Rhode Island Medicaid Managed Care Program

Annual External Quality Review Technical Report

Reporting Year 2016
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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 (Neighborhood) 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 2016, and compares and contrasts the individual performance of both Health Plans. For comparative purposes, results for 2014 and 2015 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] 2016 for Medicaid, with the exception of those shown for the 2016 Performance Goal Program (PGP). Scoring percentiles for the PGP were derived from *Quality Compass*® 2015 for Medicaid.

Corporate Profiles

As indicated previously, the Rhode Island Medicaid managed care program was comprised of two (2) Health Plans in 2016: Neighborhood, which served Medicaid and Commercial populations, and UHCP-RI, which served Medicaid, Medicare, and Commercial populations (refer to Table 1 on page 9). 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 Neighborhood 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 Neighborhood only.

2 The Rhody Health Options population is served by Neighborhood 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, both Neighborhood and UHCP-RI received *Excellent* accreditation ratings from the NCQA in 2016 for their Medicaid product lines (refer to Table 2 on page 12). 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, 2016 ratings are based on the results of the accreditation survey effective in 2015 for UHCP-RI and in 2014 for Neighborhood, while the HEDIS® and CAHPS® 2016 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 2016 (refer to Table 3 on page 13).

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, 2016, sixty-seven percent (67%) of Medicaid managed care enrollees were enrolled with Neighborhood, a total of over 178,000 members. The remaining thirty-three percent (33%) of the Medicaid managed care population were enrolled with UHCP-RI, a total of over 89,000 members (refer to Table 4 on page 14). Compared to year-end 2015, Neighborhood's Medicaid enrollment grew by ten percent (10%), while UHCP-RI saw an increase of four percent (4%) in Medicaid managed care enrollees[6].

Provider Network and Accessibility

Both Health Plans continued to achieve an *Excellent* Accreditation rating on the *Access and Service* domain of the NCQA Accreditation Survey. Additionally, Neighborhood exceeded its established GeoAccess goals for all provider types displayed, while UHCP-RI exceeded the goals for all provider types with the exception of OB/GYN in metro areas (refer to Table 6 on page 17).

HEDIS® Performance Measures

The assessment of Health Plan performance on HEDIS® 2016 is based on comparisons to the *Quality Compass*® 2016 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, both Health Plans continued to perform well on the *Childhood Immunization Status—Combo 3* and *Childhood Immunization Status—Combo 10* measures, as both Health Plans' rates, as well as the statewide rate, were above the 2016 *Quality Compass*® 90th percentile. Additionally, both Health Plans' rates, as well as the statewide rates, were at or above the *Quality Compass*® 75th percentile for the *Cervical Cancer Screening* and *Chlamydia Screening (16-24 Years)* measures. For all eight (8) measure rates displayed, rates for both Health Plans, as well as the statewide rates, exceeded the 2016 *Quality Compass*® national Medicaid mean (refer to Figure 3 on page 22).

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[5] CAHPS® (Consumer Assessment of Healthcare Providers and Systems) is a registered trademark of the U.S. 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 marked the first year in which members in the Expansion population met eligible population criteria for inclusion in performance measure calculations and quality improvement projects.

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 Neighborhood and UHCP-RI, as well as the statewide rates, exceeded the 2016 national Medicaid mean for eight (8) of the nine (9) measures. Additionally, both Health Plans' rates, as well as the statewide rate, achieved the 2016 *Quality Compass*® 90th percentile for the *7-11 Years* and *12-19 Years* age groups of the *Children and Adolescents' Access to Primary Care* measure, as well as the *Timeliness of Prenatal Care* measure. Additionally, both Health Plans' rates, as well as the statewide rate, benchmarked at the 2016 *Quality Compass*® 75th percentile for the *25 Months-6 Years* age group of the *Children and Adolescents' Access to Primary Care* measure. UHCP-RI, Neighborhood, and the statewide rate met the *Quality Compass*® 90th or 75th percentile for the *Timeliness of Postpartum Care* measure, as well (refer to Figure 4 on page 26).

Both Health Plans continued to demonstrate a strong performance in regard to HEDIS® Use of Services measures. Rates for Neighborhood and UHCP-RI, as well as the statewide rates, exceeded the 2016 *Quality Compass*® national Medicaid mean for all four (4) measures displayed. For both Health Plans, as well as statewide, rates achieved the 2016 *Quality Compass*® 90th percentile for *Well-Child Visits in the First 15 Months of Life—6+ Visits* and *Frequency of Ongoing Prenatal Care—81+ Percent* and the 75th percentile for *Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life* and *Adolescent Well-Care Visits* (refer to Figure 5 on page 30).

Member Satisfaction: CAHPS® 5.0H

Performance on the CAHPS® measures varied across Health Plans, as well as across measures. Neighborhood's rates exceeded the 2016 *Quality Compass*® national Medicaid mean for seven (7) of the nine (9) measures displayed in Figure 6, whereas UHCP-RI's rates, as well as the statewide rates exceeded the mean for eight (8) of nine (9) measures. UHCP-RI achieved the 2016 *Quality Compass*® 90th percentile for three (3) measures and the 75th percentile for two (2) measures, while Neighborhood achieved the 90th percentile for two (2) measures and the 75th percentile for two (2) measures (refer to Figure 6 on page 32).

Rhode Island Performance Goal Program

Rhode Island's Performance Goal Program (PGP) 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 2014, 2015, and 2016 Reporting Years, the following performance categories were used to evaluate Health Plan performance[7]:

- *Utilization*
- *Access to Care*
- *Prevention and Screening*
- *Women's Health*
- *Chronic Care*
- *Behavioral Health*
- *Compliance*
- *Total Cost of Care*

[7] For the 2016 Performance Goal Program, the performance categories were redefined into the eight categories listed here. For more detailed information on updates and changes to the methodology of the Performance Goal Program for Reporting Year 2016, refer to Section X of this report.

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., *Emergency Room Utilization Rate per 1,000, Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care, Accurate Submission of Encounter Data,* and *Decrease the Average Total Cost of Care—High Utilizers)*. See **Tables 7** and **8** on pages 40 and 58 for the full results of the 2016 Performance Goal Program.

For the 2016 Performance Goal Program, incentives were awarded 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 sixteen (16) State-specified measures, two (2) CAHPS® measures, and forty-three (43) HEDIS® measures, resulting in a total of sixty-one (61) PGP measures. Of these measures, fourteen (14) were considered baseline measures, leaving forty-seven (47) measures eligible for benchmarking/incentive awards. For the RHE population, there were six (6) State-specified measures, two (2) CAHPS® measures, and twenty-six (26) HEDIS® measures, resulting in thirty-four (34) PGP measures. Of these measures, three (3) were considered baseline measures, leaving thirty-one (31) measures eligible for benchmarking/incentive awards[8].

In regard to the results for the Non-RHE populations, Neighborhood did not meet the *Contract* goals for any of the three (3) applicable State-specified measures, while UHCP-RI met the goal for one (1) measure. Among the HEDIS® and CAHPS® measures, Neighborhood achieved a 2015 *Quality Compass*® benchmark (90th or 75th percentile) and qualified for a full or partial incentive award for thirty-nine (39) of forty-five (45) reported HEDIS®/CAHPS® measures, with twenty-four (24) measures ranking in the 90th percentile and fifteen (15) in the 75th percentile. UHCP-RI achieved a 2015 *Quality Compass*® benchmark (90th or 75th percentile) and qualified for a full or partial incentive award for thirty-five (35) of forty-five (45) reported HEDIS®/CAHPS® measures, with fifteen (15) measures ranking in the 90th percentile and twenty (20) ranking in the 75th percentile.

In regard to the results for the RHE population, Neighborhood did not meet the *Contract* goals for any of the three (3) applicable State-specified measures, while UHCP-RI met the goal for one (1) measure. Among the HEDIS® and CAHPS® measures, UHCP-RI achieved a 2015 *Quality Compass*® benchmark (90th or 75th percentile) and qualified for a full or partial incentive award for seventeen (17) of twenty-eight (28) measures, with eleven (11) measures ranking in the 90th percentile and six (6) in the 75th percentile. Neighborhood achieved a 2015 *Quality Compass*® benchmark (90th or 75th percentile) and qualified for a full or partial incentive award for sixteen (16) of twenty-eight (28) measures, with ten (10) ranking in the 90th percentile and six (6) ranking in the 75th percentile.

Conclusions and Recommendations

IPRO's external quality review concludes that the Rhode Island Medicaid managed care program and its participating Health Plans (Neighborhood and UHCP-RI) have had an overall positive impact on the accessibility, timeliness, and quality of services for Medicaid recipients. This is further supported by the Health Plans' ratings of four and a half (4.5) out of five (5) for their Medicaid product lines, as well as their *Excellent* accreditation status, given by the NCQA for 2016.

Overall strengths for both Health Plans include: women's health and preventive health care for children and adolescents.

[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 for the RHE population, as the eligible population criteria include members under age 19.

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 Neighborhood 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:

Quality of Care:

- NCQA Accreditation domain
  - *Getting Better*
- HEDIS® *Board Certification*
- Member Satisfaction
  - CAHPS® *Customer Service*
  - CAHPS® *Rating of Personal Doctor*
- Performance Goal Program—Non-RHE Populations
  - HEDIS® *Use of Imaging Studies for Low Back Pain*
  - HEDIS® *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - HEDIS® *Call Answer Timeliness*
  - *HIV Viral Load Suppression*
  - *Accurate Submission of Encounter Data—Claims Count*
- Performance Goal Program—RHE Population
  - HEDIS® *Cervical Cancer Screening*
  - HEDIS® *Use of Imaging Studies for Low Back Pain*
  - HEDIS® *Adherence to Antipsychotics for Individuals with Schizophrenia*
  - HEDIS® *Call Answer Timeliness*
  - *HIV Viral Load Suppression*
  - *Accurate Submission of Encounter Data—Claims Count*

Access to/Timeliness of Care:

- Performance Goal Program—RHE Population
  - HEDIS® *Adults Had Ambulatory Preventive Care Visit (20-44 Years)*
  - HEDIS® *Adults Had Ambulatory Preventive Care Visit (45-64 Years)*
  - HEDIS® *Pregnant Members Received Timely Prenatal Care*
  - HEDIS® *Postpartum Members Received Timely Postpartum Care*

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 2016 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 2014-2015 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[9].

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[10]. As members of the Health Plans, the RHP population is included in all measure calculations, where applicable.

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[9] 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.

[10] 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 Plans, the RHE population is included in all measure calculations, where applicable. Reporting Year 2015 marked the first reporting period for which RHE members met 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 the RIte Care and Rhody Health programs.

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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*® 2016 for Medicaid and represent the performance of all Health Plans that reported HEDIS® or CAHPS® data to the NCQA for HEDIS® 2016 (Measurement Year 2015).

For comparative purposes, the results for 2014-2015 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 sixth 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 in 2016:

- Neighborhood Health Plan of Rhode Island, Inc. (Neighborhood) 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 for-profit Health that 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	Neighborhood	UHCP-RI
Type of Organization	HMO	HMO
Tax Status	Not-for-profit	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 12/31/16	192,820	109,736
Total Medicaid Enrollment as of 12/31/16	178,336	89,355
NCQA Medicaid Accreditation Status	Excellent	Excellent
NCQA Medicaid Health Plan Rating[11]	4.5	4.5

[11] In 2015, the NCQA retired the *Health Insurance Plan Rankings* methodology and replaced it with the *Health Insurance Plan Ratings* methodology. For detailed information, refer to the following section of this report, or see 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 December 2014 quality strategy, entitled *Rhode Island Comprehensive Quality Strategy*[12]. 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. If 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.

[12] 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.

Health Plans are scored along five (5) dimensions using star ratings of between one (1) and four (4) stars. (1—lowest; 4—highest)[13]:

- 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, 2016 accreditation ratings are based on the Accreditation Survey conducted in September 2014 for Neighborhood and in December 2014 (effective February 2015) for UHCP-RI, while HEDIS®/CAHPS® 2016 results were used for both plans.

The table below presents the most common overall NCQA 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.

[13] www.ncqa.org.

Table 2 depicts the NCQA Accreditation findings for Neighborhood and UHCP-RI in 2016.

Table 2: 2016 NCQA Accreditation Survey Findings

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

NCQA Health Plan Ratings

In 2015, the NCQA retired its *Health Insurance Plan Rankings* methodology, which was used from 2005 through 2014[14]. It was replaced with the *Health Insurance Plan Ratings* methodology. The *Ratings* methodology evaluates Health Plans based 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* 2016-2017 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.

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.

[14] 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. In 2016, both Neighborhood and UHCP-RI earned an overall NCQA rating of four and a half (4.5) out of (5) for their Medicaid product lines.

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

Table 3: 2016 NCQA Ratings by Category

Health Plan	Consumer Satisfaction	Prevention	Treatment	2016 Overall Rating
Medicaid				
Neighborhood	3.5	4.5	4.0	4.5
UHCP-RI	4.0	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, 2016, 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. Neighborhood's membership comprised the majority of the total managed care enrollment (67%), with UHCP-RI's membership accounting for the remaining thirty-three percent (33%).

Table 4: Rhode Island Medicaid Managed Care Enrollment by Health Plan—December 31, 2016

Health Plan	Medicaid Managed Care Enrollment	Percentage of Total Medicaid Managed Care Enrollment
Neighborhood	178,336	67%
UHCP-RI	89,355	33%
Total	**267,691**	**100%**

Table 4a provides additional detail, the enrollment by Medicaid eligibility category for Neighborhood 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, 2016

	Neighborhood		UHCP-RI		Total	
Eligibility Group	**N**	**%**	**N**	**%**	**N**	**%**
Core RIte Care	100,158	56%	49,821	56%	149,979	56%
RIte Care for Children with Special Health Care Needs (CSHCN)[1]	5,267	3%	1,784	2%	7,051	3%
RIte Care for Children in Substitute Care (SC)[2]	2,023	1%			2,023	1%
Extended Family Planning (EFP)[3]	950	1%			950	<1%
Rhody Health Partners (RHP)[4]	7,575	4%	7,512	8%	15,087	6%
Rhody Health Options (RHO)[5]	23,148	13%			23,148	9%
Rhody Health Expansion (RHE)[6]	39,215	22%	30,238	34%	69,453	26%
Total Medicaid Enrollment	**178,336**	**100%[7]**	**89,355**	**100%[7]**	**267,691**	**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 describes the eligibility criteria for Rhody Health Partners.

[5] Neighborhood 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, age 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.

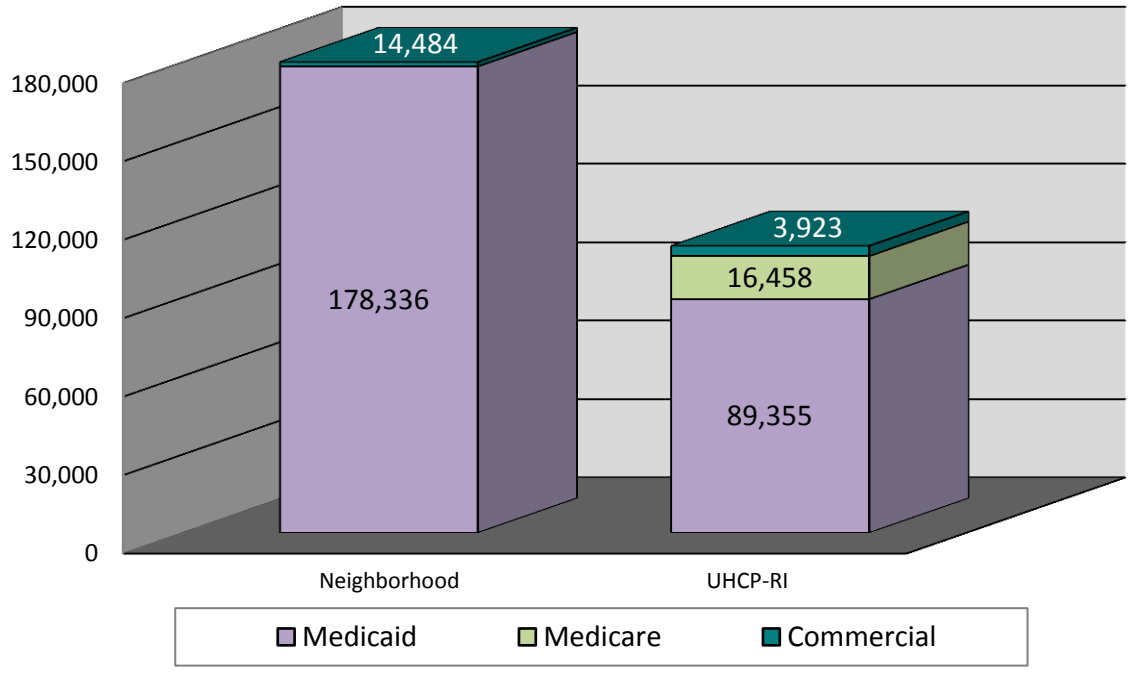
Table 5 presents the Health Plans' enrollment by product line, including the proportion of total Health Plan membership. As of December 31, 2016, the majority of UHCP-RI's membership was enrolled in the Medicaid product line (81%), followed by Medicare (15%), and Commercial (4%). Neighborhood's Medicaid product line comprised ninety-two percent (92%) of total Health Plan enrollment, with the Commercial product line accounting for the remaining eight percent (8%).

Table 5: Health Plan Enrollment by Product Line—December 31, 2016

	Neighborhood		UHCP-RI	
Product Line	**N**	**%**	**N**	**%**
Medicaid	178,336	92%	89,355	81%
Medicare[1]			16,458	15%
Commercial	14,484	8%	3,923	4%
Total Health Plan Enrollment	**192,820**	**100%**	**109,736**	**100%**

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

Figure 1: Health Plan Enrollment by Product Line—December 31, 2016



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 Neighborhood, the standards are as follows: two (2) clinicians within ten (10) miles for PCPs, and one (1) clinician within fifteen (15) miles for OB/GYN providers, high-volume specialists, and high-impact specialists. Neighborhood'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[15]. The goal was to have at least ninety percent (90%) of primary care, high-volume, and high-impact providers who met the distance requirements. The standards vary by geographic access criteria (large metro and metro).

[15] 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 and high-impact specialists may differ for each Health Plan based on Health Plan-specific information[16].

Table 6: GeoAccess Provider Network Accessibility—2016

Provider Type	Access Standard[1]	Percentage for Whom Access Standard was Met[2]
Neighborhood (as of 1/2017)		
Primary Care Practitioners	2 within 10 miles	99.9%
OB/GYN	1 within 15 miles	99.8%
High-Volume Specialists	1 within 15 miles	99.9%
High-Impact Specialists	1 within 15 miles	99.9%
UHCP-RI (as of 3/2016)[3]		
Primary Care Practitioners (Large Metro)	1 in 5-10 miles	99%
Primary Care Practitioners (Metro)	1 in 5-10 miles	100%
OB/GYN (Large Metro)	1 in 5-10 miles	97%
OB/GYN (Metro)	1 in 5-10 miles	58%
High-Volume Specialists (Large Metro)	1 in 5-30 miles	100%
High-Volume Specialists (Metro)	1 in 5-30 miles	100%
High-Impact Specialists (Large Metro)	1 in 5-30 miles	100%
High-Impact Specialists (Metro)	1 in 5-30 miles	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 Neighborhood 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] For UHCP-RI, the Access Standards differ for each type of specialty provider and for each county type. For specific Access Standards, please refer to the Health Plan-specific Technical Report for UHCP-RI.

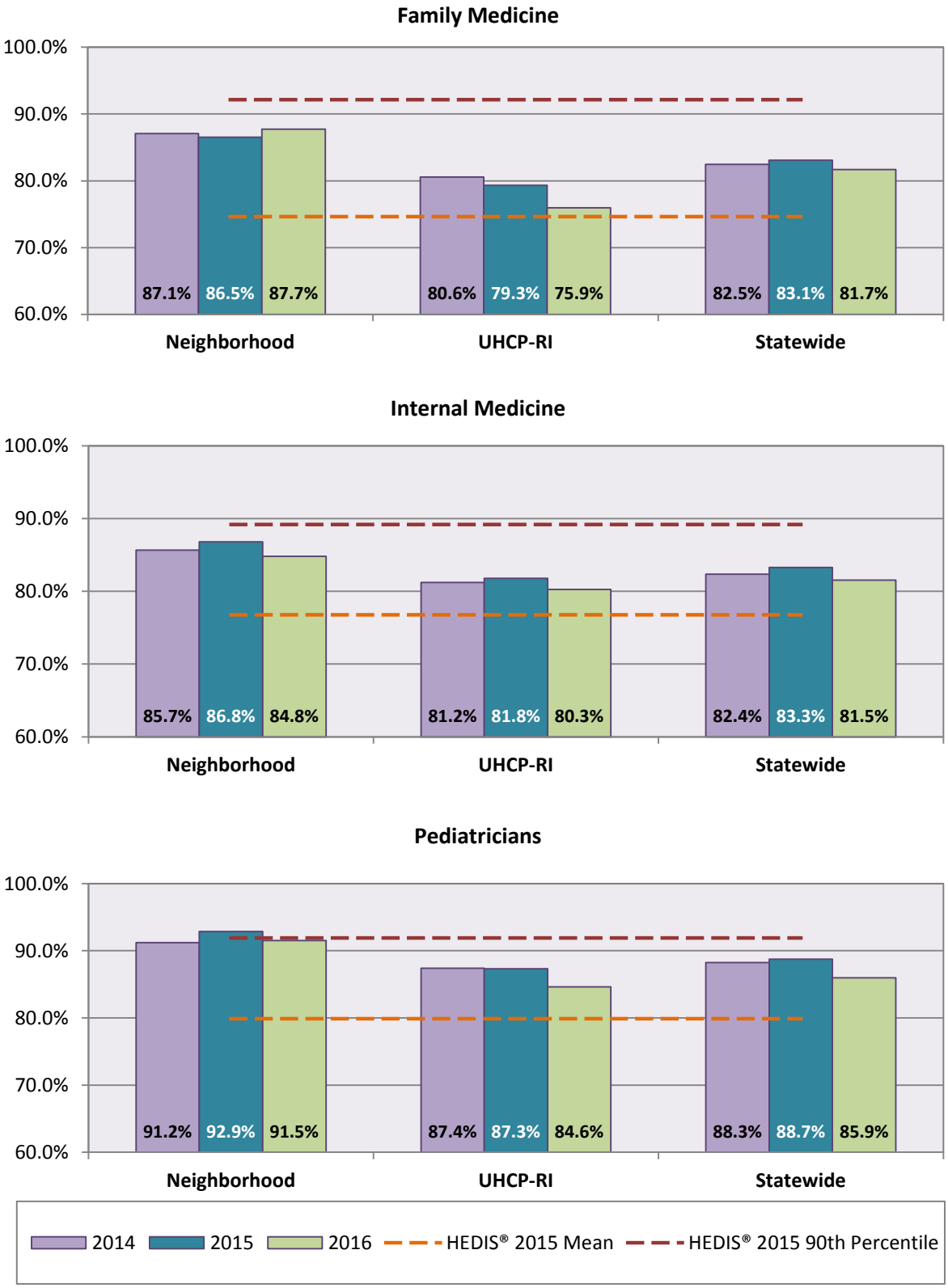
[16] The types of high-volume specialists and high-impact specialists in this report differ between the Health Plans, as the definition of each provider type differs. High-volume specialists are based on the number of visits/1,000 members, and only the top high-volume specialists are reported. For high-impact specialists, provider types are defined based on the top three mortality and morbidity statistics, according to the Centers for Disease Control.

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 2014 through 2016[17].

Of the six (6) provider types presented, Neighborhood'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 2016, both Health Plans met the 2015 *Quality Compass*® 90th percentile for *OB/GYNs*, as did the statewide rate. Neighborhood also met the 2015 *Quality Compass*® 75th percentile for *Pediatricians, Family Medicine,* and *Other Physician Specialists*. In regard to UHCP-RI's rates and the statewide rates, all measures with the exception of *OB/GYNs* fell below the 75th percentile in 2016.

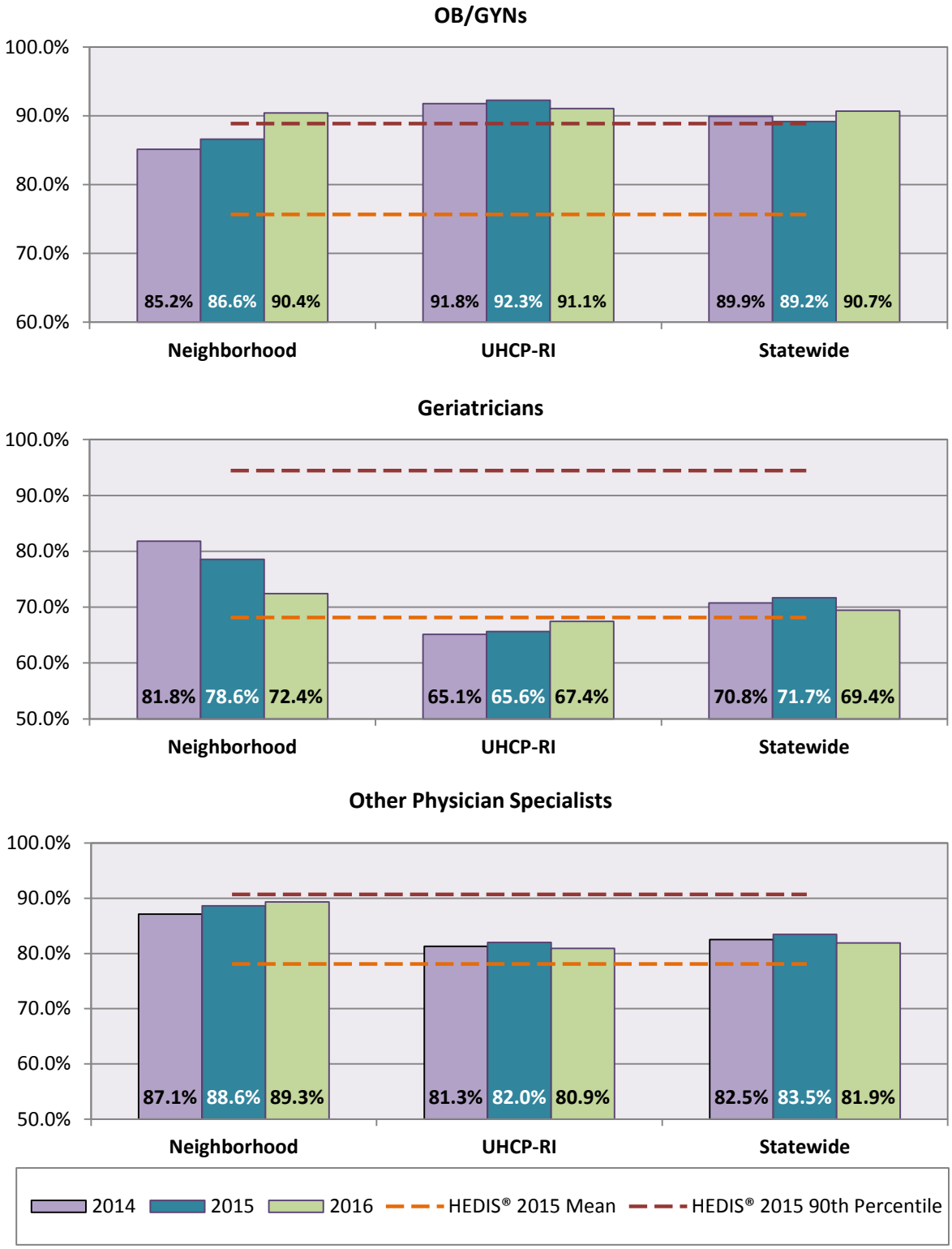
[17] No national benchmarks were available in *Quality Compass*® 2016 for the HEDIS® *Board Certification* measure. Therefore, the 2016 HEDIS® *Board Certification* rates were compared to the 2015 *Quality Compass*® benchmarks.

