Rhode Island Medicaid Managed Care Program (Aggregate Report)

Annual External Quality Review Technical Report Reporting Year 2018

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 each 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 applicable eligibility groups (Core RIte Care, RIte Care for Children with Special Health Care Needs (CSHCN), RIte Care for Children in Substitute Care[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 includes Medicaid-eligible adults, ages nineteen (19) to sixty-four (64), who are not pregnant, not eligible for Medicare Parts A or B, and are not otherwise eligible for mandatory coverage under the State plan. As members of the Health Plans, each of these populations were included in all measure calculations, where applicable. For comparative purposes, results for 2016 and 2017 are displayed when available and appropriate. The framework for this assessment is based on the guidelines established by the CMS EQRO protocols, as well as State requirements.

In addition to the individual, Health Plan-specific Technical Reports that detail IPRO's independent evaluation of the services provided by each of the three (3) Health Plans (Neighborhood Health Plan of Rhode Island, Inc. (Neighborhood), UnitedHealthcare Community Plan of Rhode Island (UHCP-RI), and Tufts Public Health Plan (Tufts)[3]), 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 Medicaid managed care Health Plans in Rhode Island for Reporting Year 2018, and compares and contrasts the individual performance of the Health Plans.

The benchmarks and HEDIS®[4] percentiles for Medicaid Health Plans cited in this annual EQR Technical Report originated from the National Committee for Quality Assurance's (NCQA) *Quality Compass*®[5] 2018 for Medicaid, with the exception of those shown for the 2018 Performance Goal Program (PGP). Scoring percentiles for the PGP were derived from *Quality Compass*® 2017.

Corporate Profiles

The Rhode Island Medicaid managed care program was comprised of three (3) Health Plans in 2018: Neighborhood served Medicaid and Commercial populations; UHCP-RI served Medicaid, Medicare, and Commercial populations; and Tufts served the Medicaid population (refer to Table 1 on page 9). All three (3) Health Plans served the Core RIte Care, RIte Care for Children with Special Health Care Needs, Rhody Health Partners, and Rhody Health Expansion populations. Neighborhood is the only Health Plan that served the RIte Care for Children in Substitute Care and Rhody Health Options populations.

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1 Neighborhood is the only Health Plan that serves the Children in Substitute Care population.
2 Neighborhood is the only Health Plan that serves the Rhody Health Options population.
3 Tufts began enrollment in the Medicaid product line in 2017; therefore, data for many of the elements contained in this report were unavailable for Reporting Year 2018.
4 HEDIS® (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA).
5 *Quality Compass*® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Accreditation

Both Neighborhood and UHCP-RI continued to receive an *"Excellent"* accreditation status from the NCQA for their Medicaid product lines in 2018. Because Tufts did not begin enrollment in the Medicaid product line until 2017, the Health Plan was unable to report sufficient data to be eligible for NCQA Accreditation for Reporting Year 2018 (refer to Table 2 on page 12). Based on the Accreditation Standards scores, as well as the Health Plans' HEDIS® and CAHPS®[6] results for 2018, both Neighborhood and UHCP-RI earned an overall rating of four and a half (4.5) out of five (5) as Medicaid Health Plans. Again, Tufts was unable to report sufficient data to be eligible for a Health Plan rating (refer to Table 3 on page 13).

Enrollment

The three (3) Health Plans varied in the proportion of the statewide Medicaid population served. According to Medicaid enrollment data for the period ending on December 31, 2018, sixty-three percent (63%) of the overall Medicaid population was enrolled in Neighborhood, a total of 170,831 members. UHCP-RI's Medicaid enrollment accounted for approximately thirty-four percent (34%) of total Medicaid membership, with 90,823 members, while the remaining two percent (3%) were enrolled in Tufts, with a total of 9,438 members (refer to Table 4a on page 14).

Provider Network

GeoAccess software was used to evaluate the adequacy of the Health Plans' provider networks. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed. Each Health Plan developed access criteria that complies with the State's July 2018 *Medicaid Managed Care Services Contract* based on Health Plan-specific criteria. Both Neighborhood and UHCP-RI exceeded their respective access standards for all provider types reported (refer to Table 5 on page 16).

HEDIS® and CAHPS® Performance Measures

The assessment of Health Plan performance on HEDIS® 2018 is based on comparisons to the *Quality Compass*® 2018 national Medicaid benchmarks and percentiles. Statewide rates were calculated by totaling the numerators and denominators for Neighborhood and UHCP-RI, as Tufts was unable to report sufficient data for HEDIS® 2018.

For the HEDIS® Effectiveness of Care domain, which assesses preventive care and care for chronic conditions, both Health Plans performed similarly across the measures. Both Health Plans achieved the 2018 *Quality Compass*® 90th percentile for the following measures: *Follow-Up After Hospitalization for Mental Illness—30 Days*, *Follow-Up After Hospitalization for Mental Illness—7 Days*, and *Childhood Immunization Status—Combination 10*. Statewide rates for these three (3) measures also achieved the 90th percentile benchmark. Neighborhood also achieved the 90th percentile benchmark for the *Childhood Immunization Status—Combination 3* and *Cervical Cancer Screening* measures, as did the statewide rate; UHCP-RI's rates for these measures benchmarked at the 75th percentile. For the *Chlamydia Screening* measure, all three (3) rates benchmarked at the *Quality Compass*® 75th percentile. Only UHCP-RI reported a rate for the *Comprehensive Diabetes Care—HbA1c Testing* measure that ranked at the 75th percentile, and all three (3) rates for the *Medication Management for People with Asthma 75% (5-64 Years)* measure were reported below the 75th percentile (refer to Figure 2 on pages 23-25).

The HEDIS® Access and Availability domain evaluates the proportions of members who access PCPs, ambulatory services, and preventive care, as well as timely perinatal care. Neighborhood reported rates above the 2018 *Quality Compass*® national Medicaid mean for all nine (9) measures included in this domain, while UHCP-RI's rates, as well as the statewide rates, were reported above the mean for eight (8) of the nine (9) measures. All three (3) rates achieved the 2018 *Quality Compass*® 90th percentile benchmark for the *Timeliness of Prenatal Care* and *Timeliness of Postpartum Care* measures, and the 75th percentile benchmark for the *7-11 Years* and *12-19 Years* age groups of the *Children and*

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

Adolescents' Access to Primary Care Practitioners measures. For the remaining measures included in this domain, all three (3) rates were reported below the 75th percentile (refer to Figure 3 on pages 27-29).

For the HEDIS® Use of Services domain, rate for both Health Plans, as well as the statewide rates, exceeded the 2018 *Quality Compass*® national Medicaid mean. Additionally, all three (3) rates reported for the *Well-Child Visits in the First 15 Months of Life—6+ Visits* measure benchmarked at the *Quality Compass*® 90th percentile, while all three (3) rates benchmarked in the 75th percentile for the *Adolescent Well-Care Visits* measure. For the *Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life* measure, UHCP-RI's rate and the statewide rate benchmarked at the 75th percentile, while Neighborhood's rate ranked below the 75th percentile (refer to Figure 4 on page 31).

Performance on the adult CAHPS® survey varied across measures and Health Plans. Rates for five (5) of the ten (10) reported measures were above the 2018 *Quality Compass*® national Medicaid mean for both Health Plans, as well as for the statewide rates. Neighborhood reported a rate above the 2018 *Quality Compass*® 90th percentile for one (1) measure and the 75th percentile for four (4) measures, while UHCP-RI's rates for five (5) measures benchmarked at the 75th percentile. Statewide rates for two (2) measures benchmarked at the 75th percentile for 2018, as well (refer to Figure 5a on pages 33-35).

In 2018, Neighborhood conducted the child CAHPS® survey for the Chronic Conditions population while UHCP-RI conducted the survey for the General population. Regarding Neighborhood's child CAHPS® survey results, rates for four (4) of seven (7) measures exceeded the 2018 *Quality Compass*® national Medicaid mean. Neighborhood reported a rate above the 2018 *Quality Compass*® 90th percentile for one (1) measure and the 75th percentile for one (1) measure. The remaining five (5) rates were below the 75th percentile. UHCP-RI's rates for five (5) of six (6) measures exceeded the 2018 *Quality Compass*® national Medicaid mean. UHCP-RI achieved the 95th percentile for one (1) measure and the 75th percentile for one (1) measure. The remaining four (4) rates were below the 75th percentile.

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 have been established as the basis for incentive awards.

For Reporting Year 2018, the following performance categories were used to evaluate Health Plan performance:

- *Utilization*
- *Access to Care*
- *Prevention and Screening*
- *Women's Health*
- *Chronic Care*
- *Behavioral Health*

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., *Developmental Screening in the First Three Years of Life* and *HIV Viral Load Suppression*).

For the 2018 Performance Goal Program, there were two (2) State-specified measures and twenty-one (21) HEDIS® measures, resulting in a total of twenty-three (23) PGP measures. Regarding the State-specified measures, Neighborhood exceeded the *Contract* goal qualifying for a full incentive award for one (1) measure and exceeded the *Contract* goal qualifying for a partial incentive award for the second measure. UHCP-RI exceeded the *Contract* goals qualifying for partial incentive awards for both State-specified measures.

Of the twenty-one (21) HEDIS® measures included in the 2018 Performance Goal Program, UHCP-RI exceeded a *Quality Compass*® benchmark qualifying for an incentive award for thirteen (13) out of twenty-one (21), with seven (7) measures exceeding the 90th percentile and six (6) exceeding the 75th percentile. The remaining eight (8) measures did not meet a *Quality Compass*® benchmark to qualify for incentive awards. Neighborhood exceeded a *Quality Compass*® benchmark qualifying for an incentive award for twelve (12) out of twenty-one (21), with eight (8) measures exceeding the 90th percentile and four (4) exceeding the 75th percentile. The remaining nine (9) measures did not meet a *Quality Compass*® benchmark to qualify for incentive awards (refer to Table 7 on page 41).

Conclusions and Recommendations

IPRO's external quality review concludes that the Rhode Island Medicaid managed care program and its participating Health Plans have had an overall positive impact on the accessibility, timeliness, and quality of services for Medicaid recipients. This is supported by both Neighborhood and UHCP-RI receiving *"Excellent"* accreditation statuses from the NCQA for 2018, as well as the Health Plans' four and a half (4.5) out of five (5) ratings. Overall strengths continue to be women's health and perinatal care, childhood immunizations, diabetes care, and follow-up care for members post-discharge from psychiatric care.

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

<u>Quality of Care:</u>

- NCQA Accreditation Survey:
  - *Getting Better*
- Member Satisfaction:
  - Child CAHPS® *Rating of Personal Doctor*
  - Children with Chronic Conditions CAHPS® *Getting Care Quickly*
  - Children with Chronic Conditions CAHPS® *Getting Needed Care*
  - Children with Chronic Conditions CAHPS® *Rating of All Health Care*
- HEDIS® Effectiveness of Care domain:
  - HEDIS® *Medication Management for People with Asthma 75% (5-64 Years)*
- Performance Goal Program Results:
  - HEDIS® *Lead Screening in Children*
  - HEDIS® *Breast Cancer Screening*
  - HEDIS® *Follow-Up After Hospitalization for Mental Illness—7 Days*
  - HEDIS® *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - HEDIS® *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

<u>Accessibility and Timeliness of Care:</u>

- Access and Availability Survey results:
  - Routine appointment availability
  - Urgent appointment availability
- HEDIS® Access and Availability domain:
  - HEDIS® *Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)*
  - HEDIS® *Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)*
  - HEDIS® *Adults' Access to Preventive/Ambulatory Health Services (20-44 Years)*
  - HEDIS® *Adults' Access to Preventive/Ambulatory Health Services (45-64 Years)*
  - HEDIS® *Adults' Access to Preventive/Ambulatory Health Services (65+ Years)*
- Performance Goal Program Results:
  - HEDIS® *Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)*
  - HEDIS® *Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)*

- HEDIS® *Initiation of Alcohol and Other Drug Dependence Treatment*

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 the quality, timeliness, and accessibility of 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, through the provision of services consistent with current professional knowledge, and through interventions for performance improvement."*

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 three (3) Rhode Island Medicaid managed care Health Plans for Reporting Year 2018, EOHHS requested that IPRO prepare an aggregate report that evaluates, compares, and contrasts the Health Plans' performance, as well as statewide performance. For comparative purposes, results for 2016 and 2017 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:

- *Increase access to and improve the quality of care for Medicaid families*
- *Expand access to health coverage to all eligible pregnant women and uninsured children*
- *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 was approved through December 31, 2018[7]. As is typical for Section 1115 waivers, CMS defined "Special Terms and Conditions" (STCs) for the demonstration. The STCs addressing quality assurance and improvement were as follows:

> *"The State shall keep in place existing quality systems for the waivers/demonstrations/projects 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 (RHP), was incorporated[8]. As members of the Health Plans, the RHP population was included in all measure calculations, where applicable.

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, ages 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, the RHE population was included in all measure calculations, where applicable.

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[7] In December 2018, 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, 2023.

[8] 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.

Refer to Appendix 1 of this report 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, 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 this report was prepared. Unless otherwise noted, the benchmarks originate from the National Committee for Quality Assurance's (NCQA) *Quality Compass*® 2018 for Medicaid and represent the performance of all Health Plans that reported HEDIS® and/or CAHPS® to the NCQA for HEDIS® 2018 (Measurement Year 2017)[9].

For comparative purposes, the results for 2016 and 2017 have also been displayed where available and appropriate. Unless otherwise noted, all statewide rates are true rates, calculated by IPRO by combining numerators and denominators for each Health Plan. The exceptions are CAHPS® rates, for which numerators and denominators are not uniformly available. Statewide rates for CAHPS® were calculated by averaging the individual ratings for each Health Plan. It is important to note that for this report, statewide rates were calculated based on the performance of two (2) Health Plans, rather than three (3), since Tufts was unable to report HEDIS® or CAHPS® rates for Reporting Year 2018.

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 this report provides summary conclusions, strengths, and recommendations. Additionally, the final section describes the communication of IPRO's findings to the Health Plan by EOHHS for follow-up, as well as a brief description of the Health Plans' progress related to the recommendations issued in the previous year's annual External Quality Review Technical Report.

[9] Annually, the NCQA produces percentile rankings for HEDIS® and CAHPS® measures and publishes them in the *Quality Compass*®. The *Quality Compass*® is a compilation of benchmarks by product line for all Health Plans that report HEDIS® and CAHPS® to the NCQA. The benchmarking percentiles include the average rate, 10th percentile, 25th percentile, 33rd percentile, 50th percentile, 66th percentile, 75th percentile, 90th percentile, and 95th percentile rates. Health Plans, purchasers, and regulators use the *Quality Compass*® benchmarks in order to evaluate the performance of one or more Health Plans against all reporting Health Plans.

IV. CORPORATE PROFILES

The Rhode Island Medicaid managed care program was comprised of three (3) Health Plans in 2018:

- Neighborhood Health Plan of Rhode Island, Inc. (Neighborhood) is a local, not-for-profit health maintenance organization (HMO) that served Commercial and Medicaid populations. For Medicaid, Neighborhood served the following eligibility groups: Core RIte Care, RIte Care for Children with Special Health Care Needs, RIte Care for Children in Substitute Care, Rhody Health Partners, Rhody Health Options, and Rhody Health Expansion.

- UnitedHealthcare Community Plan of Rhode Island (UHCP-RI) is a for-profit Health Plan that served Commercial, Medicare, and Medicaid populations. For Medicaid, UHCP-RI served the following eligibility groups: Core RIte Care, RIte Care for Children with Special Health Care Needs, Rhody Health Partners, and Rhody Health Expansion.

- Tufts Public Health Plan (Tufts) is a not-for-profit HMO that served the Medicaid populations. Tufts served the following eligibility groups: Core RIte Care, RIte Care for Children with Special Health Care Needs, Rhody Health Partners, and Rhody Health Expansion.

Table 1 presents detailed information for each of the three (3) Health Plans.

Table 1: 2018 Health Plan Corporate Profiles

	Neighborhood	UHCP-RI	Tufts
Type of Organization	HMO	HMO	HMO
Tax Status	Not-for-profit	For-profit	Not-for-profit
Model Type	Network	Mixed	Network
Year Operational	1994	1979	1979
Year Operational (Medicaid)	1994	1994	2017
Product Line(s)	Commercial, Medicaid	Commercial, Medicare, Medicaid	Medicaid
Total Medicaid Enrollment	170,831	90,823	9,438
NCQA Accreditation Status	Excellent	Excellent	N/A[1]
NCQA Medicaid Health Plan Rating	4.5	4.5	N/A[1]

N/A: Not available

[1] Tufts did not report sufficient data to be eligible for NCQA Accreditation or a Health Plan rating in 2018.

