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Rhode Island Medicaid Managed Care Program UnitedHealthcare Community Plan 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

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, PIHP¹, PAHP², or PCCM³ 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 **UnitedHealthcare Community Plan of Rhode Island**.

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 projects⁴, 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

¹ Prepaid inpatient health plan.

² Prepaid ambulatory health plan.

³ Primary care case management.

⁴ 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*⁵ 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 ^{®6}) 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 ^{®7}) 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.

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

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

⁷ 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 Waiver⁸ 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 2015⁹. 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.

⁸ 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>.

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

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 Strategy¹⁰ 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

Rhode Island Medicaid Managed Care Quality Strategy Goals and Objectives
Goal 1: Members receive quality care within all managed care delivery systems.
<ul style="list-style-type: none">▪ 1.1 Continue to work with managed care entities and the external quality review organization to collect, analyze, compare, and share clinical performance and member experience across plans and programs.▪ 1.2 Collaborate with managed care organizations, accountable entities, Office of the Health Insurance Commissioner, and other stakeholders to review and modify measures used in Medicaid managed care quality oversight.▪ 1.3 Monitor managed care organization performance for dual-eligible Medicare-Medicaid population.
Goal 2: Focus on quality performance and improvement in the following key areas: chronic disease management, maternal/infant health, preventive care for children, preventive care for adults, and behavioral health.
<ul style="list-style-type: none">▪ 2.1 Continue oversight of managed care organizations and accountable entities to increase timely preventive care, screening, and follow-up for adult and child health.▪ 2.2 Monitor and assess managed care organization and accountable entity performance improvement on quality measures related to chronic conditions.▪ 2.3 Increase the use of prenatal and postpartum services.▪ 2.4 Increase the number and percentage of well-child visits.

¹⁰ 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
Goal 1: Members receive quality care within all managed care delivery systems.	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%	▲
Goal 2: Focus on quality performance and improvement in the following key areas: Chronic Disease Management, Maternal/Infant Health, Preventive Care for Children, Preventive Care for Adults, and Behavioral Health	Breast Cancer Screening (Medicaid)	65.0%	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 ¹ (Medicaid)	82.2%	Not Available	Not Available	—
	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control ¹ (<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% ²	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%	▲
Goal 3: Improve care and service coordination and management, with focus on coordination of services among medical, behavioral, dental and specialty services providers.	Follow-Up After Hospitalization for Mental Illness – 7 Days, 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 ³	Not Available ³	—
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Medications (Medicaid)	67.0%	Not Available ³	Not Available ³	—
	Medical Assistance with Smoking and Tobacco Use Cessation – Discussed or Recommended Cessation Strategies (Medicaid)	59.9%	Not Available ³	Not Available ³	—
	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%	●
Goal 4: Enhance financial & data analytic oversight of managed care organizations.					
Goal 5: Increase health equity by improving capabilities to collect and analyze data related to social determinants of health, including race, ethnicity, and language data.					
Goal 6: Empower members to make informed choices about their health plans and care.	Adult CAHPS 5.1H (Medicaid)	Not Applicable	Not Applicable	Not Applicable	—

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

² Rates represents measurement year 2021.

³ 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*¹¹ (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.

¹¹ 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^{®12}, 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

¹² 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

UnitedHealthcare Community Plan of Rhode Island

UnitedHealthcare Community Plan of Rhode Island is a for-profit health maintenance organization. Table 9 displays UnitedHealthcare Community Plan of Rhode Island’s enrollment for year-end 2019 through year-end 2023, 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 may differ from those in prior reports as enrollment counts will vary based on the point in time in which the data were abstracted. UnitedHealthcare Community Plan of Rhode Island’s enrollment decreased by 17% from 93,804 members in 2023 to 78,065 members in 2024.

Table 9: UnitedHealthcare Community Plan of Rhode Island’s Medicaid Enrollment, 2019 to 2024

Eligibility Group	2019	2020	2021	2022	2023	2024
Rlte Care Core	47,975	51,539	53,406	53,825	55,003	45,257
Children with Special Health Care Needs	1,845	1,896	1,884	1,922	2,153	1,985
Rhody Health Partners	6,536	6,463	6,327	5,968	5,531	5,195
Rhody Health Expansion	26,742	32,622	36,448	38,606	30,934	25,251
Dual Special Needs Plan	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported	Not Reported
Extended Family Planning	417	379	302	222	183	377
Medicaid Total	83,515	92,899	98,367	100,543	93,804	78,065
Percent Change from Previous Year	-8%	+11%	+6%	+2%	-7%	-17%

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

UnitedHealthcare Community Plan of Rhode Island’s 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. UnitedHealthcare Community Plan of Rhode Island’s 2024 Quality Improvement & Population Health Management Program (February 2023) met these requirements.

Program Description

UnitedHealthcare Community Plan of Rhode Island maintains a comprehensive Quality Assurance and Performance Improvement Program designed to objectively monitor, systematically evaluate, and continuously improve the quality, safety, and accessibility of clinical care and services provided to Medicaid members. The program incorporates a population health management framework and applies to all members served across Rlte Care, Medicaid Expansion, Rhody Health Partners, and Children with Special Healthcare Needs populations.

The program encompasses all aspects of health care delivery and service, including quality of care, quality of service, patient safety, access and availability of care, coordination and continuity of medical and behavioral health services, health equity, member and provider experience, and network adequacy. Quality improvement activities are managed directly by the health plan; no quality improvement activities are delegated.

UnitedHealthcare Community Plan of Rhode Island operates its Quality Assurance and Performance Improvement Program in alignment with UnitedHealth Group’s mission to help people live healthier lives and to

improve the health system for everyone, with a strong emphasis on reducing health disparities and advancing culturally and linguistically appropriate services. The program is integrated with utilization management, credentialing, pharmacy, behavioral health, and care management programs to promote appropriate, evidence-based care across the continuum.

Oversight of the program is provided through a structured governance model that includes the Quality Management Committee, Provider Advisory Committee, Healthcare Quality and Utilization Management Committee, Member Advisory Committee, Community Advisory Committee, and the UnitedHealthcare of New England Board of Directors. The program uses a continuous quality improvement methodology that includes goal setting, performance measurement, root cause and barrier analysis, implementation of targeted interventions, and re-measurement to assess effectiveness.

An annual evaluation is conducted to assess overall program effectiveness, determine whether goals and objectives were achieved, identify barriers to performance, evaluate adequacy of resources, and inform priorities for the subsequent year.

Program Goals

- Improve the quality, safety, and effectiveness of clinical care and services provided to members
- Promote population health and improve health outcomes across all member populations
- Enhance member experience and satisfaction with care and health plan services
- Improve continuity and coordination of care across medical, behavioral health, and community settings
- Advance health equity and reduce disparities in care and outcomes
- Ensure compliance with state, federal, and accreditation requirements
- Maintain an effective governance structure that supports continuous quality improvement

Program Activities

- Promote population health management programs that address preventive care, chronic conditions, maternal and child health, behavioral health, and patient safety
- Monitor and improve performance on clinical, utilization, and service quality measures
- Identify, investigate, and address quality of care and patient safety issues
- Evaluate member experience using grievance, appeal, and member satisfaction data and implement improvement actions
- Assess and maintain network adequacy, access, and availability of care
- Support culturally and linguistically appropriate services and health equity initiatives
- Evaluate the effectiveness of quality improvement projects, incentives, and interventions
- Conduct a comprehensive annual evaluation to guide future quality improvement priorities

Quality Improvement Program Activities

Clinical Quality and Population Health Activities

- Monitoring and analysis of clinical performance measures, including preventive care, chronic disease management, maternal and child health, and behavioral health
- Implementation and evaluation of quality improvement projects and performance improvement projects
- Use of nationally recognized, evidence-based clinical practice guidelines
- Population health stratification and targeted interventions for high-risk and vulnerable members
- Complex case management and care coordination programs, including maternity and behavioral health programs
- Promotion of Early and Periodic Screening, Diagnostic, and Treatment services

Patient Safety and Quality of Care Oversight

- Monitoring and investigation of quality of care complaints and adverse events
- Peer review activities and implementation of improvement action plans when indicated
- Medication safety initiatives and pharmacy oversight
- Efforts to reduce hospital readmissions and improve transitions of care
- Monitoring of continuity and coordination of medical and behavioral health services

Member Experience and Quality of Service Activities

- Analysis of grievances, appeals, and member satisfaction survey results
- Monitoring of access to care, appointment availability, and service timeliness
- Member outreach and education through mailings, calls, digital communications, and community events
- Member incentive programs to promote preventive care and closure of gaps in care

Provider and Network-Focused Activities

- Oversight of credentialing and recredentialing processes
- Provider outreach and education through clinical practice support staff
- Provider incentive and pay-for-performance programs
- Monitoring network adequacy, geographic access, and appointment availability
- Collaboration with accountable care organizations and community providers

Health Equity and Community Engagement Activities

- Analysis of quality performance by race, ethnicity, language, and other demographic factors
- Implementation of health equity initiatives targeting identified disparities
- Development and dissemination of culturally and linguistically appropriate member communications
- Community partnerships and investments addressing social determinants of health
- Engagement of members and community organizations through advisory committees

Summary of UnitedHealthcare Community Plan's Evaluation of the 2024 Quality Assurance and Performance Improvement Program

The 2024 Quality Assurance and Performance Improvement Program Evaluation determined that the program was effective overall in supporting quality improvement, patient safety, member experience, and regulatory compliance.

Key Evaluation Findings

- Program governance, leadership engagement, and committee structures were effective and sufficient to support quality improvement activities.
- Quality improvement initiatives resulted in measurable improvements in several preventive and chronic care areas, while opportunities for improvement remain in behavioral health, childhood immunizations, and selected chronic condition measures.
- Patient safety activities, including monitoring of quality of care concerns and medication safety efforts, were effectively implemented, with timely case resolution and minimal severe adverse events identified.
- Member experience results demonstrated improvements in access to care and timeliness, while identifying targeted opportunities related to specialist access and billing-related appeals.
- Population health management programs were partially effective, with strengths in keeping members healthy and managing emerging risk, and identified opportunities for additional focus on patient safety transitions and members with multiple chronic conditions.
- Resources supporting quality management, accreditation readiness, analytics, and population health were adequate to meet program objectives.

- Health equity initiatives and community partnerships continued to expand, supporting efforts to address social determinants of health and reduce disparities.