Figure 2: HEDIS® Board Certification Rates—2014-2016[1]



[1] No national benchmarks were available in *Quality Compass*® 2016 for the HEDIS® *Board Certification* measure. Therefore, the 2016 HEDIS® *Board Certification* rates were compared to the 2015 *Quality Compass*® benchmarks.

Figure 2: HEDIS® Board Certification Rates—2014-2016[1] (continued)



[1] No national benchmarks were available in *Quality Compass*® 2016 for the HEDIS® *Board Certification* measure. Therefore, the 2016 HEDIS® *Board Certification* rates were compared to the 2015 *Quality Compass*® benchmarks.

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 all HEDIS® 2016 *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 2014 through 2016, 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*® 2016 for Medicaid. Statewide rates were calculated by totaling numerator and denominator counts for both Health Plans.

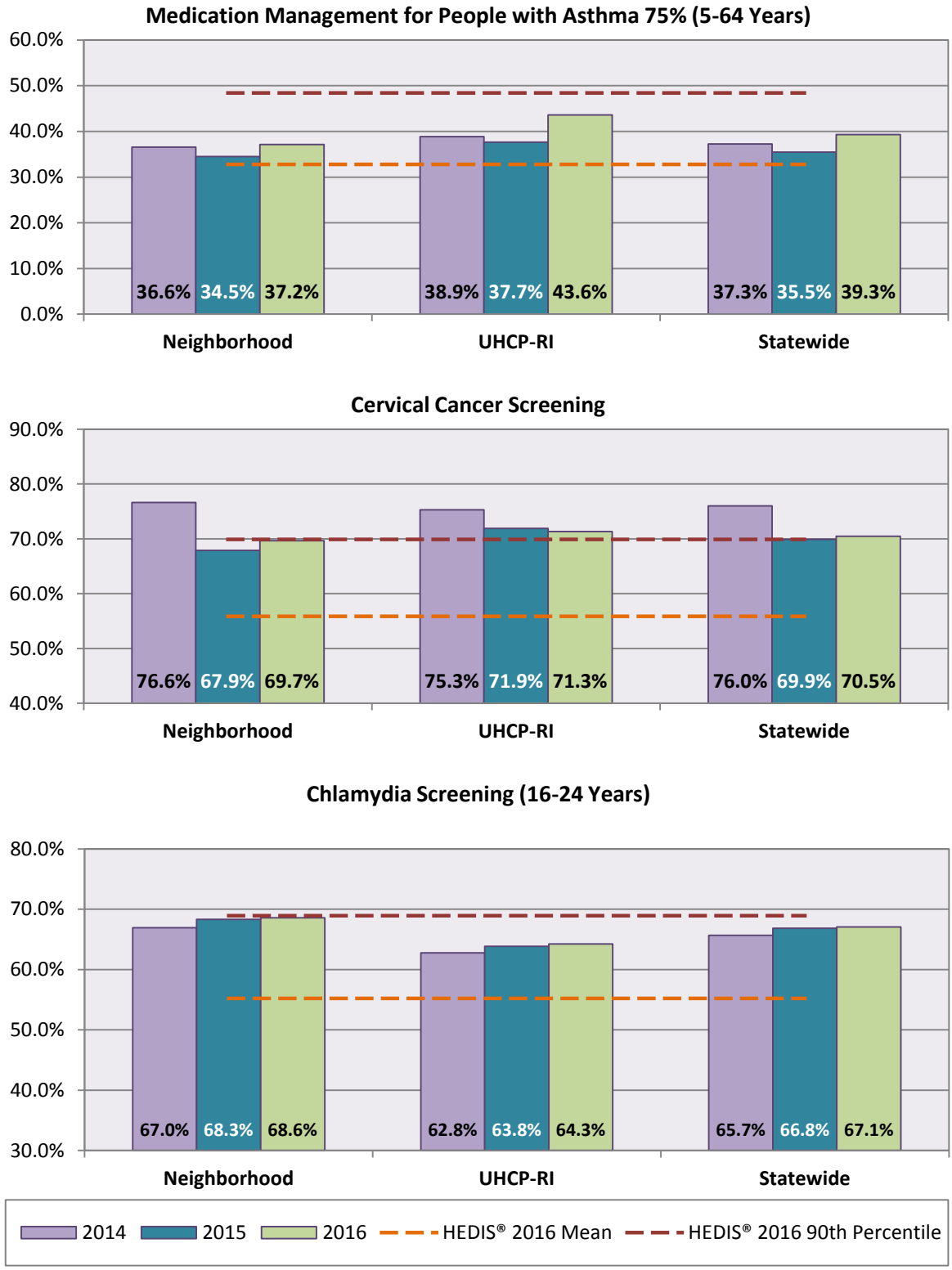
HEDIS® Effectiveness of Care Measures

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® 2014 through HEDIS® 2016 for each Health Plan, as well as the statewide rate, compared to the *Quality Compass*® 2016 national Medicaid benchmarks.

In 2016, rates for both Neighborhood and UHCP-RI, as well as the statewide rates, exceeded the 2016 *Quality Compass*® national Medicaid mean for all measures displayed in Figure 3. Additionally, Neighborhood, UHCP-RI, and the statewide rate achieved the *Quality Compass*® 90th percentile for both *Childhood Immunization Status—Combo 3* and *Childhood Immunization Status—Combo 10*, as well as the 75th percentile for *Chlamydia Screening (16-24 Years)*. UHCP-RI and the statewide rate benchmarked at the 90th percentile for *Cervical Cancer Screening*, while Neighborhood ranked at the 75th percentile. UHCP-RI also achieved the 90th percentile for both *Follow-Up After Hospitalization for Mental Illness—30 Days* and *Follow-Up After Hospitalization for Mental Illness—7 Days*. Neighborhood's rate and the statewide rate met the 75th percentile for the *30 Days* component, while the statewide rate met the 75th for the *7 Days* component. UHCP-RI's rate, as well as the statewide rate, met the *Quality Compass*® 75th percentile for *Medication Management for People with Asthma 75% (5-64 Years)*, while Neighborhood and the statewide rate met the 75th percentile for *Comprehensive Diabetes Care—HbA1c Testing*.

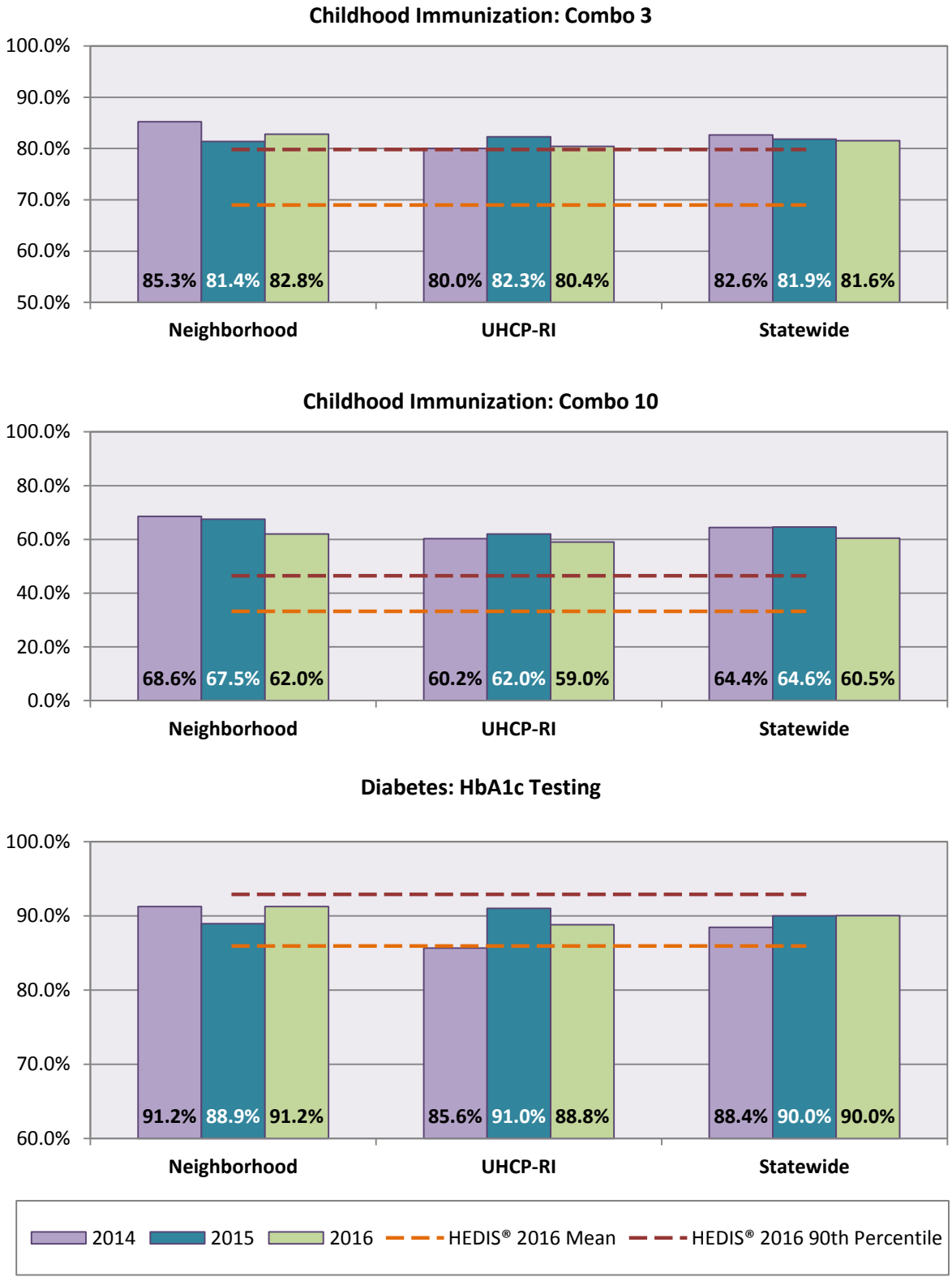
[18] The rates for all HEDIS® measures for Neighborhood and UHCP-RI include all Medicaid members, where eligible population criteria are met.

Figure 3: HEDIS® Effectiveness of Care—2014-2016[1]



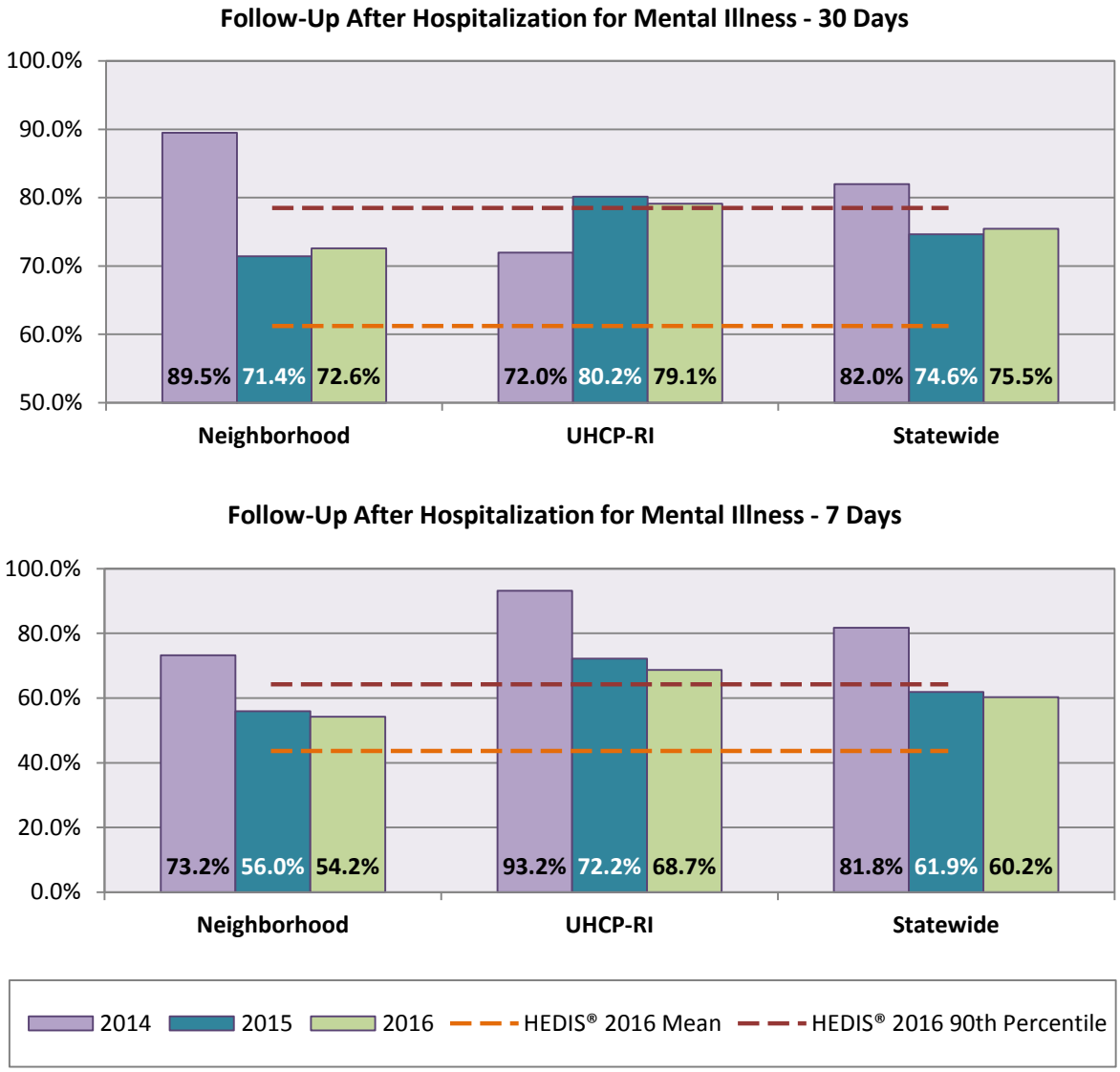
[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

Figure 3: HEDIS® Effectiveness of Care—2014-2016[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—2014-2016[1] (continued)



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

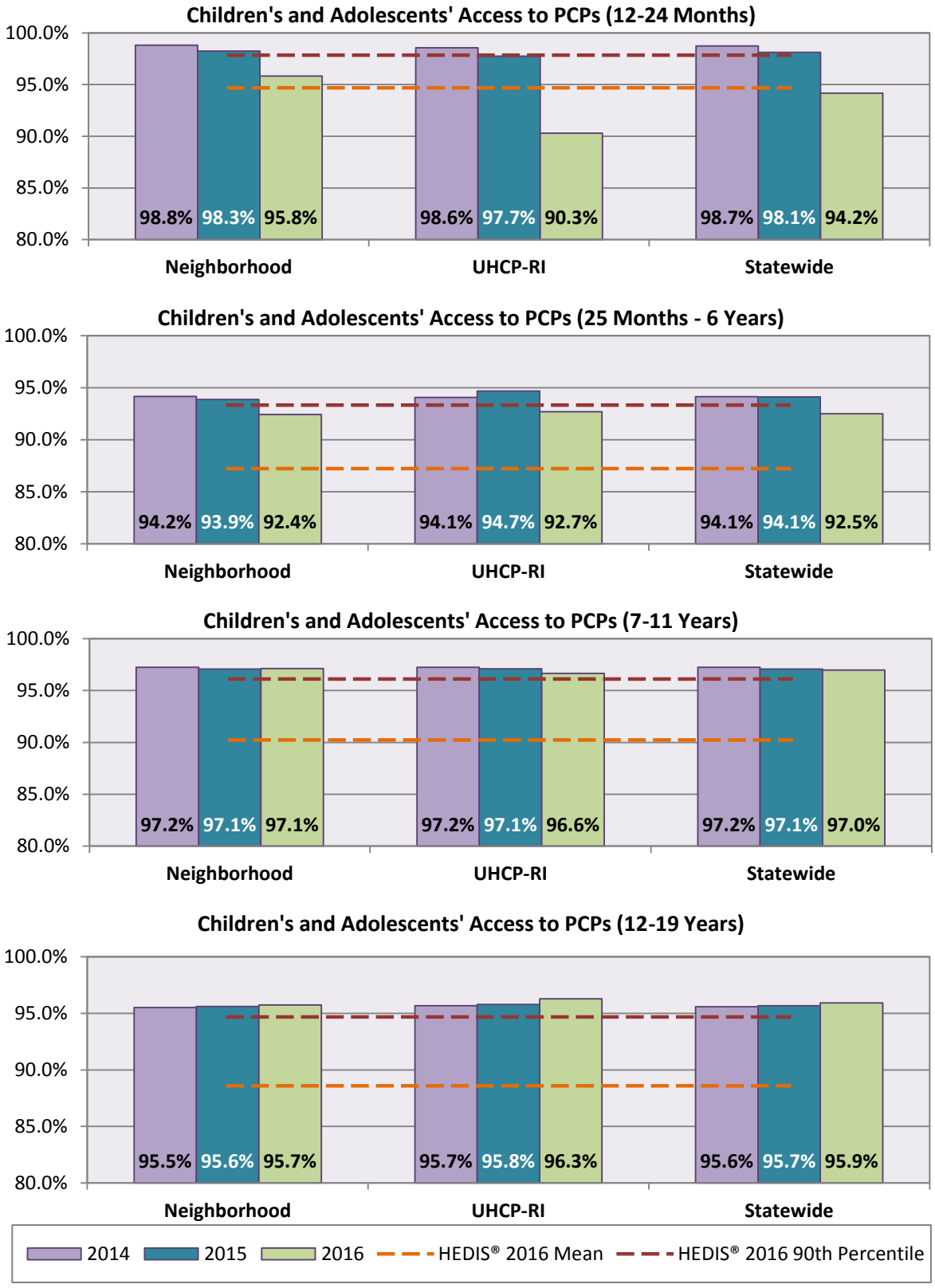
HEDIS® Access to/Availability of Care Measures

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 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® 2014 through HEDIS® 2016 as compared to national Medicaid benchmarks.

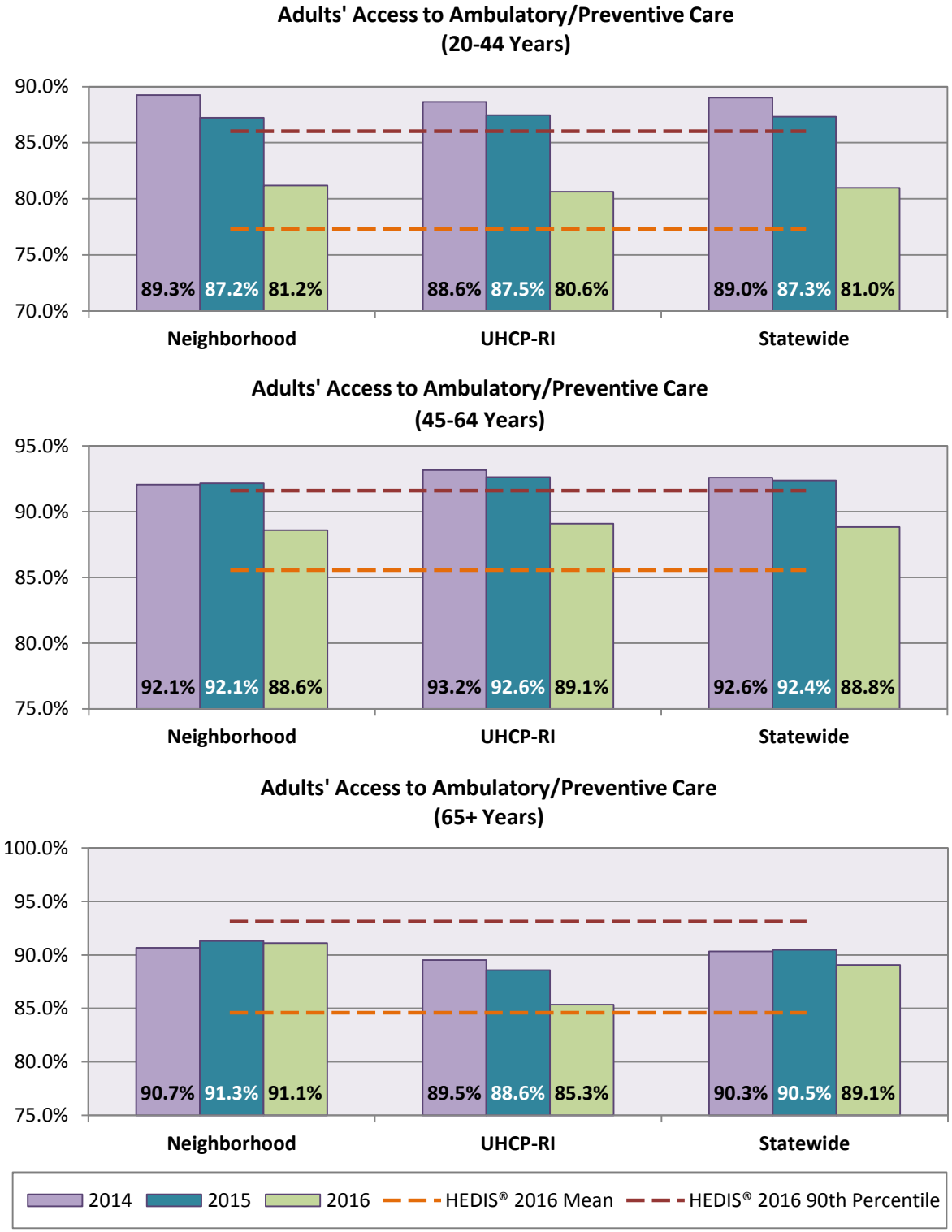
The overall performance for the Access to/Availability of Care domain of measures was varied across measures and across the two (2) Health Plans. Rates for UHCP-RI, as well as the statewide rates, exceeded the 2016 *Quality Compass*® national Medicaid mean for eight (8) of the nine (9) measures displayed. Neighborhood's rates exceeded the national Medicaid mean for all nine (9) measures. Both Neighborhood and UHCP-RI achieved the 2016 *Quality Compass*® 90th percentile for the *Children and Adolescents' Access to Primary Care* measure for the *7-11 Years* and *12-19 Years* age groups and the *Timeliness of Prenatal Care* measure, as did the statewide rates. Neighborhood's rate and the statewide rate also achieved the 90th percentile for *Timeliness of Postpartum Care*, while UHCP-RI's rate benchmarked at the 75th percentile for that measure. All three (3) rates (Neighborhood, UHCP-RI, and statewide) benchmarked at the 75th percentile for the *25 Months-6 Years* age group of the *Children and Adolescents' Access to Primary Care* measure. Only Neighborhood achieved the 75th percentile for the *65+ Years* age group of the *Adults' Access to Preventive/Ambulatory Health Services* measure.

Figure 4: HEDIS® Access to/Availability of Care Rates—2014-2016[1]



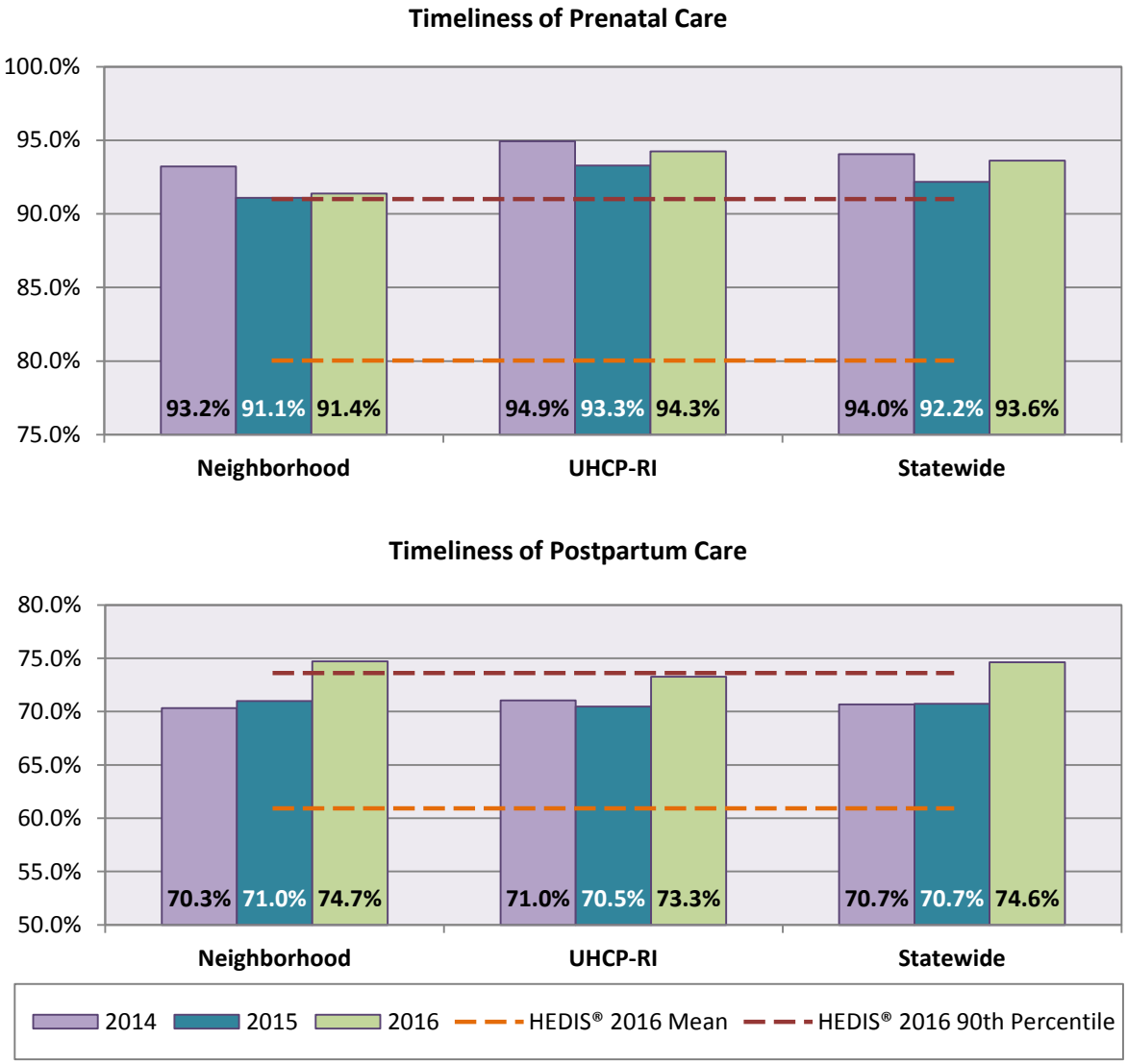
[1] For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two (2) Health Plans.