V. ACCREDITATION 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 Plan's 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 detail in the State's December 2014 quality strategy, entitled *Rhode Island Comprehensive Quality Strategy*[10].

The State of Rhode Island EOHHS relies on the NCQA Accreditation standards, review process, and findings, in addition to other sources of information, to ensure 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 the 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, with the most recent version being submitted to CMS in December 2014.

NCQA Health Plan Accreditation

The NCQA began accrediting Health Plans in 1991 to meet the demand for objective, standardized plan performance information. The NCQA's Health Plan Accreditation is considered the industry's gold standard for assuring and improving quality care and patient experience. It reflects a commitment to quality that yields tangible, bottom-line value. It also ensures essential consumer protections, including fair marketing, sound coverage decisions, access to care, and timely appeals. NCQA Accreditation is recognized or required by the majority of state Medicaid agencies and is utilized to ensure regulatory compliance in many states. The accreditation process is a rigorous, comprehensive, and transparent evaluation process through which the quality of key systems and processes that define a Health Plan are assessed. Additionally, accreditation includes an evaluation of the actual results the Health Plan achieved on key dimensions of care, service, and efficacy. Specifically, the NCQA reviews the Health Plan's quality management and improvement, utilization management, provider credentialing and re-credentialing, members' rights and responsibilities, standards for member connections, and HEDIS® and CAHPS® performance measures. 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 pf physicians, and an accreditation level is assigned based on a Health Plan's compliance with the NCQA's standards and its HEDIS® and CAHPS® performance. Compliance with standards accounts for fifty percent (50%) of the Health Plan's accreditation score, while performance measurement accounts for the remainder.

[10] 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 the following five (5) dimensions using star ratings of between one (1) and four (4) stars (1-lowest; 4-highest)[11]:

- § 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 screening?

- § 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 conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?

Although the on-site Accreditation Survey occurs once every three (3) years, star ratings are re-calculated annually by the NCQA based on the most recent Accreditation Survey findings and the latest HEDIS® and CAHPS® results. As such, the 2018 accreditation statuses are based on the Accreditation Surveys conducted in 2017 for both Neighborhood and UHCP-RI, while the Health Plans' HEDIS® and CAHPS® 2018 results were used. As noted previously, Tufts did not begin enrollment in the Medicaid product line until 2017 and was unable to report sufficient data to be eligible for NCQA Accreditation for Reporting Year 2018. The table below presents the most common overall NCQA Accreditation outcomes, including the star ratings and definitions.

NCQA 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.

[11] www.ncqa.org

Table 2 presents the NCQA Accreditation findings for Neighborhood and UHCP-RI. Again, Tufts was not eligible for NCQA Accreditation for Reporting Year 2018.

Table 2: Accreditation Survey Findings—2018

Product Line	Access and Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Accreditation Outcome
Medicaid						
Neighborhood	« « « «	« « « «	« « « «	« «	« « «	Excellent
UHCP-RI	« « « «	« « « «	« « «	« «	« «	Excellent
Tufts[1]						

[1] Tufts was unable to report sufficient data to be eligible for NCQA Accreditation for Reporting Year 2018.

NCQA Health Plan Ratings

In 2015, the NCQA retired its *Health Insurance Plan Rankings* methodology used from 2005 through 2014. Since 2015, the NCQA has calculated numerical ratings for Commercial, Medicare, and Medicaid Health Plans through the *Health Insurance Plan Ratings* methodology. The *Ratings* methodology evaluates Health Plans based on clinical performance (HEDIS® results), member satisfaction (CAHPS® scores), and NCQA Accreditation Standards scores. To be eligible for a rating, Health Plans must authorize public release of their performance data and submit enough data for statistically valid analysis.

The NCQA's *Health Insurance Plan Ratings* 2018-2019 methodology was used to calculate an overall score comprised of satisfaction measures (*Consumer Satisfaction*) and clinical measures (*Prevention* and *Treatment*), defined below. The Health Plans received a score for each of these three (3) categories from one (1) to five (5) in half-point increments, with five (5) being the highest score. The scores from each category are then combined with the Accreditation Standards score and then weighted and presented 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 and preventive care visits.

- § Treatment: Composite of clinical HEDIS® measures for how well Health Plans provide 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' scores to the national average. The scale and definitions for each level are provided below.

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

The *Health Insurance Plan Ratings* are posted to the NCQA's website. They are also posted to the *Consumer Reports'* website and published in the November issue of the magazine. Table 3 presents the Health Plans' overall ratings, along with their performance in each of the three (3) categories. Tufts was unable to report sufficient data to be eligible for a Health Plan rating for Reporting Year 2018.

Table 3: NCQA Ratings by Category—2018

Product Line	Consumer Satisfaction	Prevention	Treatment	2018 Overall Rating
Medicaid				
Neighborhood	4.5	4.5	3.5	4.5
UHCP-RI	3.5	4.5	4.0	4.5
Tufts[1]				

[1] Tufts was unable to report sufficient data to be eligible for a Health Plan rating for Reporting Year 2018.

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VI. ENROLLMENT

Table 4a and 4b present Health Plan enrollment as of December 31, 2018, according to data reported to Rhode Island Medicaid.

Table 4a presented Medicaid managed care enrollment for the Health Plans, as well as the percentage of the statewide Medicaid managed care population enrolled in each Health Plan. Neighborhood's Medicaid managed care membership comprised the majority of statewide enrollment in 2018 (63%), with UHCP-RI's membership accounting for thirty-four percent (34%), and Tufts' enrollment accounting for the remaining three percent (3%).

Table 4a: Statewide Medicaid Managed Care Enrollment by Health Plan—2018

Health Plan	Medicaid Managed Care Enrollment	% Statewide Total
Neighborhood	170,831	63%
UHCP-RI	91,167	34%
Tufts	9,472	3%
Statewide Total	271,470	100%

Table 4b provides additional detail: enrollment by Medicaid eligibility group for the three (3) Health Plans. Core RIte Care members comprised the majority of enrollment for Neighborhood and UHCP-RI, while RHE members accounted for the majority of Tufts' enrollment.

Table 4b: Medicaid Enrollment by Eligibility Group—December 31, 2018

	Neighborhood		UHCP-RI		Tufts		Statewide	
Eligibility Group	n	%	N	%	N	%	n	%
Core RIte Care	100,923	59%	52,601	58%	4,281	45%	157,805	58%
Children with Special Health Care Needs (CSHCN)[1]	5,066	3%	1,828	2%	52	<1%	6,946	3%
Children in Substitute Care[2]	2,715	2%					2,715	1%
Extended Family Planning (EFP)[3]	829	<1%	344	<1%	34	<1%	1,207	<1%
Rhody Health Partners (RHP)[4]	7,465	4%	6,883	7%	505	5%	14,853	5%
Rhody Health Options (RHO)[5]	15,698	9%					15,698	6%
Rhody Health Expansion (RHE)[6]	38,135	22%	29,511	32%	4,600	49%	72,246	27%
Total Medicaid Enrollment	170,831	100%	91,167	100%	9,472	100%	271,470	100%

[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. All of the State's current Medicaid-participating Health Plans serve CSHCN.

[2] Children in Substitute Care are enrolled on a voluntary basis. Neighborhood is the only Health Plan that serves this 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 of this report describes the eligibility criteria for Rhody Health Partners.

[5] Rhody Health Options serves individuals who are dual-eligible for Medicaid and Medicare. Neighborhood is the only Health Plan that serves this population.

[6] Rhody Health Expansion serves 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.

VII. PROVIDER NETWORK

Health Plans must ensure that a sufficient number of primary and specialty care providers are available to members to allow for a reasonable choice among providers. This is required by Federal Medicaid requirements, 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 has "reasonable distance" standards. Regarding the provider network, Section 2.08.01 of the State's July 2018 *Medicaid Managed Care Services Contract* states:

> *"The Contractor will establish and maintain a robust geographic network designed to accomplish the following goal: (1) offer an appropriate range of services, including access to preventive care, primary care, acute care, specialty care, behavioral health care, substance use disorder, and long-term 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 2.08.03.06 of the *Contract* states:

> *"The 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, the Contractor agrees to assigns 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 three thousand (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 July 2018 *Contract*, which states as follows:

> *"The Contractor will develop, maintain, and monitor a network that is geographically accessible to the population being served. Pursuant to 42 CFR 438.68, the Contractor must ensure its network is compliant with the State-established provider-specific network adequacy standards. The Contractor will make available to every member a provider whose office is located within the lesser of the time or distance standard as provided. Members may, at their discretion, select a participating provider located farther from their home."*

Consequently, the standards against which reasonable distances are assessed are developed by each Health Plan, based on Health Plan-specific criteria. The State's *Medicaid Managed Care Contracts* also have a "mainstreaming" provision requiring that, if a network's provider practice is open to any new patients, then the practice must accept Medicaid managed care enrollees.

Neighborhood and UHCP-RI monitor their provider networks for accessibility and network adequacy using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between providers and members can be assessed to determine whether members have access to care within a reasonable distance to their homes.

Neighborhood's distance requirements vary by provider type. Neighborhood's goal was to have a minimum of ninety-five percent (95%) of members with access to care within access to care within the noted distances.

In 2014, UHCP-RI revised its GeoAccess standards to align with CMS' criteria for network adequacy. UHCP-RI assessed geographic accessibility through the criteria for large metro and metro county designations[12]. The goal was to have

[12] UHCP-RI's GeoAccess standards derive from CMS' Medicare Advantage network adequacy criteria. These criteria evaluate accessibility by county type: large metro, metro, micro, rural, and counties with extreme access consideration (CEAC). County types

ninety percent (90%) of network primary care and high-volume and high-impact specialty care providers meet the distance requirements. The distance requirements vary by provider type and geographic access criteria.

Table 5 shows the percentage of members or providers for which the Health Plans met their respective access standards. Note that the types of high-volume and high-impact specialists may differ for each Health Plan based on Health Plan-specific information and the method of identifying these types of providers.

Table 5: GeoAccess Provider Network Accessibility—2018

Provider Type	Access Standard[1]	% of Members or Providers[2]
Neighborhood		
Adult Services		
Inpatient	1 in 30 miles	99.6%
Inpatient Mental Health	1 in 30 miles	98.3%
Inpatient Substance Abuse	1 in 30 miles	99.6%
Intensive Outpatient Program	1 in 30 miles	99.7%
Partial Hospital Programs	1 in 30 miles	98.3%
Outpatient	2 in 15 miles	99.7%
Outpatient Mental Health	2 in 15 miles	99.7%
Outpatient Substance Abuse	2 in 15 miles	99.5%
MD/DO/RNCS	2 in 30 miles	99.7%
PHD/PSYD	2 in 30 miles	99.7%
Child Services		
Inpatient	1 in 30 miles	98.6%
Inpatient Mental Health	1 in 30 miles	98.6%
Inpatient Substance Abuse	1 in 30 miles	98.6%
Intensive Outpatient Program	1 in 30 miles	99.7%
Partial Hospital Programs	1 in 30 miles	99.7%
Outpatient	2 in 15 miles	99.7%
Outpatient Mental Health	2 in 15 miles	99.8%
Outpatient Substance Abuse	2 in 15 miles	99.7%
MD/DO/RNCS	2 in 30 miles	99.8%
PHD/PSYD	2 in 30 miles	99.8%
UHCP-RI		
Large Metro		
Primary Care Practitioners	1 in 5 miles	97%
OB/GYN	1 in 5 miles	97%
High-Volume Specialists	1 in 5-15 miles	98%
High-Impact Specialists	1 in 20-30 miles	98%
Metro		
Primary Care Practitioners	1 in 10 miles	97%
OB/GYN	1 in 10 miles	91%
High-Volume Specialists	1 in 5-10 miles	100%
High-Impact Specialists	1 in 20-30 miles	100%

[1] The Access Standard is measured in distance to members' addresses.
[2] The percentages represent the proportion of members or providers for which the Health Plans met the access criteria.
[3] Tufts data was not reported for 2018.

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.

In addition to utilizing the GeoAccess program to assess network adequacy and provider accessibility, the State of Rhode Island Executive Office of Health and Human Services (EOHHS) conducted an Access and Availability Survey. This survey employed the "secret shopper" methodology to assess member access to timely appointments. The State's July 2018 *Medicaid Managed Care Services Contract* outlines appointment timeliness standards in Section 2.09.04 for many types of appointments, including, but not limited to, routine care, urgent care, behavioral health care, and dental care. Timeliness standards included in the *Contract* are displayed in the table below.

Appointment Type	Access Standard
After-Hours Care (telephone)	24 hours a day, 7 days a week
Emergency Care	Immediately
Urgent Care	Within 24 hours
Routine Care	Within 30 calendar days
Physical Exam	Within 180 calendar days
EPSDT	Within 6 weeks
New Member	Within 30 calendar days
Non-Emergent/Non-Urgent Mental Health	Within 10 calendar days

Table 6 on the following page displays the results of the 2018 Access and Availability Survey conducted for the Health Plans. Availability of both routine and urgent care appointments was assessed. The results of these surveys indicate there is opportunity for improvement in the area of appointment availability, as the rates for timely appointment were low for many appointment types.

Table 6: Access and Availability Survey Results—2018

Appointment Type	Neighborhood			UHCP-RI			Tufts[1]		
	Providers Surveyed	Appt. Made	% Timely Appt.[3]	Providers Surveyed	Appt. Made	% Timely Appt.[3]	Providers Surveyed	Appt. Made	% Timely Appt.[3]
Routine Care									
Primary Care Practitioners	25	6	16.0%	16	7	25.0%			
Specialty Care—Adults	36	7	2.77%	14	4	7.1%			
Specialty Care—Pediatrics	32	11	18.75%	16	2	12.5%			
Behavioral Health[2]				12	4	33.3%			
Urgent Care									
Primary Care Practitioners	27	2	3.70%	13	4	7.6%			
Specialty Care—Adults	37	8	2.70%	21	10	0.00%			
Specialty Care—Pediatrics	30	13	13.33%	19	8	0.00%			

[1] A survey was not conducted for Tufts in 2018.

[2] Behavioral health providers were not surveyed in 2018 for Neighborhood.

[3] The rate of timely appointments is based on the number of providers surveyed, and not the number of appointments made.

HEDIS® Board Certification

HEDIS® Board Certification rates represent the percentage of physicians in the provider network that are board-certified in their specialty. Figure 1 illustrates the results for Neighborhood and UHCP-RI for Reporting Years 2016-2018, as well as the statewide rates. The statewide rates were calculated by totaling the numerators and denominators for Neighborhood and UHCP-RI, since Tufts was unable to report data for HEDIS® 2016-2018.

Neighborhood's rates for five (5) of the six (6) provider types demonstrated a decline from 2017 to 2018. The rate for *OB/GYN* demonstrated a slight increase of about two (2) percentage points. The rate for *Geriatricians* demonstrated a significant decline, falling about sixteen (16) percentage points from about seventy-eight percent (78%) in 2017 to about sixty-two percent (62%) in 2018. Similarly, the rate for *Other Physician Specialists* demonstrated a decline of nearly seven (7) percentage points, year-over-year. The remaining three (3) provider types demonstrated only slight decreases year-over-year: *Family Medicine* decreased by about two (2) percentage points, *Pediatricians* decreased by about three (3) percentage points, and *Internal Medicine* decreased by about four (4) percentage points.

UHCP-RI's rates for two (2) of the six (6) provider types remained stable year-over-year. The rate for *Pediatricians* decreased by one (1) percentage point, while the rate for *OB/GYN* decreased by about half a percentage point. One (1) rate demonstrated an increase from 2017 to 2018; *Internal Medicine* increased from about seventy-six percent (76%) to about eighty-one percent (81%). Rates for the remaining three (3) provider types demonstrated declines in performance from 2017 to 2018: *Family Medicine* decreased by about two (2) percentage points, *Geriatricians* decreased by about three (3) percentage points, and *Other Physician Specialists* decreased by about five (5) percentage points.

Figure 1: HEDIS® Board Certification Rates—2016-2018

Figure 1: HEDIS® Board Certification Rates—2016-2018 (continued)

VIII. HEDIS® AND CAHPS® PERFORMANCE MEASURES

Since NCQA Accreditation is required for participation in Rhode Island's Medicaid managed care program, and HEDIS® performance is an accreditation domain, the Health Plans report HEDIS® annually to the NCQA and the State. The Health Plans' HEDIS® measure calculations were audited by NCQA-certified audit firms, in conformity with HEDIS® 2018 *Compliance Audit: Standards, Policies, and Procedures*. Both Neighborhood and UHCP-RI were found compliant with all HEDIS® Information Systems (IS) and Measure Determination (HD) standards, and both passed the medical record review process. Tufts was unable to report HEDIS® data for Reporting Year 2018; therefore, no audit was conducted for the Health Plan.