Based on the evaluation, the program structure and resources were deemed appropriate for continuation into 2025. Targeted improvement priorities were identified to further strengthen preventive care, reduce disparities, enhance member engagement, simplify access to care, and support continued collaboration with providers and community partners.

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

Each managed care plan’s 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 any managed care plan. **Table 26** displays the results of the managed care plan’s 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 **UnitedHealthcare Community Plan of Rhode Island** for measurement year 2024.

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

Managed Care Plan Quality Improvement Project Topics, 2024	
UnitedHealthcare Community Plan of Rhode Island	<ol style="list-style-type: none">1. Improving Effective Acute Phase Treatment for Major Depression2. Developmental Screening in the 1st, 2nd, 3rd Years of Life3. Improving Lead Screening in Children4. Improving Breast Cancer Screening

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 the **UnitedHealthcare Community Plan of Rhode Island**. 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 **UnitedHealthcare Community Plan of Rhode Island** 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*. Two quality improvement projects did not meet all elements reviewed to validate improvement strategies.

Quality Improvement Project 3 – Improving Lead Screening in Children

UnitedHealthcare Community Plan of Rhode Island's conduct of the Improving Lead Screening in Children quality improvement project 3 did not meet all standards related to quality improvement strategies. Through the validation process, IPRO determined that for UnitedHealthcare Community Plan of Rhode Island's 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.

Quality Improvement Project 4 – Improving Breast Cancer Screening

UnitedHealthcare Community Plan of Rhode Island's conduct of the Improving Breast Cancer Screening quality improvement project 4 did not meet all standards related to quality improvement strategies. Through the validation process, IPRO determined that for UnitedHealthcare Community Plan of Rhode Island's quality improvement project 4:

- 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.

Table 12 displays a summary of the validation results of **UnitedHealthcare Community Plan of Rhode Island's** quality improvement projects that were 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
UnitedHealthcare Community Plan of Rhode Island								
1) Improving Effective Acute Phase Treatment for Major Depression	Met	Met	Met	Met	Met	Met	Met	Met
2) Developmental Screening in the 1st, 2nd, 3rd Years of Life	Met	Met	Met	Met	Met	Met	Met	Met
3) Improving Lead Screening in Children	Met	Met	Met	Met	Met	Met	Met	Not Met
4) Improving Breast Cancer Screening	Met	Met	Met	Met	Met	Met	Met	Not Met

UnitedHealthcare Community Plan of Rhode Island

IPRO’s assessment of **UnitedHealthcare Community Plan of Rhode Island’s** methodology found that there were no validation findings that indicated that the credibility of the four quality improvement projects was at risk. Summaries of each quality improvement project immediately follow.

Table 13: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 1 Summary – Treatment for Depression, Measurement Year 2024

Quality Improvement Project 1 Summary
<p>Title: Improving Effective Acute Phase Treatment for Major Depression Start Year: 2010. End Year: Not yet determined. Validation Summary: There were no validation findings indicating that the credibility of the performance improvement project results was at risk.</p>
<p><u>Aim</u> UnitedHealthcare Community Plan of Rhode Island aimed to increase the percentage of members aged 18 years and older who remain on antidepressant medication during the acute phase of treatment.</p>
<p><u>Indicator of Performance</u> <i>HEDIS Antidepressant Medication Management – Effective Acute Phase:</i> The percentage of members 18 years of age and older who remain on their antidepressant medications during the 12-week effective acute phase treatment after being diagnosed with a new episode of depression and treated with antidepressant medications.</p>
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Published articles in the newsletter educating members on the importance of preventive care, seasonal depression, and suicide support.▪ Continue to organize, participate in, and/or fund community outreach events throughout the year to promote childhood and adult annual visits and behavioral health care.▪ Reminded adult members to complete annual well visits using interactive voice recordings, short message service, or email.
<p><u>Provider-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Conducted a live presentation best practices on multiple behavioral health measures to 16 practitioners from six Certified Community Behavioral Health Clinicians.▪ Made behavioral health measure definitions and best practices available to providers in the <i>HEDIS Measures Overview for Behavioral Health Providers</i> document via the behavioral health network website.▪ Continued targeted outreach to providers who treated two or more adult enrollees in the past 12 months for education on best treatment practices for depression, performance measure specifications, and tips to support patient medication adherence.
<p><u>Managed Care Plan-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Contributed financial funding to the Latino Policy Institute to support the mental health/behavioral health workforce pipeline.

Table 14: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 1 Indicator Summary – Treatment for Depression, Measurement Years 2009 to 2024

HEDIS Antidepressant Medication Management – Acute Phase					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2009	Baseline	134	274	48.91%	52.63%
Measurement Year 2010	Remeasurement 1	218	371	58.76%	53.18%
Measurement Year 2011	Remeasurement 2	156	345	45.22%	53.57%
Measurement Year 2012	Remeasurement 3	289	556	51.98%	52.74%
Measurement Year 2013	Remeasurement 4	529	1,031	51.31%	56.27%
Measurement Year 2014	Remeasurement 5	588	1,113	52.83%	54.48%
Measurement Year 2015	Remeasurement 6	1,188	2,173	54.67%	56.28%
Measurement Year 2016	Remeasurement 7	1,252	2,319	53.99%	59.56%
Measurement Year 2017	Remeasurement 8	1,242	2,424	51.24%	57.47%
Measurement Year 2018	Remeasurement 9	1,254	2,274	55.15%	58.01%
Measurement Year 2019	Remeasurement 10	1,361	2,236	60.87%	56.57%
Measurement Year 2020	Remeasurement 11	1,471	2,281	64.49%	64.29%
Measurement Year 2021	Remeasurement 12	1,793	2,557	70.12%	67.74%
Measurement Year 2022	Remeasurement 13	1,737	2,491	69.73%	71.26%
Measurement Year 2023	Remeasurement 14	1,408	2,015	69.88%	74.16%
Measurement Year 2024	Remeasurement 15	1,165	1,697	68.65%	76.65%

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

Table 15: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 2 Summary – Developmental Screening, Measurement Year 2024

Quality Improvement Project 2 Summary
<p>Title: Developmental Screening in the 1st, 2nd, 3rd Years of Life Start Year: 2015. End Year: Not yet determined. Validation Summary: There were no validation findings indicating that the credibility of the performance improvement project results was at risk.</p>
<p><u>Aim</u> UnitedHealthcare Community Plan of Rhode Island aimed to increase the percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first, second, and third birthdays.</p> <p><u>Indicators of Performance</u></p> <ul style="list-style-type: none">▪ Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their first birthday.▪ Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their second birthday.▪ Percentage of children who were screened for risks of developmental, behavioral, and social delays using standardized screening tools in the 12 months preceding their third birthday. <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Published an article on the importance of preventive care in the member newsletter.▪ Continued to organize, participate in, and/or fund community outreach events throughout the year to promote childhood and adult annual visits and behavioral health care.▪ Continued live agent outreach calls to parents and guardians to members in need of a well-child visit and or lead screening.▪ Launched a \$25 rewards incentive program to encourage members aged 3-21 years to complete a well-child visit no later than the last day of the measurement year. <p><u>Provider-Focused 2024 Interventions</u></p> <ul style="list-style-type: none">▪ Continued to equip accountable entities with patient specific data to assist with targeted outreach.

Table 16: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 2 Indicator Summary – First Year Developmental Screening, Measurement Years 2014 to 2024

Developmental Screening – By Age 1					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014 ¹	Baseline	57	137	41.61%	60.00%
Measurement Year 2015 ²	Remeasurement 1	505	1,517	33.29%	60.00%
Measurement Year 2016 ¹	Remeasurement 2	74	137	54.01%	60.00%
Measurement Year 2017 ¹	Remeasurement 3	79	137	57.66%	50.00%
Measurement Year 2018 ¹	Remeasurement 4	88	137	64.23%	50.00%
Measurement Year 2019 ¹	Remeasurement 5	92	137	67.15%	50.00%
Measurement Year 2020 ¹	Remeasurement 6	107	134	79.85%	50.00%
Measurement Year 2021 ¹	Remeasurement 7	111	137	81.02%	50.00%
Measurement Year 2022 ¹	Remeasurement 8	113	137	82.48%	79.00%
Measurement Year 2023 ¹	Remeasurement 9	115	137	83.94%	79.00%
Measurement Year 2024 ¹	Remeasurement 10	111	137	81.02%	79.00%

¹ Rate calculated using the hybrid methodology.

² Rate calculated using the administrative methodology.

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

Table 17: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 2 Indicator Summary – Second Year Developmental Screening, Measurement Years 2014 to 2024

Developmental Screening – By Age 2					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014 ¹	Baseline	67	137	48.91%	60.00%
Measurement Year 2015 ²	Remeasurement 1	549	1,237	44.38%	60.00%
Measurement Year 2016 ¹	Remeasurement 2	79	137	57.66%	60.00%
Measurement Year 2017 ¹	Remeasurement 3	79	137	57.66%	50.00%
Measurement Year 2018 ¹	Remeasurement 4	90	137	65.69%	50.00%
Measurement Year 2019 ¹	Remeasurement 5	101	137	73.72%	50.00%
Measurement Year 2020 ¹	Remeasurement 6	109	135	80.74%	50.00%
Measurement Year 2021 ¹	Remeasurement 7	108	137	78.83%	50.00%
Measurement Year 2022 ¹	Remeasurement 8	123	137	89.78%	79.00%
Measurement Year 2023 ¹	Remeasurement 9	115	137	83.94%	79.00%
Measurement Year 2024 ¹	Remeasurement 10	113	137	82.48%	79.00%

¹ Rate calculated using the hybrid methodology.

² Rate calculated using the administrative methodology.

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

Table 18: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 2 Indicator Summary – Third Year Developmental Screening, Measurement Years 2014 to 2024

Developmental Screening - By Age 3					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2014 ¹	Baseline	60	137	43.80%	60.00%
Measurement Year 2015 ²	Remeasurement 1	570	1,313	43.41%	60.00%
Measurement Year 2016 ¹	Remeasurement 2	81	137	59.12%	60.00%
Measurement Year 2017 ¹	Remeasurement 3	78	137	56.93%	50.00%
Measurement Year 2018 ¹	Remeasurement 4	82	137	59.85%	50.00%
Measurement Year 2019 ¹	Remeasurement 5	86	137	62.77%	50.00%
Measurement Year 2020 ¹	Remeasurement 6	115	142	80.99%	50.00%
Measurement Year 2021 ¹	Remeasurement 7	106	137	77.37%	50.00%
Measurement Year 2022 ¹	Remeasurement 8	112	137	81.75%	79.00%
Measurement Year 2023 ¹	Remeasurement 9	105	137	76.64%	79.00%
Measurement Year 2024 ¹	Remeasurement 10	112	137	81.75%	79.00%

¹ Rate calculated using the hybrid methodology.