Figure 4: HEDIS® Access to/Availability of Care Rates—2014-2016[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—2014-2016[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 2016 *Quality Compass*® national Medicaid benchmarks. **Figure 5** displays selected measure rates for HEDIS® 2014 through HEDIS® 2016, as well as comparisons to the national Medicaid means and the 2015 *Quality Compass*® 90th percentiles for Medicaid.

Overall, performance in this domain was strong across Health Plans and measures. Rates for both UHCP-RI and Neighborhood, as well as the statewide rates, exceeded the 2016 *Quality Compass*® national Medicaid mean for all four (4) measures displayed. Both Neighborhood and UHCP-RI achieved the 2016 *Quality Compass*® 90th percentile for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* and *Frequency of Ongoing Prenatal Care—81+ Percent* measures, and the 75th percentile for the *Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life* and *Adolescent Well-Care Visits* measures.

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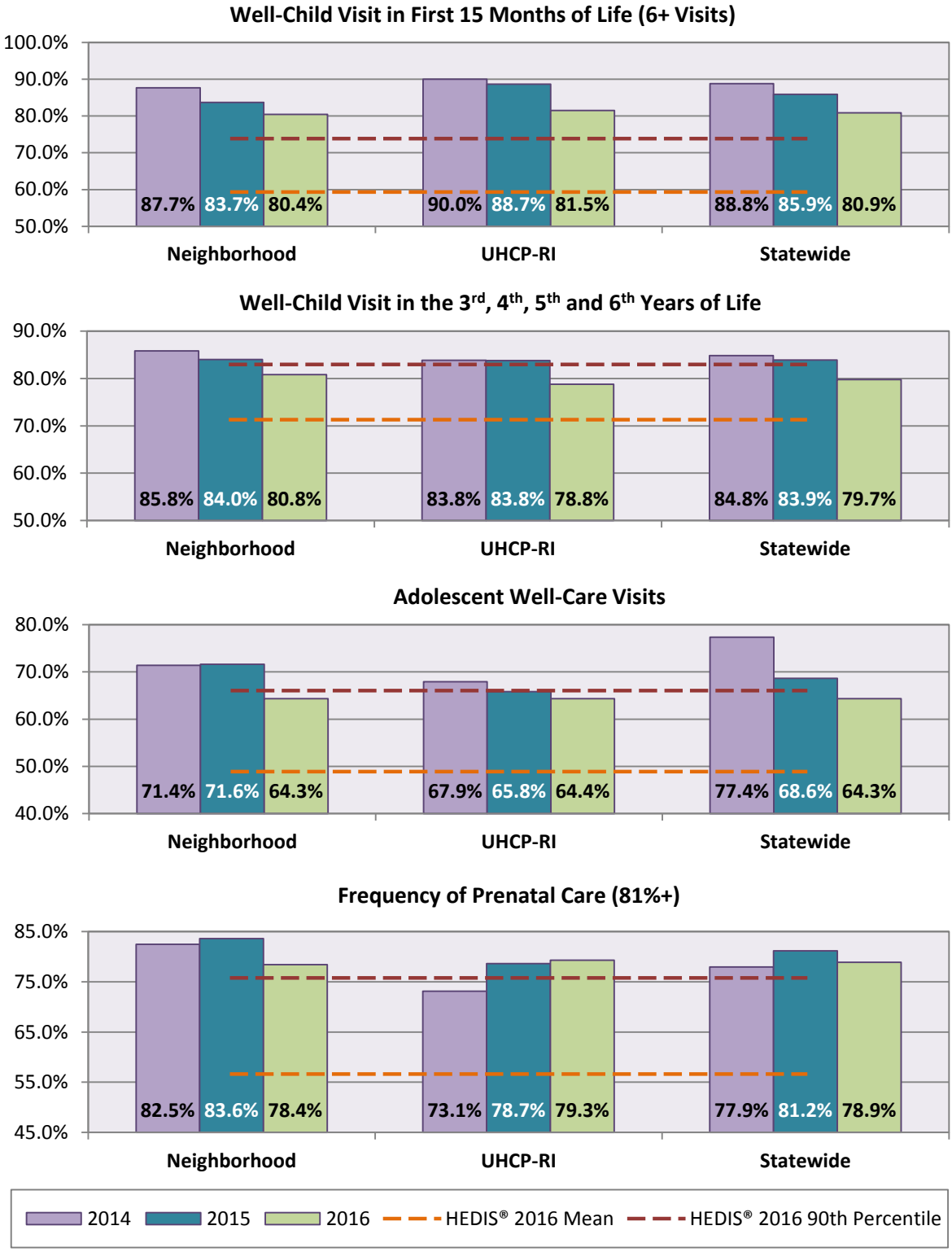
Figure 5: HEDIS® Use of Services Rates—2014-2016[1]



[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 2016, 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 2016 rating, as well as the statewide rates, compared to *Quality Compass®* 2016 national Medicaid benchmarks. In 2014, the NCQA introduced the *Flu Vaccinations for Adults (18-64 Years)* measure to the Adult CAHPS® 5.0H survey. Additionally, the composite measure *Shared Decision Making* was modified for the 2015 survey[20]. As such, this measure is not trendable, and therefore, was not included in Figure 6. Specific results for this composite measure can be found in the Health Plan-specific Technical Reports.

Performance on the CAHPS® measures varied across Health Plans, as well as across measures. Neighborhood's rates exceeded the 2016 *Quality Compass®* national Medicaid mean for seven (7) of the nine (9) measures displayed in Figure 6, whereas UHCP-RI's rates, as well as the statewide rates exceeded the mean for eight (8) of nine (9) measures. Both Neighborhood and UHCP-RI, as well as the statewide rate, achieved the 2016 *Quality Compass®* 90th percentile for *Getting Needed Care*. UHCP-RI also achieved the 90th percentile for *Rating of Specialist* and *Getting Care Quickly*, while Neighborhood achieved the 90th percentile for *Rating of Health Plan.* Neighborhood benchmarked at the 2016 *Quality Compass®* 75th percentile for the *Flu Vaccinations for Adults (18-64 Years)* and *How Well Doctors Communicate* measures, whereas UHCP-RI benchmarked at the 75th percentile for *Rating of Health Care*.

In addition to the Adult CAHPS® Survey, UHCP-RI elected to distribute and report the Child CAHPS® 5.0 survey in 2016. 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.

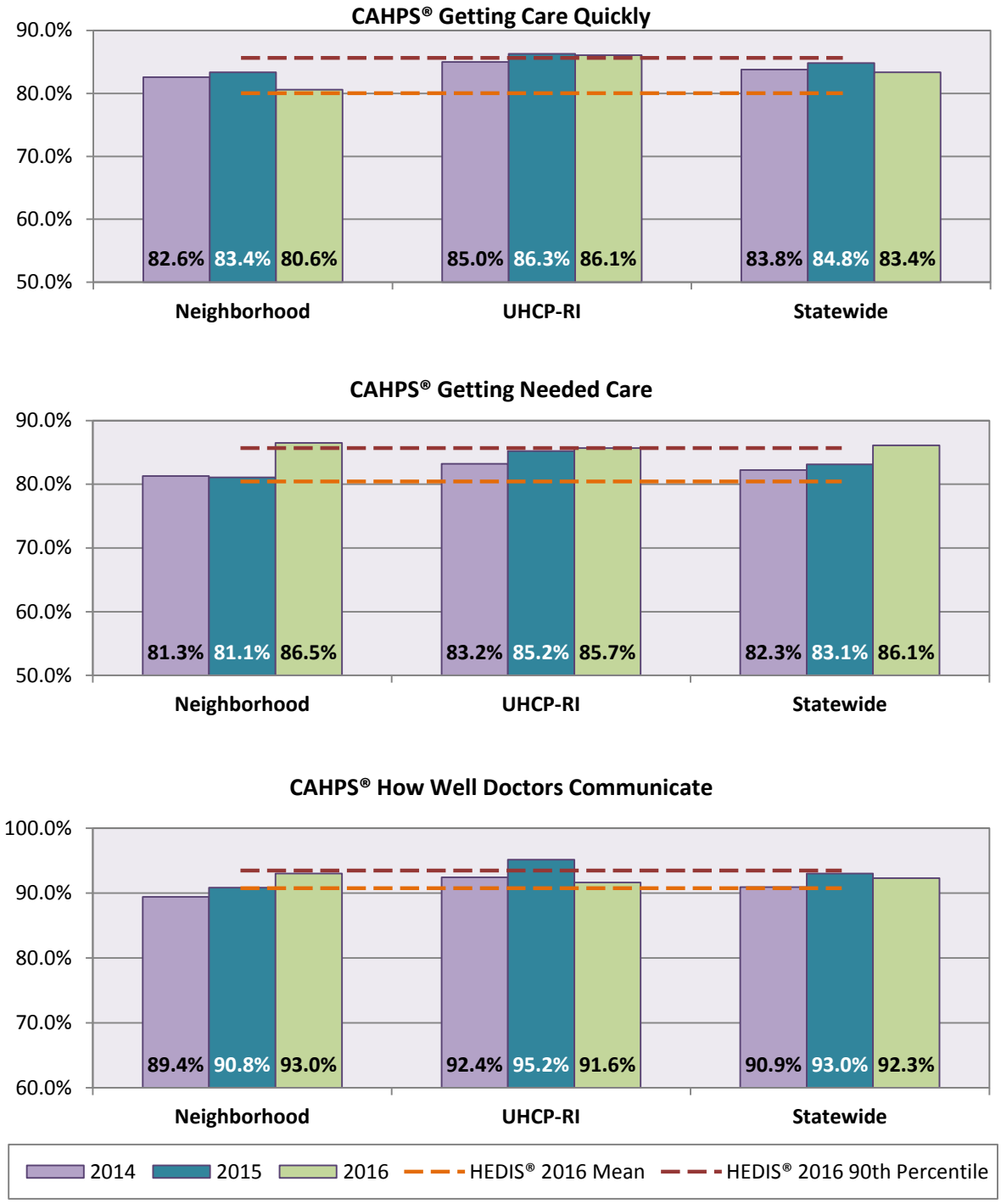
[19] The rates for all Medicaid Adult CAHPS® measures for Neighborhood and UHCP-RI include RHP and RHE members, as they were included in the random survey sample of adult members.

[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", and "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—2014-2016[1]

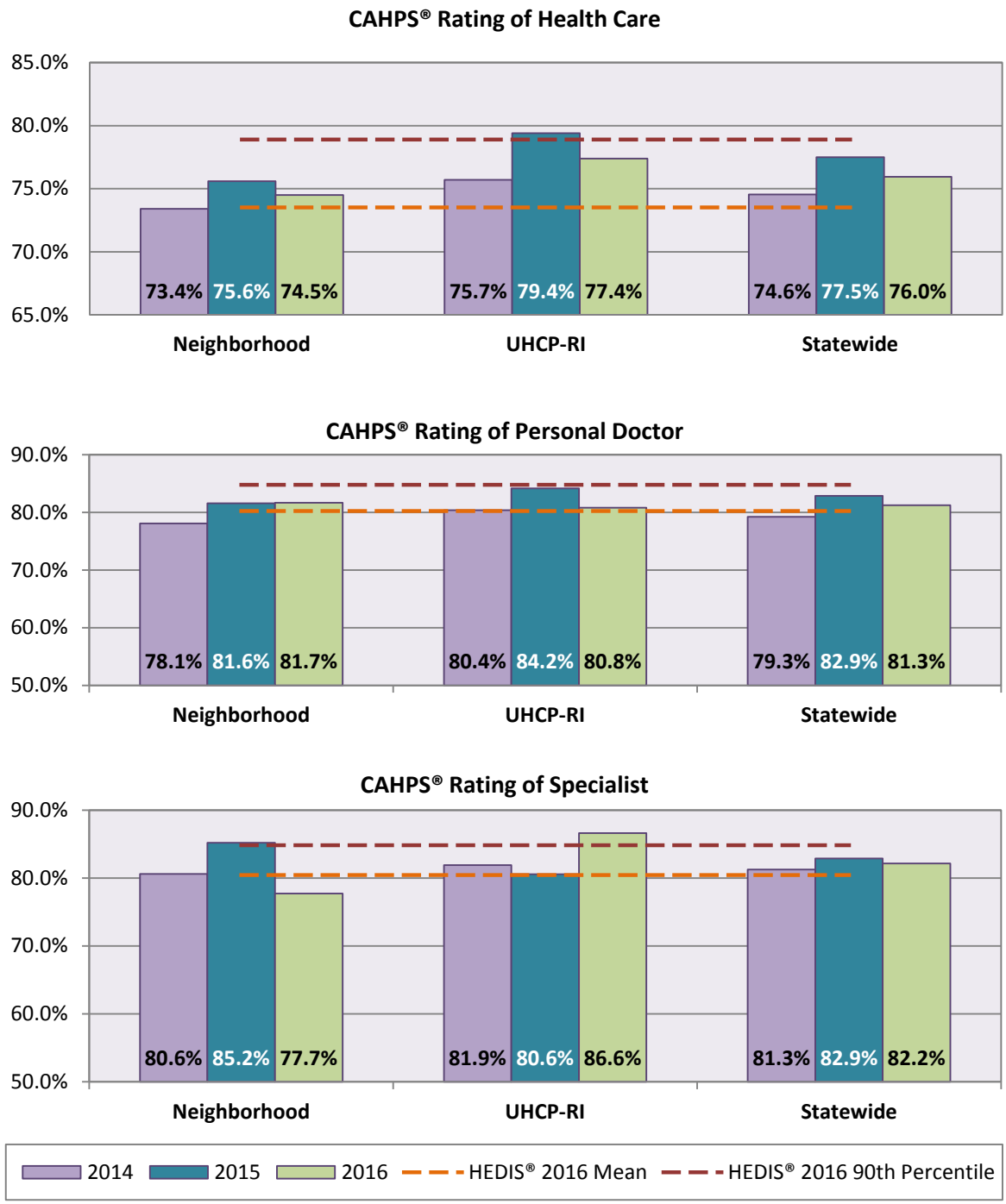
[1] The statewide rate for each of these bar charts was determined by calculating an unweighted average of the Health Plans' rates, since the size of the survey populations was similar and numerators and denominators were not available.

Figure 6: CAHPS® Member Satisfaction Rates—2014-2016[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—2014-2016[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 2016, the Performance Goal Program entered its eighteenth (18th) 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 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)*
- *Rhody Health Partners (added in 2011)*
- *Rhody Health Expansion (added in 2015)*

For the 2016 Reporting Year, the performance categories were redefined to include the following eight (8) categories:

- *Utilization*
- *Access to Care*
- *Prevention and Screening*
- *Women's Health*
- *Chronic Care*
- *Behavioral Health*
- *Compliance*
- *Total Cost of Care*

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

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

the Health Plans to EOHHS. For the reference period of Calendar Year 2015, the evaluation was conducted by EOHHS in April 2016.

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.

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 Percentile,* 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 were presented.

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, the NCQA retired the HEDIS® *Annual Monitoring for Patients on Persistent Medications—Anticonvulsants* measure in 2015. This measure was 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 the Non-RHE populations (all lines of business except RHE) for the 2015 PGP. The Health Plan earned incentive awards based on results for both the RHE and Non-RHE populations.

Changes in Methodology for the 2016 Performance Goal Program

The 2016 Performance Goal Program underwent several changes from the 2015 PGP.

The 2016 PGP realigned the metrics into eight (8) distinct categories, as noted previously. In 2016, the NCQA retired the HEDIS® *Members with Persistent Asthma Used Appropriate Meds* measure, and as such, this measure has been removed from the PGP metrics. It has been replaced with the HEDIS® *Medication Management for People with Asthma 75% (5-64 Years)* measure. Additionally, the HEDIS® measure *Annual Monitoring for Patients on Persistent Medications* has been removed from the PGP metrics.

For the 2016 PGP, several State-specified measures were removed from the metrics, including *ID Cards Sent within 10 Days of Notification of Enrollment, Member Handbook Sent within 10 Days of Notification of*

Enrollment, Two Welcome Call Attempts within the First 30 Days of Enrollment, Grievances and Appeals Resolved within Federal (BBA) Timeframes, Reduction of Emergency Department Visits for Ambulatory Care-Sensitive Conditions by 5 Percentage Points, and *Notify the State of Third-Party Liability within 5 Days of Notification.*

In addition to removing these measures, several new State-specified measures were introduced: *Emergency Department Visits per 1,000, Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care, Accurate Submission of Encounter Data, HIV Viral Load Suppression*, and *Decrease the Average Total Cost of Care—High Utilizers*. All these measures, with the exception of *HIV Viral Load Suppression* and *Accurate Submission of Encounter Data*, were considered baseline rates for the 2016 PGP, and as such, were not eligible for incentive awards or benchmarking. The State also included the following HEDIS® *Comprehensive Diabetes Care* measures as metrics for the 2016 PGP: *HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Retinal Eye Exam,* and *Blood Pressure Control*, as well as the HEDIS® *Call Answer Timeliness* measure.

In addition to the measure changes, all benchmark goals for HEDIS® and CAHPS® measures were set at the *Quality Compass*® 90th percentile (full award) and the 75th percentile (partial award).

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

2016 Rhode Island Medicaid Managed Care Performance Goal Program Results—Non-RHE

This section of the report evaluates the results of the 2016 Performance Goal Program for both Health Plans for Non-RHE members. In 2016, 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 2015 *Quality Compass*® for Medicaid. As such, these percentiles may differ from the 2016 *Quality Compass*® benchmark data displayed elsewhere in this report.

The **Utilization** domain is comprised of twelve (12) State-specified measures and four (4) HEDIS® measures[22]. The State-specified measures include the eligibility group-stratified rates for the *Emergency Department Utilization Rate per 1,000* and *Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care* measures. These measures were newly introduced for the 2016 PGP, and therefore, were considered to be baseline measures and were not eligible for benchmarking and incentive awards. Both Health Plans achieved the 2015 *Quality Compass*® 90th percentile for three (3) of the four (4) HEDIS® measures: *Infants Had Well-Child Visits in the First 15 Months of Life (6+ Visits), Adolescent Well-Care Visits,* and *Frequency of Ongoing Prenatal Care—81+ Percent*. Additionally, both Health Plans ranked at the 75th percentile for the remaining HEDIS® measure of this domain, *Children Had Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life*.

In the **Access to Care** domain, both Health Plans achieved the 2015 *Quality Compass*® 90th or 75th percentiles for the following HEDIS® measures: *Children Received Periodic PCP Visits (25 Months-6 Years), Children Received Periodic PCP Visits (7-11 Years), Children Received Periodic PCP Visits (12-19 Years), Adults Had Ambulatory/ Preventive Care Visit (20-44 Years), Adults Had Ambulatory/Preventive Care Visit (45-64 Years), Pregnant Members Received Timely Prenatal Care, Postpartum Members Received Timely Postpartum Care,* and *Engagement of Alcohol and Other Drug Treatment.* Only Neighborhood achieved the 75th percentile for the *Children Received Periodic PCP Visits (12-24 Months)* measure. Conversely, only UHCP-RI achieved the 90th percentiles for both HEDIS® *Initiation of Alcohol and Other Drug Treatment* and CAHPS® *Members were Satisfied with Access to Urgent Care.*

The **Prevention and Screening** domain consists of one (1) CAHPS® measure and nine (9) HEDIS® measures. Both Health Plans achieved a 2015 *Quality Compass*® benchmark (90th or 75th percentile) and qualified for a full or partial incentive award for all nine (9) HEDIS® measures in this domain. Only Neighborhood achieved the 2015 *Quality Compass*® 90th percentile for the CAHPS® *Medical Assistance with Smoking/Tobacco Cessation* measure.

Both Health Plans performed well in regard to **Women's Health**, as both Health Plans achieved a 2015 *Quality Compass*® benchmark (90th or 75th percentile) and qualified for a full or partial incentive award for all three (3) HEDIS® measures included in this domain.

The **Chronic Care** domain is comprised of one (1) State-specified measure and ten (10) HEDIS® measures. Neither Neighborhood nor UHCP-RI achieved the *Contract* goal of eighty-eight percent (88%) for the State-specified measure *HIV Viral Load Suppression*. In regard to the HEDIS® measures within this domain, Neighborhood demonstrated a stronger performance than UHCP-RI. Neighborhood achieved a 2015 *Quality Compass*® benchmark (90th or 75th percentile) and qualified for a full or partial incentive award for nine (9) of the ten (10) HEDIS® measures. The Health Plan did not achieve a *Quality Compass*® benchmark for HEDIS® *Use of Imaging Studies for Low Back Pain*. Conversely, UHCP-RI achieved a 2015 *Quality Compass*® benchmark (90th or 75th percentile) and qualified for a full or partial incentive award for six (6) HEDIS® measures. The measures for which UHCP-RI did not achieve the necessary *Quality Compass*® benchmarks include *Pharmacotherapy for COPD*

[22] It is important to note here that two (2) of the twelve (12) State-specified measures within the Utilization domain are not applicable for UHCP-RI, as the Health Plan does not serve the Rhody Health Options population.

Exacerbation—Corticosteroids, Use of Imaging Studies for Low Back Pain, Comprehensive Diabetes Care—HbA1c Testing, and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%).*

In regard to the **Behavioral Health** domain, the HEDIS® *Use of Multiple Concurrent Antipsychotics in Children/Adolescents* measure was considered a baseline measure for the 2016 PGP, and therefore, was not eligible for benchmarking or incentive awards. Performance in this domain was similar across the two (2) Health Plans. Neighborhood achieved the 2015 *Quality Compass*® 75th percentile for four (4) of the five (5) eligible measures in the domain. The Health Plan did not achieved a *Quality Compass*® benchmark for the HEDIS® *Antidepressant Medication Management—Effective Acute Phase Treatment* measure. UHCP-RI achieved a 2015 *Quality Compass*® benchmark (90th or 75th percentile) for three (3) measures. The measures for which UHCP-RI did not achieve a *Quality Compass*® benchmark were HEDIS® *Antidepressant Medication Management—Effective Acute Phase Treatment* and HEDIS® *Follow-Up Care for Children Prescribed ADHD Medications—Initiation Phase*.

The **Compliance** domain is comprised of one (1) HEDIS® measure and two (2) State-specified measures. Neither Health Plan achieved a 2015 *Quality Compass*® benchmark for the HEDIS® *Call Answer Timeliness* measure. In regard to the State-specified measures, UHCP-RI met the *Contract* goal of ninety-nine percent (99%) to receive a full incentive award for the *Expenditures* component of the *Accurate Submission of Encounter Data* measure, while Neighborhood did not meet a *Contract* goal for either component.

The sole measure of the **Total Cost of Care** domain, *Decrease the Average Total Cost of Care—High Utilizers*, was considered a baseline measure for the 2016 PGP, and therefore, was not eligible for benchmarking or incentive awards.

Table 7: Performance Rates and Goals—2016—Non-RHE Populations[1]

RI Medicaid Managed Care 2016 Performance Goal Measures	Neighborhood		UHCP-RI	
	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]
Utilization				
Emergency Room Utilization Rate per 1,000—RIte Care (<18 Years)[4,5,6,7]	BM		BM	
Emergency Room Utilization Rate per 1,000—RIte Care (18+ Years)[4,5,6,7]	BM		BM	
Emergency Room Utilization Rate per 1,000—RIte Care (Total)[4,5,6,7]	BM		BM	
Emergency Room Utilization Rate per 1,000—Rhody Health Partners[4,5,6,7]	BM		BM	
Emergency Room Utilization Rate per 1,000—Rhody Health Options[4,5,6,7]	BM			
Emergency Room Utilization Rate per 1,000—Health Plan Total[4,5,6,7]	BM		BM	
Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care—RIte Care (<18 Years)[4,5,6,7]	BM		BM	
Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care—RIte Care (18+ Years)[4,5,6,7]	BM		BM	
Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care—RIte Care (Total)[4,5,6,7]	BM		BM	
Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care—Rhody Health Partners[4,5,6,7]	BM		BM	
Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care—Rhody Health Options[4,5,6,7]	BM			
Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care—Health Plan Total[4,5,6,7]	BM		BM	
HEDIS® Infants Had Well-Child Visits in the First 15 Months of Life (6+ Visits)	80.4%	**90th**	81.5%	**90th**
HEDIS® Children Had Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	80.8%	**75th**	78.8%	**75th**
HEDIS® Adolescent Well-Care Visits	66.7%	**90th**	67.5%	**90th**
HEDIS® Frequency of Ongoing Prenatal Care (≥81% of Expected Visits)	79.6%	**90th**	79.5%	**90th**
Access to Care				
HEDIS® Children Received Periodic PCP Visits (12-24 Months)	95.8%	**75th**	82.1%	**NM**
HEDIS® Children Received Periodic PCP Visits (25 Months-6 Years)	92.4%	**75th**	92.7%	**75th**
HEDIS® Children Received Periodic PCP Visits (7-11 Years)	97.1%	**90th**	96.7%	**90th**

M/E: Met or exceeded *Contract* goal.
NM: Did not meet *Contract* goal.
BM: Baseline measure.

Table 7: Performance Rates and Goals—2016—Non-RHE[1] (continued)

RI Medicaid Managed Care 2016 Performance Goal Measures	Neighborhood		UHCP-RI	
	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]
Access to Care (continued)				
HEDIS® Children Received Periodic PCP Visits (12-19 Years)	96.0%	**90th**	96.4%	**90th**
HEDIS® Adults Had Ambulatory/Preventive Care Visit (20-44 Years)	86.7%	**75th**	86.0%	**75th**
HEDIS® Adults Had Ambulatory/Preventive Care Visit (45-64 Years)	91.0%	**75th**	91.6%	**75th**
HEDIS® Pregnant Members Received Timely Prenatal Care	92.1%	**90th**	88.9%	**75th**
HEDIS® Postpartum Member Received Timely Postpartum Care	75.3%	**90th**	88.9%	**90th**
HEDIS® Initiation of Alcohol and Other Drug Treatment	40.7%	**NM**	53.5%	**90th**
HEDIS® Engagement of Alcohol and Other Drug Treatment	16.2%	**75th**	18.9%	**75th**
CAHPS® Members were Satisfied with Access to Urgent Care	83.2%	**NM**	100.0%	**90th**
Prevention and Screening				
HEDIS® Children Received Immunizations by 2nd Birthday—Combination 3	82.8%	**90th**	80.4%	**75th**
HEDIS® Children Received Immunizations by 2nd Birthday—Combination 10	62.0%	**90th**	59.0%	**90th**
HEDIS® Lead Screening in Children	82.8%	**75th**	82.2%	**75th**
HEDIS® Adolescents Received Immunizations by 13th Birthday	88.1%	**90th**	86.5%	**90th**
HEDIS® Female Adolescents Received HPV Vaccination by 13th Birthday[7]	33.6%	**90th**	28.0%	**75th**
HEDIS® Weight Assessment & Counseling (3-17 Years)—BMI Percentile	87.7%	**90th**	82.2%	**75th**
HEDIS® Weight Assessment & Counseling (3-17 Years)—Nutrition	83.9%	**90th**	79.0%	**75th**
HEDIS® Weight Assessment & Counseling (3-17 Years)—Physical Activity	76.0%	**90th**	67.2%	**75th**
HEDIS® Adult BMI Assessment (18-74 Years)	92.0%	**75th**	95.5%	**90th**
CAHPS® Medical Assistance with Smoking/Tobacco Cessation	82.1%	**90th**	78.2%	**NM**
Women's Health				
HEDIS® Women Received Cervical Cancer Screening (21-64 Years)	75.1%	**90th**	74.9%	**90th**
HEDIS® Women Received Chlamydia Screening (16-20 Years)	65.1%	**75th**	61.0%	**75th**
HEDIS® Women Received Chlamydia Screening (21-24 Years)	74.2%	**90th**	70.0%	**75th**
Chronic Care				
HEDIS® Medication Management for Asthma 75% (5-64 Years)[7]	36.2%	**75th**	42.1%	**75th**

M/E: Met or exceeded *Contract* goal.
NM: Did not meet *Contract* goal.
BM: Baseline measure.

