Improvement Project 4 Indicator Summary – Member Experience and Retention**

Yearly Average Growth Rate					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2024	Baseline	-12	12	-1%	1%

**Indicator Description:** of sum of monthly growth rates during the measurement year/number of months in the measurement year.

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

### **Objectives**

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

As required by section 2.12.03.03 *Quality Assurance* of the *Medicaid Managed Care Services Agreement*, Rhode Island managed care plans must provide performance measure data, specifically HEDIS, to the Rhode Island Executive 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 Rhode Island Executive 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 Rhode Island Executive 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 Rhode Island Executive Office of Health and Human Services for measurement year 2024.

### **Technical Methods of Data Collection and Analysis**

For measurement year 2024, the Rhode Island Medicaid managed care plans were required to submit performance measure data to the Rhode Island Executive Office of Health and Human Services based on NCQA's *HEDIS Measurement Year 2024 Volume 2 Technical Specifications for Health Plans*. To ensure compliance with these reporting requirements, each managed care plan contracted with an NCQA HEDIS-certified vendor and an NCQA-licensed HEDIS compliance organization.

The HEDIS vendor collected data and calculated performance measure rates on behalf of the managed care plan for measurement year 2024. The HEDIS vendor calculated rates using NCQA's *HEDIS Measurement Year 2024 Volume 2 Technical Specifications for Health Plans*.

The HEDIS compliance auditor determined if the appropriate information processing capabilities were in place to support accurate and automated performance measurement, and they also validated the managed care plan's adherence to the technical specifications and reporting requirements. The HEDIS compliance auditor evaluated the managed care plan's information practices and control procedures, sampling methods and procedures, compliance with technical specifications, analytic file production, and reporting and documentation in two parts:

1. Information System Standards
2. HEDIS Determination Standards

Auditors considered managed care plan compliance with the Information System Standards and HEDIS Determination Standards to fully assess the organization's HEDIS reporting capabilities.

## Information System Standards

As part of the NCQA HEDIS Compliance Audit™, HEDIS compliance auditors assessed **Tufts Health Public Plans'** compliance with NCQA's four information system capabilities standards for collecting, storing, analyzing, and reporting medical, service, member, practitioner, and vendor data. The standards specify the minimum requirements that information systems should meet and criteria that are used in HEDIS data collection. Compliance with the NCQA information system capabilities standards ensures that the managed care plan has effective systems, practices, and control procedures for core business functions and for HEDIS reporting. **Table 23** displays these standards as well as the elements audited for the standard.

**Table 23: NCQA's Information System Standards**

NCQA Information System (IS) Standards	Elements Audited
IS R: Data Management and Reporting	Transfer, Consolidation, and Control Procedures that Support Measure Reporting Integrity
IS C: Clinical and Care Delivery Data	Capture, Transfer, and Entry
IS M: Medical Record Review	Training, Sampling, Abstraction, and Oversight
IS A: Administrative Data	Sound Coding Methods, Data Capture, Transfer, and Entry

NCQA: National Committee for Quality Assurance; IS: information system.

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

A managed care plan meeting the NCQA Information System Standards required for successful HEDIS reporting and submitting HEDIS data to the Rhode Island Executive Office of Health and Human Services according to contractual requirements were considered strengths during IPRO's external quality review. A managed care plan not meeting an Information System standard was considered an opportunity for improvement during IPRO's review.

## HEDIS Determination Standards

As part of the NCQA HEDIS Compliance Audit™, HEDIS compliance auditors assessed **Tufts Health Public Plans'** compliance with conventional reporting practices and HEDIS technical specifications. These standards describe required procedures for specific information such as proper identification of denominators, numerators and verifying algorithms and rate calculations. **Table 24** displays these standards as well as the elements audited for the standard.

**Table 24: NCQA's HEDIS Determination Standards**

NCQA HEDIS Determination (HD) Standards	Elements Audited
HD 4.0: Algorithmic Compliance	Calculation Procedures, and Calculations
HD 5.0: Outsourced or Delegated Reporting Functions	Compliance with Data Collection and Reporting Standards, Performance, Data Collection and Reporting Coordination, and Preliminary and Final Rates

NCQA: National Committee for Quality Assurance; HD: HEDIS Determination.

The HEDIS determination evaluation included data sources, sampling methodology, application of technical specifications, numerator and denominator logic, medical record validation, supplementation data validation, and rate calculation. The HEDIS compliance auditor determined the extent to which the managed care plan and its vendors’ application of the HEDIS technical specifications resulted in the calculation of rates that are accurate and reliable.

A managed care plan meeting the NCQA HEDIS Determination Standards required for successful HEDIS reporting and submitting HEDIS data to the Rhode Island Executive Office of Health and Human Services according to contractual requirements were considered strengths during IPRO’s external quality review. A managed care plan not meeting a Determination Standard was considered an opportunity for improvement during IPRO’s review.

### Performance Measure Validation

Tufts Health Public Plans’ calculated rates for the HEDIS 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; and
- follow-up on issues identified during documentation review or previous audits.

**Table 25: NCQA’s Performance Measure Designations**

NCQA Performance Measure Outcome Designation	Outcome Designation Definition
R	<b>Reportable.</b> A reportable rate was submitted for the measure.
NA	<b>Small Denominator.</b> The organization followed the specifications, but the denominator was too small (e.g., less than 30) to report a valid rate. a. For Effectiveness of Care and Effectiveness of Care-like measures, when the denominator is less than 30. b. For utilization measures that count member months, when the denominator is less than 360 member months. c. For all risk-adjusted utilization measures, when the denominator is less than 150. d. For electronic clinical data systems measures, when the denominator is less than 30.
NB	<b>No Benefit.</b> The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	<b>Not Reported.</b> The organization chose not to report the measure.
NQ	<b>Not Required.</b> The organization was not required to report the measure.
BR	<b>Biased Rate.</b> The calculated rate was materially biased.
UN	<b>Unaudited.</b> 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 Plans'** HEDIS compliance auditor produced a final audit report and audit review table at the conclusion of the audit. Together, these documents present a comprehensive summary of the audit activities and performance measure validation results. Each managed care plan submitted these documents, as well as final validated performance measure rates to the Rhode Island Executive Office of Health and Human Services and IPRO.

IPRO reviewed **Tufts Health Public Plans'** 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 the Rhode Island Executive Office of Health and Human Services' requirements. To assess the accuracy of the reported rates, IPRO:

- Recalculated performance measure rates using denominator and numerator member-level data and compared these recalculated rates to the rates reported by the managed care plan to NCQA via the Interactive Data Submission System tool;
- Compared performance measure rates reported by the managed care plans to NCQA's Quality Compass regional Medicaid benchmarks; and
- Analyzed performance-measure-rate-level trends to identify drastic changes in performance.

## **Description of Data Obtained**

For the 2024 external quality review, IPRO obtained **Tufts Health Public Plans'** 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 Plans'** NCQA-certified HEDIS auditor determined that the HEDIS rates reported by the managed care plan for measurement year 2024 were all "reportable," indicating that the rates were calculated in accordance with the required technical specifications. There were no data collection or reporting issues identified for **Tufts Health Public Plans**. **Table 26** displays results of the Information Systems review, while **Table 27** displays results of the HEDIS Determination Standards review.

**Table 26: Managed Care Plan Compliance with NCQA Information System Standards, Measurement Year 2024**

NCQA Information System (IS) Standards	Tufts Health Public Plans
IS R: Data Management and Reporting	Met
IS C: Clinical and Care Delivery Data	Met
IS M: Medical Record Review	Met
IS A: Administrative Data	Met

NCQA: National Committee for Quality Assurance; IS: information system.

**Table 27: Managed Care Plan Compliance with NCQA HEDIS Determination Standards, Measurement Year 2024**

NCQA HEDIS Determination (HD) Standards	Tufts Health Public Plans
HD 4.0: Algorithmic Compliance	Met
HD 5.0: Outsourced or Delegated Reporting Functions	Met

NCQA: National Committee for Quality Assurance; HD: HEDIS Determination.