² Rate calculated using the administrative methodology.

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

Table 19: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 3 Summary – Lead Screening, Measurement Year 2024

Quality Improvement Project 3 Summary
<p>Title: Improving Lead Screening in Children Start Year: 2017. End Year: Not yet determined. Validation Summary: There were no validation findings indicating that the credibility of the performance improvement project results was at risk.</p>
<p><u>Aim</u> UnitedHealthcare Community Plan of Rhode Island aimed to increase the percentage of members two years of age who received one or more capillary or venous blood tests for lead poisoning on or before their second birthday.</p> <p><u>Indicator of Performance</u> HEDIS <i>Lead Screening in Children</i>: The percentage of members 2 years of age who received one or more capillary or venous blood tests for lead poisoning on or before their second birthday.</p> <p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Continued targeted outreach to parents and guardians for Early and Periodic Screening, Diagnostic, and Treatment via interactive voice recordings, text message service, or email with a reminder to complete a lead screening. ▪ Continued live outreach to parents/guardians of members to provide education and assistance with obtaining a lead screening. ▪ Launched a \$25 rewards incentive program to encourage members aged 2 years to complete a lead screening. ▪ Published articles on the importance of preventive care and annual wellness visits in the member newsletter. <p><u>Provider-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Continued to equip accountable entities with patient specific data to assist with targeted outreach.

Table 20: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 3 Indicator Summary – Lead Screening, Measurement Years 2016 to 2024

HEDIS Lead Screening in Children					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2016 ²	Baseline 1	1,174	1,547	75.89%	84.77%
Measurement Year 2017 ¹	Remeasurement 1	315	411	76.64%	86.37%
Measurement Year 2018 ²	Remeasurement 2	1,320	1,778	74.24%	85.64%
Measurement Year 2019 ¹	Remeasurement 3	316	411	76.89%	85.90%
Measurement Year 2020 ²	Remeasurement 4	1,027	1,436	71.52%	86.62%
Measurement Year 2021 ¹	Remeasurement 5	288	411	70.07%	83.94%
Measurement Year 2022 ¹	Remeasurement 6	300	411	72.99%	79.57%
Measurement Year 2023 ¹	Remeasurement 7	301	411	73.24%	79.26%
Measurement Year 2024 ²	Remeasurement 8	818	1,097	74.57%	82.86%

¹ Rate calculated using the hybrid methodology.

² Rate calculated using the administrative methodology.

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

Table 21: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 4 Summary – Breast Cancer Screening, Measurement Year 2024

Quality Improvement Project 4 Summary	
<p>Title: Improving Breast Cancer Screening Start Year: 2018. End Year: Not yet determined. Validation Summary: There were no validation findings indicating that the credibility of the performance improvement project results was at risk.</p>	
<p><u>Aim</u> UnitedHealthcare Community Plan of Rhode Island aimed to increase the percentage of women aged 50-74 years who had a mammogram.</p>	
<p><u>Indicator of Performance</u> HEDIS <i>Breast Cancer Screening</i>: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer.</p>	
<p><u>Member-Focused 2024 Interventions</u></p> <ul style="list-style-type: none"> ▪ Continued the member incentive for a timely mammogram. ▪ Participated in community events to provide member education on the importance of timely breast cancer screenings. ▪ Published articles in the member newsletter. ▪ Continued targeted outreach to members via interactive voice recordings, text message service, or email with a reminders on women’s health screenings and the importance of mammograms. 	
<p><u>Managed Care Plan-Focused 2024 Intervention</u></p> <ul style="list-style-type: none"> ▪ Continued collaborating with and funding community-based events to expand education efforts. 	

Table 22: UnitedHealthcare Community Plan of Rhode Island’s Quality Improvement Project 4 Indicator Summary – Breast Cancer Screening, Measurement Years 2017 to 2024

HEDIS Breast Cancer Screening					
Measurement Period	Measurement Phase	Numerator	Denominator	Results	Goal
Measurement Year 2017	Baseline 1	2,834	4,551	62.27%	70.29%
Measurement Year 2018	Remeasurement 1	2,882	4,690	61.45%	68.94%
Measurement Year 2019	Remeasurement 2	2,826	4,480	63.33%	69.23%
Measurement Year 2020	Remeasurement 3	2,973	5,004	59.41%	69.22%
Measurement Year 2021	Remeasurement 4	3,330	5,669	58.74%	63.77%
Measurement Year 2022	Remeasurement 5	4,292	7,024	61.10%	61.27%
Measurement Year 2023	Remeasurement 6	3,408	5,441	62.64%	62.67%
Measurement Year 2024	Remeasurement 7	2,533	4,099	61.80%	66.31%

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

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 **UnitedHealthcare Community Plan of Rhode Island’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** 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 **UnitedHealthcare Community Plan of Rhode Island’s** 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

UnitedHealthcare Community Plan of Rhode Island’s 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	Reportable. A reportable rate was submitted for the measure.
NA	Small Denominator. The organization followed the specifications, but the denominator was too small (e.g., 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	No Benefit. The organization did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	Not Reported. The organization chose not to report the measure.
NQ	Not Required. The organization was not required to report the measure.
BR	Biased Rate. The calculated rate was materially biased.
UN	Unaudited. The organization chose to report a measure that is not required to be audited. This result only applies when permitted by NCQA.

NCQA: National Committee for Quality Assurance.

UnitedHealthcare Community Plan of Rhode Island's HEDIS compliance auditor produced a final audit report and audit review table at the conclusion of the audit. Together, these documents present a comprehensive summary of the audit activities and performance measure validation results. Each managed care plan submitted these documents, as well as final validated performance measure rates to the Rhode Island Executive Office of Health and Human Services and IPRO.

IPRO reviewed **UnitedHealthcare Community Plan of Rhode Island's** final audit report and audit review table to confirm that all performance measures were deemed reportable by the HEDIS auditor, and that calculation of these performance measures aligned with 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 **UnitedHealthcare Community Plan of Rhode Island's** final audit report and a locked copy of the audit review table that were produced by the HEDIS compliance auditor.

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

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

Comparative Results

Validation of Performance Measures

UnitedHealthcare Community Plan of Rhode Island's 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. **UnitedHealthcare Community Plan's** HEDIS auditor reported that "an opportunity for improvement of clinical data source quality was apparent over the course of the audit." **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	UnitedHealthcare Community Plan of Rhode Island
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	UnitedHealthcare Community Plan of Rhode Island
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 **UnitedHealthcare Community Plan of Rhode Island’s** 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 **UnitedHealthcare Community Plan of Rhode Island’s** 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	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2021	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2022	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2023	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2024	Quality Compass Measurement Year 2024 National Medicaid Benchmark (Met/Exceeded)	Quality Compass Measurement Year 2024 National Medicaid Mean
Use of Services						
Well-Child Visits in the First 30 Months of Life						
<i>First 15 Months</i>	64.22%	68.09%	65.53%	71.80%	90th	61.92%
<i>First 15 to 30 Months</i>	74.71%	76.34%	82.02%	81.23%	75th	72.84%
Child and Adolescent Well-Care Visits, Ages 3-21 Years	60.24%	59.86%	63.78%	64.92%	75th	55.41%
Effectiveness of Care						
Cervical Cancer Screening for Women (Hybrid)	65.21%	65.94%	66.91%	62.29%	66.67th	56.91%
Cervical Cancer Screening for Women (Electronic)	Not Applicable	Not Applicable	Not Applicable	59.74%	75th	51.82%
Chlamydia Screening for Women, Ages 16-20 Years	60.24%	59.66%	61.55%	66.17%	75th	53.32%
Childhood Immunization Status						
<i>Combination 3</i>	76.89%	78.59%	76.89%	73.97%	75th	66.18%
<i>Combination 10</i>	63.26%	55.96%	52.07%	45.74%	95th	28.17%
Follow-Up After Hospitalization for Mental Illness						
<i>7-Day, Ages 6-65+ Years</i>	56.29%	52.86%	55.06%	56.46%	75th	40.70%
<i>30-Day, Ages 6-65+ Years</i>	76.31%	72.79%	73.69%	74.05%	75th	61.25%
Glycemic Status Assessment for Patients With Diabetes - Glycemic Status <8.0%	New Measure in 2022	55.96%	61.07%	65.94%	75th	58.65%
Access and Availability						
Adults' Access to Preventive/Ambulatory Health Services						
<i>Ages 20-44 Years</i>	75.23%	72.87%	75.98%	75.81%	50th	74.39%
<i>Ages 45-64 Years</i>	84.52%	82.81%	85.12%	84.40%	50th	82.23%
<i>Ages 65+ Years</i>	81.79%	77.65%	78.52%	79.14%	33.33rd	82.59%
Prenatal and Postpartum Care						
<i>Timeliness of Prenatal Care</i>	84.67%	89.29%	90.75%	93.67%	90th	84.87%
<i>Postpartum Care</i>	82.73%	86.37%	87.35%	87.59%	75th	80.76%

In accordance with *Title 42 Code of Federal Regulations 438.6(c)(2)(ii)(B)*, accountable entity quality performance must be measured and reported to the Rhode Island Executive Office of Health and Human Services. For performance year 2024, rates of eight measures from the ‘Medicaid Comprehensive Accountable Entity Common Measure Slate’ were categorized as ‘P4P’ and included in the Office of Health Human Services’ calculation of shared savings distribution to the accountable entities.