Table 7: Performance Rates and Goals—2016—Non-RHE Populations[1] (continued)

RI Medicaid Managed Care 2016 Performance Goal Measures	Neighborhood		UHCP-RI	
	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]
Chronic Care (continued)				
HEDIS® Pharmacotherapy for COPD Exacerbation—Bronchodilators	89.7%	**90th**	75.6%	**75th**
HEDIS® Pharmacotherapy for COPD Exacerbation—Corticosteroids	81.0%	**90th**	85.8%	**NM**
HEDIS® Use of Imaging Studies for Low Back Pain	67.7%	**NM**	65.6%	**NM**
HEDIS® Comprehensive Diabetes Care—HbA1c Testing (18-75 Years)	90.2%	**75th**	86.0%	**NM**
HEDIS® Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%) (18-75 Years)[7]	28.9%	**90th**	36.8%	**NM**
HEDIS® Comprehensive Diabetes Care—HbA1c Control (<8.0%) (18-75 Years)[7]	64.0%	**90th**	57.9%	**75th**
HEDIS® Comprehensive Diabetes Care—Retinal Eye Exam Performed (18-75 Years)[7]	71.1%	**90th**	69.5%	**90th**
HEDIS® Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)[7]	76.9%	**90th**	73.7%	**75th**
HEDIS® Controlling High Blood Pressure (<140/90) (18-85 Years)	72.7%	**90th**	72.6%	**90th**
HIV Viral Load Suppression[4,7]	NM		NM	
Behavioral Health				
HEDIS® Members 6 Years and Older Get Follow-Up by *30 Days* Post-Discharge	76.3%	**75th**	76.6%	**75th**
HEDIS® Members 6 Years and Older Get Follow-Up by *7 Days* Post-Discharge	58.0%	**75th**	67.7%	**90th**
HEDIS® Antidepressant Medication Management—Effective Acute Phase	53.1%	**NM**	50.9%	**NM**
HEDIS® Follow-Up Care for Children Prescribed ADHD Medication—Initiation	49.1%	**75th**	46.6%	**NM**
HEDIS® Adherence to Antipsychotics for Individuals with Schizophrenia	67.6%	**75th**	71.6%	**75th**
HEDIS® Use of Multiple Concurrent Antipsychotics in Children/Adolescents[6]	1.8%	**BM**	1.8%	**BM**
Compliance				
Accurate Submission of Encounter Data—Claims Count[4,7,8]	NM		NM	
Accurate Submission of Encounter Data—Expenditures[4,7,8]	NM		M/E	
HEDIS® Call Answer Timeliness[7]	78.1%	**NM**	88.3%	**NM**
Total Cost of Care				
Decrease the Average Total Cost of Care—High Utilizers[4,6,7,9]	BM		BM	

M/E: Met or exceeded *Contract* goal.

NM: Did not meet *Contract* goal.

BM: Baseline measure.

[1] Performance Goal Program data are based on the previous Contract Year (i.e., 2016 rates are based on Contract Year 2015). Rates may differ from other data published in this report, as this table reflects preliminary HEDIS® and CAHPS® rates for the Non-RHE populations, while the rates in all other tables reflect final data submitted to the NCQA for all populations. 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 otherwise noted.

[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 an available, on national Medicaid 2015 *Quality Compass*® 90th and 75th percentile benchmarks (unless otherwise noted).

[4] State-specified measure.

[5] The *Emergency Room Utilization Rate per 1,000* and *Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care* measures was newly introduced for the 2016 PGP. In subsequent reports, this measure will be reported as the total, as well as rate by product line.

[6] The following measures were considered baseline rates; therefore, these measures were not eligible for incentive awards or benchmarking: *Emergency Room Utilization Rate per 1,000, Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care,* HEDIS® *Use of Multiple Concurrent Antipsychotics in Children/Adolescents,* and *Decrease the Average Total Cost of Care—High Utilizers.*

[7] The following measures were introduced for the 2016 PGP: *Emergency Room Utilization Rate per 1,000, Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care,* HEDIS® *Female Adolescents Received HPV Vaccination by 13th Birthday,* HEDIS® *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%),* HEDIS® *Comprehensive Diabetes Care—HbA1c Control (<8.0%),* HEDIS® *Comprehensive Diabetes Care—Retinal Eye Exam,* HEDIS® *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg), Accurate Submission of Encounter Data—Claims Count, Accurate Submission of Encounter Data—Expenditures,* and *Decrease the Average Total Cost of Care—High Utilizers.*

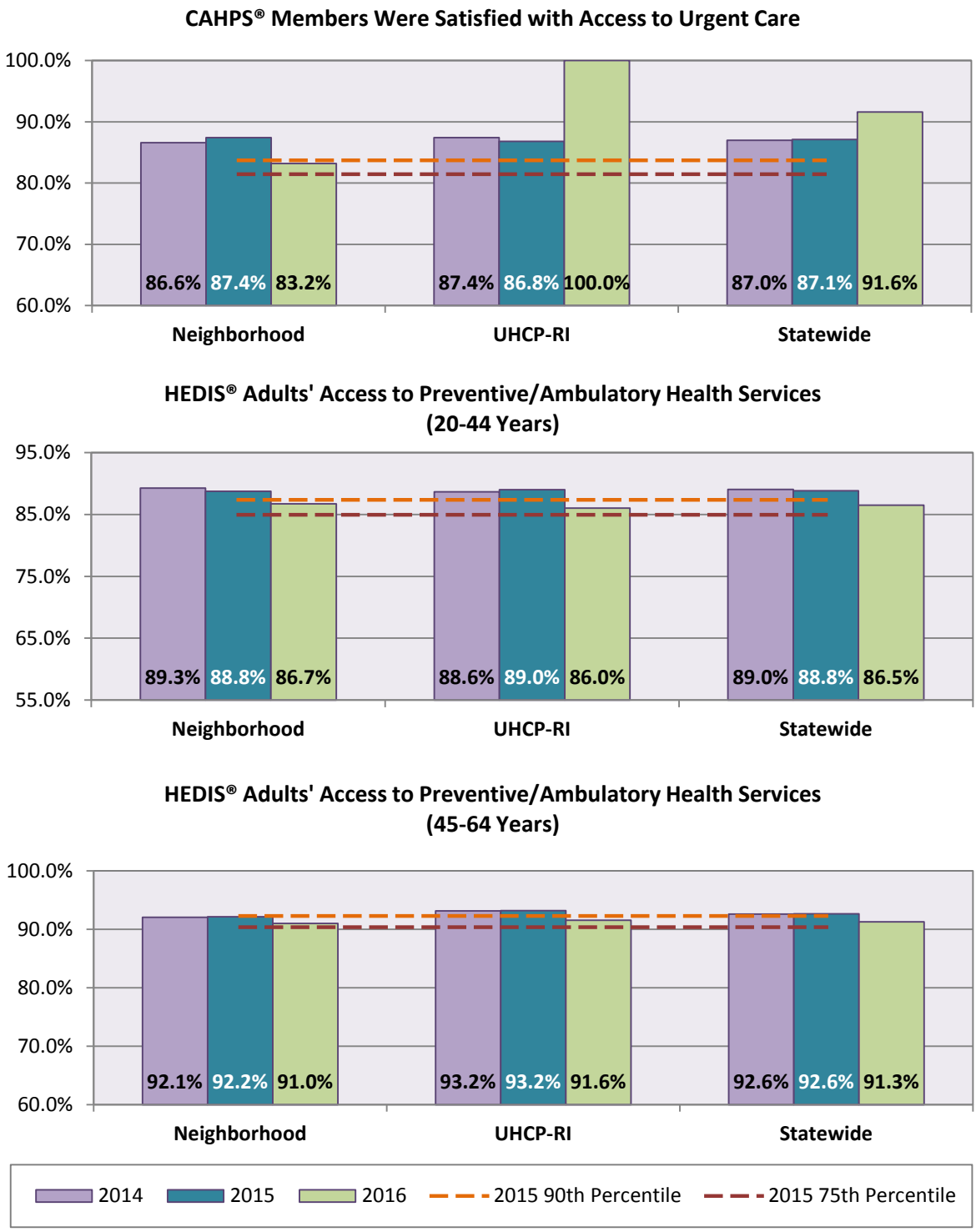
[8] The State-specified *Contract* goal for a full incentive award for this measure was 99%, while the *Contract* goal for a partial incentive award was 95%.

[9] The Health Plan's rate for *Decrease the Average Total Cost of Care—High Utilizers* was not available.

Figure 7a: PGP Results 2014-2016 Non-RHE Populations—Utilization[1]

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

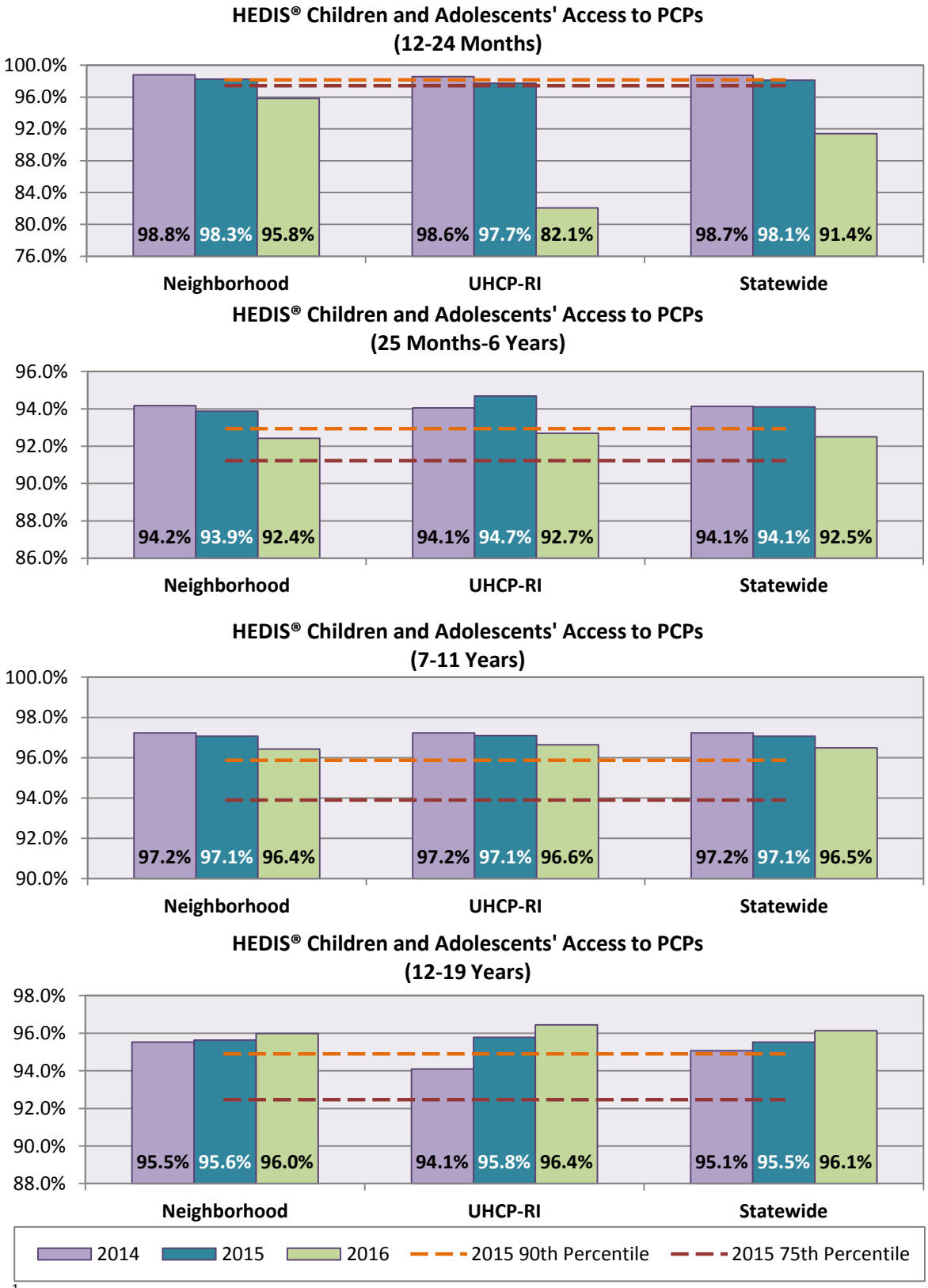
Figure 7b: PGP Results 2014-2016 Non-RHE Populations—Access to Care[1,2]



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

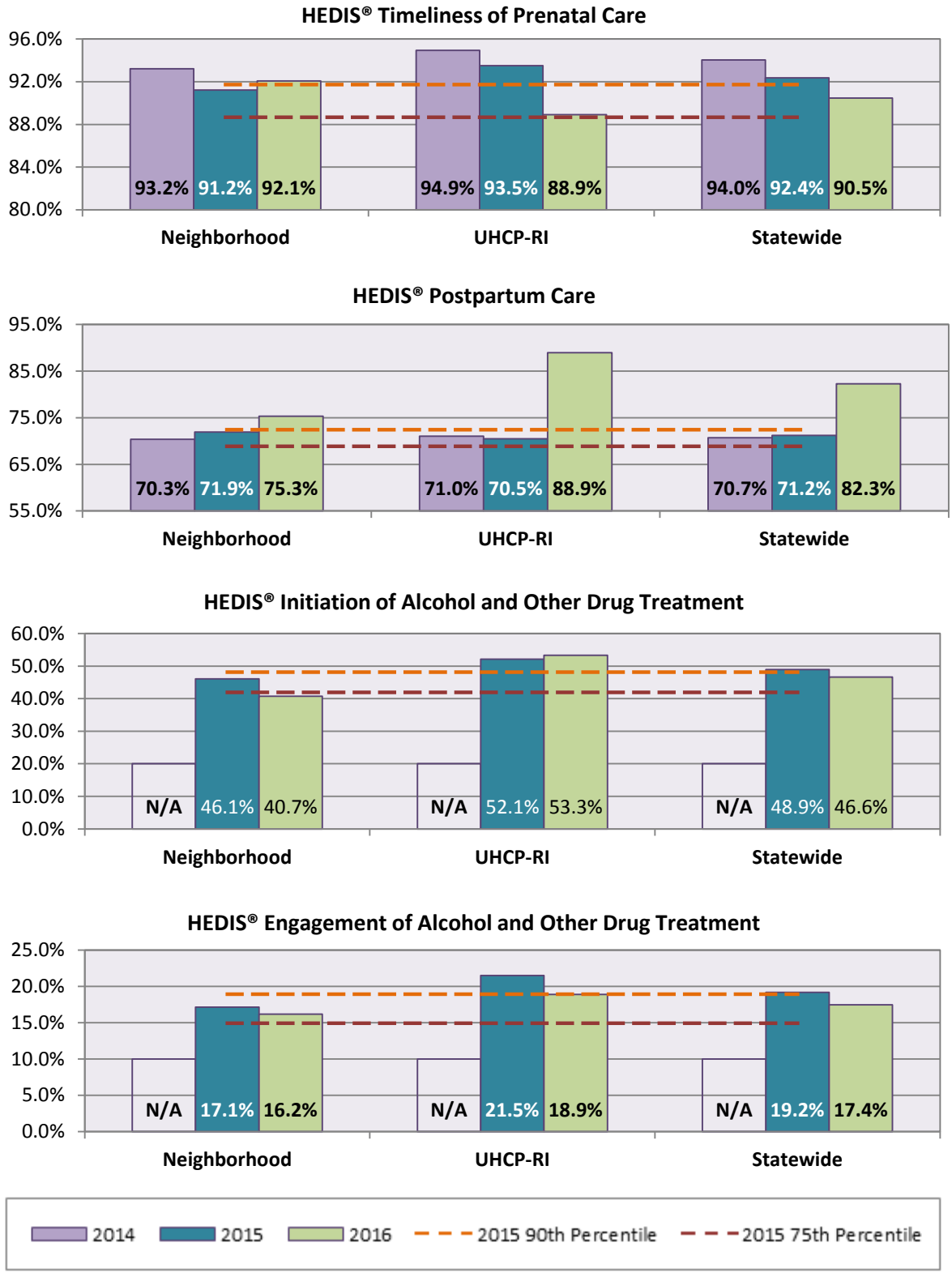
[2] The statewide rates for these measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 7b: PGP Results 2014-2016 Non-RHE Populations—Access to Care[1] (continued)



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

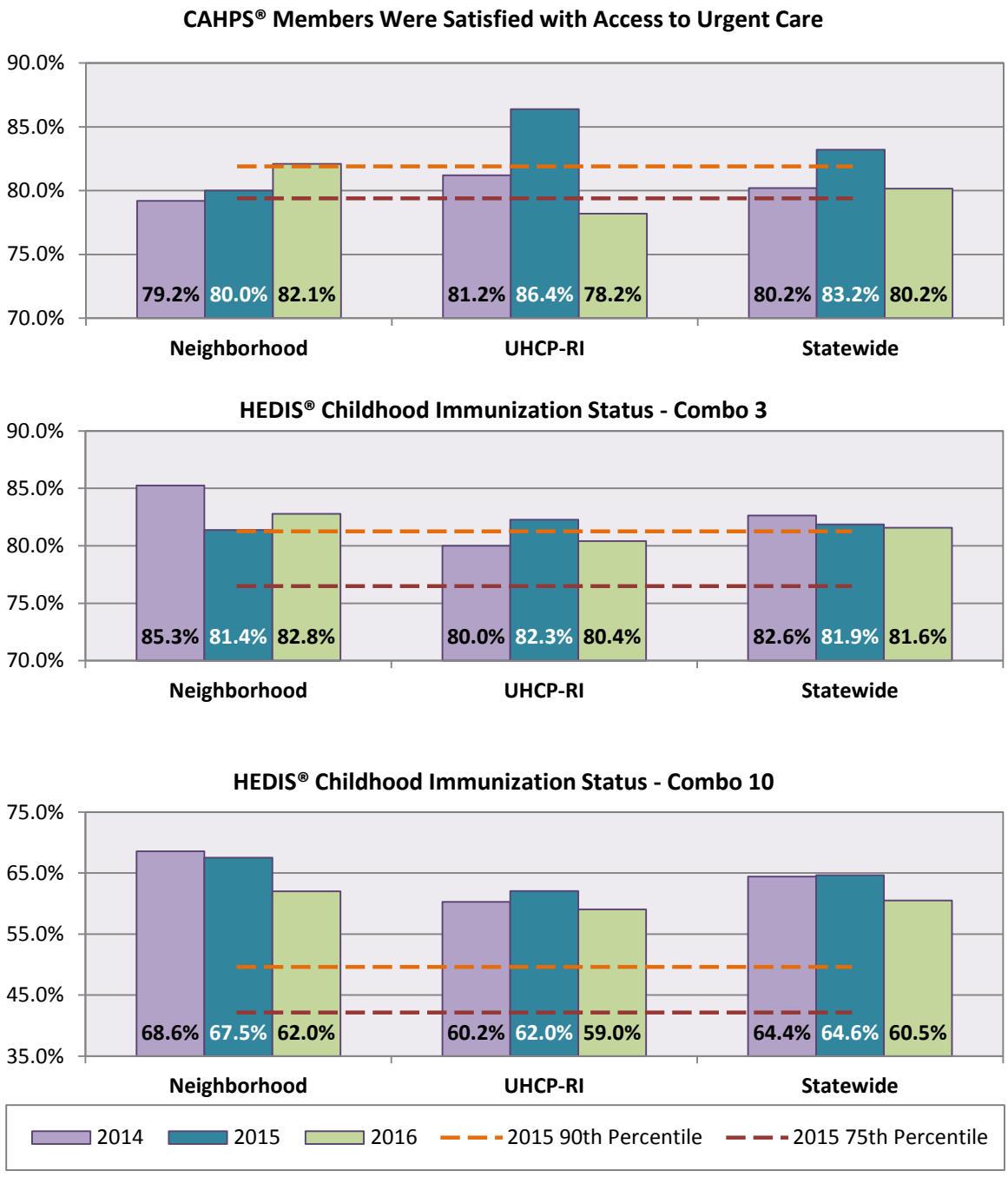
Figure 7b: PGP Results 2014-2016 Non-RHE Populations—Access to Care[1,2] (continued)



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

[2] The 'N/A' designations for 2014 were given for certain measures as these measures were introduced for the 2015 PGP and, as such, there were no data available for 2014.

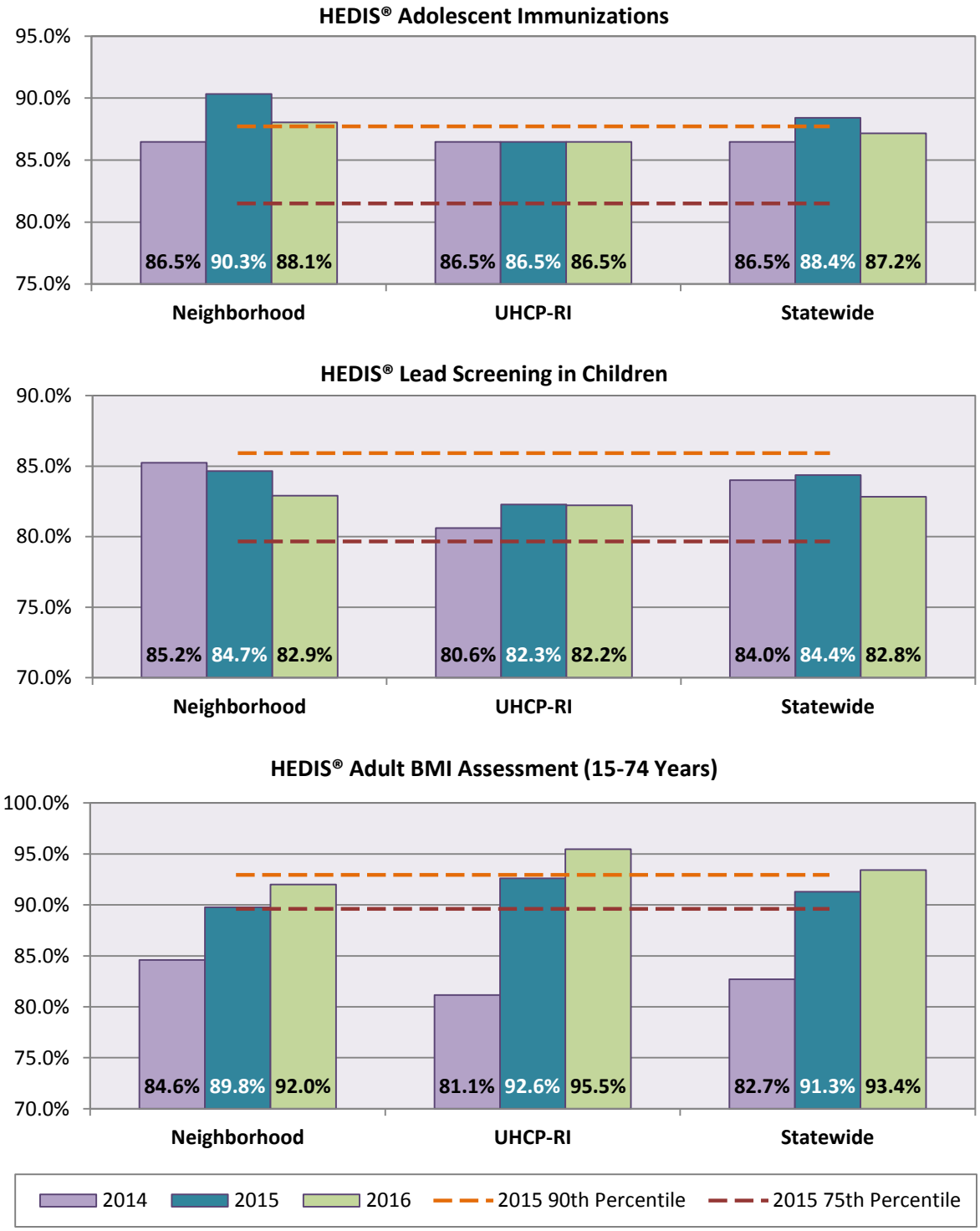
Figure 7c: PGP Results 2014-2016 Non-RHE Populations—Prevention and Screening[1,2]



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

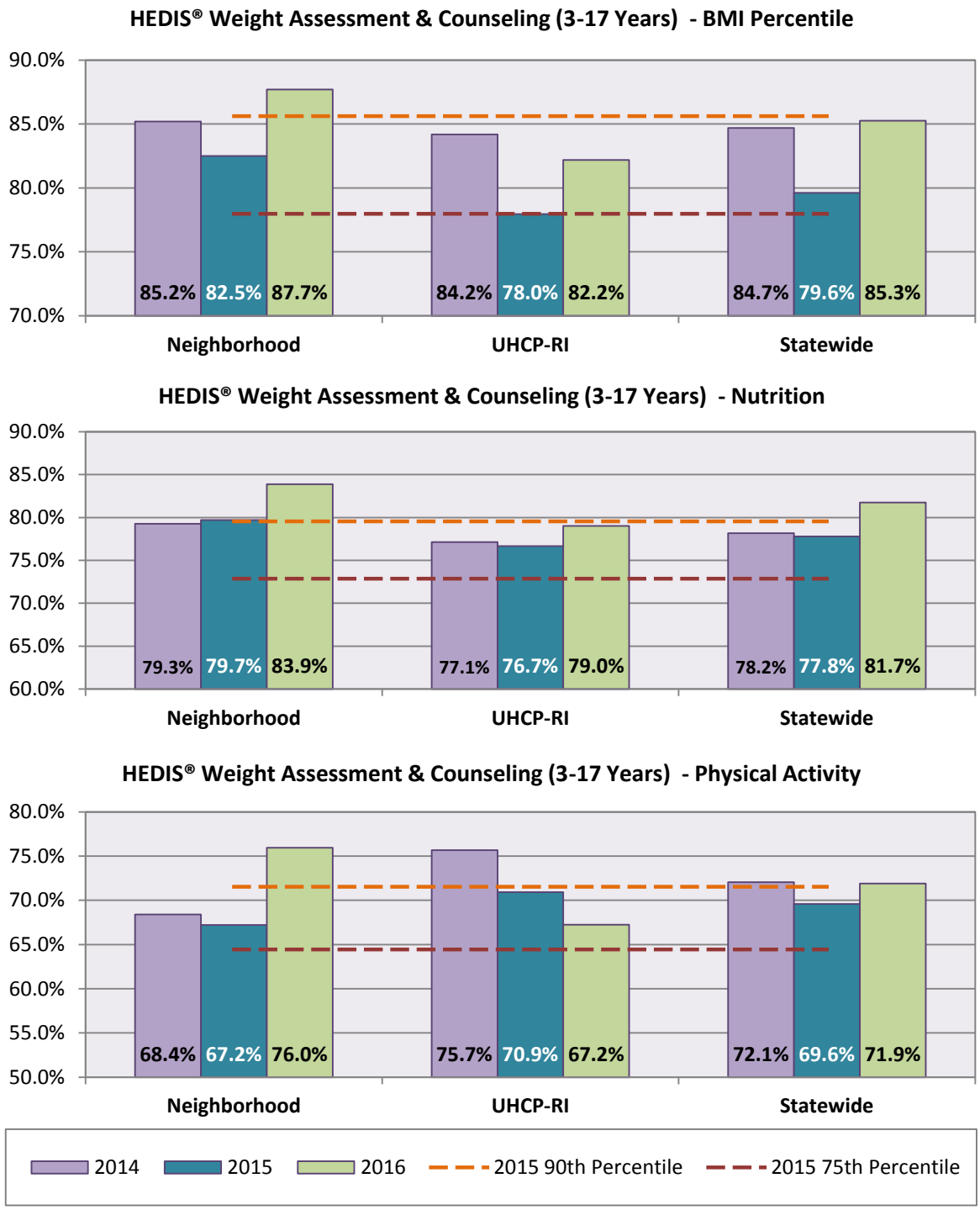
[2] The statewide rates for these measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 7c: PGP Results 2014-2016 Non-RHE Populations—Prevention and Screening[1] (continued)