Graphs depicting Health Plan and statewide rates for HEDIS® Effectiveness of Care and Access and Availability measures for Reporting Years 2016 through 2018, as well as comparative national benchmarks, are presented on the pages that follow. Additionally, utilization of Health Plan services was examined via select HEDIS® Use of Services measures. The benchmarks presented are those reported in the *Quality Compass*® 2018 for Medicaid. Statewide rates were calculated by IPRO by totaling numerator and denominator counts for Neighborhood and UHCP-RI, as Tufts was unable to report HEDIS® data for the timeframe.

HEDIS® Effectiveness of Care Measures

The HEDIS® Effectiveness of Care measures evaluate how well a Health Plan provides preventive screenings and care for members with acute and chronic illnesses. Figure 2 displays select Effectiveness of Care measure rates for HEDIS® 2016 through HEDIS® 2018 for each Health Plan, as well as the statewide rates, compared to the *Quality Compass*® 2018 national Medicaid benchmarks.

The HEDIS® 2018 rates for all eight (8) reported measures were above the *Quality Compass*® 2018 national Medicaid mean for both Health Plans, as well as statewide. Both Health Plans continued to perform well on measures related to follow-up care for mental illness, immunizations, and women's health. Rates for both Health Plans, as well as the statewide rates, were reported above the 2018 *Quality Compass*® 90th percentiles for *Follow-Up After Hospitalization for Mental Illness—30 Days* and *Follow-Up After Hospitalization for Mental Illness—7 Days*. It should be noted that while these rates maintained high performance, several showed significant decreases year-over-year. Regarding childhood immunizations, Neighborhood's rates and the statewide rates were reported above the 90th percentile for *Childhood Immunization Status—Combination 3* and *Childhood Immunization Status—Combination 10*. UHCP-RI's rate for *Childhood Immunization Status—Combination 10* also benchmarked at the 90th percentile, while the Health Plan's rate for *Childhood Immunization Status—Combination 3* ranked at the 75th percentile for 2018. For the two (2) measures related to women's health, Neighborhood's rate and the statewide rate achieved the 2018 *Quality Compass*® 90th percentile rate for *Cervical Cancer Screening for Women*, while UHCP-RI's rate benchmarked at the 75th percentile. All three (3) rates benchmarked at the 75th percentile for *Chlamydia Screening for Women (16-24 Years)*. Performance was mixed for the *Comprehensive Diabetes Care—HbA1c Testing* measure: UHCP-RI's rate benchmarked at the *Quality Compass*® 75th percentile, while both Neighborhood's rate and the statewide rate fell below the 75th percentile. For the *Medication Management for People with Asthma 75% (5-64 Years)* measure, all three (3) rates benchmarked below the *Quality Compass*® 75th percentile for 2018.

Figure 2: HEDIS® Effectiveness of Care Rates—2016-2018

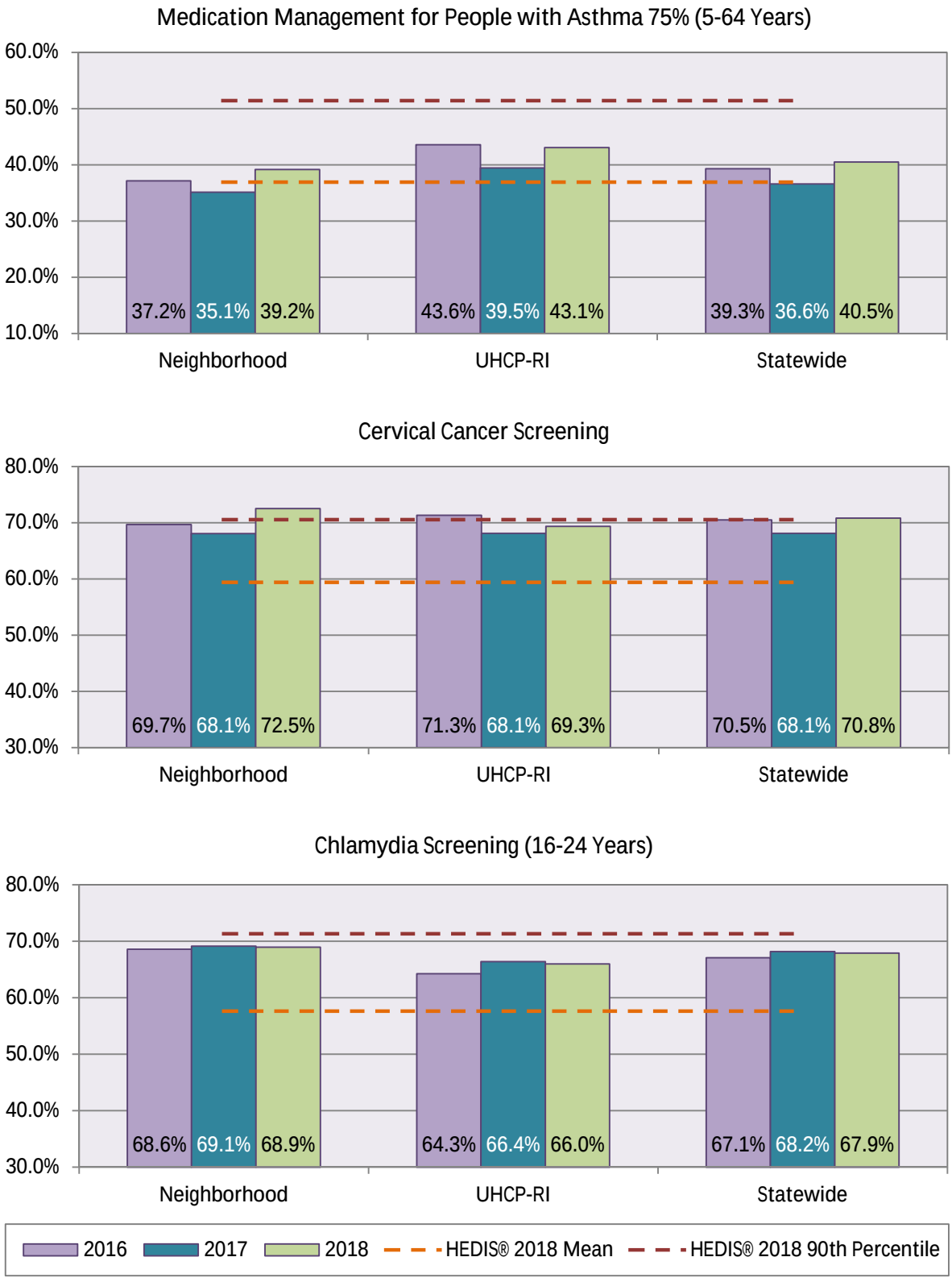


Figure 2: HEDIS® Effectiveness of Care Rates—2016-2018 (continued)

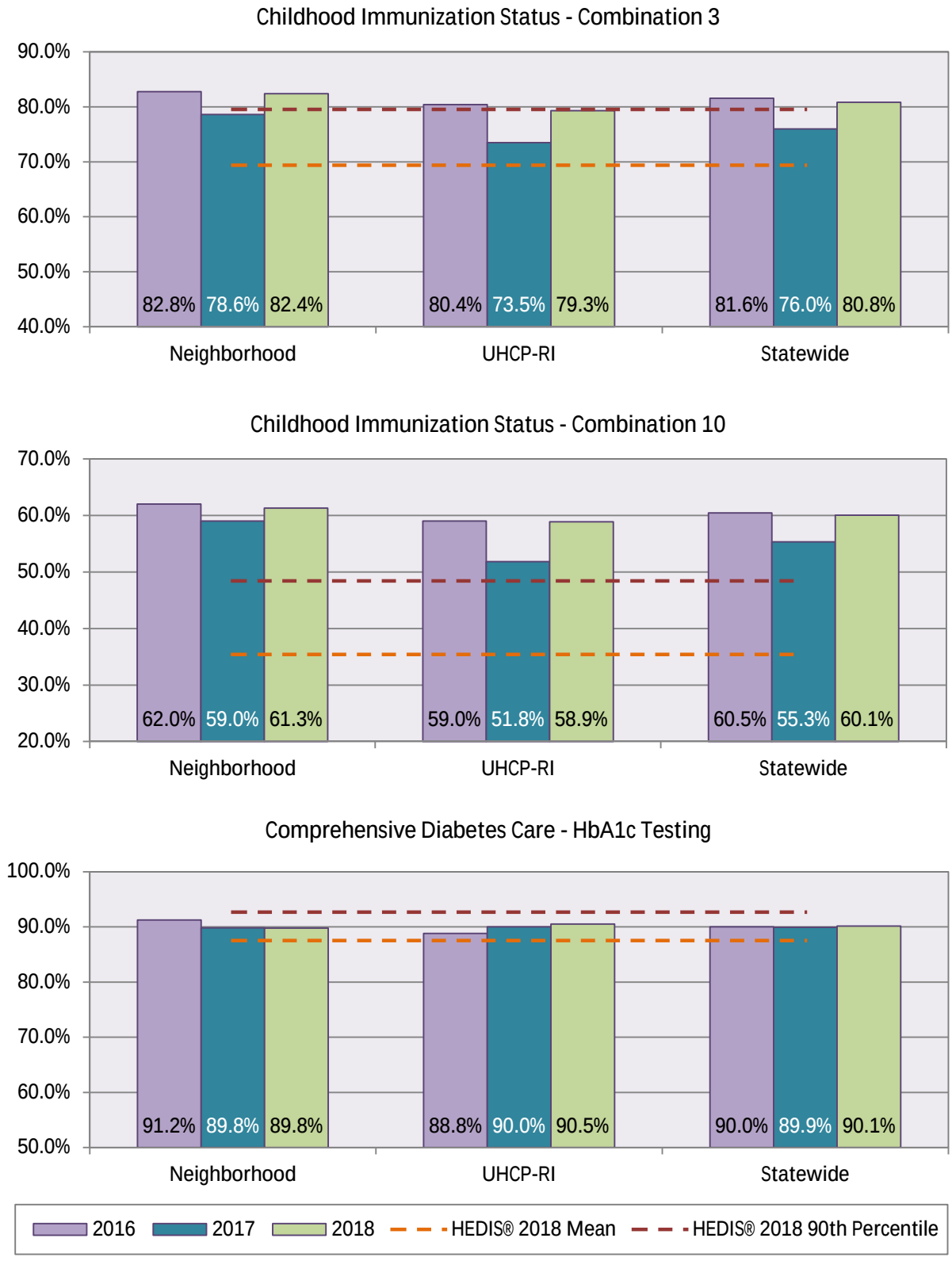
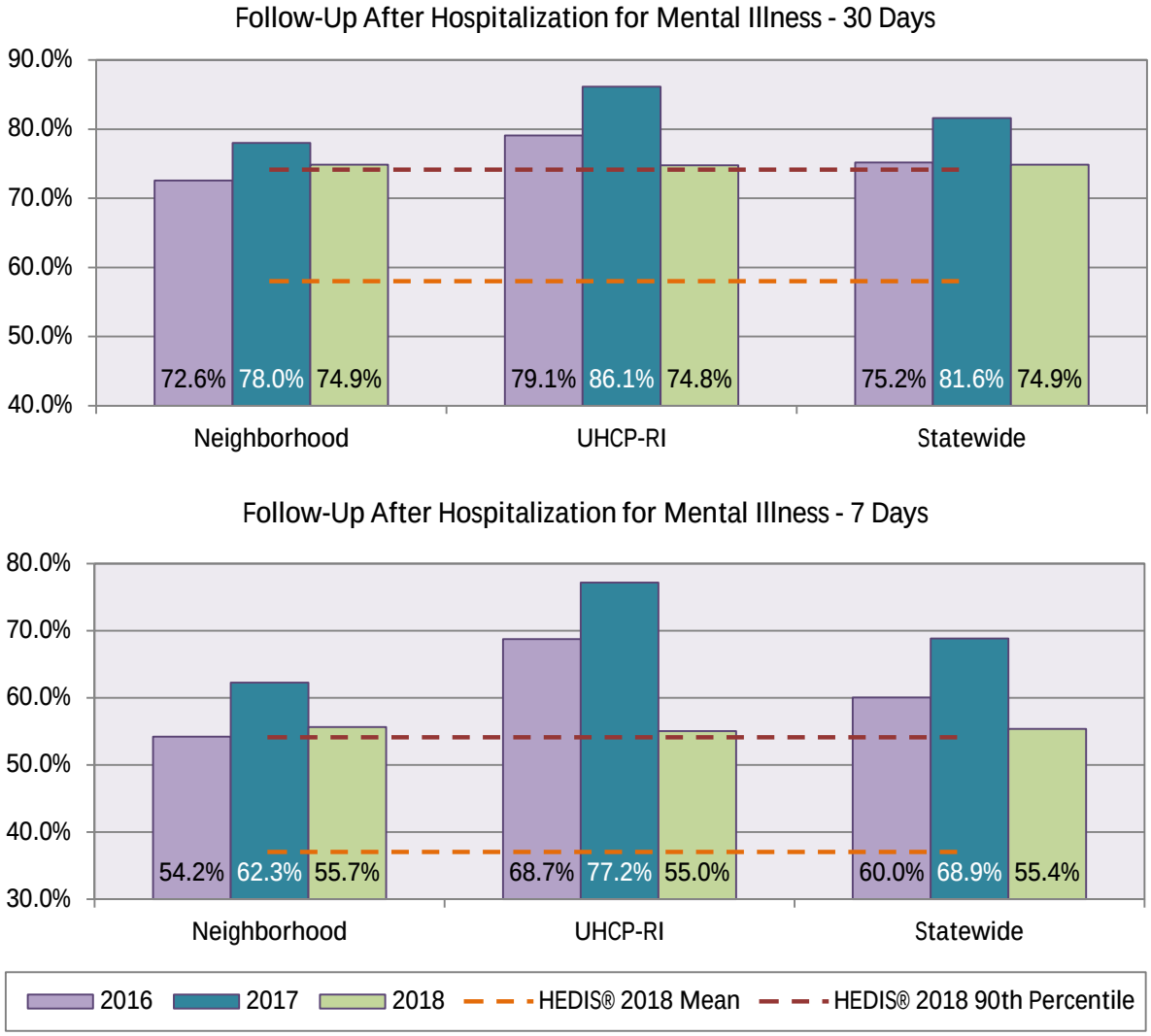


Figure 2: HEDIS® Effectiveness of Care Rates—2016-2018 (continued)



HEDIS® Access and Availability Measures

The HEDIS® Access and Availability measures examine the percentage of Medicaid children, adolescents, child-bearing women, and adults who received PCP or preventive care services, ambulatory care (adults only), or timely prenatal and postpartum care. *Children and Adolescents' Access to Primary Care Practitioners* measures the percentage of children ages twelve (12) months to six (6) years old who had one (1) or more visits with a Health Plan primary care practitioner during the Measurement Year and the percentage of children ages seven (7) to eleven (11) years old and adolescents ages twelve (12) to nineteen (19) years old 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* measure the percentage of adults ages twenty (20) years and older who had one (1) or more ambulatory or preventive care visits 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 (21) and fifty-six (56) days after delivery.

Figure 3 presents the Access and Availability measure rates for the two (2) Health Plans, as well as the statewide rates, for HEDIS® 2016 through HEDIS® 2018 as compared to national Medicaid benchmarks.

Performance in this domain varied across the measures, with both Health Plans performing similarly. Neighborhood's rates exceeded the 2018 *Quality Compass*® national Medicaid mean for all nine (9) reported measures, while UHCP-RI's rates and the statewide rates exceeded the Medicaid mean for eight (8) of the nine (9) measures. Both Health Plans continued to perform well on the *Prenatal and Postpartum Care* measures, as the rates for *Timeliness of Prenatal Care* and *Timeliness of Postpartum Care* achieved the 2018 *Quality Compass*® 90th percentile, as did the statewide rates. For the *Children and Adolescents' Access to Primary Care Practitioners* measure, both Health Plans' rates benchmarked below the *Quality Compass*® 75th percentile for the *12-24 Months* and *25 Months-6 Years* age groups, as did the statewide rates for these age groups. Conversely, both Health Plans' rates ranked at the 75th percentile for the *7-11 Years* and *12-19 Years* age groups, as did the statewide rates. Both Health Plans demonstrated an opportunity for improvement regarding the *Adults' Access to Preventive/Ambulatory Health Services* measure, as all of the rates for any of the three (3) age groups (*20-44 Years*, *45-64 Years*, and *65+ Years*) benchmarked below the 75th percentile, including the statewide rates.