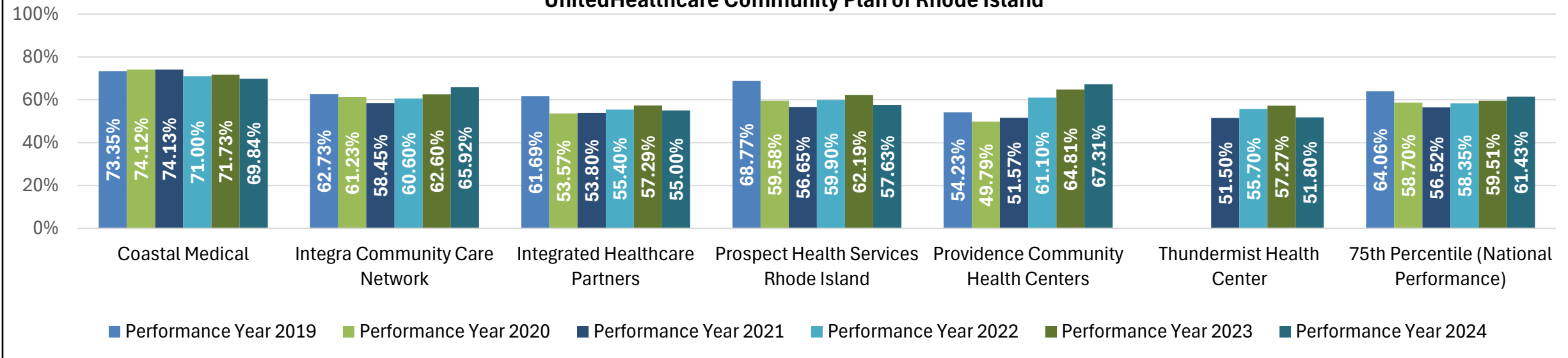
For performance year 2024, **UnitedHealthcare Community Plan of Rhode Island** maintained contracts with accountable entities. **Table 29** displays the accountable care entities that were contracted by **UnitedHealthcare Community Plan of Rhode Island** for performance year 2024.

Table 29: Accountable Entities, 2024

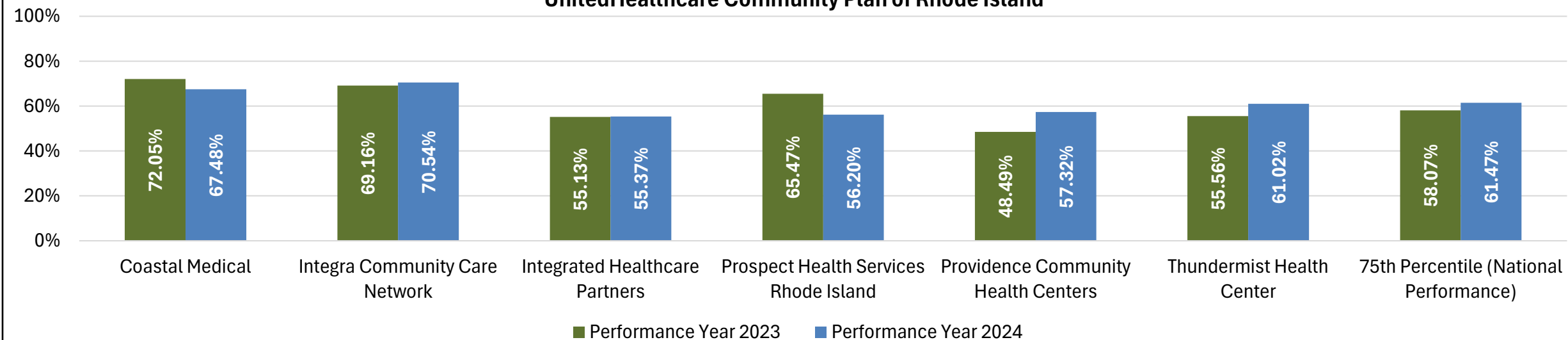
Managed Care Plan	Accountable Entity
UnitedHealthcare Community Plan of Rhode Island	<ul style="list-style-type: none"> ▪ Coastal Medical (also known as Brown Health) ▪ Integra Community Care Network ▪ Integrated Healthcare Partners ▪ Prospect Health Services Rhode Island (also known as Astrana Health) ▪ Providence Community Health Centers ▪ Thundermist Health Center

When available, rates for performance years 2019, 2020, 2021, 2022, 2023, and 2024 for **UnitedHealthcare Community Plan of Rhode Island’s** accountable entities are displayed in figures that follow.

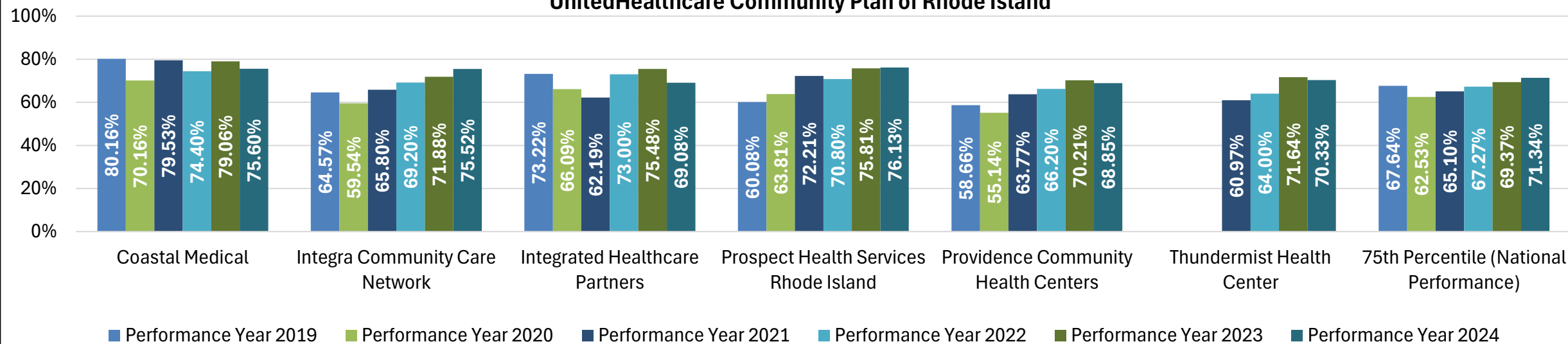
**Figure 1. Breast Cancer Screening,
UnitedHealthcare Community Plan of Rhode Island**



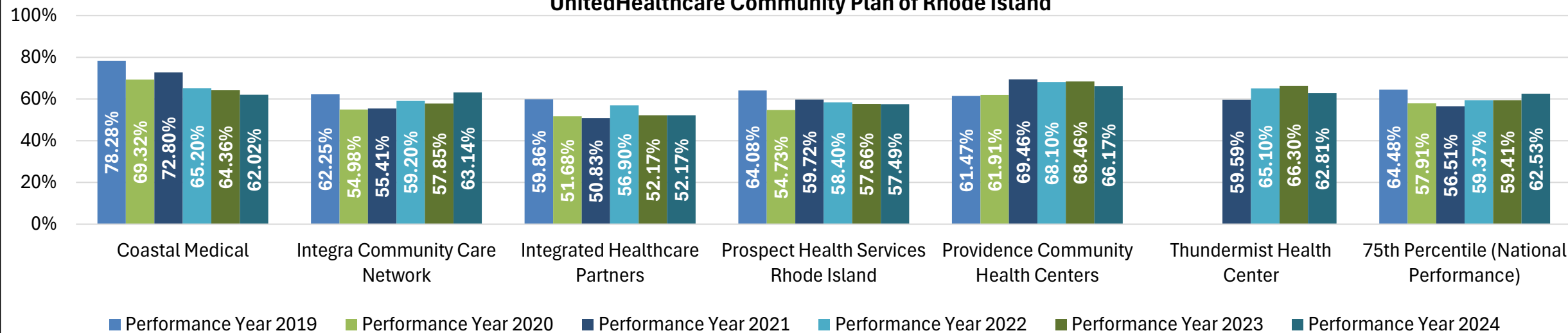
**Figure 2. Child and Adolescent Well-Care Visits (Ages 3-21 Years),
UnitedHealthcare Community Plan of Rhode Island**



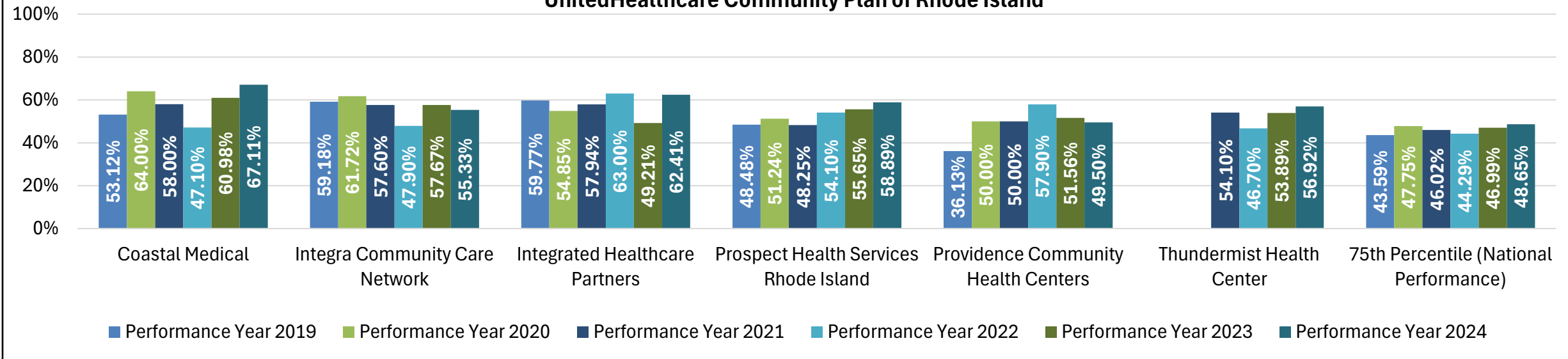
**Figure 3. Controlling High Blood Pressure,
UnitedHealthcare Community Plan of Rhode Island**



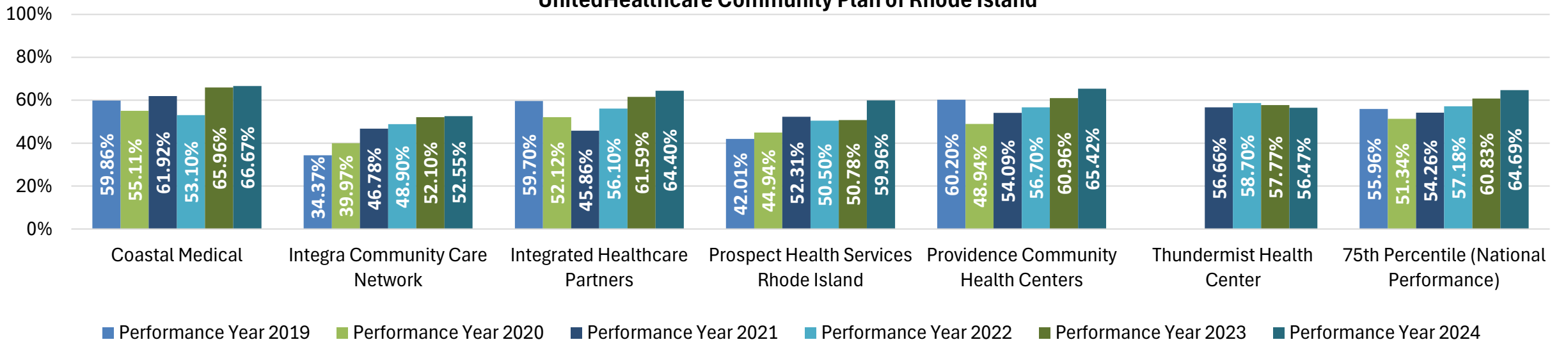
**Figure 4. Eye Exam for Patients With Diabetes,
UnitedHealthcare Community Plan of Rhode Island**



