Rhode Island Medicaid Managed Care Program

Annual External Quality Review Technical Report

Reporting Year 2015
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Prepared on Behalf of
The State of Rhode Island
Executive Office of Health and Human Services

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I. EXECUTIVE SUMMARY

Introduction

The Centers for Medicare and Medicaid Services (CMS) require that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). In order to comply with these requirements, the State of Rhode Island Executive Office of Health and Human Services (EOHHS) contracted with IPRO to assess and report the impact of its Medicaid managed care program and both of the participating Health Plans on the accessibility, timeliness, and quality of services. It is important to note that the provision of health care services to each of the eligibility groups (Core RIte Care, RIte Care for Children with Special Health Care Needs (CSHCN), RIte Care for Children in Substitute Care (SC)[1], Rhody Health Partners (RHP), Rhody Health Options (RHO)[2], and Rhody Health Expansion (RHE)) is evaluated in this report. RHP is a managed care organization (MCO) option for Medicaid-eligible adults with disabilities, while RHO members include those that are dual-eligible for Medicaid and Medicare. The RHE population, introduced in 2014, includes Medicaid-eligible adults, age nineteen (19) to sixty-four (64) years, who are not pregnant, not eligible for Medicare Parts A or B, and are otherwise not eligible or enrolled for mandatory coverage under the State plan. As members of the Health Plans, each of these populations is included in all measure calculations, where applicable.

In addition to the Health Plan-specific Technical Reports that detail IPRO's independent evaluation of the services provided by each of the two (2) Health Plans (Neighborhood Health Plan of Rhode Island (NHPRI) and UnitedHealthcare Community Plan of Rhode Island (UHCP-RI)), EOHHS requested that IPRO prepare an aggregate report that evaluates the performance of the State's Medicaid managed care program overall. Specifically, this report provides IPRO's independent evaluation of the combined services provided by the two (2) Medicaid managed care Health Plans for Reporting Year 2015, and compares and contrasts the individual performance of both Health Plans. For comparative purposes, results for 2013 and 2014 are displayed when available and appropriate. The framework for this assessment is based on the guidelines established by the CMS EQR protocols, as well as State requirements.

The benchmarks and HEDIS®[3] percentiles for Medicaid Health Plans cited in this annual EQR Technical Report originated from the National Committee for Quality Assurance (NCQA) *Quality Compass*®[4] 2015 for Medicaid, with the exception of those shown for the 2015 Performance Goal Program (PGP). Scoring percentiles for the PGP were derived from *Quality Compass*® 2014 for Medicaid.

Corporate Profiles

As indicated previously, in 2015, the Rhode Island Medicaid managed care program was comprised of two (2) Health Plans: NHPRI, which served Medicaid and Commercial populations, and UHCP-RI, which served Medicaid, Medicare, and Commercial populations (refer to Table 1 on page 10). Both Health Plans served the Core RIte Care, RIte Care for Children with Special Health Care Needs (CSHCN), Rhody Health Partners (RHP), and Rhody Health Expansion (RHE) populations. Only NHPRI served the RIte Care for Children in Substitute Care (SC) and Rhody Health Options (RHO) populations.

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1 The RIte Care for Children in Substitute Care population is served by NHPRI only.

2 The Rhody Health Options population is served by NHPRI only.

3 HEDIS® (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA).

4 *Quality Compass*® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Accreditation

Notably, NHPRI continued to receive an *Excellent* accreditation rating from the NCQA in 2015, while UHCP-RI was awarded a *Commendable* rating from the NCQA for its Medicaid product line (refer to Table 2 on page 13). Modifications were made to the NCQA's Accreditation methodology, which affected the distribution of Health Plan ratings, with fewer Health Plans achieving an *Excellent* status. Although on-site accreditation occurs once every three (3) years, ratings are recalculated annually by the NCQA based on the most recent Accreditation Survey findings and the latest HEDIS® and CAHPS®[5] results. As such, 2015 ratings are based on the results of the accreditation survey conducted in 2015 for UHCP-RI and in 2014 for NHPRI, while the HEDIS® and CAHPS® 2015 results were used for both Health Plans. Both Health Plans were awarded an overall rating of four and a half (4.5) out of five (5) for their Medicaid product lines by the NCQA in 2015 (refer to Table 3 on page 14).

Enrollment

The two (2) Health Plans varied in the proportion of Medicaid membership served. According to Medicaid enrollment data for the period ending on December 31, 2015, sixty-five percent (65%) of Medicaid managed care enrollees were enrolled in NHPRI, a total of over 162,000 members. The remaining thirty-five percent (35%) of the total Medicaid managed care population was enrolled in UHCP-RI, a total of over 86,000 members (refer to Table 4 on page 15). Compared to year-end 2014, Medicaid enrollment grew by eleven percent (11%) for both Health Plans[6]. UHCP-RI and NHPRI also reported enrollment data for the Medicare and Commercial product lines. UHCP-RI's Medicare and Commercial product lines accounted for twenty-one percent (21%) and five percent (5%) of the Health Plan's total enrollment, respectively, with the Medicaid product line comprising the remaining seventy-four percent (74%). NHPRI's Medicaid population comprised ninety-one percent (91%) of total Health Plan enrollment, while the Commercial product line accounted for the remaining nine percent (9%) (refer to Table 5 on page 16).

Provider Network and Accessibility

Both Health Plans continued to achieve *Excellent* Accreditation ratings on the *Access and Service* and *Qualified Providers* domains of the NCQA Accreditation Survey in 2015. Additionally, the Health Plans both exceeded their established GeoAccess standards for all primary care providers, as well high-volume specialty providers overall (refer to Table 6 on page 18).

HEDIS® Performance Measures

The assessment of Health Plan performance on HEDIS® 2015 is based on comparisons to the *Quality Compass*® 2015 Medicaid benchmarks and percentiles. Statewide rates were calculated by totaling the numerators and denominators for each of the two (2) Health Plans.

In the HEDIS® Effectiveness of Care domain, which assesses preventive care and care for chronic conditions, overall performance was strong for the *Childhood Immunization—Combo 3* and *Childhood Immunization—Combo 10* measures, as both Health Plans' rates, as well as the statewide rates, were above the 2015 *Quality Compass*® 90th percentile. Additionally, both Health Plans, as well as the statewide rate, benchmarked at the 75th

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[5] CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the Federal Agency for Healthcare Research and Quality (AHRQ).

[6] RI Medicaid began enrolling a new population in 2014, Rhody Health (Medicaid) Expansion. The eligibility criteria for this population include: Medicaid-eligible adults ages 19-64 who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible or enrolled for mandatory coverage under the State plan. Reporting Year 2015 marks the first year in which members in the Expansion population meet eligible population criteria for inclusion in performance measure calculations and quality improvement projects.

percentile for the *Chlamydia Screening (16-24 Years)* and *Cervical Cancer Screening* measures. For seven (7) of the eight (8) measures, all rates were above the 2015 national Medicaid mean (refer to Figure 3 on page 23).

The Access to/Availability of Care domain evaluates the proportions of members who access PCPs, ambulatory services, and preventive care, as well as timely perinatal care. Rates for NHPRI and UHCP-RI, as well as the statewide rates, exceeded the 2015 national Medicaid mean for all nine (9) measures. Additionally, both Health Plans' rates, as well as the statewide rate, achieved the 2015 *Quality Compass*® 90th percentile for the *25 Months-6 Years, 7-11 Years,* and *12-19 Years* age groups of the *Children and Adolescents' Access to Primary Care* measure. UHCP-RI, NHPRI, and the statewide rate met the *Quality Compass*® 90th or 75th percentile for the *Adults' Access to Preventive/Ambulatory Health Services (20-44 Years* and *45-64 Years), Timeliness of Prenatal Care,* and *Timeliness of Postpartum Care* measures, as well (refer to Figure 4 on page 27).

Both Health Plans demonstrated a strong performance in regard to the HEDIS® Use of Services measures. Both Health Plans' rates, as well as the statewide rates, were above the 2015 national Medicaid mean and the 2015 *Quality Compass*® 90th percentile for the following measures: *Well-Child Visits in the First 15 Months of Life—6+ Visits, Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life,* and *Frequency of Ongoing Prenatal Care—81+ Percent* (refer to Figure 5 on page 31).

Member Satisfaction: CAHPS® 5.0H

Overall performance on the 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H Medicaid Adult Survey varied greatly across measures and Health Plans. Statewide rates were above the 2015 national Medicaid mean for eight (8) of nine (9) measures. NHPRI achieved the 2015 *Quality Compass*® 90th percentile for one (1) measure and the 75th percentile for one (1) measure, whereas UHCP-RI ranked at or above the 90th percentile for six (6) measures (refer to Figure 6 on page 33).

Rhode Island Performance Goal Program

Rhode Island's Performance Goal Program was established in 1998 to measure and reward performance in the areas of administration, access, and clinical quality. Since then, the program has been steadily refined. The Performance Goal Program has been fully aligned with nationally recognized performance benchmarks through its performance categories, the majority of measures being HEDIS® and CAHPS® measures, and superior performance levels established as the basis for incentive awards.

For the 2013, 2014, and 2015 Reporting Years, the following performance categories were used to evaluate Health Plan performance:

- *Member Services*
- *Medical Home/Preventive Care*
- *Women's Health*
- *Chronic Care*
- *Behavioral Health*
- *Cost Management* (formerly *Resource Maximization*)
- *Children with Special Health Care Needs (added in 2010)*
- *Children in Substitute Care (added in 2011)*[7]
- *Rhody Health Partners (added in 2011)*
- *Rhody Health Expansion (added in 2015)*

[7] The RIte Care for Children in Substitute Care population is served by NHPRI only.

Within each of these categories is a series of measures, including a variety of standard HEDIS® and CAHPS® measures, as well as State-specified measures for areas of particular importance to the State and for which a national metric is not available for comparison (e.g., *New Member Welcome Call Attempts, Grievances and Appeals Processing, Initial Health Screens for Special Populations,* and *Notify the State of Third-Party Liability (TPL)*). See **Tables 7 and 8** on pages 41 and 53 for the full results of the 2015 Performance Goal Program.

For the 2015 Performance Goal Program, incentives were awarded separately for two (2) populations: Non-RHE (all lines of business except Rhody Health Expansion) and RHE (Rhody Health Expansion only). For the Non-RHE populations, there were fifteen (15) State-specified measures, two (2) CAHPS® measures, and forty-five (45) HEDIS® measures, resulting in a total of sixty-two (62) PGP measures. Of these measures, thirteen (13) were considered baseline measures and/or were not eligible for incentive awards, leaving forty-nine (49) measures eligible for benchmarking/incentive awards. For the RHE population, there were eight (8) State-specified measures, two (2) CAHPS® measures, and twenty-seven (27) HEDIS® measures, resulting in a total of thirty-seven (37) PGP measures. Of these measures, eleven (11) were considered baseline measures and/or were not eligible for incentive awards, leaving twenty-six (26) measures eligible for benchmarking/incentive awards[8].

In regard to the results for the Non-RHE populations, NHPRI met the *Contract* goal for two (2) of the fifteen (15) State-specified measures, while UHCP-RI met the goal for four (4) of the fifteen (15) State-specified measures. It is important to note that because UHCP-RI does not serve the Children in Substitute Care population, three (3) measures specific to that population were not applicable to the Plan.

Among the HEDIS® and CAHPS® measures, UHCP-RI achieved a *Quality Compass*® 2014 benchmark (90th, 75th, or 50th percentiles) and qualified for a full or partial incentive award for thirty (30) of forty-seven (47) reported measures, with twenty (20) measures ranking in the 90th percentile, nine (9) in the 75th percentile, and one (1) benchmarking at the 50th percentile. NHPRI achieved a *Quality Compass*® 2014 benchmark (90th, 75th, or 50th percentiles) and qualified for a full or partial incentive award for thirty (30) of forty-seven (47) reported measures, as well, with eighteen (18) measures ranking in the 90th percentile, eleven (11) in the 75th percentile, and one (1) benchmarking at the 50th percentile. Thirteen (13) HEDIS® measures were ineligible for incentive awards in 2015, due to designation as a baseline measurement or inclusion in an aggregate measure.

In regard to the results for the RHE population, NHPRI met the *Contract* goal for one (1) of the eight (8) State-specified measures, while UHCP-RI met the goal for two (2) of the eight (8) State-specified measures. Among the HEDIS® and CAHPS® measures, NHPRI achieved a *Quality Compass*® 2014 benchmark (90th, 75th, or 50th percentiles) and qualified for a full or partial incentive award for nine (9) of twenty-nine (29) measures, with seven (7) measures ranking in the 90th percentile and two (2) at the 75th percentile. UHCP-RI achieved a *Quality Compass*® 2014 benchmark (90th, 75th, or 50th percentiles) and qualified for a full or partial incentive award for twelve (12) of twenty-nine (29) reported measures, with seven (7) measures ranking in the 90th percentile and five (5) at the 75th percentile. Eleven (11) HEDIS®/CAHPS® measures were ineligible for incentive awards in 2015, as well as one (1) State-specified measure, due to designation as a baseline measurement or inclusion in an aggregate measure.

Care Management for Special Enrollment Populations

As part of the Performance Goal Program, in order to monitor access to and quality of care provided to special enrollment populations, specifically Children with Special Health Care Needs (CSHCN), Children in Substitute

[8] It is important to note here that the total number of measures for the RHE population is much lower than the total for the Non-RHE members, as the RHE population includes only members 19 years of age and over. Many of the measures are not applicable to the RHE population, as the eligible population criteria include members under age 19.

Care (SC)[9], Rhody Health Partners (RHP), and Rhody Health Expansion (RHE) members, EOHHS has required that the Health Plans annually submit HEDIS® data for *Core RIte Care Only* and for *All Populations* since 2010. The State analyzed the data for the two (2) groups to identify differences between the rates for the *Core RIte Care Only* group and those including *All Populations*. The *Quality Compass*® 2014 Medicaid managed care percentile rankings for each measure for *Core RIte Care Only* and *All Populations* were compared. Performance was considered similar if both rates ranked in the same percentile band and dissimilar if the rates ranked in different percentile bands.

For HEDIS® 2015, when performance was compared for *Core RIte Care Only* and *All Populations*, the results were as follows: for NHPRI, rates were similar for thirty-three (33) measures and dissimilar for eleven (11) measures; for UHCP-RI, rates were similar for thirty-four (34) measures and dissimilar for eleven (11) measures (refer to Table 9 on page 63).

In addition, as part of the 2015 Performance Goal Program monitoring visits in April and May 2015, the State conducted a file review of special enrollment population case records. For each of the special populations enrolled in the Health Plans, PGP goals related to timely initial health screens upon enrollment, timely needs assessments, and timely evaluation and update of active care management plans have been established (refer to Table 10 on page 64).

Conclusions and Recommendations

IPRO's external quality review concludes that the Rhode Island Medicaid managed care program and its participating Health Plans (NHPRI and UHCP-RI) have had an overall positive impact on the accessibility, timeliness, and quality of services for Medicaid recipients. This is supported by the fact that both Health Plans were awarded an overall rating of four and a half (4.5) out of five (5) as Medicaid Health Plans by the NCQA for 2015.

Overall strengths for both Health Plans include: strong performance on measures related to access to care, above average performance on measures related to women's health, and preventive health for children and adolescents.

Recommendations made in this report apply to both Health Plans, and as such, may be opportunities that EOHHS may wish to address. More specific data and recommendations are provided for both NHPRI and UHCP-RI in the Health Plan-specific EQR Technical Reports. To improve the provision of care and services to members, overall recommendations are made in the following areas:

<u>Quality of Care:</u>

- NCQA Accreditation domain
  - *Getting Better*
- HEDIS® *Board Certification*
- Member Services
  - *Member Handbook Sent within 10 Days of Notification of Enrollment*
  - *Two Welcome Call Attempts within 30 Days of Enrollment*
  - *Grievances and Appeals Resolved within Federal (BBA) Timeframes*
- Member Satisfaction
  - CAHPS® *Customer Service*
- Performance Goal Program—Non-RHE Populations
  - HEDIS® *Use of Imaging Studies for Low Back Pain*

[9] The Children in Substitute Care population is served only by NHPRI.

    - HEDIS® *Members with Persistent Asthma Used Appropriate Medications (Total)*
- Performance Goal Program—RHE Population
    - CAHPS® *Medical Assistance with Smoking/Tobacco Cessation*
    - HEDIS® *Use of Imaging Studies for Low Back Pain*
    - HEDIS® *Chlamydia Screening for Women (20-24 Years)*

Access to/Timeliness of Care:

- Performance Goal Program—RHE Population
    - HEDIS® *Adults Had Ambulatory/Preventive Care Visit (20-44 Years)*
    - HEDIS® *Pregnant Members Received Timely Prenatal Care*
    - HEDIS® *Postpartum Members Received Timely Postpartum Care*
- *Reduction in Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs) by 5 Percentage Points—CSHCN*
- *Initial Health Screens Completed within 45 Days of Enrollment—CSHCN, SC, RHP, RHE*
- *Active Care Management Plan Evaluated/Updated No Less Than Every 6 Months—SC, RHP, RHE*

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II. INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) require that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an MCO furnishes to Medicaid recipients. Quality is defined in 42 CFR §438.320 as *"the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge."*

In order to comply with these requirements, the State of Rhode Island Executive Office of Health and Human Services (EOHHS) contracted with IPRO to assess and report the impact of its Medicaid managed care program and each of the participating Health Plans on the accessibility, timeliness, and quality of services. In addition to Health Plan-specific EQR Technical Reports that present IPRO's independent evaluation of the services provided by each of the two (2) Rhode Island Medicaid managed care Health Plans for the 2015 Reporting Year, EOHHS requested that IPRO prepare this aggregate report that evaluates, compares, and contrasts both Health Plans' performance, as well as overall statewide performance. For comparative purposes, results for 2013-2014 are also displayed when available and appropriate. The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as State requirements.

RIte Care, Rhode Island's Medicaid managed care program for children, families, and pregnant women, began enrollment in August 1994 as a Section 1115 demonstration project with the following goals:

- *To increase access to and improve the quality of care for Medicaid families*
- *To expand access to health coverage to all eligible pregnant women and uninsured children*
- *To control the rate of growth in the Medicaid budget for the eligible population*

RIte Care operates as a component of the State's Global Consumer Choice Compact Waiver Section 1115(a) demonstration project, which is approved until December 31, 2018[10].

As is typical for Section 1115 waivers, CMS defines "Special Terms and Conditions" (STCs) for the demonstration. The STCs addressing quality assurance and improvement are as follows:

> *"The State shall keep in place existing quality systems for the waivers/demonstrations/programs that currently exist and will remain intact under the Global 1115 (RIte Care, Rhody Health, Connect Care, RIte Smiles, and PACE)."*

Because Federal EQR requirements apply to Medicaid managed care, initially this EQR had been focused on RIte Care. Since Reporting Year (RY) 2010, the managed care organization (MCO) system for adults with disabilities, Rhody Health Partners, was incorporated[11]. As members of the Health Plans, the RHP population is included in all measure calculations, where applicable.

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[10] In December 2013, the renewal request submitted by EOHHS was approved by CMS, resulting in an extension of the State's Global Consumer Choice Compact Waiver Section 1115(a) through December 31, 2018. The Special Terms and Conditions (STCs) of the renewed Waiver include Rhody Health Options, in addition to the care delivery systems included in the 2008 Waiver.

[11] The option to enroll in a managed care organization was extended to adult Medicaid beneficiaries with disabilities in 2008. At that time, adults with disabilities without third-party coverage were given the option to enroll in an MCO with the provision that they could choose to return to Fee-For-Service (FFS) Medicaid ("opt-out") at any time.

In 2014, Rhode Island's Medicaid managed care program began enrolling a new population, Rhody Health Expansion (RHE). Members in the RHE population meet the following criteria: Medicaid-eligible adults, age nineteen (19) to sixty-four (64) years, who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible or enrolled for mandatory coverage under the State plan. As members of the Health Plan, the RHE population is included in all measure calculations, where applicable. Reporting Year 2015 marks the first reporting period for which RHE members meet eligible population criteria for inclusion in HEDIS®, CAHPS®, the Performance Goal Program, and Quality Improvement Projects.

Please see **Appendix 1** for a description of the State's approach to quality and evaluation for RIte Care and Rhody Health Partners.

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III. METHODOLOGY

In order to assess the impact of the RIte Care and Rhody Health programs on access, timeliness, and quality of services, IPRO reviewed pertinent information from a variety of sources, including State managed care standards, Health Plan contract requirements, accreditation survey findings, member satisfaction surveys, performance measures, and State monitoring reports.

Many of the measures reported herein are derived from HEDIS® or CAHPS®. For these measures, comparisons to national Medicaid benchmarks are provided. The benchmarks utilized were the most currently available at the time of this writing. Unless otherwise noted, the benchmarks originate from the National Committee for Quality Assurance's (NCQA) *Quality Compass*® 2015 for Medicaid and represent the performance of all Health Plans that reported HEDIS® or CAHPS® data to the NCQA for HEDIS® 2015 (Measurement Year 2014).

For comparative purposes, the results for 2013-2014 have also been displayed where available and appropriate. Unless otherwise noted, all statewide rates are true rates, calculated by combining the numerators and denominators for both Health Plans. The exceptions are the State-specified Performance Goal Program (PGP) measures and CAHPS® rates, for which numerators and denominators are not uniformly available. Statewide rates for CAHPS® were calculated by averaging the individual ratings for both Health Plans. The methodology for calculating the PGP statewide rates differs by measure, and relevant figures have been annotated. It is important to note that this is the fifth EQR Aggregate Technical Report where statewide rates were calculated based on two (2) Health Plans' performance, rather than three (3), since BCBSRI opted not to seek renewal of its Medicaid *Contract* in 2010.

For each key section, a description of the data, the methods used to monitor these requirements, and key findings have been provided. The final section of the report provides summary conclusions, strengths, and recommendations derived from this report, as well as each Health Plan's individual report. Additionally, the final section describes the communication of the findings by EOHHS to the Health Plans for follow-up, as well as a brief description of the Health Plans' progress related to the previous year's annual External Quality Review Technical Report recommendations.

IV. CORPORATE PROFILES

Two (2) Health Plans comprised Rhode Island's Medicaid managed care program during 2015:

- Neighborhood Health Plan of Rhode Island, Inc. (NHPRI) is a local, not-for-profit HMO that served Commercial and Medicaid populations, including CSHCN, SC, RHP, RHO, and RHE members.

- UnitedHealthcare Community Plan—Rhode Island (UHCP-RI) is a not-for-profit HMO in Rhode Island, although it is part of a publicly traded company. It served Commercial, Medicare, and Medicaid populations, including CSHCN, RHP, and RHE members.

Table 1 presents specific information for both Health Plans.

Table 1: Corporate Profiles

Plan	NHPRI	UHCP-RI
Type of Organization	HMO	HMO
Tax Status	Not-for-profit	Not-for-profit
Model Type	Network	Mixed
Year Operational	1994	1979
Year Operational (Medicaid)	1994	1994
Product Line(s)	Commercial, Medicaid	Commercial, Medicare, Medicaid
Total Enrollment as of 12/31/15	178,888	116,163
Total Medicaid Enrollment as of 12/31/15	162,314	86,155
NCQA Medicaid Accreditation Status	Excellent	Commendable
NCQA Medicaid Health Plan Rating[12]	4.5	4.5

[12] In 2015, the NCQA retired its *Health Insurance Plan Rankings* methodology and replaced it with the *Health Insurance Plan Ratings* methodology. Further detailed information can be found in the following section of this report, or at www.ncqa.org.

V. ACCREDITATION SUMMARIES AND HEALTH PLAN RATINGS

CMS' Final Rule 42 CFR §438.358, which defines mandatory activities related to the external quality review, requires a review to determine the Health Plans' compliance with structure and operations standards established by the State, to be conducted within the previous three-year reporting period. To guide the review process, CMS further established a protocol for monitoring the Health Plans, which states must use or demonstrate a comparative validation process. In order to comply with these requirements, EOHHS uses a validation process comparable to the CMS protocol that is described in the State's October 2012 quality strategy, entitled *Rhode Island Strategy for Assessing and Improving the Quality of Managed Care Services under RIte Care*[13]. EOHHS relies on the NCQA Accreditation standards, review process, and findings, in addition to other sources of information, to assure Health Plan compliance with many of the structure and operations standards. The State also conducts an annual monitoring review to assess Health Plan processes and gather data for the State's Performance Goal Program metrics. In addition, EOHHS submitted a crosswalk to CMS, pertaining to NCQA's comparability to the regulatory requirements for compliance review, in accordance with 42 CFR §438.360(b)(4). This strategy was approved by CMS in April 2005, and again in April 2013.

NCQA Health Plan Accreditation

The NCQA began accrediting Health Plans in 1991 to meet the demand for objective, standardized plan performance information. The NCQA's Health Plan Accreditation 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. NCQA accreditation is recognized or required by the majority of state Medicaid agencies and is utilized to ensure regulatory compliance in many states. 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 actual results that the Health Plan achieves on key dimensions of care, service, and efficacy. Specifically, the NCQA reviews the Health Plans' quality management and improvement, utilization management, provider credentialing and re-credentialing, members' rights and responsibilities, standards for member connections, and HEDIS®/CAHPS® performance measures. NCQA accreditation provides an unbiased, third-party review to verify, score, and publicly report results. The NCQA regularly revises and updates its standards to reflect clinical advances and evolving stakeholder needs. In addition, the NCQA continues to raise the bar and move toward best practices in an effort to achieve continuous improvement.

The survey process consists of on-site and off-site evaluations conducted by survey teams composed of physicians and managed care experts who interview Health Plan staff and review materials such as case records and meeting minutes. The findings of these evaluations are analyzed by a national oversight committee of physicians, and an accreditation level is assigned based on a Health Plan's compliance with the NCQA's standards and its HEDIS®/CAHPS® performance. Compliance with standards accounts for approximately 55% of the Health Plan's accreditation score, while the performance measurement accounts for the remainder.

[13] Rhode Island's initial quality strategy was approved by CMS in April 2005. An updated version was submitted in October 2012 and approved by CMS in April 2013. The most recent version of the quality strategy was prepared in June 2014. Upon request from CMS in September 2014, it was revised and resubmitted in December 2014 and is pending approval by CMS.

Health Plans are scored along five (5) dimensions using star ratings of between one (1) and four (4) stars. (1—lowest; 4—highest)[14]:

- Access and Service: An evaluation of Health Plan members' access to needed care and good customer service: Are there enough primary care doctors and specialists to serve all plan members? Do members report problems getting needed care? How well does the Health Plan follow up on grievances?

- Qualified Providers: An evaluation of Health Plan efforts to ensure that each doctor is licensed and trained to practice medicine and that Health Plan members are happy with their doctors: Does the Health Plan check whether physicians have had sanctions or lawsuits against them? How do members rate their personal doctors?

- Staying Healthy: An evaluation of Health Plan activities that help people maintain good health and avoid illness: Does the Health Plan give its doctors guidelines about how to provide appropriate preventive health services? Do members receive appropriate tests and screenings?

- Getting Better: An evaluation of Health Plan activities that help people recover from illness: How does the Health Plan evaluate new medical procedures, drugs, and devices to ensure that patients have access to the most up-to-date care? Do doctors in the Health Plan advise patients to quit smoking?

- Living with Illness: An evaluation of Health Plan activities that help people manage chronic illness: Does the Health Plan have programs in place to help patients manage chronic conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?

Although the on-site accreditation occurs every three (3) years, ratings are recalculated annually by the NCQA based on the most recent Accreditation Survey findings and the latest HEDIS® and CAHPS® results. As such, 2015 accreditation ratings are based on the Accreditation Survey conducted in September 2014 for NHPRI and in December 2014 (effective February 2015) for UHCP-RI, while HEDIS®/CAHPS® 2015 results were used for both plans.

The table below presents the most common overall NQCA accreditation outcomes, including the star ratings and definitions.

Accreditation Survey Key:		
★★★★	**Excellent**	Organizations with programs for service and clinical quality that meet or exceed rigorous requirements for consumer protection and quality improvement. HEDIS® results are in the highest range of national performance.
★★★	**Commendable**	Organizations with well-established programs for service and clinical quality that meet rigorous requirements for consumer protection and quality improvement.
★★	**Accredited**	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take further action to achieve a higher accreditation status.
★	**Provisional**	Organizations with programs for service and clinical quality that meet basic requirements for consumer protection and quality improvement. Organizations awarded this status must take significant action to achieve a higher accreditation status.
(No stars)	**Denied**	Organizations whose programs for service and clinical quality did not meet NCQA requirements during the Accreditation Survey.

[14] www.ncqa.org.

Table 2 depicts the NCQA Accreditation findings for NHPRI and UHCP-RI in 2015.

Table 2: 2015 NCQA Accreditation Survey Findings

Health Plan	Access and Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Accreditation Outcome
Medicaid						
NHPRI	★★★★	★★★★	★★★	★★	★★★	Excellent
UHCP-RI	★★★★	★★★★	★★★	★★	★★★	Commendable

NCQA Health Plan Ratings

In 2015, the NCQA retired its *Health Insurance Plan Rankings* methodology, which was used from 2005 through 2014[15]. It was replaced with the *Health Insurance Plan Ratings* methodology. The *Ratings* methodology evaluates Health Plans based on clinical performance (HEDIS® results), member satisfaction (CAHPS® scores), and NCQA Accreditation standards scores. To be eligible for a rating, Health Plans must authorize public release of their performance data and submit enough data for statistically valid analysis.