Figure 3: HEDIS® Access and Availability Rates—2016-2018

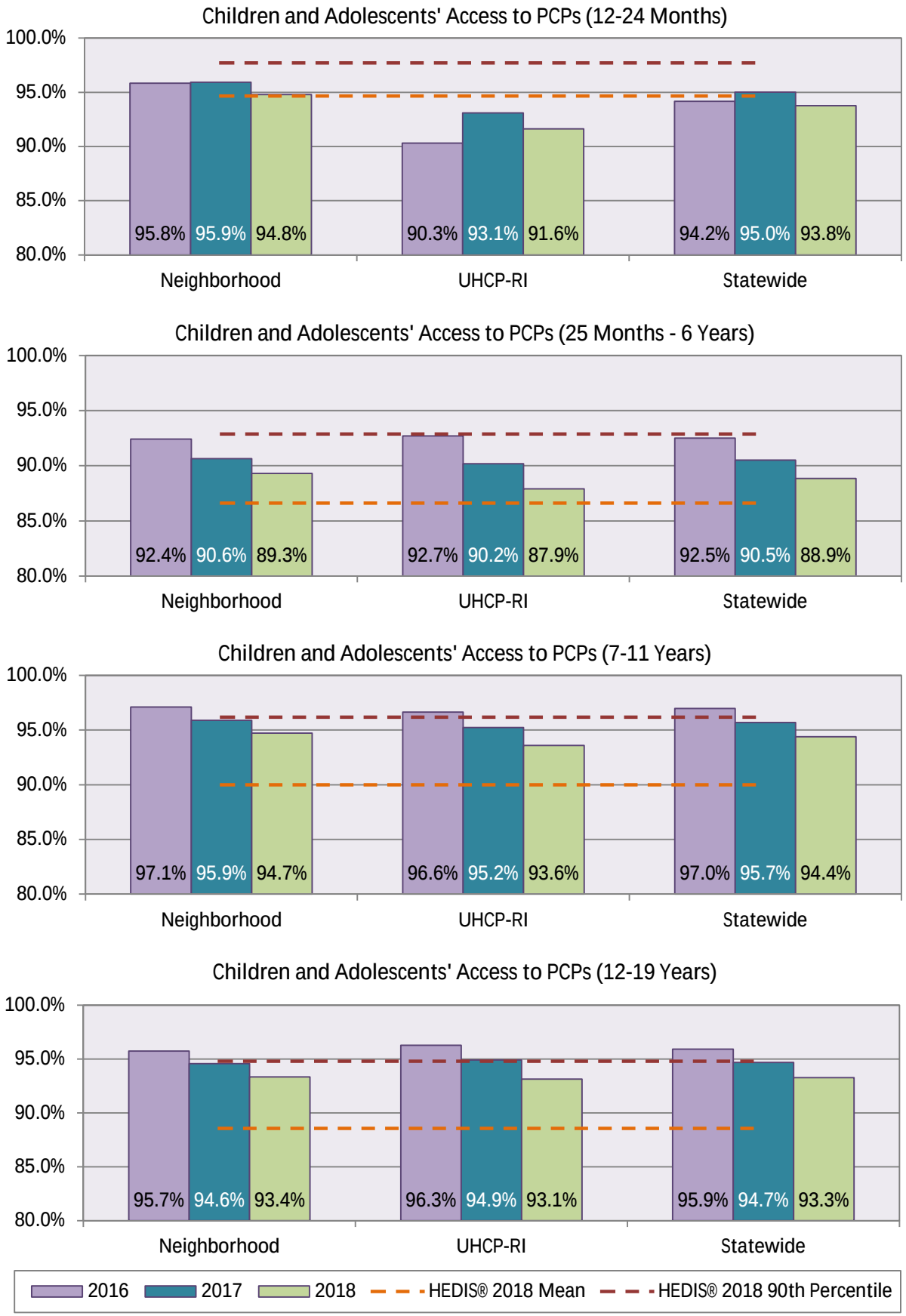


Figure 3: HEDIS® Access and Availability Rates—2016-2018 (continued)

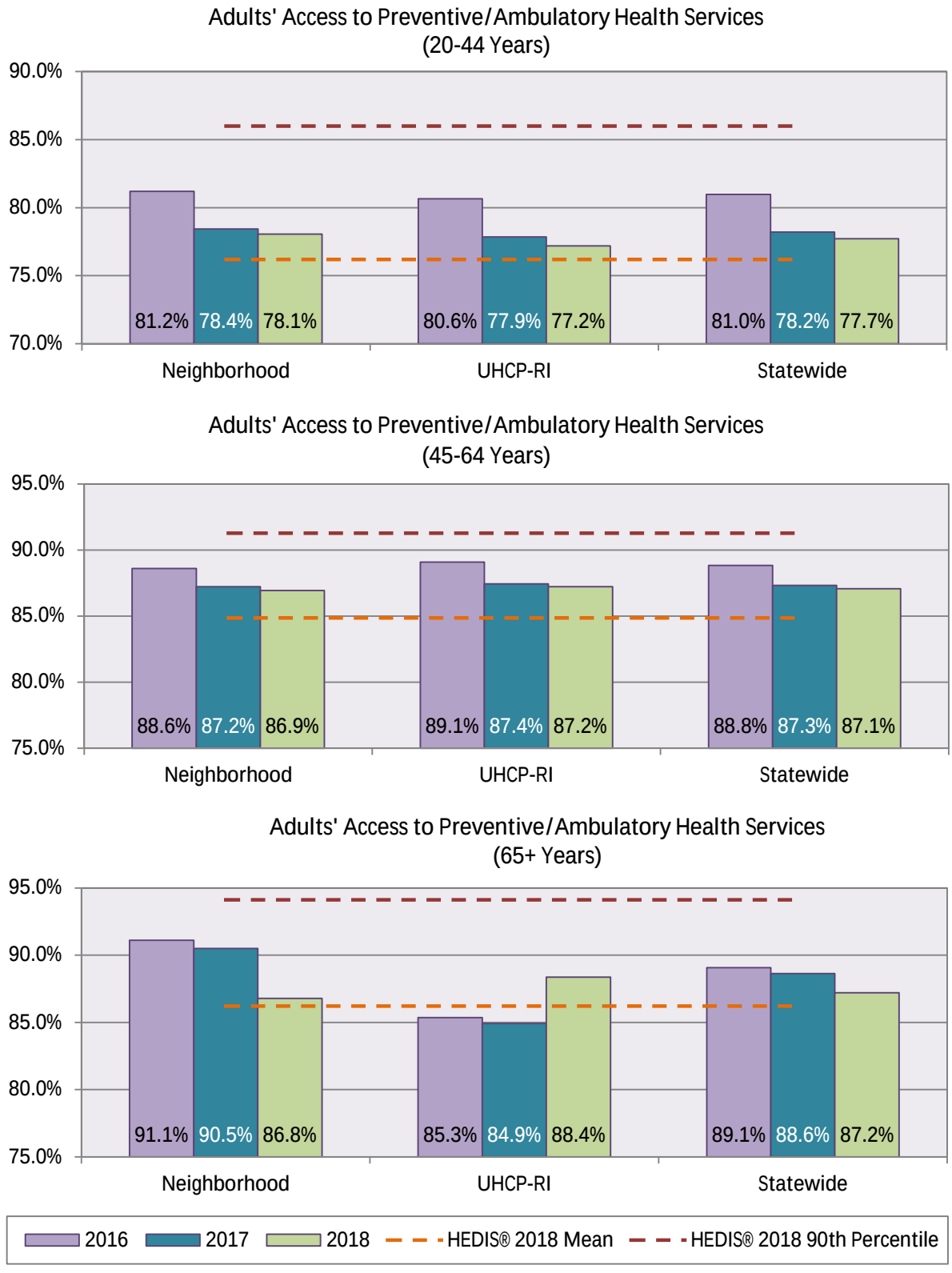
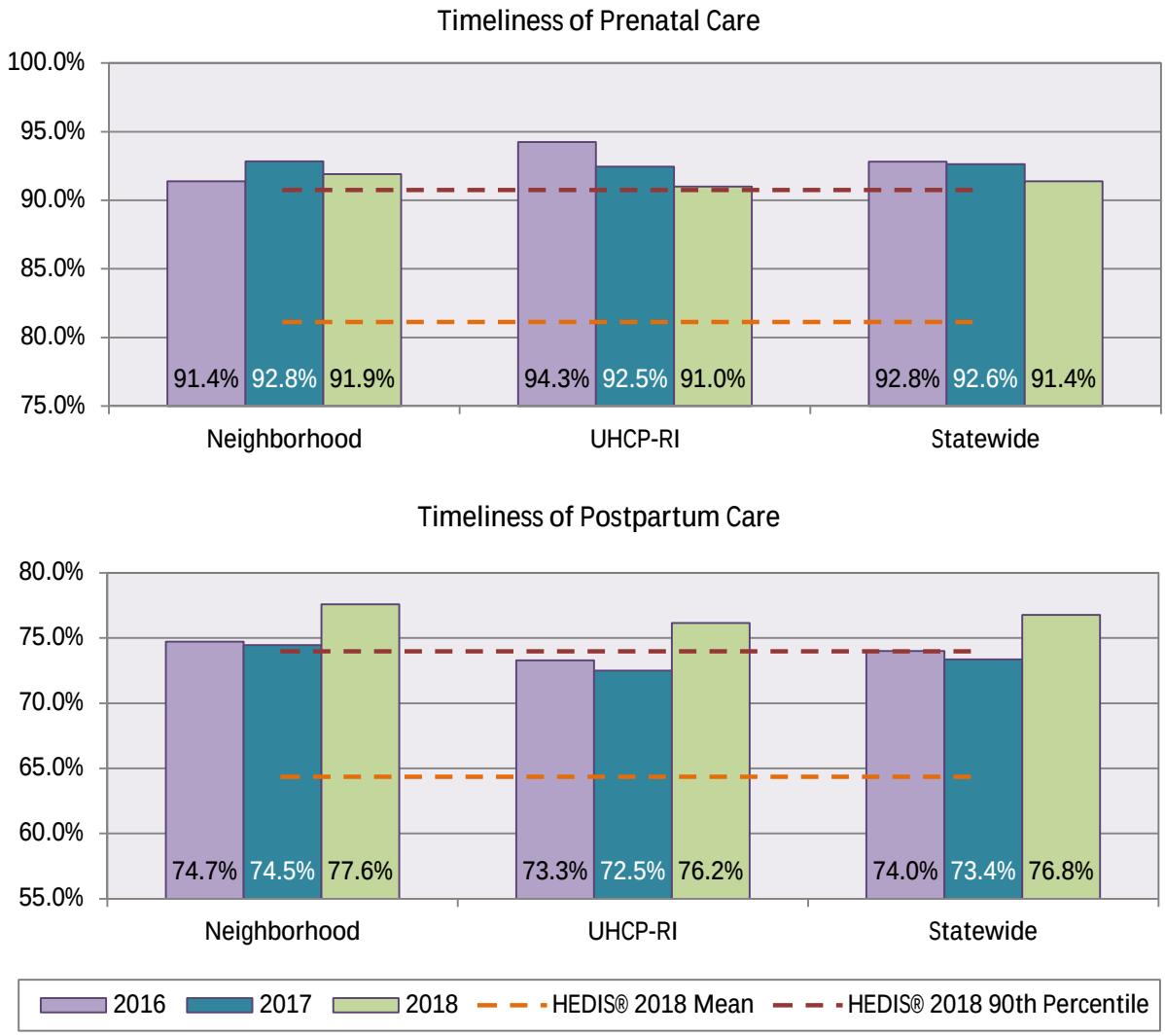


Figure 3: HEDIS® Access and Availability Rates—2016-2018

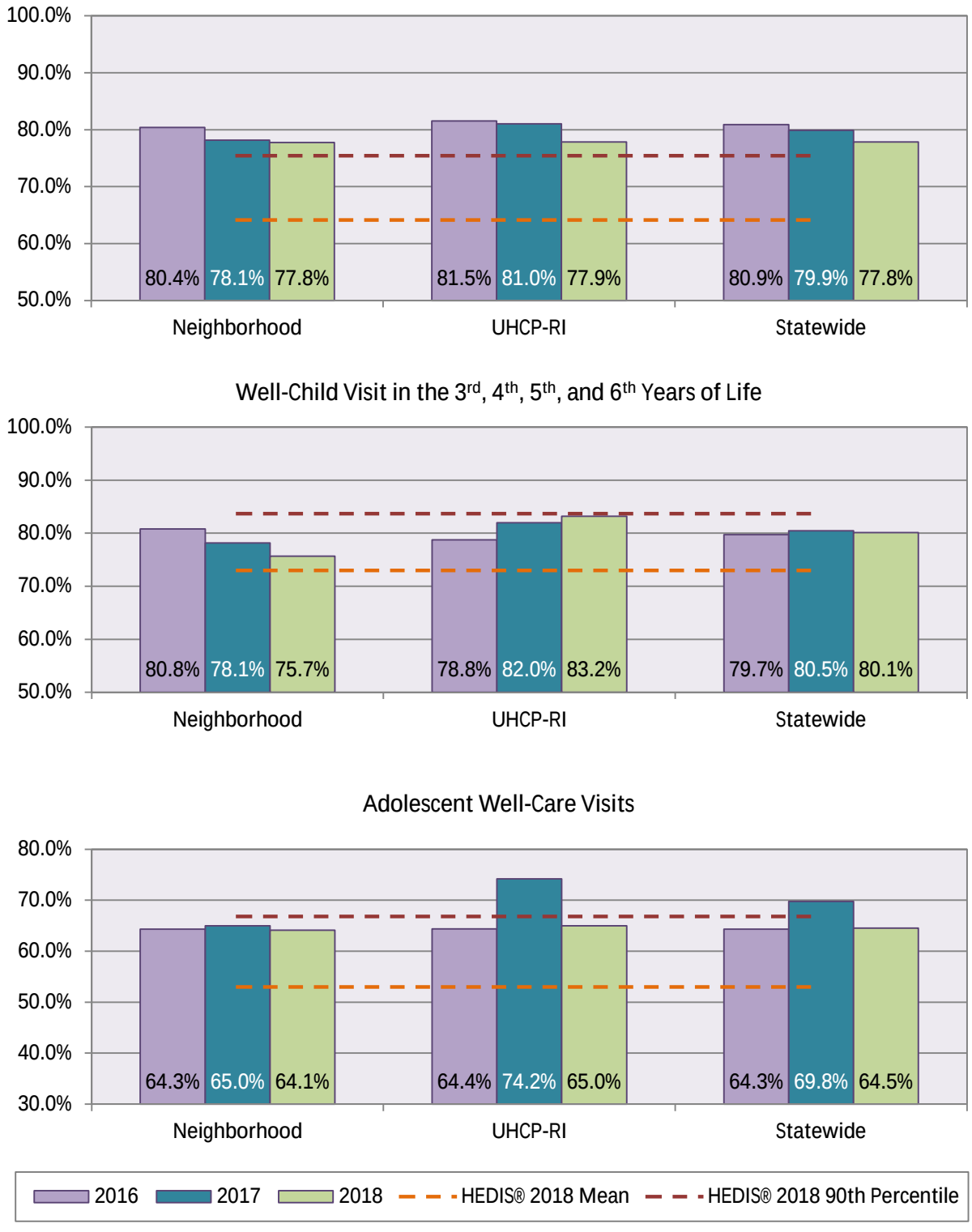


HEDIS® Use of Services Measures

The HEDIS® Use of Services measures evaluate member utilization of Health Plan services. For this domain of measures, performance is assessed by comparing the Health Plans' rates to the 2018 *Quality Compass*® national Medicaid benchmarks. Figure 4 displays select Use of Services measure rates for HEDIS® 2016 through HEDIS® 2018, as well as comparisons to the national Medicaid benchmarks.

Rates for all three (3) measures reported for this domain were above the 2018 *Quality Compass*® national Medicaid mean for both Health Plans, as well as statewide. Rates for both Health Plans, as well as the statewide rate, for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* benchmarked at the *Quality Compass*® 90th percentile. Additionally, rates for both Health Plans, as well as the statewide rate, benchmarked at the *Quality Compass*® 75th percentile. Health Plan performance for the *Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life* measure varied. UHCP-RI's rate ranked at the 75th percentile for 2018, as did the statewide rate. Neighborhood's rate for this measure was reported below the 75th percentile.

Figure 4: HEDIS® Use of Services Rates—2016-2018



Member Satisfaction: CAHPS® 5.0H[13]

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 2018, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 5.0H survey for adult Medicaid members was conducted on behalf of each Health Plan by NCQA-certified survey vendors. Figure 5a displays the Health Plans' rates for the satisfaction measures and composites for 2016 through 2018, as well as the statewide rates, compared to 2018 *Quality Compass*® 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 cycle[14].