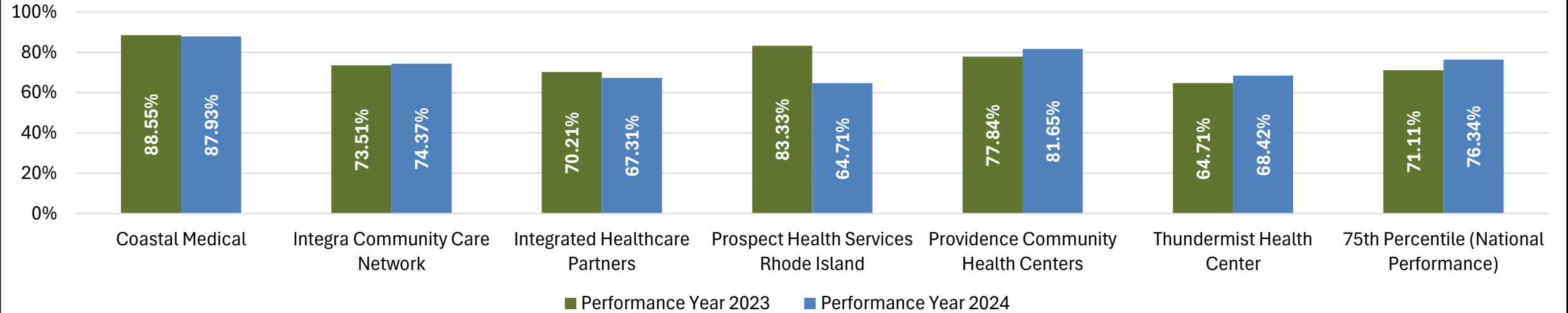
**Figure 5. Follow-up After Hospitalization for Mental Illness (7-day),
UnitedHealthcare Community Plan of Rhode Island**



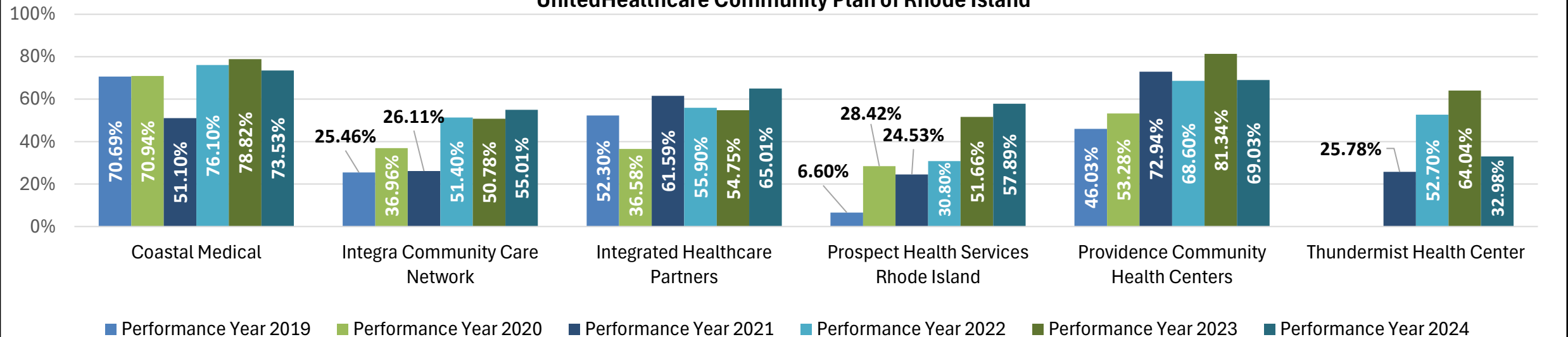
**Figure 6. Glycemic Status Assessment for Patients With Diabetes - Glycemic Status <8.0%,
UnitedHealthcare Community Plan of Rhode Island**



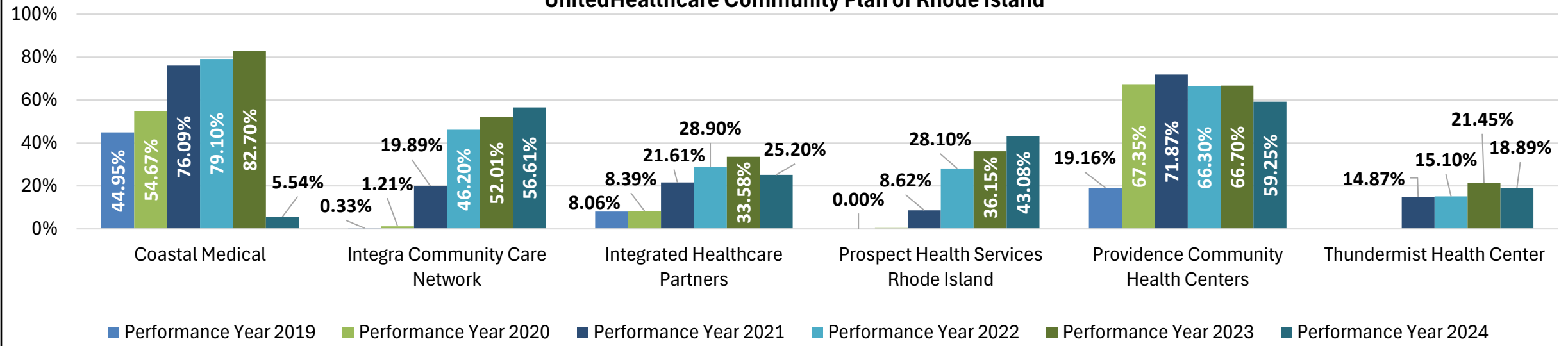
**Figure 7. Lead Screening in Children,
UnitedHealthcare Community Plan of Rhode Island**



**Figure 8. Screening for Depression and Follow-up Plan,
UnitedHealthcare Community Plan of Rhode Island**



**Figure 9. Social Determinants of Health Screening,
UnitedHealthcare Community Plan of Rhode Island**



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 **UnitedHealthcare Community Plan of Rhode Island** 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 30 displays **UnitedHealthcare Community Plan of Rhode Island’s** compliance with federal Medicaid and Children’s Health Insurance Program standards captured during the most recent NCQA Accreditation Survey. **UnitedHealthcare Community Plan of Rhode Island’s** accreditation was granted by NCQA on December 6, 2023 with an expiration date of December 6, 2026.

Table 30: Evaluation of Managed Care Plan Compliance with Federal Medicaid and Children’s Health Insurance Program Standards, 2024

Federal Medicaid Standard	UnitedHealthcare Community Plan of Rhode Island
438.56 Disenrollment requirements and limitations	Met
438.100 Enrollee rights and requirements	Met
438.114 Emergency and poststabilization services	Met
438.206 Availability of services	Met
438.207 Assurances of adequate capacity and services	Met
438.208 Coordination and continuity of care	Met
438.210 Coverage and authorization of services	Met
438.214 Provider selection	Met
438.224 Confidentiality	Met
438.228 Grievance and appeal system	Met
438.230 Sub-contractual relationships and delegation	Met
438.236 Practice guidelines	Met
438.242 Health information systems	Met
438.330 Quality assessment and performance improvement program	Met

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

Objectives

Title 42 Code of Federal Regulations 438.68 Network adequacy standards requires states that contract with a managed care plan to develop and enforce time and distance standards for the following provider types: adult and pediatric primary care, obstetrics/gynecology, adult and pediatric behavioral health (for mental health and substance use disorder), adult and pediatric specialists, hospitals, pediatric dentists, and long-term services and support. The 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 31**.

Table 31: Rhode Island Medicaid Managed Care Network Standards

Rhode Island Medicaid Managed Care Access Standards
Time and Distance Standards
▪ Primary Care, Adult and Pediatric Within 20 Minutes or 20 Miles
▪ OB/GYN Within 45 Minutes or 30 Miles
▪ Top 5 Adult Specialties Within 30 Minutes or 30 Miles
▪ Top 5 Pediatric Specialties Within 45 Minutes or 45 Miles
▪ Hospital Within 45 Minutes or 30 Miles
▪ Pharmacy Within 10 Minutes or 10 Miles
▪ Imaging Within 45 Minutes or 30 Miles
▪ Ambulatory Surgery Centers Within 45 Minutes or 30 Miles
▪ Dialysis Within 30 Minutes or 30 Miles
▪ Outpatient Behavioral/Mental Health Adult Prescribers Within 30 Minutes or 30 Miles
▪ Outpatient Behavioral/Mental Health Pediatric Prescribers Within 45 Minutes or 45 Miles
▪ Outpatient Behavioral/Mental Health Adult Non-Prescribers Within 20 Minutes or 20 Miles
▪ Outpatient Behavioral/Mental Health Pediatric Non-Prescribers Within 20 Minutes or 20 Miles
▪ Outpatient Behavioral Health Substance Use Prescribers Within 30 Minutes or 30 Miles
▪ Outpatient Behavioral Health Substance Use Non-Prescribers Within 20 Minutes or 20 Miles
Appointment Standards
▪ After-Hours Care (telephone) Available 24 Hours a Day, 7 Days a Week
▪ Emergency Care Available Immediately
▪ Urgent Care Within 24 Hours
▪ Routine Care Within 30 Calendar Days
▪ Physical Exam Within 180 Calendar Days
▪ EPSDT Within 6 Weeks
▪ New Member Within 30 Calendar Days
▪ Non-Emergent or Non-Urgent Mental Health or Substance Use Services Within 10 Calendar Days
Member-to-Primary Care Provider Ratio Standards
▪ No more than 1,500 members to any single primary care provider

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

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

UnitedHealthcare Community Plan of Rhode Island 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.

UnitedHealthcare Community Plan of Rhode Island primary care access standard is one provider in 10 miles; and for OB/GYN providers, the access standard is one provider in in 30 miles. **UnitedHealthcare Community Plan of Rhode Island** reports access data to NCQA on annual basis.