The NCQA's *Health Insurance Plan Ratings* 2015-2016 utilized components of the retired rankings methodology. The overall Health Plan score is comprised of satisfaction (*Consumer Satisfaction*) measures, clinical (*Prevention* and *Treatment*) measures, and NCQA Accreditation Standards scores, defined below. The Health Plan receives a score for each category from one (1) to five (5), in half-point increments, with five (5) being the highest score. The scores from each category, in addition to the Accreditation Standards score, are then weighted and represented as an overall rating of one (1) to five (5), in half-point increments.

- Consumer Satisfaction: Composite of CAHPS® measures for consumer experience with getting care, as well as satisfaction with Health Plan physicians and with Health Plan services.

- Prevention: Composite of clinical HEDIS® measures for how often preventive services are provided (e.g., childhood and adolescent immunizations, women's reproductive health, and cancer screenings), as well as measures of access to primary care and preventive visits.

- Treatment: Composite of clinical HEDIS® measures for how well Health Plans care for people with chronic conditions such as asthma, diabetes, heart disease, hypertension, osteoporosis, alcohol and drug dependence, and mental illness, and whether physicians have advised smokers to quit.

Since 2010, the NCQA has used a five-point numerical scale rating system, which compares the Health Plans' score to the national average. The scale and the definition for each level are provided below.

NCQA Health Plan Ratings Key:	
5	The top 10 percent of plans, which are also statistically different from the mean.
4	Plans in the top one-third that are not in the top 10 percent of Health Plans and are statistically different from the mean.
3	The middle one-third of plans, and plans that are not statistically different from the mean.
2	Plans in the bottom one-third that are not in the bottom 10 percent and are statistically different from the mean.
1	The bottom 10 percent of plans, which are statistically different from the mean.

[15] www.ncqa.org.

The *Health Insurance Plan Ratings* is posted on the NCQA website. It is also posted to the *Consumer Reports'* website and published in the November issue of the magazine. Both NHPRI and UHCP-RI earned an overall NCQA rating of four and a half (4.5) out of five (5) for their Medicaid product lines in 2015.

Table 3 presents the Health Plans' overall ratings, along with their performance in each of the three (3) categories.

Table 3: 2015 NCQA Rating by Category

Health Plan	Consumer Satisfaction	Prevention	Treatment	2015 Overall Rating
Medicaid				
NHPRI	4.0	4.5	4.0	4.5
UHCP-RI	3.5	4.5	4.0	4.5

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VI. ENROLLMENT

Tables 4, 4a, and **5** depict Health Plan enrollment as of December 31, 2015, according to data reported to Rhode Island Medicaid.

Table 4 presents Medicaid managed care enrollment for both Health Plans, as well as the percentage of the total Medicaid managed care population enrolled in each. NHPRI's membership comprised the majority of the total managed care enrollment (65%), with UHCP-RI's membership accounting for the remaining 35%.

Table 4: Rhode Island Medicaid Managed Care Enrollment by Health Plan—December 31, 2015

Health Plan	Medicaid Managed Care Enrollment	Percentage of Total Medicaid Managed Care Enrollment
NHPRI	162,314	65%
UHCP-RI	86,155	35%
Total	**248,469**	**100%**

Table 4a provides additional detail, the enrollment by Medicaid eligibility category for NHPRI and UHCP-RI. Core RIte Care members comprise the majority of enrollment for both Health Plans.

Table 4a: Health Plan Medicaid Enrollment by Category—December 31, 2015

	NHPRI		UHCP-RI		Total	
Eligibility Group	**N**	**%**	**N**	**%**	**N**	**%**
Core RIte Care	94,606	58%	48,710	57%	143,316	58%
RIte Care for Children with Special Health Care Needs (CSHCN)[1]	5,251	3%	1,691	2%	6,942	3%
RIte Care for Children in Substitute Care (SC)[2]	2,288	1%			2,288	1%
Extended Family Planning (EFP)[3]	449	<1%			449	<1%
Rhody Health Partners (RHP)[4]	6,758	4%	7,372	9%	14,130	6%
Rhody Health Options (RHO)[5]	18,705	12%			18,705	8%
Rhody Health Expansion (RHE)[6]	34,257	21%	28,382	33%	62,639	25%
Total Medicaid Enrollment	**162,314**	**100%[7]**	**86,155**	**100%[7]**	**248,469**	**100%[7]**

[1] Children with Special Health Care Needs (CSHCN) were enrolled in RIte Care on a voluntary basis, effective 01/29/2003, because only one Health Plan was willing to enroll this population. As of 10/01/2008, managed care enrollment became mandatory for all RIte Care-eligible CSHCN who do not have another primary health insurance coverage. Both of the State's current Medicaid-participating Health Plans serve CSHCN.

[2] UHCP-RI does not serve the RIte Care for Children in Substitute Care population.

[3] The EFP population includes women who lose Medicaid coverage at 60 days postpartum who do not have access to creditable health insurance.

[4] Appendix 1, Chapter 4 describes the eligibility criteria for Rhody Health Partners.

[5] NHPRI began enrolling a new population in November 2013, Rhody Health Options (RHO), which serves those individuals who are dual-eligible for Medicaid and Medicare. This marked the first phase of Rhode Island's Integrated Care Initiative, which integrates the provision of primary care, acute care, behavioral health care, and long-term services and supports through care management strategies focused on the person's needs.

[6] Beginning in 2014, Rhode Island's Medicaid program was expanded to include Medicaid-eligible adults who meet the following criteria: adults ages 19-64 who are not pregnant, not eligible for Medicare Parts A or B, and are otherwise not eligible or enrolled for mandatory coverage.

[7] Total may not equal 100% due to rounding.

Table 5 presents the Health Plans' enrollment by product line, including the proportion of total Health Plan membership. As of December 31, 2015, the majority of UHCP-RI's membership was enrolled in the Medicaid product line (74%), followed by Medicare (21%), and Commercial (5%). NHPRI's Medicaid product line comprised 91% of total Health Plan enrollment, with the Commercial product line accounted for the remaining 9% of membership.

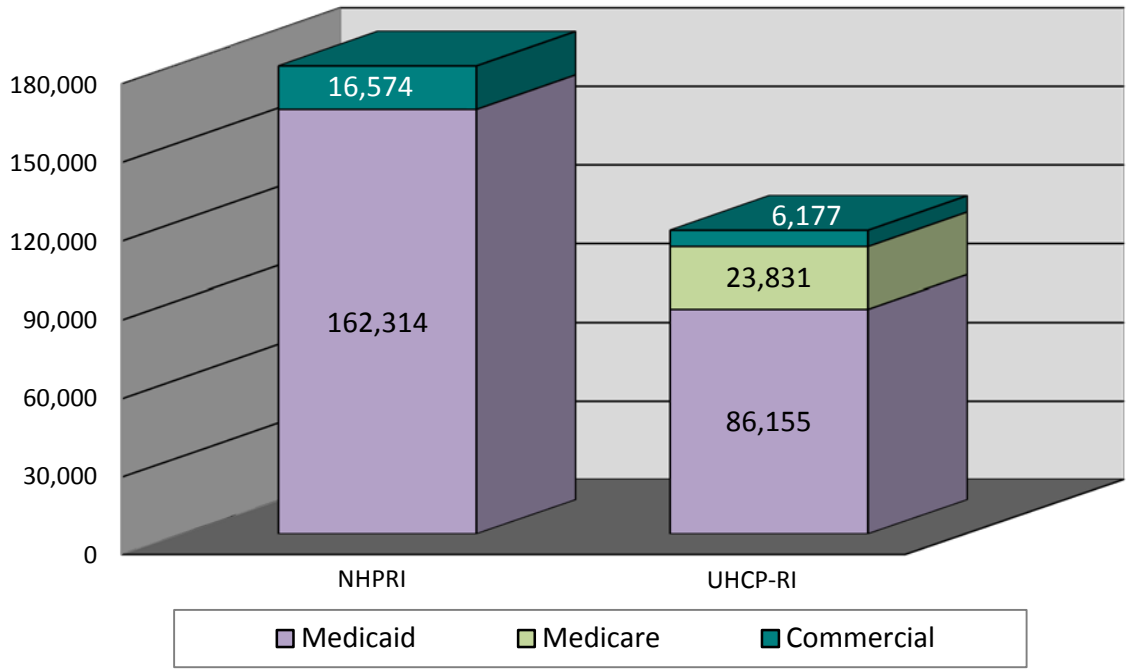
Table 5: Health Plan Enrollment by Product Line—December 31, 2015

	NHPRI		UHCP-RI	
Product Line	**N**	**%**	**N**	**%**
Medicaid	162,314	91%	86,155	74%
Medicare[1]			23,831	21%
Commercial	16,574	9%	6,177	5%
Total Health Plan Enrollment	**178,888**	**100%**	**116,163**	**100%**

[1] NHPRI did not serve the Medicare population in 2015.

Figure 1 graphically illustrates the data presented in **Table 5**.

Figure 1: Health Plan Enrollment by Produce Line—December 31, 2015



VII. PROVIDER NETWORK AND GEOACCESS

Health Plans must ensure that a sufficient number of primary and specialty care providers are available to members to allow a reasonable choice among providers. This is required by Federal Medicaid regulations, State licensure requirements, NCQA Accreditation Standards, and the State's *Medicaid Managed Care Services Contract*.

It is important to note that the *Medicaid Managed Care Services Contract* has never had "reasonable distance" standards. Regarding the provider network, Section 2.08.01 of the State's September 2010 *Medicaid Managed Care Services Contract* states:

> *"Contractor will establish and maintain a geographic network designed to accomplish the following goals: (1) offer an appropriate range of services, including access to preventive services, primary care services, and specialty care services for the anticipated number of enrollees in the services area; (2) maintain providers in sufficient number, mix, and geographic area; and (3) make available all services in a timely manner."*

For primary care, Section 2.08.02.06 of the *Contract* states:

> *"Contractor agrees to assign no more than fifteen hundred (1,500) Members to any single PCP in its network. For PCP teams and PCP sites, Contractor agrees to assign no more than one thousand (1,000) Members per single primary care provider within the team or site, e.g., a PCP team with three (3) providers may be assigned up to 3,000 Members."*

With respect to access, the *Contract* has always contained service accessibility standards (e.g., days-to-appointment for non-emergency services), including a "travel time" standard in Section 2.09.02 of the State's September 2010 *Contract*, which states as follows:

> *"Contractor agrees to make available to every Member a PCP whose office is located within or adjacent to the Member's local primary care area. Primary Care Areas for Rhode Island are available from the Department of Health, Division of Health Statistics. Members may, at their discretion, select PCPs located farther away from their homes."*

Consequently, the standards against which reasonable distances are assessed are developed by each Health Plan, based on Health Plan-specific criteria. For NHPRI, the standard was two (2) clinicians within ten (10) miles for both PCP and OB/GYN providers, and the standard for high-volume specialists was one (1) within fifteen (15) miles. NHPRI's goal was to meet the access criteria for at least ninety-seven percent (97%) of members for each provider type.

UHCP-RI revised its GeoAccess standards in 2014 to align with CMS' most recent criteria for network adequacy. UHCP-RI assessed geographic accessibility utilizing the large metro and metro access criteria[16]. The goal was to have ninety percent (90%) of primary care and high-volume specialty care providers who met the distance requirements. The standards vary by geographic access criteria (large metro and metro).

[16] UHCP-RI's GeoAccess standards derive from CMS' Medicare Advantage network adequacy criteria. These criteria assess accessibility by county type: large metro, metro, micro, rural, and counties with extreme access consideration (CEAC). County types are defined by population and population density, based on the most recently available census data. All counties in Rhode Island meet criteria for the large metro and metro county designations. Detailed information can be found at www.cms.gov.

Table 6 shows the percentage of members or providers for which the Health Plans met their respective access standards for the various provider types. Note that the types of high-volume specialists differ for each Health Plan based on Health Plan-specific information[17].

Table 6: GeoAccess Provider Network Accessibility—2015

Provider Type	Access Standard[1]	Percentage for Whom Access Standard was Met[2]
NHPRI (as of 12/2014)		
Primary Care Practitioners	2 within 10 miles	99.9%
OB/GYNs	2 within 10 miles	97.2%
High-Volume Specialists[3]	1 within 15 miles	99.4%
UHCP-RI (as of 02/2015)		
Primary Care Practitioners (Large Metro)	1 within 5 miles	99%
Primary Care Practitioners (Metro)	1 within 10 miles	100%
OB/GYNs (Large Metro)	1 within 15 miles	100%
OB/GYNs (Metro)	1 within 30 miles	100%
High-Volume Specialists[4] (Large Metro)	1 within 5-15 miles[5]	98%
High-Volume Specialists[4] (Metro)	1 within 20-30 miles[5]	100%

[1] The Access Standard is measured by distance in miles to members. Both Health Plans established their respective GeoAccess standards, and all standards are compliant with the State's *Medicaid Managed Care Services Contract* requirements.

[2] The percentages for NHPRI represent the proportion of members for whom the Access Standards were met. The percentages for UHCP-RI represent the proportion of providers who met the Access Standards.

[3] High-volume specialists for NHPRI in 2015 are defined as Allergists, Dermatologists, Diagnostic Radiologists, Orthopedists, Optometrists, Ophthalmologists, Otolaryngologists, Podiatrists, and Physical Therapists.

[4] High-volume specialists for UHCP-RI in 2015 are defined as Cardiologists, Orthopedists, Dermatologists, Gastroenterologists, ENTs, and OB/GYNs.

[5] For UHCP-RI, the Access Standards differ for each type of specialty provider. For specific Access Standards, please refer to the Health Plan-specific Technical Report for UHCP-RI.

[17] The types of high-volume specialists displayed in this report differ between the Health Plans, as the definition of a high-volume specialist provider differs. High-volume specialists are based on the number of visits/1,000 members, and only the top high-volume specialists are reported.

HEDIS® *Board Certification* rates represent the percentage of physicians in the provider network that are board-certified. **Figure 2** illustrates the results and percentile rankings for both Health Plans for Reporting Years 2013 through 2015.

Of the six (6) providers types presented, NHPRI's rates, as well as the statewide rates, exceeded the 2015 national Medicaid mean for all measures, while UHCP-RI's rates exceeded the Medicaid mean for all measures with the exception of *Geriatricians.* In 2015, only NHPRI met the 2015 *Quality Compass*® 90th percentile for *Pediatricians,* while both UHCP-RI's rate and the statewide rate ranked at the 90th percentile for *OB/GYNs*. Both Health Plans' rates, as well as the statewide rate, continue to rank well below the 90th percentile for *Geriatricians*.

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Figure 2: HEDIS® Board Certification Rates—2013-2015

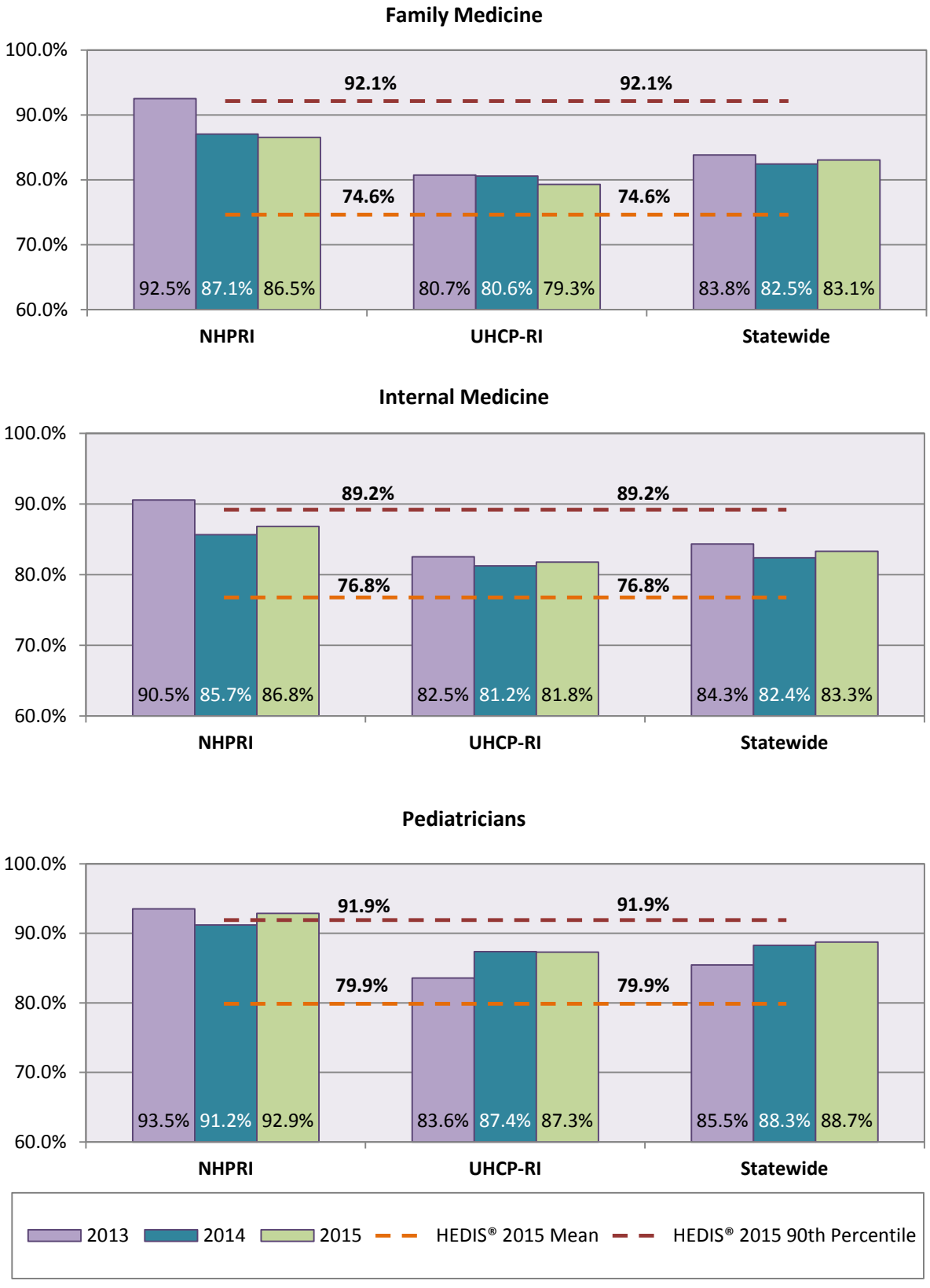
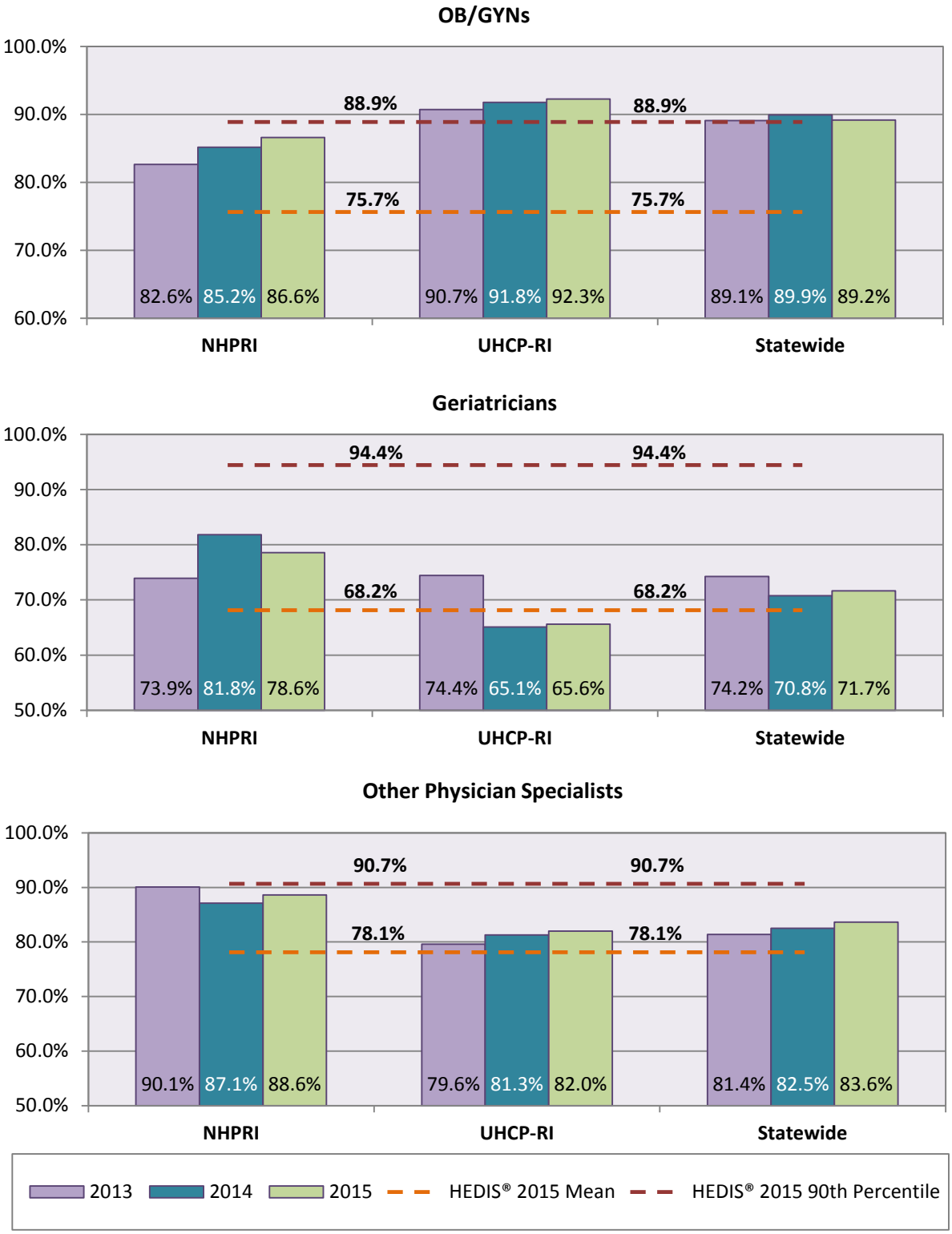


Figure 2: HEDIS® Board Certification Rates—2013-2015 (continued)



VIII. HEDIS® PERFORMANCE MEASURES[18]

Since NCQA Accreditation is required for participation in Rhode Island's Medicaid managed care program, and HEDIS® performance is an accreditation domain, both of the Health Plans report HEDIS® annually to the NCQA and the State. The two (2) Health Plans' HEDIS® measure calculations were audited by NCQA-certified audit firms, in conformity with the HEDIS® 2015 *Compliance Audit: Standards, Policies, and Procedures*. Both Health Plans were found compliant with all HEDIS® Information Systems (IS) and Measure Determination (HD) standards, and both passed the medical record review validation process.

Graphs depicting Health Plan and statewide rates for HEDIS® **Effectiveness of Care** and **Access and Availability** measures for Reporting Years 2013 through 2015, as well as comparative national benchmarks, are displayed on the following pages. Additionally, utilization of services was examined via selected HEDIS® **Use of Services** rates, while Health Plans' provider networks were evaluated by examining the *Board Certification* measure rates. The benchmarks utilized are those reported in the *Quality Compass*® 2015 for Medicaid. Statewide rates were calculated by totaling numerator and denominator counts for both Health Plans.

HEDIS® Effectiveness of Care Measures

HEDIS® **Effectiveness of Care** measures evaluate how well a Health Plan provides preventive screenings and care for members with acute and chronic illnesses. **Figure 3** displays selected Effectiveness of Care measure rates for HEDIS® 2013 through HEDIS® 2015 for each Health Plan, as well as the statewide rate, compared to the *Quality Compass*® 2015 national Medicaid benchmarks.

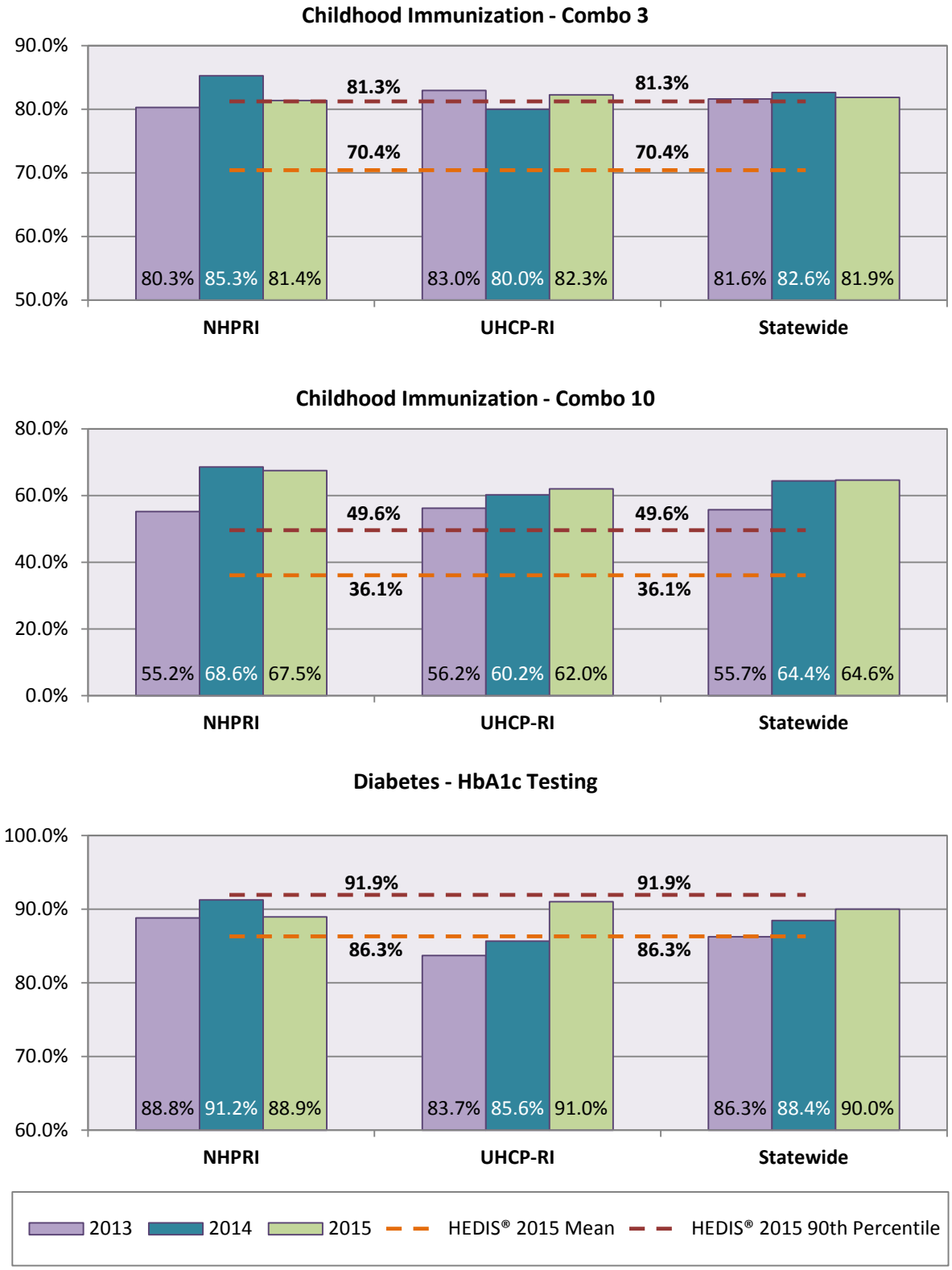
The statewide rates for all eight (8) measures displayed exceeded the 2015 national Medicaid mean, as did NHPRI's rates. UHCP-RI's rates exceeded the Medicaid mean for seven (7) measures; the Health Plan's rate for *Use of Appropriate Medications for Persistent Asthma (Total)* did not meet the Medicaid mean. Additionally, both Health Plans' rates, as well as the statewide rates, exceeded the 2015 *Quality Compass*® 90th percentile for both the *Childhood Immunization—Combo 3* and *Childhood Immunization—Combo 10* measures. UHCP-RI also exceeded the 90th percentile for the *Follow-Up After Hospitalization for Mental Illness—30 Days* and *Follow-Up After Hospitalization for Mental Illness—7 Days* measures. Both the Health Plans' rates and the statewide rates benchmarked at the *Quality Compass*® 75th percentile for the *Cervical Cancer Screening* and *Chlamydia Screening (16-24 Years)* measures, as well.

[18] The rates for all HEDIS® measures for NHPRI and UHCP-RI include all Medicaid members, where eligible population criteria are met.