Neighborhood's rates exceeded the 2018 *Quality Compass*® national Medicaid mean for ten (10) of the ten (10) measures presented in Figure 5a, while UHCP-RI's rates exceeded the 2018 *Quality Compass*® national Medicaid mean for seven (7) of the eight (8) measures reported. Neighborhood's, UHCP-RI's and the statewide rates for *Rating of All Health Care* exceeded the 90th percentile. Additionally, Neighborhood reported three (3) rates that met or exceeded the 2018 *Quality Compass*® 90th percentile for the following measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, and *Shared Decision Making*. Neighborhood also reported five (5) rates at the 75th percentile for *Customer Service,* Getting Needed Care, *How Well Doctors Communicate*, *Rating of Personal Doctor* and *Flu Vaccinations for Adults*. UHCP-RI also report three (3) rates at the 75th percentile for the following measures: *Getting Care Quickly*, *Rating of Personal Doctor*, and *Flu Vaccinations for Adults*.

[13] The rates for CAHPS® measures included all Medicaid members in the survey sample, where eligible population criteria are met. As such, the RHP and RHE populations were included in the adult CAHPS® sample for each Health Plan.

[14] In 2015, the questions included in the *Shared Decision Making* composite measure were modified and the responses were changed to "Yes" and "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?

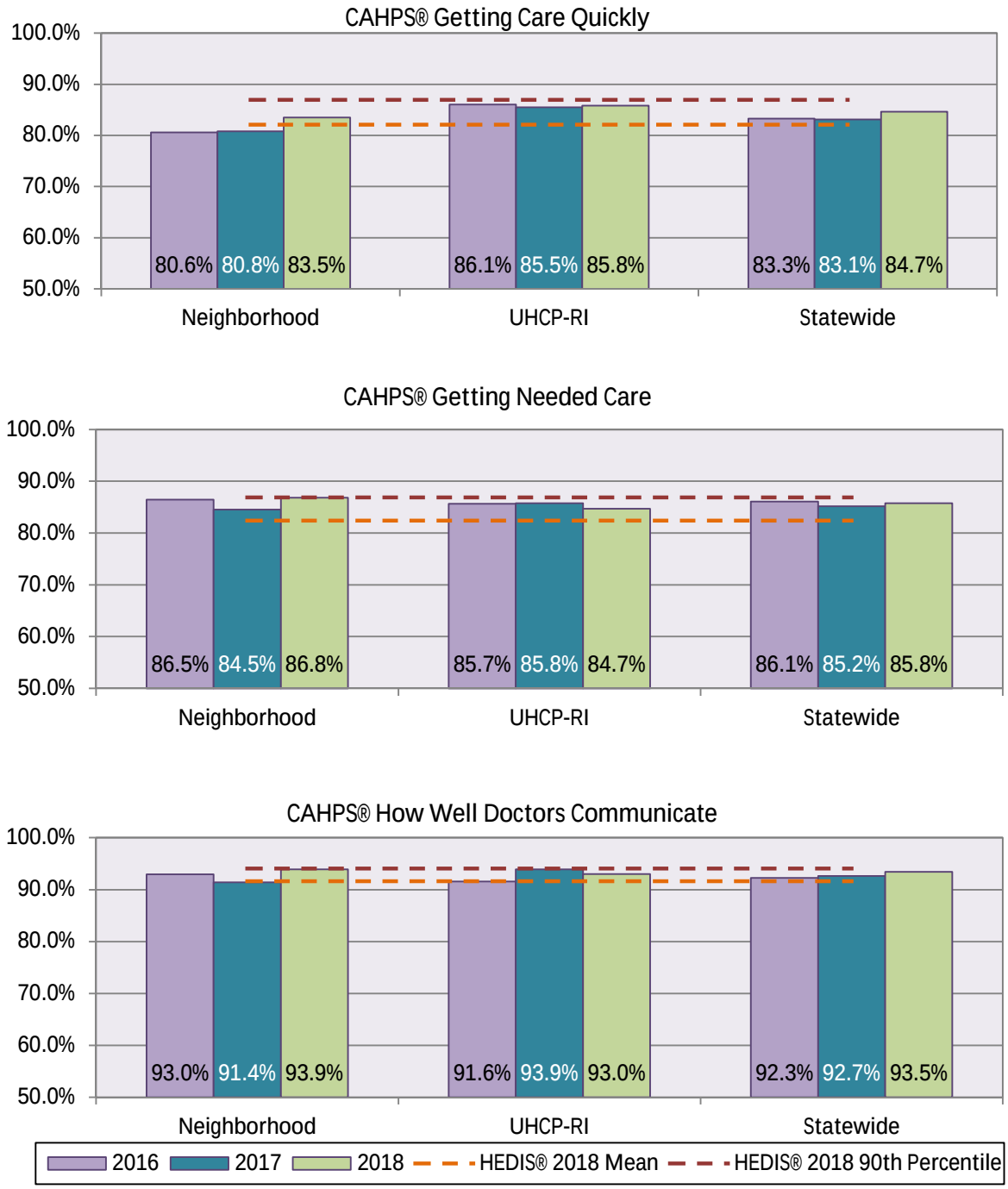
Figure 5a: Adult CAHPS® Member Satisfaction Rates—2016-2018[1]

SS: Sample size too small to report.

[1] The statewide rate for each of these bar charts was determined by calculating an unweighted average of Neighborhood and UHCP-RI's CAHPS® rates, since the size of the survey populations was similar and numerators and denominators were not available. Tufts did not conduct a CAHPS® survey for 2018.

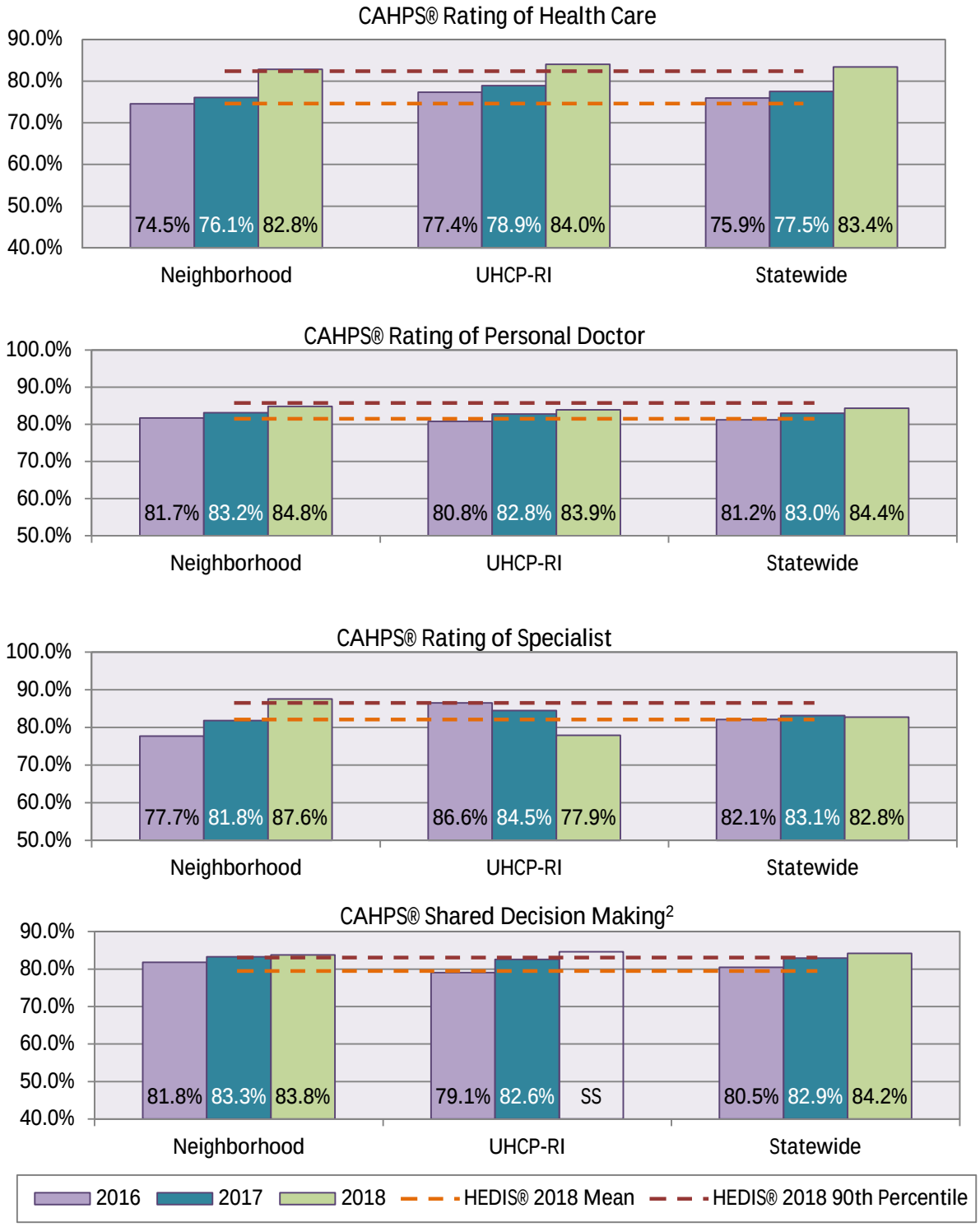
[2] The "SS" designation was given for UHCP-RI's *Customer Service* rate in 2017 and 2018 because the denominator was less than 100 members. However, the rate was included in the calculation of the statewide rate.

Figure 5a: Adult CAHPS® Member Satisfaction Rates—2016-2018[1] (continued)



[1] The statewide rate for each of these bar charts was determined by calculating an unweighted average of Neighborhood and UHCP-RI's CAHPS® rates, since the size of the survey populations was similar and numerators and denominators were not available. Tufts did not conduct a CAHPS® survey for 2018.

Figure 5a: Adult CAHPS® Member Satisfaction Rates—2016-2018[1] (continued)



SS: Sample size too small to report.

[1] The statewide rate for each of these bar charts was determined by calculating an unweighted average of Neighborhood and UHCP-RI's CAHPS® rates, since the size of the survey populations was similar and numerators and denominators were not available. Tufts did not conduct a CAHPS® survey for 2018.

[2] The "SS" designation was given for UHCP-RI's *Shared Decision Making* rate in 2018 because the denominator was less than 100 members. However, the rate was included in the calculation of the statewide rate.

Member Satisfaction: Child CAHPS® 5.0[15]

In addition to the adult CAHPS® survey, both Neighborhood and UHCP-RI elected to conduct the child CAHPS® 5.0 survey. Neighborhood surveyed the Children with Chronic Conditions (CCC) population while UHCP-RI surveyed the Child General population. Although reporting of the child CAHPS® survey is not required, this extended effort demonstrates a commitment to providing quality health care to all members. Comparisons across Health Plans and to statewide rates could not be made due to the differences in populations surveyed.

Neighborhood's rates exceeded the 2018 *Quality Compass*® national Medicaid mean for four (4) of the seven (7) measures reported. Neighborhood achieved the 90th percentile for the *Rating of Health Plan* measure and achieved the 75th percentile for the *Rating of Specialist* measure. The remaining five (5) rates were below the 75th percentile.

UHCP-RI's rates exceeded the 2018 *Quality Compass*® national Medicaid mean for five (5) of the six (6) measures reported. UHCP-RI achieved the 95th percentile for the *Getting Care Quickly* measure and achieved the 75th percentile for the *How Well Doctors Communicate* measure. The remaining four (4) rates were below the 75th percentile.

[15] The rates for CAHPS® measures included all Medicaid members in the survey sample, where eligible population criteria are met. As such, the CSHCN and Substitute Care (Neighborhood only) populations were included in the child CAHPS® sample for each Health Plan.

IX. RHODE ISLAND PERFORMANCE GOAL PROGRAM[16]

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 (PGP), 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 2018, the Performance Goal Program entered its twentieth (20th) 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. From Reporting Year 2005 through Reporting Year 2016, 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)*

In Reporting Year 2017, the performance categories were redefined into eight (8) categories. For Reporting Year 2018, the following performance categories were used to evaluate Health Plan performance:

- *Utilization*
- *Access to Care*
- *Prevention and Screening*
- *Women's Health*
- *Chronic Care*
- *Behavioral Health*

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 that do not have national metrics for comparison. Many of the measures are calculated through the Health Plan's HEDIS® and CAHPS® data submissions. Other measures are derived from data collected during the annual, on-site Health Plan monitoring visit conducted by EOHHS, and others are calculated by EOHHS using encounter data submitted by the Health Plans. For the reference period of Calendar Year 2017, the evaluation was conducted by EOHHS in April 2018.

Prior to 2005, the State defined performance goal standards in its contracts with the 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®

[16] The rates for all PGP measures include all Medicaid members, where eligible population criteria are met.

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. PGP 2011 was the first year that benchmarks for several measures were set at the 75th percentile (full award) and the 50th percentile (partial award) for the following HEDIS® measures: *Adult BMI Assessment*, *Weight Assessment & Counseling for Nutrition and Physical Activity for Children and Adolescents*, and *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 HEDIS® *Members with Persistent Asthma Used Appropriate Medications (Total)* measure was introduced. This measure was an aggregate of the *Members with Persistent Asthma Used Appropriate Medications* age-stratified measures. Prior to the 2013 PGP, each age-stratified measure was individually eligible for an incentive award; however, only the total rate was used in the calculation of the 2013 incentive awards. Although the age-stratified measures were not eligible for inclusion in the calculation of the incentive awards, rates for these measures were presented.

The following HEDIS® measures were added to the Behavioral Health domain for the 2015 PGP: *Initiation of Alcohol and Other Drug Dependence Treatment*, *Engagement of Alcohol and Other Drug Dependence 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 benchmarking or incentive awards. In addition, the NCQA retired the HEDIS® *Annual Monitoring for Patients on Persistent Medications—Anticonvulsants* measure in 2015. Therefore, this measure was removed from the PGP metrics.

Additionally, with the introduction of the Rhody Health Expansion (RHE) population, PGP 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 Plans earned separate incentive awards based on the results for each.

In 2016, the NCQA retired the HEDIS® *Members with Persistent Asthma Used Appropriate Medications* measure, and as such, the measure was removed from the PGP metrics. It was replaced with the HEDIS® *Medication Management for People with Asthma 75% (5-64 Years)* measure. Additionally, the HEDIS® *Annual Monitoring for Patients on Persistent Medications* measure was removed from the PGP metrics in 2016.

Further, several State-specified measures were removed from the metrics for the 2016 PGP, including: *ID Card 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*, and *Notify the State of Third-Party Liability within 5 Days of Identification*.

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 of 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 benchmarking or incentive awards. The State also included the HEDIS® *Call Answer Timeliness* measure as a metric for the 2016 PGP, along with the following HEDIS® *Comprehensive Diabetes Care* sub-measures: *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Retinal Eye Exam Performed*, and *Blood Pressure Control*.

In addition to the measure changes for the 2016 PGP, all benchmark goals for HEDIS® and CAHPS® measures were set at the 90th percentile (full award) and the 75th percentile (partial award), with no exceptions.

Several HEDIS® and CAHPS® measures were removed from the PGP metrics for the 2017 PGP, including: HEDIS® *Use of Imaging Studies for Low Back Pain*, CAHPS® *Access to Urgent Care*, HEDIS® *Adolescent Immunizations—HPV*, HEDIS® *Call Answer Timeliness*, and HEDIS® *Pharmacotherapy Management of COPD*. Additionally, the State-specified measure *Decrease the Average Total Cost of Care—High Utilizers* was removed. Several measures were also introduced for the 2017 PGP, including: *Payments Made in an Alternative Payment Model*, HEDIS® *Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis*, CAHPS® *Access to Specialists*, *Developmental Screening in the First Three Years of Life*, HEDIS® *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance*, CAHPS® *Flu Vaccinations for Adults (18-64 Years)*, HEDIS® *Adolescent Immunizations—Combination 2*, HEDIS® *Breast Cancer Screening*, and *Health Plan All-Cause Readmissions*. Finally, the HEDIS® *Initiation of Alcohol and Other Drug Dependence Treatment* and *Engagement of Alcohol and Other Drug Dependence Treatment* measures were moved from the Behavioral Health domain to the Access to Care domain.

Changes in Methodology for the 2018 Performance Goal Program

The PGP underwent several methodology changes for Reporting Year 2018. First, the Health Plans reported PGP metrics for the total population, rather than separately for the RHE population and the Non-RHE populations. Incentive awards were earned based on the results for *All Populations*, rather than separately awarded. Additionally, the PGP metrics were chosen based on the measures in most need of improvement across the Health Plans.