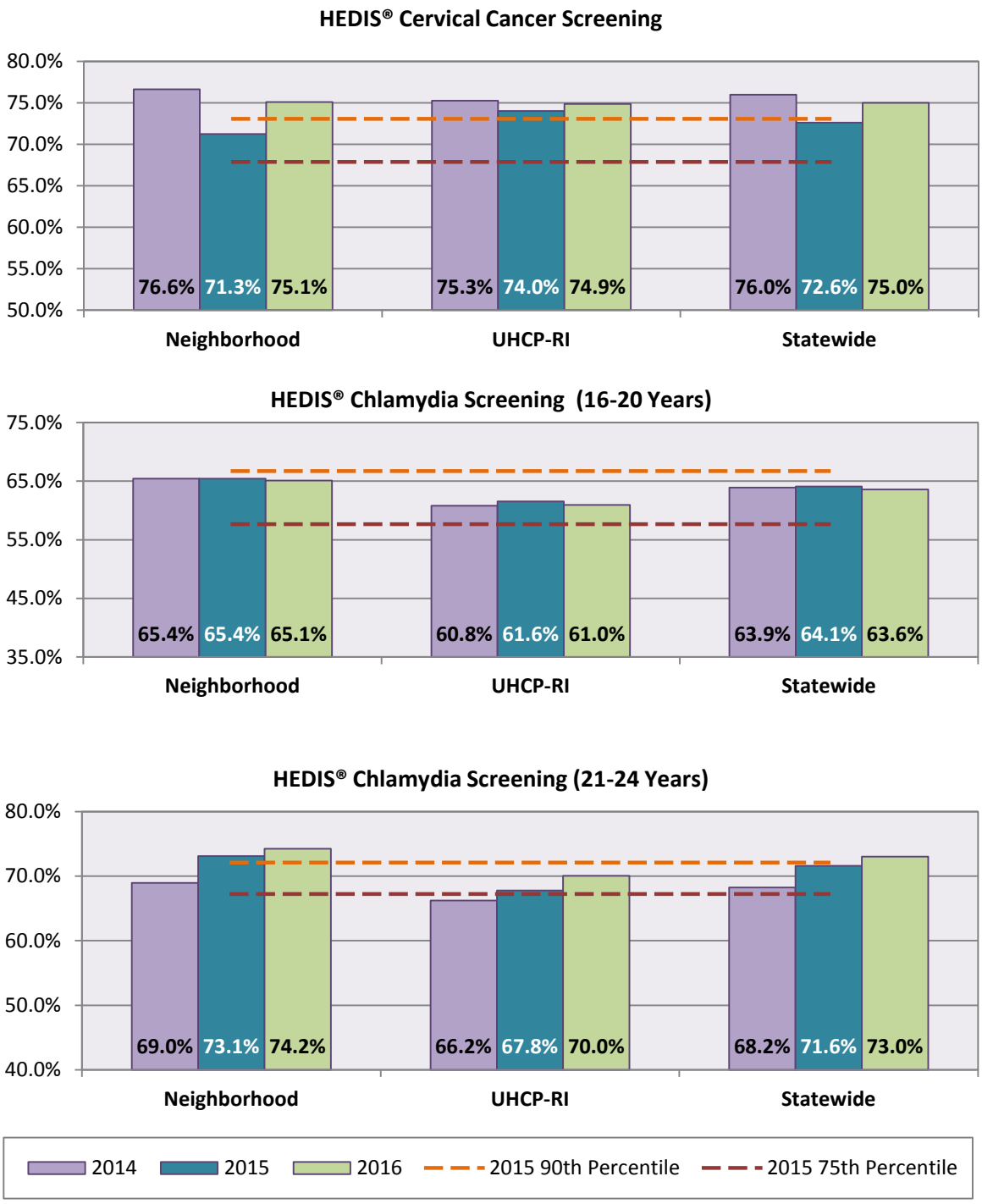
[1] The statewide rates for these measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 7c: PGP Results 2014-2016 Non-RHE Populations—Prevention and Screening[1] (continued)



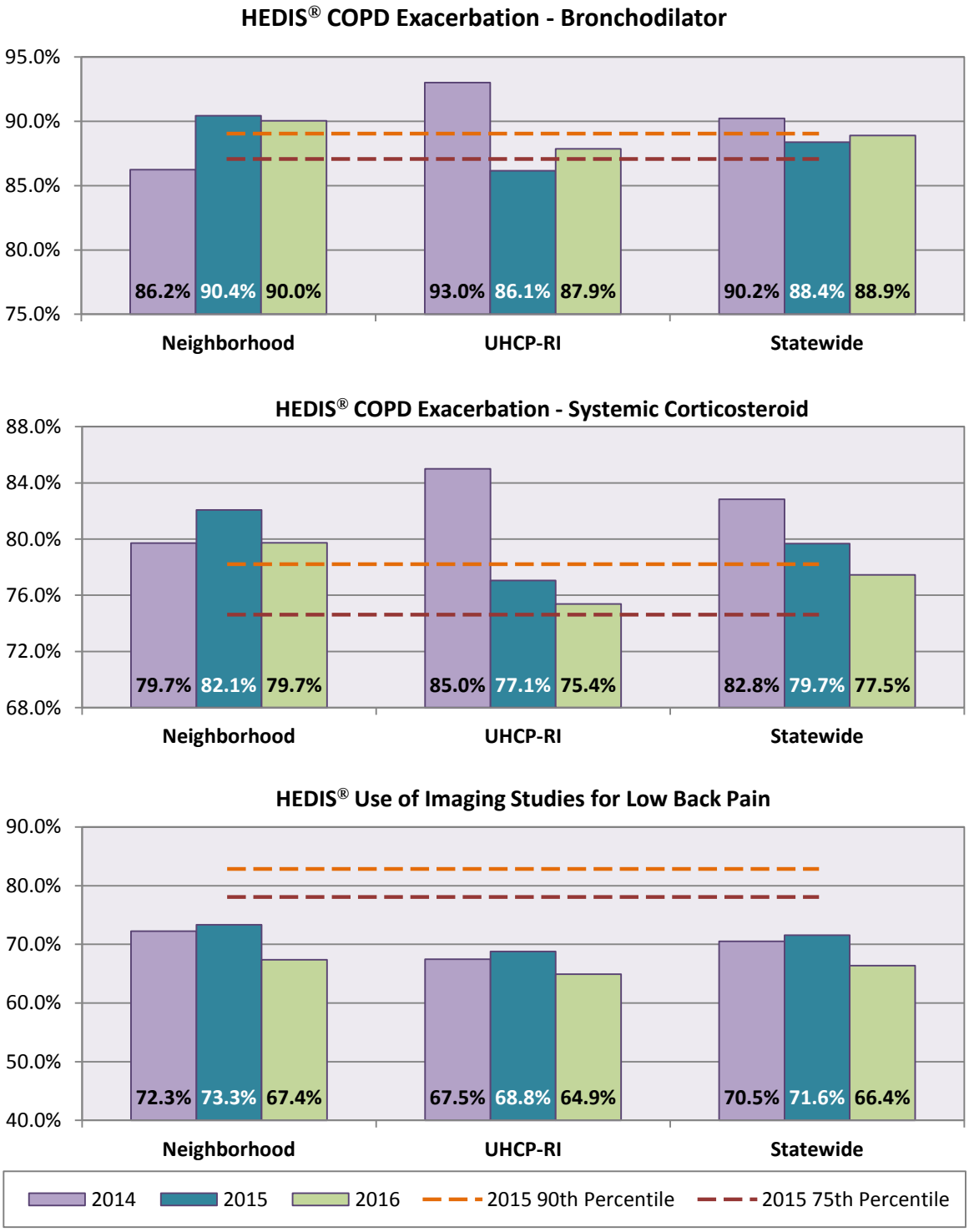
[1] The statewide rates for these measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 7d: PGP Results 2014-2016 Non-RHE Populations—Women's Health[1]



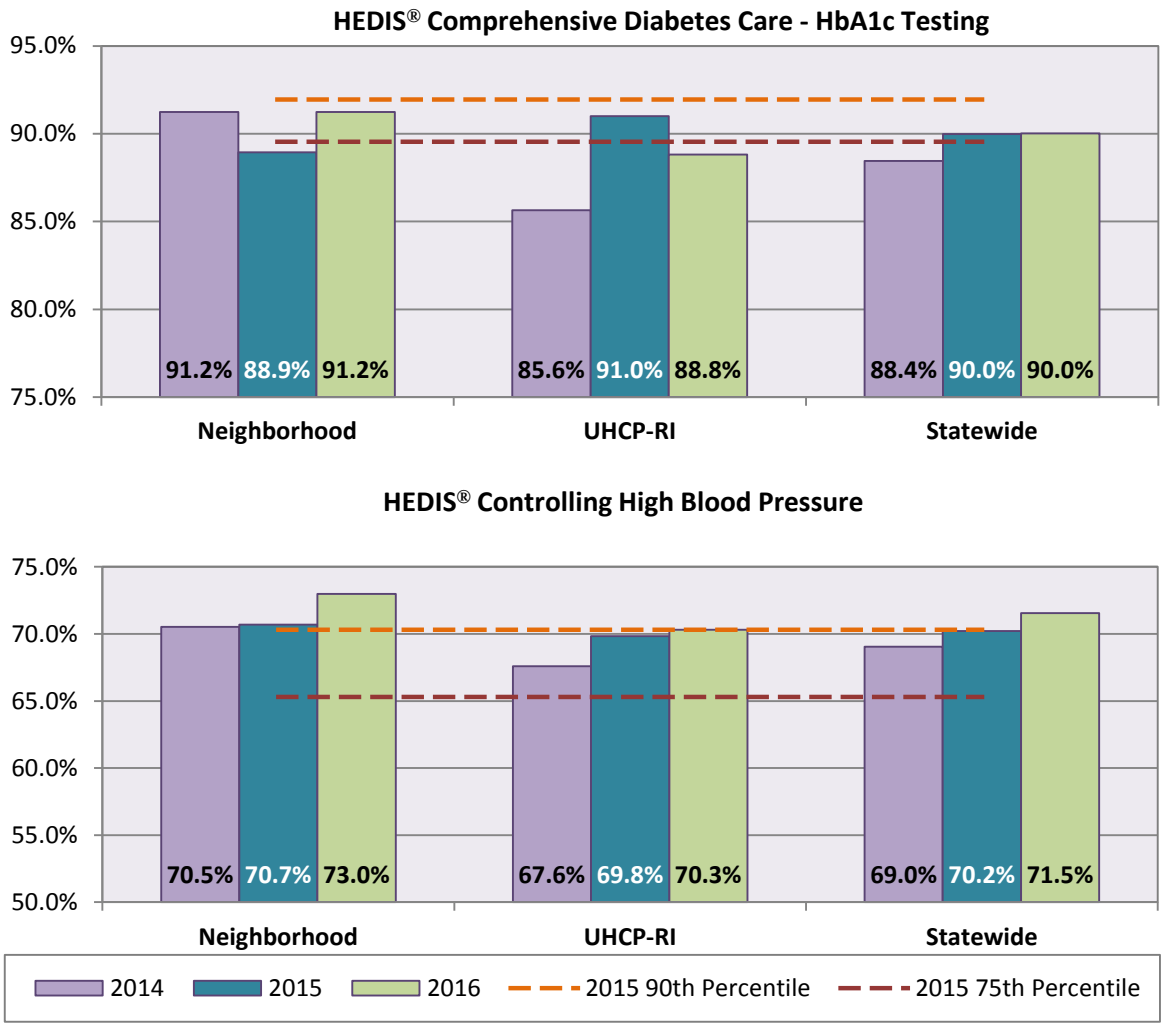
[1] The statewide rates for these measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 7e: PGP Results 2014-2016 Non-RHE Populations—Chronic Care[1]



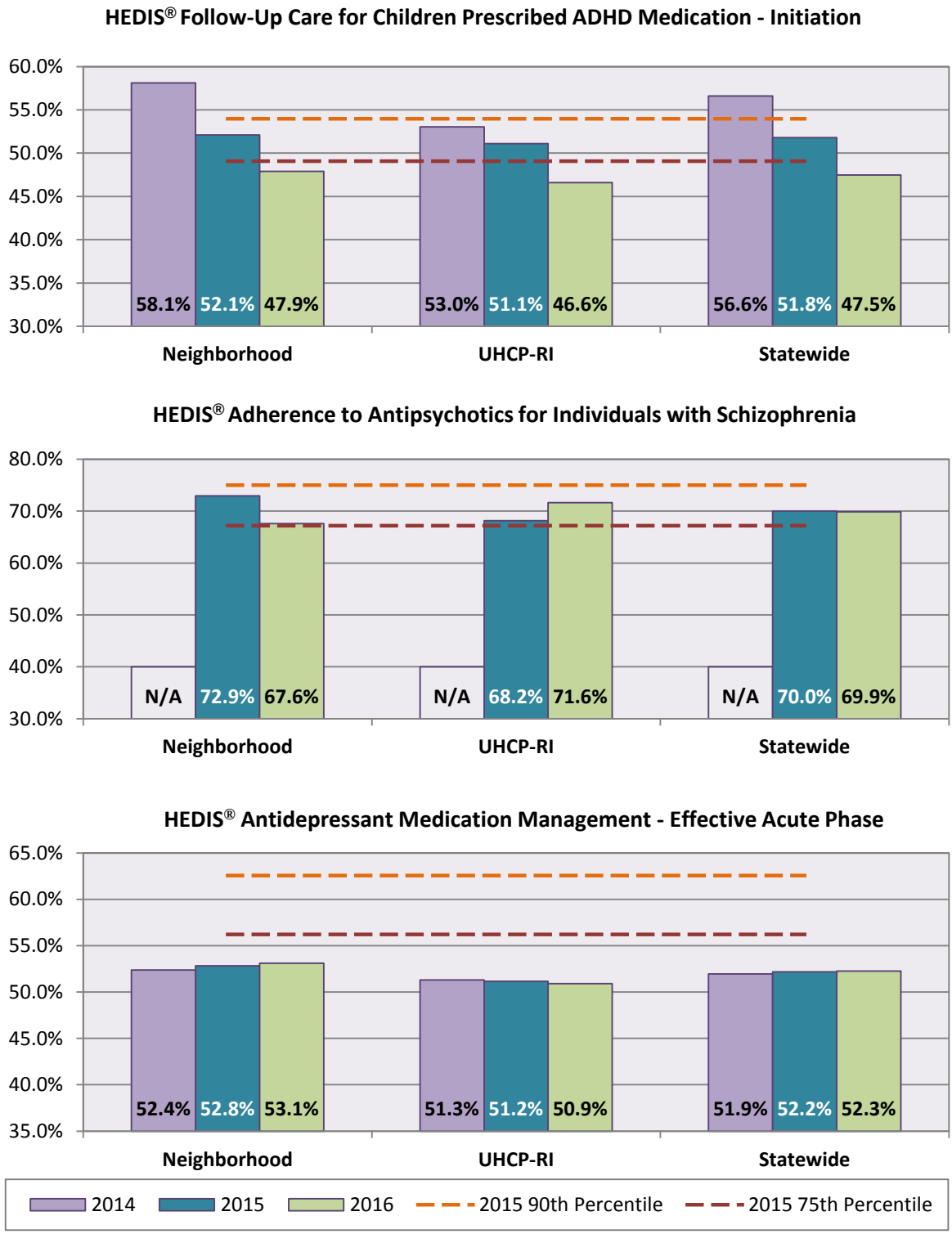
[1] The statewide rates for these measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 7e: PGP Results 2014-2016 Non-RHE Populations—Chronic Care[1] (continued)



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

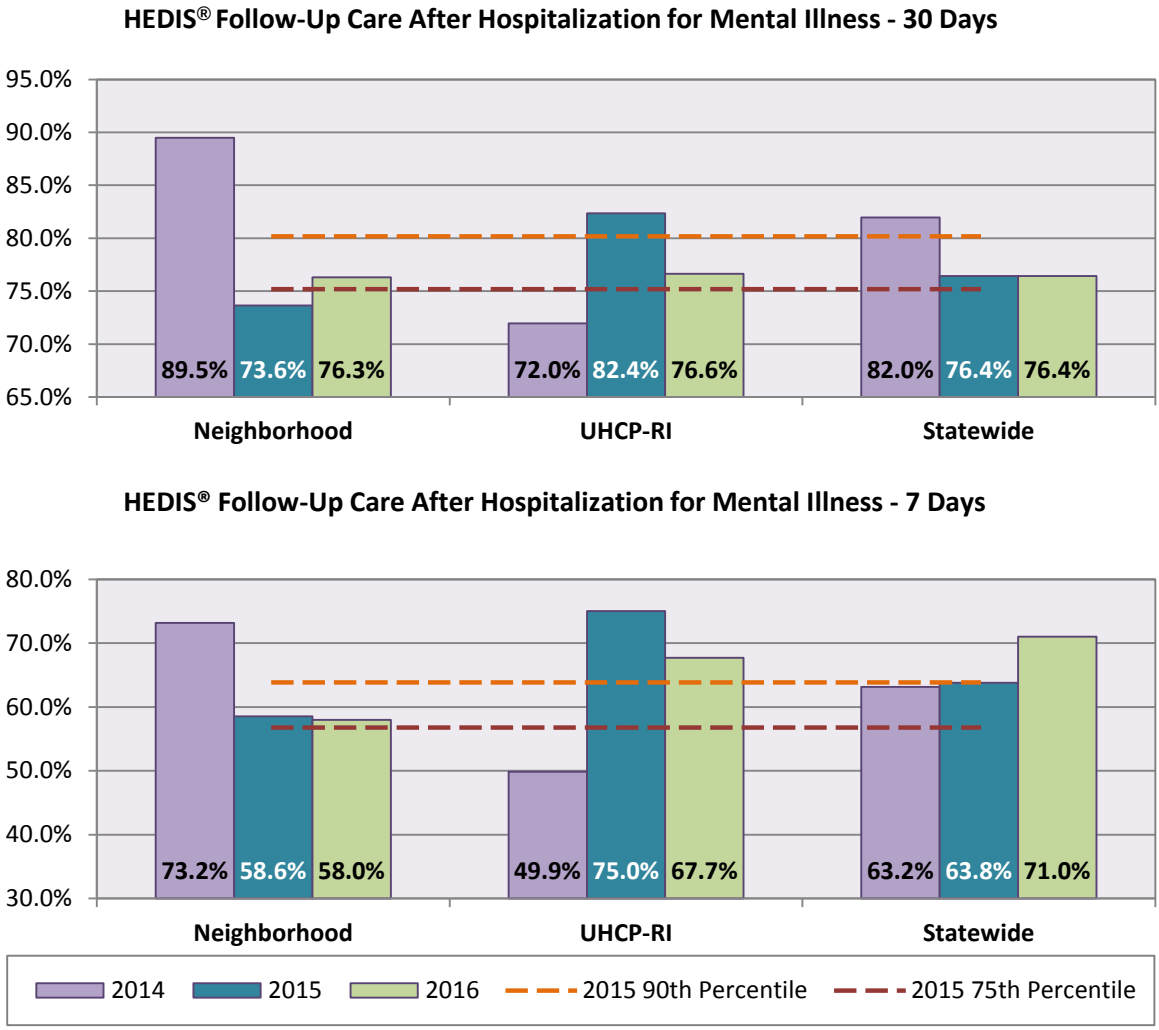
Figure 7f: PGP Results 2014-2016 Non-RHE Populations—Behavioral Health[1]



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

[2] The 'N/A' designation for 2014 was given for one measure as this measure was introduced for the 2015 PGP and, as such, there were no data available for 2014.

Figure 7f: PGP Results 2014-2016 Non-RHE Populations—Behavioral Health[1] (continued)



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

2016 Rhode Island Medicaid Managed Care Performance Goal Program Results—RHE

This section of the report evaluates the results of the 2016 Performance Goal Program for both Health Plans for RHE members. In 2016, 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® percentile derived from the 2015 *Quality Compass*® for Medicaid. As such, these percentiles may differ from the 2016 *Quality Compass*® benchmark data displayed elsewhere in this report.

The **Utilization** domain is comprised of two (2) State-specified measures and one (1) HEDIS® measure. The State-specified measures include the *Emergency Department Utilization Rate per 1,000* and *Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care* measures. These measures were newly introduced for the 2016 PGP, and therefore, were considered to be baseline measures and were not eligible for benchmarking and incentive awards. For the HEDIS® *Frequency of Ongoing Prenatal Care (≥81% of Expected Visits)* measure, UHCP-RI achieved the 2015 *Quality Compass*® 90th percentile and qualified for a full incentive award, while Neighborhood did not meet a *Quality Compass*® benchmark to qualify for an incentive award.

In the **Access to Care** domain, UHCP-RI achieved the 2015 *Quality Compass*® 90th percentile and qualified for a full incentive award, while Neighborhood achieved the 75th percentile and qualified for a partial incentive award, for the following HEDIS® measures: *Initiation of Alcohol and Other Drug Treatment* and *Engagement of Alcohol and Other Drug Treatment*. Neither Health Plan achieved a *Quality Compass*® benchmark to qualify for an incentive award for the remaining four (4) HEDIS® measures in this domain. In regard to the CAHPS® *Members were Satisfied with Access to Urgent Care*, UHCP-RI achieved the 90th percentile, while Neighborhood did not meet a *Quality Compass*® benchmark to qualify for an incentive award.

The **Prevention and Screening** domain consists of one (1) CAHPS® measure and one (1) HEDIS® measure. Both Health Plans achieved the 2015 *Quality Compass*® 90th percentile and qualified for a full incentive award for the HEDIS® *Adult BMI Assessment (18-74 Years)* measure. Only Neighborhood achieved the 2015 *Quality Compass*® 90th percentile for the CAHPS® *Medical Assistance with Smoking/Tobacco Cessation* measure.

In regard to **Women's Health**, performance varied across Health Plans and measures. Neither Health Plan achieved a *Quality Compass*® benchmark (90th or 75th percentile) to qualify for an incentive award for the HEDIS® *Women Received Cervical Cancer Screening (21-64 Years)* measure. In regard to the HEDIS® *Women Received Chlamydia Screening* measure, Neighborhood met the 90th percentile for the *16-20 Years* age group and the 75th percentile for the *21-24 Years* age group. Conversely, UHCP-RI met the 75th percentile for the *16-20 Years* age group and did not meet a *Quality Compass*® percentile for the *21-24 Years* age group.

The **Chronic Care** domain is comprised of one (1) State-specified measure and ten (10) HEDIS® measures. Neither Neighborhood nor UHCP-RI achieved the *Contract* goal of eighty-eight percent (88%) for the State-specified measure *HIV Viral Load Suppression*. In regard to the HEDIS® measures within this domain, performance was similar across Health Plans. Both Health Plans achieved a 2015 *Quality Compass*® benchmark and qualified for a full or partial incentive award for the following HEDIS® measures: *Medication Management for People with Asthma 75% (5-64 Years), Pharmacotherapy for COPD Exacerbation—Bronchodilators, Pharmacotherapy for COPD Exacerbation—Corticosteroids, Comprehensive Diabetes Care—HbA1c Testing, Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), Comprehensive Diabetes Care—Retinal Eye Exam Performed, Comprehensive Diabetes Care—BP Control (140/90),* and *Controlling High Blood Pressure.* Neighborhood also met the 90th percentile for *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*, while UHCP-RI did not achieve a *Quality Compass*® percentile. Neither Health Plan met a *Quality Compass*® benchmark for the *Use of Imaging Studies for Low Back Pain* measure.

In regard to the **Behavioral Health** domain, UHCP-RI demonstrated a stronger performance than Neighborhood. UHCP-RI met the 2015 *Quality Compass*® 90th or 75th percentile for three (3) of the four (4) measures that comprise this domain. The measure for which UHCP-RI did not meet a *Quality Compass*® percentile to qualify for an incentive award was HEDIS® *Adherence to Antipsychotics for Individuals with Schizophrenia*. Conversely, Neighborhood met the *Quality Compass*® 75th percentile for one (1) measure: HEDIS® *Antidepressant Medication Management—Effective Acute Phase Treatment*. The Health Plan did not achieve a *Quality Compass*® benchmark for the other three (3) measures in this domain.

The **Compliance** domain is comprised of one (1) HEDIS® measure and two (2) State-specified measures. Neither Health Plan achieved a 2015 *Quality Compass*® benchmark for the HEDIS® *Call Answer Timeliness* measure. In regard to the State-specified measures, UHCP-RI met the *Contract* goal of ninety-five percent (95%) to receive a partial incentive award for the *Expenditures* component of the *Accurate Submission of Encounter Data* measure, while Neighborhood did not meet a *Contract* goal for either component.

The sole measure of the **Total Cost of Care** domain, *Decrease the Average Total Cost of Care—High Utilizers*, was considered a baseline measure for the 2016 PGP, and therefore, was not eligible for benchmarking or incentive awards.