### **Performance Measure Results**

This section of the report explores the utilization of managed care plan 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.

To assess managed care plan performance, IPRO compared **Tufts Health Public Plans'** rates to national Medicaid benchmarks reported in the *2025 Quality Compass* (measurement year 2024) for all lines of business that reported measurement year 2024 HEDIS data to NCQA. **Table 28** displays **Tufts Health Public Plans'** HEDIS rates for measurement years 2021, 2022, 2023, and 2024, as well as the measurement year 2024 national Medicaid benchmarks achieved by the managed care plan, and the national Medicaid means.

**Table 28: Managed Care Plan HEDIS Rates, Measurement Years 2021, 2022, 2023, and 2024**

Domain/Measures	Tufts Health Public Plans Measurement Year 2021	Tufts Health Public Plans Measurement Year 2022	Tufts Health Public Plans Measurement Year 2023	Tufts Health Public Plans Measurement Year 2024	Quality Compass Measurement Year 2024 National Medicaid Benchmark (Met/Exceeded)	Quality Compass Measurement Year 2024 National Medicaid Mean
<b>Use of Services</b>						
Well-Child Visits in the First 30 Months of Life						
<i>First 15 Months</i>	44.55%	59.25%	50.62%	66.30%	50th	61.92%
<i>First 15 to 30 Months</i>	69.39%	68.77%	64.44%	70.10%	33.33rd	72.84%
Child and Adolescent Well-Care Visits, Ages 3-21 Years	46.85%	46.24%	47.03%	52.22%	33.33rd	55.41%
<b>Effectiveness of Care</b>						
Cervical Cancer Screening for Women (Hybrid)	40.88%	42.09%	46.72%	50.61%	10th	56.91%
Cervical Cancer Screening for Women (Electronic)	Not Applicable	Not Applicable	Not Applicable	Not Required	Not Applicable	51.82%
Chlamydia Screening for Women, Ages 16-20 Years	56.51%	51.61%	57.20%	57.14%	50th	53.32%
Childhood Immunization Status						
<i>Combination 3</i>	70.89%	73.96%	75.18%	72.12%	75th	66.18%
<i>Combination 10</i>	55.04%	48.89%	49.15%	41.82%	90th	28.17%
<b>Follow-Up After Hospitalization for Mental Illness</b>						
<i>7-Day, Ages 6-65+ Years</i>	63.78%	52.54%	50.00%	52.94%	75th	40.70%
<i>30-Day, Ages 6-65+ Years</i>	43.78%	63.28%	67.55%	72.40%	75th	61.25%
Glycemic Status Assessment for Patients With Diabetes - Glycemic Status <8.0%	New Measure in 2022	37.96%	48.91%	47.69%	<10th	58.65%
<b>Access and Availability</b>						
Adults' Access to Preventive/Ambulatory Health Services						
<i>Ages 20-44 Years</i>	56.91%	53.26%	56.85%	58.86%	<10th	74.39%
<i>Ages 45-64 Years</i>	67.24%	63.67%	67.09%	68.81%	<10th	82.23%
<i>Ages 65+ Years</i>	56.91%	53.26%	62.16%	63.64%	<10th	82.59%
Prenatal and Postpartum Care						
<i>Timeliness of Prenatal Care</i>	76.44%	75.68%	70.12%	80.48%	10th	84.87%
<i>Postpartum Care</i>	73.78%	74.32%	64.32%	74.29%	10th	80.76%

# **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 federal Medicaid and Children’s Health Insurance Program standards is a mandatory external quality activity. Further, the state, its agent, or the external quality review organization must conduct this review within the previous 3-year period.

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

*Title 42 Code of Federal Regulations 438.358 Activities related to external quality review (a)(1)* mandates that the state or an external quality review organization must perform the review to determine managed care compliance with federal Medicaid and Children’s Health Insurance Program standards. Per *Title 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 Rhode Island Executive 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 Executive Office of Health and Human Services, IPRO reviewed the results of each managed care plan’s most recent NCQA Accreditation Survey to verify managed care plan compliance with state and federal Medicaid and Children’s Health Insurance Program requirements.

## **Technical Methods of Data Collection and Analysis**

IPRO received NCQA Accreditation Survey results from each managed care plan and reviewed these results to verify managed care plan compliance with federal Medicaid standards of under *Title 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 Rhode Island Executive 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

**Table 29** displays managed care plan compliance with federal Medicaid and Children’s Health Insurance Program standards captured during the most recent NCQA Accreditation Survey. **Tufts Health Public Plans’** accreditation was granted by NCQA on December 27, 2023 with an expiration date of April 12, 2026.

**Table 29: Evaluation of Managed Care Plan Compliance with Federal Medicaid and Children’s Health Insurance Program Standards, 2024**

Federal Medicaid Standard	Tufts Health Public Plans
438.56 Disenrollment requirements and limitations	Met
438.100 Enrollee rights and requirements	Met
438.114 Emergency and poststabilization services	Met
438.206 Availability of services	1 Not 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	3 Not Mets

# 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 Rhode Island Executive 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 Rhode Island Executive Office of Health and Human Services-established access standards are presented in **Table 30**.

**Table 30: Rhode Island Medicaid Managed Care Network Standards**

<b>Rhode Island Medicaid Managed Care Access Standards</b>
<b>Time and Distance Standards</b>
▪ 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
<b>Appointment Standards</b>
▪ 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
<b>Member-to-Primary Care Provider Ratio Standards</b>
▪ No more than 1,500 members to any single primary care provider

### Rhode Island Medicaid Managed Care Access Standards

- No more than 1,000 members per single primary care provider within a primary care provider team

#### 24 Hour Coverage Standard

- On a 24 hours a day, 7 days a week basis access to medical and behavioral health services must be available to members either directly through the managed care plan or primary care provider

#### Other Standards

- Each Medicaid network should include Patient Centered Medical Homes that serve as primary care providers

*Title 42 Code of Federal Regulations 438.356 State contract options for external quality review and Title 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 Rhode Island Executive Office of Health and Human Services contracted IPRO to perform the 2024 validation of network adequacy for each managed care plan.

### Technical Methods of Data Collection and Analysis

**Tufts Health Public Plans** 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 Plans** 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 Plans’** access standard for primary care providers is one provider within 20 miles and one provider within 30 miles for obstetricians/gynecologists. Tufts Health Public Plans’ 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 Plans** in the quarterly *Tufts Health Public Plans Network Analysis Report* for 2024 and Tufts Health Public Plans’ fourth quarter *Access Survey Report* for January 2024 and July 2024.

### Comparative Results

#### Network Adequacy Validation Results

**Tufts Health Public Plans** evaluated network adequacy using acceptable methodologies. **Table 31** displays the results of IPRO’s validation of network adequacy for the managed care plan’s Medicaid and Children’s Health Insurance Program network.

**Table 31: Managed Care Plan Network Adequacy Validation Results, Measurement Year 2024**

Information Systems Capabilities Assessment Results Issued by IPRO	
Topic Under Review	Tufts Health Public Plans
Validation of Network Adequacy Data Collection and Reporting	Met

**Met** means that the managed care plan met or exceeded standards.

### **Compliance with State Access Requirements**

**Table 32** shows the percentage of members for whom the geographic access standards were met. The results of this analysis show that **Tufts Health Public Plans** exceeded the 90% goal for member geographic access for all primary care and behavioral health provider types reported. **Tufts Health Public Plans** did not meet the 90% goal member geographic access pediatric allergy/immunology specialists.