2018 Rhode Island Medicaid Managed Care Performance Goal Program Results

This section of the report evaluates performance on the PGP measures for 2018 for Neighborhood and UHCP-RI. Tufts was unable to report sufficient data for Reporting Year 2018, and therefore did not participate in the Performance Goal Program for 2018. Table 7 presents the rates for the 2018 PGP metrics. The HEDIS® percentiles displayed were derived from the 2018 Performance Goal Program results, in which rates were benchmarked against the NCQA's *Quality Compass*® 2017 for Medicaid.

The Utilization domain included one (1) measure for Reporting Year 2018, HEDIS® *Adolescent Well-Care Visits*. Both Neighborhood and UHCP-RI reported rates that exceeded the 2017 *Quality Compass*® 75th percentile and qualified for a partial incentive award for this measure.

Of the five (5) measures included in the Access to Care domain, the Health Plans reported rates qualifying for incentive awards for two (2) of the measures. Both Health Plans achieved the 2017 *Quality Compass*® 90th percentile for HEDIS® *Postpartum Care* and the 75th percentile for HEDIS® *Engagement of Alcohol and Other Drug Dependence Treatment*. Neighborhood and UHCP-RI both reported rates that did not meet a *Quality Compass*® benchmark to qualify for an incentive award for the following three (3) HEDIS® measures: *Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)*, *Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)*, and *Initiation of Alcohol and Other Drug Dependence Treatment*.

The Prevention and Screening domain was comprised of eight (8) HEDIS® measures and one (1) State-specified measure for Reporting Year 2018. For the State-specified measure *Developmental Screening in the First Three Years of Life*, Neighborhood reported a rate that exceeded the State-selected target to qualify for a full incentive award, while UHCP-RI reported a rate that exceeded the State-selected target to qualify for a partial incentive award.

Regarding the eight (8) HEDIS® measures within this domain, both Health Plans reported rates that exceeded the 2017 *Quality Compass*® 90th percentile for the following measures: *Childhood Immunization Status—Combination 10*, *Adolescent Immunizations—Combination 2*, *Weight Assessment & Counseling—BMI Percentile (3-17 Years)*, *Weight Assessment & Counseling—Nutrition (3-17 Years)*, and *Weight Assessment & Counseling—Physical Activity (3-17 Years)*. Additionally, Neighborhood reported a rate exceeding the 2017 *Quality Compass*® 90th percentile for the *Adult BMI*

Assessment measure, while UHCP-RI reported a rate exceeding the 75th percentile for this measure. Neither Health Plan reported a rate that qualified for an incentive award for the two (2) remaining HEDIS® measures in this domain, *Lead Screening in Children* and *Breast Cancer Screening*.

In the Women's Health domain, both Health Plans reported rates exceeding the 2017 *Quality Compass*® 75th percentile and qualified for partial incentive awards for the sole measure included, HEDIS® *Chlamydia Screening in Women (16-20 Years)*.

For Reporting Year 2018, the Chronic Care domain included three (3) HEDIS® measures and one (1) State-specified measure. For the State-specified measure *HIV Viral Load Suppression*, both Health Plans reported rates exceeding the State-selected target to qualify for a partial incentive award. Regarding the three (3) HEDIS® measures, performance varied across the Health Plans. For the *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure, UHCP-RI's rate exceeded the 2017 *Quality Compass*® 90th percentile and qualified for a full incentive award, while Neighborhood's rate exceeded the 75th percentile and qualified for a partial incentive. Conversely, for the *Controlling High Blood Pressure* measure, Neighborhood reported a rate exceeding the 90th percentile, while UHCP-RI reported a rate exceeding the 75th percentile. UHCP-RI also earned a partial incentive award for the *Medication Management for People with Asthma 75% (5-64 Years)* measure with a rate exceeding the 75th percentile, while Neighborhood's rate for that measure did not meet a *Quality Compass*® benchmark to qualify for an incentive award.

The Behavioral Health domain included the following three (3) HEDIS® measures: *Follow-Up After Hospitalization for Mental Illness—7 Days*, *Antidepressant Medication Management—Effective Acute Phase Treatment*, and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*. Neither Health Plan reported a rate meeting a *Quality Compass*® benchmark to qualify for an incentive award for any of the measures included in this domain.

Table 7: Performance Goal Program Results—2018[1]

RI Medicaid Managed Care Performance Goal Program Measures	Neighborhood		UHCP-RI	
	2018 Rate	2017 Target Met[2,3]	2018 Rate	2017 Target Met[2,3]
Utilization				
HEDIS® Adolescent Well-Care Visits	64.1%	75th	65.0%	75th
Access to Care				
HEDIS® Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)	94.8%	NM	91.6%	NM
HEDIS® Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)	89.3%	NM	87.9%	NM
HEDIS® Postpartum Care	77.6%	90th	76.2%	90th
HEDIS® Initiation of Alcohol and Other Drug Dependence Treatment	42.7%	NM	45.1%	NM
HEDIS® Engagement of Alcohol and Other Drug Dependence Treatment	18.6%	75th	18.8%	75th
Prevention and Screening				
HEDIS® Childhood Immunization Status—Combination 10	61.3%	90th	58.9%	90th
HEDIS® Lead Screening in Children	79.0%	NM	76.6%	NM
HEDIS® Adolescent Immunizations—Combination 2	53.3%	90th	45.5%	90th
HEDIS® Weight Assessment & Counseling—BMI Percentile (3-17 Years)	91.6%	90th	89.3%	90th
HEDIS® Weight Assessment & Counseling—Nutrition (3-17 Years)	85.5%	90th	83.5%	90th
HEDIS® Weight Assessment & Counseling—Physical Activity (3-17 Years)	82.4%	90th	75.9%	90th
HEDIS® Breast Cancer Screening	64.6%	NM	62.3%	NM
HEDIS® Adult BMI Assessment	94.2%	90th	93.2%	75th
Developmental Screening in the First Three Years of Life[4,5]	65.5%	M/E	57.4%	PM
Women's Health				
HEDIS® Chlamydia Screening in Women (16-20 Years)	68.3%	75th	65.2%	75th
Chronic Care				
HEDIS® Comprehensive Diabetes Care—HbA1c Control (<8.0%)	57.4%	75th	60.1%	90th
HEDIS® Controlling High Blood Pressure (18-85 Years)	74.4%	90th	69.6%	75th
HEDIS® Medication Management for People with Asthma 75% (5-64 Years)	39.2%	NM	43.1%	75th
HIV Viral Load Suppression[4,6]	71.6%	PM	72.4%	PM
Behavioral Health				
HEDIS® Follow-Up After Hospitalization for Mental Illness—7 Days	55.5%	NM	55.1%	NM
HEDIS® Antidepressant Medication Management—Effective Acute Phase Treatment	50.5%	NM	51.2%	NM
HEDIS® Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	47.2%	NM	47.6%	NM

M/E: Met or exceeded the State-specified *Contract* goal for a full incentive award; PM: Met or exceeded the State-specified *Contract* goal for a partial incentive award; NM: Did not meet a *Contract* goal to qualify for an incentive award

[1] Performance Goal Program data are based on the previous Contract Year (i.e., 2018 rates are based on Contract Year 2016). Rates may differ from other data published in this report, as this table reflects preliminary HEDIS® rates, while the rates in all other tables reflect final data submitted to the NCQA for all populations.

[2] For State-specified measures, national benchmarks are not available. Incentive awards were determined using State-selected benchmarks.

[3] For HEDIS® measures, incentive awards were based on 2017 *Quality Compass*® national Medicaid 90th and 75th percentile benchmarks.

[4] State-specified measure.

[5] The benchmark for a full award for this measure was 65% and the benchmark for a partial award was 50%.

[6] The benchmark for a full award for this measure was 88% and the benchmark for a partial award was 68%.

Figures 6a through 6f display the results of the PGP for Reporting Years 2016 through 2018 for each domain compared to the 2017 *Quality Compass*® benchmarks. Statewide rates presented in each of these figures were calculated by totaling the numerators and denominators for each Health Plan.

Figure 6a: PGP Results 2016-2018—Utilization

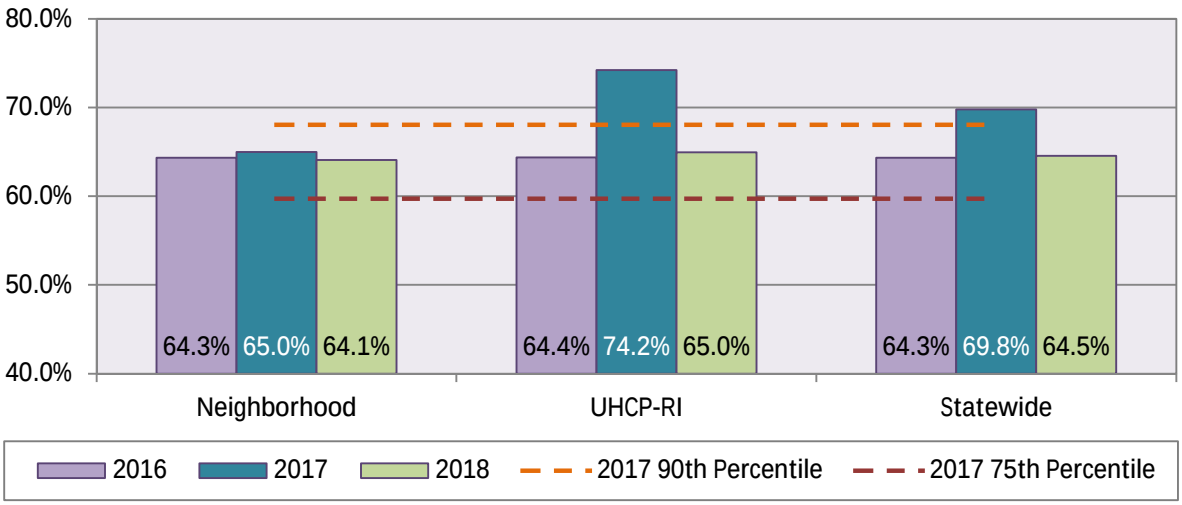


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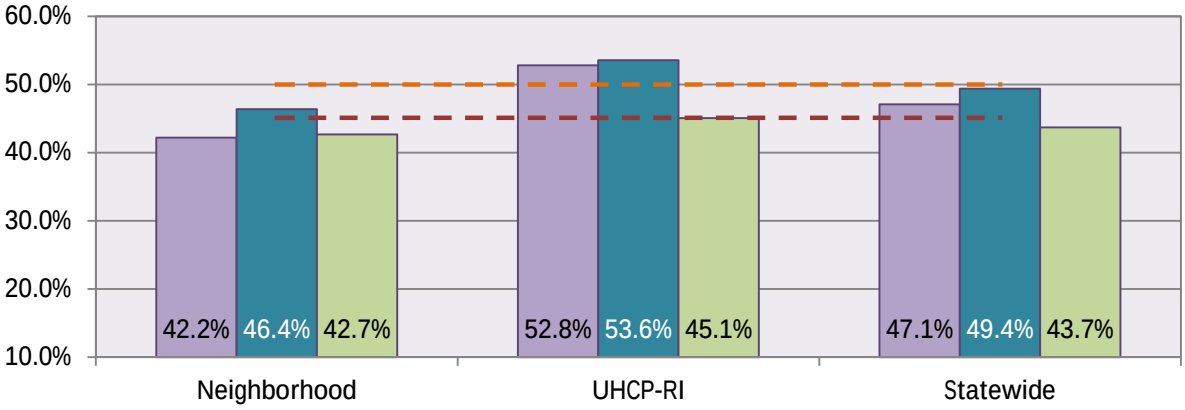
Figure 6b: PGP Results 2016-2018—Access to Care

Figure 6b: PGP Results 2016-2018—Access to Care (continued)

HEDIS® Initiation of Alcohol and Other Drug Treatment



HEDIS® Engagement of Alcohol and Other Drug Treatment

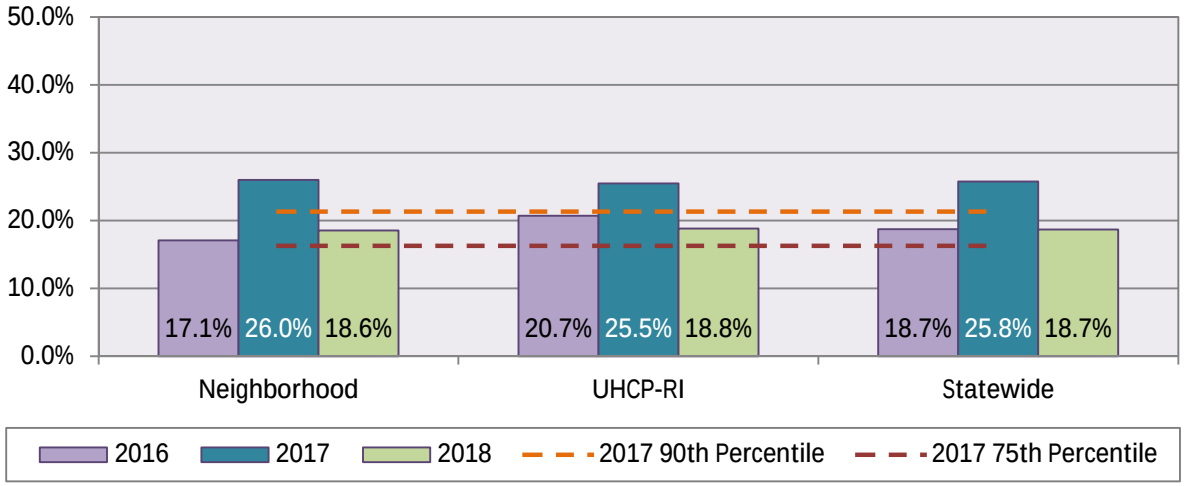


Figure 6c: PGP Results 2016-2018—Prevention and Screening

N/A: Not available

[1] The HEDIS® *Adolescent Immunizations—Combination 2* measure was not included in the PGP metrics for Reporting Year 2016.

Figure 6c: PGP Results 2016-2018—Prevention and Screening (continued)

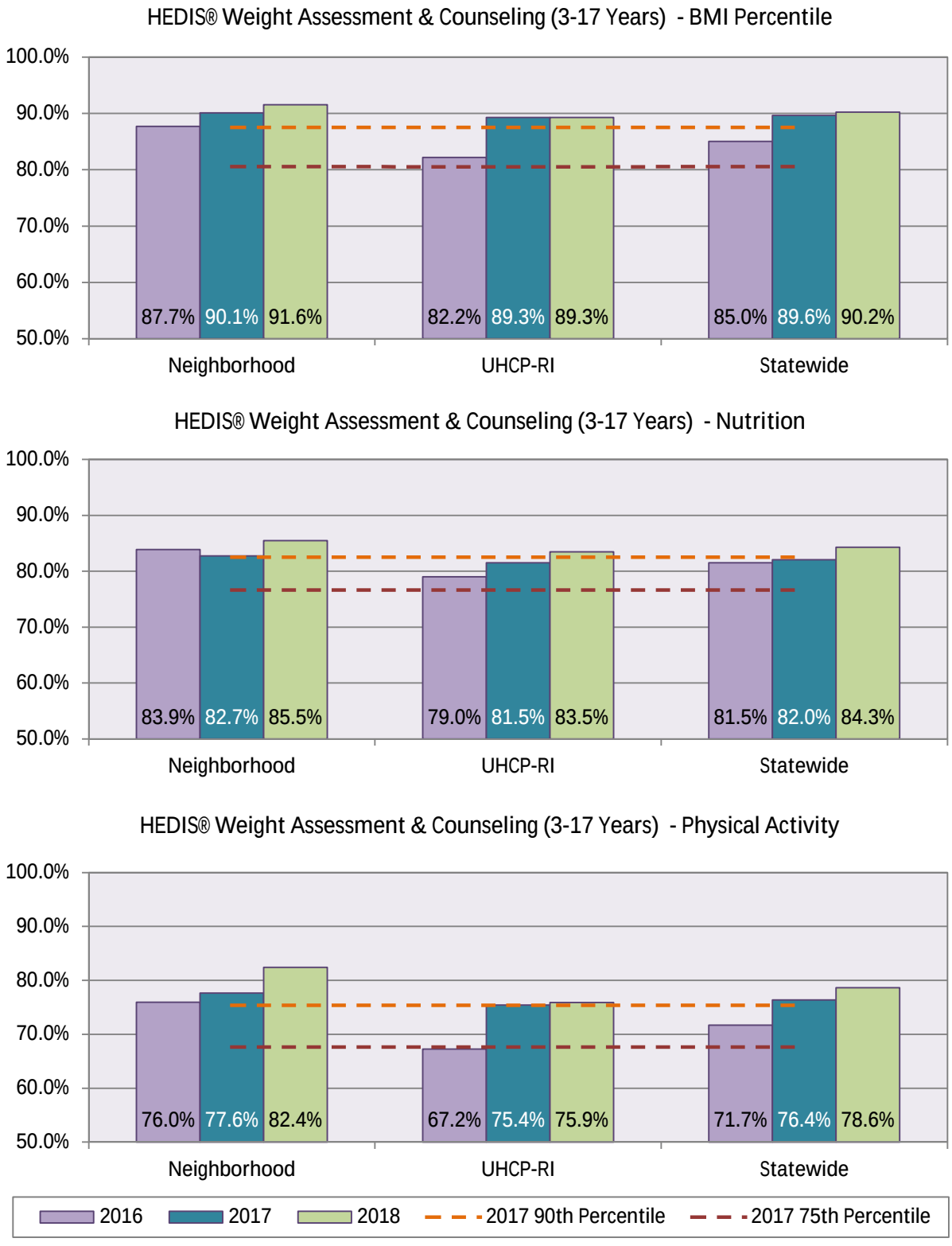


Figure 6c: PGP Results 2016-2018—Prevention and Screening (continued)

N/A: Not available

[1] The HEDIS® *Breast Cancer Screening* and *Developmental Screening in the First Three Years of Life* measures were not included in the PGP metrics for Reporting Year 2016.