Table 8: Performance Rates and Goals—2016—RHE Population[1]

RI Medicaid Managed Care 2016 Performance Goal Measures	Neighborhood		UHCP-RI	
	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]
Utilization				
Emergency Room Utilization Rate per 1,000[4,5,6,7]	BM		BM	
Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care[4,5,6,7]	BM		BM	
HEDIS® Frequency of Ongoing Prenatal Care (≥81% of Expected Visits)	60.0%	**NM**	77.3%	**90th**
Access to Care				
HEDIS® Adults Had Ambulatory/Preventive Care Visit (20-44 Years)	72.6%	**NM**	74.5%	**NM**
HEDIS® Adults Had Ambulatory/Preventive Care Visit (45-64 Years)	86.6%	**NM**	87.3%	**NM**
HEDIS® Pregnant Members Received Timely Prenatal Care	80.0%	**NM**	81.8%	**NM**
HEDIS® Postpartum Member Received Timely Postpartum Care	65.0%	**NM**	63.3%	**NM**
HEDIS® Initiation of Alcohol and Other Drug Treatment	43.5%	**75th**	52.4%	**90th**
HEDIS® Engagement of Alcohol and Other Drug Treatment	17.9%	**75th**	22.5%	**90th**
CAHPS® Members were Satisfied with Access to Urgent Care	78.1%	**NM**	100.0%	**90th**
Prevention and Screening				
HEDIS® Adult BMI Assessment (18-74 Years)	97.9%	**90th**	95.7%	**90th**
CAHPS® Medical Assistance with Smoking/Tobacco Cessation	74.4%	**90th**	78.2%	**NM**
Women's Health				
HEDIS® Women Received Cervical Cancer Screening (21-64 Years)	56.9%	**NM**	66.2%	**NM**
HEDIS® Women Received Chlamydia Screening (16-20 Years)	67.5%	**90th**	61.0%	**75th**
HEDIS® Women Received Chlamydia Screening (21-24 Years)	67.9%	**75th**	66.8%	**NM**
Chronic Care				
HEDIS® Medication Management for Asthma 75% (5-64 Years)[7]	47.9%	**90th**	51.8%	**90th**
HEDIS® Pharmacotherapy for COPD Exacerbation—Bronchodilators	90.6%	**90th**	92.7%	**90th**
HEDIS® Pharmacotherapy for COPD Exacerbation—Corticosteroids	77.1%	**75th**	75.0%	**75th**
HEDIS® Use of Imaging Studies for Low Back Pain	66.7%	**NM**	63.9%	**NM**

M/E: Met or exceeded *Contract* goal.

NM: Did not meet *Contract* goal.

BM: Baseline measure.

Table 8: Performance Rates and Goals—2016—RHE[1] (continued)

RI Medicaid Managed Care 2016 Performance Goal Measures	Neighborhood		UHCP-RI	
	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]	2016	*Quality Compass®* 2015 90th/75th Percentile Met[2]
Chronic Care				
HEDIS® Comprehensive Diabetes Care—HbA1c Testing (18-75 Years)	92.5%	**90th**	91.8%	**75th**
HEDIS® Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%) (18-75 Years)[7]	22.0%	**90th**	27.3%	**90th**
HEDIS® Comprehensive Diabetes Care—HbA1c Control (<8.0%) (18-75 Years)[7]	63.4%	**90th**	52.5%	**NM**
HEDIS® Comprehensive Diabetes Care—Retinal Eye Exam Performed (18-75 Years)[7]	67.2%	**75th**	71.4%	**90th**
HEDIS® Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)[7]	76.9%	**90th**	71.6%	**75th**
HEDIS® Controlling High Blood Pressure (<140/90) (18-85 Years)	73.3%	**90th**	68.5%	**75th**
HIV Viral Load Suppression[4,7]	NM		NM	
Behavioral Health				
HEDIS® Members 6 Years and Older Get Follow-Up by *30 Days* Post-Discharge	66.3%	**NM**	82.5%	**90th**
HEDIS® Members 6 Years and Older Get Follow-Up by *7 Days* Post-Discharge	47.8%	**NM**	70.4%	**90th**
HEDIS® Antidepressant Medication Management—Effective Acute Phase	60.2%	**75th**	58.4%	**75th**
HEDIS® Adherence to Antipsychotics for Individuals with Schizophrenia	53.0%	**NM**	56.2%	**NM**
Compliance				
Accurate Submission of Encounter Data—Claims Count[4,7,8]	NM		NM	
Accurate Submission of Encounter Data—Expenditures[4,7,8]	NM		M/E	
HEDIS® Call Answer Timeliness[7]	78.1%	**NM**	88.3%	**NM**
Total Cost of Care				
Decrease the Average Total Cost of Care—High Utilizers[4,6,7,9]	BM		BM	

M/E: Met or exceeded *Contract* goal.

NM: Did not meet *Contract* goal.

BM: Baseline measure.

[1] Performance Goal Program data are based on the previous Contract Year (i.e., 2016 rates are based on Contract Year 2015). Rates may differ from other data published in this report, as this table reflects preliminary HEDIS® and CAHPS® rates for the Non-RHE populations, while the rates in all other tables reflect final data submitted to the NCQA for all populations. 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 otherwise noted.

[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 an available, on national Medicaid 2015 *Quality Compass®* 90th and 75th percentile benchmarks (unless otherwise noted).

[4] State-specified measure.

[5] The *Emergency Room Utilization Rate per 1,000* and *Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care* measures was newly introduced for the 2016 PGP. In subsequent reports, this measure will be reported as the total, as well as rate by product line.

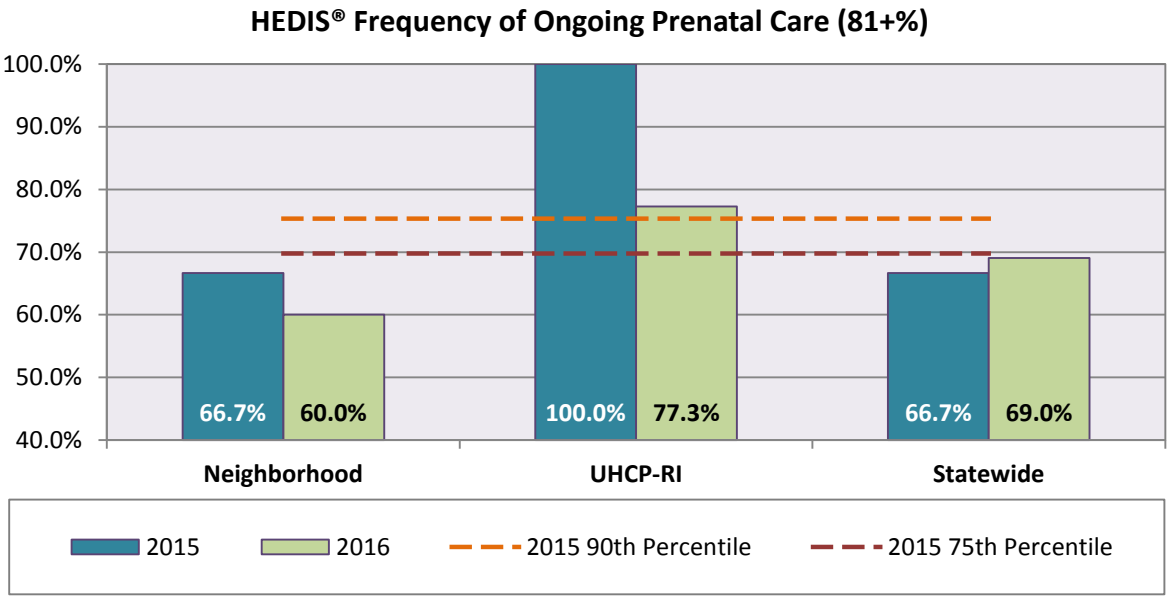
[6] The following measures were considered baseline rates; therefore, these measures were not eligible for incentive awards or benchmarking: *Emergency Room Utilization Rate per 1,000, Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care,* HEDIS® *Use of Multiple Concurrent Antipsychotics in Children/Adolescents,* and *Decrease the Average Total Cost of Care—High Utilizers.*

[7] The following measures were introduced for the 2016 PGP: *Emergency Room Utilization Rate per 1,000, Re-Hospitalization within 30 Days of Discharge from Inpatient Psychiatric Care,* HEDIS® *Female Adolescents Received HPV Vaccination by 13th Birthday,* HEDIS® *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%),* HEDIS® *Comprehensive Diabetes Care—HbA1c Control (<8.0%),* HEDIS® *Comprehensive Diabetes Care—Retinal Eye Exam,* HEDIS® *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg), Accurate Submission of Encounter Data—Claims Count, Accurate Submission of Encounter Data—Expenditures,* and *Decrease the Average Total Cost of Care—High Utilizers.*

[8] The State-specified *Contract* goal for a full incentive award for this measure was 99%, while the *Contract* goal for a partial incentive award was 95%.

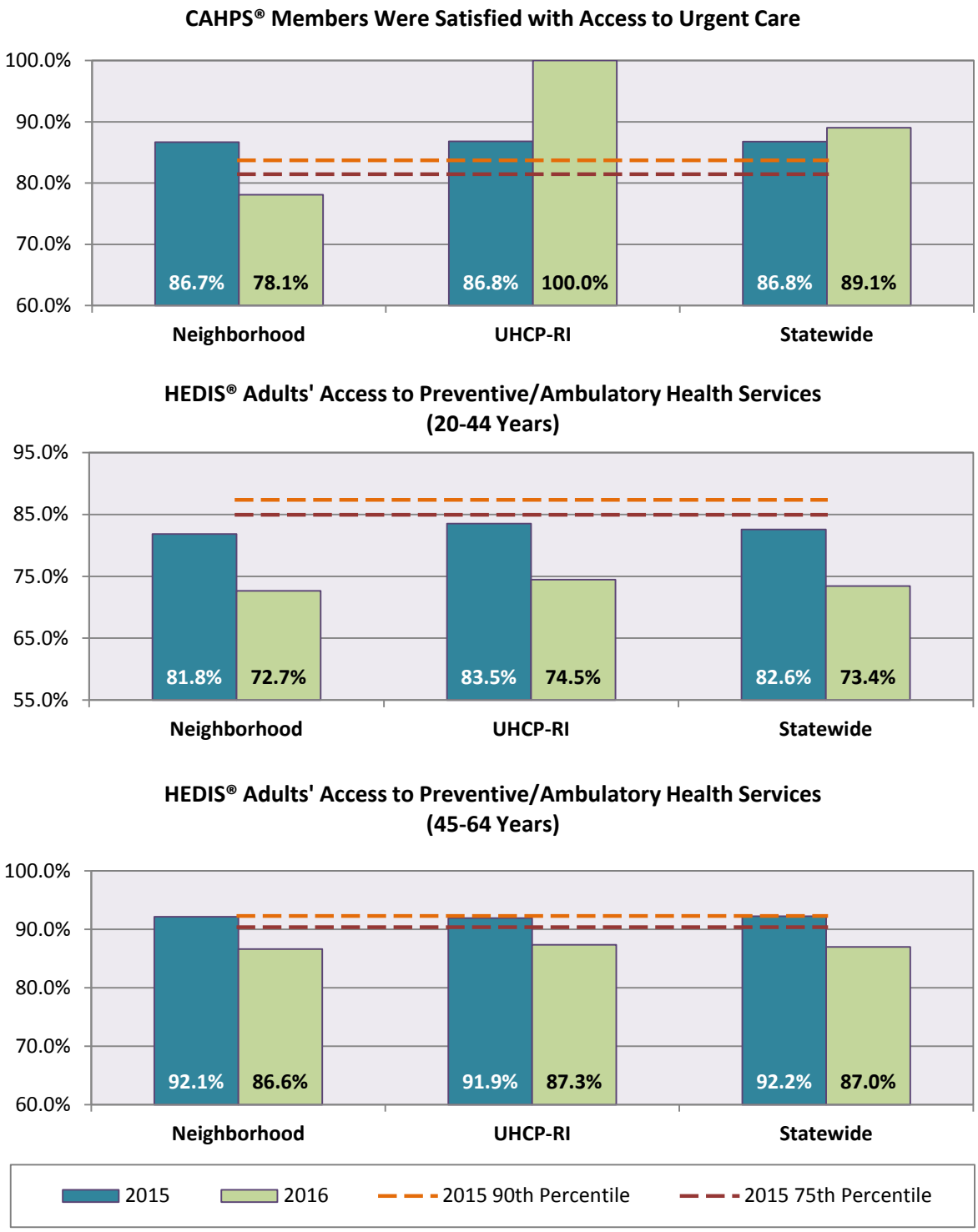
[9] The Health Plan's rate for *Decrease the Average Total Cost of Care—High Utilizers* was not available.

Figure 8a: PGP Results 2015-2016 RHE Population—Utilization[1]



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

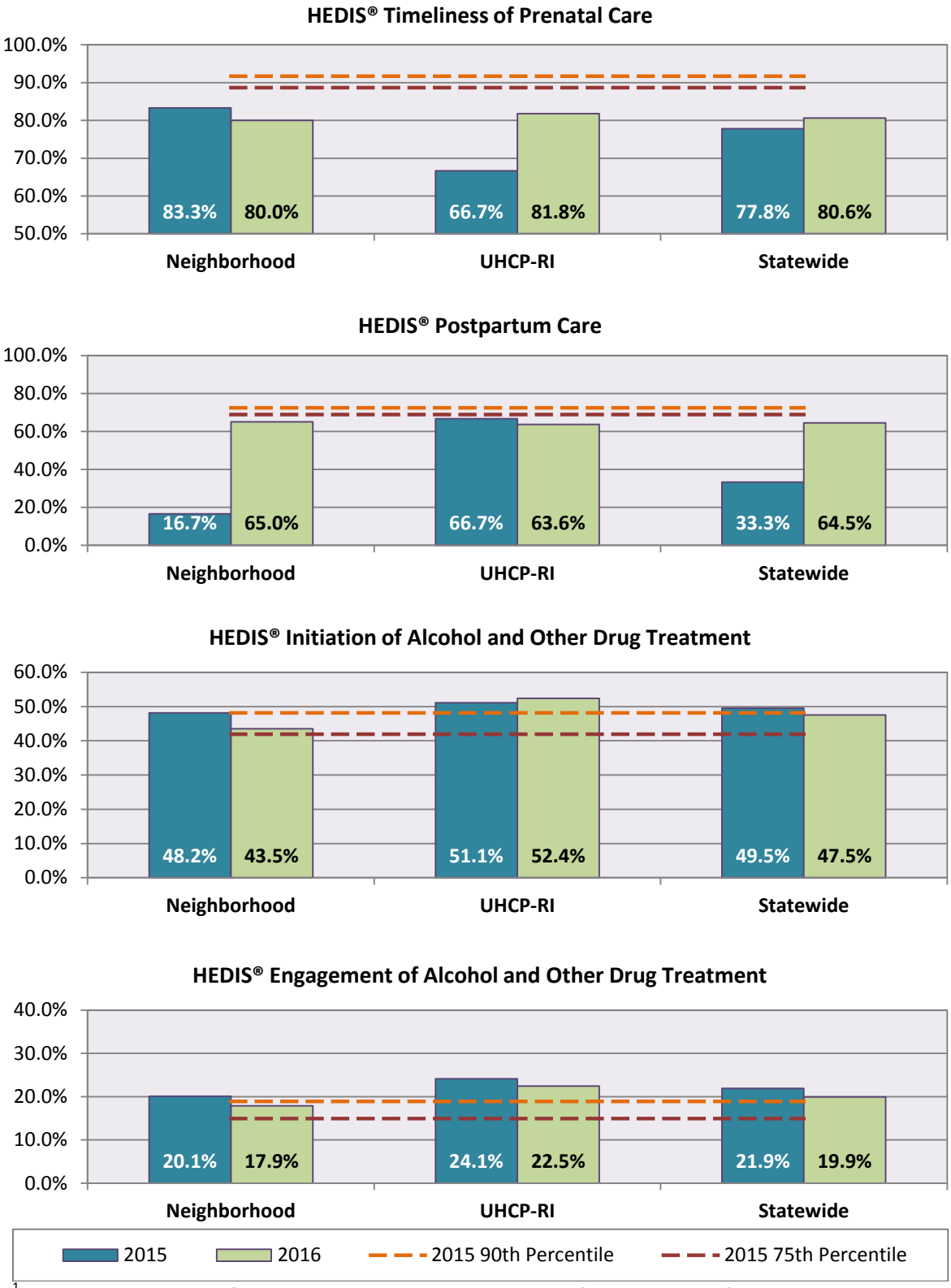
Figure 8b: PGP Results 2015-2016 RHE Population—Access to Care[1,2]



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

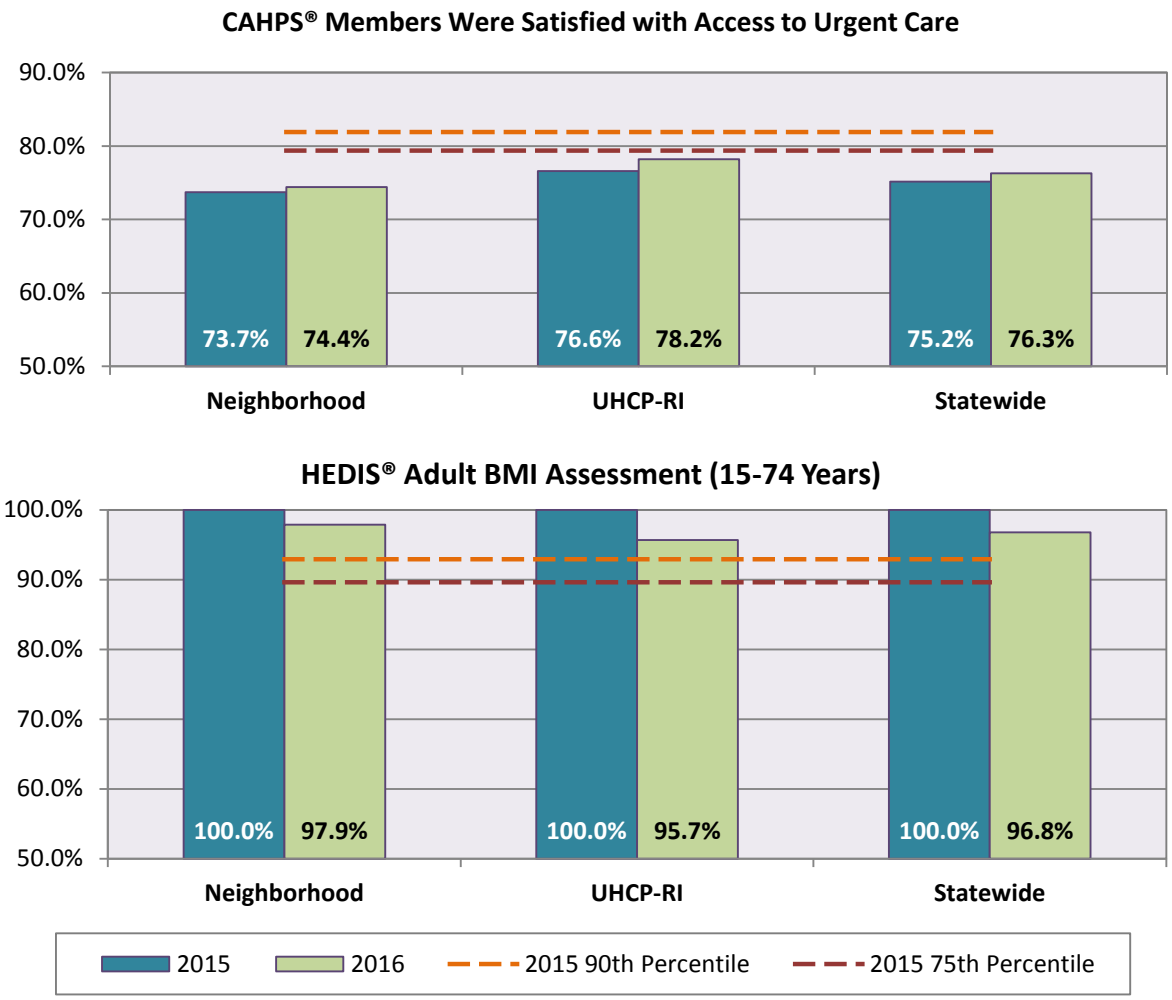
[2] The statewide rates for these measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 8b: PGP Results 2015-2016 RHE Population—Access to Care[1] (continued)



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

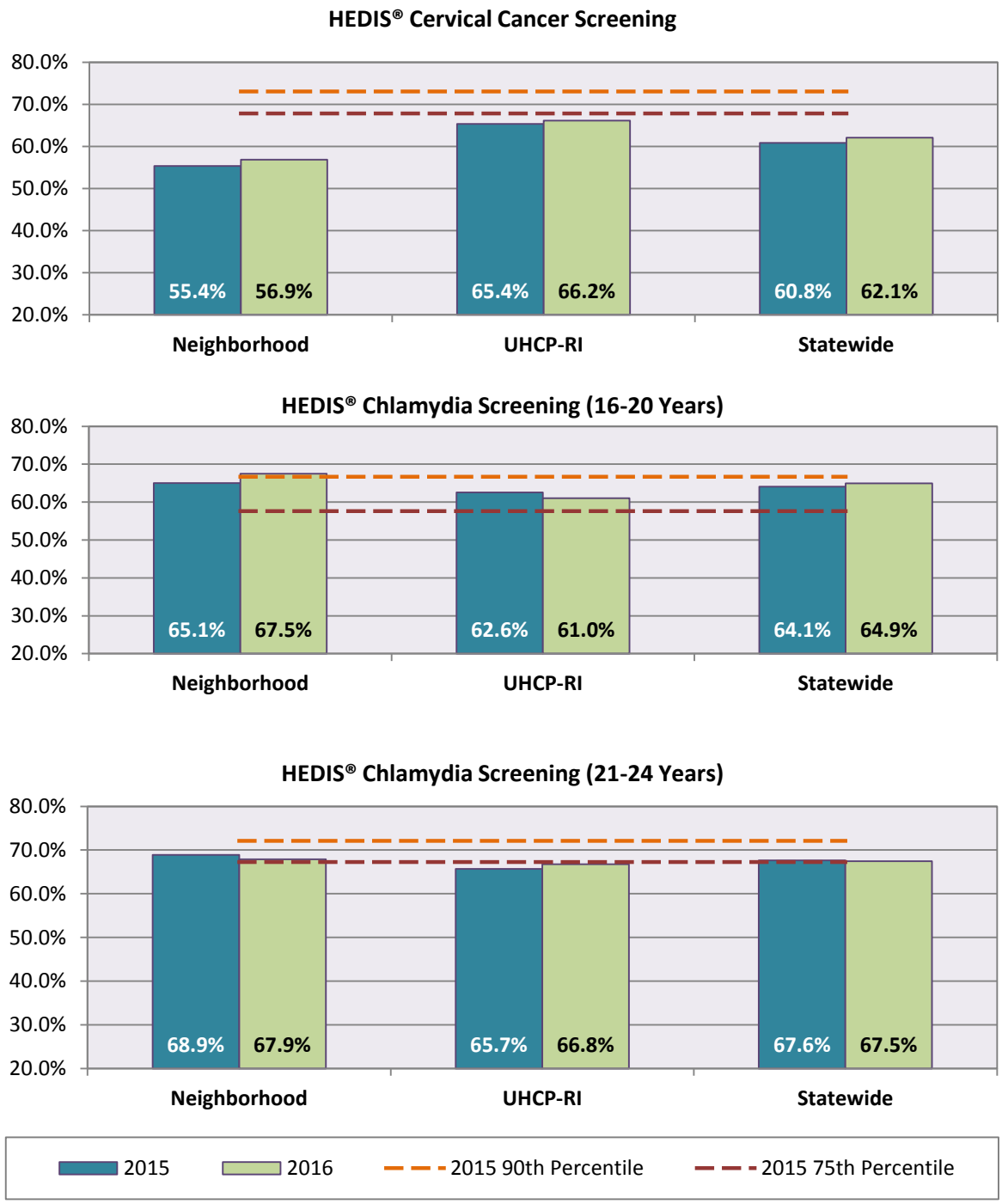
Figure 8c: PGP Results 2015-2016 RHE Population—Prevention and Screening[1,2]



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

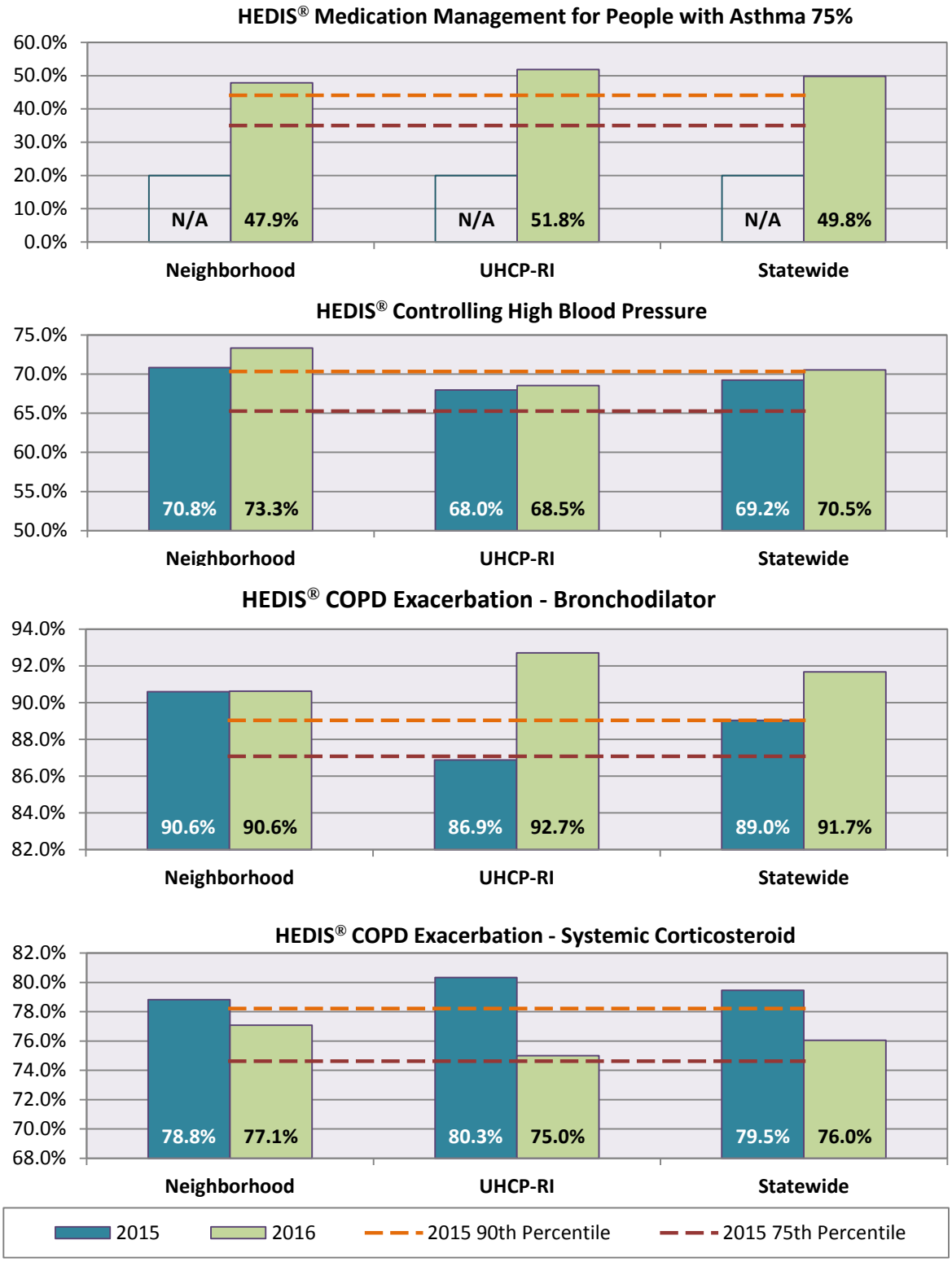
[2] The statewide rates for these measures were calculated following HEDIS® methodology, totaling numerators and denominators for the two (2) Health Plans.