**Table 32: Tufts Health Public Plans’ Geo Access Analysis, 2024**

Provider Specialty	Access to Provider Standard <sup>1</sup>	% of Members With Access 2024 Quarter 1	Goal = 90% Met/Not Met	% of Members With Access 2024 Quarter 2	Goal = 90% Met/Not Met	% of Members With Access 2024 Quarter 3	Goal = 90% Met/Not Met	% of Members With Access 2024 Quarter 4	Goal = 90% Met/Not Met
<b>Primary Care</b>									
Internal Medicine	1 in 20 Miles or 1 in 20 Minutes	99.9%	Met	99.9%	Met	99.9%	Met	100.0%	Met
Family Medicine	1 in 20 Miles or 1 in 20 Minutes	99.9%	Met	99.9%	Met	99.9%	Met	99.9%	Met
Pediatrics	1 in 20 Miles or 1 in 20 Minutes	99.9%	Met	99.9%	Met	99.9%	Met	99.9%	Met
Obstetrics/Gynecology	1 in 20 Miles or 1 in 20 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
<b>Specialty Care</b>									
Adult Cardiology	1 in 30 Miles or 1 in 30 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
Adult Dermatology	1 in 30 Miles or 1 in 30 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
Adult Endocrinology	1 in 30 Miles or 1 in 30 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
Adult Gastroenterology	1 in 30 Miles or 1 in 30 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
Adult Pulmonary	1 in 30 Miles or 1 in 30 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
Pediatric Allergy/Immunology	1 in 45 Miles or 1 in 45 Minutes	98.7%	Met	98.7%	Met	98.8%	Met	100.0%	Met
Pediatric Gastroenterology	1 in 45 Miles or 1 in 45 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
Pediatric Neurology	1 in 45 Miles or 1 in 45 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
Pediatric Otolaryngology	1 in 45 Miles or 1 in 45 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
<b>Behavioral Health Care</b>									

<b>Provider Specialty</b>	<b>Access to Provider Standard<sup>1</sup></b>	<b>% of Members With Access 2024 Quarter 1</b>	<b>Goal = 90% Met/Not Met</b>	<b>% of Members With Access 2024 Quarter 2</b>	<b>Goal = 90% Met/Not Met</b>	<b>% of Members With Access 2024 Quarter 3</b>	<b>Goal = 90% Met/Not Met</b>	<b>% of Members With Access 2024 Quarter 4</b>	<b>Goal = 90% Met/Not Met</b>
Adult Behavioral Health Outpatient Mental Health	1 in 30 Miles or 1 in 30 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
Pediatric Behavioral Health Outpatient Mental Health	1 in 45 Miles or 1 in 45 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met
Adult Behavioral Health Substance Use	1 in 30 Miles or 1 in 30 Minutes	100.0%	Met	100.0%	Met	100.0%	Met	100.0%	Met

<sup>1</sup> The Access Standard is measured in travel time from a member's home to provider offices.

**Table 33** displays aggregate results of the secret shopper appointment availability surveys conducted by **Tufts Health Public Plans** in January 2024 and July 2024. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

**Table 33: Tufts Health Public Plans' Appointment Availability Survey Results, January 2024 and July 2024**

Appointment Type/Provider Specialty	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made <sup>1</sup>
<b>Primary Care Routine Appointments</b>				
Family/General/Internal	172	48	27.9%	8.7%
Pediatricians	63	10	15.9%	7.9%
Obstetrics/Gynecology	2	2	100.0%	50.0%
<b>Primary Care Urgent Appointments</b>				
Family/General/Internal	121	30	24.8%	11.6%
Pediatricians	10	10	100.0%	30.0%
Obstetrics/Gynecology	2	2	100.0%	50.0%
<b>Adult Specialty Care Routine Appointments</b>				
Cardiology	74	28	37.8%	20.3%
Dermatology	30	25	83.3%	3.3%
Endocrinology	12	1	8.3%	0.0%
Gastroenterology	29	14	48.3%	6.9%
Pulmonary	22	12	54.5%	4.5%
<b>Adult Specialty Care Urgent Appointments</b>				
Cardiology	77	8	10.4%	2.6%
Dermatology	19	12	63.2%	10.5%
Endocrinology	16	2	12.5%	0.0%
Gastroenterology	26	12	46.2%	0.0%
Pulmonary	23	11	47.8%	4.3%
<b>Pediatric Specialty Care Routine Appointments</b>				
Allergy/Immunology	7	2	28.6%	14.3%
Gastroenterology	5	4	80.0%	0.0%
Neurology	42	10	23.8%	0.0%
Orthopedics	54	35	64.8%	57.4%
Otolaryngology/Ear, Nose and Throat	14	7	50.0%	0.0%
<b>Pediatric Specialty Care Urgent Appointments</b>				
Allergy/Immunology	4	2	50.0%	0.0%
Gastroenterology	10	5	50.0%	0.0%
Neurology	31	9	29.0%	0.0%
Orthopedics	43	12	27.9%	14.0%
Otolaryngology/Ear, Nose and Throat	11	9	81.8%	0.0%
<b>Behavioral Health Care Routine Appointments</b>				
Adult Behavioral Health	127	97	76.4%	75.6%
Pediatric/Adolescent Behavioral Health	8	4	50.0%	37.5%

<sup>1</sup>The Number of Providers Surveyed is the denominator for Rate of Timely Appointments Made.

## **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, *Title 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 Rhode Island Executive Office of Health and Human Services uses results from the survey to determine variation in member satisfaction among the managed care plans. Further, section 2.13.04 *EOHHS Quality Assurance* of the *Medicaid Managed Care Services Agreement* requires that the CAHPS survey tool be administered.

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

Each managed care plan independently contracted with a certified CAHPS vendor to administer an adult and child survey for measurement year 2024. On behalf of the Rhode Island Executive Office of Health and Human Services, IPRO validated satisfaction surveys sponsored by the managed care plans for measurement year 2024.

### **Technical Methods of Data Collection and Analysis**

The CAHPS Health Plan Survey 5.1H survey instruments selected for measurement year 2024 were the Adult Version for Medicaid, and the Child Version – Children With Chronic Conditions for Medicaid or Child Version – Children Without Chronic Conditions for Medicaid.

HEDIS specifications require that the managed care plan provide a list of all eligible members for the sampling frame. Following HEDIS requirements, each managed care plan included members in their respective sample frames who were 18 years of age or older for adult members or 17 years of age or younger for child members as of December 31, 2024, continuously enrolled for at least five of the last six months of 2024, and currently enrolled in the managed care plan.

**Table 34** provides a summary of **Tufts Health Public Plans'** technical methods of data collection by managed care plan.

**Table 34: CAHPS Technical Methods of Data Collection, Measurement Year 2024**

Managed Care Plan/Methodology Element	Adult CAHPS Survey	Child CAHPS Survey
<b>Tufts Health Public Plans</b>		
Survey Tool	5.1H Medicaid Adult	5.1H Medicaid Child with Chronic Conditions Supplemental Items Set
Survey Timeframe	2/12/2025 to 5/9/2025	3/4/2025 to 5/14/2025
Method of Collection	Mail, Telephone	Mail, Telephone
Sample Size	3,983	1,650
Response Rate	7.0%	5.1%

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 35** displays these categories and the measures which these response categories are used.

**Table 35: CAHPS Categories and Response Options**

Category/Measure	Response Options
<b>Composite Measures</b>	
<ul style="list-style-type: none"> <li>▪ Getting Needed Care</li> <li>▪ Getting Care Quickly</li> <li>▪ How Well Doctors Communicate</li> <li>▪ Coordination of Care</li> <li>▪ Customer Service</li> </ul>	Never, Sometimes, Usually, Always <i>(Top-level performance is considered responses of “usually” or “always.”)</i>
<b>Global Rating Measures</b>	
<ul style="list-style-type: none"> <li>▪ Rating of All Health Care</li> <li>▪ Rating of Personal Doctor</li> <li>▪ Rating of Specialist Talked to Most Often</li> <li>▪ Rating of Health Plan</li> </ul>	0-10 Scale <i>(Top-level performance is considered scores of “8” or “9” or “10.”)</i>

To assess managed care plan performance, IPRO compared **Tufts Health Public Plans’** scores to national Medicaid performance reported in the *2025 Quality Compass* (measurement year 2024) for all lines of business that reported measurement year 2024 CAHPS data to NCQA.