Figure 3: HEDIS® Effectiveness of Care Rates—2013-2015[1]

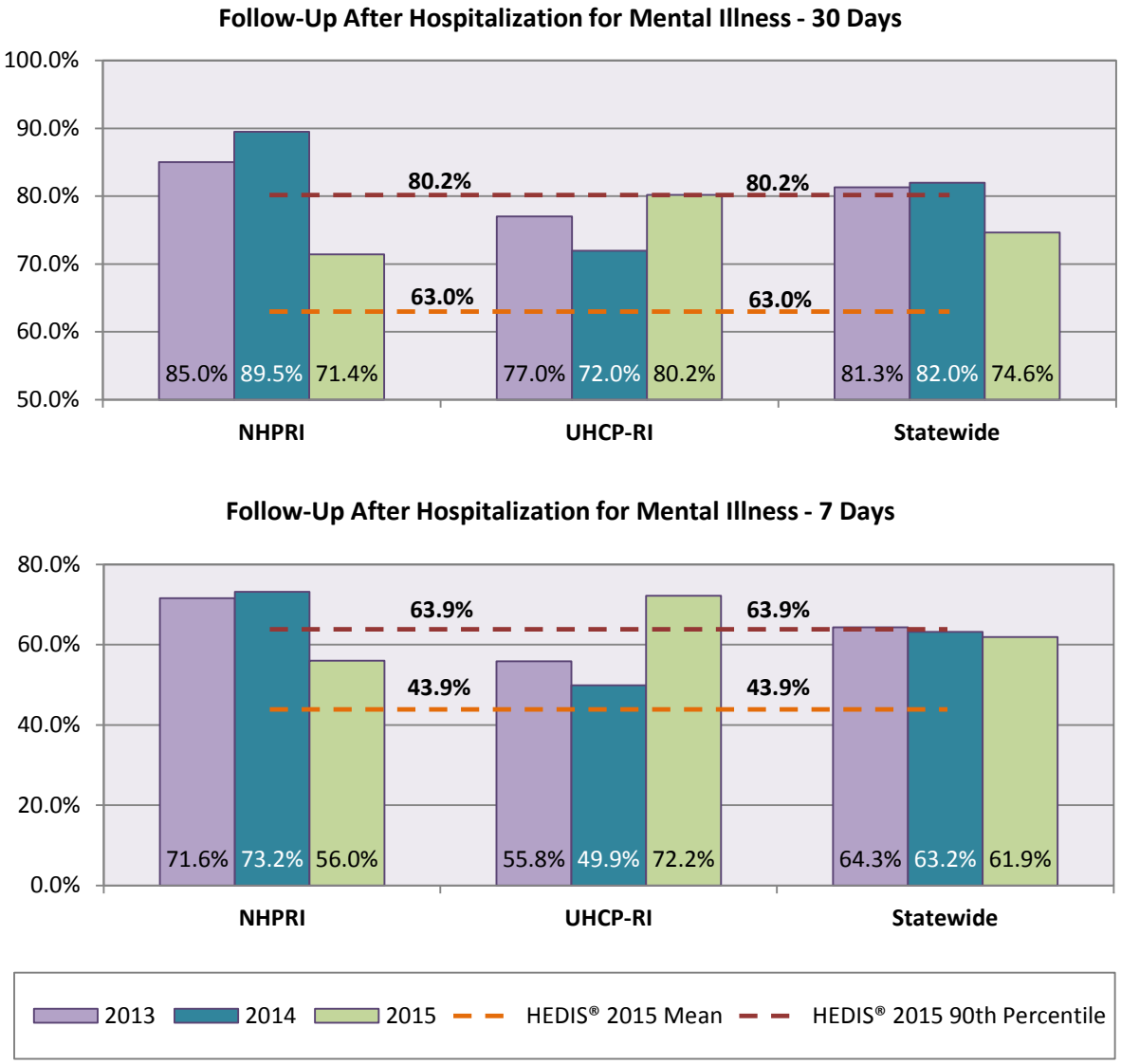
[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

Figure 3: HEDIS® Effectiveness of Care Rates—2013-2015[1] (continued)



[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

Figure 3: HEDIS® Effectiveness of Care Rates—2013-2015[1] (continued)



[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

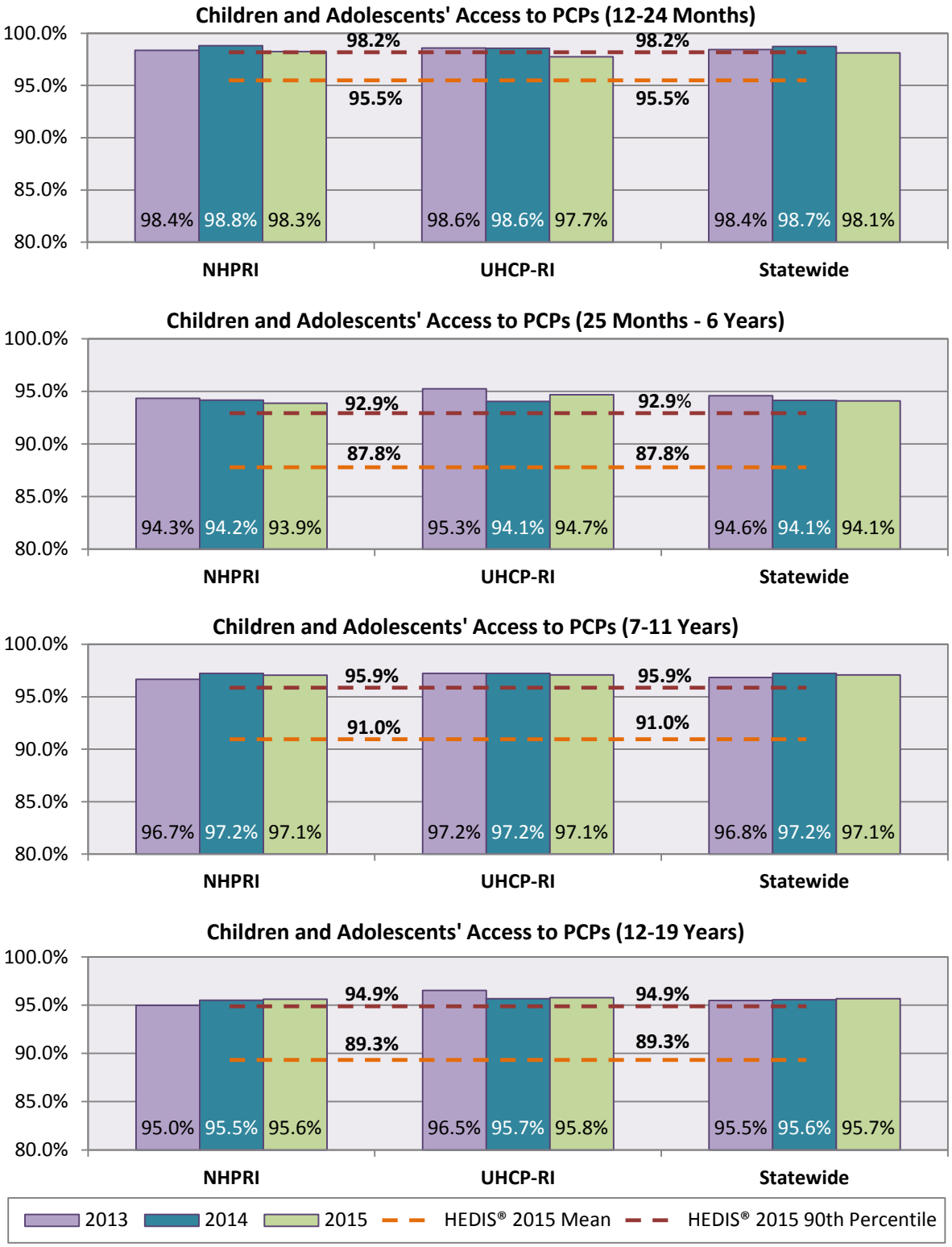
HEDIS® Access to/Availability of Care Measures

The HEDIS® **Access to/Availability of Care** measures examine the percentages of Medicaid children/adolescents, child-bearing women, and adults who receive PCP/preventive care services, ambulatory care (adults only), or receive timely prenatal and postpartum services. *Children and Adolescents' Access to Primary Care* measures the percentage of children aged twelve (12) months to six (6) years who had one (1) or more visits with a Health Plan primary care practitioner during the Measurement Year and the percentage of children aged seven through nineteen (7 through 19) years of age who had one (1) or more visits with a Health Plan primary care practitioner during the Measurement Year or the year prior. *Adults' Access to Preventive/Ambulatory Health Services* measures adults aged twenty (20) years and older who had one (1) or more ambulatory or preventive care visit(s) during the Measurement Year. *Prenatal and Postpartum Care* measures the percentage of women who received a prenatal care visit in the first trimester or within forty-two (42) days of enrollment in the Health Plan and the percentage of women who had a postpartum visit on or between twenty-one and fifty-six (21 and 56) days after delivery.

Figure 4 presents the Access to/Availability of Care measure rates for the two (2) Health Plans, as well as the statewide rates, for HEDIS® 2013 through HEDIS® 2015 as compared to national Medicaid benchmarks.

Overall performance for the Access to/Availability of Care domain was strong across the Health Plans. The rates for both Health Plans and the statewide rates exceeded the 2015 national Medicaid mean for all nine (9) measures. In regard to *Children and Adolescents' Access to Primary Care*, both Health Plans' rates, as well as the statewide rates, exceeded the 2015 *Quality Compass*® 90th percentile for the following age groups: *25 Months-6 Years, 7-11 Years,* and *12-19 Years.* While NHPRI did achieve the 90th percentile for the *12-24 Months* age group, UHCP-RI's rate and the statewide rate benchmarked at the 75th percentile. Both UHCP-RI's rate and the statewide rates met the 90th percentile for the *20-44 Years* and *45-64 Years* age groups of the *Adults' Access to Preventive/Ambulatory Health Services* measure, while NHPRI met the 75th percentile for all three (3) age groups, including the *65+ Years* group. Additionally, both UHCP-RI and the statewide rate achieved the 2015 *Quality Compass*® 90th percentile for *Timeliness of Prenatal Care*, while NHPRI met the 75th percentile. All three (3) rates exceeded the 75th percentile for *Timeliness of Postpartum Care*, as well.

Figure 4: HEDIS® Access to/Availability of Care Rates—2013-2015[1]

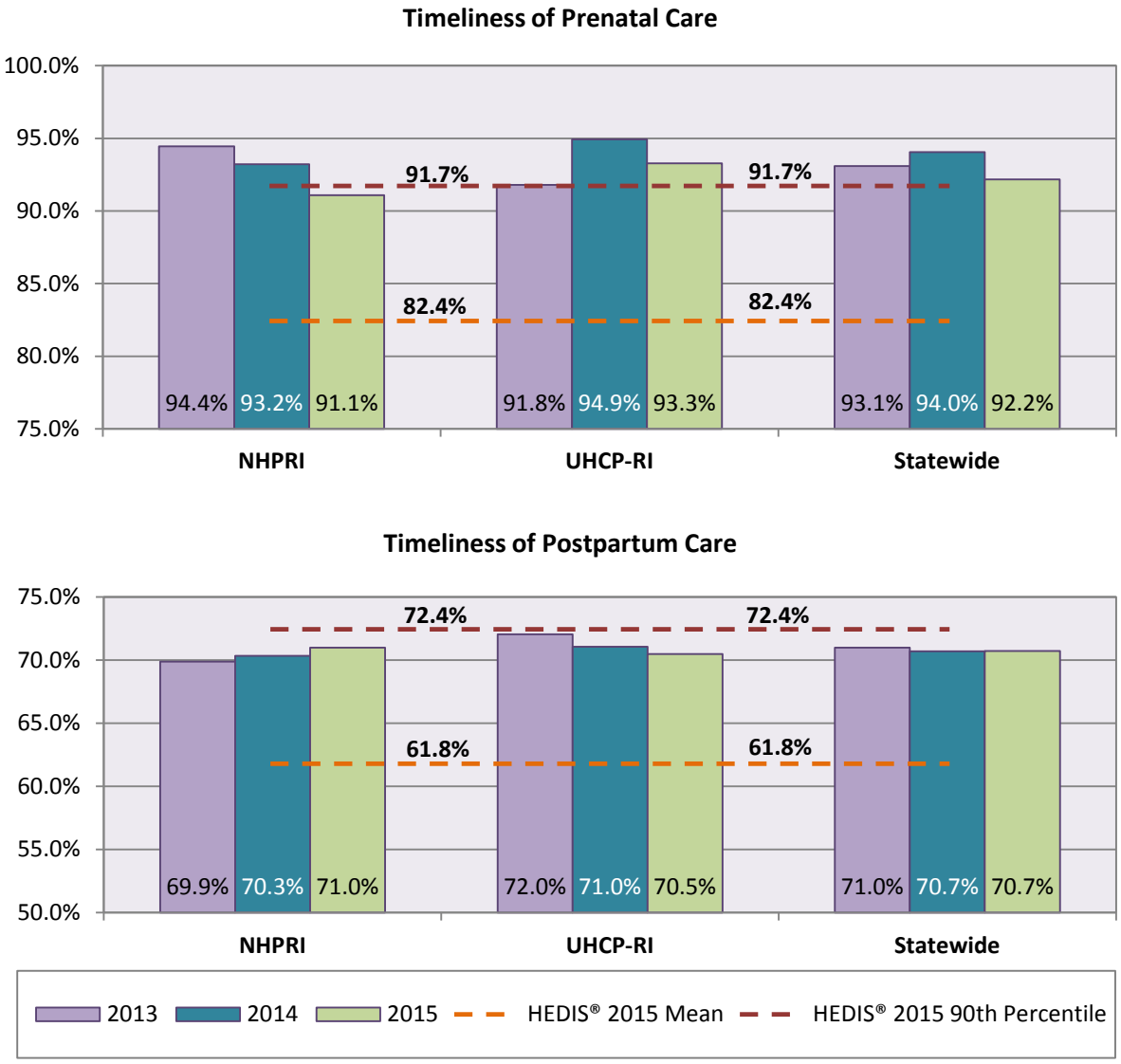


[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

Figure 4: HEDIS® Access to/Availability of Care Rates—2013-2015[1] (continued)

[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

Figure 4: HEDIS® Access to/Availability of Care Rates—2013-2015[1] (continued)



[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

HEDIS® Use of Services Measures

The HEDIS® **Use of Services** measures evaluate member utilization of Health Plan services. For this domain of measures, performance is assessed by comparison to *Quality Compass*® 2015 national Medicaid benchmarks. **Figure 5** displays selected measure rates for HEDIS® 2013 through HEDIS® 2015, as well as comparisons to the national Medicaid means and the 2015 *Quality Compass*® 90th percentiles for Medicaid.

Overall, both Health Plans demonstrated superior performance in the Use of Services domain. For HEDIS® 2015, the rates for all four (4) measures for both Health Plans exceeded the 2015 national Medicaid mean, as did the rates statewide. Additionally, both Health Plans' rates, as well as the statewide rates, achieved the 2015 *Quality Compass*® 90th percentile for the following measures: *Well-Child Visits in the First 15 Months of Life—6+ Visits, Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life,* and *Frequency of Ongoing Prenatal Care—81+%.* While NHPRI and the statewide rate both met exceeded the 90th percentile for *Adolescent Well-Care Visits,* UHCP-RI's rate benchmarked at the 75th percentile.

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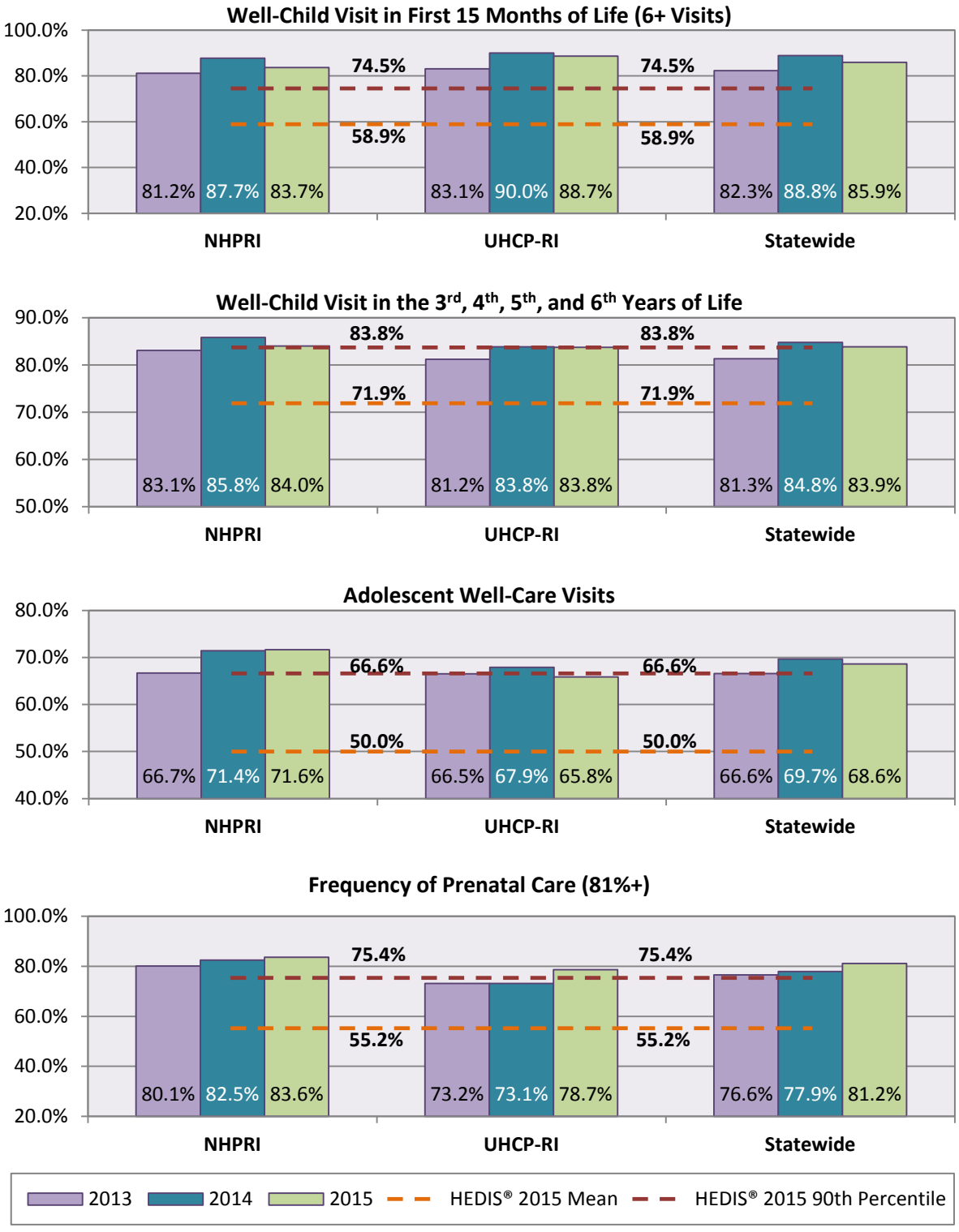
Figure 5: HEDIS® Use of Services Rates—2013-2015[1]



[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

IX. MEMBER SATISFACTION

Adult CAHPS® 5.0H[19]

The Rhode Island Executive Office of Health and Human Services requires, as part of the *Medicaid Managed Care Services Contract*, that each Health Plan collect member satisfaction data through an annual survey of a representative sample of its Medicaid members. In 2015, the **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H** survey of adult Medicaid members was conducted on behalf of each Health Plan by NCQA-certified survey vendors. **Figure 6** presents the survey items/composites and each Health Plan's 2015 rating, as well as the statewide rates, compared to *Quality Compass®* 2015 national Medicaid benchmarks. In 2014, the NCQA introduced the *Flu Vaccinations for Adults (18-64 Years)* measure to the Adult CAHPS® 5.0H survey. As such, this measure was not included in Figure 6. Rates for this measure can be found in the individual Plan Technical Reports. Additionally, the composite measure *Shared Decision Making* was modified for the 2015 survey, and therefore, was not included in the figure[20]. Specific results for this composite measure can be found in the Health Plan-specific Technical Reports.

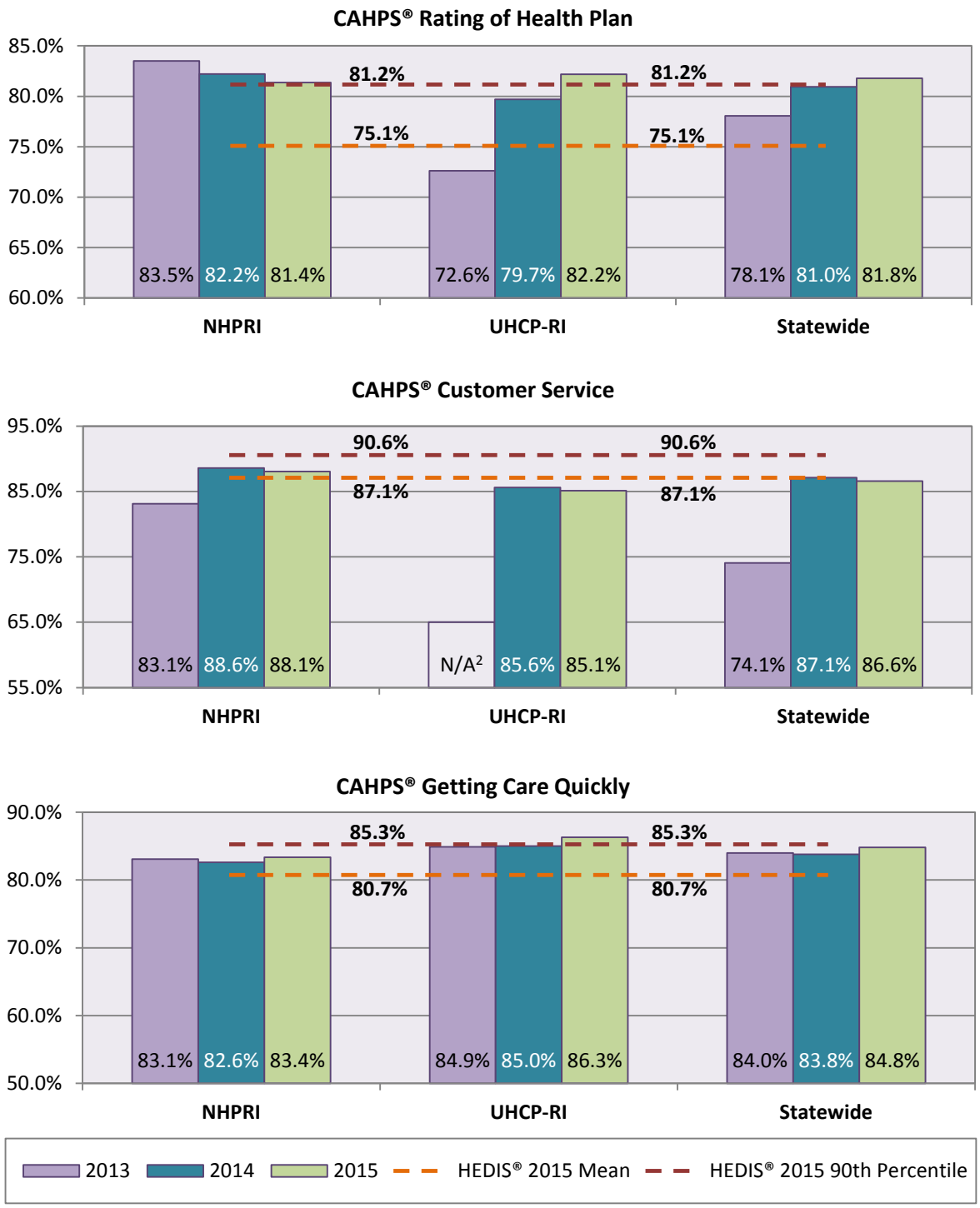
The results of the 2015 Adult CAHPS® 5.0H survey varied across the Health Plans. The Health Plans' rates, as well as the statewide rates, were above the 2015 national Medicaid mean for eight (8) of the nine (9) measures, all except *Customer Service.* Additionally, both Health Plans achieved the 2015 *Quality Compass®* 90th percentile for *Rating of Health Plan*, as did the rate statewide. In addition to the *Rating of Health Plan* measure, UHCP-RI's rates exceeded the 2015 *Quality Compass®* 90th percentile for the following measures: *Getting Care Quickly, How Well Doctors Communicate, Rating of All Health Care, Rating of Personal Doctor*, and *Shared Decision Making.* NHPRI did not achieve the 90th percentile for any additional measures.

In addition to the Adult CAHPS® Survey, UHCP-RI elected to distribute and report the Child CAHPS® 5.0 Survey in 2015. The Child Member Satisfaction results are not displayed here, as only one (1) Health Plan conducted this survey, and therefore, no comparison can be made. Specific results of this survey can be found in the individual Plan Technical Report for UHCP-RI.

[19] The rates for all Medicaid Adult CAHPS® measures for NHPRI and UHCP-RI include RHP and RHE members, as they were included in the random survey sample of adult members.

[20] In 2015, the questions within the *Shared Decision Making* composite measure were modified and the responses changed to "Yes" or "No", rather than "A Lot", "Some", "A Little", or "Not At All": Q10—Did you and a doctor or other health provider talk about the reasons you might want to take a medicine? Q11—Did you and a doctor or other health provider talk about the reasons you might not want to take a medicine? Q12—When you talked about starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you?

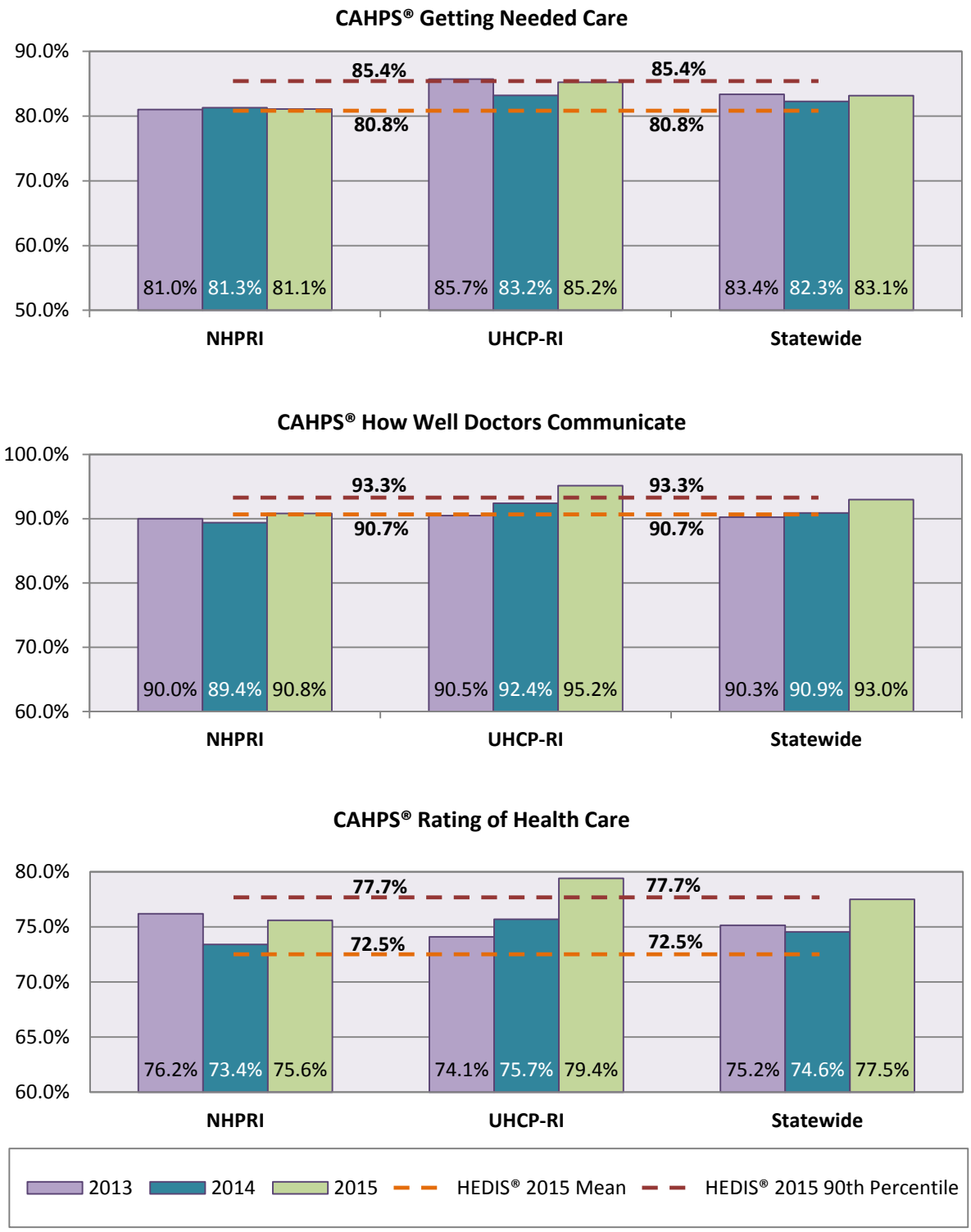
Figure 6: CAHPS® Member Satisfaction Rates—2013-2015[1,2]



[1] The statewide rate for each of these bar charts was determined by calculating an unweighted average of the Health Plans' rates, since the size of the survey populations was similar and numerators and denominators were not available.