Figure 8d: PGP Results 2015-2016 RHE Population—Women's Health[1]



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

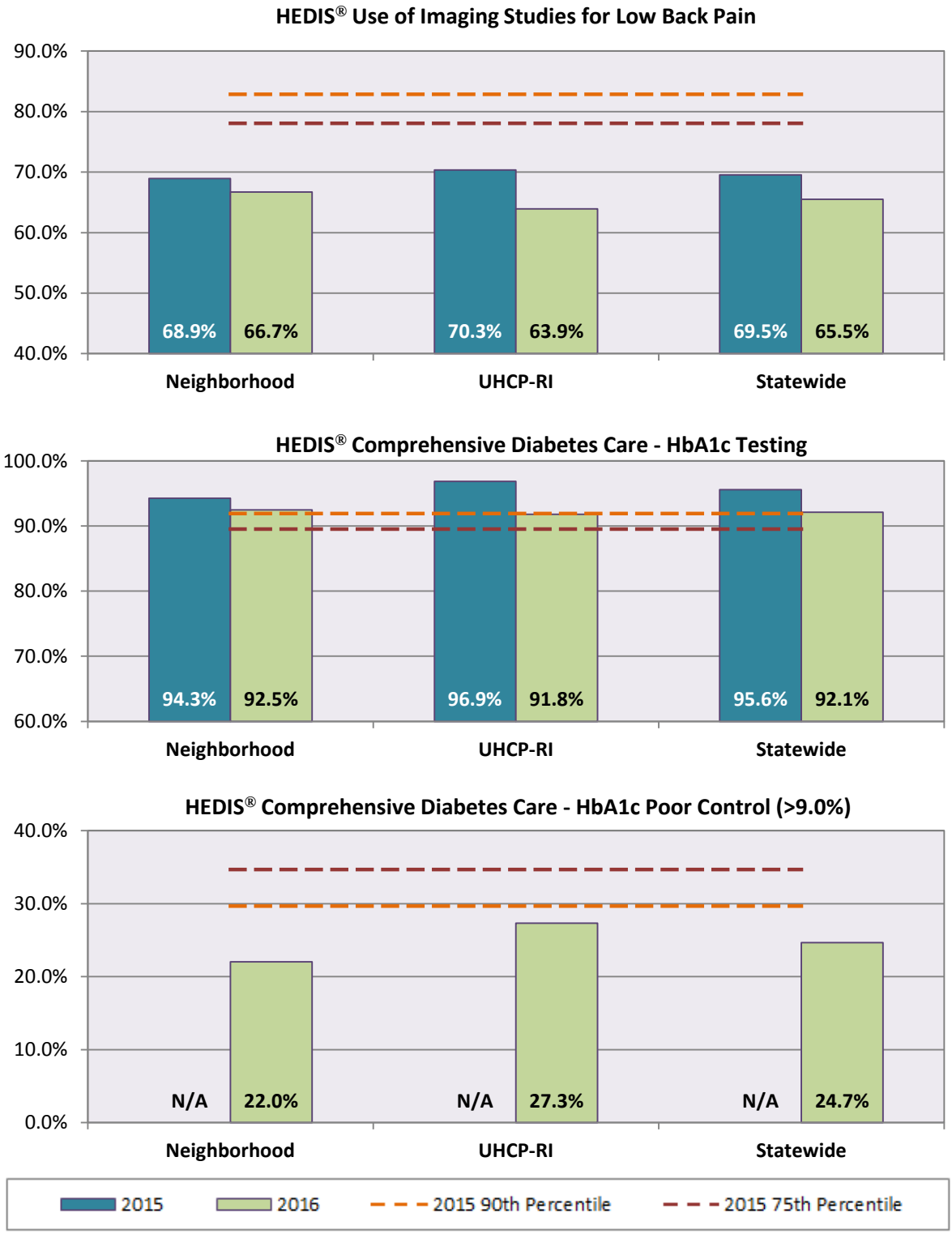
Figure 8e: PGP Results 2015-2016 RHE Population—Chronic Care[1,2]



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

[2] The 'N/A' designations were given for certain measures as these measures were introduced for the 2016 PGP and, as such, there were no data available for 2015.

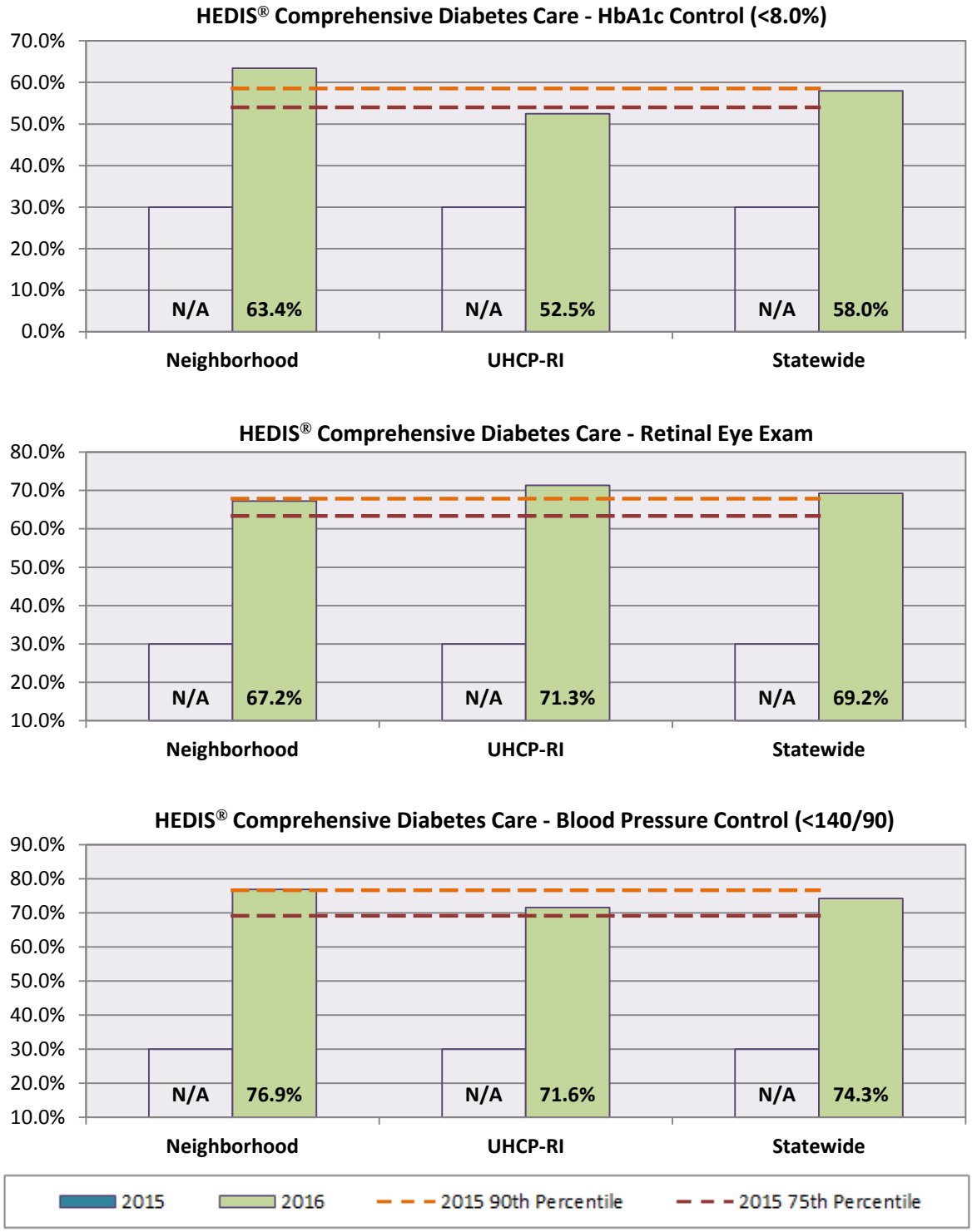
Figure 8e: PGP Results 2015-2016 RHE Population—Chronic Care[1,2] (continued)



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

[2] The 'N/A' designations were given for certain measures as these measures were introduced for the 2016 PGP and, as such, there were no data available for 2015.

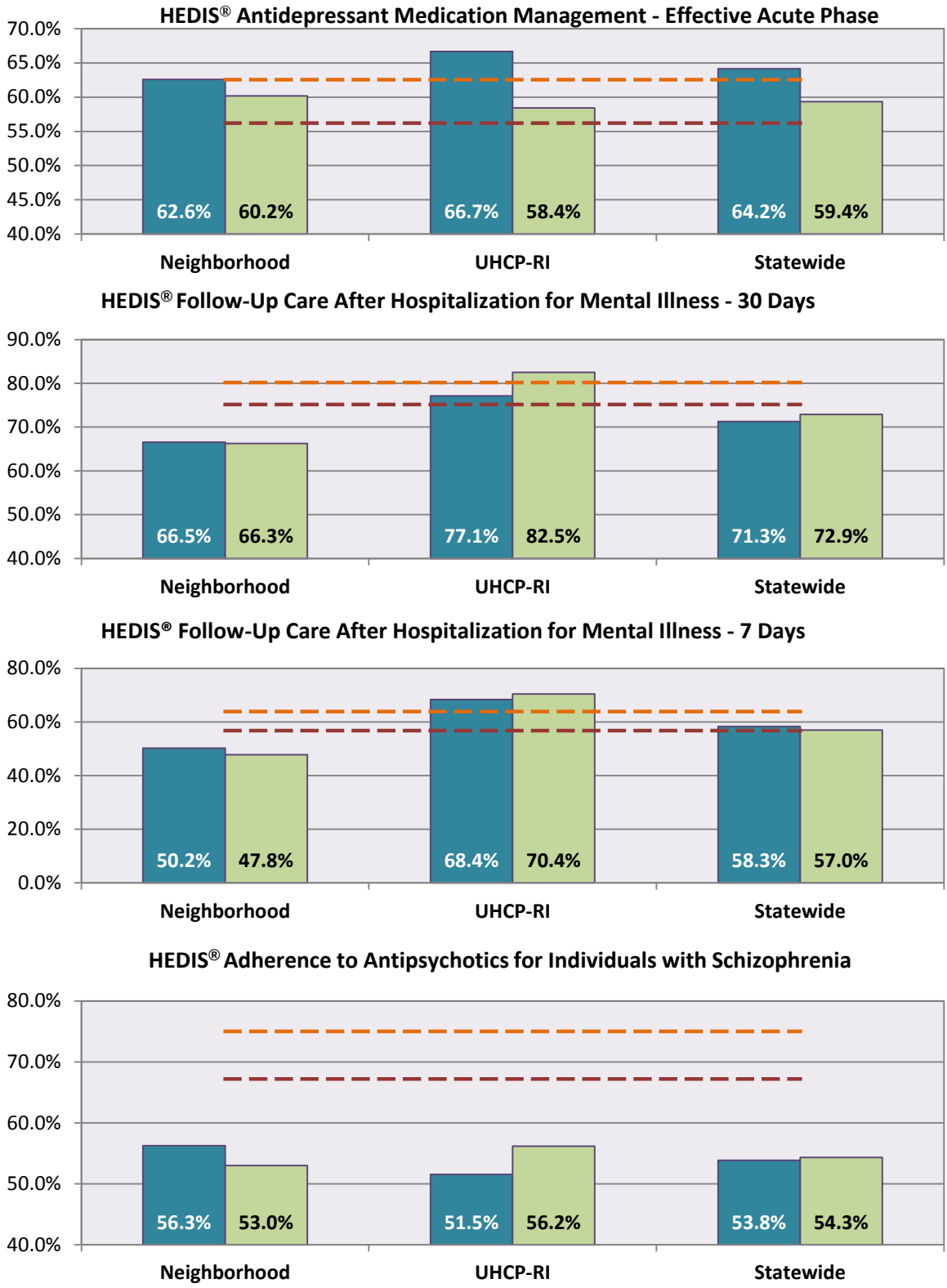
Figure 8e: PGP Results 2015-2016 RHE Population—Chronic Care[1,2] (continued)



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

[2] The 'N/A' designations were given for certain measures as these measures were introduced for the 2016 PGP and, as such, there were no data available for 2015.

Figure 8f: PGP Results 2015-2016 RHE Population—Behavioral Health[1]



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

Monitoring of Care and Services for Special Enrollment Populations

HEDIS® Performance for Core RIte Care versus All Populations

The *Quality Compass*® 2015 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 (Neighborhood 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 Neighborhood's rates for the two (2) groups for HEDIS® 2016 demonstrated that performance was similar for thirty-one (31) measures and dissimilar for thirteen (13) measures, based on the *Quality Compass*® 2015 Medicaid percentile rankings. Of the thirteen (13) measures with dissimilar rates, the rates ranked lower, comparatively, for *All Populations* (i.e., with the special enrollment population members included) for nine (9) measures and higher for four (4) measures.

UHCP-RI's performance for the two (2) groups for HEDIS® 2016 was similar for twenty-four (24) measures and dissimilar for nineteen (19) measures, based on *Quality Compass*® 2015 Medicaid percentile rankings. Of the measures with dissimilar rates, the rate ranked higher for *All Populations* (i.e., with the special enrollment population members included) for fourteen (14) measures and lower for five (5) measures, as compared to *Core RIte Care Only*.

The findings are displayed in the table that follows.

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 vs. All Populations

HEDIS® Measure Name	Neighborhood	UHCP-RI
Adults' Access to Preventive/Ambulatory Care (20-44 Years)	▼	▼
Adults' Access to Preventive/Ambulatory Care (45-64 Years)	S	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	▲
Adolescent Well-Care Visits	▼	S
Childhood Immunization—Combo 3	S	▲
Childhood Immunization—Combo 10	S	▲
Lead Screening in Children	S	▲
Immunizations for Adolescents	S	▲
HPV Immunizations for Females	S	S
Prenatal and Postpartum Care—Timeliness of Prenatal Care	▼	▲
Prenatal and Postpartum Care—Postpartum Care Visit within 21-56 Days	S	▲
Frequency of Ongoing Prenatal Care—81+ Percent of Expected Visits	S	▲
Cervical Cancer Screening for Women (21-64 Years)	▼	▼
Chlamydia Screening for Women (16-20 Years)	S	S
Chlamydia Screening for Women (21-24 Years)	▼	S
Adult BMI Assessment	▲	▲
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
Comprehensive Diabetes Care—HbA1c Testing	S	S
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	▼	▼
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	S	▲
Comprehensive Diabetes Care—Retinal Eye Exam Performed	S	S
Comprehensive Diabetes Care—BP Control (<140/900 mm Hg)	▲	▼
Medication Management for People with Asthma 75%	▲	S
Pharmacotherapy for COPD Exacerbation—Bronchodilators	S	▲
Pharmacotherapy for COPD Exacerbation—Corticosteroids	S	▲
Controlling High Blood Pressure (<140/90)	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
Engagement of Alcohol and Other Drug Treatment	▼	S
Adherence to Antipsychotics for Individuals with Schizophrenia	S	▲
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
Call Answer Timeliness	S	N/A
CAHPS® Urgent Care—Get Care as Soon as You Thought You Needed It?	S	S
CAHPS® Medical Assistance with Smoking/Tobacco Use Cessation	S	S

[1] The 'N/A' designation indicates that the measure is considered a baseline rate for 2016 or that no comparison can be made between the two groups.

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

XI. QUALITY IMPROVEMENT PROGRAM[23]

The State of Rhode Island Executive Office of Health and Human Services requires that contracted Health Plans have a written quality assurance plan (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)[24], Rhody Health Partners (RHP), and Rhody Health Expansion (RHE), as well as for the Health Plan-established Communities of Care[25] 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 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, 2015/2016, 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 Screening in the First Three Years of Life,* HEDIS® *HbA1c Control*, and

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

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

[25] 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.

HEDIS® *Follow-Up Care for Children Prescribed ADHD Medication*. The fourth QIP topic was of the Health Plan's own choosing, with the State's approval, from among State-suggested topics for each Health Plan. Both Health Plans chose to conduct QIPs 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 2016, the Rhode Island Medicaid managed care program, and both of the participating Health Plans continue to have a generally positive impact on the accessibility, timeliness, and quality of services for Rhode Island Medicaid recipients. This is supported by the Health Plans' NCQA Accreditation Status of *Excellent*, as well as 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. Additionally, both Health Plans demonstrated above average performance (rates in the 90th and 75th percentiles) on many quality and accessibility measures. Despite the Health Plans' overall strong performance, there are a number of areas where improvement is warranted for both Health Plans.

With the exception of those shown for the HEDIS® *Board Certification* measure and the Performance Goal Program (PGP), the Medicaid benchmarks and HEDIS®/CAHPS® percentiles cited in this annual EQR Technical Report originated from the NCQA's 2016 *Quality Compass*® for Medicaid. Scoring percentiles for the HEDIS® *Board Certification* measure and the 2016 Performance Goal Program were derived from the 2015 *Quality Compass*® for Medicaid[26].

In addition to the overall conclusions on the performance of the 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[27].

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 *Excellent* accreditation status from the NCQA as Medicaid Health Plans. Additionally, both Health Plans received an overall rating of four and a half (4.5) out of five (5) for their Medicaid product lines, with both Health Plans earning a four and a half (4.5) and a four (4) for the *Prevention* and *Treatment* categories, respectively.
- In regard to the HEDIS® Effectiveness of Care measures, rates for both Health Plans, as well as the statewide rates, exceeded the 2016 *Quality Compass*® 90th percentile for the *Childhood Immunization Status—Combo 3* and *Childhood Immunization Status—Combo 10* measures. The Health Plans' rates, as well as the statewide rate, were above the 2016 *Quality Compass*® 75th percentile for the *Chlamydia Screening (16-24 Years)* measure, as well.
- The results of the CAHPS® 5.0H survey showed that both Health Plans' rates, as well as the statewide rate, exceeded the 2016 *Quality Compass*® 90th percentile for the *Getting Needed Care* measure.
- For the Prevention and Screening domain of the Performance Goal Program, both Health Plans demonstrated an overall strong performance for the Non-RHE populations. Both Health Plans achieved the 2015 *Quality Compass*® 90th percentile for the HEDIS® *Adolescents Received Immunizations by 13th Birthday* and *Children Received Immunizations by 2nd Birthday (Combo 10)* measures, and the 75th

[26] No national benchmarks were available in *Quality Compass*® 2016 for the HEDIS® *Board Certification* measure. Therefore, the 2016 HEDIS® *Board Certification* rates were compared to the 2015 *Quality Compass*® benchmarks.

[27] For further information, refer to each Health Plan's Annual External Quality Review Technical Report.

percentile for the *Lead Screening in Children* measure. Additionally, Neighborhood and UHCP-RI achieved the 90th and 75th percentiles, respectively, for the following HEDIS® measures: *Children Received Immunizations by 2nd Birthday (Combo 3), Female Adolescents Received HPV Vaccination by 13th Birthday,* and *Weight Assessment and Counseling for Children and Adolescents (BMI Percentile, Nutrition,* and *Physical Activity)*. UHCP-RI and Neighborhood also achieved the 90th and 75th percentiles, respectively for the HEDIS® *Adult BMI Assessment (18-74 Years)* measure.

- Both Health Plans performed well on the Women's Health domain of the Performance Goal Program for the Non-RHE populations. Neighborhood and UHCP-RI achieved the 2015 *Quality Compass*® 90th and 75th percentiles for the HEDIS® *Women Received Cervical Cancer Screening (21-64 Years)* and HEDIS® *Women Received Chlamydia Screening (16-20 Years)* measures, respectively. Additionally, Neighborhood achieved the 90th percentile for the HEDIS® *Women Received Chlamydia Screening (21-24 Years)* measure, while UHCP-RI achieved the 75th percentile.
- In the Chronic Care domain for the Non-RHE populations, both Health Plans achieved the 2015 *Quality Compass*® 90th percentile for HEDIS® *Controlling High Blood Pressure (140/90) (18-85 Years)* and HEDIS® *Comprehensive Diabetes Care—Retinal Eye Exam Performed.* Additionally, both Health Plans met the 75th percentile for the HEDIS® *Medication Management for People with Asthma 75% (5-64 Years)* measure. Neighborhood and UHCP-RI achieved the 90th and 75th percentiles, respectively, for the following HEDIS® measures within this domain: *Pharmacotherapy for COPD Exacerbation—Bronchodilators, Comprehensive Diabetes Care—HbA1c Control (<8.0%),* and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90).*
- For the Non-RHE populations, in regard to the Behavioral Health domain of the Performance Goal Program, both Health Plans benchmarked at the 2015 *Quality Compass*® 75th percentile for the HEDIS® measures *Members 6 Years and Older Get Follow-Up After Hospitalization for Mental Illness—30 Days* and *Adherence to Antipsychotics for Individuals with Schizophrenia*. Additionally, UHCP-RI achieved the 90th percentile for the HEDIS® *Members 6 Years and Older Get Follow-Up After Hospitalization for Mental Illness—7 Days* measure, while Neighborhood met the 75th percentile.
- In the Prevention and Screening domain for the RHE population, both Health Plans achieved the 2015 *Quality Compass*® 90th percentile for the HEDIS® *Adult BMI Assessment (18-74 Years)* measure.
- For the RHE population, in regard to Women's Health, Neighborhood achieved the 2015 *Quality Compass*® 90th percentile for the HEDIS® *Women Received Chlamydia Screening (16-20 Years)* measure, while UHCP-RI met the 75th percentile.
- Both Health Plans performed well overall in regard to the Chronic Care domain for the RHE population. Both Health Plans achieved the 2015 *Quality Compass*® 90th percentile for HEDIS® *Medication Management for People with Asthma 75% (5-64 Years), Pharmacotherapy for COPD Exacerbation—Bronchodilator,* and *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, and the 75th percentile for HEDIS® *Pharmacotherapy for COPD Exacerbation—Corticosteroids.* Additionally, Neighborhood and UHCP-RI achieved the 90th and 75th percentiles, respectively, for the following HEDIS® measures: *Comprehensive Diabetes Care—HbA1c Testing, Comprehensive Diabetes Care—Blood Pressure Control (<140/90),* and *Controlling High Blood Pressure (18-85 Years) (<140/90)*. UHCP-RI achieved the 90th percentile for the HEDIS® *Comprehensive Diabetes Care—Retinal Eye Exam Performed*, while Neighborhood met the 75th percentile.
- In regard to the Behavioral Health domain, both Health Plans achieved the 2015 *Quality Compass*® 75th percentile for the HEDIS® *Antidepressant Medication Management—Effective Acute Phase Treatment* measure for the RHE population.

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 continue to demonstrate poor performance on the *Getting Better* domain of the NCQA accreditation survey, as both received two (2) of four (4) stars for that domain.
- Both Health Plans demonstrated below average performance in regard to the HEDIS® *Board Certification* measure.
- In regard to the Chronic Care domain of the Performance Goal Program, the Health Plans demonstrated opportunities for improvement for both the Non-RHE and RHE populations for two (2) measures: HEDIS® *Use of Imaging Studies for Low Back Pain* and *HIV Viral Load Suppression*.
- The Health Plans demonstrated opportunities for improvement in regard to the Behavioral Health domain of the Performance Goal Program. For the Non-RHE populations, the Health Plans failed to achieve a 2015 *Quality Compass*® benchmark to qualify for an incentive award for the HEDIS® *Antidepressant Medication Management—Effective Acute Phase Treatment* measure. For the RHE population, the Health Plans failed to achieve a 2015 *Quality Compass*® benchmark to qualify for an incentive award for the HEDIS® *Adherence to Antipsychotics for Individuals with Schizophrenia* measure.
- In regard to the Compliance domain of the Performance Goal Program, the Health Plans demonstrated opportunities for improvement for both the Non-RHE and RHE populations. Neither Neighborhood nor UHCP-RI achieved a 2015 *Quality Compass*® benchmark to qualify for an incentive award for the HEDIS® *Call Answer Timeliness* measure. Additionally, neither Health Plan met the *Contract* goal for the State-specified measure *Accurate Submission of Encounter Data—Claims Count*.
- Both Health Plans continue to demonstrate an opportunity for improvement in regard to member satisfaction. Specifically, rates for both Health Plans were at or below the 2016 *Quality Compass*® 50th percentile for both *Customer Service* and *Rating of Personal Doctor.*

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

- Both Health Plans continue to struggle to improve their scores on the *Getting Better* domain of the NCQA Accreditation Survey. The Health Plans should conduct measure-level analyses to determine the key drivers that are affecting this domain and implement interventions to improve these measures.
- The Health Plans should work to enhance their recruitment strategies for the purposes of recruiting more board-certified physicians into their networks, as both Health Plans continue to demonstrate below average performance on the HEDIS® *Board Certification* measure.
- As both Health Plans failed to meet *Contract* goal for the *HIV Viral Load Suppression* measure, the Health Plans should consider utilizing supplemental data sources or medical record reviews to determine if some encounters were not included in the rates. Additionally, as the Health Plans continue to struggle with the HEDIS® *Use of Imaging Studies for Low Back Pain* measure, the Health Plans should reevaluate their current strategies aimed at educating providers and members on the use of these imaging studies. Since both Health Plans have identified Emergency Departments and Urgent Care Centers as the highest utilizers of imaging studies for low back pain, the Health Plans should target these two (2) provider types for targeted interventions regarding this measure.
- The Health Plans should collaborate with their respective Behavioral Health vendors to address the *Antidepressant Medication Management—Effective Acute Phase* and *Adherence to Antipsychotics for Individuals with Schizophrenia* measures in order to develop effective and meaningful interventions to improve these rates.
- As neither Health Plan met the *Contract* goal for *Accurate Submission of Encounter Data—Claims Count*, the Health Plans should reevaluate their processes for obtaining, aggregating, and reporting claims data to ensure that data are accurate and complete.

- As both Health Plans continue to demonstrate an opportunity for improvement in regard to the *Customer Service* measure of the CAHPS® survey, the Health Plan should conduct an analysis of this measure to determine the root causes of the below average performance, taking into consideration that the Health Plans' below average performance for the HEDIS® *Call Answer Timeliness* may be a factor. Additionally, the Health Plans should conduct an analysis to determine root causes for the below average performance on the CAHPS® *Rating of Personal Doctor* measure.

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 continued to receive *Excellent* ratings on the *Access and Service* domain of the NCQA Accreditation survey. Additionally, both Health Plans met all or most of their established GeoAccess standards for primary care and specialty providers.
- In regard to the HEDIS® Access to/Availability of Care measures, both Neighborhood and UHCP-RI achieved the 2016 *Quality Compass*® 90th percentile for the *Children and Adolescents' Access to PCPs* and *Adults' Access to Preventive/Ambulatory Health Services* for the following age groups: *7-11 Years, 12-19 Years,* and *65+ Years*. The Health Plans also met the 75th percentile for the *25 Months-6 Years* age group. Additionally, both Health Plans achieved the 2016 *Quality Compass*® 90th percentile for the *Timeliness of Prenatal Care* measure, while Neighborhood and UHCP-RI achieved the 90th and 75th percentiles, respectively, for the *Timeliness of Postpartum Care* measure.
- The Health Plans performed well in regard to the HEDIS® Use of Services measures. Both Health Plans' rates benchmarked at the 2016 *Quality Compass*® 90th percentile for the *Well-Child Visits in the First 15 Months of Life (6+ Visits)* and *Frequency of Ongoing Prenatal Care (81+%)* measures, and the 75th percentile for the *Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life* and *Adolescent Well-Care Visits* measures.