### **Description of Data Obtained**

For each managed care plan, IPRO received a copy of the final measurement year 2024 study reports produced by the certified CAHPS vendor. These reports included comprehensive descriptions of the project objectives and methodology, as well as managed care plan-level results and analyses.

## Comparative Results

**Table 36** displays **Tufts Health Public Plans'** results of the 2025 CAHPS Adult Medicaid Survey for measurement years 2020, 2021, 2022, 2023, and 2024 while **Table 37** displays **Tufts Health Public Plans** results of the 2025 CAHPS Child Medicaid Survey for measurement years 2020, 2021, 2022, 2023, and 2024. The national Medicaid benchmarks displayed in these tables come from *NCQA's 2025 Quality Compass* for measurement year 2024 and represent all lines of business.

**Table 36: Managed Care Plan Medicaid Adult Population CAHPS Results, Measurement Years 2020, 2021, 2022, 2023, and 2024**

Measures	Tufts Health Public Plans Measurement Year 2020	Tufts Health Public Plans Measurement Year 2021	Tufts Health Public Plans Measurement Year 2022	Tufts Health Public Plans Measurement Year 2023	Tufts Health Public Plans Measurement Year 2024	Quality Compass Measurement Year 2024 National Medicaid Benchmark (Met/Exceeded)	Quality Compass Measurement Year 2024 National Medicaid Mean
Rating of All Health Care <sup>1</sup>	76.0%	Small Sample	76.7%	79.7%	75.15%	33.33rd	76.48%
Rating of Personal Doctor <sup>1</sup>	82.3%	81.8%	87.0%	83.6%	84.24%	33.33rd	84.56%
Rating of Specialist <sup>1</sup>	Small Sample	Small Sample	85.5%	Small Sample	79.17%	10th	83.06%
Rating of Health Plan <sup>1</sup>	72.1%	75.8%	75.1%	79.2%	74.62%	10th	77.61%
Getting Care Quickly <sup>2</sup>	Small Sample	Small Sample	83.8%	Small Sample	80.82%	33.33rd	81.57%
Getting Needed Care <sup>2</sup>	Small Sample	Small Sample	81.1%	81.6%	83.13%	50th	82.05%
How Well Doctors Communicate <sup>2</sup>	Small Sample	Small Sample	93.4%	93.8%	93.07%	33.33rd	93.37%
Customer Service <sup>2</sup>	Small Sample	Small Sample	89.0%	Small Sample	Small Sample	Not Applicable	89.27%
Coordination of Care <sup>2</sup>	Small Sample	Small Sample	83.2%	Small Sample	Small Sample	Not Applicable	85.94%

<sup>1</sup> Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the “best possible”).

<sup>2</sup> Rates reflect responses of “always” or “usually.”

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

**Table 37: Managed Care Plan Medicaid General Child Population CAHPS Results, Measurement Years 2020, 2021, 2022, 2023, and 2024**

<b>Measures</b>	<b>Tufts Health Public Plans Measurement Year 2021</b>	<b>Tufts Health Public Plans Measurement Year 2022</b>	<b>Tufts Health Public Plans Measurement Year 2023</b>	<b>Tufts Health Public Plans Measurement Year 2024</b>	<b>Quality Compass Measurement Year 2024 National Medicaid Benchmark (Met/Exceeded)</b>	<b>Quality Compass Measurement Year 2024 National Medicaid Mean</b>
Rating of All Health Care <sup>1</sup>	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	87.35%
Rating of Personal Doctor <sup>1</sup>	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	90.59%
Rating of Specialist <sup>1</sup>	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	87.36%
Rating of Health Plan <sup>1</sup>	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	86.50%
Getting Care Quickly <sup>2</sup>	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	86.20%
Getting Needed Care <sup>2</sup>	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	83.95%
How Well Doctors Communicate <sup>2</sup>	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	93.95%
Customer Service <sup>2</sup>	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	88.21%
Coordination of Care <sup>2</sup>	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	84.90%

<sup>1</sup> Rates reflect respondents who gave a rating of 8, 9, or 10 (with 10 being the “best possible”).

<sup>2</sup> 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 Rhode Island Executive 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*, the managed care plans administer the provider satisfaction surveys annually. The general objective of these surveys is to assess provider perception of the managed care plan’s Medicaid operations and services to better understand strengths, pain points, and opportunities.

On behalf of the Rhode Island Executive Office of Health and Human Services, IPRO validated satisfaction surveys sponsored by the managed care plans for measurement year 2024.

## Technical Methods of Data Collection and Analysis

**Tufts Health Public Plans** contracted a vendor to conduct the measurement year 2024 provider satisfaction survey. **Table 38** provides a summary of the technical methods of data collection.

**Table 38: Tufts Health Public Plans’ Provider Satisfaction Survey Technical Methods of Data Collection, Measurement Year 2024**

Methodology Element	Provider Satisfaction Survey
Survey Tool	Homegrown ( <i>Provider Relationship Survey</i> )
Survey Timeframe	October 2023-December 2023
Method of Collection	Telephone
Programs	Medicaid/Medicaid-Medicare/Qualified Health Plan
Eligible Provider Types	Medical and Behavioral Health
Total Surveys Completed	500

Due to the methodology changes that occurred in 2023, **Tufts Health Public Plans** recalculated rates for measurement year 2022 using the new methodology. **Table 39** displays the survey’s measure categories and possible response options.

**Table 39: Tufts Health Public Plans’ Provider Satisfaction Survey Categories and Response Options**

Measure Category	Response Options
▪ Satisfaction with...[policy/service]	<b>0 – 10 Scale</b> 0=Not At All Satisfied 10=Completely Satisfied <i>(Top-level performance is considered scores of “9” or “10”.)</i>
▪ Ease of...[process]	<b>0 – 10 Scale</b> 0=Not At All Easy 10=Extremely Easy <i>(Top-level performance is considered scores of “9” or “10”.)</i>

Survey responses were captured using a Likert scale of 0 (not satisfied) to 10 (very satisfied). Responses of “9” and ‘10’ were evaluated as top box performance.

**Description of Data Obtained**

IPRO received a copy of **Tufts Health Public Plans’** final study report and utilized the reported results to evaluate the administration of the 2024 provider satisfaction survey. The report included an executive summary, high-level summary of methodology and objectives, key takeaways, results, and a copy of the survey tool.

**Comparative Results**

**Table 40** displays the survey questions and results for the ‘overall measures’ for measurement years 2022, 2023, and 2024. Results in this table reflect response scores of “9” or “10.”