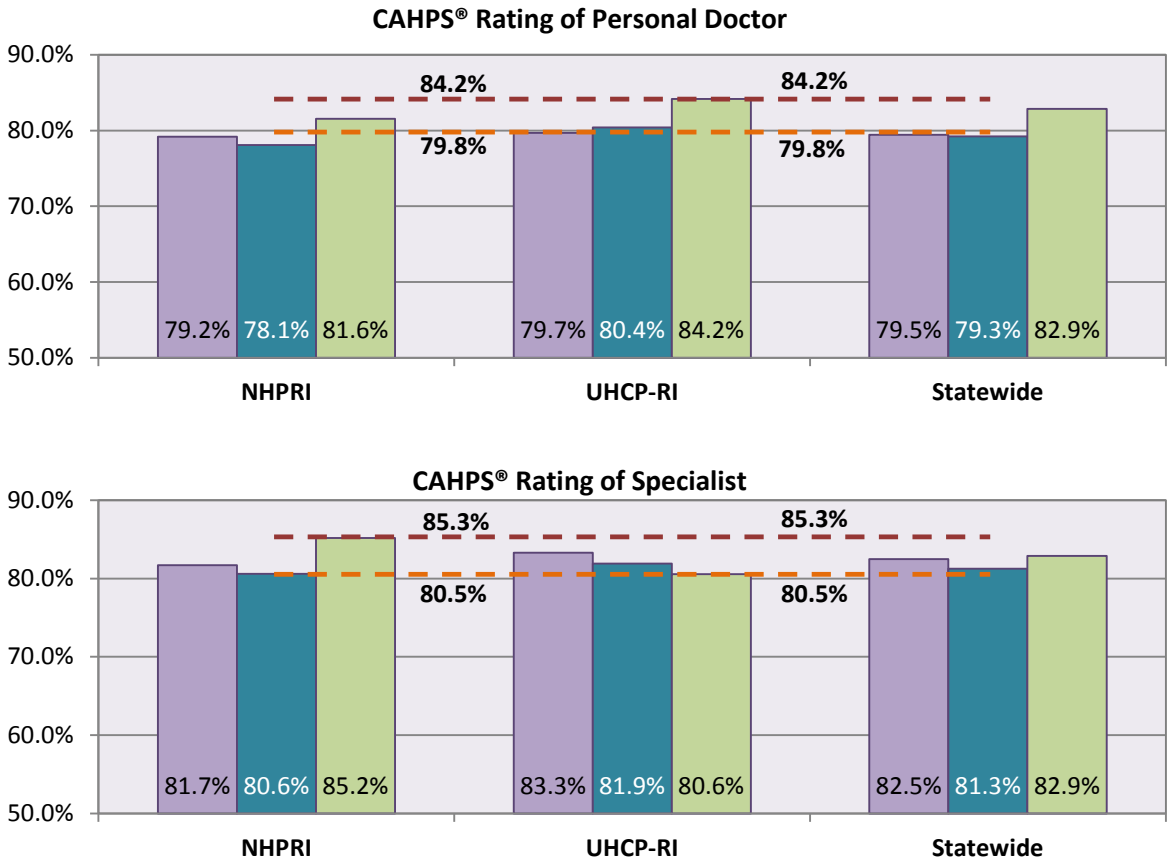
[2] The 'N/A' designation for the *Customer Service* measure for UHCP-RI in 2013 indicates that the denominator was less than 30 respondents.

Figure 6: CAHPS® Member Satisfaction Rates—2013-2015[1] (continued)



[1] The statewide rate for each of these bar charts was determined by calculating an unweighted average of the Health Plans' rates, since the size of the survey populations was similar and numerators and denominators were not available.

Figure 6: CAHPS® Member Satisfaction Rates—2013-2015[1] (continued)



[1] The statewide rate for each of these bar charts was determined by calculating an unweighted average of the Health Plans' rates, since the size of the survey populations was similar and numerators and denominators were not available.

X. RHODE ISLAND MEDICAID PERFORMANCE GOAL PROGRAM[21]

In order to measure the quality of care provided through the Health Plans, the State prepares and reviews a number of reports on a variety of quality indicators.

Rhode Island Performance Goal Program Background

In 1998, the State initiated the Rhode Island Performance Goal Program, an incentive program that established benchmark standards for quality and access performance measures. Rhode Island was the second state in the nation to implement a value-based purchasing incentive for its Medicaid program. In 2015, the Performance Goal Program entered its seventeenth (17th) year.

The 2005 Reporting Year marked a particularly important transition for the Performance Goal Program, wherein the program was redesigned to be more fully aligned with nationally recognized performance benchmarks through the use of new performance categories and standardized HEDIS® and CAHPS® measures. In addition, superior performance levels were clearly established as the basis for incentive awards. Since the 2005 Reporting Year, six (6) of the following ten (10) performance categories have been used to evaluate Health Plan performance:

- *Member Services*
- *Medical Home/Preventive Care*
- *Women's Health*
- *Chronic Care*
- *Behavioral Health*
- *Cost Management* (formerly *Resource Maximization*)
- *Children with Special Health Care Needs (added in 2010)*
- *Children in Substitute Care (added in 2011)*[22]
- *Rhody Health Partners (added in 2011)*
- *Rhody Health Expansion (added in 2015)*

Within these categories is a series of measures, including a variety of standard HEDIS® and CAHPS® measures, as well as State-specified measures for areas of particular importance to the State that do not have national metrics for comparison. Many of the measures are calculated through the Health Plans' HEDIS® and CAHPS® data submissions. Other measures are derived from data collected during the annual, on-site Health Plan monitoring visits conducted by EOHHS, and others are calculated by EOHHS using encounter data submitted by the Health Plans to EOHHS. For the reference period of Calendar Year 2014, the evaluation was conducted by EOHHS in April and May of 2015.

Prior to 2005, the State specified performance goal standards in its contracts with Health Plans, and the Health Plans received awards based on meeting or exceeding the specified targets. From 2005 to 2010, Rhode Island's Medicaid-participating Health Plans were benchmarked against the *Contract* standards, as well as national Medicaid HEDIS® percentiles. Health Plans that met or exceeded the 90th percentile received a full award for those measures, and Health Plans that met or exceeded the 75th percentile received a partial award for those measures.

[21] The rates for all PGP measures for NHPRI and UHCP-RI include all Medicaid members, where eligible population criteria are met.

[22] UHCP-RI does not serve the Children in Substitute Care population.

As of 2011, only *Quality Compass*® benchmarks are used to assess performance for all HEDIS® and CAHPS® measures, as directed in *Attachment M* of the State's 2009/2010 *Medicaid Managed Care Services Contract*. PGP 2011 was the first year that several measure benchmarks were set at the 75th percentile (full award) and the 50th percentile (partial award). The following measures were included: HEDIS® *Adult BMI Assessment,* HEDIS® *Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents,* and HEDIS® *Antidepressant Medication Management*. State-selected targets continued to be used for the State-specified measures, as no national benchmark data exist. In addition, modifications made to the Performance Goal Program in 2011 included a change in the allocation of full incentive award percentages. Available percentage points were reduced for the Member Services domain and increased for the Behavioral Health domain.

For the 2013 PGP, the following measure was introduced: HEDIS® *Members with Persistent Asthma Used Appropriate Meds (Total)*. This measure is an aggregate of the *Members with Persistent Asthma Used Appropriate Meds* age group-stratified measures. Prior to the 2013 PGP, each age-stratified measure was eligible for the incentive award; however, only the total rate was used in the calculation of the 2013 incentive. Although the age-stratified HEDIS® *Members with Persistent Asthma Used Appropriate Meds* measures were not individually eligible for inclusion in the incentive award, rates for these measures are presented.

Changes in Methodology for the 2015 Performance Goal Program

The 2015 Performance Goal Program underwent some changes from the 2014 PGP.

For the 2015 PGP, the following HEDIS® measures were added to the Behavioral Health domain: *Initiation of Alcohol and Other Drug Treatment, Engagement of Alcohol and Other Drug Treatment, Adherence to Antipsychotics for Individuals with Schizophrenia*, and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*. These measures were considered baseline rates in the 2015 PGP, and as such were not eligible for incentive awards. In addition, in 2015, the NCQA retired the HEDIS® *Annual Monitoring for Patients on Persistent Medications—Anticonvulsants* measure. This measure has been removed from the PGP metrics.

Additionally, with the introduction of the Rhody Health Expansion (RHE) population, results were reported separately for the RHE population and Non-RHE populations (all lines of business except RHE) for the 2015 PGP. The Health Plan earned incentive awards for both the RHE and Non-RHE populations for the 2015 PGP.

As in the past, any measure rates rotated by the Health Plan were not eligible for incentive awards.

2015 Rhode Island Medicaid Managed Care Performance Goal Program Results—Non-RHE

This section of the report evaluates the results of the 2015 Performance Goal Program for both Health Plans' for Non-RHE members. In 2015, incentives were awarded separately for the Non-RHE lines of business (all lines of business except RHE) and the RHE population. The Health Plans' rates were compared to HEDIS® percentiles derived from the 2014 *Quality Compass*® for Medicaid. As such, these percentiles may differ from the *Quality Compass*® 2015 benchmark data displayed elsewhere in this report.

The **Member Services** domain is comprised of four (4) State-specified measures regarding Health Plan processes related to new members and appeals and grievances: *ID Cards Sent within 10 Days of Notification of Enrollment, Member Handbook Sent within 10 Days of Notification of Enrollment, Two Member Welcome Call Attempts within the First 30 Days of Enrollment*, and *Grievances and Appeals Resolved within Federal (BBA) Timeframes.* NHPRI did not meet the *Contract* goal for any of the four (4) measures, demonstrating a decline in performance, as the Health Plan had met the goals for both *10 Days of Notification of Enrollment* and *Member Handbook Sent within 10 Days of Notification of Enrollment* in 2014. UHCP-RI met the goal for one (1) measure, *ID Cards Sent within 10 Days of Notification of Enrollment,* demonstrating improvement, as the Health Plan had not met the goal for any of the four (4) measures in 2014.

Overall, the Health Plans continued to perform well and demonstrate some improvement in the **Medical Home/ Preventive Care** domain, with rates benchmarking in the 2014 *Quality Compass*® 90th and 75th percentiles for many of the measures. Both Health Plans achieved the 2014 *Quality Compass*® 90th or 75th percentiles for the following HEDIS® measures: *Adults Had Ambulatory/Preventive Care Visit (20-44 Years* and *45-64 Years); Infants Had Well-Child Visits in the First 15 Months of Life (6+ Visits); Children Had Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Children Received Immunizations by 2nd Birthday (Combo 3* and *Combo 10); Adolescents Received Immunizations by 13th Birthday; Children Received Periodic PCP Visits (25 Months-6 Years, 7-11 Years,* and *12-19 Years); Lead Screening in Children; Pregnant Members Received Timely Prenatal Care; Postpartum Members Received Timely Postpartum Care; Adolescent Well-Care Visits; Frequency of Ongoing Prenatal Care—81+ Percent of Expected Visits; Adult BMI Assessment;* and *Weight Assessment and Counseling for Children and Adolescents (BMI Percentile, Nutrition,* and *Physical Activity)*. Only NHPRI achieved a *Quality Compass*® percentile benchmark to qualify for an incentive award for the *Children Received Periodic PCP Visits (12-24 Months)* measure. In addition, neither Health Plan met a benchmark goal for the *Use of Imaging Studies for Low Back Pain* measure.

The Medical Home/Preventive Care domain also contains two (2) CAHPS® measures: *Members were Satisfied with Access to Urgent Care* and *Medical Assistance with Smoking/Tobacco Use Cessation*. NHPRI met the 2014 *Quality Compass*® 75th percentile for both of these measures, while UHCP-RI benchmarked at the 90th percentile for both measures.

In regard to the State-specified measure, *Reduction in Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs)*[23] *by 5 Percentage Points,* NHPRI met the *Contract* goal for the Core RIte Care population, while UHCP-RI met the goal for the Rhody Health Partners population. NHPRI did not meet the *Contract* goal for the Substitute Care[24] population, and neither Health Plan met the goal for the Children with Special Health Care Needs population. This demonstrates a decline in performance, as both UHCP-RI and NHPRI met the *Contract* goal for the Children with Special Health Care Needs population in 2014.

[23] The State's *Medicaid Managed Care Services Contract* (09/01/2010) requires that all Health Plans establish and maintain a *Communities of Care* program to decrease non-emergent and avoidable ED utilization and costs through service coordination, defined member responsibilities, and associated incentives and awards.

[24] UHCP-RI does not serve the Children in Substitute Care population.

In the Medical Home/Preventive Care domain, four (4) measures were not eligible for an incentive award: HEDIS® *Monitoring of Persistent Medications—ACE/ARB, Digoxin, Diuretics,* and *Total.*

In the **Women's Health** domain, both Health Plans demonstrated improvement. NHPRI achieved the 2014 *Quality Compass*® 90th percentile for both *Chlamydia Screening for Women (16-20 Years)* and *(21-24 Years)*. Comparatively, UHCP-RI achieved the 2014 *Quality Compass*® 75th percentile for both age groups in 2015. In 2014, both Health Plans benchmarked at the 75th percentile for the *16-20 Years* age group and did not meet a *Quality Compass*® benchmark to qualify for an incentive award for the *21-24 Years* cohort. The third measure in this domain, *Cervical Cancer Screening for Women (21-64 Years)* was not eligible for an incentive award.

In 2015, there were five (5) HEDIS® measures in the **Chronic Care** domain that were eligible for incentive awards. For this domain, performance varied across the Health Plans and measures. Both NHPRI and UHCP-RI met the 2014 *Quality Compass*® 90th percentile for the *Controlling High Blood Pressure (<140/90) (18-85 Years)* measure. Additionally, NHPRI and UHCP-RI met the 90th and 75th percentiles for the *Pharmacotherapy for COPD Exacerbation—Systemic Corticosteroids* measure, respectively. NHPRI was the only Health Plan to achieve a *Quality Compass*® percentile to qualify for an incentive award for the *Pharmacotherapy for COPD Exacerbation—Bronchodilators* measure, benchmarking at the 90th percentile. Comparatively, UHCP-RI was the only Health Plan to achieve a *Quality Compass*® percentile to qualify for an incentive award for the *Members with Diabetes Had HbA1c Testing (18-75 Years)* measure, benchmarking at the 75th percentile. Both Health Plans failed to meet the benchmark percentile goals for the *Members with Persistent Asthma Used Appropriate Medications (Total)* measure. The remaining four (4) measures in this domain, *Members with Persistent Asthma Used Appropriate Medications (5-11 Years, 12-18 Years, 19-50 Years,* and *51-64 Years)* were recorded, but were not eligible for incentive awards, as the aggregate rate was used to calculate the incentive.

In 2015, the **Behavioral Health** domain was comprised of eight (8) HEDIS® measures. The following four (4) measures were introduced for the 2015 PGP, and therefore were considered baseline rates and were not eligible for incentive awards: *Initiation of Alcohol and Other Drug Treatment, Engagement of Alcohol and Other Drug Treatment, Adherence to Antipsychotics for Individuals with Schizophrenia,* and *Use of Multiple Concurrent Antipsychotics in Children/Adolescents.*

In the Behavioral Health domain, performance varied across Health Plans: NHPRI demonstrated a decline in performance for three (3) of the four (4) applicable measures in this domain, while UHCP-RI demonstrated improvement. In 2014, NHPRI achieved the *Quality Compass*® 90th percentile for both *Members 6 Years and Older Get Follow-Up 30 Days Post-Discharge* and *Members 6 Years and Older Get Follow-Up 7 Days Post-Discharge*. However, in 2015, the Health Plan's rates declined to the 75th percentile for the *30 Days* measure and did not meet a benchmark percentile to qualify for an incentive award for the *7 Days* measure. Conversely, UHCP-RI achieved the *Quality Compass*® 90th percentile for both the *30 Days* and the *7 Days* measures in 2015 after not achieving a benchmark percentile to qualify for an incentive in 2014. Both Health Plans achieved the *Quality Compass*® 75th percentile for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure in 2015, whereas both Health Plans achieved the 90th percentile in 2014. NHPRI maintained the same performance for the *Antidepressant Medication Management—Effective Acute Phase* measure as 2014, benchmarking at the 50th percentile; UHCP-RI also benchmarked at the 50th percentile for this measure, after not achieving a benchmark percentile to qualify for an incentive in 2014.

Both Health Plans continued to meet the State-specified goal for the sole measure in the **Cost Management** (formerly Resource Maximization) domain: *Notify the State of Third-Party Liability (TPL) within Five (5) Days of Identification*.

Overall, performance was similar between the Health Plans for the 2015 Performance Goal Program. NHPRI met a benchmark goal for thirty-two (32) of forty-nine (49) applicable PGP measures[25]: two (2) of fifteen (15) State-specified measures (including one (1) of nine (9) measures related to special enrollment populations) and thirty (30) of thirty-four (34) HEDIS®/CAHPS® measures.

Comparatively, UHCP-RI's evaluation was comprised of forty-six (46) PGP measures, as three (3) of fifteen (15) State-specified measures did not apply due to UHCP-RI's lack of the Children in Substitute Care (SC) population. UHCP-RI met a benchmark goal for thirty-five (35) of forty-six (46) applicable PGP measures, as well, including four (4) State-specified measures and twenty-nine (29) HEDIS® measures.

Total measure counts for both Health Plans excluded measures designated as baseline measures and those not eligible for incentive awards.

Table 7 displays the Performance Goal Program rates for each of the Health Plans. It is important to note that a total of nine (9) HEDIS® measures were recorded, but were not eligible for incentive awards, including, four (4) measures related to the *Members with Persistent Asthma Used Appropriate Medications* measure were noted as 'N/A', as these measures were not included in the calculation of the incentive award. In addition, four (4) measures were introduced for PGP 2015, and therefore were considered baseline measures and were not eligible for incentive awards.

Graphs of select measures follow Table 7. **Figures 7a, 7b, 7c,** and **7d** graphically depict Health Plan and statewide performance on measures not displayed elsewhere in this report, including CAHPS®, HEDIS®, and State-specified measures in the Medical Home/Preventive Care (Figure 7a), Chronic Care (Figure 7b), Behavioral Health (Figure 7c), and Cost Management (Figure 7d) domains.

Certain measures were not graphed due to insufficient data points (e.g., baseline measures) or because the 2015 Performance Goal Program measures were based on HEDIS® or CAHPS® measures exhibited elsewhere in this report.

[25] For NHPRI, there were three (3) additional performance measures related to the special enrollment populations, as the Health Plan served Children in Substitute Care, in addition to CSHCN and RHP members. This resulted in NHPRI having a total of forty-nine (49) applicable PGP measures.

Table 7: Performance Rates and Goals—2015—Non-RHE Populations[1,2,3]

RI Medicaid Managed Care 2015 Performance Goal Measures	NHPRI		UHCP-RI	
	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]
Member Services				
ID Cards Sent within 10 Days of Notification of Enrollment[4]	NM		M/E	
Member Handbook Sent within 10 Days of Notification of Enrollment[4]	NM		NM	
Two Welcome Call Attempts within the First 30 Days of Enrollment[4]	NM		NM	
Grievances and Appeals Resolved within Federal (BBA) Timeframes[4]	NM		NM	
Medical Home/Preventive Care				
CAHPS® Members Were Satisfied with Access to Urgent Care	87.4%	**75th**	89.3%	**90th**
Reduce ED Visits for ACSCs by 5 Percentage Points—Core RC Members[4,5,6]	M/E		NM	
Reduce ED Visits for ACSCs by 5 Percentage Points—RC for CSHCN[4,5,6]	NM		NM	
Reduce ED Visits for ACSCs by 5 Percentage Points—RC for SC[4,5,6,7]	NM			
Reduce ED Visits for ACSCs by 5 Percentage Points—RHP[4,5,6]	NM		M/E	
CAHPS® Medical Assistance with Smoking/Tobacco Use Cessation	80.0%	**75th**	86.4%	**90th**
HEDIS® Adults Had Ambulatory/Preventive Care Visit (20-44 Years)	88.8%	**90th**	89.0%	**90th**
HEDIS® Adults Had Ambulatory/Preventive Care Visit (45-64 Years)	92.2%	**75th**	93.2%	**90th**
HEDIS® Infants Had Well-Child Visits in the First 15 Months of Life (6+ Visits)	83.7%	**90th**	88.7%	**90th**
HEDIS® Children Had Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	84.0%	**90th**	83.8%	**90th**
HEDIS® Children Received Immunizations by 2nd Birthday—Combination 3	81.4%	**90th**	82.3%	**90th**
HEDIS® Children Received Immunizations by 2nd Birthday—Combination 10	67.5%	**90th**	62.0%	**90th**
HEDIS® Adolescents Received Immunizations by 13th Birthday	90.3%	**90th**	86.5%	**90th**
HEDIS® Children Received Periodic PCP Visits (12-24 Months)	98.3%	**75th**	97.8%	**NM**
HEDIS® Children Received Periodic PCP Visits (25 Months-6 Years)	93.9%	**90th**	94.7%	**90th**
HEDIS® Children Received Periodic PCP Visits (7-11 Years)	97.1%	**90th**	97.1%	**90th**
HEDIS® Children Received Periodic PCP Visits (12-19 Years)	95.6%	**90th**	95.8%	**90th**
HEDIS® Lead Screening in Children	84.7%	**75th**	82.3%	**75th**

M/E: Met or exceeded *Contract* goal.
NM: Did not meet *Contract* goal.
BM: Baseline measure.
N/A: Not applicable for measurement.

Table 7: Performance Rates and Goals—2015—Non-RHE Populations[1,2,3]

RI Medicaid Managed Care 2014 Performance Goal Measures	NHPRI		UHCP-RI	
	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]
Medical Home/Preventive Care (continued)				
HEDIS® Pregnant Members Received Timely Prenatal Care	91.2%	**75th**	93.5%	**90th**
HEDIS® Postpartum Members Received Timely Postpartum Care	71.9%	**75th**	70.5%	**75th**
HEDIS® Adolescent Well-Care Visits	71.6%	**90th**	67.5%	**90th**
HEDIS® Frequency of Ongoing Prenatal Care (≥81% of Expected Visits)	83.9%	**90th**	78.5%	**90th**
HEDIS® Adult BMI Assessment (18-74 Years)[8]	89.8%	**75th**	92.6%	**90th**
HEDIS® Weight Assessment & Counseling (3-17 Years)—BMI Percentile[8]	82.5%	**90th**	78.0%	**75th**
HEDIS® Weight Assessment & Counseling (3-17 Years)—Nutrition[8]	79.7%	**90th**	76.7%	**75th**
HEDIS® Weight Assessment & Counseling (3-17 Years)—Physical Activity[8]	67.2%	**75th**	70.9%	**90th**
HEDIS® Monitoring of Persistent Medications—ACE/ARB[9]	85.4%	**BM**	86.2%	**BM**
HEDIS® Monitoring of Persistent Medications—Digoxin[9,10]	NR	**BM**	47.4%	**BM**
HEDIS® Monitoring of Persistent Medications—Diuretics[9]	84.8%	**BM**	84.2%	**BM**
HEDIS® Monitoring of Persistent Medications—Total[9]	85.0%	**BM**	85.1%	**BM**
HEDIS® Use of Imaging for Low Back Pain	74.2%	**NM**	31.5%	**NM**
Women's Health				
HEDIS® Women Received Cervical Cancer Screening (21-64 Years)[9]	71.3%	**BM**	74.0%	**BM**
HEDIS® Women Received Chlamydia Screening (16-20 Years)	65.4%	**90th**	61.6%	**75th**
HEDIS® Women Received Chlamydia Screening (21-24 Years)	73.1%	**90th**	67.8%	**75th**
Chronic Care				
HEDIS® Members with Persistent Asthma Used Appropriate Meds (5-11 Years)[11,12]	91.6%	**N/A**	89.9%	**N/A**
HEDIS® Members with Persistent Asthma Used Appropriate Meds (12-18 Years)[11,12]	87.5%	**N/A**	84.7%	**N/A**
HEDIS® Members with Persistent Asthma Used Appropriate Meds (19-50 Years)[11,12]	78.8%	**N/A**	73.3%	**N/A**
HEDIS® Members with Persistent Asthma Used Appropriate Meds (51-64 Years)[11,12]	74.2%	**N/A**	76.0%	**N/A**
HEDIS® Members with Persistent Asthma Used Appropriate Meds (Total)[12]	86.1%	**NM**	81.0%	**NM**
HEDIS® Members with Diabetes Had HbA1c Testing (18-75 Years)	86.6%	**NM**	88.3%	**75th**

M/E: Met or exceeded *Contract* goal.
NM: Did not meet *Contract* goal.
BM: Baseline measure.
N/A: Not applicable for measurement.
NR: Not reported.

Table 7: Performance Rates and Goals—2015—Non-RHE Populations[1,2,3]

RI Medicaid Managed Care 2014 Performance Goal Measures	NHPRI		UHCP-RI	
	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]
Chronic Care				
HEDIS® Controlling High Blood Pressure (<140/90) (18-85 Years)	70.6%	**90th**	70.9%	**90th**
HEDIS® Pharmacotherapy for COPD Exacerbation—Bronchodilators	90.4%	**90th**	86.0%	**NM**
HEDIS® Pharmacotherapy for COPD Exacerbation—Systemic Corticosteroids	83.7%	**90th**	75.0%	**75th**
Behavioral Health				
HEDIS® Members 6 Years and Older Get Follow-Up by *30 Days* Post-Discharge	73.6%	**NM**	82.4%	**90th**
HEDIS® Members 6 Years and Older Get Follow-Up by *7 Days* Post-Discharge	58.6%	**75th**	75.1%	**90th**
HEDIS® Antidepressant Medication Management—Effective Acute Phase[8]	52.8%	**50th**	51.2%	**50th**
HEDIS® Follow-Up Care for Children Prescribed ADHD Medication—Initiation	52.1%	**75th**	51.1%	**75th**
HEDIS® Initiation of Alcohol and Drug Treatment[13]	46.1%	**BM**	52.2%	**BM**
HEDIS® Engagement of Alcohol and Drug Treatment[13]	17.1%	**BM**	21.5%	**BM**
HEDIS® Adherence to Antipsychotics for Individuals with Schizophrenia[13]	72.9%	**BM**	68.2%	**BM**
HEDIS® Use of Multiple Concurrent Antipsychotics in Children/Adolescents[13]	2.3%	**BM**	1.4%	**BM**
Cost Management				
Notify State of Third-Party Liability within 5 Days of Identification[4]	M/E		M/E	
Children with Special Health Care Needs (CSHCN)				
Initial Health Screen Completed within 45 Days[4,14]	NM		NM	
Active Care Management Plan Evaluated/Updated No Less Than Every 6 Months[4,14]	NM		M/E	
Children in Substitute Care (Foster)[7]				
Initial Health Screen Completed within 45 Days[4,14]	NM			
Active Care Management Plan Evaluated/Updated No Less Than Every 6 Months[4,14,15]	N/A			
Rhody Health Partners (RHP)				
Initial Health Screen Completed within 45 Days[4,14]	NM		NM	
Active Care Management Plan Evaluated/Updated No Less Than Every 6 Months[4,14]	NM		NM	

M/E: Met or exceeded *Contract* goal.
NM: Did not meet *Contract* goal.
BM: Baseline measure.
N/A: Not applicable for measurement.

[1] Performance Goal Program data are based on the previous Contract Year (i.e., 2015 rates are based on Contract Year 2014). Rates may differ from other data published in this report, as this table reflects preliminary HEDIS® and CAHPS® rates, while rates in all other tables reflect final data submitted to the NCQA. In addition, it is important to note that, where applicable and eligible population criteria are met, all Medicaid members (Core, CSHCN, SC, and RHP) are included in the rates, including State-specified measures, unless noted otherwise.

[2] For State-specified measures, national benchmarks are not available. Incentive awards are determined using State-selected benchmarks. These are defined in the September 2010 *Medicaid Managed Care Services Contract, Attachment M.*

[3] For HEDIS®- and CAHPS®-based measures, incentive awards were based, where applicable and available, on national Medicaid 2014 *Quality Compass®* 90th, 75th, and 50th percentile benchmarks (unless otherwise noted).

[4] State-specified measure.

[5] *Reduction in Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs)* was reported by product line for the first time for the 2011 PGP. Previously, an aggregate rate was reported across Health Plan membership. The measure goal was a 5 percentage point reduction, year-over-year, in the rate calculated by the State for each of the applicable populations.

[6] As of July 1, 2013, the State's encounter data submission process was modified as a result of the implementation of the State's new 837 Encounter Data System. As a result of the modification, EOHHS based the outcome of the *Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs)* measure for the 2015 PGP on encounter data from July 2014 through December 2014 as compared to the findings in the corresponding six-month period in the prior calendar year.

[7] Children in Substitute Care are served only by NHPRI.

[8] The benchmarks for incentive awards were the 75th percentile (full award) and the 50th percentile for the following measures: HEDIS® *Adult BMI Assessment;* HEDIS® *Weight Assessment and Counseling (3-17 Years) for BMI Percentile, Nutrition, and Physical Activity;* and HEDIS® *Antidepressant Medication Management—Effective Acute Phase.*

[9] Benchmarks were available in *Quality Compass®* 2014 for HEDIS® *Monitoring of Persistent Medications—ACE/ARB, Digoxin, Diuretics,* and *Total,* and HEDIS® *Cervical Cancer Screening for Women (21-64 Years)*; however, the rates were not eligible for incentive awards for PGP 2015.

[10] The 'NR' designation for HEDIS® *Monitoring of Persistent Medications—Digoxin* for NHPRI indicates a sample size of less than 30 members.