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

Description of Data Obtained

IPRO's evaluation was performed using network data submitted by **UnitedHealthcare Community Plan of Rhode Island** in the *annual Network Accessibility and Availability Adequacy Report* for 2024 and in **UnitedHealthcare Community Plan of Rhode Island's Access Survey Report** for January 2024 and July 2024.

Comparative Results

Network Adequacy Validation Results

UnitedHealthcare Community Plan of Rhode Island evaluated network adequacy using acceptable methodologies. Table 32 displays the results of IPRO’s validation of network adequacy for the UnitedHealthcare Community Plan of Rhode Island’s and Children’s Health Insurance Program network.

Table 32: Managed Care Plan Network Adequacy Validation Results, Measurement Year 2024

Information Systems Capabilities Assessment Results Issued by IPRO	
Topic Under Review	UnitedHealthcare Community Plan of Rhode Island
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 33 shows the percentage of members for whom the geographic access standards were met. The results of this analysis show that UnitedHealthcare Community Plan of Rhode Island met the 90% goal for member geographic access for all provider types reported.

Table 33: UnitedHealthcare Community Plan of Rhode Island’s Geo Access Provider Network Accessibility, 2024

Provider Specialty	Access to Provider Standard ¹	% of Members With Access in 2024	Goal = 90% Met/Not Met
Adult Primary Care Providers (Total)	1 in 10 Miles	100%	Met
Family/General Practice	1 in 10 Miles	100%	Met
Internal Medicine	1 in 10 Miles	100%	Met
Pediatrics	1 in 10 Miles	98%	Met
Cardiology High Volume, High Impact Specialist	1 in 20 Miles	100%	Met
Obstetrics/Gynecology High Volume Specialist	1 in 30 Miles	100%	Met
Oncology/Hematology High Impact Specialist	1 in 30 Miles	100%	Met
Ophthalmology High Volume Specialist	1 in 20 Miles	100%	Met

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

Table 38 displays aggregate results of the secret shopper appointment availability surveys conducted by **UnitedHealthcare Community Plan of Rhode Island** in January 2024 and July 2024. Availability of both routine and urgent care appointments was assessed for a variety of provider types.

Table 34: UnitedHealthcare Community Plan of Rhode Island’s Appointment Availability for Network Providers, January 2024, and July 2024

Appointment Type/Provider Specialty	Number of Providers Surveyed	Number of Appointments Made	Appointment Rate	Rate of Timely Appointments Made ¹
Primary Care Routine Appointments				
Family/General/Internal	14	2	14.3%	7.1%
Pediatricians	16	0	0.0%	0.0%
Obstetrics/Gynecology	13	4	30.8%	30.8%
Primary Care Urgent Appointments				
Family/General/Internal	12	0	0.0%	0.0%
Pediatricians	11	0	0.0%	0.0%
Obstetrics/Gynecology	12	4	33.3%	8.3%
Adult Specialty Care Routine Appointments				
Cardiology	8	2	25.0%	12.5%
Dermatology	8	0	0.0%	0.0%
Endocrinology	3	0	0.0%	0.0%
Gastroenterology	7	1	14.3%	0.0%
Pulmonary	2	0	0.0%	0.0%
Adult Specialty Care Urgent Appointments				
Cardiology	8	0	0.0%	0.0%
Dermatology	8	2	25.0%	12.5%
Endocrinology	3	0	0.0%	0.0%
Gastroenterology	5	2	40.0%	11.1%
Pulmonary	5	0	0.0%	0.0%
Pediatric Specialty Care Routine Appointments				
Allergy/Immunology	7	2	28.6%	28.6%
Gastroenterology	5	0	0.0%	0.0%
Neurology	5	1	20.0%	0.0%
Orthopedics	8	3	37.5%	37.5%
Otolaryngology/Ear, Nose and Throat	8	0	0.0%	0.0%
Pediatric Specialty Care Urgent Appointments				
Allergy/Immunology	6	0	0.0%	0.0%
Gastroenterology	4	0	0.0%	0.0%
Neurology	7	0	0.0%	0.0%
Orthopedics	8	1	12.5%	12.5%
Otolaryngology/Ear, Nose and Throat	7	0	0.0%	0.0%
Behavioral Health Care Routine Appointments				
Adult Behavioral Health	4	0	0.0%	0.0%
Pediatric/Adolescent Behavioral Health	4	1	25.0%	25.0%

¹The 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 35 provides a summary of **UnitedHealthcare Community Plan of Rhode Island's** technical methods of data collection for each survey.

Table 35: CAHPS Technical Methods of Data Collection, Measurement Year 2024

Managed Care Plan/Methodology Element	Adult CAHPS Survey	Child CAHPS Survey
UnitedHealthcare Community Plan of Rhode Island		
Survey Tool	5.1H Medicaid Adult	5.1H Medicaid Child with Chronic Conditions Supplemental Items Set
Survey Timeframe	2/14/2025 to 5/1/2025	2/14/2025 to 5/1/2025
Method of Collection	Mail, Telephone, Internet	Mail, Telephone, Internet
Sample Size	2,430	1,980
Response Rate	10.5%	8.3%

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

Table 36: CAHPS Categories and Response Options

Category/Measure	Response Options
Composite Measures	
<ul style="list-style-type: none"> ▪ Getting Needed Care ▪ Getting Care Quickly ▪ How Well Doctors Communicate ▪ Coordination of Care ▪ Customer Service 	Never, Sometimes, Usually, Always <i>(Top-level performance is considered responses of “usually” or “always.”)</i>
Global Rating Measures	
<ul style="list-style-type: none"> ▪ Rating of All Health Care ▪ Rating of Personal Doctor ▪ Rating of Specialist Talked to Most Often ▪ Rating of Health Plan 	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 **UnitedHealthcare Community Plan of Rhode Island’s** 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 37 displays **UnitedHealthcare Community Plan of Rhode Island's** results of the 2025 CAHPS Adult Medicaid Survey for measurement years 2020, 2021, 2022, 2023, and 2024 while **Table 38** displays **UnitedHealthcare Community Plan of Rhode Island's** 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 37: Managed Care Plan Medicaid Adult Population CAHPS Results, Measurement Years 2020, 2021, 2022, 2023, and 2024

Measures	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2020	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2021	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2022	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2023	UnitedHealthcare Community Plan of Rhode Island 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 ¹	78.6%	80.4%	76.3%	85.2%	54.30%	<10th	76.48%
Rating of Personal Doctor ¹	82.4%	82.4%	83.2%	85.1%	65.67%	<10th	84.56%
Rating of Specialist ¹	Small Sample	Small Sample	82.0%	88.8%	67.24%	<10th	83.06%
Rating of Health Plan ¹	80.6%	84.5%	81.9%	82.4%	59.92%	<10th	77.61%
Getting Care Quickly ²	82.0%	Small Sample	84.9%	90.3%	80.81%	33.33rd	81.57%
Getting Needed Care ²	81.4%	Small Sample	84.9%	86.6%	81.14%	33.33rd	82.05%
How Well Doctors Communicate ²	90.6%	94.6%	92.2%	95.7%	92.38%	25th	93.37%
Customer Service ²	Small Sample	Small Sample	Small Sample	Small Sample	88.41%	33.33rd	89.27%
Coordination of Care ²	Small Sample	Small Sample	Small Sample	Small Sample	79.81%	<10th	85.94%

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

² Rates reflect responses of “always” or “usually.”

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

Table 38: Managed Care Plan Medicaid General Child Population CAHPS Results, Measurement Years 2020, 2021, 2022, 2023, and 2024

Measures	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2020	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2021	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2022	UnitedHealthcare Community Plan of Rhode Island Measurement Year 2023	UnitedHealthcare Community Plan of Rhode Island 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 ¹	88.4%	Small Sample	Small Sample	Small Sample	86.49%	33.33rd	87.35%
Rating of Personal Doctor ¹	95.1%	94.3%	90.4%	89.4%	90.00%	33.33rd	90.59%
Rating of Specialist ¹	Small Sample	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	87.36%
Rating of Health Plan ¹	92.4%	86.8%	80.5%	88.6%	90.26%	75th	86.50%
Getting Care Quickly ²	Small Sample	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	86.20%
Getting Needed Care ²	Small Sample	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	83.95%
How Well Doctors Communicate ²	95.6%	94.1%	Small Sample	Small Sample	94.10%	50th	93.95%
Customer Service ²	Small Sample	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	88.21%
Coordination of Care ²	Small Sample	Small Sample	Small Sample	Small Sample	Small Sample	Not Applicable	84.90%

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

² Rates reflect responses of “always” or “usually.”

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

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

Objectives

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

Section 2.13.06 *Provider Satisfaction Report* of the *Medicaid Managed Care Services Agreement* requires the Medicaid managed care plan to sponsor a satisfaction survey for all Medicaid network providers. The goal of the survey is to get feedback from these providers about how they view the Medicaid program and the managed care plan. The 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

UnitedHealthcare Community Plan of Rhode Island utilized a homegrown survey tool for measurement year 2024. Key metrics were maintained to allow UnitedHealthcare Community Plan of Rhode Island to trend performance year-over-year. **Table 39** provides a summary of the technical methods of data collection.

Table 39: UnitedHealthcare Community Plan of Rhode Island’s Provider Satisfaction Survey Technical Methods of Data Collection, Measurement Year 2024

Methodology Element	Provider Satisfaction Survey
Survey Tool	UnitedHealthcare Community Plan of RI Provider Satisfaction Survey (non-standard)
Survey Timeframe	November 2024 to December 2024
Program	Managed Medicaid
Provider Types	Primary Care Providers and Specialists
Method of Collection	Mail, Email, QR Code
Sample Size	2500194
Response Rate	5.44%

There was variation between the 2024 survey instrument and historical versions making trending not possible for some measures. **Table 40** displays the survey’s measure categories and possible response options.

Table 40: UnitedHealthcare Community Plan of Rhode Island’s Provider Satisfaction Survey Categories and Response Options

Measure Category	Response Options
<ul style="list-style-type: none"> ▪ Satisfaction with...[policy/service] 	<p>0 – 5 Scale 1=Very Dissatisfied 5= Very Satisfied <i>Responses of “4” and “5” were evaluated as top box performance.</i></p>
<ul style="list-style-type: none"> ▪ Ease of...[process] 	<p>0 – 5 Scale 1=Very Dissatisfied 5=Very Satisfied Responses of “4” and “5” were evaluated as top box performance.</p>

Survey responses were captured using a Likert scale of 1 (very dissatisfied) to 5 (very satisfied). Responses of “4” and “5” were evaluated as top box performance. Key question categories with some changes made in measurement year 2024 aimed at refining content and streamlining layout to improve respondent rate.