**Table 40: Tufts Health Public Plans’ Provider Satisfaction Survey Results, Measurement Years 2022, 2023, and 2024**

Measures	Tufts Health Public Plans’ Provider Satisfaction Survey Results		
	Measurement Year 2022	Measurement Year 2023	Measurement Year 2024
Overall satisfaction	36% (n=44)	50% (n=34)	44% (n=48)
Provider ease	41% (n=44)	53% (n=34)	60% (n=48)
Trust	New In 2024	New in 2024	58% (n=48)
<b>Claims</b>			
Timeliness of claims payments	46% (n=13)	59% (n=29)	56% (n=36)
Accuracy of claims payments	42% (n=12)	46% (n=28)	63% (n=45)
Clarity of payment documents	25% (n=12)	50% (n=28)	61% (n=46)
Clarity of payment explanations	33% (n=12)	59% (n=29)	51% (n=37)
Ability to resolve claims payment problems or disputes	25% (n=12)	41% (n=29)	56% (n=34)
Claims appeals procedures	23% (n=13)	48% (n=29)	50% (n=34)
<b>Call Center Representative</b>			
Ease of reaching a representative	45% (n=20)	47% (n=17)	48% (n=21)
Professionalism of representative	60% (n=20)	59% (n=17)	76% (n=21)
Representative’s effectiveness in responding to your issue	50% (n=20)	53% (n=17)	62% (n=21)
Representative’s ability to resolve issue during the same call	45% (n=20)	59% (n=17)	57% (n=21)
Timeliness of callbacks to resolve issue, when necessary	38% (n=13)	47% (n=15)	41% (n=17)
Ease of reaching a supervisor	45% (n=11)	45% (n=11)	25% (n=16)
<b>Communication</b>			
On credentialing, enrollment, and demographic changes	46% (n=28)	54% (n=24)	63% (n=35)
On claims payments and appeals	46% (n=13)	57% (n=28)	67% (n=36)
Of authorization policies, guidelines, and changes	41% (n=37)	59% (n=27)	61% (n=41)
Of product/benefit information	42% (n=38)	48% (n=27)	60% (n=42)
Through provider public website	38% (n=37)	57% (n=28)	64% (n=36)
Through secure provider portal	52% (n=31)	56% (n=25)	68% (n=38)
<b>Referral/Authorization</b>			
Ease of obtaining referrals	37% (n=19)	65% (n=26)	50% (n=40)
Ease of obtaining authorizations	45% (n=20)	56% (n=27)	51% (n=43)
Clarity of referral policies	30% (n=20)	64% (n=28)	52% (n=42)
Clarity of authorization policies	37% (n=17)	60% (n=30)	52% (n=44)
Ease of review process	37% (n=19)	62% (n=29)	50% (n=40)
Ease of appeals process	40% (n=15)	42% (n=26)	49% (n=35)
Ease of completing online authorizations and referrals	33% (n=18)	52% (n=31)	57% (n=37)
Overall referral and authorization process/procedures	36% (n=22)	66% (n=32)	55% (n=44)

n=Denominator.

# 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 Rhode Island Executive 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.

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.

In July 2022, NCQA introduced health equity–focused updates that emphasized the collection and reporting of member demographic data. Beginning with HEDIS Measurement Year 2023, NCQA renamed the Equity category to Description of Membership to better reflect the descriptive nature of the member demographic measures included, such as race, ethnicity, and language preferences. In September 2025, NCQA further updated its terminology by renaming the Health Equity Accreditation program as the Health Outcomes Accreditation program, reflecting an expanded focus on improving health outcomes while maintaining an emphasis on equity.

## Technical Methods of Data Collection and Analysis

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

**Table 41: NCQA Accreditation Status Levels and Points**

Accreditation Status	Points Needed
Accredited	At least 80% of applicable points
Accredited with Provisional Status	Less than 80% but no less than 55% of applicable points
Denied	Less than 55% of applicable points

To distinguish quality among the accredited managed care plans, NCQA calculates an overall rating for each managed care plan as part of its Health Plan Ratings program. The overall rating is the weighted average of a managed care plan’s HEDIS and CAHPS measure ratings, plus accreditation bonus points (if the plan is accredited by NCQA), rounded to the nearest half point and displayed as stars.

Overall ratings are recalculated annually and presented in the *Health Plan Ratings* report that is released every September. The *Health Insurance Plan Ratings 2024* 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 42**.

**Table 42: 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.

## Description of Data Obtained

IPRO accessed the NCQA Health Plan Reports website<sup>13</sup> to review the *Health Plan Report Cards 2025* 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 2025.

IPRO also received from each managed care plan, the accreditation survey decision letter issued by NCQA, the certificate of accreditation issued by NCQA, and the NCQA 2024 Renewal Survey Summary for Medicaid. The accreditation decision survey decision letter included information about the managed care plan's accreditation status and level achieved, the effective dates of the accreditation, and tentative dates of future accreditation surveys. The certificate of accreditation issued by NCQA displayed the managed care plan's accreditation status and level achieved, as well as the effective dates of the accreditation. The NCQA 2024 Renewal Survey Summary for Medicaid listed all the elements reviewed by NCQA during the managed care plan's accreditation survey and determinations of 'Met' or 'Not Met' issued to the managed care plan by element.

## Comparative Results

**Tufts Health Public Plans** was compliant with the state's requirement to achieve and maintain NCQA Accreditation. **Tufts Health Public Plans'** *Accredited* status is effective December 27, 2023 to April 23, 2026. Tufts Health Public Plans achieved overall health plan star ratings of 3.5 out of 5 for the *Health Plan Ratings 2025*.

**Tufts Health Public Plans** achieved Health Equity Accreditation Status, recognizing the managed care plan's efforts to improve culturally and linguistically appropriate services and reduce health care disparities.

**Table 43** displays **Tufts Health Public Plans'** 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.

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<sup>13</sup> NCQA Health Plan Report Cards Website: <https://reportcards.ncqa.org/health-plans>.

**Table 43: Managed Care Plan NCQA Rating by Category, Measurement Year 2024**

Overarching and Subcategories <i>(Number of Measures Included in Subcategory)</i>	NCQA Star Rating Achieved <i>(out of 5 stars)</i>
	Tufts Health Public Plans <b>3.5 Stars Overall</b>
<b>Patient Experience</b>	<b>3.0 Stars</b>
Getting Care (2)	3.0 Stars
Satisfaction with Plan Physicians (1)	3.0 Stars
Satisfaction with Plan and Plan Services (2)	2.5 Stars
<b>Prevention and Equity</b>	<b>3.5 Stars</b>
Children and Adolescent Well Care (3)	4.5 Stars
Women’s Reproductive Health (3)	3.0 Stars
Cancer Screening (2)	2.0 Stars
Description of Membership (2)	5.0 Stars
<b>Other Preventive Services (5)</b>	
Chlamydia Screening	3.0 Stars
Influenza Immunizations for Adults	3.0 Stars
Td/Tdap Immunizations for Adults	3.0 Stars
Zoster Immunizations for Adults	2.0 Stars
Pneumococcal Immunizations for Adults	Not Applicable
<b>Treatment</b>	<b>2.5 Stars</b>
Respiratory (5)	3.0 Stars
Diabetes (6)	2.0 Stars
Heart Disease (3)	2.5 Stars
Behavioral Health-Care Coordination (4)	4.0 Stars
Behavioral Health-Medication Adherence (3)	3.5 Stars
Behavioral Health-Access, Monitoring and Safety (5)	Insufficient Data
Risk-Adjusted Utilization (1)	3.0 Stars
Other Treatment Measures (1)	1.0 Star

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

# Managed Care Plan Response to the 2023 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 44** displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2023 external quality review recommendations.

**Table 45** displays **Tufts Health Public Plans’** progress related to the recommendations made in the 2023 *External Quality Review Aggregate Annual Technical Report* as well as IPRO’s assessment of the managed care plan’s response.

**Table 44: Managed Care Plan Response to Recommendation Assessment Levels**

Assessment Determinations and Definitions
<b>Addressed</b>
Managed care plan’s quality improvement response resulted in demonstrated improvement.
<b>Remains an Opportunity for Improvement</b>
Managed care plan’s quality improvement response was appropriate; however, more time is needed to observe for performance improvement.
<b>Not Addressed</b>
Managed care plan’s quality improvement response did not address the recommendation; or performance declined.