[11] Rates for the following measures are presented for PGP 2015; however, were not eligible for an incentive award: HEDIS® *Members with Persistent Asthma Used Appropriate Meds (5-11 Years),* HEDIS® *Members with Persistent Asthma Used Appropriate Meds (12-18 Years),* HEDIS® *Members with Persistent Asthma Used Appropriate Meds (19-50 Years),* and HEDIS® *Members with Persistent Asthma Used Appropriate Meds (51-64 Years).*

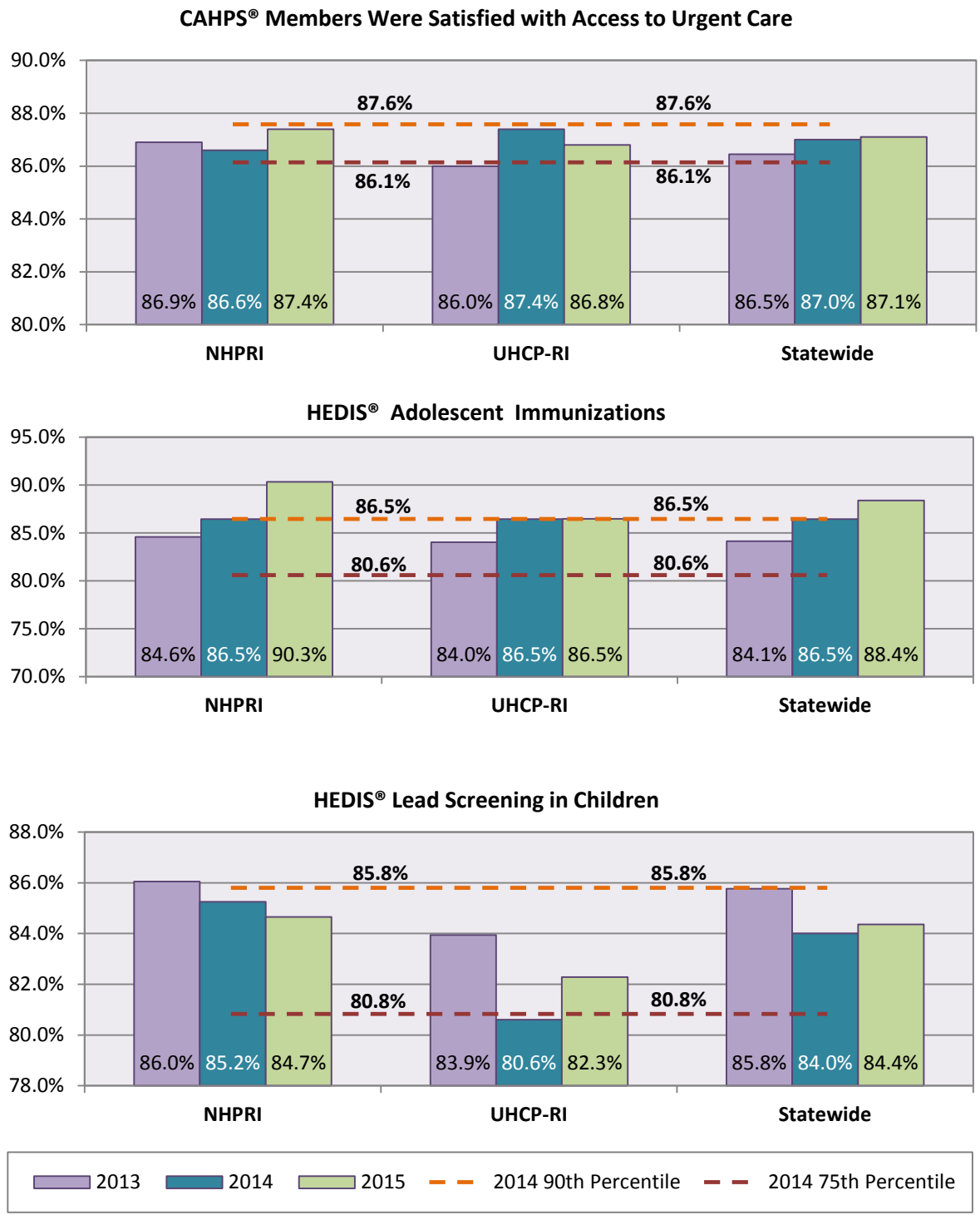
[12] Prior to PGP 2012, the HEDIS® *Members with Persistent Asthma Used Appropriate Meds* reported a single rate for the age group 12-50 years old. For the 2012 PGP, this age group was split, with rates reported separately for ages 5-11 years, 12-18 years, 19-50 years, and 51-64 years. For PGP 2015, all age groups are reported, in addition to an aggregate measure, HEDIS® *Members with Persistent Asthma Used Appropriate Meds (Total)*; however, the incentive award was based solely on the total rate.

[13] The following measures were introduced for the 2015 PGP: *Reduction* HEDIS® *Initiation of Alcohol and Other Drug Treatment,* HEDIS® *Engagement of Alcohol and Other Drug Treatment,* HEDIS® *Adherence to Antipsychotics for Individuals with Schizophrenia,* and HEDIS® *Use of Multiple Concurrent Antipsychotics in Children/Adolescents.*

[14] The following State-specified measures were eligible for incentive awards: *Initial Health Screens Completed within 45 Days of Enrollment* and *Active Care Management Plans are Evaluated and Updated, as Needed, No Less Than Every 6 Months* for the CSHCN, SC (NHPRI only), and RHP special enrollment populations.

[15] The 'N/A' designations for the *Active Care Management Plans are Evaluated and Updated, as Needed, No Less Than Every 6 Months* measure for NHPRI's Children in Substitute Care population indicate that there were no eligible members in the case review sample that required care management services or the members' care plans did not require evaluation and update during the review periods.

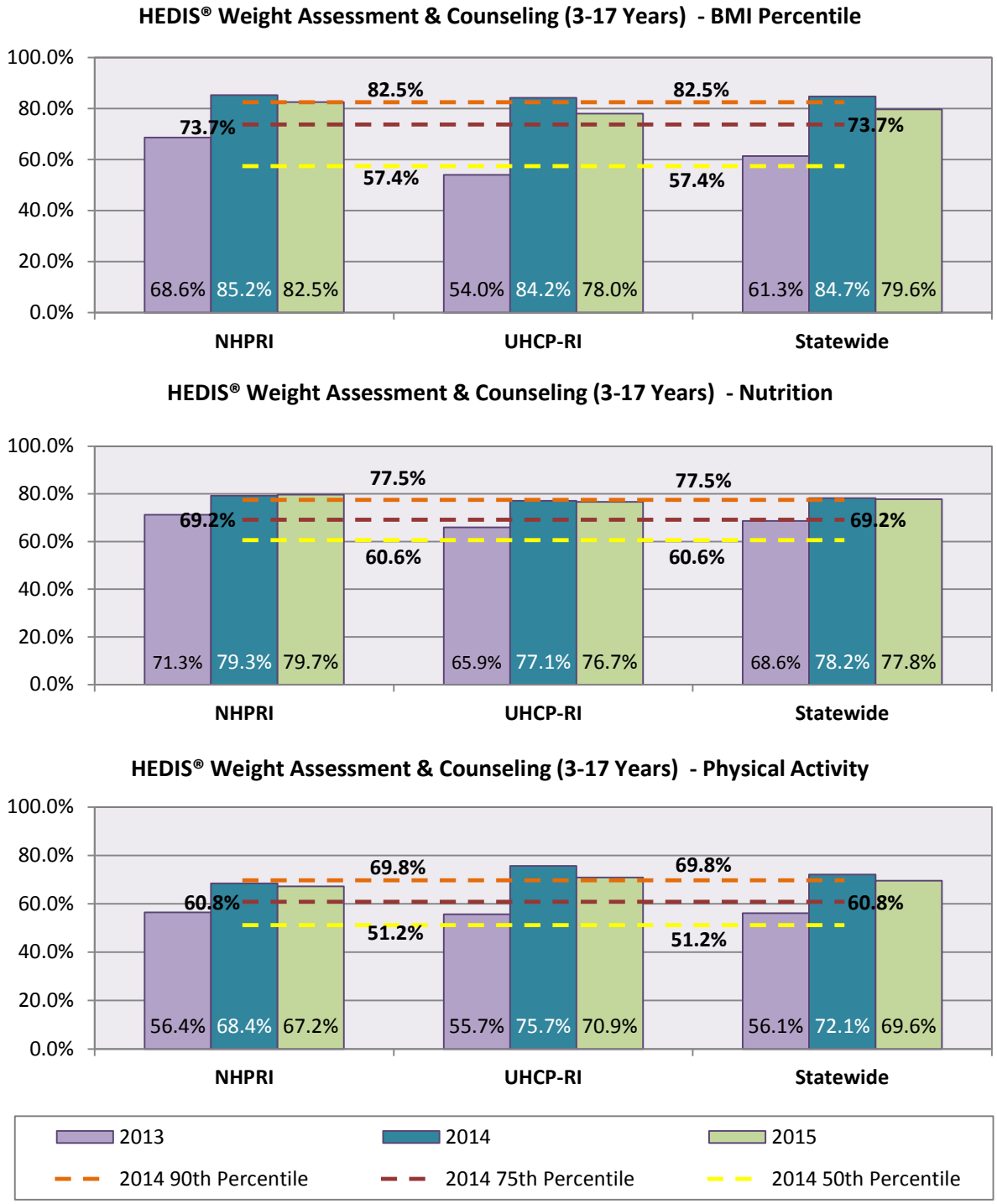
Figure 7a: PGP Results 2013-2015 Non-RHE Populations—Medical Home/Preventive Care[1,2]



[1] Statewide rates for the CAHPS® measures were determined by calculating an unweighted average of the two (2) Health Plans' rates, since the size of the survey populations were similar and numerators and denominators were not available.

[2] The statewide rates for the remaining measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 7a: PGP Results 2013-2015 Non-RHE Populations—Medical Home/Preventive Care[1,2,3] (continued)

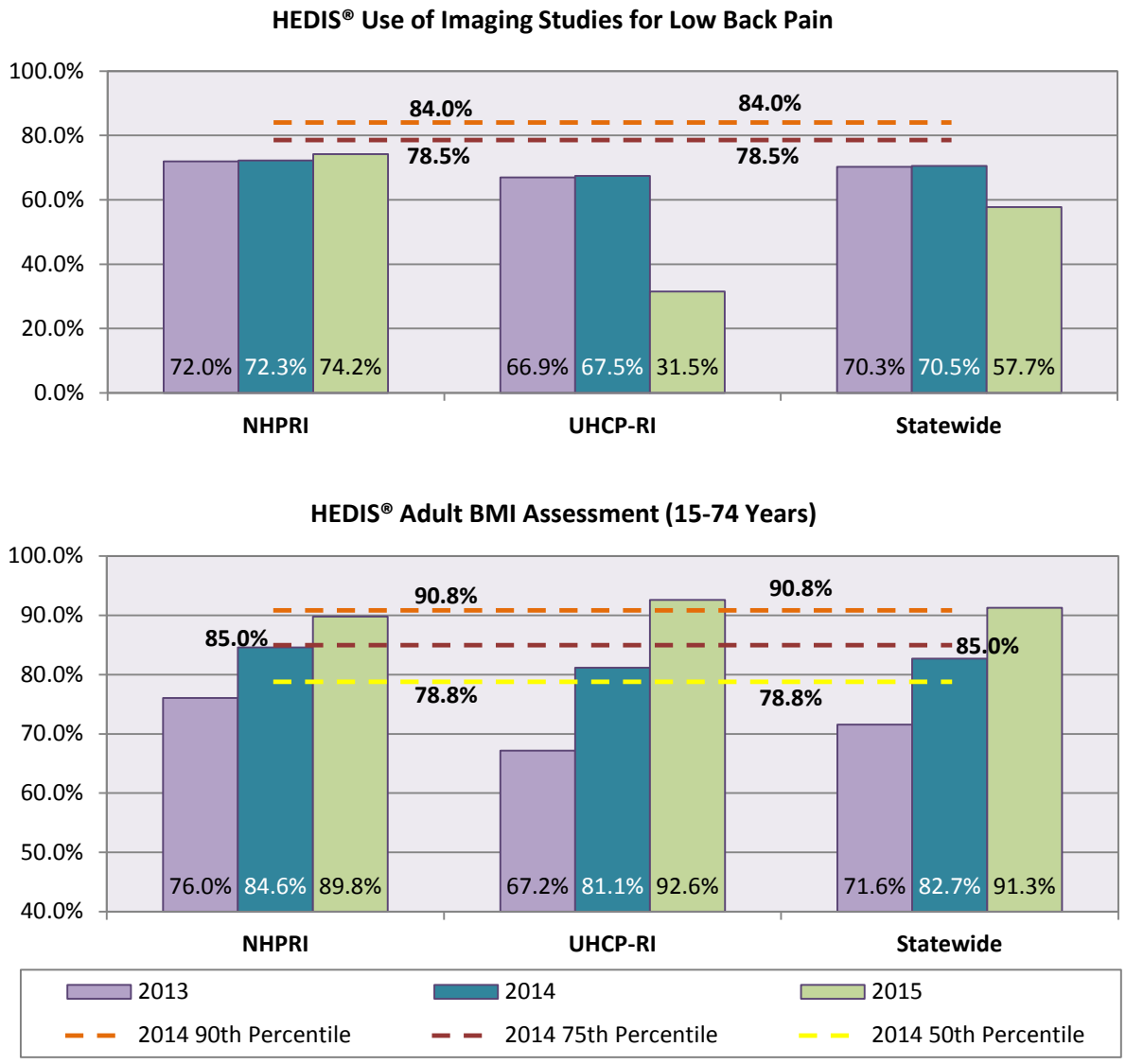


[1] Statewide rates for the CAHPS® measures were determined by calculating an unweighted average of the two (2) Health Plans' rates, since the size of the survey populations were similar and numerators and denominators were not available.

[2] The statewide rates for the remaining measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

[3] Benchmarks for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* were at the 75th percentile (full award) and 50th percentile (partial award).

Figure 7a: PGP Results 2013-2015 Non-RHE Populations—Medical Home/Preventive Care[1,2,3] (continued)

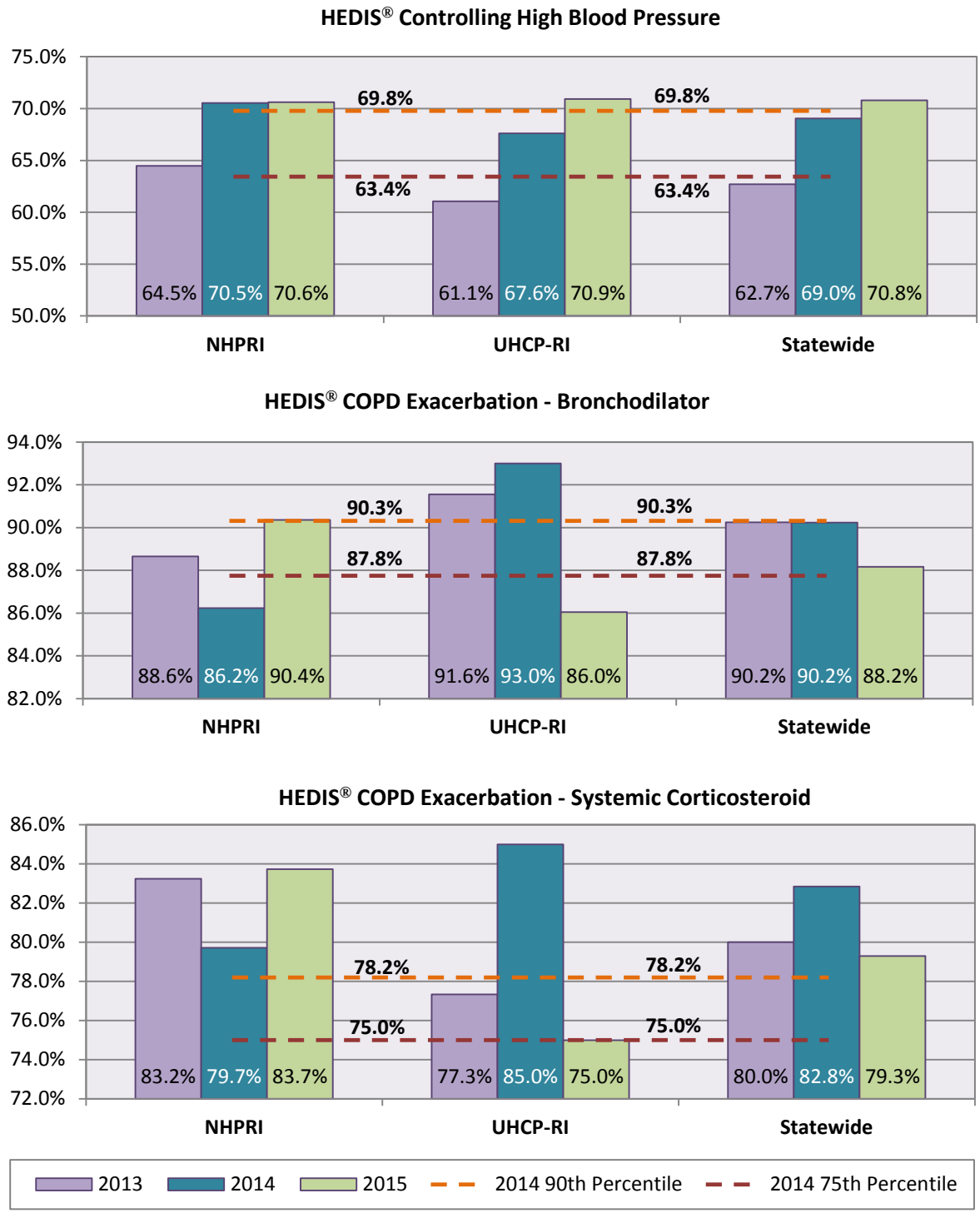


[1] Statewide rates for the CAHPS® measures were determined by calculating an unweighted average of the two (2) Health Plans' rates, since the size of the survey populations were similar and numerators and denominators were not available.

[2] The statewide rates for the remaining measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

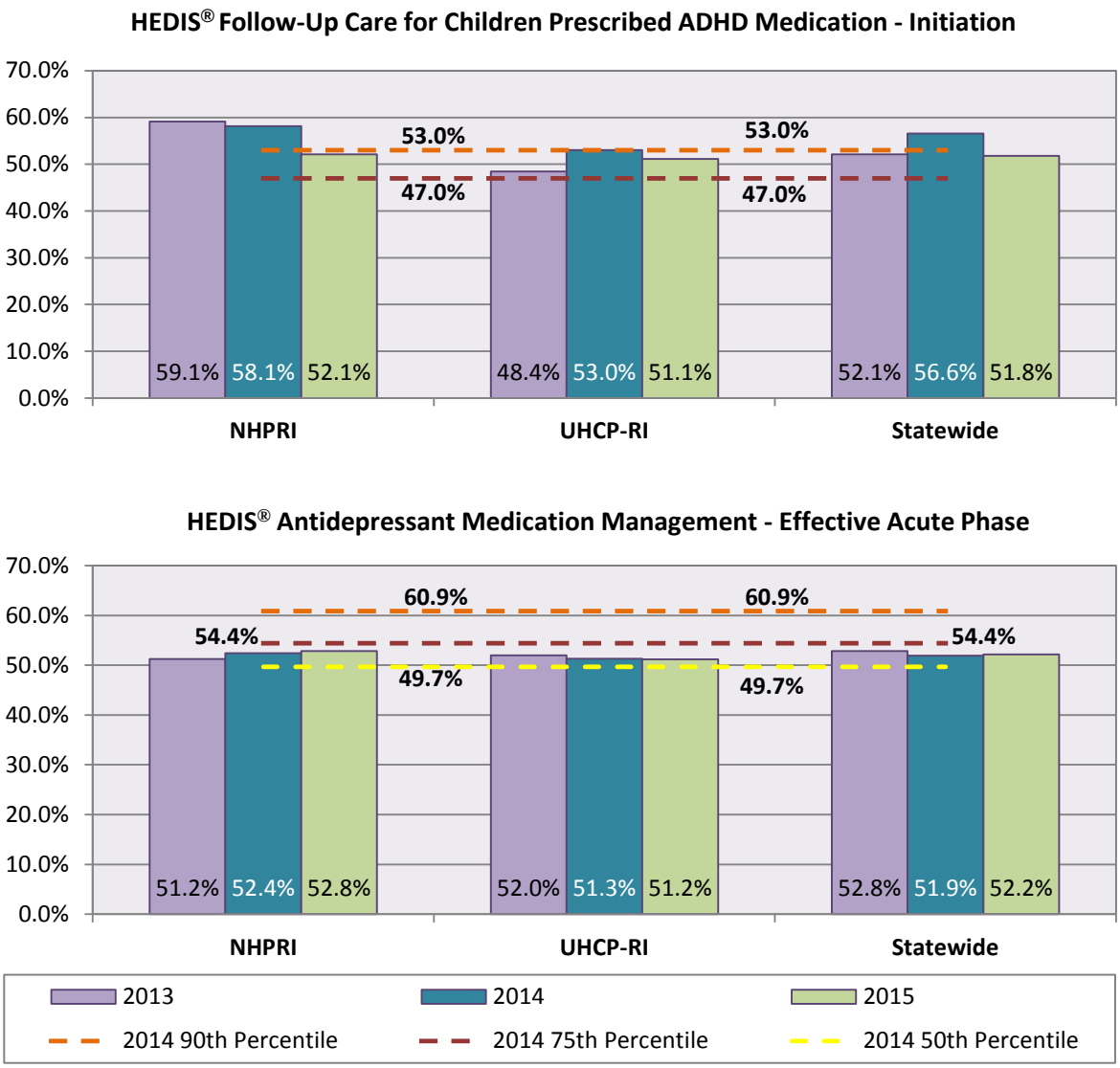
[3] Benchmarks for *Adult BMI Assessment* were at the 75th percentile (full award) and 50th percentile (partial award).

Figure 7b: PGP Results 2013-2015 Non-RHE Populations—Chronic Care[1]



[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

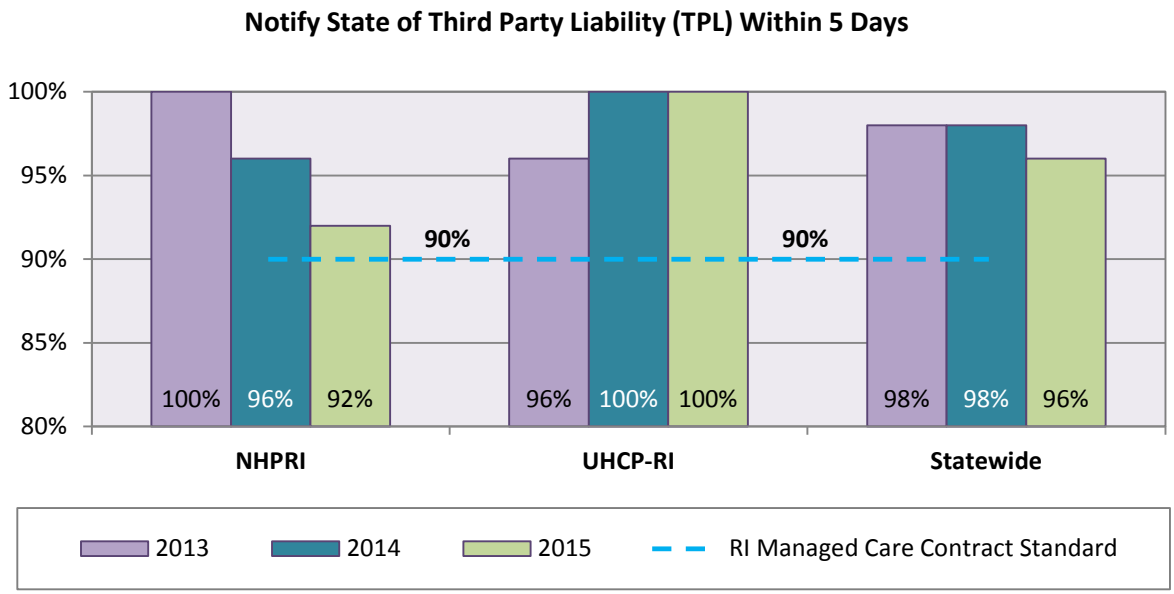
Figure 7c: PGP Results 2013-2015 Non-RHE Populations—Behavioral Health[1,2]



[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

[2] Benchmarks for *Antidepressant Medication Management—Effective Acute Phase* were at the 75th percentile (full award) and 50th percentile (partial award).

Figure 7d: PGP Results 2013-2015 Non-RHE Populations—Cost Management



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2015 Rhode Island Medicaid Managed Care Performance Goal Program Results—RHE

This section of the report evaluates the results of the 2015 Performance Goal Program for both Health Plans' for RHE members. In 2015, incentives were awarded separately for the Non-RHE lines of business (all lines of business except RHE) and the RHE population. The Health Plans' rates were compared to HEDIS® percentiles derived from the 2014 *Quality Compass*® for Medicaid. As such, these percentiles may differ from the *Quality Compass*® 2015 benchmark data displayed elsewhere in this report.

The **Member Services** domain is comprised of four (4) State-specified measures regarding Health Plan processes related to new members and appeals and grievances: *ID Cards Sent within 10 Days of Notification of Enrollment, Member Handbook Sent within 10 Days of Notification of Enrollment, Two Member Welcome Call Attempts within the First 30 Days of Enrollment*, and *Grievances and Appeals Resolved within Federal (BBA) Timeframes.* NHPRI did not meet the *Contract* goal for any of the four (4) measures. UHCP-RI met the goal for one (1) measure, *ID Cards Sent within 10 Days of Notification of Enrollment*.

Overall, both Health Plans demonstrated poor performance in the **Medical Home/Preventive Care** domain. Only UCHP-RI achieved a *Quality Compass*® benchmark goal to qualify for an incentive award for the HEDIS® *Frequency of Ongoing Prenatal Care—81+ Percent of Expected Visits* measure, achieving the 90th percentile. Both Health Plans failed to achieve a *Quality Compass*® benchmark goal to qualify for an incentive award for the following HEDIS® measures: *Adults Had Ambulatory/Preventive Care Visit (20-44 Years), Pregnant Members Received Timely Prenatal Care, Postpartum Members Received Timely Postpartum Care,* and *Use of Imaging Studies for Low Back Pain*. Notably, both Health Plans achieved the 2014 *Quality Compass*® 90th percentile for the HEDIS® *Adult BMI Assessment* measure, with scores of 100%. Additionally, both Health Plans benchmarked at the 75th percentile for the HEDIS® *Adults Had Ambulatory/Preventive Care Visit (45-64 Years)* measure.

The Medical Home/Preventive Care domain also contains two (2) CAHPS® measures: *Members were Satisfied with Access to Urgent Care* and *Medical Assistance with Smoking/Tobacco Use Cessation*. Both UHCP-RI and NHPRI met the 2014 *Quality Compass*® 75th percentile for the *Members were Satisfied with Access to Urgent Care* measure. Neither Health Plan met a *Quality Compass*® benchmark to qualify for incentive awards for the *Medical Assistance with Smoking/Tobacco Use Cessation* measure.

In the Medical Home/Preventive Care domain, four (4) measures were not eligible for an incentive award: HEDIS® *Monitoring of Persistent Medications—ACE/ARB, Digoxin, Diuretics,* and *Total.* In addition, the State-specified measure *Reduction in Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs) by 5 Percentage Points* was considered a baseline measure, and therefore, was not eligible for an incentive award.

In the **Women's Health** domain, performance was similar across Health Plans. NHPRI and UHCP-RI met a *Quality Compass*® percentile benchmark to qualify for an incentive award for the *Chlamydia Screening for Women (16-20 Years)*, benchmarking at the 90th and 75th percentile, respectively. Neither Health Plan met a *Quality Compass*® percentile benchmark for the *Chlamydia Screening for Women (21-24 Years)* measure. The third measure in this domain, *Cervical Cancer Screening for Women (21-64 Years),* was not eligible for an incentive award.

In 2015, there were five (5) HEDIS® measures in the **Chronic Care** domain that were eligible for incentive awards. Performance varied across Health Plans and measures. NHPRI met the 2014 *Quality Compass*® 90th percentile for four (4) measures: *Members with Diabetes Had HbA1c Testing (18-75 Years), Controlling High Blood Pressure (<140/90) (18-85 Years), Pharmacotherapy for COPD Management—Bronchodilators,* and *Pharmacotherapy for COPD Exacerbation—Systemic Corticosteroids*. The Health Plan did not meet a *Quality Compass*® benchmark for the *Members with Persistent Asthma Used Appropriate Medications (Total)* measure. Comparatively, UHCP-RI

met the 2014 *Quality Compass*® 90th percentile for the *Members with Persistent Asthma Used Appropriate Medications (Total), Members with Diabetes Had HbA1c Testing (18-75 Years),* and *Pharmacotherapy for COPD Exacerbation—Systemic Corticosteroids* measures, and the 75th percentile for the *Controlling High Blood Pressure (<140/90) (18-85 Years)* measure. UHCP-RI did not meet a *Quality Compass*® benchmark for the *Pharmacotherapy for COPD Exacerbation—Bronchodilators* measure.

The **Behavioral Health** domain was comprised of six (6) HEDIS® measures. The following three (3) measures were introduced for the 2015 PGP, and therefore, were considered baseline rates and were not eligible for incentive awards: *Initiation of Alcohol and Other Drug Treatment, Engagement of Alcohol and Other Drug Treatment,* and *Adherence to Antipsychotics for Individuals with Schizophrenia.*

Performance in the Behavioral Health domain varied across Health Plans. Both Health Plans achieved the 2014 *Quality Compass*® 90th percentile for the *Antidepressant Medication Management—Effective Acute Phase* measure. UHCP-RI met a *Quality Compass*® benchmark goal for the *Members 6 Years and Older Get Follow-Up 30 Days Post-Discharge* and *Members 6 Years and Older Get Follow-Up 7 Days Post-Discharge* measures, benchmarking at the 75th and 90th percentiles, respectively. Conversely, NHPRI did not achieve a *Quality Compass*® benchmark goal to qualify for an incentive award for either of these measures.

Both Health Plans met the *Contract* goal for the sole measure of the **Cost Management** (formerly *Resource Maximization*) domain, *Notify the State of Third-Party Liability (TPL) within 5 Days of Identification.*

Overall, UHCP-RI demonstrated a better performance for the 2015 Performance Goal Program than NHPRI. The Health Plan met a total of fourteen (14) of twenty-six (26) applicable PGP measures: two (2) of seven (7) State-specified measures and eleven (11) of nineteen (19) HEDIS®/CAHPS® measures.

Comparatively, NHPRI met a total of ten (10) of twenty-six (26) applicable PGP measures, including one (1) of seven (7) State-specified measures and nine (9) of nineteen (19) HEDIS®/CAHPS® measures.