Figure 6d: PGP Results 2016-2018—Women's Health

HEDIS® Chlamydia Screening (16-20 Years)

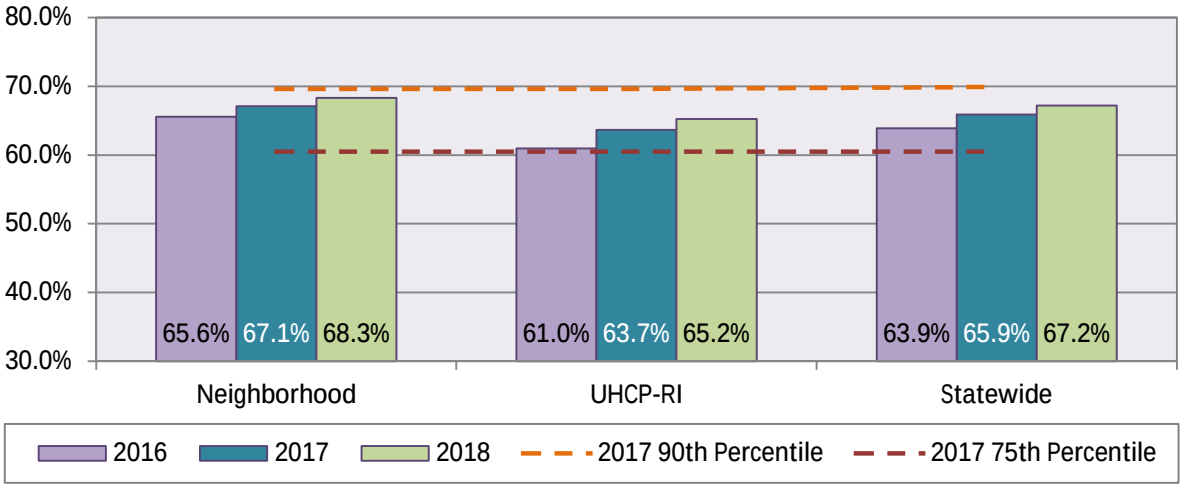


Figure 6e: PGP Results 2016-2018—Chronic Care

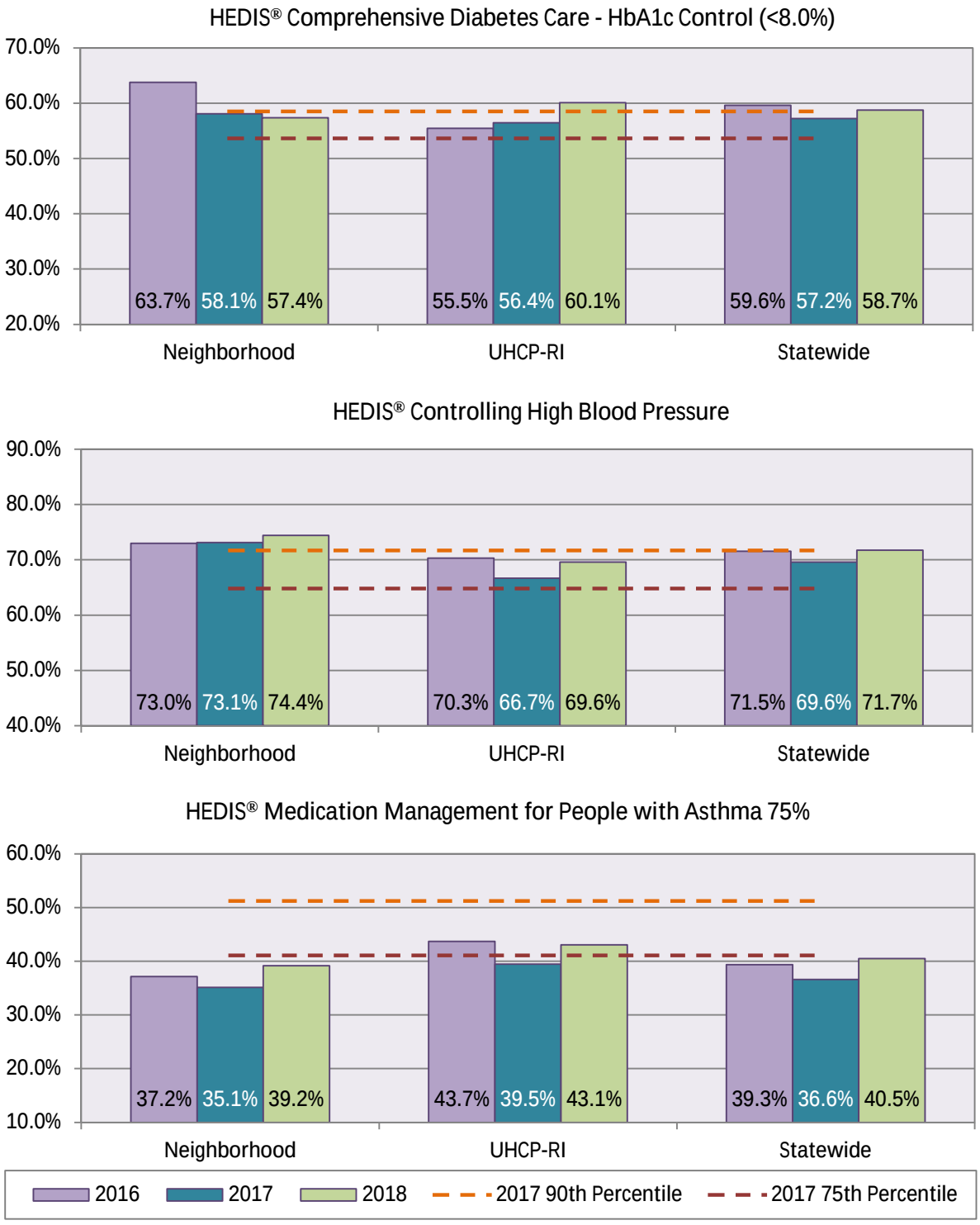


Figure 6e: PGP Results 2016-2018—Chronic Care (continued)

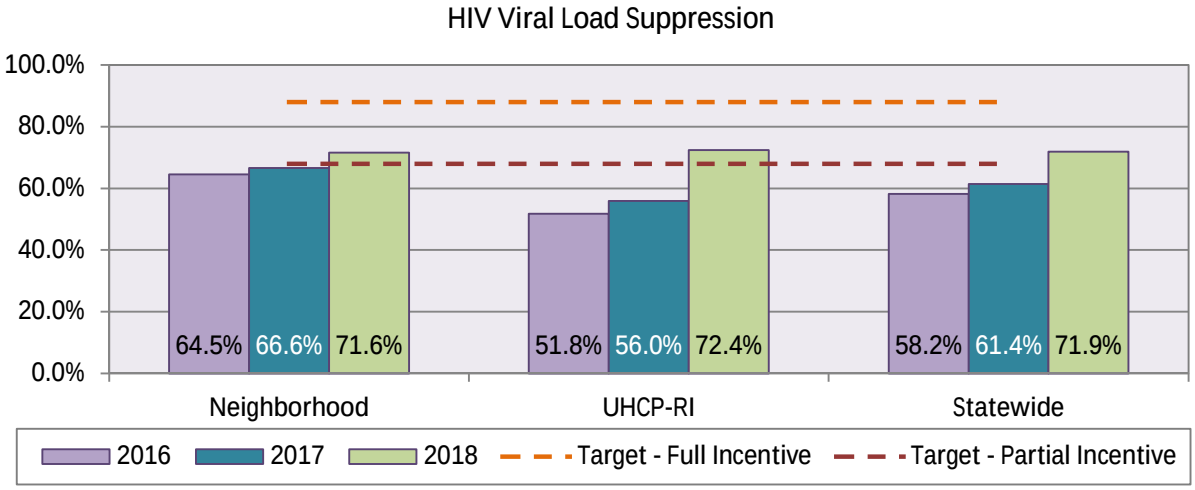
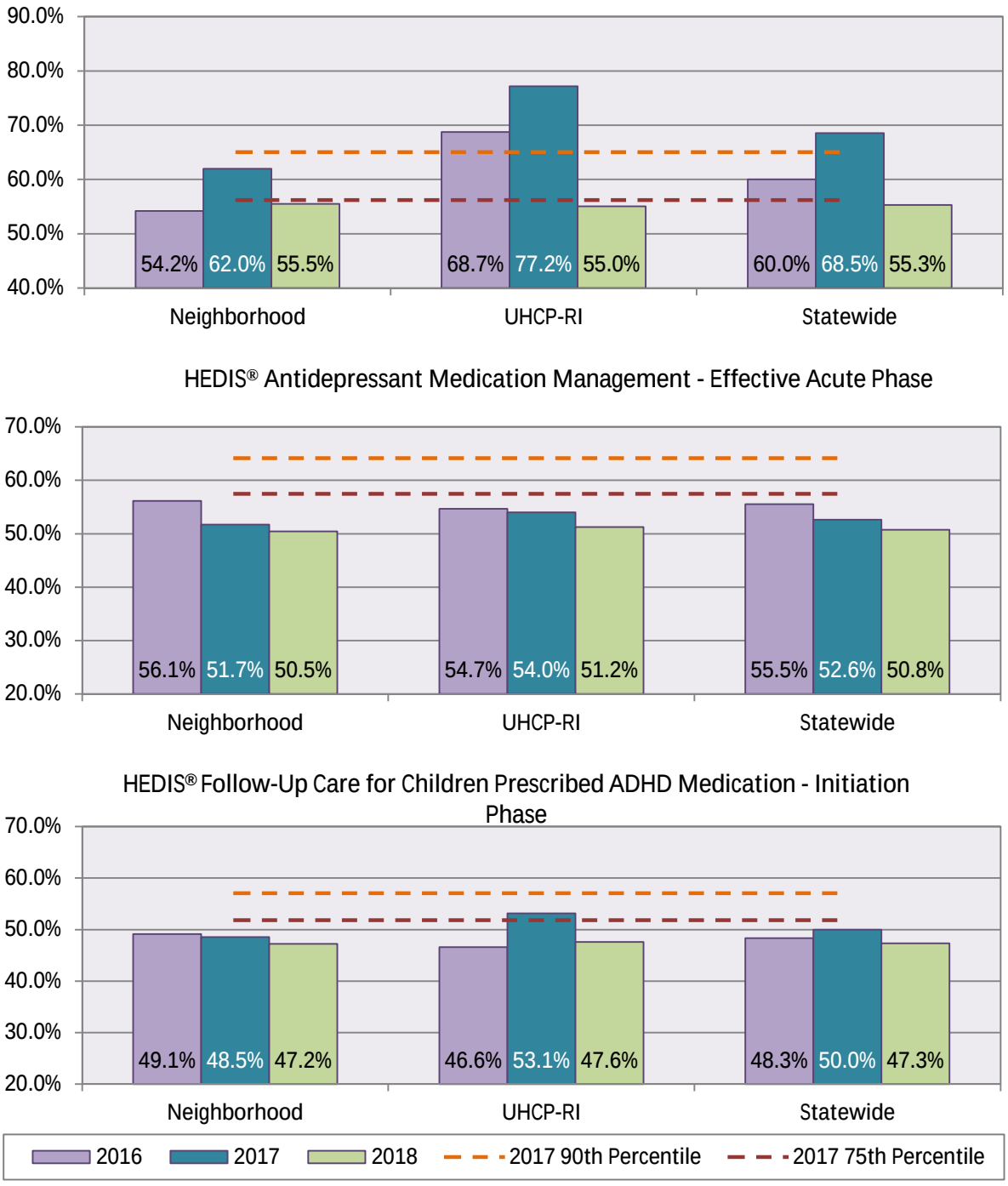


Figure 6f: PGP Results 2016-2018—Behavioral Health



X. QUALITY IMPROVEMENT PROGRAM

The State of Rhode Island Executive Office of Health and Human Services requires that contracted Health Plans have a written quality assurance (QA) or quality management (QM) plan that monitors, assures, and improves the quality of care delivered over a wide range of clinical and health service delivery areas, including all subcontractors. Emphasis shall be placed on, but need not be limited to, clinical areas related to management of chronic disease, 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; and
- 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; and
- Provide for systematic data collection of performance and patient results, interpretation of these data to practitioners, and making needed changes when problems are found.

Quality Improvement Program Structure

Full descriptions of each Health Plan's Quality Improvement Program structure can be found in the individual, Health Plan-specific 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, as well as the Health Plan-established Communities of Care programs[17]. All QIPs were to be documented on the NCQA's Quality Improvement Activity (QIA) Form, as has been the case since 2008. The QIA Form template can be found in Appendix 2 of this report.

Topic selection guidelines have been revised over the years. 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 each Health Plan's own choosing. For the period of 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 each Health Plan's own choosing, with the State's approval. Beginning in 2011, and for the most recent contract period (2017-2018), three (3) QIP topics were chosen by the State that would address the quality improvement needs of all Health Plans. For Reporting Year 2018, the State directed the Health Plans to conduct QIPs related to the following topics: *Developmental Screening in the First Three Years of Life*, HEDIS® *Lead Screening in Children*, and HEDIS® *Follow-Up Care for Children Prescribed ADHD Medication*. The fourth QIP topic was of each Health Plan's own choosing from among State-suggested topics specific to each Health Plan, with the State's approval. Neighborhood elected to conduct a QIP targeting specific age groups of the HEDIS® *Children and Adolescents' Access to Primary Care Practitioners*, while UHCP-RI chose to focus the QIP on the HEDIS® *Breast Cancer Screening* measure. As Tufts did not begin enrollment in the Medicaid product line until Calendar Year 2017, the Health Plan did not have sufficient information to participate in meaningful QIPs for Reporting Year 2018.

[17] The State's *Medicaid Managed Care Services Contract* (July 2018) requires that all Health Plans establish and maintain a Communities of Care program designed to decrease non-emergent and avoidable emergency department (ED) utilization through service coordination, defined member responsibilities, and associated incentives and rewards.

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 validation of performance improvement projects. Summaries of each of the QIPs conducted by the Health Plans can be found in the individual, Health Plan-specific Technical Reports.

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XI. CONCLUSIONS AND RECOMMENDATIONS[18]

IPRO's external quality review concludes that, in the measurement period 2017-2018, the Rhode Island Medicaid managed care program, as well as the participating Health Plans, continued to have an overall positive impact on the accessibility, timeliness, and quality of health care services provided to Medicaid recipients. Both Health Plans continued to receive *"Excellent"* accreditation from the NCQA for their Medicaid product lines. Additionally, both Health Plans earned an overall rating of four and a half (4.5) out of five (5) as Medicaid Health Plans. Neighborhood and UHCP-RI continued to demonstrate above average performance (rates in the *Quality Compass*® 95th, 90th, and 75th percentiles) for many of the quality and accessibility measures reported, as well as on the State's Performance Goal Program metrics.

Despite an overall strong performance, there remain a number of areas in which improvement is warranted, particularly in areas that are consistently defined as opportunities for improvement for the Health Plans.

With the exception of those shown for the 2018 Performance Goal Program, the Medicaid benchmarks and HEDIS® and CAHPS® percentiles cited in this annual EQR Technical Report originated from the NCQA's *Quality Compass*® 2018 for Medicaid. Scoring percentiles for the 2018 Performance Goal Program were derived from the *Quality Compass*® 2017 for Medicaid.

In addition to the overall conclusions on the performance of the State's Medicaid managed care program, both Neighborhood and UHCP-RI demonstrated varying strengths and opportunities for improvement. Each Health Plan was issued individual recommendations addressing the noted areas for improvement. These findings are described in detail in Section XII of each Health Plan's individual EQR Technical Report.