**Table 45: Tufts Health Public Plans’ Response to the 2023 External Quality Review Recommendations**

External Quality Review Activity	2023 External Quality Review Recommendation	Tufts Health Public Plans’ Response to the 2023 External Quality Review Recommendation	IPRO’s Assessment of Tufts Health Public Plans’ Response
Quality Improvement Projects - General	<p>Tufts Health Public Plans should continue to utilize the NCQA Quality Improvement Activity Form to ensure that quality improvement project reporting is consistent and adequate.</p> <p>To ensure that future quality improvement project methodologies are effectively designed, Tufts Health Public Plans should consult the Centers for Medicare &amp; Medicaid Services' external quality review protocol for the validation of performance improvement projects and seek technical assistance from IPRO.</p>	<p>Tufts Health Public Plans implemented the NCQA Quality Improvement Activity Form in 2024 and will continue to complete it annually each January. This process includes reviewing prior interventions and activities, as well as evaluating the associated data and metrics.</p> <p>Tufts Health Public Plans performs quarterly reviews and maintains supervisory oversight to ensure completion and validation of quality improvement projects, including performance improvement initiatives. Quarterly meetings are held with EOHHS, and ad hoc sessions with IPRO occur as needed to address questions about the improvement process. Staff training is ongoing, with annual sessions and additional training for new team members or those assuming related responsibilities. The Organization recently designated a point person to oversee improvement requirements and implement processes for quality-related regulatory updates.</p>	Addressed.
Quality Improvement Project - Prenatal/ Postpartum Care	Tufts Health Public Plans must implement a test of change for this to be a valid quality improvement project. The test of change should be proactive and impactful, and it should be evidence-based.	Tufts Health Public Plans has revised its quality improvement project interventions and activities to incorporate new initiatives and enhance existing ones. These updates enable the organization to demonstrate effectiveness through the evaluation of measurement year data.	Remains an opportunity for improvement.
Quality Improvement Project - Increase Flu Vaccination Rate	Tufts Health Public Plans must implement at least one intervention that aims to address a problem or barrier	Tufts Health Public Plans updated its quality improvement projects to address this recommendation by implementing an intervention designed to reduce barriers for the identified subpopulation—Hispanic members—through culturally appropriate materials and language translation.	Remains an opportunity for improvement.

External Quality Review Activity	2023 External Quality Review Recommendation	Tufts Health Public Plans' Response to the 2023 External Quality Review Recommendation	IPRO's Assessment of Tufts Health Public Plans' Response
	that is specific to its Hispanic members.		
Quality Improvement Projects	Although Tufts Health Public Plans complied with the contractually required NCQA Quality Improvement Activity Form for all quality improvement projects, the 2023 reports submitted by the managed care plan were incomplete. Tufts Health Public Plans should annually review the Centers for Medicare & Medicaid Services' External Quality Review Protocol for the Validation of Performance Improvement Projects and offer training to quality improvement staff to ensure that quality improvement projects are appropriately designed and reported.	Tufts Health Public Plans has addressed the identified deficiencies by revising policies and procedures for Enrollee Rights & Protections, Availability of Services, Grievances and Appeals, and Quality Assessment and Performance to ensure alignment with NCQA and federal standards. The organization has strengthened oversight through compliance dashboards, gap analyses, and comprehensive document tracking grids. Workplan documents now clearly outline NCQA requirements, with trackers incorporating analysis components and review timelines. Additionally, staff training has been expanded to reinforce NCQA and regulatory standards, and progress is monitored through biweekly huddles.	Remains an opportunity for improvement.
Compliance with Medicaid and Children's Health Insurance Program Standards	Tufts Health Public Plans should address the deficiencies identified during the compliance review, as well as implement mechanisms to support routine monitoring and performance reporting. Tufts Health Public Plans should also investigate whether these deficiencies have inadvertently introduced	Tufts Health Public Plans has addressed the identified deficiencies by revising policies and procedures for Enrollee Rights & Protections, Availability of Services, Grievances and Appeals, and Quality Assessment and Performance to ensure alignment with NCQA and federal standards. The organization has strengthened oversight through compliance dashboards, gap analyses, and comprehensive document tracking grids. Workplan documents now clearly outline NCQA requirements, with trackers incorporating analysis components and review timelines. Additionally, staff	Remains an opportunity for improvement.

External Quality Review Activity	2023 External Quality Review Recommendation	Tufts Health Public Plans' Response to the 2023 External Quality Review Recommendation	IPRO's Assessment of Tufts Health Public Plans' Response
	barriers for members and providers.	training has been expanded to reinforce NCQA and regulatory standards, and progress is monitored through biweekly huddles.	
Compliance with State Contract Requirements	Tufts Health Public Plans should ensure that future provider satisfaction surveys are designed to align with state reporting requirements.	Tufts Health Public Plans has ensured that provider satisfaction surveys and associated reporting for 2023 and subsequent years includes segmentation for RI Medicaid within our annual reports. Each annual report provides a year-over-year comparison, including the current measurement year required and the prior year, to support transparency and trend analysis.	Addressed.
Compliance with State Contract Requirements	Tufts Health Public Plans should identify and address the gaps in its data collection and reporting systems that are preventing the managed care plan from meeting the contractually required reporting of patient-centered medical home assignments.	Tufts Health Public Plans has established a more robust process for collecting and communicating PCMH assignments to our network of providers. The process has been communicated internally and implemented.	Addressed.
Performance Measures	Tufts Health Public Plans should continue using HEDIS results to shape its annual quality assurance and performance improvement program. Given that low performance measure rates typically suggest that members received subpar care, encountered barriers to accessing care, and suffered adverse health outcomes, Tufts Health Public Plans should prioritize monitoring child and adult primary care utilization	A number of new activities were initiated in 2024 and 2025 to address the needs of this population. Our Community Engagement team sponsored a number of events for members in 2024 including back to school and immunization events together with local partners. In addition to our standard member outreach that involves reminders for cancer screenings, immunizations, and EPSDT, our marketing team also works through a number of SMS pathways to reach members and assess care needs. In 2025 our Community Health Worker team conducted targeted outreach using data from the HEDIS team for members with multiple gaps in care. These calls were prioritized based on member needs, number and type of gaps, and included measures such as AAP, WCV, diabetes care, and cancer screenings. We also partnered with GroundGame Health, again using data from the HEDIS team to	Remains an opportunity for improvement.

External Quality Review Activity	2023 External Quality Review Recommendation	Tufts Health Public Plans' Response to the 2023 External Quality Review Recommendation	IPRO's Assessment of Tufts Health Public Plans' Response
	<p>rates, women's health, and chronic conditions. Additionally, the managed care plan should adopt an evidence-based and proactive approach to address these issues, ensuring that interventions are grounded in reliable data.</p>	<p>reach out to members in need of a well visit or any of the 3 cancer screenings: Breast, Cervical, and Colorectal Cancer Screening. HEDIS rates for measurement year 2024 demonstrated significant improvement in a number of the measures identified in the measurement year 2023 EQRO report including a 16% increase in the Well Child visits in the first 15 months of life rate and 6% increase in the same measure for visits between 15 and 30 months. In addition, the Child and Adolescent Well-Care visit rate increased 5% and prenatal and postpartum care each increased by 10%.</p>	
Network Adequacy	<p>Tufts Health Public Plans should continue monitoring access to care, specifically Medicaid member access to timely appointments. Tufts Health Public Plans should consider establishing a routine schedule for reminding network providers of state appointment standards and their contractual obligation to meet those standards, promoting provider use of scheduling tools, and proactively seeking feedback from members paneled to providers with access deficiencies or concerns.</p>	<p>Tufts Health Public Plans monitors network adequacy quarterly and acts upon identified opportunities to enhance access where possible. Appointment availability is assessed through provider surveys to identify member access to timely appointments. Quarterly reminders are published in the provider newsletter "Insights &amp; Updates for Providers" emphasizing the importance of timely access to care for members with access standard requirements for medical and behavioral health care. Tufts Health Public Plans contracts with various providers to enhance access and availability such as physicians, advanced practitioners, and other licensed providers that render in office care as well as telehealth services. Current efforts will continue including collaboration with providers focused on increasing access and incorporate feedback from member servicing teams.</p>	Remains an opportunity for improvement.
Network Adequacy	<p>Tufts Health Public Plans should continue efforts to increase the number of in-network pediatric allergy/immunology specialists available to members.</p>	<p>Tufts Health Public Plans monitors network adequacy quarterly and acts upon identified opportunities to enhance access where possible. In 2023, pediatric allergy/immunology was identified as a high volume specialty that did not meet the 90% access goal. Extensive research was conducted and determined the access was</p>	Remains an opportunity for improvement.