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 managed care program demonstrated the following opportunities for improvement:

- Both Health Plans continued to demonstrated opportunities for improvement in regard to the Access to Care domain of the Performance Goal Program for the RHE population. Neither Neighborhood nor UHCP-RI achieved a 2015 *Quality Compass*® benchmark to qualify for an incentive award for the following HEDIS® measures within this domain: *Adults Had Ambulatory/Preventive Care Visit (20-44 Years), Adults Had Ambulatory/Preventive Care Visit (45-64 Years), Pregnant Members Received Timely Prenatal Care*, and *Postpartum Members Received Timely Postpartum Care*.

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

- Because the Health Plans continue to struggle with certain measures related to access to care for members of the RHE population, the Health Plans should conduct population-specific root cause analyses for these measures. This will allow the Health Plans to identify barriers to care specific to the RHE members that can be addressed with targeted interventions.

Quality Improvement Program

The overall strengths of each of the Health Plans' 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 2015/2016, each Health Plan engaged in at least 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 2015/2016 quality improvement activities were mixed across projects and health Plans: some performance measures demonstrated improvement, whereas others 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 2016. 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, and State monitoring visit findings, as well as the EQR Technical Report. Information regarding these is detailed below.

2016 Performance Goal Program/On-Site Monitoring Feedback

EOHHS issued the results of the 2016 PGP to the Health Plans in June 2016, accompanied by a cover letter containing commendations for the Health Plans' accomplishments and improvement 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) 2015 EQR Technical Report Feedback

During December 2016, a separate correspondence was sent by the State in conjunction with the transmittal of the EQR Technical Report, which focused on RY 2015. 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 2016 regarding the RY 2015 EQR Technical Report, as well as any recommendations issued by the EQRO.

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APPENDIX 1: Rhode Island Comprehensive Quality Strategy—December 2014[1]

I. Introduction

The goal of the Rhode Island Executive Office of Health and Human Services (EOHHS) and of the Rhode Island Medicaid Program is to be a catalyst for the Triple Aim and the Department of Health and Human Services (DHHS) National Quality Strategy by providing eligible beneficiaries with services that are ***accessible, of high quality, and promote positive health outcomes in a cost efficient and effective manner.*** The goals and objectives discussed in further detail below demonstrate Rhode Island's quality approach and efforts to advance the following National Quality Strategy priorities:

- Patient Safety
- Person and Family Centered Care
- Effective Communication & Care Coordination
- Prevention and Treatment
- Health and Well Being
- Affordable Care

Rhode Island's *Comprehensive Quality Strategy* (CQS) for its Comprehensive Section 1115 Demonstration (Demonstration) builds on the State's initial framework for continuous quality improvement, *Strategy for Assessing and Improving the Quality of Managed Care Services Offered Under RIte Care*. This seminal framework was one of the first of its kind in the United States, was approved by the Centers for Medicare and Medicaid Services (CMS) in April 2005, and focused on Rhode Island's first capitated Medicaid managed care program, RIte Care.

The Comprehensive 1115 Demonstration was built upon the following three fundamental goals:

- Prevent or delay growth in the population eligible for Medicaid
- Reform Rhode island Medicaid's long-term care system
- Use administrative flexibility to operate more efficiently, through the application of care management systems, and links to "medical homes"

These goals are based on a commitment by the State to incorporate the following principles in the Rhode Island Medicaid program:

Consumer Empowerment and Choice with the provision of more information about the health care delivery system to that consumers can make more reasoned and cost-effective choices about their health care.
Community-Based Solutions so that individuals may live and receive care in the communities in which they live, a more cost-effective and preferable approach to the institutional setting.
Prevention, Wellness, and Independence initiatives to reduce the incidences of illness and injuries and their associated costs.
Value-Based Purchasing by linking provider reimbursement to the provision of quality and cost-effective care.
Integrated Physical and Behavioral health
Care Coordination and Care Management efforts focused on the highest utilizers of care.
Attention to the Social Determinants of Health
Improved Technology that assists decision-makers, consumers, and providers so that they may make the most informed and cost-effective decisions regarding the delivery of health care.

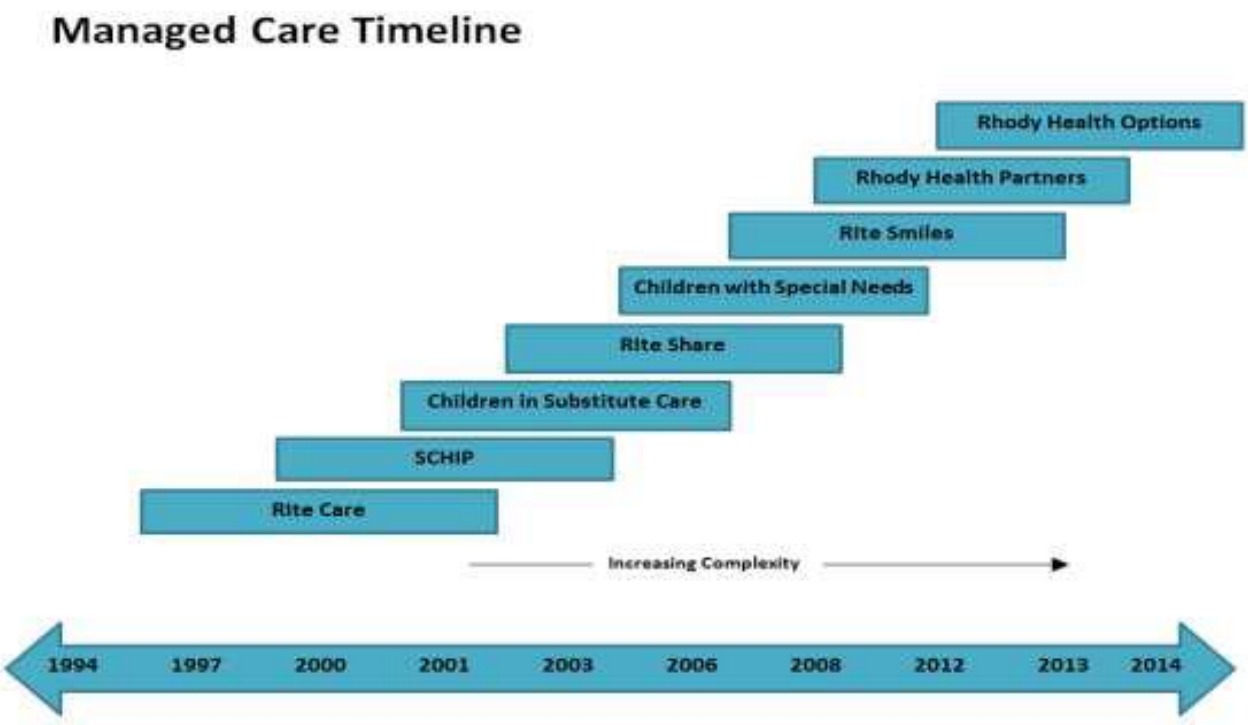
[1] The Quality Strategy included in this appendix was submitted by EOHHS in December 2014.

Through the Comprehensive 1115 Demonstration, Medicaid-funded services on the continuum of care are now organized, financed, and delivered through a single demonstration.[2] This approach provides the infrastructure by which the State can implement a quality strategy that allows for measurement of specific goals and objectives across all Medicaid delivery systems. In effect, the Comprehensive 1115 Demonstration sets forth a strategic approach for reforming the Medicaid program to build a more responsive and a more accountable program that serves Medicaid beneficiaries with the ***right services, in the right setting, and at the right time.***

A. Managed Care Goals and Objectives

Rhode Island has utilized managed care as a strategy for improving access, service integration, quality and outcomes while effectively managing costs. Within this strategy are integral core components, objectives and measurement strategies to ensure a robust oversight and monitoring framework.

As Figure 1 below shows, Rhode Island initiated its Medicaid managed care program twenty years ago (beginning in 1994) with the launch of the RIte Care program, a Medicaid managed care program for children and families and pregnant women. Rhode Island has embraced managed care as a core strategy to meet these goals. Over subsequent years, additional populations with more complex needs have been progressively enrolled in managed care programs.



[2] Excluded from the Demonstration are: (1) disproportionate share hospital (DSH) payments; (2) administrative expenses; (3) phased-Part D contributions; and (4) payments to local education agencies (LEA) for services that are furnished only in a school-based setting, and for which there is no third party payer.

Key Milestones:

- **Initiation of RIte Care**
  The State's initial Medicaid managed care program, RIte Care, began in August 1994, enrolling over 70,000 low-income children and families and pregnant women. A key contractual element was the "mainstreaming" provision, requiring that managed care organizations (MCOs, or Health Plans) must ensure that if a provider accepted enrollees from commercial lines of business, they must also accept RIte Care enrollees without discrimination. The number of providers participating in RIte Care Health Plan networks represented marked expansion with primary care provider participation in Medicaid more than doubling. Physician visits more than doubled by June 1998.

- **SCHIP and Coverage Expansions**
  Effective November 1, 1998, RIte Care expanded to families with children under 18 including parents and relative caretakers with incomes up to 185% of the Federal poverty level (FPL). Effective July 1, 1999, RIte Care expanded to cover children up to age 19 in households with incomes up to 250% of the FPL. The passage of Federal legislation establishing the State Child Health Insurance Program (SCHIP) with enhanced Federal match was key to this expansion.[3]

- **Voluntary Enrollment of Children in Substitute Care Arrangements**
  Beginning in December 2000, the State began to transition children in Rhode Island Department of Children, Youth, and Families- (DCYF-) sponsored substitute care arrangements (also referred to as foster care) from fee-for-service (FFS) Medicaid to RIte Care.

- **RIte Share Initiated – Leveraging Employer Sponsored Coverage**
  RIte Share, the State's premium assistance program, was implemented beginning in February 2001 for RIte Care-eligible children and families. Whenever a RIte Care-eligible beneficiary is eligible for other third-party coverage (e.g. employer-sponsored insurance), the case is evaluated for the "cost effectiveness" of the State paying the employee's share of employer coverage rather than enrolling that family in RIte Care.

- **Enrollment of Children with Special Health Care Needs**
  Enrollment of this special needs population into a MCO was initiated in September 2003 on a voluntary basis. In the fall of 2008, enrollment in a MCO became mandatory for Children with Special Health Care Needs (CSHCN) who did not have another source of insurance coverage. Rhode Island defines CSHCN as: The blind and disabled up to the age of twenty-one and eligible for Medical Assistance on the basis of SSI, children eligible under Section 1902(e) (3) of the Social Security Administration (SSA) up to nineteen years of age "Katie Beckett", children up to the age of twenty-one receiving subsidized adoption assistance, children in substitute care "Foster Care".

- **RIte Smiles – Managed Dental Benefit for Children**
  Beginning in May 2006, Rhode Island implemented RIte Smiles, a managed dental benefit for children born on or after May 1, 2000.

- **Rhody Health Partners – Managed Care for "Medicaid-Only" Adults with Disabilities**
  In the past, Rhode Island's adult aged, blind, and disabled (ABD) populations were provided services through the Medicaid fee-for-service (FFS) system. In 2008, voluntary enrollment in Rhody Health

[3] As of State Fiscal Year (SFY) 2014 eligibility for parents and relative caregivers in RIte Care was reduced from 175% of the FPL to 138% of the FPL.

Partners was implemented. In the fall of 2009, all Medicaid-eligible ABD adults without third-party overage were required to either enroll in a Health Plan through the Rhody Health Partners program, or in the State's FFS Primary Care Case Management (PCCM) program, Connect Care Choice (CCC).

- **Rhody Health Options and Connect Care Choice Community Partners-Managed Long Term Services and Support for "Medicaid Only" and "Dual Eligible" Beneficiaries**
  In 2013, Rhode Island Medicaid began the integration of long term services and supports into its managed care delivery systems, including the primary care case management model. Effective November 1, 2013, Medicaid-only adults receiving long term services and supports and Dual Eligibles were given the option to enroll in an MCO. Long term care eligible beneficiaries now have an option to enroll in an MCO, the State's Primary Care Case Management Program, PACE (Program All Inclusive for the Elderly) and/or Medicaid FFS.

Table 1: Enrollment (as of September, 2014) in each of these programs has been provided below[4]:

Children & Families					Adults			Adults & LTSS***			
Children < 21 years of age, pregnant woman, and families					Adults with disabilities >21 years of age		Adults >21 years of age	Adults with disabilities < 65 With LTSS*		Adults > 65 years of age with & without LTSS*	
RIte Care	Rite Share	Children with Special Health Care Needs (CSN)	Children in Substitute Care**	Rite Smiles	Rhody Health Partners	Connect Care Choice	Rhody Health Partners (Expansion)	Rhody Health Options	Connect Care Choice Community Partners	Rhody Health Options	Connect Care Choice Community Partners
MCO 133,149	MCO 9,455	MCO 6,882 FFS 2,639	MCO 2,143 FFS 217	MCO 76,215	MCO 13,934	PCCM 4,736	MCO 48,321 FFS 4,105	MCO 466	PCCM 705	MCO 16,696	PCCM 4,259

* Long Term Services and Supports
**Includes Former Foster Children up to 26 years of age "Chafee Children"
***There are a total of 7,987 not enrolled in either program as of 9/30/2014.

The overarching goal of Rhode Island's managed care program is to increase access to and improve the quality of care for Medicaid families eligible for the Demonstration by:

- Providing all enrollees in the Demonstration with a *medical home*
- Increasing the appropriate use of inpatient hospitals and hospital emergency departments
- Improving access to health care for populations eligible for the demonstration
- Reducing infant mortality and improving maternal and child health outcomes
- Expanding access to health coverage to all eligible pregnant women and all eligible uninsured children
- Reducing un-insurance in the expansion population groups eligible for the Demonstration
- Ensuring a high satisfaction level among enrolled populations

[4] These enrollment figures represent a point-in-time snapshot as of 09/30/14.

Table 2: Managed Care Objectives (Abstracted from Rhode Island's Section 1115 Evaluation Design)		
Objective	**Data Source(s)**	**Illustrative Measure(s)**
The rate of un-insurance in the expansion population groups eligible for the Demonstration will be reduced as a result of this Demonstration	• Current Population Survey (CPS) • Behavioral Risk Factor Surveillance Survey (BRFSS)	• Percent of Rhode Island population that is uninsured
All enrollees in the Demonstration will have a *medical home*	• Encounter Data System • HEDIS®	• Practice participation in multi-payer medical home initiative • Primary care practitioner (PCP) assignment • Child and Adolescent to PCPs • Adult Access to Prev./Ambulatory Health Services
Access to health care for populations eligible for the Demonstration will be improved	• HEDIS®[5]	• Child and Adolescent Use of PCPs • Adult Use of Prev./Ambulatory Health Services • Well-Child Visits • Adolescent Well-Care Visits • Prenatal and Postpartum care • Frequency of Ongoing Prenatal Care
The appropriate use of inpatient hospitals and hospital emergency departments will increase.	• Encounter Data System	• Use of hospital EDs for ambulatory-sensitive conditions • Potentially preventable re-admissions • Hospital admission rates
The rate of infant mortality in the State will be reduced during the course of this Demonstration	• Vital Statistics	• Infant mortality rate per 1,000 live births • Post-neonatal mortality rate per 1,000 live births
Maternal and child health outcomes for populations enrolled in the Demonstration will improve.	• Vital Statistics	• Month of entry into prenatal care • Adequacy of prenatal care • Maternal smoking • Interbirth interval • Percent low birth weight births
Populations enrolled in the Demonstration will have a high level of satisfaction with the Demonstration.	• CAHPS®[6] • Complaints, Grievances, and Appeals	• Rating of All Health Care • Rating of Health Plan • Getting Care Quickly • Getting Needed Care • Overall Satisfaction with RIte Care • Satisfaction with Health Plan • Ability to Receive Timely Care • Number of complaints, grievances, and appeals by type

[5] HEDIS® (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA). The State expects to follow the annual specifications in HEDIS® for these measures.

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

In order to meet the objective of increased access and improved health outcomes, Rhode Island's managed care delivery system includes the following:

- Establishment of an Accountable Entity—The State's contract with an MCO establishes a performance-based business relationship and a means of enforcing standards.
- Defined Required Performance Standards through MCO Contract—This is the means by which the State defines what it believes to be the essential features of an effective health services delivery system for enrolled Medicaid populations.
- Oversight and Monitoring—The State's active oversight and monitoring or performance is critical to understanding and ensuring performance by the MCO.
- Ensure Adequate/Appropriate Funding—Federal regulatory financing requirements and states employ a variety of mechanisms to ensure adequate funding along with responsible stewardship of public funds and a proper alignment of incentives.

In addition to the performance standards outlined in **Sections II** and **III** of this document, Rhode Island has continually used data to drive a number of quality improvements and cost containment efforts.
Below are a few examples of efforts implemented by Rhode Island (RI) Medicaid.

Communities of Care Program

Rhode Island received a Federal grant to develop alternative strategies to reduce avoidable Emergency Room (ER) use. After a thoughtful analytic process, EOHHS developed and implemented the Communities of Care (CoC) program. Health Plans are now required to administer a CoC program which is designed to reduce unnecessary and avoidable ER visits for Medicaid recipients with high ER use (i.e., four or more ER visits within a twelve month period). The CoC program consists of three key components: (1) enriched care management and peer navigation supports to educate and assist members to access alternatives to ERs, when appropriate; (2) designated providers to serve members who use multiple providers or have complex medical conditions; and (3) a Healthy Rewards Program to provide incentives that promote members' participation in the health care program. CoC was implemented in November 2010 in the two Health Plans serving Medicaid recipients and in April 2011 in Connect Care Choice. The CoC program can be seen as an initial super utilizer strategy and continues to be an integral part of the Medicaid program's overall approach to super utilizers. In addition to the CoC program, the MCOs have been developing Health Plan-specific super utilizer strategies focused on high cost utilizers, mainly individuals whose annual healthcare costs are equal to $15,000. This includes 6,800 adults enrolled in Rhody Health Partners, 1,299 adults enrolled in RIte Care, and 1,388 children enrolled in RIte Care as of June 2014. Most the identified "high utilizers" have re-occurring behavioral health condition, either primary or secondary diagnosis. EOHHS works collaboratively with the Health Plans to provide all necessary support and technical assistance in the implementation of these efforts.

A preliminary evaluation design for CoC program includes the following metrics:

- Engagement and Assignment in the CoC program among Continuously Enrolled Members
- Change in ER Utilization Rate Adjusted for Level of Care, Program Engagement, Assignment, and Participation in Care Management as a function of Enrollment
- Change in ER Utilization Rate (Pre vs. Post Enrollment) by Engagement Status[7] among all CoC Enrollees
- Change in Total Medical Expenses (Pre vs. Post Enrollment) by Engagement Status among all CoC Members Enrolled in RIte Care and Rhody Health Partners
- Change in ER Utilization Rate (Pre vs. Post Enrollment) by Engagement Status and Population
- Change in ER Utilization Rate (Pre vs. Post Enrollment) by Engagement Status and Level of Care

[7] Engagement status is defined by the proxy measure of a returned emergency room survey.

Extension of the Generic First Pharmacy Policy and Pharmacy Home Program

Health Plans are required to implement policies and procedures that promulgate the Generic First Policy across all Medicaid populations, including Children with Special Health Care Needs, Children in Substitute Care, Rhody Health Partners, and Rhody Health Options members. In addition, health Plans are required to establish a Medicaid Pharmacy Home Program for all populations to restrict members whose utilization of prescriptions is documented as being excessive. Members are "locked-in" to a specific pharmacy in order to monitor prescriptions received and reduce unnecessary or inappropriate utilization. This program is intended to prevent members from obtaining excessive quantities of prescription medications through multiple visits to multiple pharmacies.

Medicaid Expenditures

In addition to the above examples of ongoing quality improvement and cost containment efforts, Rhode Island Medicaid produces an annual Medicaid Expenditure report. The data and information included in this annual Medicaid expenditure report, includes but is not limited to the following:

- Providing an overview of Medicaid Expenditures by eligible population served (elders, adults with disabilities, adults, children and families, and children with special health care needs)
- Enrollment and expenditure trends by service type, provider type, and delivery mechanism
- Optional services used to reduce expenditure for mandatory services
- Overall utilization rates, including the identification of high cost users

The data and information provided by the Medicaid Expenditure report, in addition to the following reports are examples of how data can be used to identify programmatic opportunities, cost saving initiatives, and ultimately drive system change:

- Medicaid Program Indicator Report[8]
- Monthly operational reports specific to children with special health care needs programs (CEDARRs, Katie Beckett, Respite, RIte Share, Info Line, SSI Recertification, and Early Intervention)
- Analytic Claims Extract (ACE Report)[9]
- Quarterly Health Plan Reports

B. RIte Smiles (Dental Benefit Management Program)

RIte Smiles was designed to increase access to dental services, promote the development of good oral health behaviors, decrease the need for restorative and emergency dental care, and decrease Medicaid expenditures for oral health care. To achieve these goals, Rhode Island transitioned from functioning simply as a payer of services to becoming a purchaser of a new oral health delivery system, a dental benefit manager (DBM) program provided by United Healthcare-Dental. Among other responsibilities, the DBM program was charged with:

- Ensuring a robust network beyond safety-net providers and inclusive of specialty providers
- Access to care and services especially for children with special health care needs
- Increased preventive dental care and services
- Increased the number of children between ages 6-9 who received a sealant on a molar

[8] The Medicaid Program Indicator Report is a monthly report comprised of budget, enrollment, and utilization indicators across Medicaid Managed Care and components of the Medicaid FFS program such as neonatal intensive care unit (NICU).
[9] This quarterly report serves as a comprehensive extract of MMIS data across the Medicaid program.

In order to restructure the Medicaid dental benefit for children from fee-for-service to a Dental Benefit Manager (DBM), Rhode Island obtained a Section 1915(b) waiver specifically to implement the RIte Smiles Prepaid Ambulatory Health Plan (PAHP) dental waiver. As proposed, the following categories of children on Medicaid born on or after May 1, 2000 would be enrolled in RIte Smiles on a mandatory basis and receive all their Medicaid dental benefits through the DBM:

- Low-income children
- Blind and disabled children
- Children in substitute care

Effective January 16, 2009, RIte Smiles was incorporated into the 1115 Demonstration, with all of its Section 1915(b) waivers and other requirements intact. Excluded from enrollment in RIte Smiles, and therefore continuing to obtain their dental benefits through Medicaid fee-for-service if applicable would be the following groups of children on Medicaid: (1) those with other insurance; (2) residents of nursing facilities and ICF/MR; and (3) children in substitute care residing outside Rhode Island. A listing of important development dates for RIte Smiles follows.

The developmental timeline for RIte Smiles was as follows:

- December 2005 – The State submitted Section 1915(b) Waiver Application to CMS
- December 23, 2005 – The State issued Bid Specifications Document (RFP # B05923) for Dental Benefit Management (DBM)
- February 2, 2006 – State issued Addendum #1 to RFP # B05923
- February 17, 2006 – The State set the due date for submittal of proposals in response to RHP #B05923; two proposals were received
- April 1, 2006 – Section 1915(b) waiver authority was received from CMS
- May 2006 – State's contract with united Healthcare Dental/RIte Smiles was effective
- September 1, 2006 – After determining adequate DBM readiness, the initial group of 10,000 children was enrolled statewide into RIte Smiles
- October 1, 2006 – A second geographic group was enrolled
- November 1, 2006 – the third and final region with active waiver-eligible Medicaid recipients were enrolled.

To increase access to dental care for children on Medicaid, the RIte Smiles program had to address issues of: (1) reimbursement for dental providers, (2) workforce capacity, and (3) provider education and training. The programmatic strategies used to address these issues are as follows:

- **Reimbursement and Workforce Capacity**—Prior to RIte Smiles the number of Medicaid-participating providers was very limited. The State reasoned that if the Medicaid reimbursement level were increased that it would increase the likelihood that more dental providers would participate in Medicaid. Therefore, the DBM was charged with increasing Medicaid reimbursement rates to be

closer to commercial preferred provider organization (PPO) rates. Under the RIte Smiles, the DBM is also required to establish and maintain a network of participating dental providers.

It should also be mentioned that to the increase the number of private dentists providing oral health services to children on Medicaid, additional efforts have been taken to address oral health workforce capacity. These efforts include: strengthening the dental services infrastructure of Rhode Island's dental safety net providers; enhancing Medicaid reimbursement for hospital based dental centers; implementing recruitment and retention strategies for dental professional (dentists, dental hygienists, and dental assistants); strengthening school-linked dental services and dental centers; increasing training of pediatric dentists, general dentists, and dental assistants in Rhode Island; and increasing oral health education programs.

- **Provider Education and Training**—The first enrollees in the RIte Smiles program were children under age six. It was recognized that to improve access to dental care for young children, providing training on the topic of delivering oral health care services to very young children would be beneficial to Rhode Island dental professionals. To this end, the Rhode Island Department of Health, St. Joseph's Health Services, Central Rhode Island Area Health Education Center (criAHEC), and the Samuels Sinclair Dental Center at Rhode Island Hospital partnered to offer an annual "Mini-Residency Series." Each mini-residency within the series featured national expert faculty at two-day continuing education programs targeting Rhode Island's oral health professionals.

Table 3 shows the quality design for RIte Smiles.

Table 3

RIte Smiles Quality Design

Data Collection Method	Type of Method	Performed By
Administrative data, as set forth annually by the NCQA.	The HEDIS® methodology: *Annual Dental Visit (ADV)* measure.	UHC Dental
One Quality Improvement Project (QIP)	PDSA (Plan->Do->Study->Act) Methodology developed by RI Medicaid, based upon the Performance Improvement Work plan developed by the State of NH DHHS, Division of Public Health (May 2006).	UHC Dental
Informal Complaints, Grievances, and Appeals	Informal complaints reports are submitted electronically in a spreadsheet template established by RI Medicaid.	UHC Dental
Member Satisfaction Survey	Mailed survey written in English and Spanish focusing on access to	RI Medicaid

Data Collection Method	Type of Method	Performed By
	services, use of services, customer service, and satisfactions with service.	
Dental-specific components of the CMS 416	Analysis of paid claims and enrollment data for beneficiaries through the 20th year of life, to address the following: (1) Total eligibles receiving any dental services; (2) Total eligibles receiving preventive dental services; (3) Total eligibles receiving dental treatment services.	RI Medicaid
Network Adequacy Assurance	The following measurements will be analyzed to assess access to preventive and specialty dental services: Informal complaints; grievances and appeals; network provider additions & terminations reports; and GeoAccess data.	RI Medicaid
Locus of Care Analysis	Locus of care information (site of care: FQHC; hospital-based practice; solo or group office-based practice) will be analyzed to determine whether ambulatory dental care services have shifted toward solo or group office-based settings.	RI Medicaid
Periodic Medicaid Provider Comparison	Network enrollment by provider type will be compared to the State's pre-RIte Smiles Medicaid participating provider enrollment.	RI Medicaid

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.

A