Description of Data Obtained

IPRO received a copy of **UnitedHealthcare Community Plan of Rhode Island’s 2024 Provider Satisfaction Summary**. This document presented the metrics evaluated and performance rates at the state and national levels.

Comparative Results

Key question categories were updated in measurement year 2024 to refine content and streamline the layout, improving response rates. **Table 41** displays provider survey measures and results for **UnitedHealthcare Community Plan of Rhode Island** for measurement years 2021, 2022, 2023, and 2024. Results in this table reflect response scores of “4” or “5.”

Table 41: UnitedHealthcare Community Plan of Rhode Island’s Provider Satisfaction Survey Results, Measurement Years 2021, 2022, 2023, and 2024

Measure	UnitedHealthcare Community Plan of Rhode Island’s Provider Satisfaction Survey Results			
	Measurement Year 2021 (n=43)	Measurement Year 2022 (n=31)	Measurement Year 2023 (n=38)	Measurement Year 2024 (n=136)
Ease of Credentialing	20%	26%	19%	48%
Ease of Contracting	21%	25%	18%	49%
Quality of the Network	31%	41%	21%	51%
Availability of Specialists to Accommodate Referrals	26%	39%	15%	50%
Ease of Prior Authorization for Inpatient/Outpatient ¹	3%	17%	19%	37%
Ease of Prior Authorization for Pharmacy	10%	13%	12%	41%
Accuracy of Claims Processing on First Submission	14%	16%	26%	39%
Ease of Appeals ¹	9%	20%	19%	36%
Overall Satisfaction with Customer Service ¹	5%	18%	14%	42%
Ease of Accessing Information	11%	21%	20%	38%
Overall Satisfaction with UnitedHealthcare	12%	19%	16%	46%
Easy to Get Answers to Questions ¹	10%	17%	16%	46%
Policies are Aligned with the Latest Evidence Based Best Practices ¹	8%	15%	19%	37%

¹Due to significant changes to the technical specifications for measure calculation, measurement year 2024 rates cannot be trended.

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

Table 42: 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 43**.

Table 43: NCQA Health Plan Star Rating Scale

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

Description of Data Obtained

IPRO accessed the NCQA Health Plan Reports website¹³ 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

UnitedHealthcare Community Plan of Rhode Island was compliant with the state's requirement to achieve and maintain NCQA Accreditation. **UnitedHealthcare Community Plan of Rhode Island's** *Accredited* status is effective December 6, 2023 to December 6, 2026. **UnitedHealthcare Community Plan of Rhode Island** achieved overall health plan star ratings of 4.0 out of 5 for the *Health Plan Ratings 2025*.

UnitedHealthcare Community Plan of Rhode Island 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 44 displays each managed care plan's overall health plan star ratings, as well as the ratings for the three overarching categories (patient experience, prevention and equity, and treatment) and their subcategories under review.

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

Table 44: 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>
	UnitedHealthcare Community Plan of Rhode Island 1.0 Stars Overall
Patient Experience	2.5 Stars
Getting Care (2)	3.0 Stars
Satisfaction with Plan Physicians (1)	2.0 Stars
Satisfaction with Plan and Plan Services (2)	2.5 Stars
Prevention and Equity	4.0 Stars
Children and Adolescent Well Care (3)	4.5 Stars
Women’s Reproductive Health (3)	4.5 Stars
Cancer Screening (2)	4.0 Stars
Description of Membership (2)	3.5 Stars
Other Preventive Services (5)	
Chlamydia Screening	4.0 Stars
Influenza Immunizations for Adults	2.0 Stars
Td/Tdap Immunizations for Adults	4.0 Stars
Zoster Immunizations for Adults	3.0 Stars
Pneumococcal Immunizations for Adults	2.0 Stars
Treatment	3.5 Stars
Respiratory (5)	3.0 Stars
Diabetes (6)	4.0 Stars
Heart Disease (3)	4.0 Stars
Behavioral Health-Care Coordination (4)	3.5 Stars
Behavioral Health-Medication Adherence (3)	4.0 Stars
Behavioral Health-Access, Monitoring and Safety (5)	3.5 Stars
Risk-Adjusted Utilization (1)	1.0 Star
Other Treatment Measures (1)	2.0 Stars

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

Managed Care Plan Responses 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 45** displays the assessment categories used by IPRO to describe managed care plan progress towards addressing the to the 2023 external quality review recommendations.

Table 46 displays **UnitedHealthcare Community Plan of Rhode Island’s** 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 45: Managed Care Plan Response to Recommendation Assessment Levels

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

Table 46: UnitedHealthcare Community Plan of Rhode Island’s Response to the 2023 External Quality Review Recommendations

External Quality Review Activity	2023 External Quality Review Recommendation	UnitedHealthcare Community Plan of Rhode Island’s Response to the 2023 External Quality Review Recommendation	IPRO’s Assessment of UnitedHealthcare Community Plan of Rhode Island’s Response
Quality Improvement Projects	Opportunities for improvement remain for all four quality improvement projects, as UnitedHealthcare Community Plan of Rhode Island did not achieve the established project goals. UnitedHealthcare Community Plan of Rhode Island should consider tailored interventions for subpopulations that have yet to achieve improved outcomes related to the quality improvement topics.	UnitedHealthcare Community Plan of Rhode Island continuously monitors priority quality measures—including AMM, Developmental Screening, LSC, and BCS—using data analytics to identify geographic, member, and provider-level opportunities. The plan works closely with providers, accountable entities, and community-based organizations to address barriers through a multifaceted approach that includes targeted outreach, community investments, culturally and linguistically appropriate member materials, and provider incentives. Performance improved across several measures from MY 2022 to MY 2023, with AMM retired effective January 1, 2025 following NCQA guidance and replaced with WCV, while provider staffing shortages remained a common challenge impacting performance across measures.	Remains an opportunity for improvement.
Performance Measures	UnitedHealthcare Community Plan of Rhode Island should continue efforts to improve member access to preventive and ambulatory services. Additionally, UnitedHealthcare Community Plan of Rhode Island should evaluate whether the current composition of its provider network is contributing to rates related to adult access and chlamydia screening.	UnitedHealthcare Community Plan of Rhode Island continued targeted outreach and incentive strategies to improve preventive care measures, including breast and cervical cancer screening, chlamydia screening, and adult access to care. For CHL, MY 2023 showed improved performance among women ages 21–24, supported by strong practitioner network access, AE pay for reporting alignment, community investments, and multi channel member outreach (letters, email, IVR, SMS, and women’s health campaigns). For AAP, MY 2023 results improved for both age cohorts (20–44 and 65+), driven by provider and AE collaboration, community partnerships, in person House Calls outreach, and sustained member engagement, with no access related barriers identified.	Remains an opportunity for improvement.

External Quality Review Activity	2023 External Quality Review Recommendation	UnitedHealthcare Community Plan of Rhode Island’s Response to the 2023 External Quality Review Recommendation	IPRO’s Assessment of UnitedHealthcare Community Plan of Rhode Island’s Response
Compliance with Medicaid and Children’s Health Insurance Program Standards	None.	Not applicable.	Not applicable.
Network Adequacy	<p>UnitedHealthcare Community Plan of Rhode Island should continue monitoring access to care, specifically Medicaid member access to timely appointments.</p> <p>UnitedHealthcare Community Plan of Rhode Island 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>UHCCP RI’s MY 2023 network analyses confirmed reliable results and demonstrated compliance with Rhode Island Medicaid geographic access standards for nearly 100% of members, as validated in the 2023 External Quality Review report. The plan conducts robust, ongoing access monitoring through CAHPS® feedback, advisory committees, access surveys (including secret shopper), provider directory validation, and quarterly geographic and capacity reporting, with no systemic access deficiencies identified. While staffing shortages—particularly in behavioral health—were identified as a driver of appointment availability challenges, UHCCP RI implemented targeted survey methodology enhancements, provider engagement, and collaboration with Optum and CCBHCs to improve responsiveness and accuracy, supported by one of the most comprehensive provider networks in the state.</p>	Remains an opportunity for improvement.
Quality of Care Surveys – Member Satisfaction	UnitedHealthcare Community Plan of Rhode Island should share the results of the member experience surveys with network providers, along with	UHCCP-RI’s Rating of Personal Doctor CAHPS® score did not meet the goal and trailed the national Medicaid 50th percentile. A cross-functional team reviews CAHPS® results annually to identify opportunities, with feedback indicating concerns about provider communication, visit experience, appointment convenience,	Remains an opportunity for improvement.

External Quality Review Activity	2023 External Quality Review Recommendation	UnitedHealthcare Community Plan of Rhode Island’s Response to the 2023 External Quality Review Recommendation	IPRO’s Assessment of UnitedHealthcare Community Plan of Rhode Island’s Response
	<p>recommendations on how providers can positively impact member experience.</p>	<p>cultural representation, and health literacy. In response, UHCCP-RI implemented provider education and outreach, expanded community-based and member engagement initiatives, and advanced system-wide improvements—including prior authorization reductions, pharmacy enhancements, and digital tools—to simplify care access and improve the overall member experience.</p>	
<p>Quality of Care Surveys – Provider Satisfaction</p>	<p>UnitedHealthcare Community Plan of Rhode Island should investigate low scores that may act as indicators of quality of care, timeliness, and access to care.</p>	<p>UHCCP-RI reviews practitioner survey results through a cross-functional team to identify strengths and develop targeted improvement workplans, informed by ongoing monitoring of grievances, appeals, access surveys, and GEO Access reports, which have not identified gaps in care. In 2024, the practitioner satisfaction survey was redesigned and shortened to improve response rates and clarity for the Medicaid line of business. Based on practitioner feedback and advisory committee input, UHCCP-RI continues to streamline administrative processes—most notably through prior authorization simplification—to improve the experience for both providers and members.</p>	<p>Remains an opportunity for improvement.</p>

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

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

- **Quality** is the degree to which a managed care plan increases the likelihood of desired health outcomes of its enrollees through: (1) its structural and operational characteristics. (2) The provision of health services that are consistent with current professional, evidence-based knowledge. (3) Interventions for performance improvement. (*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 47** for **UnitedHealthcare Community Plan of Rhode Island**. 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 47: UnitedHealthcare Community Plan of Rhode Island’s Strengths, Opportunities, and Recommendations, Measurement Year 2024