External Quality Review Activity	2023 External Quality Review Recommendation	Tufts Health Public Plans' Response to the 2023 External Quality Review Recommendation	IPRO's Assessment of Tufts Health Public Plans' Response
		not met due to the limited number of providers that specialize and are board certified in the separate specialties. Although no additional providers were identified to be added to the network, five (5) provider records were updated to include the two (2) specialties.	
Quality of Care Survey – Member Satisfaction	<p>Tufts Health Public Plans should share the results of the member experience surveys with network providers, along with recommendations on how providers can positively impact member experience.</p> <p>Tufts Health Public should evaluate whether the current composition of its provider network is contributing to scores for getting needs care and rating of health plan.</p>	<p>As part of standard business operations, Tufts Health Public Plans regularly monitors and evaluates network movement, stability and adequacy, in support of ensuring our members have access to care and services they need. We do this through network assessments and qualitative engagements that assess appointment availability. In addition, Tufts Health Public Plans engaged and invited network Rhode Island providers, in support of Primary Care Physician appointment access, through our Alternative Payment Models. Moreover, in addition to our Alternative Payment Models with Tufts Health Public Plans provider organizations, we have renewed our value-based contract that has been in place for several years with a large provider organization in our Rhode Island network, aimed at improving clinical outcomes, which we believe will also improve patient perception of quality of care. In addition to sharing data with our providers in support of enhancing care, experience, and outcomes we also produce 2 articles each year detailing member access to care rights in our Insights and Updates for Providers newsletters. (May and November of 2024 and 2025). In 2025, we stood up a Customer Experience team who is focused on member experience measurement and improvement, which includes socializing survey results.</p>	Remains an opportunity for improvement.
Quality of Care Survey – Provider Satisfaction	None.	Not applicable.	Not applicable.

## Managed Care Plan 2024 Strengths, Opportunities and Recommendations Related to Quality, Timeliness, and Access

Tufts Health Public Plans’ 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. (*Title 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. (*Title 42 Code of Federal Regulations 438.320 Definitions.*)

The strengths and opportunities for improvement based on the managed care plans’ 2024 performance, as well recommendations for improving quality, timeliness, and access to care are presented in **Table 46** for **Tufts Health Public Plans**. In the table, links between strengths, opportunities, and recommendations to quality, timeliness and access are made by IPRO (indicated by a checkmark ✓). In some cases, IPRO determined that there were no links between these elements (indicated by gray shading).

**Table 46: Tufts Health Public Plans’ Strengths, Opportunities, and Recommendations, Measurement Year 2024**

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
<b>NCQA Accreditation</b>				
Strengths	Tufts Health Public Plans maintained NCQA Accreditation status in 2024.	✓	✓	✓
	Tufts Health Public Plans achieved Health Outcomes Accreditation.	✓	✓	✓
Opportunities	Tufts Health Public Plans’ overall star rating was 3.5 out of 5. Tufts Health Public Plans has opportunities to improve member experience and satisfaction, strengthen performance across multiple treatment and preventive care measures—particularly chronic disease management and cancer screening—and improve data completeness for behavioral health access, monitoring, and safety to support more comprehensive quality assessment and improvement efforts.	✓	✓	✓
Recommendation	Tufts Health Public Plans should implement initiatives to improve member experience (e.g., addressing access, communication, and service responsiveness concerns), strengthen clinical quality improvement activities for chronic disease management and preventive care measures such as cancer screening (e.g., provider performance feedback or focused improvement initiatives), and enhance behavioral health data collection and reporting processes to support more complete and reliable performance monitoring.	✓	✓	✓
<b>Performance Improvement Projects</b>				
Strengths	Improve Prenatal/Postpartum Care - Tufts Health Public Plans demonstrated performance improvement from baseline to measurement year 2024 on one (1) of two (2) indicators.	✓	✓	✓
	Increase Flu Vaccination Rate - Tufts Health Public Plans demonstrated performance improvement from baseline to measurement year 2024 on one (1) of two (2) indicators.	✓	✓	✓
	Follow-up After Hospitalization for Mental Illness – 7 Day - Tufts Health Public Plans demonstrated performance improvement from baseline to measurement year 2024 on the single indicator.	✓	✓	✓
Opportunities	All four (4) of Tufts Health Public Plans’ quality improvement projects did not meet all validation elements reviewed.			