Total measure counts for both Health Plans excluded measures designated as baseline measures and those not eligible for incentive awards.

Table 8 displays the Performance Goal Program rates for each of the Health Plans. It is important to note that a total of seven (7) HEDIS® measures were recorded, but were not eligible for incentive awards, including, two (2) measures related to the *Members with Persistent Asthma Used Appropriate Medications* measure were noted as 'N/A', as these measures were not included in the calculation of the incentive award. In addition, four (4) measures were introduced for PGP 2015, including one (1) State-specified measure and three (3) HEDIS® measures, and therefore, were considered baseline measures and were not eligible for incentive awards.

Graphs of select measures follow Table 8. **Figures 8a, 8b, 8c,** and **8d** graphically depict Health Plan and statewide performance on measures not displayed elsewhere in this report, including CAHPS®, HEDIS®, and State-specified measures in the Medical Home/Preventive Care (Figure 8a), Chronic Care (Figure 8b), Behavioral Health (Figure 8c), and Cost Management (Figure 8d) domains.

Certain measures were not graphed due to insufficient data points (e.g., baseline measures) or because the 2015 Performance Goal Program measures were based on HEDIS® or CAHPS® measures exhibited elsewhere in this report.

Table 8: Performance Rates and Goals—RHE Population[1,2,3]

RI Medicaid Managed Care 2014 Performance Goal Measures	NHPRI		UHCP-RI	
	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]
Member Services				
ID Cards Sent within 10 Days of Notification of Enrollment[4]	NM		M/E	
Member Handbook Sent within 10 Days of Notification of Enrollment[4]	NM		NM	
Two Welcome Call Attempts within the First 30 Days of Enrollment[4]	NM		NM	
Grievances and Appeals Resolved within Federal (BBA) Timeframes[4]	NM		NM	
Medical Home/Preventive Care				
CAHPS® Members Were Satisfied with Access to Urgent Care	86.7%	**75th**	86.8%	**75th**
Reduce ED Visits for ACSCs by 5 Percentage Points—RHE[4,5,6,7]	BM		BM	
CAHPS® Medical Assistance with Smoking/Tobacco Use Cessation	73.7%	**NM**	76.6%	**NM**
HEDIS® Adults Had Ambulatory/Preventive Care Visit (20-44 Years)	81.8%	**NM**	83.5%	**NM**
HEDIS® Adults Had Ambulatory/Preventive Care Visit (45-64 Years)	92.1%	**75th**	91.9%	**75th**
HEDIS® Pregnant Members Received Timely Prenatal Care	83.3%	**NM**	66.7%	**NM**
HEDIS® Postpartum Members Received Timely Postpartum Care	16.7%	**NM**	66.7%	**NM**
HEDIS® Frequency of Ongoing Prenatal Care (≥81% of Expected Visits)	66.7%	**NM**	100.0%	**90th**
HEDIS® Adult BMI Assessment (18-74 Years)[8]	100.0%	**90th**	100.0%	**90th**
HEDIS® Monitoring of Persistent Medications—ACE/ARB[9]	87.6%	**BM**	88.8%	**BM**
HEDIS® Monitoring of Persistent Medications—Digoxin[9,10]	NR	**BM**	55.6%	**BM**
HEDIS® Monitoring of Persistent Medications—Diuretics[9]	88.4%	**BM**	85.8%	**BM**
HEDIS® Monitoring of Persistent Medications—Total[9]	87.8%	**BM**	87.4%	**BM**
HEDIS® Use of Imaging for Low Back Pain	68.9%	**NM**	70.3%	**NM**
Women's Health				
HEDIS® Women Received Cervical Cancer Screening (21-64 Years)[9]	55.4%	**BM**	65.4%	**BM**
HEDIS® Women Received Chlamydia Screening (16-20 Years)	65.1%	**90th**	62.6%	**75th**
HEDIS® Women Received Chlamydia Screening (21-24 Years)	68.9%	**NM**	65.7%	**NM**

M/E: Met or exceeded *Contract* goal.
NM: Did not meet *Contract* goal.
BM: Baseline measure.
N/A: Not applicable for measurement.

Table 8: Performance Rates and Goals—2015—RHE Populations[1,2,3]

RI Medicaid Managed Care 2014 Performance Goal Measures	NHPRI		UHCP-RI	
	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]	2014	*Quality Compass*® 2014 90th/75th/50th Percentile Met[3]
Chronic Care				
HEDIS® Members with Persistent Asthma Used Appropriate Meds (19-50 Years)[11,12]	70.6%	**N/A**	100.0%	**N/A**
HEDIS® Members with Persistent Asthma Used Appropriate Meds (51-64 Years)[11,12]	66.7%	**N/A**	100.0%	**N/A**
HEDIS® Members with Persistent Asthma Used Appropriate Meds (Total)[12]	70.0%	**NM**	100.0%	**90th**
HEDIS® Members with Diabetes Had HbA1c Testing (18-75 Years)	94.3%	**90th**	96.9%	**90th**
HEDIS® Controlling High Blood Pressure (<140/90) (18-85 Years)	70.8%	**90th**	68.0%	**75th**
HEDIS® Pharmacotherapy for COPD Exacerbation—Bronchodilators	90.6%	**90th**	80.3%	**NM**
HEDIS® Pharmacotherapy for COPD Exacerbation—Systemic Corticosteroids	78.8%	**90th**	86.9%	**90th**
Behavioral Health				
HEDIS® Members 6 Years and Older Get Follow-Up by *30 Days* Post-Discharge	66.5%	**NM**	77.1%	**75th**
HEDIS® Members 6 Years and Older Get Follow-Up by *7 Days* Post-Discharge	50.2%	**NM**	68.4%	**90th**
HEDIS® Antidepressant Medication Management—Effective Acute Phase[8]	62.6%	**90th**	66.7%	**90th**
HEDIS® Initiation of Alcohol and Drug Treatment[13]	48.2%	**BM**	51.1%	**BM**
HEDIS® Engagement of Alcohol and Drug Treatment[13]	20.1%	**BM**	24.1%	**BM**
HEDIS® Adherence to Antipsychotics for Individuals with Schizophrenia[13]	56.2%	**BM**	51.5%	**BM**
Cost Management				
Notify State of Third-Party Liability within 5 Days of Identification[4]	M/E		M/E	
Rhody Health Expansion (RHE)				
Initial Health Screen Completed within 45 Days[4,14]	NM		NM	
Active Care Management Plan Evaluated/Updated No Less Than Every 6 Months[4,14,15]	NM		N/A	

M/E: Met or exceeded *Contract* goal.
NM: Did not meet *Contract* goal.
BM: Baseline measure.
N/A: Not applicable for measurement.
NR: Not reported.

[1] Performance Goal Program data are based on the previous Contract Year (i.e., 2015 rates are based on Contract Year 2014). Rates may differ slightly from other data published in this report, as this table reflects preliminary HEDIS® and CAHPS® rates, while the rates in other tables reflect final data submitted to the NCQA. In addition, it is important to note that, where applicable and eligible population criteria are met, all Rhody Health Expansion members are included in the rates, including State-specified measures, unless noted otherwise.

[2] For State-specified measures, national benchmarks were not available. Incentive awards were determined using State-specified benchmarks. These are defined in the September 2010 *Medicaid Managed Care Services Contract, Attachment M*.

[3] For HEDIS®- and CAHPS®-based measures, incentive awards were based, where applicable and available, on national Medicaid *Quality Compass®* 2014 90th, 75th, and 50th percentile benchmarks (unless otherwise noted).

[4] State-specified measure.

[5] *Reduction in Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs)* was reported by product line for the first time for the 2011 PGP. Previously, an aggregate rate was reported across Health Plan membership. The measure goal was a 5 percentage point reduction, year-over-year, in the rate calculated by the State for each of the applicable populations.

[6] As of July 1, 2013, the State's encounter data submission process was modified as a result of the implementation of the State's new 837 Encounter Data System. As a result of the modification, EOHHS based the outcome of the *Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs)* measures for the 2015 PGP on encounter data from July 2014 through December 2014 as compared to the findings in the corresponding six-month period in the prior calendar year.

[7] The *Reduction in Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs)* rate for the RHE population served as a baseline for PGP 2015, and therefore was not eligible for an incentive award.

[8] The benchmarks for incentive awards were the 75th percentile (full award) and the 50th percentile (partial award) for the following measures: HEDIS® *Adult BMI Assessment* and HEDIS® *Antidepressant Medication Management—Effective Acute Phase.*

[9] Benchmarks were available in *Quality Compass®* 2014 for HEDIS® *Monitoring of Persistent Medications—ACE/ARB, Digoxin, Diuretics,* and *Total*, and HEDIS® *Cervical Cancer Screening for Women (21-64 Years)*; however, the rates were not eligible for incentives for PGP 2015.

[10] The 'NR' designation for HEDIS® *Monitoring of Persistent Medications—Digoxin* for NHPRI indicates a sample size of less than 30 members.

[11] Rates for the following measures are presented for PGP 2015; however, were not eligible for an incentive award: HEDIS® *Members with Persistent Asthma Used Appropriate Meds (19-50 Years),* and HEDIS® *Members with Persistent Asthma Used Appropriate Meds (51-64 Years).*

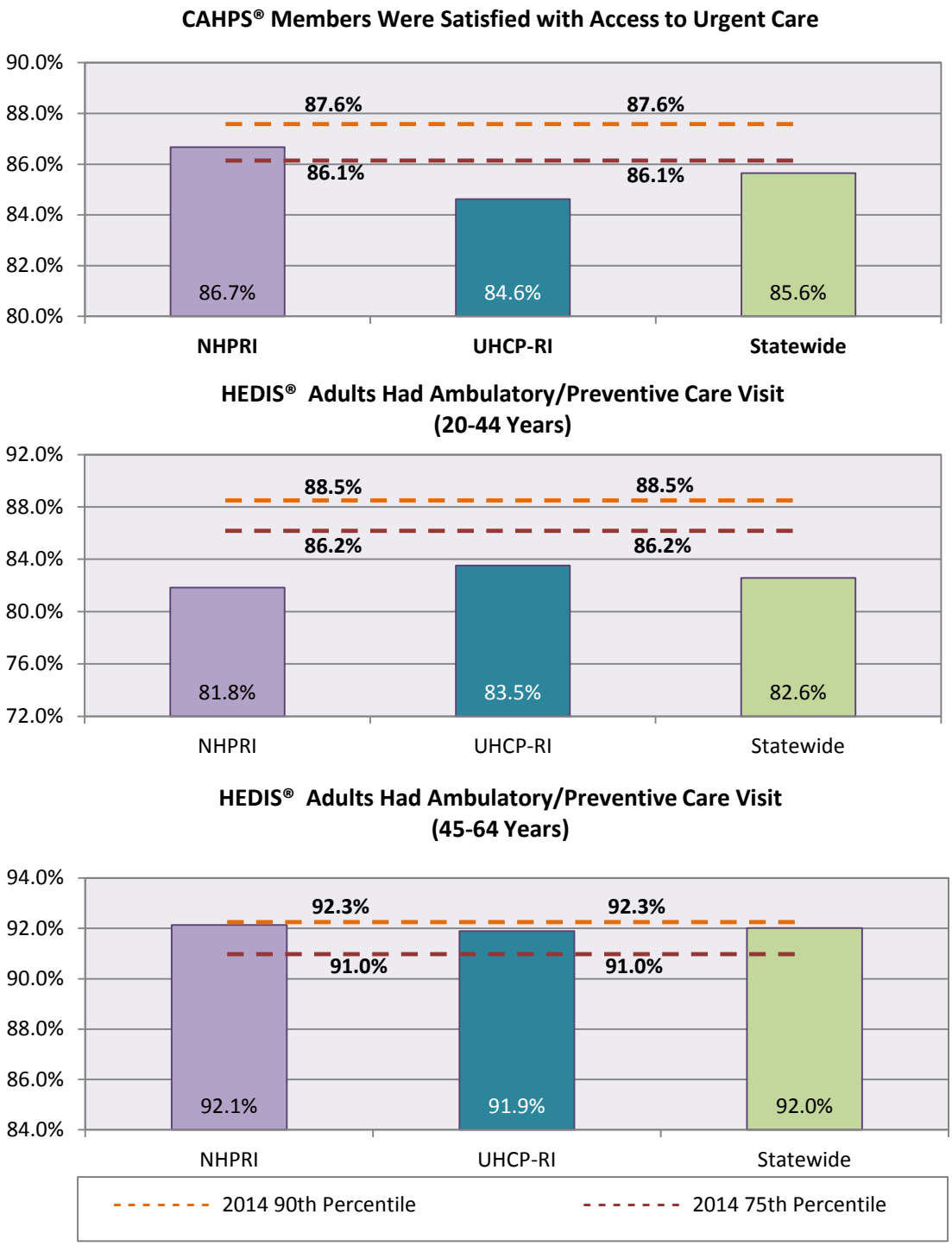
[12] Prior to PGP 2012, the HEDIS® *Members with Persistent Asthma Used Appropriate Meds* reported a single rate for the age group 12-50 years old. For the 2012 PGP, this age group was split, with rates reported separately for ages 5-11 years, 12-18 years, 19-50 years, and 51-64 years. For PGP 2015, all age groups are reported, in addition to an aggregate measure, HEDIS® *Members with Persistent Asthma Used Appropriate Meds (Total)*; however, the incentive award was based solely on the total rate.

[13] The following measures were introduced for the 2015 PGP: *Reduction* HEDIS® *Initiation of Alcohol and Other Drug Treatment,* HEDIS® *Engagement of Alcohol and Other Drug Treatment,* and HEDIS® *Adherence to Antipsychotics for Individuals with Schizophrenia.*

[14] The following State-specified measures were eligible for incentive awards: *Initial Health Screens Completed within 45 Days of Enrollment* and *Active Care Management Plans are Evaluated and Updated, as Needed, No Less Than Every 6 Months* for the RHE special enrollment population.

[15] The 'N/A' designations for the *Active Care Management Plans are Evaluated and Updated, as Needed, No Less Than Every 6 Months* measure for UHCP-RI's Rhody Health Expansion population indicate that there were no eligible members in the case review sample that required care management services or the members' care plans did not require evaluation and update during the review periods.

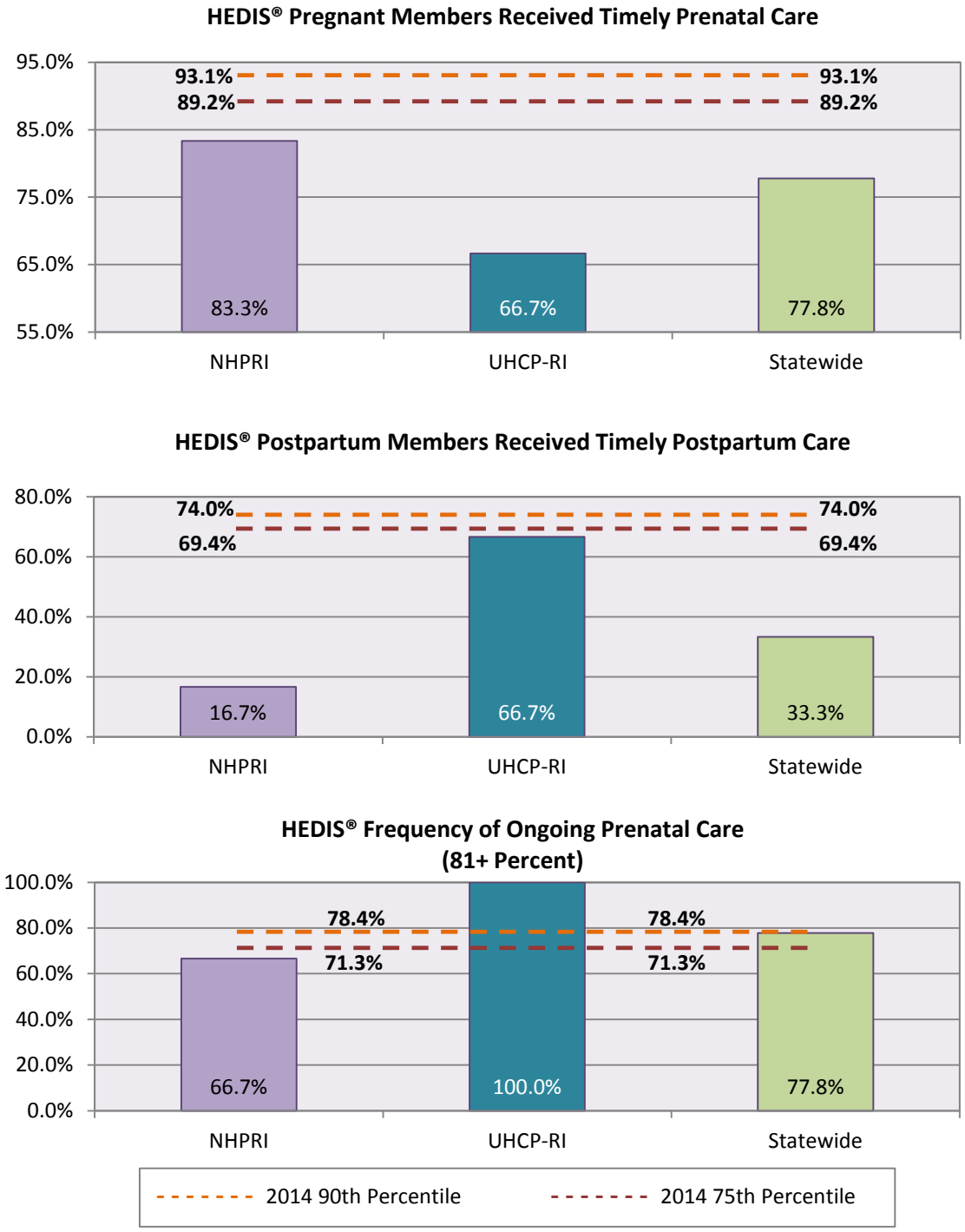
Figure 8a: PGP Results 2015 RHE Population—Medical Home/Preventive Care[1]



[1] Statewide rates for the CAHPS® measures were determined by calculating an unweighted average of the two (2) Health Plans' rates, since the size of the survey populations were similar and numerators and denominators were not available.

[2] The statewide rates for the remaining measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

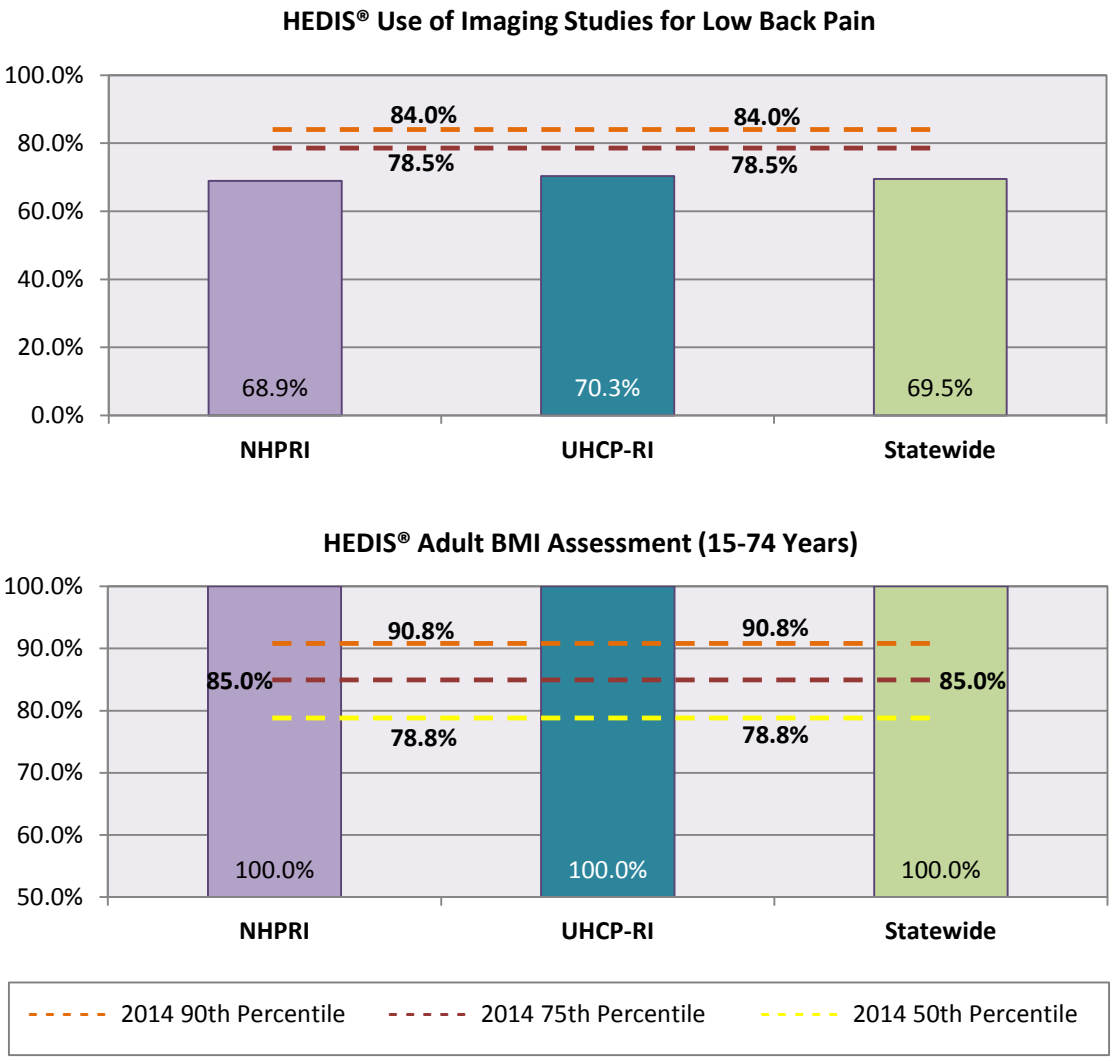
Figure 8a: PGP Results 2015 RHE Population—Medical Home/Preventive Care[1,2] (continued)



[1] Statewide rates for the CAHPS® measures were determined by calculating an unweighted average of the two (2) Health Plans' rates, since the size of the survey populations were similar and numerators and denominators were not available.

[2] The statewide rates for the remaining measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 8a: PGP Results 2015 RHE Population—Medical Home/Preventive Care[1,2,3] (continued)

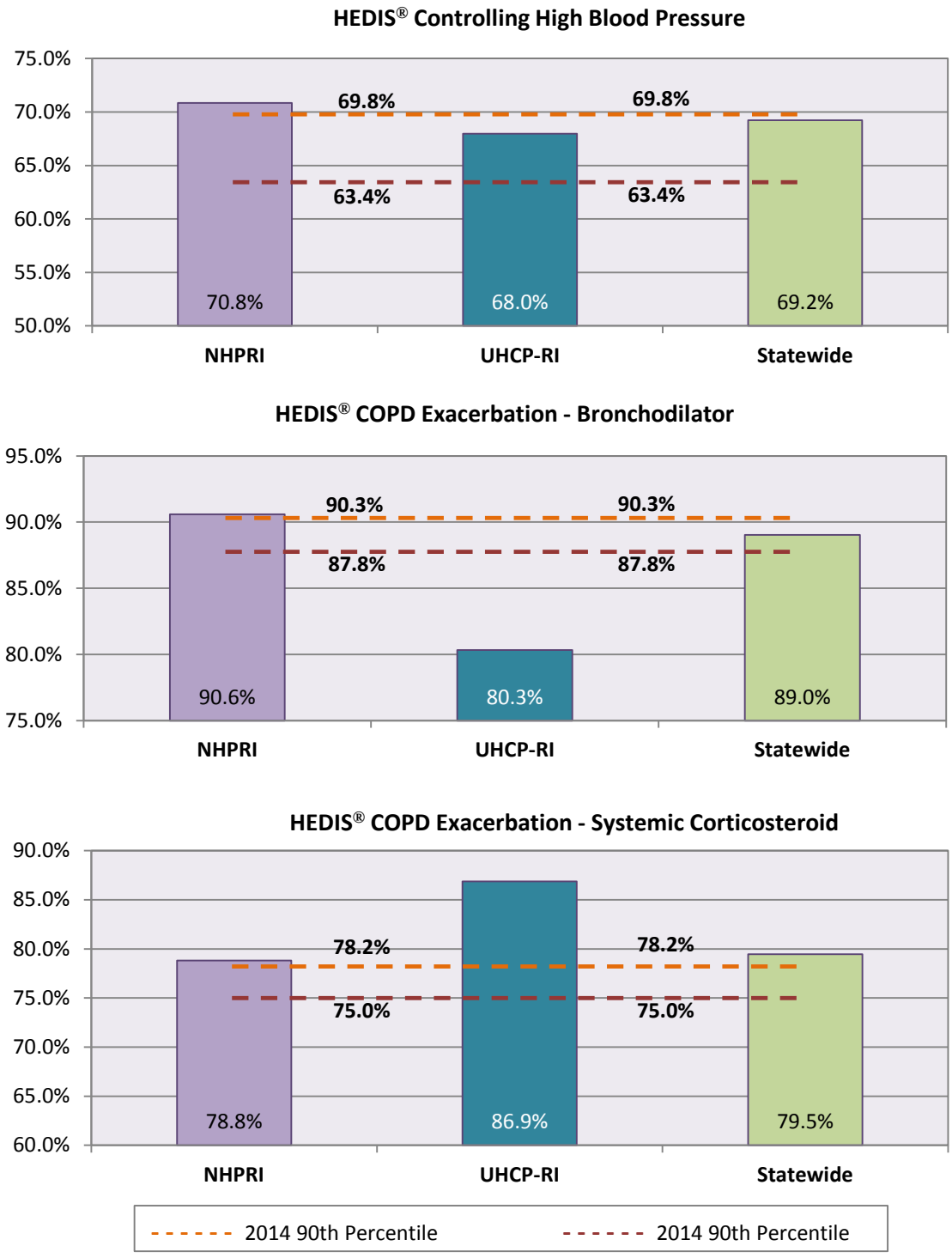


[1] Statewide rates for the CAHPS® measures were determined by calculating an unweighted average of the two (2) Health Plans' rates, since the size of the survey populations were similar and numerators and denominators were not available.

[2] The statewide rates for the remaining measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

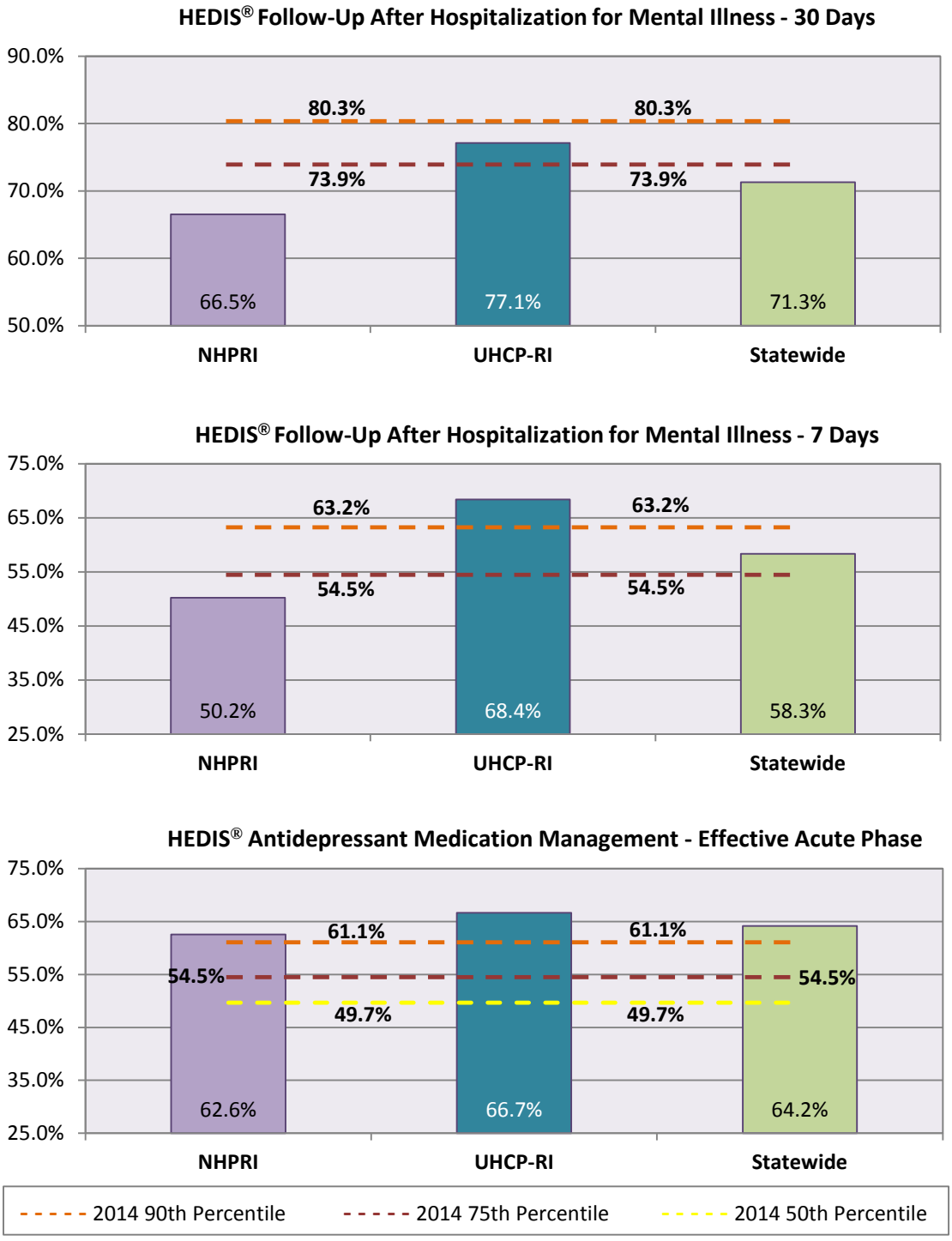
[3] Benchmarks for *Adult BMI Assessment* were at the 75th percentile (full award) and 50th percentile (partial award).