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
NCQA Accreditation				
Strengths	UnitedHealthcare Community Plan of Rhode Island maintained NCQA Accreditation status in 2024.	✓	✓	✓
	UnitedHealthcare Community Plan of Rhode Island achieved Health Outcomes Accreditation.	✓	✓	✓
	UnitedHealthcare Community Plan of Rhode Island’s overall star rating was 4 out of 5.	✓	✓	✓
Opportunities	Although UnitedHealthcare Community Plan of Rhode Island achieved a 4.0-star overall NCQA rating, performance varied across domains. Patient Experience rated 2.5 stars, with lower ratings for Satisfaction with Plan Physicians and Satisfaction with the Plan and Plan Services, and Risk-Adjusted Utilization was rated 1.0 star. Selected preventive and treatment measures also performed below the plan’s overall rating, indicating opportunities to improve member experience, utilization management, and consistency across quality domains.	✓	✓	✓
Recommendation	UnitedHealthcare Community Plan of Rhode Island should implement member experience improvement strategies (e.g., improving provider communication and plan service responsiveness), strengthen utilization management practices (e.g., monitoring risk-adjusted utilization patterns and care coordination for high-need members), expand outreach and follow-up to increase adult immunization rates, and apply targeted quality improvement interventions to address identified gaps in treatment measure performance	✓	✓	✓
Performance Improvement Projects				
Strengths	Two (2) of four (4) of UnitedHealthcare Community Plan of Rhode Island quality improvement projects met all validation elements reviewed: Improving Effective Acute Phase Treatment for Major Depression and Developmental Screening in the 1st, 2nd, 3rd Years of Life.			
	Improving Effective Acute Phase Treatment for Major Depression - UnitedHealthcare Community Plan of Rhode Island demonstrated	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	performance improvement from baseline to measurement year 2024 on the single indicator.			
	Developmental Screening in the 1st, 2nd, 3rd Years of Life - UnitedHealthcare Community Plan of Rhode Island demonstrated performance improvement from baseline to measurement year 2024 on all three (3) indicators. Measurement year 2024 rates exceeded established goal rates.	✓	✓	✓
Opportunities	Two (2) of UnitedHealthcare Community Plan of Rhode Island’s quality improvement projects did not meet all validation elements reviewed. Issues related to improvement strategies for the following quality improvement topics were identified: Improving Lead Screening in Children and Improving Breast Cancer Screening.			
	Improving Effective Acute Phase Treatment for Major Depression – Although UnitedHealthcare Community Plan of Rhode Island demonstrated performance improvement from baseline to measurement year 2024 on the single indicator, it did not achieve the established goal rate for measurement year 2024.	✓	✓	✓
	Improving Lead Screening in Children - UnitedHealthcare Community Plan of Rhode Island demonstrated performance decline from baseline to measurement year 2024 on the single indicator, and did not achieve the goal for measurement year 2024.	✓	✓	✓
	Improving Breast Cancer Screening -UnitedHealthcare Community Plan of Rhode Island demonstrated performance decline from baseline to measurement year 2024 on the single indicator, and did not achieve the goal for measurement year 2024.	✓	✓	✓
Recommendation	UnitedHealthcare Community Plan of Rhode Island should ensure that each performance improvement project includes the implementation of a clearly defined intervention that represents a meaningful test of change. Interventions should be designed to differ from activities implemented in prior measurement periods and from strategies used across other performance improvement projects, particularly when prior approaches have not resulted in sustained or statistically meaningful improvement.	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	For each performance improvement project, UnitedHealthcare Community Plan of Rhode Island should implement targeted interventions informed by analysis of prior performance results and evaluate whether the change in approach results in measurable improvement in the selected performance indicators, consistent with the Centers for Medicare & Medicaid Services' expectations for performance improvement project methodology.			
Performance Measures				
Strengths	UnitedHealthcare Community Plan of Rhode Island met all Information System and HEDIS Determination Standards reviewed during the HEDIS audit for measurement year 2024.			
	For measurement year 2024, UnitedHealthcare Community Plan of Rhode Island reported one (1) rate that benchmarked at the 95th percentile, two (2) rates that the 90th percentile, and nine (9) rates that 75th percentile.	✓	✓	✓
	For measurement year 2024, UnitedHealthcare Community Plan of Rhode Island reported one (1) rate that benchmarked at the 66.67th percentile, two (2) rates at the 50th percentile, and one (1) rate at the 33.33rd percentile.	✓	✓	✓
Opportunities	Although UnitedHealthcare Community Plan of Rhode Island's measurement year 2024 performance is generally at or above the 75th national Medicaid benchmark, slight year to year declines were observed for well-child visits for members age 15 to 30 months, cervical cancer screening, chlamydia screening, childhood immunizations, adults' access to preventive and ambulatory health services, and postpartum care. In particular, adult access to preventive and ambulatory services demonstrates performance at or below the 50th national Medicaid benchmark.	✓	✓	✓
Recommendation	UnitedHealthcare Community Plan of Rhode Island should conduct a targeted review of measures showing recent year to year declines, with priority attention to adults' access to preventive and ambulatory health services where cohort performance remains at or below the national Medicaid average. The UnitedHealthcare Community Plan of Rhode Island	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	should identify potential drivers contributing to access related performance trends and assess whether focused quality improvement actions are warranted to stabilize performance and sustain benchmark level achievement across preventive and maternal health measures.			
Network Adequacy				
Strengths	UnitedHealthcare Community Plan of Rhode Island’s network analyses for measurement year 2024 were determined to be reliable.			
	In 2024, UnitedHealthcare Community Plan of Rhode Island met geographic access standards for the provider types reviewed for approximately 100% of its Medicaid membership.	✓	✓	✓
Opportunities	Among primary care and specialty providers surveyed for routine and urgent appointment availability in 2024 by UnitedHealthcare Community Plan of Rhode Island, appointment availability and timely access were highly limited across multiple provider types, particularly for pediatric primary care, specialty services, and urgent care.	✓	✓	✓
	The number of providers surveyed in 2024 for appointment availability was limited.			
Recommendation	UnitedHealthcare Community Plan of Rhode Island should prioritize review of appointment scheduling and network capacity for primary care, specialty care, and behavioral health services with minimal appointment success to identify access barriers and determine whether targeted actions are needed to improve timely access to care.	✓	✓	✓
	UnitedHealthcare Community Plan of Rhode Island should increase sample sizes when administering future appointment availability surveys.			
Review of Compliance with Medicaid and Children’s Health Insurance Program Standards				
Strengths	UnitedHealthcare Community Plan of Rhode Island is compliant with the standards reviewed under <i>42 Code of Federal Regulations Part 438 Managed Care</i> .	✓	✓	✓
Opportunities	None.			
Recommendation	None.			
Validation of Quality of Care Survey, Adult Medicaid Member Experience Survey				

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
Strengths	None.			
Opportunities	UnitedHealthcare Community Plan of Rhode Island’s performance on the CAHPS Adult Medicaid Survey global experience measures, including Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist, and Rating of Health Plan, was substantially below national Medicaid benchmarks, with multiple measures performing below the 10th percentile. In addition, Coordination of Care performance was notably below the national Medicaid mean, signaling potential challenges in managing transitions and continuity across providers and services.	✓	✓	✓
	Performance on global experience measures, including Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist, and Rating of Health Plan, was notably lower compared to national benchmarks. Coordination of Care performance also suggests challenges in managing continuity of care and transitions across services.	✓	✓	✓
Recommendation	UnitedHealthcare Community Plan of Rhode Island should implement comprehensive quality improvement strategies to address member experience and care coordination gaps identified through CAHPS results. The plan should conduct root cause analyses focused on care continuity and provider integration, strengthen oversight of care coordination processes, and establish ongoing monitoring to track progress. Improvement activities should be aligned with the Quality Assessment and Performance Improvement Program requirements to support sustained compliance and improved member experience.	✓	✓	✓
Validation of Quality of Care Survey, Child Medicaid Member Experience Survey				
Strengths	UnitedHealthcare Community Plan of Rhode Island demonstrated favorable performance on the measurement year 2024 CAHPS Child Medicaid Survey for Rating of Health Plan, meeting the 75th percentile national Medicaid benchmark for measurement year 2024.	✓	✓	✓
Opportunities	UnitedHealthcare Community Plan of Rhode Island demonstrated performance that generally did not exceed national Medicaid benchmarks on reported CAHPS measures. Rating of All Health Care and Rating of Personal Doctor ranked at the 33rd percentile, while other domains were	✓	✓	✓

External Quality Review Activity	External Quality Review Organization Assessment/Recommendation	Quality	Timeliness	Access
	either at or near median performance or could not be assessed due to small sample sizes. The limited availability of reportable data constrains comprehensive evaluation of access, customer service, and coordination of care.			
Recommendation	UnitedHealthcare Community Plan of Rhode Island should implement focused quality improvement initiatives aimed at enhancing overall member experience and strengthening provider communication. In addition, the plan should address survey participation challenges to increase data availability across CAHPS domains. Ongoing monitoring and improvement activities should be integrated into the Quality Assessment and Performance Improvement Program to support sustained improvements and enable more robust performance evaluation.	✓	✓	✓
Validation of Quality of Care Survey, Provider Satisfaction Survey				
Strengths	UnitedHealthcare Community Plan of Rhode Island’s performance demonstrated improvement between measurement year 2023 and measurement year 2024. Although not statistically significant, overall provider satisfaction increased to 46% in 2024 from 16% in 2023.	✓	✓	✓
Opportunities	Despite improved measurement year 2024 results, provider satisfaction levels across many measures remained below 50 percent.	✓	✓	✓
Recommendation	UnitedHealthcare Community Plan of Rhode Island should continue efforts to strengthen administrative, authorization, claims, and customer service processes and closely monitor provider satisfaction in future measurement years to confirm sustained improvement under the revised specifications. These activities should be incorporated into the Quality Assessment and Performance Improvement Program.	✓	✓	✓

Appendix A – NCQA Quality Improvement Activity Form

QUALITY IMPROVEMENT FORM NCQA Quality Improvement Activity Form

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

First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
C. Baseline Methodology.	
C.1 Data Sources.	
<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.	
C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.	
If medical/treatment records, check below: <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.

Data Analysis 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

- 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>						

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

#3 Quantifiable Measure:							
Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	<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.