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	Improve Prenatal/Postpartum Care - Tufts Health Public Plans demonstrated performance decline from baseline to measurement year 2024 on one (1) of two (2) indicators. Performance goals for measurement year 2024 were lowered from the initial goals established for all indicators.	✓	✓	✓
	Increase Flu Vaccination Rate - Tufts Health Public Plans demonstrated performance decline from baseline to measurement year 2024 on one (1) of two (2) indicators. Performance goals for measurement year 2024 were lowered or were not aggressive. The quality improvement strategy did not include a single targeted intervention for the population identified by Tufts Health Public Plans as having disparate outcomes.	✓	✓	✓
	Follow-up After Hospitalization for Mental Illness – 7 Day – The performance goal established for measurement year 2024 was lower than the initial goal.			
	Member Experience and Retention Tufts Health Public Plans’ conduct of the Member Experience and Retention quality improvement project 4 did not meet all standards related to topic selection, data collection, and interpretation of study results.			
Recommendation	Tufts Health Public Plans should strengthen the design and implementation of its quality improvement projects by establishing performance goals that are sufficiently ambitious to drive improvement rather than adjusting goals downward in response to performance, implementing targeted interventions aligned to identified performance gaps and disparities, and ensuring that topic selection, data collection, and analysis methods support valid interpretation of results and measurable improvement.	✓	✓	✓
<b>Performance Measures</b>				
Strengths	Tufts Health Public Plans met all Information System and HEDIS Determination Standards reviewed during the HEDIS audit for measurement year 2024.			
	For measurement year 2024, Tufts Health Public Plans reported one (1) rate that benchmarked at the 90th percentile and three (3) rates at the 75th percentile.	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Opportunities	For measurement year 2024, Tufts Health Public Plans reported two (2) rates that benchmarked at the 50th percentile, two (2) rates at the 33.33rd percentile, three (3) rates at the 10th percentile, and four (4) rates below the 10th percentile.	✓	✓	✓
	Tufts Health Public Plans demonstrated year to year declines in performance for chlamydia screening and childhood immunizations. While overall performance trends across measures are generally improving, performance in these preventive care areas remains below national Medicaid benchmarks, indicating continued opportunity to strengthen outcomes and close persistent gaps in preventive care.	✓	✓	✓
Recommendation	Tufts Health Public Plans should prioritize focused review of preventive care and related measures performing well below the national Medicaid average, including chlamydia screening, glycemic control among adults with diabetes, adults’ access to preventive and ambulatory health services, and prenatal and postpartum care. Tufts Health Public Plans should identify potential drivers of underperformance and determine whether targeted quality improvement actions are needed to accelerate improvement and move performance closer to national Medicaid benchmarks.	✓	✓	✓
<b>Network Adequacy</b>				
Strengths	Tufts Health Public Plans’ network analyses for measurement year 2024 were determined to be reliable.	✓	✓	✓
	In 2024, approximately 100% of Tufts Health Public Plans membership had appropriate distance access to primary and specialty care providers.	✓	✓	✓
	Among behavioral health providers surveyed for routine adult appointment availability in 2024 by Tufts Health Public Plans, 75.6% of appointments scheduled met the access to standard.	✓	✓	✓
Opportunities	Among primary care and specialty providers surveyed for routine and urgent appointment availability in 2024 by Tufts Health Public Plans, appointment availability declined substantially when timeliness was evaluated, particularly for specialty and urgent care services.	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Recommendation	Tufts Health Public Plans should conduct focused review of appointment scheduling and network capacity for specialty and urgent care services to better understand factors contributing to reduced timely access. Tufts Health Public Plans should identify potential barriers to meeting timeliness expectations and determine whether targeted quality improvement actions are needed to improve timely access across provider types.	✓	✓	✓
<b>Review of Compliance with Medicaid and Children’s Health Insurance Program Standards</b>				
Strengths	Tufts Health Public Plans is fully compliant with 12 of the standards reviewed under <i>42 Code of Federal Regulations Part 438 Managed Care</i> .	✓	✓	✓
Opportunities	Tufts Health Public Plans was not fully compliant with three of the standards reviewed under <i>42 Code of Federal Regulations Part 438 Managed Care</i> . Tufts Health Public Plans’ documentation did not clearly demonstrate how cultural needs and preferences data were used to support network availability as required under 42 CFR 438.206, nor did it sufficiently describe access improvement interventions, outcome measures, data sources, and CAHPS analyses needed to support evaluation of quality assessment and performance improvement activities under 42 CFR 438.330.	✓	✓	✓
Recommendation	Tufts Health Public Plans should address the issues identified through the review and implement monitoring activities to ensure that corrective actions are taken, progress is tracked, and sustained compliance with applicable federal requirements is maintained over time.	✓	✓	✓
<b>Validation of Quality of Care Survey, Adult Medicaid Member Experience Survey</b>				
Strengths	None.			
Opportunities	Performance on member experience ratings, including Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist, and Rating of Health Plan, performed below national benchmarks, with several measures performing at or below the 33.33rd percentile. Additionally, Customer Service and Coordination of Care results could not be reliably assessed due to small sample sizes, limiting the plan’s ability to fully evaluate member experience in these domains.	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Recommendation	Tufts Health Public Plans should prioritize initiatives aimed at improving overall member perception of care and the health plan while also addressing survey response volume and representation. The plan should evaluate outreach and engagement strategies to strengthen CAHPS sampling reliability and use available member feedback to inform targeted interventions focused on provider experience, care coordination, and customer service processes. Ongoing monitoring should be incorporated to assess the effectiveness of improvement efforts and ensure alignment with national performance expectations.	✓	✓	✓
<b>Validation of Quality of Care Survey, Child Medicaid Member Experience Survey</b>				
Strengths	None.			
Opportunities	Due to small sample sizes across nearly all CAHPS measures, Tufts Health Public Plans was unable to report sufficient data to assess performance relative to national Medicaid benchmarks. The lack of reportable results limits the plan’s ability to evaluate member experience, identify performance gaps, and demonstrate compliance with quality monitoring expectations for consumer experience measures.			
Recommendation	Tufts Health Public Plans should prioritize strategies to increase CAHPS survey participation and ensure sufficient sample sizes for reliable reporting and benchmarking. The plan should review enrollment dynamics, survey outreach methods, and member engagement approaches to support more complete data collection. Improving data completeness will enable meaningful evaluation of member experience and inform targeted quality improvement activities within the Quality Assessment and Performance Improvement Program.			
<b>Validation of Quality of Care Survey, Provider Satisfaction Survey</b>				
Strengths	Between Measurement Years 2023 and 2024, Tufts Health Public Plans demonstrated improvements in several operational areas, including claims accuracy and clarity, issue resolution, provider communications, and use of electronic platforms, indicating progress in administrative and communication functions.	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Opportunities	Despite targeted improvements, overall provider satisfaction declined between Measurement Years 2023 and 2024, and performance worsened across multiple referral and authorization measures as well as selected call center access indicators. These declines suggest ongoing challenges affecting provider workflow and overall experience, notwithstanding modest and variable response counts.	✓	✓	✓
Recommendation	Tufts Health Public Plans should sustain improvements in claims and provider communication while prioritizing corrective actions for referral, authorization, and escalation processes that declined year over year. Targeted root cause analyses and ongoing monitoring should be incorporated into the Quality Assessment and Performance Improvement Program to support improved provider experience.	✓	✓	✓

# Appendix A – NCQA Quality Improvement Activity Form

## QUALITY IMPROVEMENT FORM NCQA Quality Improvement Activity Form

<b>Activity Name:</b>	
<b>Section I: Activity Selection and Methodology</b>	
<b>A. Rationale.</b> Use objective information (data) to explain your rationale for why this activity is important to members or practitioners <i>and</i> why there is an opportunity for improvement.	
<b>B. Quantifiable Measures.</b> List and define <i>all</i> 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.	
<b>Quantifiable Measure #1:</b>	
<b>Numerator:</b>	
<b>Denominator:</b>	
<b>First measurement period dates:</b>	
<b>Baseline Benchmark:</b>	
<b>Source of benchmark:</b>	
<b>Baseline goal:</b>	
<b>Quantifiable Measure #2:</b>	
<b>Numerator:</b>	
<b>Denominator:</b>	
<b>First measurement period dates:</b>	
<b>Benchmark:</b>	
<b>Source of benchmark:</b>	
<b>Baseline goal:</b>	
<b>Quantifiable Measure #3:</b>	
<b>Numerator:</b>	
<b>Denominator:</b>	

<b>First measurement period dates:</b>	
<b>Benchmark:</b>	
<b>Source of benchmark:</b>	
<b>Baseline goal:</b>	
<b>C. Baseline Methodology.</b>	
<b>C.1 Data Sources.</b>	
<input type="checkbox"/> Medical/treatment records <input type="checkbox"/> Administrative data: <input type="checkbox"/> Claims/encounter data <input type="checkbox"/> Complaints <input type="checkbox"/> Appeals <input type="checkbox"/> Telephone service data <input type="checkbox"/> Appointment/access data <input type="checkbox"/> Hybrid (medical/treatment records and administrative) <input type="checkbox"/> Pharmacy data <input type="checkbox"/> Survey data (attach the survey tool and the complete survey protocol) <input type="checkbox"/> 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.	
<b>C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.</b>	
If medical/treatment records, check below: <input type="checkbox"/> Medical/treatment record abstraction If survey, check all that apply: <input type="checkbox"/> Personal interview <input type="checkbox"/> Mail <input type="checkbox"/> Phone with CATI script <input type="checkbox"/> Phone with IVR <input type="checkbox"/> Internet <input type="checkbox"/> Incentive provided <input type="checkbox"/> Other (list and describe):	If administrative, check all that apply: <input type="checkbox"/> Programmed pull from claims/encounter files of all eligible members <input type="checkbox"/> Programmed pull from claims/encounter files of a sample of members <input type="checkbox"/> Complaint/appeal data by reason codes <input type="checkbox"/> Pharmacy data <input type="checkbox"/> Delegated entity data <input type="checkbox"/> Vendor file <input type="checkbox"/> Automated response time file from call center <input type="checkbox"/> Appointment/access data <input type="checkbox"/> 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*
	<i>Baseline:</i>						

<b>#2 Quantifiable Measure:</b>							
<b>Time Period Measurement Covers</b>	<b>Measurement</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Rate or Results</b>	<b>Comparison Benchmark</b>	<b>Comparison Goal</b>	<b>Statistical Test and Significance*</b>
	<i>Baseline:</i>						

<b>#3 Quantifiable Measure:</b>							
<b>Time Period Measurement Covers</b>	<b>Measurement</b>	<b>Numerator</b>	<b>Denominator</b>	<b>Rate or Results</b>	<b>Comparison Benchmark</b>	<b>Comparison Goal</b>	<b>Statistical Test and Significance*</b>
	<i>Baseline:</i>						

\* 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.