Figure 8b: PGP Results 2015 RHE Population—Chronic Care[1]



[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

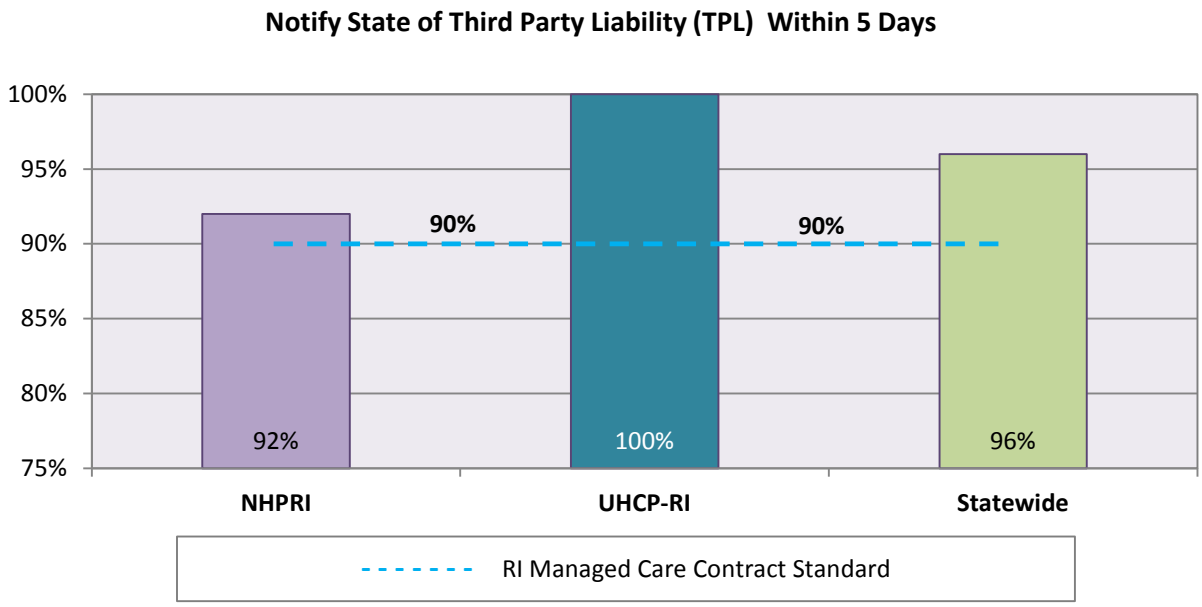
Figure 8c: PGP Results 2015 RHE Population—Behavioral Health[1,2]



[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

[2] Benchmarks for *Antidepressant Medication Management—Effective Acute Phase* were at the 75th percentile (full award) and 50th percentile (partial award).

Figure 8d: PGP Results 2015 RHE Population—Cost Management



Monitoring of Care and Services for Special Enrollment Populations

HEDIS® Performance for Core RIte Care versus All Populations

The *Quality Compass*® 2014 for Medicaid percentile rankings were used to make comparisons between the HEDIS® and CAHPS® measure rates for *Core RIte Care Only* members and the rates for *All Populations* (Core RIte Care, RIte Care for CSHCN, RIte Care for SC (NHPRI only), RHP, and RHE members). Performance was considered similar if the rates ranked within the same percentile band and dissimilar if the rates ranked in different percentile bands.

A comparison of NHPRI's rates for the two (2) groups for HEDIS® 2015 demonstrated that performance was similar for thirty-three (33) measures and dissimilar for eleven (11) measures, based on the *Quality Compass*® 2014 Medicaid percentile rankings. Of the eleven (11) measures with dissimilar rates, the rates ranked higher comparatively for *All Populations* (i.e., with the special enrollment population members included) for five (5) measures and lower for six (6) measures.

UCHP-RI's performance for the two (2) groups for HEDIS® 2015, was similar for thirty-four (34) measures, dissimilar for eleven (11) measures, based on *Quality Compass*® 2014 Medicaid percentile rankings. Of the measures with dissimilar rates, the rates ranked higher for *All Populations* (i.e., with the special enrollment population members included) for seven (7) measures and lower for four (4) measures as compared to *Core RIte Care Only.*

These findings are displayed in the table on the following page.

Table Notes for Table 9	
N/A:	Not Applicable
NR:	Not Reported
S:	Similar (ranking within the same percentile band).
▲:	Rate for *All Populations* (includes special enrollment populations) ranks in a higher percentile band.
▼:	Rate for *All Populations* (includes special enrollment populations) ranks in a lower percentile band.

Table 9: Comparison of HEDIS® Performance for Core RIte Care Only vs. All Populations

HEDIS® Measure Name	NHPRI	UHCP-RI
Adults' Access to Preventive/Ambulatory Care (20-44 Years)	▼	▼
Adults' Access to Preventive/Ambulatory Care (45-64 Years)	S	▲
Children's and Adolescents' Access to Primary Care Practitioners (12-24 Months)	S	S
Children's and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	S	S
Children's and Adolescents' Access to Primary Care Practitioners (7-11 Years)	S	S
Children's and Adolescents' Access to Primary Care Practitioners (12-19 Years)	S	S
Well-Child Visits in the First 15 Months of Life—6+ Visits	S	S
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	S	S
Adolescent Well-Care Visits	S	S
Childhood Immunization—Combo 3	S	S
Childhood Immunization—Combo 10	S	S
Lead Screening in Children	S	S
Immunizations for Adolescents	S	▲
Prenatal and Postpartum Care—Timeliness of Prenatal Care	S	S
Prenatal and Postpartum Care—Postpartum Care Visit within 21-56 Days	S	S
Frequency of Ongoing Prenatal Care—81+ Percent of Expected Visits	S	S
Cervical Cancer Screening for Women (21-64 Years)[1]	N/A	N/A
Chlamydia Screening for Women (16-20 Years)	S	S
Chlamydia Screening for Women (21-24 Years)	▼	S
Adult BMI Assessment	S	▲
Weight Assessment and Counseling for Children/Adolescents—BMI Percentile	S	S
Weight Assessment and Counseling for Children/Adolescents—Nutrition	S	S
Weight Assessment and Counseling for Children/Adolescents—Physical Activity	S	S
Annual Monitoring for Patients on Persistent Medications—ACE/ARB	S	S
Annual Monitoring for Patients on Persistent Medications—Digoxin	NR	S
Annual Monitoring for Patients on Persistent Medications—Diuretics	S	S
Annual Monitoring for Patients on Persistent Medications—Total	S	S
Use of Appropriate Medications for People with Asthma (5-11 Years)	S	S
Use of Appropriate Medications for People with Asthma (12-18 Years)	S	S
Use of Appropriate Medications for People with Asthma (19-50 Years)	S	▼
Use of Appropriate Medications for People with Asthma (51-64 Years)	▲	S
Use of Appropriate Medications for People with Asthma (Total)	▼	S
Comprehensive Diabetes Care—HbA1c Testing	▲	▲
Pharmacotherapy for COPD Exacerbation—Bronchodilators	▲	▲
Pharmacotherapy for COPD Exacerbation—Systemic Corticosteroids	S	▲
Controlling High Blood Pressure (<140/90)	S	S
Antidepressant Medication Management—Effective Acute Phase Treatment	S	S
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	S	S
Follow-Up After Hospitalization for Mental Illness—30 Days	▼	▼
Follow-Up After Hospitalization for Mental Illness—7 Days	▼	S
Initiation of Alcohol and Other Drug Treatment	S	S
Engagement of Alcohol and Other Drug Treatment	▼	S
Adherence to Antipsychotics for Individuals with Schizophrenia	▲	▲
Use of Multiple Concurrent Antipsychotics in Children and Adolescents[1]	N/A	N/A
Use of Imaging Studies for Low Back Pain[2]	S	S
CAHPS® Urgent Care—Get Care as Soon as You Thought You Needed it?	▲	S
CAHPS® Medical Assistance with Smoking/Tobacco Use Cessation	S	▼

[1] The 'N/A' designation indicates that the measure is considered a baseline rate for 2015.

[2] A lower rate is better for this measure.

Initial Health Screens and Care Management for Special Enrollment Populations

Beginning with the 2011 PGP, two (2) measures, *Initial Health Screens Completed within 45 Days of Enrollment* and *Active Care Management Plans are Evaluated and Updated, as Needed, but No Less Than Every 6 Months*, were examined for each of the four (4) member populations: CSHCN, SC (NHPRI only), RHP, and RHE. The State monitoring review was comprised of an assessment of policies and procedures, documentation tools and processes, tracking and follow-up, as well as a case review of a random sample of newly enrolled members of all four (4) populations.

Table 10: Care Management for Special Enrollment Populations Case Review Results

Special Enrollment Population Cohort	Initial Health Screen	Level I Needs Review	Level II Needs Review	Timely Care Plan Update
Neighborhood Health Plan of Rhode Island (NHPRI)				
Children with Special Health Care Needs (CSHCN)	NM	M/E	M/E	NM
Children in Substitute Care (SC)	NM	M/E	N/A[1]	N/A[2]
Rhody Health Partners (RHP)	NM	M/E	NM	NM
Rhody Health Expansion (RHE)	NM	NM	NM	NM
UnitedHealthcare Community Plan—Rhode Island (UHCP-RI)				
Children with Special Health Care Needs (CSHCN)	NM	NM	NM	M/E
Rhody Health Partners (RHP)	NM	M/E	NM	NM
Rhody Health Expansion (RHE)	NM	M/E	NM	N/A[2]

M/E: Met/Exceeded the *Contract* goal.
NM: Did not meet the *Contract* goal.
N/A: Not applicable.

[1] The 'N/A' designation for *Level II Needs Review* for NHPRI's Children in Substitute Care population indicates that there were no members in the case review sample that triggered a Level II Needs Review.

[2] The 'N/A' designations for *Timely Care Plan Update* for NHPRI's Children in Substitute Care population and for UHCP-RI's Rhody Health Expansion population indicate that there were no eligible members in the case review samples that required case management services or that the members' care plans did not require evaluation and update during the review period.

XI. QUALITY IMPROVEMENT PROGRAM[26]

The State of Rhode Island Executive Office of Health and Human Services requires that contracted Health Plans have a written quality assurance (QA) or quality management (QM) 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. Emphasis shall be placed on, but need not be limited to, clinical areas relating to management of chronic diseases, mental health and substance abuse care, members with special needs, and access to services for members.

The QA/QM plan shall include:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of interventions
- Planning and initiation of activities for increasing or sustaining improvement

The Quality Assurance Plan also shall:

- Be developed and implemented by professionals with adequate and appropriate experience in QA
- Detect both under-utilization and over-utilization of services
- Assess the quality and appropriateness of care furnished to enrollees
- Provide for systematic data collection of performance and patient results
- Provide for interpretation of these data to practitioners
- Provide for making needed changes when problems are found

Full descriptions of each Health Plan's Quality Improvement Program structure can be found in the individual Plan Technical Reports.

Quality Improvement Activities

During the reporting year under study, Health Plans were required to perform at least four (4) quality improvement projects (QIPs) directed at the needs of the Medicaid-enrolled population, including Core RIte Care, Children with Special Health Care Needs (CSHCN), Children in Substitute Care (SC)[27], Rhody Health Partners (RHP), and Rhody Health Expansion (RHE), as well as for the Health Plan-established Communities of Care[28] programs. All QIPs were to be documented on the NCQA Quality Improvement Activity (QIA) Form, as has been the case since 2008. The QIA Form template can be found in **Appendix 2**.

Topic selection guidelines were revised in 2010/2011. Starting in 2008, one (1) area of focus was chosen by the State and addressed by all Health Plans, another QIP topic was chosen by the State based on each Health Plan's individual performance, and the third QIP topic was of the Health Plan's own choosing. For the period 2009/2010, two (2) QIP topics were chosen by the State to be addressed by all Health Plans, and one (1) QIP topic was of the Health Plan's own choosing, with the State's approval. Beginning in 2011, and for the most recent contract period, 2014/2015, three (3) QIP topics were chosen by the State that would address the quality improvement needs of both Health Plans. Of those, the State directed both Health Plans to conduct QIPs related to the following topics: *Developmental Screenings in the First Three Years of Life,* HEDIS® *Use of Imaging Studies*

[26] All QIPs for NHPRI and UHCP-RI include all Medicaid members in the rate calculations, where eligible population criteria are met.

[27] As noted previously, UHCP-RI does not serve RIte Care for Children in Substitute Care.

[28] The State's *Medicaid Managed Care Services Contract* (09/01/2010) requires that all Health Plans establish and maintain a *Communities of Care* program to decrease non-emergent and avoidable ED utilization and costs through service coordination, defined member responsibilities, and associated incentives and rewards.

for Low Back Pain, and HEDIS® *Follow-Up After Hospitalization for Mental Illness*. The fourth QIP topic was of the Health Plans' own choosing, with the State's approval, from among State-suggested topic areas for each Health Plan. NHPRI selected the HEDIS® *Postpartum Care* measure, while UHCP-RI elected to perform a QIP related to the HEDIS® *Antidepressant Medication Management* measure.

In accordance with 42 CFR §438.358, IPRO conducted a review and validation of these quality improvement projects using methods consistent with the CMS protocol for validating performance improvement projects. Summaries of each of the QIPs conducted by the Health Plans can be found in Section XI of the individual Plan Technical Reports.

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XII. CONCLUSIONS AND RECOMMENDATIONS

IPRO's external quality review concludes that, in 2015, the Rhode Island Medicaid managed care program, and both of the participating Health Plans have had a generally positive impact on the accessibility, timeliness, and quality of services for Rhode Island Medicaid recipients. This is supported by the fact that both Health Plans earned an overall rating of four and a half (4.5) out of five (5) for their Medicaid product lines, as well as above average performance (rates in the 90th and 75th percentiles) on many quality and accessibility measures. Despite the Health Plans' strong performance, there are a number of areas where improvement is warranted.

With the exception of those shown for the Performance Goal Program (PGP), the Medicaid benchmarks and HEDIS®/CAHPS® percentiles cited in this Annual EQR Technical Report originated from the NCQA's *Quality Compass*® 2015 for Medicaid. Scoring percentiles for the 2015 Performance Goal Program were derived from *Quality Compass*® 2014 for Medicaid.

In addition to the overall conclusions on the performance of State's Medicaid managed care program, both Health Plans demonstrated various strengths and opportunities for improvement. Each Health Plan was also issued individual recommendations. These findings are described in detail in Section XII of each Health Plan's individual Annual External Quality Review Technical Report[29].

Quality of Care

This section provides a description of the strengths and opportunities for improvement exhibited by both Health Plans, and the Medicaid managed care program overall, as well as recommendations regarding the quality of care provided to Medicaid enrollees.

In the domain of quality, the Health Plans and the Medicaid managed care program demonstrated the following strengths:

- As noted above, both Health Plans earned an overall rating of four and a half (4.5) out of five (5) for their Medicaid product lines from the NCQA. Additionally, both Plans achieved scores of four and a half (4.5) and four (4) out of five (5) for the *Prevention* and *Treatment* categories, respectively.
- In regard to the HEDIS® Effectiveness of Care measures, both Health Plans' rates, as well as the statewide rates, exceeded the 2015 *Quality Compass*® 90th percentile for both the *Childhood Immunization Status* measures (*Combo 3* and *Combo 10*). Additionally, both Health Plans' rates and the statewide rates benchmarked at the 75th percentile for the *Cervical Cancer Screening for Women* and the *Chlamydia Screening for Women (16-24 Years)* measures.
- Overall, both Health Plans continued to perform well in the Medical Home/Preventive Care domain for the Non-RHE populations. Both Health Plans achieved the 2014 *Quality Compass*® 90th or 75th percentiles for the following HEDIS® measures: *Children Received Immunizations by 2nd Birthday (Combo 3* and *Combo 10), Adolescents Received Immunizations by 13th Birthday, Adult BMI Assessment,* and *Weight Assessment and Counseling for Children and Adolescents (BMI Percentile, Nutrition,* and *Physical Activity*).
- In the Women's Health domain of the PGP, both Health Plans demonstrated improvement. NHPRI achieved the *Quality Compass*® 90th percentile for both the *16-20 Years* and *21-24 Years* age groups of the *Chlamydia Screening for Women* measure, while UHCP-RI achieved the 75th percentile for both age groups for the Non-RHE populations.
- In regard to the Chronic Care and Behavioral Health domains of the PGP, both Health Plans achieved a *Quality Compass*® benchmark percentile (90th, 75th, or 50th) for the following measures for the Non-RHE

[29] For further information, refer to each Health Plans' Annual External Quality Review Technical Report.

populations: *Controlling High Blood Pressure (<140/90) (18-85 Years), Pharmacotherapy for COPD Exacerbation—Systemic Corticosteroids, Members 6 Years and Older Get Follow-Up 7 Days Post-Discharge, Antidepressant Medication Management—Effective Acute Phase,* and *Follow-Up Care for Children Prescribed ADHD Medications—Initiation Phase.*

- Results of the Performance Goal Program for the RHE population show that both Health Plans achieved the 2014 *Quality Compass*® 90th percentile for the HEDIS® *Adult BMI Assessment* measure with scores of 100%. Additionally, the Health Plans both achieved *Quality Compass*® benchmark percentiles (90th, 75th, or 50th) to qualify for incentive awards for the following HEDIS® measures for the RHE population: *Chlamydia Screening for Women (16-20 Years), Members with Diabetes Had HbA1c Testing (18-75 Years), Controlling High Blood Pressure (<140/90) (18-85 Years), Pharmacotherapy for COPD Exacerbation—Systemic Corticosteroids,* and *Antidepressant Medication Management—Effective Acute Phase*.
- The results of the CAHPS® 5.0H survey showed that both Health Plans, as well as the statewide rate, exceeded the 2015 *Quality Compass*® 90th percentile for *Rating of Health Plan*.

Several areas are noted in which there are opportunities for improvement common to both Health Plans. Continued collaboration on QI initiatives may help to drive both individual and statewide improvement. Through such collaborations, the Health Plans can share successful intervention strategies to be implemented statewide, as well as lessons learned.

In the domain of quality, the Health Plans and the Medicaid managed care program demonstrated the following opportunities for improvement:

- Both Health Plans continued to receive two (2) of four (4) stars for the *Getting Better* domain of the NCQA accreditation survey.
- Despite receiving *Excellent* ratings on the *Qualified Providers* component of the NCQA Accreditation, both Health Plans demonstrated an opportunity for improvement for increasing the number of board-certified physicians in each Plan's network.
- The Member Services domain of the Performance Goal Program demonstrated an opportunity for improvement for both the Non-RHE populations and the RHE populations. Neither Health Plan met the *Contract* goal for the *Member Handbooks Sent within 10 Days of Notification of Enrollment, Two Welcome Call Attempts within the First 30 Days of Enrollment,* and *Grievances and Appeals Resolved within Federal (BBA) Timeframes* measures.
- For the Non-RHE and RHE populations, both Health Plans reported rates that did not achieve a *Quality Compass*® percentile benchmark for the HEDIS® *Use of Imaging Studies for Low Back Pain* measure. Additionally, both Health Plans demonstrated an opportunity for improvement for the Non-RHE populations for the *Members with Persistent Asthma Used Appropriate Medications (Total)* measure, as neither Plan achieved a *Quality Compass*® benchmark goal.
- For the RHE population, the Health Plans failed to meet a *Quality Compass*® benchmark goal for the HEDIS® *Chlamydia Screening for Women (21-24 Years)* and CAHPS® *Medical Assistance with Smoking/Tobacco Cessation* measures for the Performance Goal Program.
- Member satisfaction continued to demonstrate an opportunity for improvement for both Health Plans, as both Plans reported rates at or below the 2015 *Quality Compass*® 50th percentile, specifically for the *Customer Service* composite measure.

The following recommendations are made in regard to quality of care:

- Both Health Plans continue to score low on the *Getting Better* domain of the NCQA Accreditation Survey. Because both Health Plans continue to struggle with the same measures that encompass the

Getting Better domain, specifically *Use of Imaging Studies for Low Back Pain* and *Follow-Up After Hospitalization for Mental Illness,* the Health Plans should consider collaborating to determine best practices and successful intervention strategies in order to encourage the improvement of these measures. The Health Plans should also conduct measure-level root cause analyses, reevaluate existing interventions, specifically those outlined as interventions for the State-selected Quality Improvement Projects, and modify the interventions based on the findings of the analyses.

- The Health Plans should continue to monitor their provider networks for adequacy and quality, specifically for Geriatricians, and develop and implement interventions to enhance the networks when necessary.
- Both Health Plans should conduct root cause analyses on new poorly performing PGP and HEDIS® measures, such as *Use of Appropriate Medications for Asthma,* and develop and implement interventions based on the findings.
- As both Health Plans continue to report below average CAHPS® rates, specifically for *Customer Service*, the Health Plans should reevaluate their strategies concerning improving member satisfaction. Additionally, the Health Plans should also review policies and procedures relating to customer services and update them as necessary, as well as consider implementing more frequent or updated trainings for customer service representatives.
- Both Health Plans reported several PGP measures that did not achieve *Quality Compass*® benchmarks for the Rhody Health Expansion population. The Health Plans should conduct barrier analyses for these measures to determine the causes for the low-scoring rates specific to this population.

Access to/Timeliness of Care

This section provides a description of the strengths and opportunities for improvement exhibited by both Health Plans, and the Medicaid managed care program overall, as well as recommendations in regard to the access to/timeliness of care provided to Medicaid enrollees.

In the domain of access to/availability of care, the Health Plans and the Medicaid managed care program demonstrated the following strengths:

- Both Health Plans received an *Excellent* rating on the *Access and Service* domain of the NCQA Accreditation survey. Additionally, both Plans met their established GeoAccess standards for primary care and specialty providers overall.
- In regard to the HEDIS® Access to/Availability of Care measures, both Health Plans reported rates that benchmarked in the 2015 *Quality Compass*® 90th or 75th percentiles for all four (4) age groups of the *Children and Adolescents' Access to Primary Care* measure (*12-24 Months, 25 Months-6 Years, 7-11 Years,* and *12-19 Years)*. Additionally, UHCP-RI's rates for *Adults' Access to Preventive/Ambulatory Health Services* exceeded the 90th percentile for the *20-44 Years* and *45-64 Years* age groups, while NHPRI's rates exceeded the 75th percentile for all three (3) age groups of the measure. Both Health Plans' rates benchmarked above the 90th or 75th percentiles for *Timeliness of Prenatal Care* and *Timeliness of Postpartum Care,* as well.
- The rates for both Health Plans, as well as the statewide rates, exceeded the 2015 *Quality Compass*® 90th percentile for *Well-Child Visits in the First 15 Months of Life, Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life,* and *Frequency of Ongoing Prenatal Care—81+ Percent.* Additionally, NHPRI benchmarked at the 90th percentile for *Adolescent Well-Care Visits,* while UHCP-RI's rate exceeded the 75th percentile for that measure.

Several areas are noted in which there are opportunities for improvement common to both Health Plans. Continued collaboration on QI initiatives may help to drive both individual and statewide improvement. Through

such collaborations, the Health Plans can share successful intervention strategies to be implemented statewide, as well as lessons learned.

In the domain of access to/timeliness of care, the Health Plans and the Medicaid managed care program demonstrated the following opportunities for improvement:

- Neither Health Plan met the *Contract* goal for *Reduction in Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs) by 5 Percentage Points* for the Children with Special Health Care Needs population.
- In regard to care management for special enrollment populations, both Health Plans continued to fail to meet the *Contract* goals for the completion of initial health screens within forty-five (45) days of enrollment for all four (4) special enrollment populations (CSHCN, SC (NHPRI only), RHP, and RHE).
- Neither Health Plan met the *Contract* goal for timely evaluation and update of active care management plans for the RHP population. Additionally, the Health Plans continue to receive 'N/A' designations for some measures related to care management.
- In regard to the results of the 2015 PGP for the RHE population, both Health Plans failed to achieve a *Quality Compass*® benchmark percentile to qualify for an incentive award for the following HEDIS® measures: *Pregnant Members Received Timely Prenatal Care, Postpartum Members Received Timely Postpartum Care,* and *Adults Had Ambulatory/Preventive Care Visit (20-44 Years).*

The following recommendations are made in regard to access to/timeliness of care:

- Because neither Health Plan met the *Contract* goal for *Reduction in Emergency Department (ED) Visits for Ambulatory Care-Sensitive Conditions (ACSCs)* for the Children with Special Health Care Needs population, the Health Plans should evaluate intervention strategies that were successful for other populations and modify them to apply to the CSHCN population. Additionally, the Health Plans should consider member demographics, such as top ED diagnoses and top pre-existing health conditions such as persistent asthma these members have that could result in an ED visit, as well as analyzing CSHCN members' access to PCPs, specialists, and urgent care centers.
- Both Health Plans continued to fail to meet the *Contract* goals for the *Initial Health Screens* measures for all four (4) special enrollment populations. The Health Plans should consider getting feedback from members on best times to reach members by phone, as well as best ways to contact members to complete the Initial Health Screens. Additionally, the Health Plans should collaborate with members' PCPs and the State's CEDARR Family Centers to facilitate Initial Health Screen completion, for new members with pre-existing relationships with the Centers, as well as local social service agencies, such as the Department for Children, Youth, and Family and homeless shelters.
- The Health Plans should conduct barrier analyses specific to the Rhody Health Expansion population to address the PGP measures that failed to achieve *Quality Compass*® percentile benchmarks and develop and implement interventions, specific to this population, that address identified barriers.
- Health Plans are still receiving 'N/A' designations for several measures related to care management for special enrollment populations, especially the *Active Care Plan Evaluated/Updated No Less Than Every 6 Months* measure. The methodology for sampling member case files for the special enrollment populations has not been changed or updated. EOHHS should consider extracting more member files in order to control for cases that may not apply to the measures.

Quality Improvement Program

The overall strengths of each of the Health Plan's Quality Improvement Programs include a variety of staff, resources, and committees across all levels of the organizations. Full descriptions of the Health Plans' Quality Improvement Programs can be found in Section XI of the Health Plan-specific annual EQR Technical Reports. In

addition, the Quality Improvement Activity (QIA) Form template is included in Appendix 2 of the Health Plan-specific reports.

In 2014/2015, each Health Plan engaged in four (4) Quality Improvement Projects (QIPs). The four (4) contractually mandated QIPs comprised multi-faceted intervention strategies that targeted providers and member populations, as well as system-level changes to Health Plan processes. Results of the 2014/2015 quality improvement activities were mixed across projects and Health Plans: some performance measures demonstrated improvement, where other demonstrated either no change or a decline in performance. The Health Plans presented the results of each of the four (4) QIPs to EOHHS in December 2015. Summaries of the QIPs can be found in Section XI of the individual Health Plan annual Technical Reports.

EOHHS Responses and Follow-Up to Recommendations

As required by Federal regulations, the EQR must annually assess the degree to which the Health Plans effectively addressed the previous year's recommendations. In order to ensure that each Health Plan had the information required to achieve this, EOHHS provided feedback to the Health Plans regarding their HEDIS® and CAHPS® scores, PGP outcomes, State monitoring visit findings, as well as the EQR Technical Report. Information regarding these is detailed below.

2015 Performance Goal Program/On-Site Monitoring Feedback

EOHHS issued the results of the 2015 PGP to the Health Plans in July 2015, accompanied by a cover letter containing commendations for the Health Plans' accomplishments and improvements and delineating opportunities for improvement, as well as the EOHHS expectation that the Health Plans develop an action plan to address noted opportunities for improvement. The Health Plans' progress related to improvement was a topic of discussion at the monthly *Contract* oversight meetings.

Reporting Year (RY) 2014 EQR Technical Report Feedback

During December 2015, a separate correspondence was sent by the State in conjunction with the transmittal of the EQR Technical Report, which focused on RY 2014. The report was accompanied by a cover letter providing commendations for the Health Plans' accomplishments and improvements. In addition, the report outlined the Health Plans' opportunities for improvement and included the EOHHS expectation that the Health Plans develop an action plan to address the noted opportunities for improvement.

As was done in the past, EOHHS indicated that its intent was to include the Health Plans' performance as an agenda item in its *Contract* oversight meetings. In addition, the Health Plans were required to make a presentation to EOHHS in December 2015 regarding the RY 2014 EQR Technical Report, as well as any recommendations issued by the EQRO.

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APPENDIX 1: Rhode Island Strategy for Assessing and Improving the Quality of Managed Care Services – October 2012[1]

CHAPTER 1

OVERVIEW OF FEDERAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REQUIREMENTS

This chapter describes the various Federal quality assessment and performance improvement requirements applicable to RIte Care, including:

- Medicaid Managed Care Final Regulations
- Medicaid External Quality Review Final Regulations
- Waivers and Special Terms and Conditions
- Children's Health Insurance Program (CHIP) Quality Requirements

Each set of requirements is described in separate sections below. Detailed descriptions of these requirements are provided in Appendix A to this strategy document.