Quality of Care

This section provides a description of the strengths and opportunities for improvement exhibited by Neighborhood and UHCP-RI, 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 of care, Neighborhood and UHCP-RI, and the Medicaid managed care program, demonstrated the following strengths:

- The Health Plans earned an *"Excellent"* accreditation from the NCQA. Specifically, both Health Plans earned four (4) stars for the *Access and Service* and *Qualified Providers* domains of the Accreditation Survey, while Neighborhood earned four (4) stars and UHCP-RI earned three (3) stars for the *Staying Healthy* domain.
- Both Health Plans received an overall Health Plan rating of four and a half (4.5) out of five (5) for their Medicaid product line in 2018. Specifically, for the *Consumer Satisfaction* category, Neighborhood received a four and a half (5) and UHCP-RI received a three and a half (3.5); for the *Prevention* category, both Health Plans received a four and a half (5); and for the *Treatment* category, Neighborhood received a three and a half (3.5) and UHCP-RI received a four (4).
- The Health Plans, and the Medicaid managed care program overall, performed well on the HEDIS® Effectiveness of Care domain. Rates for both Health Plans, as well as the statewide rate, benchmarked at the 2018 *Quality Compass*® 90th percentile for *Follow-Up After Hospitalization for Mental Illness—30 Days* and *Follow-Up After Hospitalization for Mental Illness—7 Days*. Additionally, Both Health Plans' rates benchmarked at the 90th percentile for *Childhood Immunization Status—Combination 10*, as did the statewide rate. For the *Childhood Immunization Status—Combination 3* measure, Neighborhood's rate and the statewide rate benchmarked at the 90th percentile, while UHCP-RI's rate benchmarked at the 75th percentile. Neighborhood's rate and the statewide rate benchmarked at the 90th percentile for *Cervical Cancer Screening for Women*, while UHCP-RI's rate

[18] The comments noted in this section of the report are based on the performance of Neighborhood and UHCP-RI, as Tufts was unable to report data for the majority of measures included in this Annual EQR Technical Report.

benchmarked at the 75th percentile, as well. For the *Chlamydia Screening for Women (16-24 Years)* measure, all rates benchmarked at the 75th percentile for 2018.

- Both Health Plans performed well on the Performance Goal Program Prevention and Screening domain. Both Health Plans reported rates benchmarking at a 2017 *Quality Compass*® percentile qualifying for an incentive award for the following six (6) HEDIS® measures: *Childhood Immunization Status—Combination 10*, *Adolescent Immunizations—Combination 2*, *Weight Assessment & Counseling—BMI Percentile*, *Weight Assessment & Counseling—Nutrition*, *Weight Assessment & Counseling—Physical Activity*, and *Adult BMI Assessment*. All rates reported by Neighborhood benchmarked in the 90th percentile, while UHCP-RI's rates benchmarked at the 90th percentile for five (5), with *Adult BMI Assessment* benchmarking at the 75th percentile. Additionally, Neighborhood reported a rate that met the *Contract* goal to qualify for a full incentive award for the State-specified measure *Developmental Screening in the First Three Years of Life*, while UHCP-RI's rate qualified for a partial incentive award.
- Neighborhood and UHCP-RI reported rates that benchmarked at the 2017 *Quality Compass*® 75th percentile for the only measure included in the Women's Health domain of the Performance Goal Program: *Chlamydia Screening in Women (16-20 Years)*.
- Regarding the Chronic Care domain of the Performance Goal Program, both Health Plans reported rates qualifying for a partial incentive award for the State-specified measure *HIV Viral Load Suppression*. For the HEDIS® *Controlling High Blood Pressure (18-85 Years)* measure, Neighborhood reported a rate benchmarking in the 2017 *Quality Compass*® 90th percentile, while UHCP-RI's rate benchmarked in the 75th percentile. Conversely, UHCP-RI's rate for HEDIS® *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* benchmarked in the 90th percentile, while Neighborhood's rate benchmarked in the 75th percentile.
- Neighborhood and UCHP-RI reported a rate above the 2018 *Quality Compass*® 90th percentile for the Adult CAHPS® *Rating of All Health Care* measure and a rate at the 75th percentile for the Adult CAHPS® *Flu Vaccinations for Adults* measure. Neighborhood reported a rate at the 90th percentile for the Children with Chronic Conditions CAHPS® *Rating of Health Plan* measure and a rate at the 75th benchmark for the Children with Chronic Conditions CAHPS® *Shared Decision Making* measure. UHCP-RI reported a rate at the 95th percentile for the General Child CAHPS® *Getting Care Quickly* measure and reported a rate at the 75th percentile for the General Child CAHPS® *How Well Doctors Communicate* measure.

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

In the domain of quality of care, Neighborhood and UHCP-RI, and the Medicaid managed care program, demonstrated the following opportunities for improvement:

- Despite both Health Plans receiving an *"Excellent"* accreditation from the NCQA, there remains an opportunity for improvement regarding the NCQA Accreditation Survey. Both Health Plans received two (2) stars on the *Getting Better* domain of the Survey.
- In the HEDIS® Effectiveness of Care domain, both Health Plans demonstrate an opportunity for improvement regarding the *Medication Management for People with Asthma 75% (5-64 Years)* measure, and both Health Plans' rates were reported below the 2018 *Quality Compass*® 75th percentile.
- The Health Plans demonstrate an opportunity for improvement regarding the Performance Goal Program. Neither Health Plan reported rates qualifying for incentive awards for the following five (5) HEDIS® measures included in the Prevention and Screening and Behavioral Health domains: *Lead Screening in Children*, *Breast Cancer Screening*, *Follow-Up After Hospitalization for Mental Illness—7 Days*, *Antidepressant Medication Management—Effective Acute Phase Treatment*, and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*.
- Both Health Plans demonstrate an opportunity for improvement regarding member satisfaction in the child and children with chronic conditions populations. Neighborhood reported three (3) rates that are below both the

2018 *Quality Compass*® National Medicaid Mean and the 75th percentile for the Children with Chronic Conditions CAHPS® survey: *Getting Care Quickly*, *Getting Needed Care*, and *Rating of All Health Care.* UHCP-RI reported a rate that is below both the 2018 *Quality Compass*® National Medicaid Mean and below the 75th percentile for the General Child CAHPS® *Rating of Personal Doctor*.

In the domain of quality of care, IPRO recommends the following:

- The Health Plans continue to have difficulty improving their performance on the *Getting Better* domain of the NCQA Accreditation Survey. The Health Plans should conduct measure-level root cause analyses, reevaluate existing interventions, and modify the interventions based on the findings of the analyses.
- Although both Health Plans reported rates below the 75th percentile for the HEDIS® *Medication Management for People with Asthma 75% (5-64 Years)* measure, HEDIS® 2018 rates for both Neighborhood and UHCP-RI trended up from the previous year. As such, the Health Plans should continue with current the quality improvement strategy this measure and identify ways to enhance upon and to expand highly effective interventions.
- Both Health Plans reported several PGP measures that did not achieve *Quality Compass*® benchmarks. Similar to the previous reporting period, these measures are related to preventive screenings and behavioral health. The Health Plans should assess the effectiveness of the interventions implemented to address these areas of care and modify the interventions as needed. The Health Plans should also consider a collaborative approach to educating providers on the appropriate standards of care. Lastly, the Health Plans should consider utilizing pharmacists to conduct outreach to members regarding medication adherence.

Access to/Timeliness of Care

This section provides a description of the strengths and opportunities for improvement exhibited by Neighborhood and UHCP-RI, and the Medicaid managed care program overall, as well as recommendations regarding the access to/timeliness of care provided to Medicaid enrollees.

In the domain of access to/timeliness of care, Neighborhood and UHCP-RI, and the Medicaid managed care program, demonstrated the following strengths:

- Both Neighborhood and UHCP-RI continued to receive *Excellent* ratings on the *Access and Service* domain of the NCQA Accreditation Survey. Additionally, the Health Plans met or exceeded most or all of their established GeoAccess goals for the provider types reported.
- Regarding the HEDIS® Use of Services domain, all rates benchmarked at the 2018 *Quality Compass*® 90th percentile for *Well-Child Visits in the First 15 Months of Life (6+ Visits)* and the 75th percentile for *Adolescent Well-Care Visits*.
- In the HEDIS® Access and Availability domain, both Health Plans reported rates benchmarking in the 2018 *Quality Compass*® 75th percentile for the *7-11 Years* and *12-19 Years* age groups of the *Children and Adolescents' Access to Primary Care Practitioners* measure. Additionally, rates for both Health Plans benchmarked at the 90th percentile for both *Timeliness of Prenatal Care* and *Postpartum Care*.
- In the Utilization domain of the Performance Goal Program, the Health Plans reported rates benchmarking at the 2017 *Quality Compass*® 75th percentile and qualifying for a partial incentive award for the only measure included in the domain, HEDIS® *Adolescent Well-Care Visits*.
- For the Performance Goal Program Access to Care domain, the Health Plans' rates for the HEDIS® *Postpartum Care* measure benchmarked in the 2017 *Quality Compass*® 90th percentile and qualified for a full incentive award, while the rates for HEDIS® *Engagement of Alcohol and Other Drug Dependence Treatment* benchmarked in the 75th percentile and qualified for a partial incentive award.

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

In the domain of access to/timeliness of care, Neighborhood and UHCP-RI, and the Medicaid managed care program, demonstrated the following opportunities for improvement:

- The Health Plans demonstrated an opportunity for improvement regarding the Access and Availability Survey. The Health Plans' rates for timely appointments were low across many of the providers and appointment types.
- Both Health Plans continued to demonstrate an opportunity for improvement regarding the HEDIS® Access and Availability domain. Regarding the *Children and Adolescents' Access to Primary Care Practitioners* measure, both Health Plans reported rates below the 2018 *Quality Compass*® 75th percentile for the *12-24 Months* and *25 Months-6 Years* age groups. Additionally, both Health Plans reported rates below the 75th percentile for all three (3) age groups of the *Adults' Access to Preventive/Ambulatory Health Services* measure.
- Regarding the Access to Care domain of the Performance Goal Program, the Health Plans' reported rates did not benchmark in a 2017 *Quality Compass*® percentile to qualify for an incentive award for the following HEDIS® measures: *Children and Adolescents' Access to Primary Care Practitioners (12-24 Months)*, *Children and Adolescents' Access to Primary Care Practitioners (25 Months-6 Years)*, and *Initiation of Alcohol and Other Drug Dependence Treatment*.

In the domain of quality of care, IPRO recommends the following:

- Overall, the Health Plans should both evaluate the adequacy of its provider network as it relates to quality and size. The results of the most current Access and Availability surveys suggest that adult and pediatric members from both Health Plans face difficulty obtaining timely appointments. The Health Plans should monitor member services calls and member grievances related to access to identify barriers to care. The Health Plans should also reiterate appointment standards to network providers. The Health Plans should conduct outreach to members that have a history of not accessing primary care and assist these members with making appointments.

Quality Improvement Program

The overall strengths of the Health Plans' Quality Improvement Programs include the involvement of a variety of staff and departments, resources, and committees across all levels of the organizations. Full descriptions of each Health Plan's Quality Improvement Program can be found in Section XI of the Health Plan-specific Annual EQR Technical Reports. In addition, the Quality Improvement Activity (QIA) Form template in included in Appendix 2 of the Health Plan-specific reports, as well as Appendix 2 of this Aggregate EQR Technical Report.

In the contract period 2017-2018, 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 the Health Plans' processes. Results of the 2017-2018 quality improvement activities were mixed across projects and the Health Plans; some performance measures demonstrated improvement, while others demonstrated declines in performance. The Health Plans presented the results of each of the four (4) QIPs to EOHHS in December 2018. Summaries of the QIPs can be found in Section XI of the individual Health Plan Annual EQR Technical Reports.

EOHHS Responses and Follow-Up 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.

2018 Performance Goal Program/On-Site Monitoring Feedback

EOHHS issued the results of the 2018 PGP to the Health Plans in September 2018, 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) 2017 EQR Technical Report

During 2018, a separate correspondence was sent by the State in conjunction with the transmittal of the EQR Technical Report, which focused on RY 2017. 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 2018 regarding the RY 2017 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

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 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 so 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.

Through the Comprehensive 1115 Demonstration, Medicaid-funded services on the continuum of care are now organized, financed, and delivered through a single demonstration.[19] 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

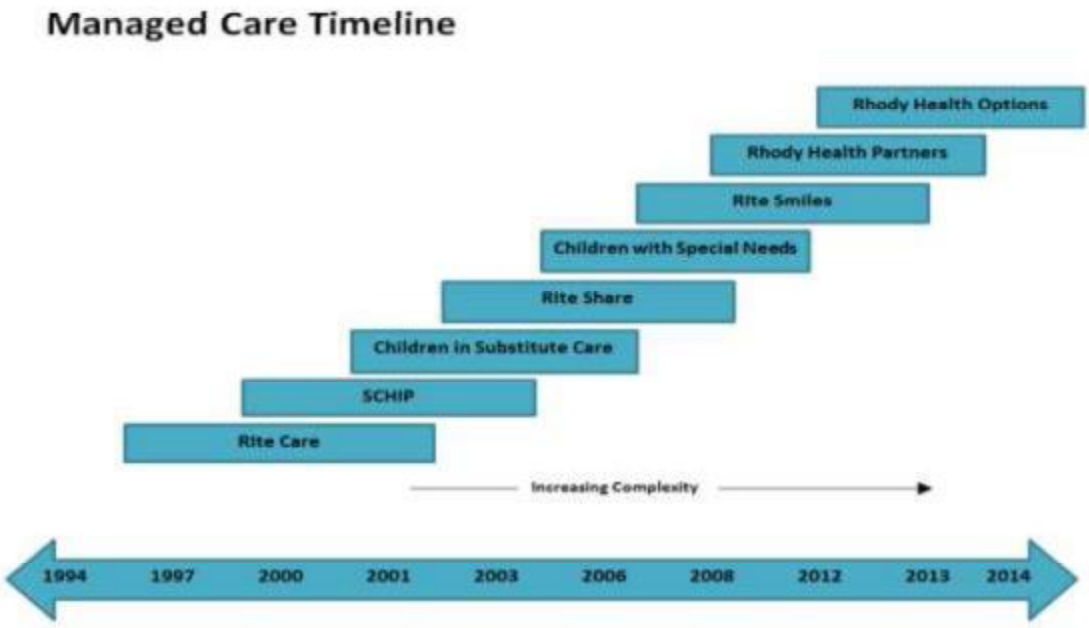
[19] Excluded from the Demonstration are: (1) disproportionate share hospital (DSH) payments; (2) administrative expenses; (3) phased-Part D contributions; and (4) payments to local education agencies (LEA) for services that are furnished only in a school-based setting, and for which there is no third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

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.



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 have more than double since June 1998.

- SCHIP and Coverage Expansions
  Effective November 1, 1998, RIte Care expanded to families with children under 18 including parents and relative caretakers within incomes up to 185% of the Federal poverty line (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.[20]

- 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 the 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 year 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 Partners was implemented. In the fall of 2009, all Medicaid-eligible ABD adults without third-party coverage 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.

[20] 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.

Table 1: Enrollment (as of September, 2014) in each of these programs have been provided below[21]:

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

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®[22]	· 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

[21] These enrollment figures represent a point-in-time snapshot as of 09/30/2014.
[22] 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.

Table 2: Managed Care Objectives (Abstracted from Rhode Island's Section 1115 Evaluation Design)		
Objective	Data Source(s)	Illustrative Measure(s)
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®[23] · 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

In order to meet the objective of increase 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 the 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 of 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 alternatives 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

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

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 users" have a 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.

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[24]
- 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)[25]
- Quarterly Health Plan Reports

[24] 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).
[25] This quarterly report serves as a comprehensive extract of MMIS data across the Medicaid program.

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

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	UHC Dental

Data Collection Method	Type of Method	Performed By
	established by RI Medicaid.	
Member Satisfaction Survey	Mailed survey written in English and Spanish focusing on access to services, use of services, customer service, and satisfactions with service.	RI Medicaid
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

Note: The full quality strategy is available at
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Reports/RIMedicaidComprehensiveQualityStrategy.pdf

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:	If administrative, check all that apply:
[ ] Medical/treatment record abstraction	[ ] Programmed pull from claims/encounter files of all eligible members
If survey, check all that apply:	[ ] Programmed pull from claims/encounter files of a sample of members
[ ] Personal interview	[ ] Complaint/appeal data by reason codes
	[ ] Pharmacy data

[ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet [ ] Incentive provided [ ] Other (list and describe): _____	[ ] 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.