1.1 Medicaid Managed Care Final Regulations

Except for those Federal legal requirements specifically waived in the *approval letter* for the demonstrations, the State must meet all other applicable, Federal legal requirements. Salient requirements include those contained in the June 14, 2002 *Final Rule* implementing the managed care provisions of the Balanced Budget Act of 1997 (BBA)[2]. States had until June 16, 2003 "to bring all aspects of their managed care programs (that is, contracts, waivers, State plan amendments, and State operations) into compliance with the *Final Rule* provisions."[3]

This strategy document is essentially a required element of the June 14, 2002 *Final Rule*. Specifically, Subpart D of the *Final Rule* "implements Section 1932(c)(1) of the Act and sets forth specifications for quality assessment and performance improvement strategies that States must implement to ensure the delivery of quality health." It also establishes "standards" that States and Health Plans must meet. Section 438.204 of the *Final Rule* delineates the following minimum elements of the State's quality strategy:

- Health Plan "contract provisions that incorporate the standards specified in this subpart"
- Procedures that:
  - Assess the quality and appropriateness of care and services furnished to all Medicaid recipients enrolled in Health Plans
  - Identify the race, ethnicity, and primary language spoken of each enrollee
  - Monitor and evaluate Health Plan compliance with the standards regularly

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1 The Quality Strategy included in this appendix was submitted by EOHHS in October 2012, and approved by CMS on April 25, 2013. Chapters 1 – 4 of the approved Quality Strategy have been provided in Appendix 1. In June 2014, EOHHS submitted a revised quality strategy to CMS. In September 2014, CMS requested the EOHHS revise the Quality Strategy and resubmit it. EOHHS resubmitted the revised Quality Strategy in December 2014, and it is pending approval by CMS.

2 *Federal Register,* 67(115), June 14, 2002, 41094-41116. The BBA also created the State Children's Health Insurance Program (SCHIP).

3 *Ibid.*, 40989.

- Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each Health Plan contract
- Appropriate use of intermediate sanctions, at a minimum, to meet Subpart I of the June 14, 2002 *Final Rule*
- An information system that supports initial and ongoing operation and review of the State's quality strategy
- Standards, at least as stringent as those in Subpart D, for access to care, structure and operations, and quality measurement and improvement.

1.2 Medicaid External Quality Review Final Regulations

On January 24, 2003, the Centers for Medicare and Medicaid Services (CMS) published an external quality review (EQR) *Final Rule* in the *Federal Register* to implement Section 4705 of the BBA.[4] The effective date of this *Final Rule* is March 25, 2003, and provides[5]:

"Provisions that must be implemented through contracts with MCOs, PIHPs, and external quality review organizations (EQROs) are effective with contracts entered into or revised on or after 60 days following the publication date. States have until March 25, 2004 to bring contracts into compliance with the *Final Rule* provisions."

The basic requirements of the January 24, 2003 *Final Rule* are as follows:

- EQRO Must Perform an Annual EQR of Each Health Plan – The State must ensure that: "a qualified external quality review organization (EQRO) performs an annual EQR for each contracting MCO."[6]
- EQR Must Use Protocols – The January 24, 2003 Final Rule stipulates how the EQR must be performed. It should be noted that this includes the requirement[7] that "information be obtained through methods consistent with the protocols established under §438.352."
- EQRO Must Produce a Detailed Technical Report – The January 24, 2003 Final Rule requires[8] that the EQR produce a "detailed technical report" that "describes the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP."
- State Must Perform Mandatory EQR Activities – The January 24, 2003 Final Rule distinguishes between "mandatory" and "optional" EQR-related activities. Apart from the required "detailed technical report", the mandatory activities include[9]:
  - Validation of performance improvement projects
  - Validation of MCO performance measures reported
  - Review to determine the MCO's compliance with standards

It would appear that, at a minimum, the "detailed technical report" must be prepared by an EQRO. Other "mandatory" EQR activities need not be performed by an EQRO, although enhanced FMAP is not available unless an EQRO performs them[10].

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4 Essentially Section 1932(c) of the Social Security Act.
5 *Federal Register,* 68(16), January 24, 2003, 3586.
6 42 CFR 438.350(a).
7 42 CFR 438.350(e).
8 42 CFR 438.364.
9 42 CFR 438.358(b).
10 *Federal Register. Op. Cit.,* 3611.

"Optional" activities[11] include:

- Validation of encounter data
- Administration or validation of consumer or provider surveys of quality of care
- Calculation of additional performance measures[12]
- Conduct of additional quality improvement projects[13]
- Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time

Table 1-1 shows these obligations in tabular form.

Table 1-1
EXTERNAL QUALITY REVIEW (EQR) ACTIVITIES

Activity	Mandatory Activity[14]	Must Be Performed by EQRO[15]
Prepare detailed technical report	Yes[16]	Yes
Validation of performance improvement projects	Yes	No
Validation of MCO performance measures reported	Yes	No
Review to determine MCO compliance with standards	Yes	No
Validation of encounter data	No	No
Administration or validation of consumer or provider surveys of quality of care	No	No
Calculations of additional performance measures	No	No
Conduct of additional quality improvement projects	No	No
Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time	No	No

1.3 Waivers and Special Terms and Conditions

The *waivers* approved by CMS, which have allowed the State to operate RIte Care (and now RIte Share), were actually waivers of specific provisions of the Social Security Act (SSA). These waivers include ones to permit the State to receive Federal funds "not otherwise matchable" except under the authority of Section 1115 of the Act. For Medicaid, this provides Federal matching for the expansion populations. For CHIP, this provided Federal matching for eligible parents and relative caretakers, as well as eligible pregnant women.

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11 42 CFR 438.358(c).

12 Any "additional" performance measures must be validated by an EQRO.

13 Any "additional" performance improvement projects must be validated by an EQRO.

14 Defined as "mandatory" under the January 24, 2003 *Final Rule.*

15 According to the provisions of the January 24, 2003 *Final Rule.*

16 Not listed in the *Final Rule* as a "mandatory" activity in 42 CFR 438.358(b) but "required" by 42 CFR 438.364.

The approval of these waivers and Federal matching was contingent upon the State's compliance with Special Terms and Conditions (STCs). These STCs also delineated the "nature, character, and extent of anticipated Federal involvement" in the **demonstration**.

Demonstration has been highlighted because RIte Care was a "demonstration project," according to the DHHS *approval letter*[17].

The STCs contained a number of elements germane to quality assessment and performance improvement, as follows:

- Encounter Data Requirements – The Sate had to have an encounter data "minimum data set," and must perform "periodic reviews, including validation studies, to ensure compliance." The State had to have a "plan for using encounter data to pursue health care quality improvement." This plan had to, at a minimum, focus on:
  - Childhood immunizations
  - Prenatal care and birth outcomes
  - Pediatric asthma
  - One additional clinical condition to be determined by the State based on the population(s) served

- Quality Assurance Requirements – The State had to fulfill the following quality assurance requirements:
  - Develop a methodology to monitor the performance of the Health Plans, that will include, at a minimum, monitoring the quality assurance activities of each Health Plan
  - Contract with an external quality review organization (EQRO) for an independent audit each year of the demonstration
  - Establish a quality improvement process for bringing Health Plans that do not meet State requirements up to an acceptable level
  - Collect and review quarterly reports on complaints and grievances received by the Health Plans, and their resolution
  - Conduct by the EQRO of a focused study of emergency room services, including inappropriate emergency room utilization by RIte Care enrollees
  - Require, by contract, that Health Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required by 42 CFR 438.240 and monitor on a periodic basis each Health Plan's adherence to these standards
  - As noted at the beginning of this update, the STCs[18] for the Global Compact Choice Waiver specified with respect to Quality Assurance and Improvement:

  "The state shall keep in place the existing quality systems for the waivers/demonstrations/programs that currently exist and will remain intact under the Global 1115 Waiver (RIte Care, Rhody Health Partners, Connect Care Choice, RIte Smiles, and PACE)."

- General Administrative/Reporting Requirements – The State was required to report quarterly and annually in writing to CMS on[19]:

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17 The most recent version of the approval letter with both the waivers and the STCs explicated was June 18, 2008.

18 STCs dated January 16, 2009.

19 Three quarterly and one annual report were required to be submitted to CMS. All reports could be combined Medicaid and CHIP reports.

- Events affecting health care delivery, the enrollment process for newly-eligible individuals, enrollment and outreach activities, access, complaints and appeals, the benefit package, quality of care, access, financial results, and other operational and policy issues
- Utilization of health services based on encounter data, including physician visits, hospital admissions, and hospital days

These STCs basically remained the same since RIte Care was first implemented in 1994.

1.4 CHIP Quality Requirements

CHIP, too, has quality requirements. Specifically, 42 CFR 457.495 addresses "access to care and procedures to assure quality and appropriateness of care[20]. The State CHIP Plan must describe how it will assure:

- Access to well-baby care, well-child care, well-adolescent care, and childhood and adolescent immunizations
- Access to covered services, including emergency services
- Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition
- Decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after receipt of a request for services, with an extension possible under certain circumstances, and in accordance with State law[21]

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[20] *Federal Register*, 66(8), January 11, 2002, 2666-2688.
[21] *Federal Register*, 66(122), June 25, 2001, 33810-33824.

CHAPTER 2

COMPONENTS OF RITE CARE'S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

From the very beginning of RIte Care, the State has taken to heart the fact that it is a *demonstration* initiative. RI Medicaid developed a plan for monitoring RIte Care Health Plans early on. The plan included the following mechanisms for monitoring 13 areas of Health Plan operations:

- Annual Site Visit Protocol
- Disenrollment Grievance Log
- Informal Complaints and Grievance and Appeals Log
- Primary Care Provider (PCP) Survey
- Enhanced Services Report
- MMIS Special "Runs"
- Member Satisfaction Survey
- Self-Assessment Tool for Health Plan Internal Quality Assurance Plan Compliance with HCQIS
- Access Study Format
- PCP Open Practice Report
- Other Provider Report
- Financial Reporting Requirements
- Third-Party Liability Report

The State also crafted and has implemented an extensive research and evaluation program to determine how well RIte Care has done in accomplishing its goals. In fact, research began before RIte Care was actually implemented in order to have some baseline data for comparison with *demonstration* results.

2.1 Principles Forming the Foundation of RIte Care's Quality Strategy

As with the earlier monitoring plan, principles have been developed to frame the strategy as follows:

- **Principle 1: The strategy must embrace the unique feature of the program while fulfilling the Federal requirements** – Chapter 1 described the Federal requirements applicable to the demonstration with respect to quality assessment and performance improvement. The strategy must incorporate all of the requirements in order to comply fully with the regulations and STCs. Yet, the strategy must make sense given the features of RIte Care[22], what the State has been attempting to accomplish, and how it has been assessing accomplishments.

- **Principle 2: The strategy must build on, not duplicate or supplant, other requirements** – The service delivery system for RIte Care does not exist in isolation. The State made a policy decision[23] in

[22] The focus here is RIte Care and not RIte Share, because RIte Care is the mandatory managed care program. RIte Share, while there is mandatory enrollment, does **not** have mandatory enrollment into a *managed care plan*.

[23] When Blue Cross and Blue Shield of Rhode Island (BCBSRI) made a decision to give up its HMO license for CHIP effective January 1, 2005, the State changed its requirements that non-HMO RIte Care Health Plans had to meet, including NCQA accreditation and certain HMO requirements that plans had to meet under Rhode Island Department of Health regulations. These requirements were incorporated into the *RIte Care Health Plan Contract* effective January 1, 2005. BCBSRI ceased participating in Medicaid managed care in December 2010, when it declined to bid on the State's new Medicaid managed care procurement.

the very beginning that only State-licensed health maintenance organizations (HMOs) would be allowed to participate in RIte Care. HMOs in the State are overseen by the Division of Facility Regulation (DFR) within the Rhode Island Department of Health (DOH) and by the Department of Business Regulation (DBR). In Rhode Island, this also means that the HMOs are accredited by the National Committee for Quality Assurance (NCQA), since this is a requirement of State law[24]. So, the strategy should build on, not duplicate or supplant, these requirements.

- **Principle 3: The strategy must recognize and not interfere with the relationships between the Health Plans and their networks and between the networks and their patients** – Failure to do so could undermine these relationships, thereby jeopardizing the Health Plans' ability to maintain viable operations and RIte Care as a whole. Nonetheless, quality assessment needs to include these relationships to assure they are working well and meet all legal requirements.

- **Principle 4: The strategy must include, among other things, the requirements levied on the Health Plans through the contracts between the Health Plans and the State** – Health Plans cannot be held accountable for operations or performance for which they are not contractually obligated (or obligated as a matter of law, ethics, or sound business practice) to meet.

2.2 The Components of Rhode Island's Quality Strategy for Managed Care

Using the above principles as a backdrop, the following will constitute the various components of the strategy for quality assessment and performance improvement. Table 2-1 shows the various components of RIte Care's CMS-approved quality strategy. In order to track compliance with Federal requirements, the table is organized first according to those minimum elements delineated in the June 14, 2002 *Final Rule* and then according to the applicable STCs for the RIte Care waivers.

In this update to the quality strategy, the State has set forth its quality design for Rhody Health Partners, Connect Care Choice, and RIte Smiles, building upon the core principles that have been previously approved by CMS for RIte Care. Table 4-1 delineates the components of the quality design for Rhody Health Partners, the State's MCO-based Medicaid managed care program for disabled adults; Table 5-1 outlines the quality design for the State's primary care case management program for disabled adults, Connect Care Choice[25]. The quality design for RIte Smiles, the State's dental managed care program for Medicaid-enrolled children born on or after May 1, 2000, has been provided in Table 6-1.

[24] All three MCOs that were participating in RIte Care during Reporting Year 2010 (the most recent EQR period) had full, three-year accreditation from NCQA. All three Health Plans – BCBSRI, Neighborhood Health Plan of Rhode Island (NHPRI), and United Healthcare of New England (UHCNE) – received an "excellent" designation from NCQA. Both BCBSRI and UHCNE had their Medicaid product lines accredited separately by NCQA and both were Medicare Advantage participating plans (and had their Medicare product lines separately accredited by NCQA).

[25] Rhody Health Partners and Connect Care Choice serve disabled adults whose only source of health insurance coverage is Rhode Island Medicaid.

Table 2-1
COMPONENTS OF RITE CARE'S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

QUALITY/PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
1. Assess the quality and appropriateness of care and services to enrollees	• Performance incentive program • Encounter Data System • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO studies • Special studies • Contract compliance review	
2. Identify the race, ethnicity, and primary language spoken of each enrollee	• MMIS data	
3. Arrange for annual, external independent reviews of the quality and timeliness of, and access to, the services covered under each Health Plan contract	• Performance incentive program • Encounter Data System • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO studies • Special studies • Contract compliance review	The State's EQRO is responsible for preparing an annual, plan-specific detailed technical report that assesses the quality, timeliness, and access to the care furnished by each Health Plan.
4. Appropriate use of intermediate sanctions	• Contract compliance review	Provisions for levying intermediate sanctions have always been a part of the RIte Care Health Plan Contract. Contracts were amended to incorporate Subpart I of the June 14, 2002 *Final Rule* requirements.

QUALITY/PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
5. Standards for Access to Care, Structure and Operations, and Quality Measurement and Improvement **5.a. Access Standards**		
5.a.1 Availability of services	• Performance incentive program • Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Special studies • Contract compliance review	As Table 2-2 shows, the State has quantitative access standards and has since 1994.
5.a.2 Assurances of adequate capacity and services	• Provider network reporting • NCQA information • Contract compliance review	As Table 2-2 shows, the State has quantitative capacity standards and has since 1994.
5.a.3 Coordination and continuity of care	• Complaint, grievance, and appeals reporting • NCQA information • EQRO activities • Special studies • Contract compliance review	The State defers principally to NCQA standards in this area.
5.a.4 Coverage and authorization of services	• Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Contract compliance review	The State defers principally to NCQA standards in this area.
5.b. Structure and Operations Standards		
5.b.1 Provider selection	• Provider network data • NCQA information • Complaint, grievance, and appeals reporting	The State defers principally to NCQA standards in this area.

QUALITY/PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
	• Contract compliance review	
5.b.2 Enrollee information	• Performance incentive program • On-site reviews • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review	The State defers to NCQA standards in this area, except for certain State-specific requirements to be met in the contract.
5.b.3 Confidentiality	• NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review	The State defers principally to NCQA standards in this area.
5.b.4 Enrollment and disenrollment	• MMIS data • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review	State requirements must be met as specified in the contract.
5.b.5 Grievance systems	• NCQA information • Annual Member Satisfaction Survey • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review	The State defers to NCQA standards in this area, except for certain requirements that must be met under State law.
5.b.6 Subcontractual relationships and delegation	• NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review	The State defers principally to NCQA standards in this area.
5.c. Quality Measurement and Improvement Standards		
5.c.1 Practice guidelines	• NCQA information • Special studies • Contract compliance review	The State defers principally to NCQA standards in this area.
5.c.2 Quality assessment and performance improvement program	• Performance incentive program • Encounter Data System • Complaint, grievance, and appeals	The State defers to NCQA standards in this area, except for certain State-specific

QUALITY/PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
	reporting • NCQA information • Special studies • Contract compliance review	requirements to be met under the contract.
5.c.3 Health information systems	• Encounter Data System • Risk-share reporting • NCQA information • EQRO activities • Special studies • Contract compliance review	The State defers to NCQA standards in this area, except for certain State-specific requirements to be met under the contract.
6. Encounter Data Requirements	• Encounter Data System • EQRO activities • Special studies • Contract compliance review	The Encounter Data System has been used to produce reports since 1998. It is supplemented by EQRO studies and special studies in areas of access and clinical care interest.
7. Quality Assurance Requirements		
7.a. Methodology to monitor performance	• All mechanisms	Previously, the State had a *Plan for Monitoring RIte Care Health Plans*. That plan is superseded by this strategy document with respect to quality.
7.b. Contract with EQRO	• EQRO activities	The State's EQRO contract was reprocured in 2003, 2006, and 2012[26].
7.c. Quarterly reports on complaints and grievances	• Complaint, grievance, and appeals reporting • Contract compliance review	Complaint, grievance, and appeals reporting have been in place since 1994.
7.d. EQRO focused study of emergency room services	• EQRO study	Study report was submitted to CMS (HCFA) in 1998.
7.e. Require that Health Plans meet certain quality assurance requirements	• NCQA information • Contract compliance review	Contracts were amended to conform to the *Final Rule.*
8 General Administrative/Reporting Requirements – quarterly and annual reports	• All mechanisms	

[26] In 2012, Rhode Island issues its Request for Proposals (RFP) for the managed care EQR functions.

Table 2-2 shows those areas where the State has established quantitative standards for access.

Table 2-2
RIte Care's Quantitative Standards for Access and Mechanisms for Measuring Them

Area	Quantitative Standard	Mechanism for Measuring It
Availability of services	• Emergency services are available 24 hours a day, 7 days a week • Make services available immediately for an "emergent" medical condition including a mental health or substance abuse condition • Make treatment available within 24 hours for an "urgent" medical problem including a mental health or substance abuse condition • Make services available within 30 days for treatment of a non-emergent, non-urgent medical condition, except for routine physical examinations or for regularly scheduled visits to monitor a chronic medical condition for visits less frequently than once every 30 days • Make services available within 5 business days for diagnosis or treatment of a non-emergent, non-urgent mental health or substance abuse condition	• Complaint, grievance, and appeals data • Contract compliance review • Member Satisfaction Survey
Adequate capacity and services	• No more than 1,500 RIte Care members for any single PCP in a Health Plan network • No more 1,000 Rite Care members per single PCP within the team or site • No more than 4,000 members per network mental health provider • No more than 10,000 members per network psychiatrist	• Provider network reporting • Informal complaints reporting • Encounter Data System

Area	Quantitative Standard	Mechanism for Measuring It
	• Members may self-refer for up to 4 GYN/family planning (FP) visits annually or for RP services, without obtaining a referral from the PCP	
Coverage and authorization of services	• Assignment of a PCP within 20 days of enrollment, if none selected by the enrollee • For children with special health care needs, completion of an Initial Health Screen within 45 days of the effective date of enrollment • For children with special health care needs for whom it is applicable, completion of a Level I Needs Review and Short Term Care Management Plan within 30 days of the effective date of enrollment • Provide initial assessments of RIte Care members within 90 days of enrollment • Provide initial assessments of pregnant women and members with complex and serious medical conditions within 30 days of the date of identification • Allow women direct access to women's health care specialist within the Health Plan's network for women's routine and preventive services • Resolution of a standard appeal of an adverse decision within 14 days • Resolution of an expedited appeal of an adverse decision within 3 days	• On-site review • Member Satisfaction Survey • Complaint, grievance, and appeals data

The State's "standards" are "at least as stringent" as required by 42 CFR 438.204(g).

As noted in Chapter 2, information gathering for EQR must be consistent with *protocols* established under 42 CFR 438.352. Table 2-3 describes the entity that will perform each EQRO activity and the *protocol* used/to be used to guide the activity.

Table 2-3
Protocols Used/To Be Used for EQR

Activity	Who Has, Will, or May Perform	Protocol Used/To Be Used
Prepare detailed technical report	EQRO	No protocol specified by CMS
Validation of performance improvement projects	• EQRO • Xerox State Healthcare, LLC • State staff	Methods consistent with CMS protocols
Validation of MCO performance measures reported	NCQA auditors	NCQA audit standards and protocols, which the State has found to be consistent with CMS protocols
Review to determine MCO compliance with standards	• State staff • Xerox State Healthcare, LLC	State-specified protocols consistent with CMS protocols
Validation of encounter data	• Xerox State Healthcare, LLC • May be the EQRO	Validate against bills and/or against medical records
Administration or validation of consumer or provider surveys of quality of care	• Xerox State Healthcare, LLC • State staff • MCH Evaluation	State-specific consumer survey consistent with CMS protocols and CAHPS® standards
Calculation of additional performance measures	• Xerox State Healthcare, LLC • MCH Evaluation	Methods consistent with CMS protocols
Conduct additional quality improvement projects	• State staff • Xerox State Healthcare, LLC • MCH Evaluation	Methods consistent with CMS protocols
Conduct studies that focus on a particular aspect of clinical or non-clinical services at a point in time	EQRO	EQRO's methods consistent with CMS protocols

Xerox State Healthcare, LLC, (formerly ACS) is the State's management assistance contractor. MCH Evaluation is the State's research and evaluation contractor. IPRO, Incorporated is the State's EQRO.

CHAPTER 3

PROCESS FOR INVOLVING RECIPIENTS AND OTHER STAKEHOLDERS

To fulfill the requirements of 42 CFR 438.202(b) to "obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final," the State used the following process:

- RI Medicaid posted the "final draft" on the RI Medicaid Website.
- RI Medicaid put a notice in English and Spanish in The Providence Journal, the newspaper of widest circulation in the State, making the public aware that the "final draft" was available for review and how to obtain a copy of it. RI Medicaid had a 30-day comment period.
- RI Medicaid put the "final draft" on the agenda of the Child and Family Health Consumer Advisory Council for discussion.
- With there being no comments received from the public, the document was finalized and copies forwarded to CMS Central and Regional Offices.

The State will review the Quality Strategy periodically with the EOHHS' Consumer Advisory Committee (CAC) and the Global Waiver's Quality and Evaluation Workgroup to assess the strategy's effectiveness and to update it, as needed. In addition, Rhode Island will review its Quality Strategy whenever the following temporal events occur: a) new population groups are to be enrolled in managed care delivery systems; and b) Medicaid managed care re-procurement takes place.

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CHAPTER 4

RHODY HEALTH PARTNERS

The option to enroll in a managed care organization (MCO)[27] was extended to adult Medicaid beneficiaries with disabilities in 2008. At that time, adults with disabilities without third-party coverage were given the option to enroll in an MCO with the provision that they could choose to return to fee-for-service (FSS) Medicaid ("opt-out") at any time. Effective September 1, 2010, all adults residing in the community without third-party coverage were required to either enroll in a Health Plan (i.e., MCO) through Rhody Health Partners or in the State's FFS programs, which are Connect Care Choice and Connect Care. The Connect Care Choice program is a primary care practice-based model that includes care coordination and nurse care management. Connect Care is not a focus of the quality strategy, given that it is not a managed care product.

Eligibility for enrollment in Rhody Health Partners is based on State determination of Medicaid beneficiaries who meet the following criteria:

- Age twenty-one (21) or older
- Categorically eligible for Medicaid
- Not covered by other third-party insurance, including Medicare
- Residents of Rhode Island
- Not residing in an institutional facility

Beneficiaries have a choice of Health Plans in which to enroll. Following ninety (90) days after their initial enrollment into a Health Plan, beneficiaries are restricted to that Health Plan until the next open enrollment period or unless they are disenrolled by the State under certain conditions (e.g., placement in a nursing facility for more than 30 consecutive days).

Rhody Health Partners members have the same comprehensive benefits package as RIte Care members, with the exception of Home Care Services. However, Rhody Health Partners members do have Home Health Services benefits. In addition, Rhody Health Partners have access to out-of-plan benefits covered prior to the Global Waiver by Section 1915 waivers including, for example, homemaker services, environmental modification, home-delivered meals, supportive living arrangements, adult companion services, respite services, and assisted living. As noted previously, the State's former 1915(c) waiver services were integrated into Rhode Island's Global Waiver.

An important component of Rhody Health Partners is a Care Management program, for which the Health Plan must comply with the *Rhode Island Department of Human Services Care Management Protocols for Adults Enrolled in Rhody Health Partners*. Key elements of this program are:

- Initial Adult Health Screen – completed within forty-five (45) days of enrollment in the Health Plan
- Level I Needs Review – completed within thirty (30) days of completion of the Initial Health Screen
- Level II Needs Review – completed within thirty (30) days of completion of the Initial Health Screen or Level I Review, including development of an Intensive Care Management Plan, as needed
- Short-Term Care Management – completed within thirty (30) days of completion of the Initial Health Screen

[27] Prior to the State's *Medicaid Managed Care Services* re-procurement in September of 2010, NHPRI and UHCNE were the MCOs available to adults with disabilities in which to enroll; BCBSRI never made itself available to this population.

- Intensive Care Management – as deemed necessary

As part of its Contract with the State, each Health Plan agrees to conduct at least one quality improvement project annually directed at Rhody Health Partners members.

Table 4-1 shows the quality design for Rhody Health Partners.

Table 4-1
Rhody Health Partners Quality Design

Data Collection Method	Type of Method	Performed By
Administrative data and hybrid measures, as set forth annually by the NCQA	The HEDIS® methodology.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Quality Improvement Project (QIP)	NCQA's Quality Improvement Assessment (QIA) methodology that meets CMS protocol requirements.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Annual External Quality Review	Elements as mandated by 42 CFR 438.350(a).	Rhode Island's designated External Quality Review Organization (IPRO)
Informal Complaints, Grievances, and Appeals	Informal complaint reports are submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Health Plan Member Satisfaction Survey	The CAHPS® 4.0 Survey Methodology for Adults in Medicaid.	NCQA-certified CAHPS® vendor
Care Management Report for RHP	Care management reports are submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Encounter Data Reporting and Analysis	The managed care encounter dataset is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Access to Health Care for Adults with Disabilities on Medicaid Survey	Telephone survey of a sample of Rhode Island's ABD (Aged, Blind, and Disabled) population, including RHPD enrollees.	Independent Contractor

APPENDIX 2: Quality Improvement Activity Form Template

QUALITY IMPROVEMENT FORM

NCQA Quality Improvement Activity Form

Activity Name:	
Section I: Activity Selection and Methodology	
A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.	
B. Quantifiable Measures. List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established, list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.	
Quantifiable Measure #1:	
Numerator:	
Denominator:	
First measurement period dates:	
Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #2:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #3:	
Numerator:	
Denominator:	

First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	

C. Baseline Methodology.

C.1 Data Sources.

[ ] Medical/treatment records
[ ] Administrative data:
[ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] Other (list and describe):
_The Plan also uses a local access database to track all pregnant members as part of our Healthy First Steps Program. Although this database was not used as an administrative database from NCQA perspective, it was used by local Plan team members to identify and outreach to pregnant members. In addition, we used this database to track number of members who participated in our Diaper Reward Program.

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.

If medical/treatment records, check below:
[ ] Medical/treatment record abstraction

If survey, check all that apply:
[ ] Personal interview
[ ] Mail
[ ] Phone with CATI script
[ ] Phone with IVR
[ ] Internet
[ ] Incentive provided
[ ] Other (list and describe):

If administrative, check all that apply:
[ ] Programmed pull from claims/encounter files of all eligible members
[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Complaint/appeal data by reason codes
[ ] Pharmacy data
[ ] Delegated entity data
[ ] Vendor file
[ ] Automated response time file from call center
[ ] Appointment/access data
[ ] Other (list and describe):

C.3 Sampling. If sampling was used, provide the following information.

Measure	Sample Size	Population	Method for Determining Size *(describe)*	Sampling Method *(describe)*

C.4 Data Collection Cycle.	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:

- Measure and time period covered
- Type of change
- Rationale for change
- Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method
- Any introduction of bias that could affect the results

Section II: Data/Results Table

Complete for each quantifiable measure; add additional sections as needed.

#1 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

#2 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

#3 Quantifiable Measure:

Time Period Measurement Covers	Measurement	Numerator	Denominator	Rate or Results	Comparison Benchmark	Comparison Goal	Statistical Test and Significance*
	Baseline:						

* If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing.

Section III: Analysis Cycle

Complete this section for EACH analysis cycle presented.

A. Time Period and Measures That Analysis Covers.

B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.

B.1 For the quantitative analysis:

B.2 For the qualitative analysis:

- Opportunities identified through the analysis

Impact of interventions

- Next steps

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 UM nurses" as opposed to "hired UM nurses"). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address

Section V: Chart or Graph (Optional)

Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation.