



Rhode Island
Medicaid Managed Care Program
Annual External Quality Review Technical Report

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Prepared on Behalf of
The State of Rhode Island
Executive Office of Health and Human Services
Center for Child and Family Health

IPRO Corporate Headquarters
Managed Care Department
1979 Marcus Avenue
Lake Success, NY 11042-1002
phone: (516) 326-7767
fax: (516) 326-6177
www.ipro.org

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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)¹ contracted with IPRO to assess and report the impact of its Medicaid managed care program and both of the participating Health Plans on the accessibility, timeliness, and quality of services. It is important to note that the provision of health care services to each of the eligibility groups, including Core Rite Care, Rite Care for Children with Special Health Care Needs (CSHCN), Rite Care for Children in Substitute Care (SC) (NHPRI only) and Rhody Health Partners (RHP) is evaluated in this report. RHP is a managed care option for adults with disabilities populations. As members of the Health Plans, each of these populations is included in all measure calculations, where applicable.

In addition to individual technical reports that detail IPRO's independent evaluation of the services provided by each of the two (2) Health Plans (Neighborhood Health Plan of Rhode Island (NHPRI) and UnitedHealthcare Community Plan of Rhode Island (UHCP-RI)), EOHHS requested that IPRO prepare an aggregate report that evaluates the performance of the State's Medicaid managed care program overall. Specifically, this report provides IPRO's independent evaluation of the combined services provided by the two Medicaid managed care Health Plans for the year 2010, and compares and contrasts the individual performance of both Health Plans. For comparative purposes, results for 2009 and 2010 are displayed when available and appropriate. The framework for this assessment is based on the guidelines established by CMS as well as State requirements. IPRO reviewed pertinent information from a variety of sources including State managed care standards, accreditation survey findings, member satisfaction surveys, performance measures and State monitoring reports.

The benchmarks and HEDIS^{®2} percentiles for Medicaid Health Plans cited in this Annual EQR Technical Report originated from the NCQA *Quality Compass*^{®3} 2011 for Medicaid, with the exception of those shown for the 2011 Performance Goal Program (PGP). Scoring percentiles for the PGP were derived from *Quality Compass*[®] 2010 for Medicaid.

It is important to note that in September 2010, Blue Cross Blue Shield of Rhode Island (BCBSRI) did not seek to renew its *Contract* to serve the Rhode Island Medicaid population after more than sixteen (16) years. The *Contract* was extended through December 31, 2010 in order to transition members into one of the two (2) remaining Health Plans (NHPRI and UHCP-RI). Therefore, no Health Plan-specific EQR Technical Report was prepared for this Health Plan, and this Aggregate EQR Technical Report does not contain any data related to BCBSRI.

A summary of IPRO's evaluation follows:

¹ During 2011, oversight of Rhode Island Medicaid managed care Health Plans transitioned from the Department of Human Services (DHS) to the Executive Office of Health and Human Services (EOHHS). For purposes of this report, "DHS", "EOHHS", and "the State" are used interchangeably.

² HEDIS[®] (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA).

³ *Quality Compass*[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Corporate Profiles

As indicated previously, in 2010, the Rhode Island Medicaid managed care program was comprised of two (2) Health Plans: NHPRI, which served the Medicaid population only, and UHCP-RI, which served Medicaid, Medicare and Commercial populations. Both Health Plans served the Core Rite Care, Rite Care for Children with Special Health Care Needs (CSHCN), and adults with disabilities/Rhody Health Partners (RHP) populations. Only NHPRI served the Rite Care for Children in Substitute Care (SC) population.

Accreditation

Notably, both Health Plans were awarded an *Excellent* accreditation rating for their Medicaid product lines by the National Committee for Quality Assurance (NCQA) in 2011. Although the on-site accreditation occurs every three (3) years, ratings are recalculated annually by NCQA based on the most recent Accreditation Survey Findings and the latest HEDIS[®] and CAHPS[®] results. As such, 2011 accreditation ratings are based on the results of the accreditation survey conducted in 2009 for UHCP-RI and in 2011 for NHPRI, while the HEDIS[®] and CAHPS^{®4} 2011 results were used for both Health Plans. Among all Medicaid Health Plans ranked by the NCQA, NHPRI and UHCP-RI ranked 8th and 16th, respectively, based on accreditation standards, HEDIS[®] results, and CAHPS[®] scores. UHCP-RI ranked within the top ten (10) percent of Medicaid Health Plans evaluated by the NCQA, while NHPRI ranked as one of the top ten (10) of two-hundred thirteen (213) Health Plans evaluated by the NCQA. Both Health Plans ranked within the top 20 Medicaid Health Plans. One of Rhode Island's two (2) participating Medicaid Health Plans (NHPRI) has been ranked by the NCQA within the top ten (10) Medicaid Health Plans nationally for seven (7) consecutive years.

Enrollment

The two Health Plans varied in the proportion of Medicaid membership served. According to Medicaid enrollment data for the period ending December 31, 2010, NHPRI comprised the majority (67%) of Rhode Island Medicaid managed care total enrollment with over 91,000 members, while UHCP-RI encompassed the remaining 33%, with over 44,000 members. Compared to year-end 2009, there were large increases in Medicaid enrollment for both Health Plans, due to the transitioning of members from BCBSRI. UHCP-RI also reported enrollment data for its Medicare and Commercial product lines, which comprised 22% and 21% of its total enrollment, respectively, with the largest proportion of members enrolled in the Medicaid product line (57%).

Rhode Island Medicaid's Performance Goal Program⁵

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. In 2011, the Performance Goal Program (PGP) entered its thirteenth (13th) year. The PGP 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 which have been established as the basis for incentive awards. For the 2011 PGP, the assessment of performance on HEDIS[®] and CAHPS[®] 2011 is based upon comparisons to the *Quality Compass*[®] 2010 Medicaid benchmarks and percentiles. As noted previously, in 2010, BCBSRI opted not to seek a renewal of its *Medicaid Managed Care Services Contract*. Therefore, this is the first EQR Aggregate Technical Report in which statewide rates for the current reporting period have been calculated based on two (2) Health Plans' performance data, rather than three (3). These measures are annotated.

⁴ CAHPS[®] (Consumer Assessment of Health care Providers and Services) is a registered trademark of the federal Agency for Health Research and Quality (AHRQ).

⁵ The rates for NHPRI and UHCP-RI for all measures in the PGP include CSHCN, SC, and RHP members, where eligible population criteria are met.

As such, for the annotated measures, care should be taken in interpreting the rate trends for the statewide rates which span the interval from 2009 through 2011.

For the 2009, 2010 and 2011 reporting years, the following performance categories were used to evaluate Health Plan performance:

- **Member Services**
- **Medical Home/Preventive Care**
- **Women's Health**
- **Chronic Care**
- **Behavioral Health**
- **Resource Maximization**
- **Children with Special Health Care Needs (Added in 2010)**
- **Children in Substitute Care (Added in 2011)**
- **Rhody Health Partners (Added in 2011)**

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 (e.g., *New Member Welcome Call Attempts, Grievances and Appeals Processing, Initial Health Screens for Special Populations, Notify EOHHS of Third Party Liability (TPL)*).

In the **Member Services** domain, one Health Plan met the *Contract* goal for one of the four (1 of 4) measures. This represents a decline for both Health Plans from the prior reporting periods where both Health Plans met a *Contract* goal for a single measure. Due to the nature of these measures, statewide rates were not calculated.

The Health Plans performed well overall in the **Medical Home/Preventive Care** domain with rates exceeding the *Quality Compass*[®] 2010 90th, 75th, or 50th percentiles for several measures. Related to children's and adolescents' preventive care, both Health Plans achieved the 90th, 75th or 50th percentile for eleven (11) measures of child and adolescent preventive care. Related to adult preventive care, both Health Plans achieved the 75th or 90th percentile goal for both age groups of the measure *Adults' Access to Preventive/Ambulatory Care*. Related to pregnancy care, performance varied, with NHPRI achieving a *Contract* goal for each of the three (3) measures, and UHCP-RI achieving the goal for none.

In the **Women's Health** domain, performance was fair, with a goal met for only one of three (1 of 3) measures, *Cervical Cancer Screening*, by one Health Plan (NHPRI).

In the **Chronic Care** domain, three of six (3 of 6) measures were eligible for a performance incentive, with the other three (3) being new measures with baseline rates. Again, performance was mixed, with one Health Plan (NHPRI) meeting the goal for two of three (2 of 3) applicable measures, and the other Health Plan (UHCP-RI) meeting a goal for none.

In the **Behavioral Health** domain, both Health Plans met a goal for two of three (2 of 3) applicable measures, although the measure differed. Both Health Plans met a goal for *Members Age 6 and Older Get Follow-Up by 30 Days Post Discharge*. UHCP-RI met the goal for *Antidepressant Medication Management: Effective Acute Phase* and NHPRI met the goal for *Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase*.

In the **Cost Management** domain (formerly known as Resource Maximization), only UHCP-RI met the goal for the measure related to reporting third-party liability (TPL) to the State timely.

The **Care Management for Special Enrollment Populations** domain was expanded for the 2011 PGP. *Initial Health Screens* and *Care Management* were evaluated for each of the three member populations: CSHCN, SC (NHPRI only), and RHP. Neither NHPRI nor UHCP-RI met the goal for conducting timely initial health screenings for any of their respective eligible populations (three (3) for NHPRI and two (2) for UHCP-RI). NHPRI met the goal for each of the three (3) populations for evaluation and update of active care management plans, while UHCP-RI received a finding of N/A (not applicable) for both of its eligible populations.⁶ The State also evaluated HEDIS[®] performance related to special enrollment populations through a comparison of the *Quality Compass*[®] 2010 rankings of the rates for Core Rite Care members only versus that of All Populations (Core Rite Care and special enrollment population members). NHPRI's rates ranked in the same percentile band for twenty-nine (29) measures, ranked in different percentile bands for eight (8) measures and were determined N/A (not applicable)⁷ for four (4) measures, while UHCP-RI's rates were comparable for twenty-one (21) measures, dissimilar for twelve (12) measures with eight (8) measures determined N/A.

As a result of its performance on the 2011 PGP, UHCP-RI was required to develop and implement a Corrective Action Plan (CAP) aimed at quality improvement in its performance for HEDIS[®] /CAHPS[®] measures, State-specified measures, and initial health screens and care management for its special enrollment populations, CSHCN and RHP members.

HEDIS[®] Performance Measures⁸

The assessment of performance on HEDIS[®] 2011 is based upon comparisons to the *Quality Compass*[®] 2011 Medicaid benchmarks and percentiles. As stated previously, since BCBSRI opted not to seek a renewal of its Medicaid *Contract* in 2010, this is the first EQR Aggregate Technical Report in which statewide rates for the current reporting period have been calculated based on two (2) Health Plans' performance, rather than three (3). As such, care should be taken in interpreting the rate trends for the statewide rates which span the interval from 2009 through 2011.

In the HEDIS[®] **Effectiveness of Care** domain, which assesses preventive care and care for chronic conditions, performance was strong for *Childhood Immunizations: Combo 3* and *Follow-up after Hospitalization for Mental Illness (30 Days)*, with both Health Plans and the statewide rate achieving either the 75th or 90th percentile.

The **Access to/Availability of Care** domain evaluates the proportions of members who access PCPs, ambulatory services and preventive care, as well as timely prenatal and postpartum care. Both Health Plans and the statewide rate ranked at the 75th or 90th percentiles for the following measures: *Children's Access to Primary Care* (all four (4) age groups) and the two (2) *Adults' Access to Preventive/Ambulatory Health Services* measures (both 20 – 44 years and 45 – 64 years).

Within the HEDIS[®] 2011 **Use of Services** measures, which assess members' utilization of Health Plan services, both Health Plans and the statewide rate achieved the 90th percentile for the measures *Well Child Visits in the First 15 Months of Life: 6+ Visits* and *Adolescent Well Care Visits*. The statewide rate also achieved the 75th percentile for the measure *Well Child Visits in the 3rd, 4th, 5th & 6th Years of Life*. In addition, the statewide rate demonstrated improvement for each of the four (4) measures.

⁶ UHCP-RI received an N/A designation for both CSHCN and RHP for care plan updates as either none of the members in the sample required care management or the care plans were not due for update during the review period.

⁷ Comparison was considered not applicable (N/A) if there was no rate available or a population < 30 members.

⁸ The rates for NHPRI and UHCP-RI for all HEDIS measures include CSHCN, SC (NHPRI only) and RHP members, where eligible population criteria are met.

Provider Network Accessibility and GeoAccess

Both Health Plans received *Excellent* accreditation ratings on the *Access and Service* and *Qualified Providers* domains, and met or exceeded the Health Plan-established *GeoAccess* standards for all primary care and high-volume specialty types.

Member Satisfaction: CAHPS® 4.0

Overall performance on the 2011 **Consumer Assessment of Healthcare Providers and Systems Medicaid Adult survey (CAHPS® 4.0H)** measures showed a generally high degree of member satisfaction across both Health Plans and statewide. Again, since BCBSRI opted not to seek a renewal of its Medicaid *Contract* in 2010, this is the first EQR Aggregate Technical Report in which statewide rates have been calculated based on two (2) Health Plans' performance data, rather than three (3). As such, care should be taken in interpreting the trends for the statewide rates which span the interval from 2009 through 2011. Collectively, both Health Plans' and the statewide rate remained fairly stable over the three-year period, except *Rating of Specialist*, which achieved between seven and ten (7 – 10) percentage points gain for NHPRI, UHCP-RI, and the statewide rate. NHPRI met or exceeded the 75th or 90th percentiles for five (5) measures and UHCP-RI for four (4) measures. Statewide rates attained the 75th percentile for four (4) measures (*Rating of Health Plan*, *Rating of Health Care*, *Rating of Personal Doctor* and *Rating of Specialist*).

Conclusions and Recommendations

IPRO's external quality review concludes that the Rhode Island Medicaid managed care program and its participating Health Plans, NHPRI and UHCP-RI, have had an overall positive impact on the accessibility, timeliness and quality of services for Medicaid recipients. This is supported by the fact that both Health Plans achieved an *Excellent* NCQA accreditation status and ranked among or above the top ten (10) percent of Medicaid Health Plans evaluated by the NCQA in 2011, with NHPRI ranking 8th within the top ten (10) Health Plans, and UHCP-RI improving substantially from its 2010 ranking of 26th to its 2011 ranking of 16th.

Common strengths for both Health Plans include: strong performance on access to care and provision of well care and preventive screening services for children and adolescents, excellent access to ambulatory and preventive care for adults and generally high levels of member satisfaction.

NHPRI's strengths include: overall strong member satisfaction levels, excellent timeliness of and access to care, relatively robust performance on a variety of preventive, acute, and chronic care measures, a consistently *Excellent* NCQA accreditation designation with *Excellent* ratings on the *Access and Service*, *Qualified Providers*, *Staying Healthy* and *Living with Illness* metrics and five of five (5 of 5) stars for the *Prevention* and *Treatment* categories in the NCQA's Health Plan Rankings.

UHCP-RI demonstrated strong performance in a number of areas, while others represented opportunities for improvement. Strengths include: a consistently *Excellent* NCQA accreditation designation with *Excellent* ratings on the *Access and Service* and *Qualified Providers* metrics, *Commendable* ratings on the *Staying Healthy* and *Living with Illness* categories, and was awarded five of five (5 of 5) stars for the *Prevention* category of the NCQA's Health Plan Rankings, achievement of a substantial improvement in its NCQA Health Plan Ranking, above average ranking for some CAHPS® member satisfaction measures, and exceptional access to care for children, adolescents and adults.

Recommendations are summarized in this report, while more specific data and recommendations were provided for both NHPRI and UHCP-RI in the Health Plan-specific EQR Technical Reports. To improve the provision of care and services to members, overall recommendations are made in the following areas: Performance Goal Program

measures related to member services, *Member Satisfaction with Access to Urgent Care*, *Chlamydia Screening for Women* (ages 16 to 24 years), *Appropriate Medications for People with Persistent Asthma*, the NCQA accreditation domain *Getting Better*, timeliness of initial health screens for special enrollment population members, and CAHPS[®] member satisfaction with the *Doctors' Communication*. Additionally, both Health Plans should assess performance on the new/baseline PGP measures in anticipation of the 2012 PGP.

For NHPRI specifically, recommendations were provided for the HEDIS[®] measures: *Adults Access to Ambulatory and Preventive Care (Ages 65 Years +)* and *Antidepressant Medication Management: Effective Acute Phase*, CAHPS[®] measures: *Getting Care Quickly* and *Rating of Personal Doctor*, and the metrics related to initial health screens and care plan updates for special enrollment populations. In addition, each of the quality improvement projects (QIPs) represented a continued opportunity for improvement, as NHPRI did not achieve its goals for any of the four (4).

Relative to UHCP-RI specifically, recommendations were provided for the HEDIS[®] measures: *Cervical Cancer Screening*, *Adult BMI Assessment*, *Weight Assessment and Counseling for Nutrition and Physical Activity - BMI Percentile* component, the three measures related to timely and adequate perinatal care, *Comprehensive Diabetes Care – HbA1c Testing*, *Follow-Up for Children Prescribed Medications for ADHD: Initiation Phase*, the CAHPS[®] measures: *Getting Needed Care*, *Customer Service*, *Rating of Health Plan*, the NCQA accreditation domain: *Consumer Satisfaction*, and the metrics related to initial health screens and care plan updates for special enrollment populations. In addition, each of the quality improvement projects (QIPs) represented a continued opportunity for improvement, as UHCP-RI met its goal for only one of five (1 of 5) QIPs.

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INTRODUCTION

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

In order to comply with these requirements, the State of Rhode Island Executive Office of Health and Human Services (EOHHS)⁹ contracted with IPRO to assess and report the impact of its Medicaid managed care program and each of the participating Health Plans on the accessibility, timeliness, and quality of services. In addition to Health Plan-specific EQR Technical Reports that present IPRO’s independent evaluation of the services provided by each of the two Rhode Island Medicaid managed care Health Plans for the 2011 reporting year, EOHHS requested that IPRO prepare this aggregate report that evaluates, compares and contrasts both Health Plans performance as well as overall Statewide performance. For comparative purposes, results for 2009-2010 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.

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

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

Rlte Care operates as a component of the State’s Global Consumer Choice Compact Waiver Section 1115(a) demonstration project, which is currently approved until December 31, 2014. As is typical for Section 1115 waivers, CMS defines “Special Terms and Conditions” (STCs) for the demonstration. The STCs addressing quality assurance and improvement are as follows:

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

Because Federal EQR requirements apply to Medicaid managed care, this EQR had initially been focused on Rlte Care¹⁰. Since Reporting Year (RY) 2010, the managed care organization system for adults with disabilities, Rhody Health Partners¹¹, was incorporated. The option to enroll in a managed care organization (MCO) 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. During RY 2010, the “opt out” option was modified; adults with

⁹ During 2011, oversight of Rhode Island Medicaid managed care Health Plans transitioned from the Department of Human Services (DHS) to the Executive Office of Health and Human Services (EOHHS). For purposes of this report, “DHS”, “EOHHS”, and “the State” are used interchangeably.

¹⁰ See Appendix 1 for a description of Rlte Care and the State’s approach to quality and evaluation for it.

¹¹ See Appendix 2 for a description of Rhody Health Partners and the State’s approach to quality and evaluation for it.

disabilities without third-party coverage could either enroll in a Medicaid-participating Health Plan or in the State's Primary Care Case Management (PCCM) program.

For both Medicaid-participating Health Plans, Neighborhood Health Plan of Rhode Island, Inc. (NHPRI) and UnitedHealthcare Community Plan -Rhode Island (UHCP-RI), special enrollment populations, including Children with Special Health Care Needs (CSHCN), Children in Substitute Care (SC)¹² and Rhody Health Partners (RHP) were included in all reported data, where eligibility criteria were met for inclusion in HEDIS^{®13}, CAHPS^{®14}, the Performance Goal Program (PGP), and Quality Improvement Projects (QIPs). When the State examined the Health Plans' performance it was noted that the inclusion of these populations enhanced some metrics, whereas for other measures, the rates were negatively impacted.

Please see Appendices 1 and 2 for descriptions of the State's approach to quality and evaluation for Rite Care and for Rhody Health Partners.

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¹² Children in Substitute Care (SC) members are served by NHPRI only.

¹³ HEDIS[®] (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA).

¹⁴ Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) is a registered trademark of the US Agency for Healthcare Research and Quality (AHRQ).

METHODOLOGY

In order to assess the impact of the RItE Care and Rhody Health Partners Programs on access, timeliness and quality, IPRO reviewed pertinent information from a variety of sources including State managed care standards, *Medicaid Managed Care Services Contract* requirements, accreditation survey findings, member satisfaction surveys, performance measures and State monitoring reports.

The majority of measures reported herein are derived from HEDIS[®] or CAHPS[®]. For these measures, comparisons to national Medicaid benchmarks have been provided. The benchmarks utilized were the ones most currently available at the time of this writing. Unless otherwise noted, the benchmarks originate from the National Committee for Quality Assurance (NCQA) *Quality Compass*^{®15} 2011 for Medicaid and represent the performance of all Health Plans that reported HEDIS[®] and CAHPS[®] data to the NCQA for the HEDIS[®] 2011 (measurement year (MY) 2010).

For comparative purposes, the results for 2009-2010 have also been displayed where available and appropriate. Unless otherwise noted, all statewide rates are true rates – calculated by combining numerators and denominators for both Health Plans. The exceptions are the State-specified Performance Goal Program (PGP) measures and CAHPS[®] rates, for which numerators or denominators were not uniformly available. Statewide rates for CAHPS[®] were calculated by averaging the individual ratings for both Health Plans. The methodology for calculating the PGP statewide rates differs by measure, and the relevant Figures have been annotated. It is important to note that this is the first EQR Aggregate Technical Report where statewide rates are calculated based on two (2) Health Plans' performance, rather than three (3), since BCBSRI opted not to seek a renewal of its Medicaid *Contract* in 2010. Therefore, care should be taken in interpreting the rate trends for the statewide rates which span the interval from 2009 through 2011.

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

¹⁵ Quality Compass[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

CORPORATE PROFILES

Two (2) Health Plans comprised Rhode Island’s Medicaid managed care program during 2011:

- Neighborhood Health Plan of Rhode Island, Inc. (NHPRI) is a local, not-for-profit HMO that served the Medicaid population only, including CSHCN, SC, and RHP members.
- UnitedHealthcare Community Plan - Rhode Island (UHCP-RI) is a not-for-profit HMO in Rhode Island, although it is part of a publicly traded company. It served Commercial, Medicare and Medicaid populations, including CSHCN and RHP members.

Figure 1 presents specific information for both Health Plans.

Figure 1: Corporate Profiles

	NHPRI	UHCP-RI
Type of Organization	HMO	HMO
Tax Status	Not-for-profit	Not-for-profit
Model Type	Network	Mixed
Year Operational	1994	1979
Year Operational (Medicaid)	1994	1994
Product Line(s)	Medicaid	Commercial, Medicare, Medicaid
Total Enrollment as of 12/31/10	91,405	77,245
Total Medicaid Enrollment as of 12/31/10	91,405	44,299
NCQA Medicaid Accreditation Status	Excellent	Excellent (Medicaid)
NCQA National Medicaid ranking	8 th	16 th

ACCREDITATION SUMMARIES AND HEALTH PLAN RANKING

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 3-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 April 2005 Quality Strategy, entitled *Rhode Island Strategy for Assessing and Improving the Quality of Managed Care Services under RIte Care*. EOHHS relies on the NCQA Accreditation standards, review process, and findings to assure Health Plan compliance with many of the structure and operations standards. This strategy has been approved by CMS. The State also conducts an annual monitoring review to assess Health Plan processes and gather data for the State's Performance Goal Program metrics.

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 that the Health Plan achieves on key dimensions of care, service and efficiency. Specifically, the NCQA reviews the Health Plans' quality management and improvement, utilization management, provider credentialing and re-credentialing, members' rights and responsibilities, standards for member connections, and HEDIS[®]/CAHPS[®] performance measures. The 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, and raises the bar, moves toward best practices, and leads to continuous improvement.

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

Health Plans are scored along five dimensions using ratings of between one and four stars (1 – lowest, 4 – highest)¹⁶:

- **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 Health Plan members are happy with their doctors: Does the Health Plan check whether physicians have had sanctions or lawsuits against them? How do members rate their personal doctors?
- **Staying Healthy:** An evaluation of Health Plan activities that help people maintain good health and avoid illness: Does the Health Plan give its doctors guidelines about how to provide appropriate preventive health services? Do members receive appropriate tests and screenings?
- **Getting Better:** An evaluation of Health Plan activities that help people recover from illness: How does the Health Plan evaluate new medical procedures, drugs and devices to ensure that patients have access to the most up-to-date care? Do doctors in the Health Plan advise patients to quit smoking?
- **Living with Illness:** An evaluation of Health Plan activities that help people manage chronic illness: Does the Health Plan have programs in place to help patients manage chronic conditions like asthma? Do diabetics, who are at risk for blindness, receive eye exams as needed?

Although the on-site accreditation occurs every three (3) years, ratings are recalculated annually by the NCQA based on the most recent Accreditation Survey Findings and the latest HEDIS[®] and CAHPS[®] results. As such, 2011 accreditation ratings are based on the Accreditation Survey conducted in 2011 for NHPRI, and in 2009¹⁷ for UHCP-RI, while the HEDIS[®]/CAHPS[®] 2011 results were used for both Health Plans.

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

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

¹⁶ www.ncqa.org

¹⁷ UHCP-RI’s next onsite accreditation review is due in Q1 2012.

Figure 2 depicts the NCQA Accreditation findings for NHPRI and UHCP-RI in 2011.

Figure 2: 2011 NCQA Accreditation Survey Findings

Health Plan	Access and Service	Qualified Providers	Staying Healthy	Getting Better	Living with Illness	Accreditation Outcome
Medicaid						
NHPRI	★★★★	★★★★	★★★★	★★	★★★★	EXCELLENT
UHCP-RI ¹⁸	★★★★	★★★★	★★★	★★	★★★	EXCELLENT

NCQA Health Plan Rankings

Annually, the NCQA calculates rankings for Commercial, Medicare, and Medicaid Health Plans, known as the *Health Plan Rankings*. In 2011, the NCQA evaluated over two-hundred thirteen (213) Medicaid Health Plans and ranked ninety-nine (99) of those based on clinical performance (HEDIS[®] results), member satisfaction (CAHPS[®] scores), and NCQA accreditation standards (quality, satisfaction, and systems and processes). To be eligible for ranking, Health Plans must authorize public release of their performance information and submit enough data for statistically valid analysis. The NCQA’s Health Insurance Plan Rankings 2011-2012 used the NCQA’s established rankings methodology, which has been used and widely recognized since 2005¹⁹. The overall Health Plan score is comprised of satisfaction (Consumer Satisfaction) measures (25%), clinical (Prevention and Treatment) measures (60%), and NCQA Accreditation Standards scores (15%), defined below. These are then weighted and represented as a 0-100 score.

- **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, cancer screenings) as well as measures of access to primary care and other preventive visits.
- **Treatment:** Composite of clinical HEDIS[®] measures for how well Health Plans care for people with conditions such as, asthma, diabetes, heart disease, hypertension, osteoporosis, alcohol and drug dependence, and mental illness.

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

NCQA Health Plan Rankings Key:	
5	The top 10 percent of Health Plans and statistically different from the mean
4	The top one-third of Health Plans (not in the top 10 percent) and statistically different from the mean
3	The middle one-third of plans and not statistically significantly different from the mean
2	The bottom one-third (not in the bottom 10 percent) and statistically different from the mean
1	The bottom 10 percent of plans and statistically different from the mean

¹⁸ UHCP-RI’s next onsite accreditation review is due in Q1 2012.

¹⁹ www.ncqa.org

The overall methodology is the same as was used for the 2010-2011 rankings, except for minor changes to the list of measures and Medicaid rankings utilized a CAHPS[®] measure of the Health Plan’s choosing²⁰. The Health Plan rankings are posted on the NCQA website, and since 2010, have been posted on the *Consumer Reports’* website and published in the November issue of *Consumer Reports* magazine.

NHPRI was ranked 8th nationally among Medicaid Health Plans ranked by the NCQA. NHPRI has consistently ranked among the top ten Medicaid Health Plans.

UHCP-RI was ranked 16th nationally among Medicaid Health Plans ranked by the NCQA. This is within the top 10% of Medicaid Health Plans evaluated by the NCQA, and a substantial improvement from the 2010 ranking at 26th.

Figure 3 below presents the Health Plans’ total scores and ranks along with the performance ratings across the three categories:

Figure 3. 2011 NCQA Ranking by Category

Health Plan	Consumer Satisfaction	Prevention	Treatment	2011 Score	National Rank
Medicaid					
NHPRI	4	5	5	87.4	8 th
UHCP-RI	3	5	4	86.4	16 th

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²⁰ Measure changes to the 2011-2012 methodology for Medicaid Health Plans included: Consumer Satisfaction: removed *Customer Service*; Prevention: added *Immunizations for Adolescents, Adult BMI Assessment, and Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*; Treatment: added *Use of Imaging Studies for Low Back Pain and Smoking Cessation*; removed *Controlling High Blood Pressure (<140/90)*.

ENROLLMENT

Figures 4, 4a, 5, and 6 depict Health Plan enrollment as of December 31, 2010 according to data reported to the State.

Figure 4 presents Medicaid managed care enrollment for both Health Plans and the percentage total Medicaid managed care population enrolled in each. NHPRI's (a Medicaid-only Health Plan) membership comprised the majority (67%) of the total enrollment, with UHCP-RI's membership accounting for the remaining 33% of the population.

Figure 4: Rhode Island Medicaid Managed Care Enrollment by Health Plan – December 31, 2010

Health Plan	Medicaid Managed Care Enrollment	Percentage of Total Medicaid Managed Care Enrollment
NHPRI	91,405	67%
UHCP-RI	44,299	33%
Total	135,704	100%

Figure 4a provides additional detail, the enrollment by Medicaid eligibility category for NHPRI and UHCP-RI. For both Health Plans, the majority of members are Core Rite Care enrollees at 84% and 82%, respectively.

Figure 4a: Health Plan Medicaid Enrollment by Category – December 31, 2010

Medicaid Managed Care Eligibility Group ²	NHPRI		UHCP-RI		Total	
	N	%	N	%	N	%
Core Rite Care	77,607	84%	36,462	82%	114,069	84%
Rite Care for CSHCN	5,352	6%	1,375	3%	6,727	5%
Rite Care for Children in Substitute Care	2,591	3%	NA ¹	NA ¹	2,591	2%
Rhody Health Partners	6,155	7%	6,462	15%	12,617	9%
Total Medicaid Enrollment	91,405	100%	44,299	100%	135,704	100%

¹ UHCP-RI did not serve the Rite Care for Children in Substitute Care (SC) population.

² Refer to Appendices 1 and 2 for a description of how each of the eligibility groups is comprised.

Figure 5 presents the Health Plans' enrollment by product line, including the proportion of total Health Plan membership. As noted previously, NHPRI serves only Medicaid populations. As of December 31, 2010, the majority of UHCP-RI's membership was enrolled in the Medicaid product-line (57%), followed by Medicare (22%) and Commercial (21%).

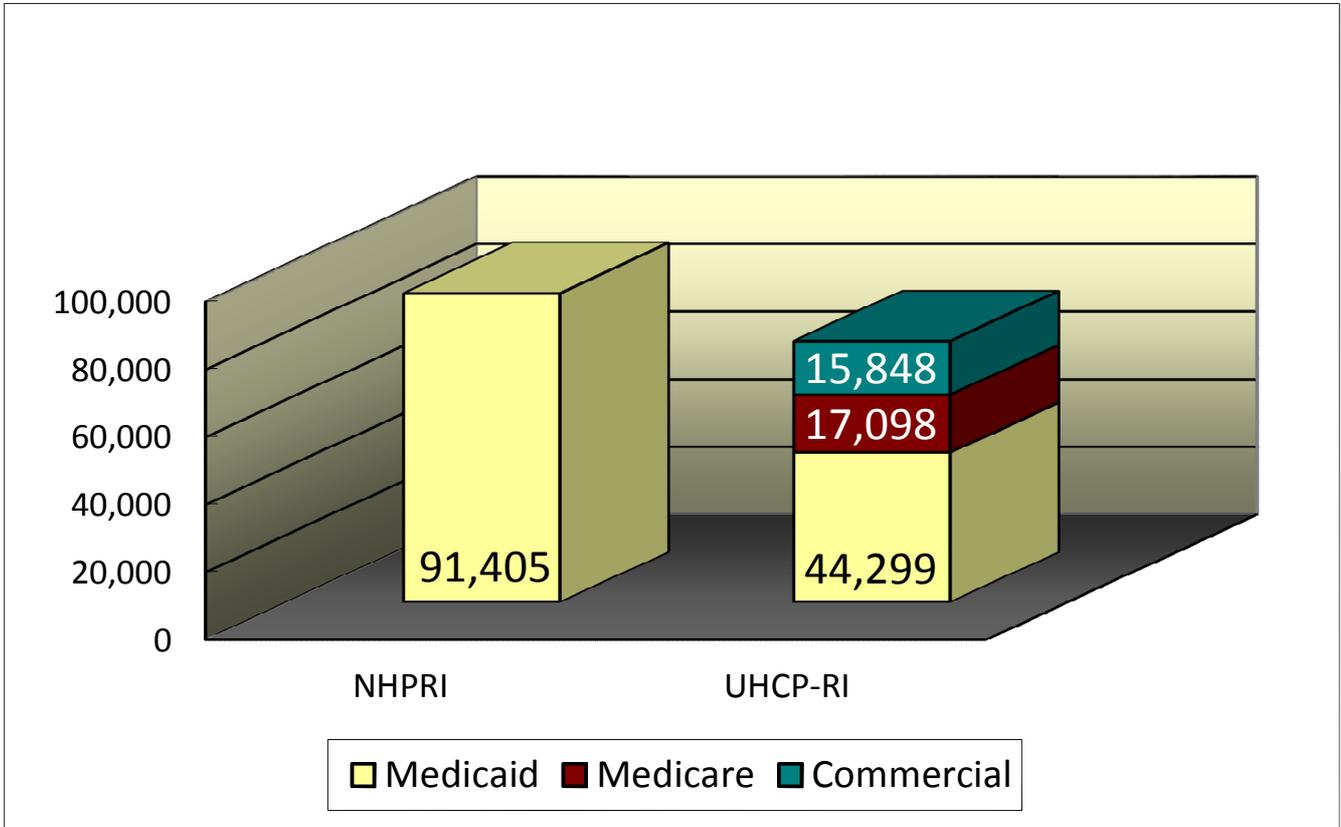
Figure 5: Health Plan Enrollment by Product Line – December 31, 2010

Product Line	NHPRI		UHCP-RI	
	N	%	N	%
Medicaid	91,405	100%	44,299	57%
Medicare	N/A ¹	N/A ¹	17,098	22%
Commercial	N/A ¹	N/A ¹	15,848	21%
Total Health Plan Enrollment	91,405	100%	77,245	100%

¹ NHPRI did not serve Medicare or Commercial members.

Figure 6 graphically illustrates the data in Figure 5.

Figure 6: Health Plan Enrollment by Product Line – December 31, 2010



RHODE ISLAND MEDICAID'S PERFORMANCE GOAL PROGRAM²¹

In order to measure the quality of care provided by each of the Health Plans, the State prepares and reviews a number of reports on a variety of quality indicators – both national metrics (HEDIS[®] and CAHPS[®]) and State-specified measures.

Rhode Island Medicaid Managed Care Performance Goal Program Background

In 1998, the State initiated the Performance Goal Program, an incentive program that established benchmark standards for quality and access performance measures. Rhode Island was the second state in the nation to implement a value-based purchasing initiative for its Medicaid program. In 2011, the Performance Goal Program entered its thirteenth (13th) 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, and superior performance levels were clearly established as the basis for incentive awards. Since the 2005 reporting year, six (6) of the following nine (9) performance categories have been used to evaluate Health Plan performance:

- **Member Services**
- **Medical Home/Preventive Care**
- **Women's Health**
- **Chronic Care**
- **Behavioral Health**
- **Cost Management**
- **Children with Special Health Care Needs (Added in 2010)**
- **Children in Substitute Care (Added in 2011)²²**
- **Rhody Health Partners (Added in 2011)**

Within these categories is a series of HEDIS[®], CAHPS[®], and State-specified measures for areas of particular importance to the State that do not have national metrics for comparison. Many of the measures are calculated through the Health Plans' HEDIS[®] and CAHPS[®] data submissions. Other measures are derived from data collected during the annual on-site Health Plan monitoring visits conducted by the EOHHS. Others are calculated by EOHHS using encounter data submitted by the Health Plan to EOHHS. For the reference period of calendar year 2010, onsite evaluations were conducted by EOHHS in April and May 2011.

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

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

²² UHCP-RI does not serve the Children in Substitute care population; therefore, the related PGP measures are not applicable to the Health Plan.

Changes in Methodology for the 2011 Performance Goal Program

The year 2011 marked the first time that only *Quality Compass*[®] benchmarks were used to assess performance for all HEDIS[®] and CAHPS[®] measures as directed in *Attachment M* of the State's 2009/2010 *Medicaid Managed Care Services Contract*. State-selected targets continued for the State-specified measures, as no national benchmark data exist. One important distinction between the 2011 PGP and prior years is that several measure benchmarks were set at the 75th percentile (full award) and the 50th percentile (partial award). The measures included: HEDIS[®] *Adult BMI Assessment*, HEDIS[®] *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents*, and HEDIS[®] *Antidepressant Medication Management*.

Several additional modifications were made to the Performance Goal Program in 2011. The percentages of the full incentive award were re-allocated, with points for the Member Services domain decreasing, and points for the Behavioral Health domain increasing. As was the case for the 2010 PGP, due to significant changes in specifications for the CAHPS[®] measure *Advising Smokers to Quit*, the measure *Medical Assistance with Smoking and Tobacco Use Cessation* was not included in the 2010 or 2011 Performance Goal Program. The State intends to resume this measure as part of the 2012 Performance Goal Program.

For the first time the HEDIS[®] measures *Adult Body Mass Index Assessment*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index Percentile, Counseling for Nutrition and Counseling for Physical Activity* had benchmarks published in *Quality Compass*[®] 2010 for Medicaid and therefore, were eligible for incentive awards.

Scores for several HEDIS[®] measures were treated as baseline measurements. These scores were recorded, but not eligible for incentive awards. The HEDIS[®] measure, *Immunizations for Adolescents* was considered a baseline rate, as no benchmarking data were available in *Quality Compass*[®] 2010 for Medicaid. Additional measures were added to the PGP/*Attachment M* of the *Rhode Island Medicaid Managed Care Services Contract*, effective September 2010 and the rates for each of these new measures were considered baseline measurements. These included the following HEDIS[®] measures: *Annual Monitoring for Patients on Persistent Medications* (5 numerators), *Use of Imaging Studies for Low Back Pain*, *Controlling High Blood Pressure (< 140/90)*, *Pharmacotherapy Management of COPD Exacerbation* (2 numerators), *Follow-Up after Hospitalization for Mental Illness: 7 Days* and *Childhood Immunizations: Combination 10*.

The following State-specified measures were retired with the 2011 PGP: *Teen Delivery Rate*, *Generic Substitution Rate*, and *Members' Access to Emergency Services*. However, the following measures have been retained for assessment of access to urgent/emergency care: the CAHPS[®] measure *Members Satisfied with Access to Urgent Care* and the State-calculated *Reduction in ED Visits for Ambulatory Sensitive Conditions (ACSCs)*.

Finally, two (2) State-specified measures related to care for Children with Special Health Care Needs (CSHCN), Children in Substitute Care (SC), and Rhody Health Partners (RHP) members were added. These measures evaluated the completion of an initial health screening by the Health Plan within forty-five (45) days of the member's enrollment and the timely evaluation and update of active care management plans, every six (6) months, at a minimum. The time parameter for the latter measure differed from the 2010 PGP measures related to CSHCN.

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

2011 Rhode Island Medicaid Managed Care Performance Goal Program Results

This report evaluates both Health Plans' results for the 2011 Performance Goal Program compared to HEDIS[®] percentiles derived from the NCQA's *Quality Compass*[®] 2010 for Medicaid. As such, these percentiles may differ from the *Quality Compass*[®] 2011 benchmark data displayed elsewhere in this report.

In addition, care should be taken in interpreting the rate trends for the statewide rates for the interval spanning 2009 through 2011, as this is the first EQR Aggregate Technical Report where some statewide rates are calculated based on two (2) Health Plans' performance, rather than three (3), since BCBSRI opted not to seek a renewal of its Medicaid *Contract* in 2010. These measures are annotated.

The **Member Services** domain is comprised of State-specified measures related to Health Plan processes related to new members and appeals and grievances. NHPRI met the State-selected goal for one of four (1 of 4) measures, while UHCP-RI did not meet the goal for any of the measures. This represents a decline from the prior reporting period when both Health Plans met a single goal. An important consideration is that the specification for the measure related to new member welcome calls was revised from *Welcome Calls Completed within 30 Days of Enrollment* to *Two New Member Call Attempts Completed within 30 Days of Enrollment* and the goal increased from 65% to 98%.

Overall, the Health Plans performed well in the **Medical Home/Preventive Care** domain, with rates exceeding the *Quality Compass*[®] 2010 90th or 75th percentiles for many measures. Both Health Plans achieved the *Quality Compass*[®] 2010 90th or 75th percentile goal for each of the following measures: *Adults' Access to Preventive/Ambulatory Care* (both 20 – 44 years and 45 – 64 years age categories), *Children's Access to PCPs*, *Well-Child Visits* (all four (4) age categories), *Well Child Visits in the First 15 Months of Life*, *Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life*, *Adolescent Well Care Visits*, *Childhood Immunization Status: Combo 3*, and *Lead Screening in Children*.

Both Health Plans exceeded the 50th or 75th percentile goal for two (2) of the three (3) *Weight Assessment & Counseling for Children and Adolescents* (ages 3 – 17 years) measures: *Counseling for Nutrition* and *Counseling for Physical Activity*.

Only NHPRI achieved a rate that met a *Quality Compass*[®] 2010 percentile goal for the following HEDIS[®] measures: *Timely Prenatal Care* (90th percentile), *Timely Postpartum Care* (90th percentile), *Frequency of Ongoing Prenatal Care* (75th percentile), *Adult BMI Assessment* (75th percentile), and *Weight Assessment and Counseling for Children and Adolescents: BMI Percentile* (50th percentile).

Regarding urgent and emergency care, both Health Plans fell below the *Quality Compass*[®] 2010 *Contract* goal for the CAHPS[®] measure *Members Were Satisfied with Access to Urgent Care*. As for the State-specified measure *Five (5) Percentage Point Reduction In the Rate of Emergency Department (ED) Visits for Ambulatory Care Sensitive Conditions (ACSCs)*²³, NHPRI achieved the State-selected goal for each of its four (4) applicable populations (CSHCN, SC, and RHP), while UHCP-RI achieved the goal for two (2) of three (3) of its applicable populations (CSHCN and RHP).

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

HEDIS[®] measures for which there were no *Quality Compass*[®] 2010 percentile benchmarks or were first-year or baseline measurements included: *Childhood Immunizations: Combo 10*, *Immunizations for Adolescents* and the two (2) new measures in this domain, *Monitoring of Persistent Medications* and *Use of Imaging for Low Back Pain*.

In the **Women's Health** domain, neither Health Plan met a *Quality Compass*[®] 2010 percentile goal for either age group (16 – 20 years and 21 – 24 years) of the *Chlamydia Screening* measure. Only NHPRI met a *Quality Compass*[®] 2010 percentile goal for *Cervical Cancer Screening* measure, at the 75th percentile. The State-specified measure *Teen Delivery* was retired for 2011 PGP.

Of the six (6) measures in the **Chronic Care** domain, only NHPRI met or exceeded the *Quality Compass*[®] 2010 90th or 75th percentile for the HEDIS[®] measures *Members with Persistent Asthma are Prescribed Appropriate Medications (12 – 50 years)* (90th percentile) and *Members with Diabetes had HbA1c Testing* (75th percentile). Neither Health Plan met the *Quality Compass*[®] 2010 goal for the 5-11 year age group of the *Appropriate Medications for Persistent Asthma* measure. The remaining two (2) measures in this domain, *Controlling High Blood Pressure (< 140/90)* and *Pharmacotherapy for Management of COPD Exacerbation*, were first year measures and rates were recorded as baseline.

For the 2011 PGP, the **Behavioral Health** domain was expanded to include four (4) HEDIS[®] measures: *Members 6 Years of Age and Older Get Follow-Up by 30 Days Post Discharge*, *Members 6 Years of Age and Older Get Follow-Up by 7 Days Post Discharge* (new measure), *Antidepressant Medication Management: Effective Acute Phase Treatment*, and *Follow-Up Care Prescribed for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication: Initiation Phase*. Two (2) of these measures had previously been categorized in the Chronic Care domain. Both Health Plans exceeded at least the *Quality Compass*[®] 2010 75th percentile for the HEDIS[®] measure *Members 6 Years of Age and Older Get Follow-Up by 30 Days Post Discharge*. Only UHCP-RI exceeded the *Quality Compass*[®] 2010 75th percentile for *Antidepressant Medication Management: Effective Acute Phase Treatment*, while only NHPRI achieved a benchmark rate for *Follow-Up Care Prescribed for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication: Initiation Phase* (90th percentile). The newly added measure, *Members 6 Years of Age and Older Get Follow-Up by 7 Days Post Discharge*, was considered a baseline measurement and therefore, not measured against the *Contract* standard.

Only UHCP-RI met the sole measure in the **Cost Management** domain (formerly Resource Maximization), *Notify the State of TPL (Third Party Liability) within five (5) Days of Identification*.

Overall, NHPRI demonstrated better performance for the 2011 PGP than UHCP-RI. The Health Plan met a total of thirty-one (31) of forty-three (43) (72%) of the applicable PGP measures²⁴, eight (8) of fifteen (15) State-specified measures (including six (6) of nine (9) measures related to the Special Enrollment Populations) and twenty-three (23) of twenty-eight (28) HEDIS[®]/CAHPS[®] measures.

Comparatively, UHCP-RI's PGP evaluation was comprised of a total of forty (40) PGP measures. Two (2) of twelve (12) State-specified measures were designated 'N/A' due to lack of eligible members in the sample. This resulted in a total of thirty-eight (38) total PGP measures including ten (10) State-specified measures. UHCPRI met a total of eighteen (18) of thirty-eight (38) or 47% of the applicable PGP measures, including three (3) of ten (10) applicable State-specified measures and fifteen (15) of twenty-eight (28) HEDIS[®]/CAHPS[®] PGP measures. Notably, only one (1) of the six (6) applicable measures for the Special Enrollment Populations was met.

²⁴ For NHPRI, there were three (3) additional performance measures related to the special enrollment populations, as the Health Plan served SC enrollees in addition to CSHCN and RHP enrollees. This resulted in NHPRI having a total of forty-three (43) applicable PGP measures.

Counts for both Health Plans excluded new PGP measures designated as baseline, and those with no available *Quality Compass*[®] 2010 benchmarks for Medicaid.

As a result of its performance in the 2011 PGP, UHCP-RI was required by EOHHS to prepare and implement a Corrective Action Plan (CAP) for quality improvement for the PGP measures as well as for initial screening and case management for special enrollment populations. The CAP requirements included the following deliverables:

- An additional Quality Improvement Project (QIP), focusing on the HEDIS[®] *Prenatal and Postpartum Care* measure.
- Submission by UHCP-RI of its internal HEDIS[®] administrative data analyses on at least a quarterly basis.
- Monthly (rather than quarterly) care management reporting for the Health Plan's special enrollment populations.

Figure 7 displays the Performance Goal Program scores for each of the Health Plans. Measures with **bold titles** are graphed in Figures 8, 9 and 10 and are not displayed in subsequent sections of the report. A **bolded red, blue or purple** rate indicates that the Health Plan met the *Quality Compass*[®] 2010 90th, 75th, or 50th percentile, respectively. A **bolded green** rate indicates that a State-selected *Contract* goal was met. State-specified measures are designated **M/E** (Met/Exceeded) or **NM** (Not Met) only. Rates for measures that did not meet the respective HEDIS[®]/CAHPS[®] percentile goal are not displayed in color or bolded. Measures that did not apply to a Health Plan or had too few/no eligible members are designated as not applicable "N/A". Furthermore, it is important to note that a total of thirteen (13) HEDIS[®]/CAHPS[®] PGP measures were baseline measurements and/or had no respective benchmark. For baseline measures, the rates are displayed in **bold orange** font. For measures with no benchmarks available in *Quality Compass*[®] 2010 for Medicaid, N/A is displayed in **bold orange** font.

Graphs of select measures follow the Figure 7 table. Figures 8, 9 and 10 graphically depict Health Plan and statewide performance on measures not displayed elsewhere in this report, including CAHPS[®], HEDIS[®] and State-specified measures in the Medical Home/Preventive Care (Figure 8), Chronic Care (Figure 9) and Cost Management (Figure 10) domains.

Certain measures are not graphed due to insufficient data points (e.g., new PGP measures) or because the 2011 PGP measures were based on HEDIS[®] or CAHPS[®] measures exhibited elsewhere in this report. The measure *Five (5) Percentage Points Decrease in ED Visits for ACSCs* is a State-specified measure for which the 2011 PGP marked the first time this measure was calculated by individual eligibility groups. In prior years, a single rate was calculated for the Health Plans' total Medicaid membership. Since the measurement methodology differed from 2009 -2010, there are insufficient comparable data points, and this measure has not been displayed graphically. Details for each enrollment group are provided in the PGP table, Figure 7. The percentage of ED visits declined from 2010-2011 among all eligibility groups in both Health Plans. All but one (1) rate met the *Contract* goal (five (5) percentage point decrease), Children with Special Health Care Needs – UHCP-RI.

Figure 7: Performance Goal Program Rates – 2011^{1, 2, 3}

Rhode Island Medicaid Managed Care 2011 Performance Measures	Health Plan	
	NHPRI	UHCP-RI
Member Services		
ID Cards Sent within 10 Days of Notification of Enrollment ⁴	M/E	NM
Member Handbook Sent within 10 Days of Notification of Enrollment ⁴	NM	NM
Two New Member Welcome Call Attempts within the First 30 Days of Enrollment ⁴	NM	NM
Grievance and Appeals Resolved within Federal (BBA) Timeframes ⁴	NM	NM
Medical Home/Preventive Care		
CAHPS[®] Members Were Satisfied with Access to Urgent Care	81.0%	84.8%
Reduce the Rate of ED Visits for ACSCs by 5 Percentage Points - Core RC ^{4, 5}	M/E	M/E
Reduce the Rate of ED Visits for ACSCs by 5 Percentage Points - RC for CSHCN ^{4, 5}	M/E	NM
Reduce the Rate of ED Visits for ACSCs by 5 Percentage Points - RC for SC ^{4, 5, 6}	M/E	N/A
Reduce the Rate of ED Visits for ACSCs by 5 Percentage Points - RHP ^{4, 5}	M/E	M/E
CAHPS [®] Medical Assistance with Smoking/Tobacco Use Cessation ⁷	N/A	N/A
HEDIS [®] Adults Had an Ambulatory or Preventive Care Visit (20-44 Years)	88.4%	87.7%
HEDIS [®] Adults Had an Ambulatory or Preventive Care Visit (45-64 Years)	91.3%	92.4%
HEDIS [®] Infants Had Well-Child Visits in the First 15 Months of Life (6+ Visits)	85.8%	78.6%
HEDIS [®] Children Had Well-Child Visits in the 3 rd , 4 th , 5 th & 6 th Years of Life	80.0%	83.5%
HEDIS [®] Children Received Immunizations by 2 nd Birthday - Combination 3 ⁸	77.1%	84.2%
HEDIS [®] Children Received Immunizations by 2 nd Birthday - Combination 10 ⁹	23.6%	40.4%
HEDIS [®] Adolescents Received Immunizations by the 13 th Birthday ⁹	79.8%	91.3%
HEDIS [®] Children Received Periodic PCP Visits (12-24 Months)	99.1%	98.6%
HEDIS [®] Children Received Periodic PCP Visits (25 Months-6 Years)	94.5%	93.1%
HEDIS [®] Children Received Periodic PCP Visits (7-11 Years)	96.7%	96.3%
HEDIS [®] Children Received Periodic PCP Visits (12-19 Years)	94.7%	96.2%

Figure 7: Performance Goal Program Rates – 2011^{1,2,3} (continued)

Rhode Island Medicaid Managed Care 2011 Performance Measures	Health Plan	
	NHPRI	UHCP-RI
Medical Home/Preventive Care (continued)		
HEDIS [®] Lead Screening in Children	83.6%	83.7%
HEDIS [®] Pregnant Members Received Timely Prenatal Care	95.2%	86.1%
HEDIS [®] Postpartum Members Received Timely Postpartum Care	74.6%	57.5%
HEDIS [®] Adolescent Well-Care Visit	65.6%	65.8%
HEDIS [®] Frequency of Ongoing Prenatal Care ($\geq 81\%$ + of Expected Visits)	81.8%	66.1%
HEDIS [®] Adult BMI Assessment (15-74 Years) ^{10,11}	49.2%	32.9%
HEDIS [®] Weight Assessment/Counseling for Children & Adolescents (3 – 17 Yrs) - BMI Percentile ^{10,11}	41.6%	25.3%
HEDIS [®] Weight Assessment/Counseling for Children & Adolescents (3 – 17 Yrs) - Nutrition ^{10,11}	59.6%	62.3%
HEDIS [®] Weight Assessment/Counseling for Children & Adolescents (3 – 17 Yrs) - Physical Activity ^{10,11}	38.9%	54.7%
HEDIS [®] Monitoring of Persistent Medications - ACE/ARB ¹²	85.5%	87.3%
HEDIS [®] Monitoring of Persistent Medications - Digoxin ¹²	89.1%	84.2%
HEDIS [®] Monitoring of Persistent Medications - Diuretics ¹²	85.0%	86.5%
HEDIS [®] Monitoring of Persistent Medications - Anticonvulsants ¹²	79.2%	77.8%
HEDIS [®] Monitoring of Persistent Medications - TOTAL ¹²	84.6%	85.5%
HEDIS [®] Use of Imaging for Low Back Pain ¹² (a lower rate is better)	71.8%	64.9%
Women's Health		
HEDIS [®] Women Received Cervical Cancer Screening (21-64 Years)	78.9%	70.0%
HEDIS [®] Women Received Chlamydia Screening (16-20 Years)	57.2%	54.2%
HEDIS [®] Women Received Chlamydia Screening (21-24 Years)	67.2%	64.7%
Chronic Care		
HEDIS [®] Members with Persistent Asthma Used Appropriate Medications (5-11 Years)	93.8%	91.6%
HEDIS [®] Members with Persistent Asthma Used Appropriate Medications (12-50 Years)	91.0%	85.1%
HEDIS [®] Members (18-75 Years) with Diabetes Had HbA1c Testing	89.3%	81.5%
HEDIS [®] Controlling High Blood Pressure (< 140/90) (Members 18-85 Years) ¹²	63.3%	59.8%

Figure 7: Performance Goal Program Rates – 2011^{1,2,3} (continued)

Rhode Island Medicaid Managed Care 2011 Performance Measures	Health Plan	
	NHPRI	UHCP-RI
Chronic Care (continued)		
HEDIS [®] Pharmacotherapy for Management of COPD Exacerbation - Bronchodilators ¹²	89.3%	93.6%
HEDIS [®] Pharmacotherapy for Management of COPD Exacerbation - Systemic Corticosteroids ¹²	76.8%	80.9%
Behavioral Health		
HEDIS [®] Members 6 Years of Age and Older Get Follow-up by 30 Days Post Discharge	86.8%	78.0%
HEDIS [®] Members 6 Years of Age and Older Get follow-up by 7 Days Post Discharge ¹²	68.3%	58.8%
HEDIS [®] Antidepressant Medication Management: Effective Acute Phase ¹¹	46.6%	58.8%
HEDIS [®] Follow-up Care for Children Prescribed Medication for ADHD: Initiation Phase	52.2%	41.5%
Cost Management		
Notify the State of TPL (third party liability) within 5 Days of Identification ⁴	NM	M/E
Children With Special Health Care Needs (CSHCN)¹²		
Initial Health Screen Completed within 45 Days ^{4,13}	NM	NM
Care Management Plans Evaluated and Updated as Needed, But No Less Than Every 6 Months ^{4,13,14}	M/E	N/A
Children in Substitute Care (Foster)⁶		
Initial Health Screen Completed within 45 Days ^{4,13}	NM	N/A
Care Management Plans Evaluated and Updated as Needed, But No Less Than Every 6 Months ^{4,13}	M/E	N/A
Rhody Health Plan Partners (RHP)		
Initial Health Screen Completed within 45 Days ^{4,13}	NM	NM
Care Management Plans Evaluated and Updated as Needed, But No Less Than Every 6 Months ^{4,13,14}	M/E	N/A

Met/exceeded Quality Compass[®] 90th percentile. Met/exceeded Quality Compass[®] 75th percentile. Met/Exceeded Quality Compass[®] 50th percentile.

State-specified measures: M/E = Met or Exceeded Contract goal. NM = Did not meet Contract goal.

N/A or Rate in Bold Orange Font = Measure did not have a Quality Compass[®] 2010 benchmark percentile and/or is considered a baseline measurement.

N/A - Measure is not applicable; see report narrative for further details.

- ¹ Performance Goal Program data were based on the previous calendar year (i.e., 2011 rates are based on contract year 2010). Rates may differ slightly from other data published in this report as this table reflects preliminary HEDIS[®] and CAHPS[®] rates, while rates in all other figures reflect final data submitted to the NCQA. In addition, it is important to note, that where applicable, and eligible population criteria are met, all Medicaid members (Core, CSHCN, SC (NHPRI only), and RHP) are included in the rates, including State-specified measures, unless noted otherwise.
- ² Bolded measure names are graphed in Figures 8, 9 and 10 as these measures are not displayed in subsequent report sections. Bolded red, blue, purple, and green rates indicate that a Health Plan met either the Quality Compass[®] 90th, 75th, or 50th percentile or the State-selected goal. Bolded orange rates indicate that the measure was not eligible for benchmarking due to no available benchmark in *Quality Compass*[®] 2010 or the rate is a baseline measurement.
- ³ Awards were based on both State-selected goals and, for HEDIS[®] and CAHPS[®] measures, where available, on *Quality Compass*[®] 2010 for Medicaid 50th, 75th and 90th percentile benchmarks.
- ⁴ State-specified measure. National benchmarking data were not available.
- ⁵ *Reduction in Emergency Department (ED) visits for Ambulatory Sensitive Care Conditions (ACSCs)* was reported by product-line for the first time for the 2011 PGP. Previously, an aggregate rate was reported across Health Plan membership.
- ⁶ Children in Substitute Care (SC) were served only by NHPRI.
- ⁷ The measure *Medical Assistance with Smoking/Tobacco Use Cessation* (CAHPS[®]) was not included in the 2011 PGP due to specification changes in HEDIS[®] 2011. The measure will be included in the 2012 PGP.
- ⁸ For *Childhood Immunization Status: Combination 3*, it is important to note that for HEDIS[®] 2009 and HEDIS[®] 2010, 2 rather than 3 HiB doses were required due to a national shortage of the Hib vaccine. For HEDIS[®] 2011, 3 Hib doses were required. Therefore trending from HEDIS[®] 2009/HEDIS[®] 2010 to HEDIS[®] 2011 is not possible.
- ⁹ No benchmarks were available in *Quality Compass*[®] 2010 for Medicaid for the measures *Childhood Immunizations: Combination 10* and *Immunizations for Adolescents*.
- ¹⁰ The 2011 PGP was the first year that Health Plan findings for *Adult BMI Assessment* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* were eligible for incentive awards as benchmarks were included for the first time in *Quality Compass*[®] 2010 for Medicaid.
- ¹¹ The incentive award benchmarks for the following measures: *Adult BMI Assessment*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, and *Antidepressant Medication Management: Effective Acute Phase* were the 75th percentile (full award) and the 50th percentile (partial award).
- ¹² The following were first year measures for the 2011 PGP: *Childhood Immunizations: Combination 10*, *Annual Monitoring for Persistent Medications*, *Use of Imaging for Low Back Pain*, *Controlling High Blood Pressure*, *Pharmacotherapy Management of COPD Exacerbation*, *Follow-Up for Hospitalization for Mental Illness: 7 Days*. These measure rates were considered baseline measurements and were not eligible for benchmarking or incentive awards.
- ¹³ The 2011 Monitoring Visits/2011 PGP marked the first year in which new member engagement and care management case files were reviewed for the RHP and Rite Care for Children in Substitute Care (SC) enrollment cohorts. The following State-specified measures were eligible for incentive awards: *Initial Health Screens within 45 Days of Enrollment* and *Active Care Management Plans Are Evaluated and Updated, as Needed, No Less than Every 6 Months* for the CSHCN, Children in Substitute Care (NHPRI only), and RHP special enrollment populations.
- ¹⁴ The 'N/A' designations for the *Active Care Management Plans Are Evaluated and Updated as Needed, but No Less Than Every 6 Months* for evaluation for UHCP-RI's CSHCN and RHP populations indicate there were no eligible members in the case review sample that required care management services or the members' care plans did not require an evaluation and update during the review period.

Figure 8: Performance Goal Program Results 2009-2011 – Medical Home/Preventive Care^{1, 2, 3, 4, 5}

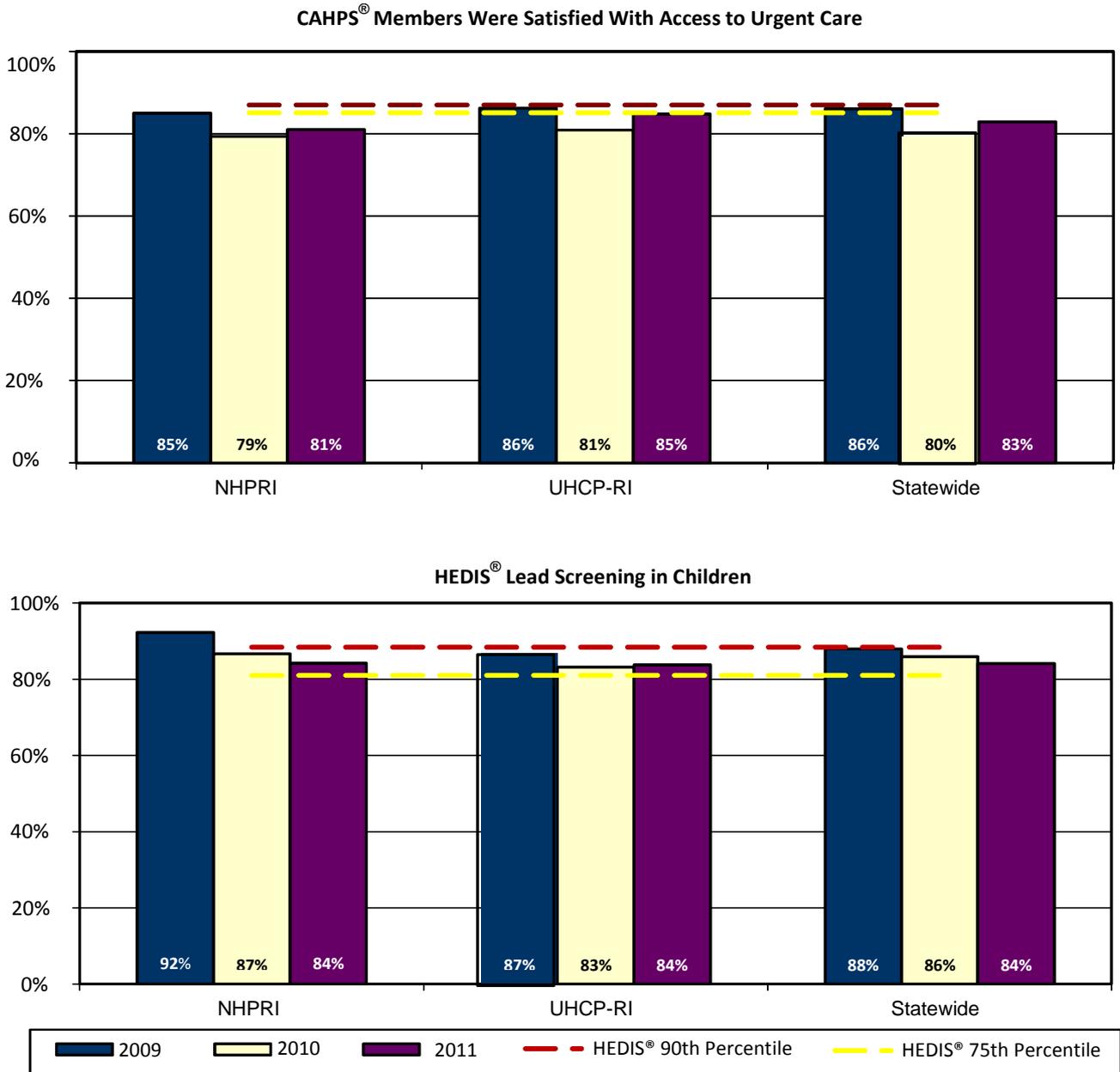
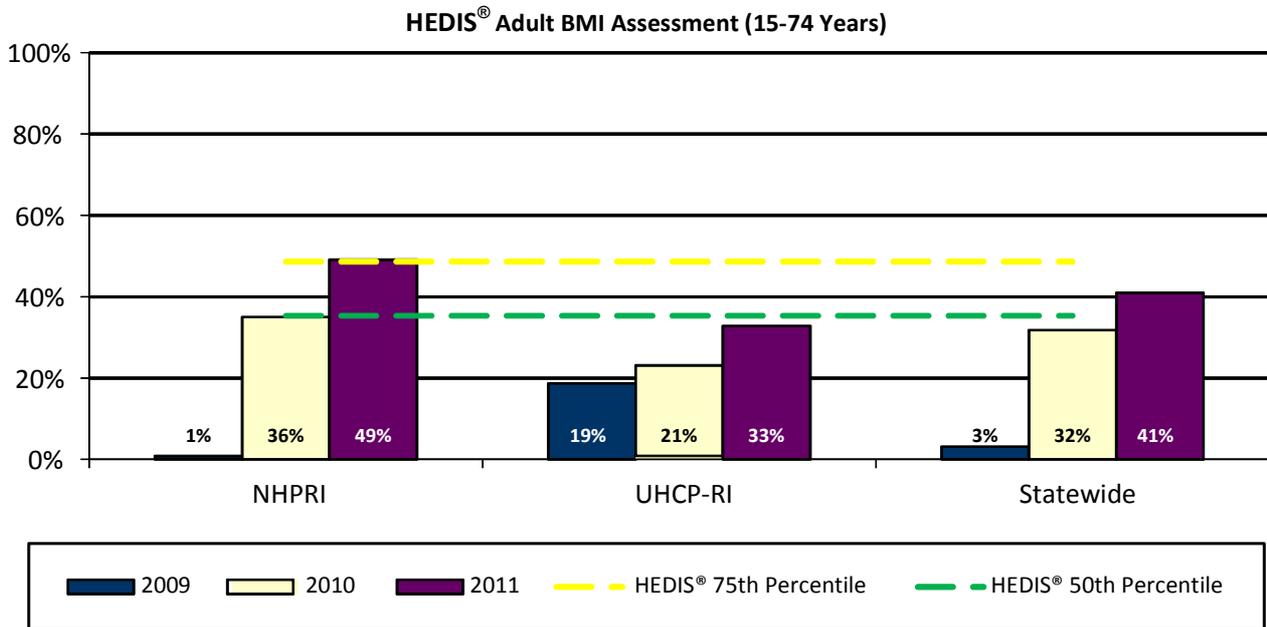
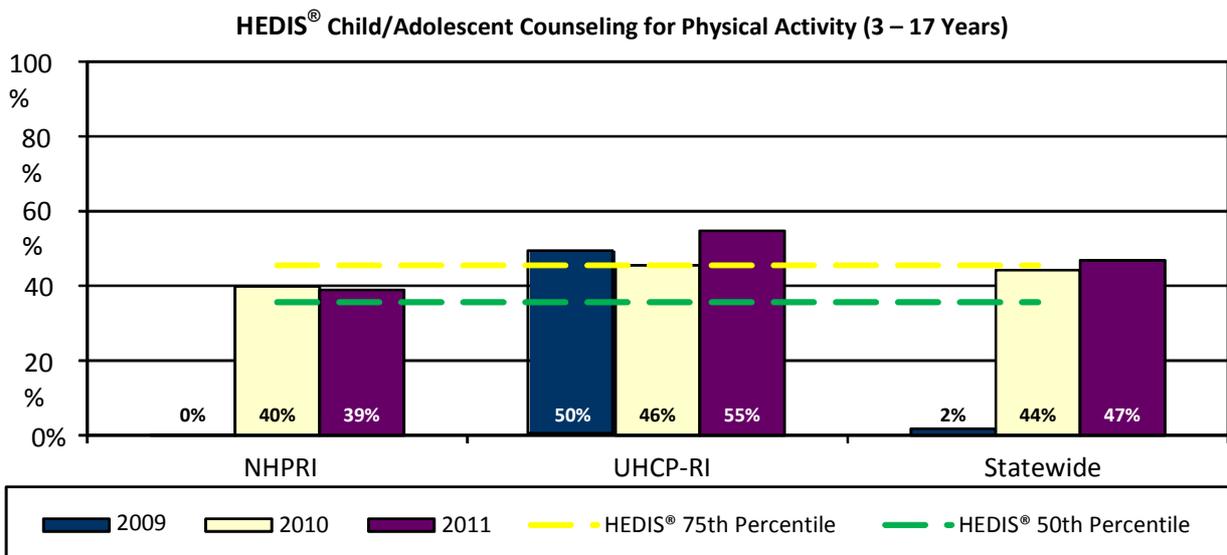
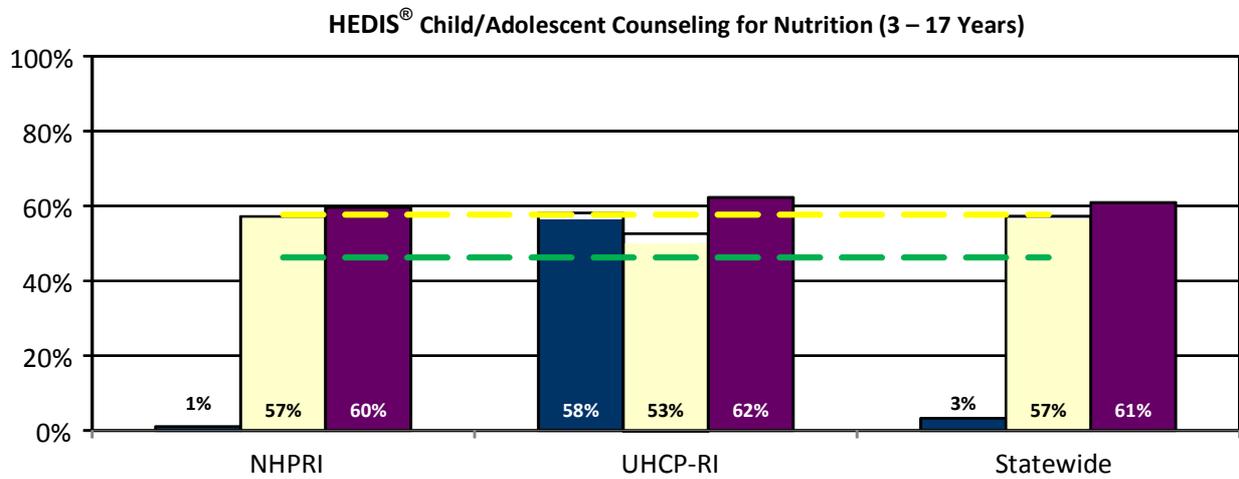
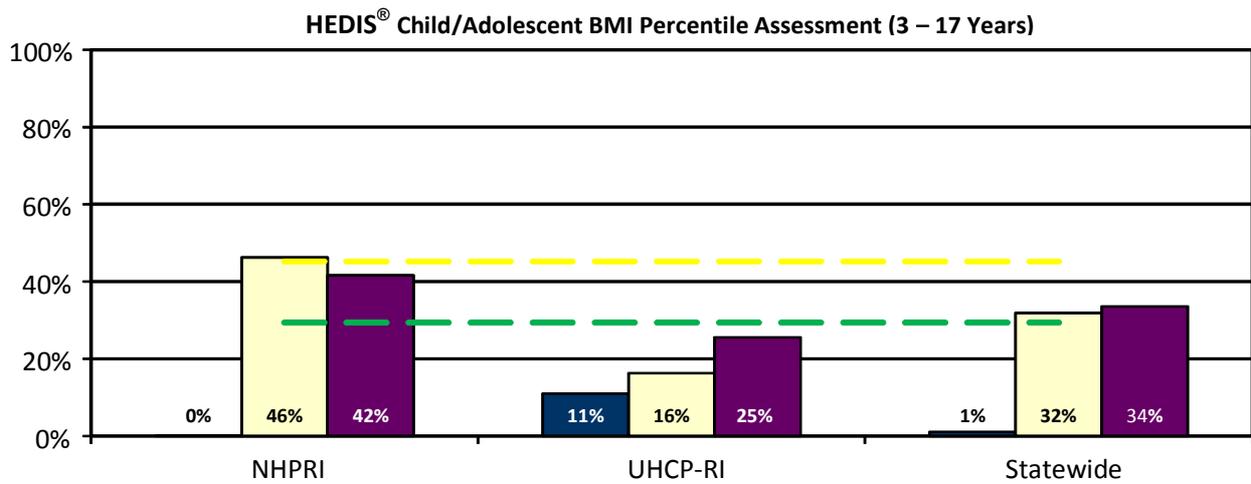


Figure 8: Performance Goal Program Results 2009-2011 – Medical Home/Preventive Care^{1, 2, 3, 4, 5} (continued)



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Figure 8: Performance Goal Program Results 2009-2011 – Medical Home/Preventive Care^{1, 2, 3, 4, 5} (continued)



Notes on Figure 8:

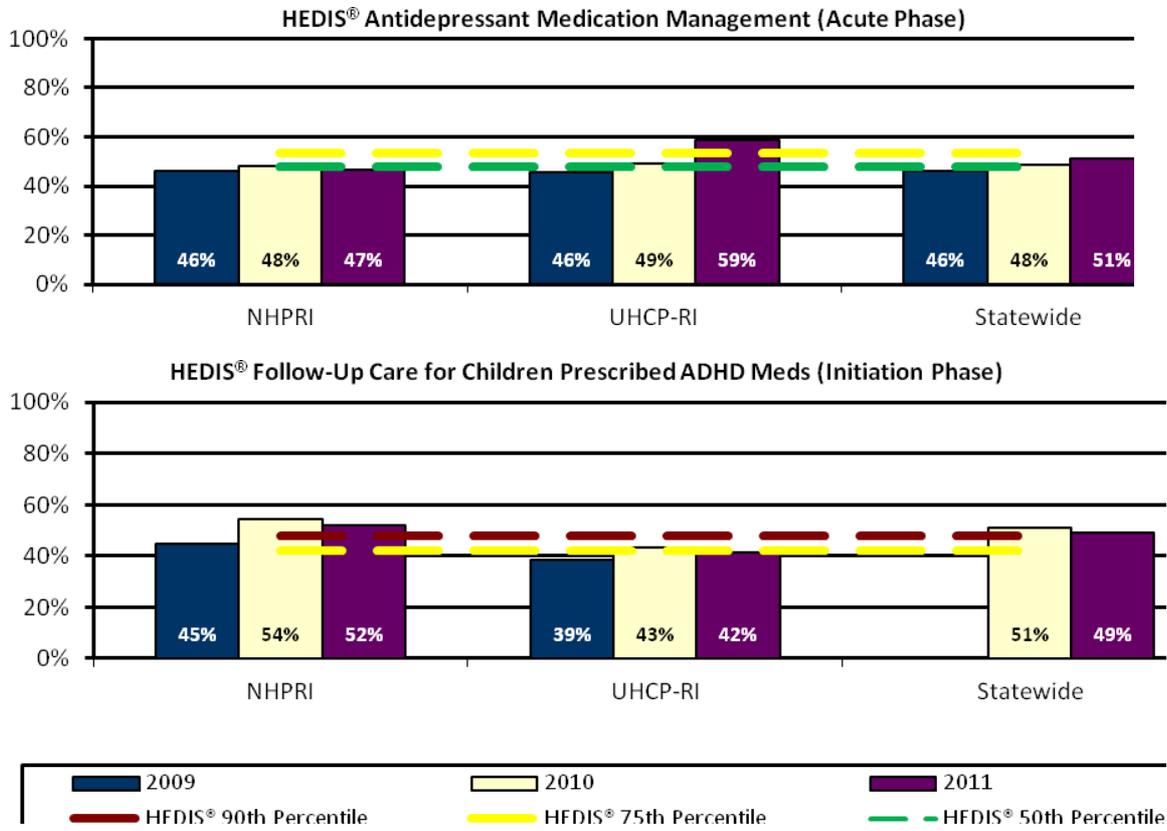
¹ Care should be taken when viewing the rate trends for the statewide averages for the interval spanning 2009 through 2011. The Statewide rates for 2009 and 2010 were calculated based on three (3) Health Plans' rates

(NHPRI, UHCP-RI, and BCBSRI). This is the first year that the Statewide Average was calculated based on two (2) Health Plans' rates (NHPRI and UHCP-RI), since BCBSRI no longer participated in the Rhode Island Medicaid program in 2011.

- ² Statewide rates for the CAHPS[®] measures were determined by calculating an un-weighted average of the two (2) Health Plans' rates since the size of the survey populations were similar and numerators and denominators were not available.
- ³ The statewide rates for the remaining measures were calculated following HEDIS[®] methodology, totaling numerators and denominators for the two (2) Health Plans.
- ⁴ Due to changes in CAHPS[®] methodology made by the NCQA, the *Advice on Smoking Cessation* measure was not included in the Performance Goal program for the current reporting year and is therefore not represented in the Figure 7 table or the Figure 8 graphs. EOHHS will include this measure in the 2012 PGP.
- ⁵ Benchmarks for *Adult BMI Assessment* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* were the 75th percentile (full award) and 50th percentile (partial award).

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Figure 9: Performance Goal Program Results 2009-2011 – Behavioral Health^{1,2}



¹ For these bar charts, statewide rates were calculated by totaling numerators and denominators for the two Health Plans. A statewide rate is not presented for the HEDIS® measure *Follow-Up Care for Children Prescribed ADHD Meds: Initiation Phase* for 2009, as the rate for one participating Health Plan, BCBSRI, was not reported due to small sample size (eligible members < 30).

² Benchmarks for *Antidepressant Medication Management* were the 75th percentile (full award) and 50th percentile (partial award).

Monitoring Care and Service Provided to Special Enrollment Populations

HEDIS Performance for Core Rite Care versus All Populations

The *Quality Compass*[®] 2010 for Medicaid percentile rankings were used to make comparisons between the HEDIS[®] and CAHPS[®] measure rates for Core Rite Care members only and the rates for *All Populations* (Core Rite Care, Rite Care for CSHCN, Rite Care for SC (NHPRI only) and RHP members). Performance was considered similar if the rates ranked within the same percentile band and dissimilar if the rates ranked in different percentile bands.

A comparison of NHPRI's rates for the two (2) groups for HEDIS[®] 2011 demonstrated that performance was similar for twenty-nine (29) measures, dissimilar for eight (8) measures, and not applicable for four (4) measures based on the *Quality Compass*[®] 2010 for Medicaid percentile rankings. Of the eight (8) measures with dissimilar rates, the rates ranked higher comparatively for *All Populations* (i.e., with the special enrollment population members included) for seven (7) measures and lower for one (1) measure.

For the current reporting period, HEDIS[®] 2011, UHCP-RI's performance was similar for twenty-one (21) measures, dissimilar for twelve (12) measures, and was not applicable for eight (8) measures, based on the *Quality Compass*[®] 2010 for Medicaid percentile rankings. Of the twelve (12) measures with dissimilar rankings, the rates ranked higher comparatively for *All Populations* (i.e., with the special enrollment population members included) for six (6) measures and lower for six (6) measures.

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

Comparison of HEDIS® 2011 Performance for Core Rite Care versus All Populations – UHCP-RI and NHPRI

HEDIS® Measure Name	UHCP-RI HEDIS 2011	NHPRI HEDIS 2011
Adults Access to Preventive/Ambulatory Care (Ages 20 -44 Years)	▼	S
Adults Access to Preventive/Ambulatory Care (Ages 45 -64 Years)	▲	S
Children’s and Adolescents’ Access to Primary Care Practitioners (Ages 12 -24 Mos)	S	S
Children’s and Adolescents’ Access to Primary Care Practitioners (Ages 25 Mos – 6 Years)	S	S
Children’s and Adolescents’ Access to Primary Care Practitioners (Ages 7 – 11 Years)	S	S
Children’s and Adolescents’ Access to Primary Care Practitioners (Ages 12 – 19 Years)	S	S
Well-Child Visits in the First 15 Months of Life – 6+ Visits	S	S
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	S	S
Adolescent Well-Care Visits	S	S
Childhood Immunizations – Combination 3	S	S
Childhood Immunizations – Combination 10	N/A	N/A
Immunizations for Adolescents	N/A	N/A
Lead Screening in Children	S	S
Prenatal and Postpartum Care – Timeliness of Prenatal Care	S	S
Prenatal and Postpartum Care – Postpartum Care Visit within 21 – 56 Days	S	S
Frequency of Ongoing Prenatal Care ≥ 81%+ Expected Visits	S	S
Cervical Cancer Screening (Women Ages 21 – 64 Years)	▼	▼
Chlamydia Screening in Women (Ages 16 -20 Years)	▲	S
Chlamydia Screening in Women (Ages 21 -24 Years)	S	S
Adult BMI Assessment	S	S
Weight Assessment and Counseling for Children/Adolescents – BMI Percentile	S	S
Weight Assessment and Counseling for Children/Adolescents – Physical Activity	S	S
Weight Assessment and Counseling for Children/Adolescents – Nutrition	S	S
Annual Monitoring for Patients on Persistent Medications – Digoxin	N/A	▲
Annual Monitoring for Patients on Persistent Medications – Diuretics	▲	▲
Annual Monitoring for Patients on Persistent Medications – ACE/ARBs	▲	S
Annual Monitoring for Patients on Persistent Medications – Anticonvulsants	N/A	▲
Annual Monitoring for Patients on Persistent Medications – TOTAL	▲	▲
Use of Appropriate Medications for People with Asthma (Ages 5 – 11 Years)	S	S
Use of Appropriate Medications for People with Asthma (Ages 12 -50 Years)	▼	▲
Comprehensive Diabetes Care – HbA1c Testing	▲	S
Pharmacotherapy Management of COPD Exacerbation – Bronchodilators	N/A	▲
Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroids	N/A	▲
Controlling High Blood Pressure < 140/90	S	S
Antidepressant Medication Management – Effective Acute Phase Treatment	S	S
Follow-Up Care for Children Prescribed ADHD Medication – Initiation Phase	▼	S
Follow-Up Care for Hospitalization for Mental Illness – 30 Days	▼	S
Follow-Up Care for Hospitalization for Mental Illness – 7 Days	▼	S
Use of Imaging Studies for Low Back Pain ¹	S	S
CAHPS® Urgent Care – Get care as soon as you thought you needed it?	N/A	N/A
CAHPS® Medical Assistance with Smoking/Tobacco Use Cessation	N/A	N/A

¹ A lower rate is better for this measure

S Similar (ranking within the same percentile band)

▲ Rate for *All Populations* (includes special enrollment populations) ranks in a higher percentile band

▼ Rate for *All Populations* (includes special enrollment populations) ranks in a lower percentile band

N/A Not applicable due to population < 30 members or a rate is not available

Initial Health Screens and Care Management for Special Enrollment Populations

This domain was expanded for the 2011 PGP. *Initial Health Screens within 45 Days of Enrollment and Active Care Management Plans were Evaluated and Updated As Needed, but No Less than Every 6 Months* were examined for each of the three (3) member populations: CSHCN, SC (NHPRI only), and RHP. The State monitoring review was comprised of an assessment of policies and procedures, documentation tools and processes, tracking and follow-up, as well as a case review for a random sample of newly enrolled members of all three (3) populations. Neither Health Plan met the State-selected goal of 100% compliance for conduct of timely initial health screens. Regarding care management plan updates, NHPRI achieved 95% compliance for each of its member populations (CSHCN, SC, and RHP), while UHCP-RI received a rating of not applicable (N/A) for both its CSHCN and RHP populations. The measure was not applicable either because no members in the random case file samples were in need of case management or the members’ care plans were not due for update during the review period.

Care Management for Special Populations Case Review Results – Measurement Year (MY) 2010

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

NM = Not Met M/E = Met/Exceeded

¹ The ‘N/A’ designation for the *Active Care Management Plans are Evaluated and Updated as Needed, but No Less Than Every 6 Months* measures for both the CSHCN and RHP populations indicates that none of the members in the case review sample required care management services or the members’ care plans did not require an update within the review period.

HEDIS® PERFORMANCE MEASURES

Since NCQA Accreditation is required for participation in Rhode Island's Medicaid managed care program and HEDIS® performance is an accreditation domain, both of the Health Plans reports HEDIS® annually to the NCQA and the State. The two (2) Health Plans' HEDIS® measure calculations were audited by NCQA-certified audit firms, in conformity with the HEDIS® 2011 *Compliance Audit: Standards, Policies, and Procedures*. Both Health Plans were found compliant with all HEDIS® IS (Information Systems) and HD (HEDIS® Measure Determination) standards. Both Health Plans passed the medical record review validation. As a result, all measures detailed in this report were deemed "Reportable".

Graphs depicting Health Plan and statewide rates for HEDIS® Effectiveness of Care and Access and Availability measures for reporting years 2009 through 2011 and comparative national benchmarks are displayed on the following pages. Additionally, utilization of services was examined via selected HEDIS® Use of Services rates, while Health Plans' provider networks were evaluated by examining the *Board Certification* measure rates. The benchmarks utilized are those reported in NCQA's *Quality Compass*® 2011 for Medicaid. Statewide rates were calculated by totaling numerator and denominator counts for both Health Plans. This is the first EQR Aggregate Technical Report where statewide rates are calculated based on two (2) Health Plans' performance, rather than three (3), since BCBSRI opted not to seek a renewal of its *Medicaid Managed Care Services Contract* in 2010. Care should be taken in interpreting the trends for the statewide rates that span the interval between 2009 through 2011.

HEDIS® Effectiveness of Care Measures

HEDIS® **Effectiveness of Care** measures evaluate how well a Health Plan provides preventive screenings and care for members with acute and chronic illnesses. Figure 10 displays selected Effectiveness of Care measure rates for HEDIS® 2009 through 2011, for each Health Plan and the statewide rate, compared to *Quality Compass*® 2011 national Medicaid benchmarks. For HEDIS® 2010 the upper age limit for *Use of Appropriate Medications for People with Asthma* was lowered to fifty (50) years of age; therefore rate trends from 2009 to 2010 should be viewed with this in mind. Additionally, due to a national shortage of the Hib vaccine, only two of three (2 of 3) Hib doses were required for HEDIS® 2009 and HEDIS® 2010, consistent with CDC recommendations for 2008 and 2009. As a result, it is not possible to trend rates from HEDIS® 2009/HEDIS® 2010 to HEDIS® 2011.

Overall performance on the HEDIS® 2011 Effectiveness of Care measures was strong. Both Health Plans met or exceeded the *Quality Compass*® 2011 average rate for four reported measures: *Cervical Cancer Screening*, *Chlamydia Screening*, *Childhood Immunizations (Combo 3)*, and *Follow-up After Hospitalization for Mental Illness (30 Days)*, and both Health Plans met either the 75th or 90th percentile for the measures *Childhood Immunizations (Combo 3)* and *Follow-up After Hospitalization for Mental Illness (30 Days)*. NHPRI exceeded the *Quality Compass*® 2011 average rates for all reported measures.

The statewide rates met or exceeded the *Quality Compass*® 2011 averages for all six (6) measures, and achieved the 75th percentile for two (2) measures: *Childhood Immunizations (Combo 3)* and *Follow-up After Hospitalization for Mental Illness (30 Days)*. All six (6) statewide rates remained fairly stable from HEDIS® 2010 to HEDIS® 2011, and one (1) rate (*Cervical Cancer Screening*) demonstrated an increase of eight (8) percentage points.

Figure 10: HEDIS® Results 2009 - 2011 - Effectiveness of Care Measures¹

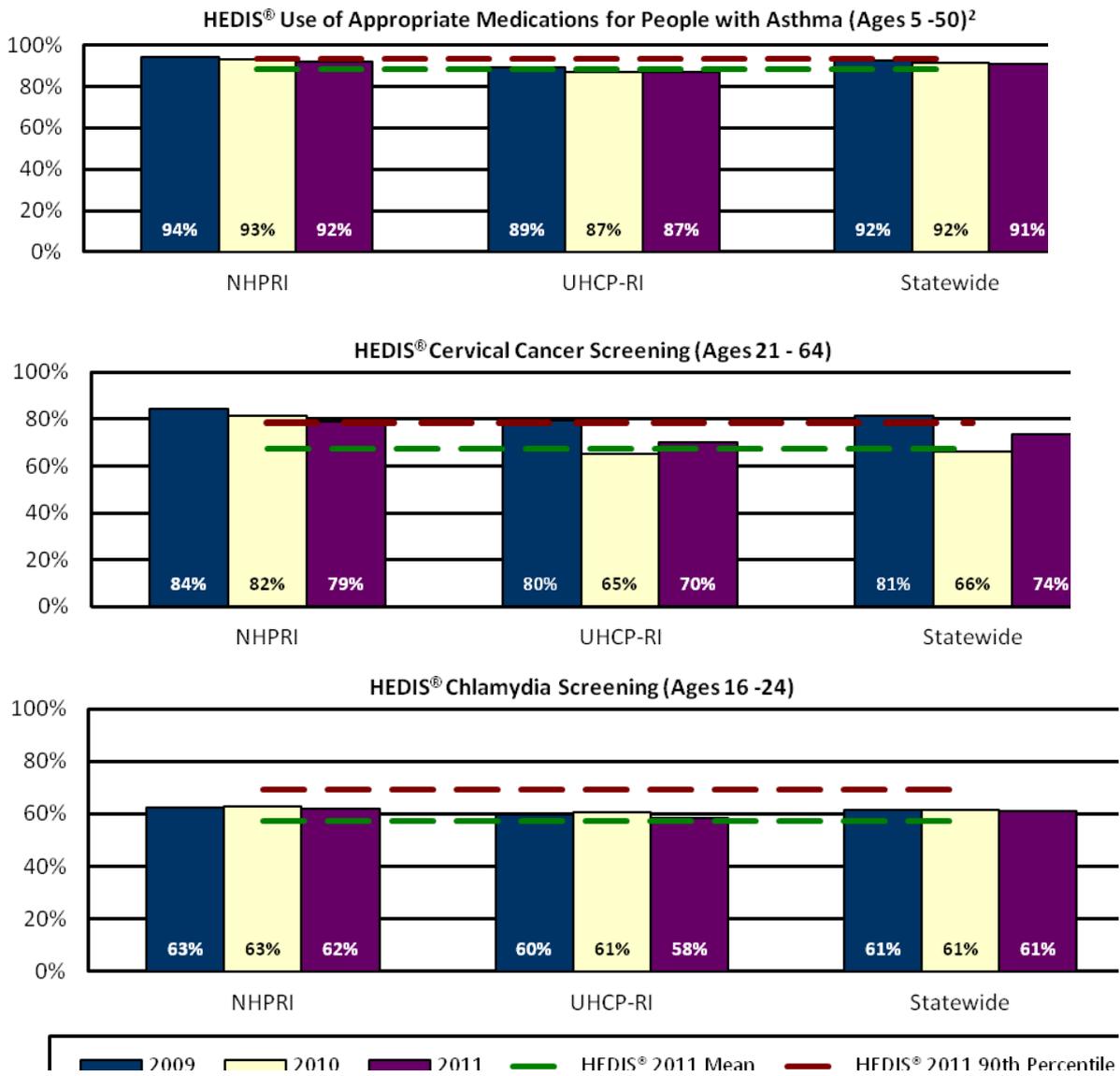
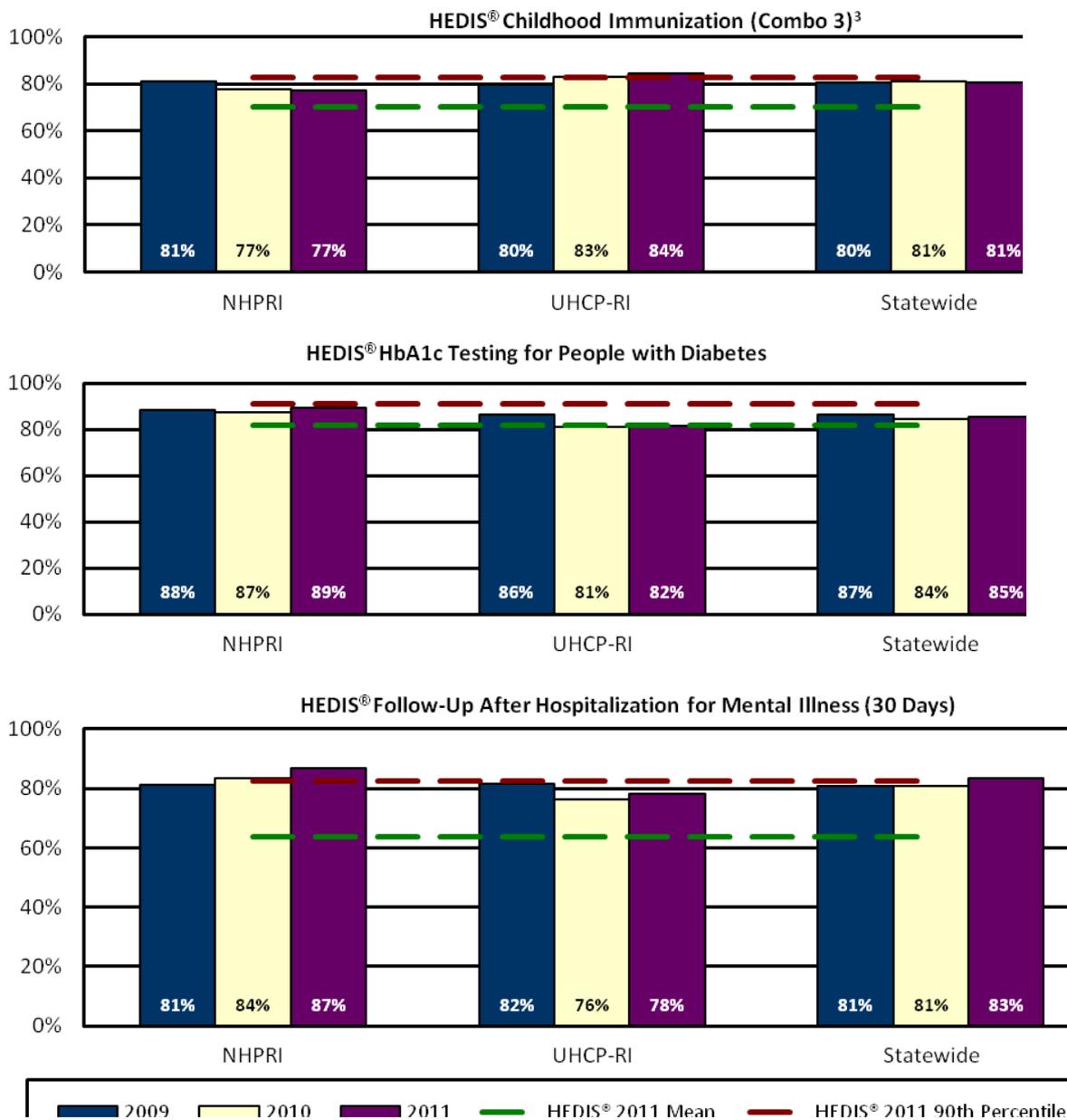


Figure 10: HEDIS® Results 2009 - 2011 Effectiveness of Care Measures¹ (continued)



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

² Due to changes in HEDIS® specifications made by the NCQA for the *Appropriate Medications for Asthma* measure for HEDIS® 2010, the age stratifications were revised and the upper age threshold measure was changed. Therefore, trending was not possible HEDIS® 2009 to HEDIS® 2011.

³ Due to a national shortage of the HiB vaccine in 2009 and 2010, the HEDIS® 2009 and HEDIS® 2010 specifications required only 2 of 3 HiB vaccine dosages. Therefore, rates cannot be trended for the interval from HEDIS® 2009 to HEDIS® 2011.

HEDIS[®] Access to/Availability of Care Measures

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

Figure 11 presents the Access to/Availability of Care Measure rates for the two (2) Health Plans and the statewide rate for HEDIS[®] 2009 through HEDIS[®] 2011 as compared to national Medicaid benchmarks. The 65 years and older age category for *Adults' Access to Preventive/Ambulatory Health Services* was not included in this report, due to insufficient data points. Both Health Plans had an eligible population of less than 30 for HEDIS[®] 2009, which resulted in the measure rates being designated "NR" (not reported).

Both Health Plans and the statewide rate ranked at or above the HEDIS[®] average rate for seven (7) of the eight (8) HEDIS[®] 2011 Access to/Availability of Care measures displayed in Figure 11. The exception was UHCP-RI's rate for *Timely Postpartum Care*. Statewide rates exceeded the *Quality Compass*[®] 2011 75th or 90th percentile for the following seven (7) measures: *Children's Access to Primary Care* measures (12 – 24 months; 25 months – 6 years; 7–11 years; 12-19 years) and *Adults' Access to Preventive/Ambulatory Health Services* (45-64 years) exceeding the 90th percentile; and *Adults' Access to Preventive/Ambulatory Health Services* (20 – 44 years) and *Timeliness of Prenatal Care* exceeding the 75th percentile. Statewide and both Health Plan's rates remained relatively stable from HEDIS[®] 2009 to HEDIS[®] 2011 for the majority of measures, the exception being UHCP-RI's rate for *Timely Postpartum Care Visit*, which has declined each year.

Figure 11: HEDIS® Results 2009 - 2011 Access to/Availability of Care Measures¹

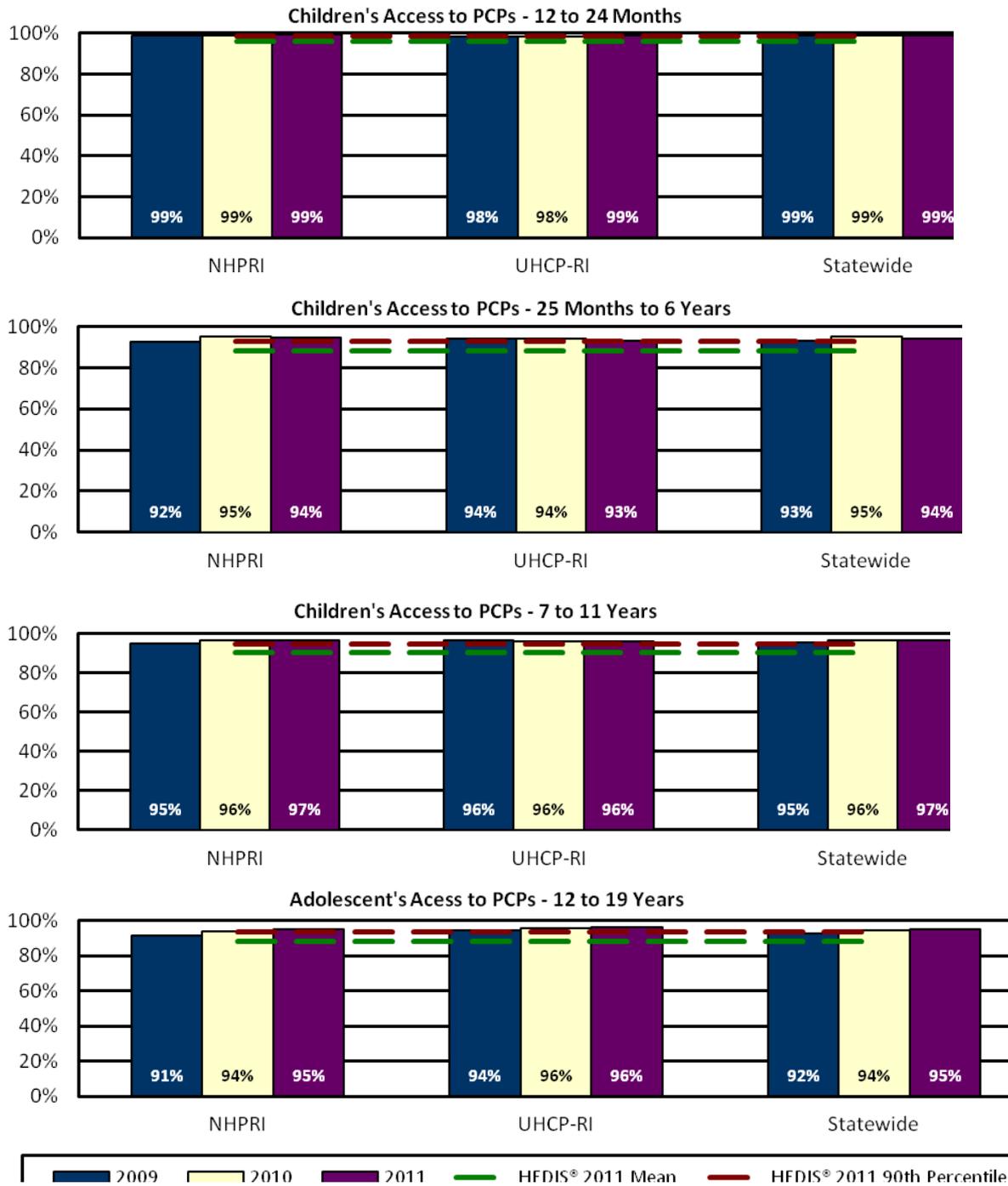
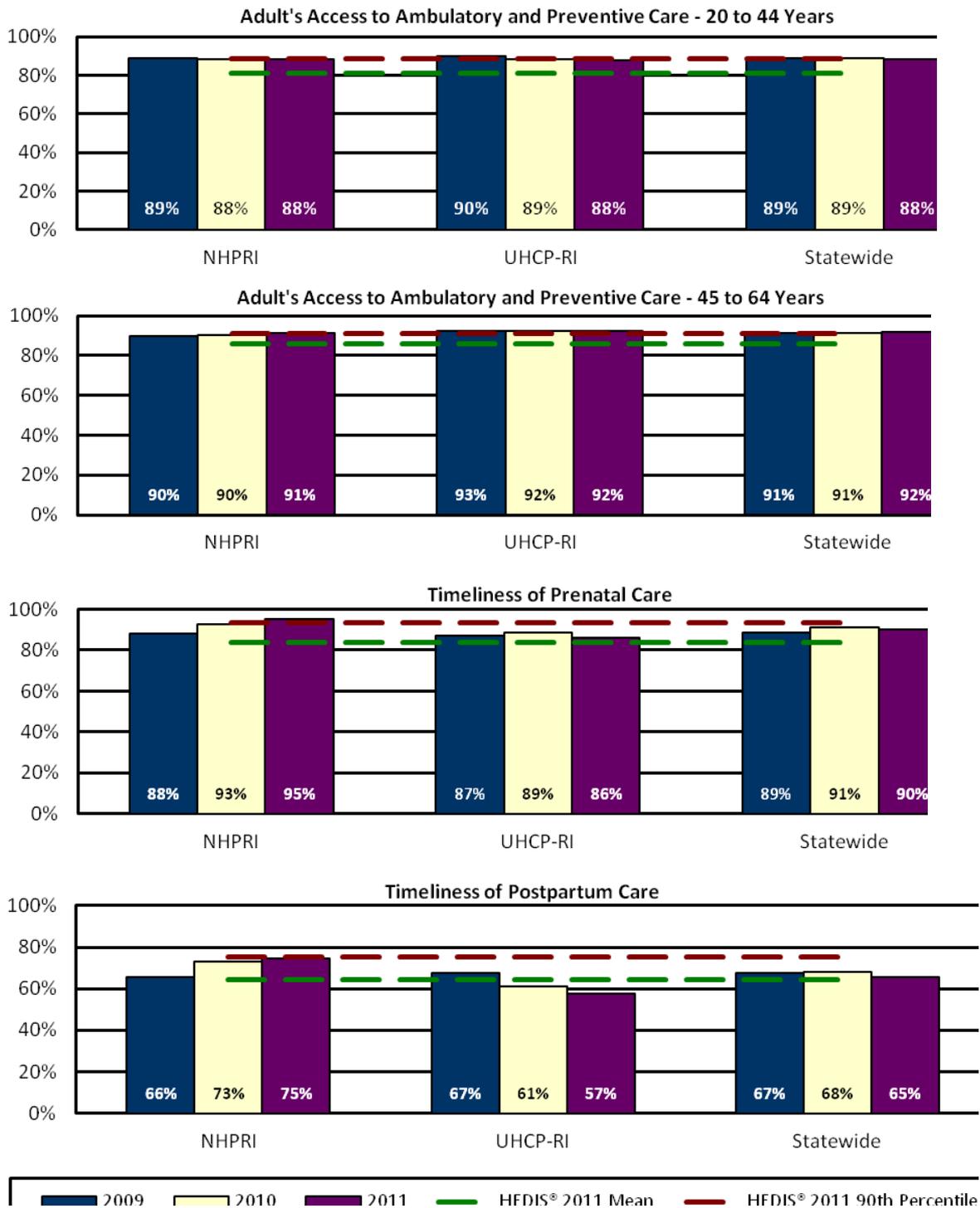


Figure 11: HEDIS® Results 2009 - 2011 Access to/Availability of Care Measures¹ (continued)



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

HEDIS[®] Use of Services Measures

The HEDIS[®] **Use of Services** measures evaluate member utilization of Health Plan services. For this domain of measures, performance is assessed by comparison to *Quality Compass*[®] 2011 national Medicaid benchmarks. Figure 12 displays selected measure rates for HEDIS[®] 2009 through 2011, as well as comparisons to national Medicaid averages and the *Quality Compass*[®] 2011 90th percentiles for Medicaid.

For HEDIS[®] 2011, both Health Plans and the statewide rate met or exceeded the *Quality Compass*[®] 2011 Medicaid average rate for all measures displayed: *Frequency of Ongoing Prenatal Care: 81%+ Expected Visits*, *Well Child Visits 15 Months: 6+ Visits*, *Well Child Visits in the 3rd, 4th, 5th & 6th Years of Life*, and *Adolescent Well Care Visits*. Both Health Plans and the statewide rate achieved the 90th percentile for the measures *Well Child Visits in the First 15 Months of Life: 6+ Visits* and *Adolescent Well Care Visits*. The statewide rate also achieved the 75th percentile for the *Well Child Visits in the 3rd, 4th, 5th, & 6th Years of Life* measure. Statewide rates fluctuated somewhat for all measures from HEDIS[®] 2009 to HEDIS[®] 2011; however the statewide rates all demonstrated improvement from HEDIS[®] 2010 to HEDIS[®] 2011, with rates increasing between three to seven (3 to 7) percentage points.

Figure 12: HEDIS® Results 2009 – 2011 Use of Services Measures¹



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

HEDIS[®] Provider Measures

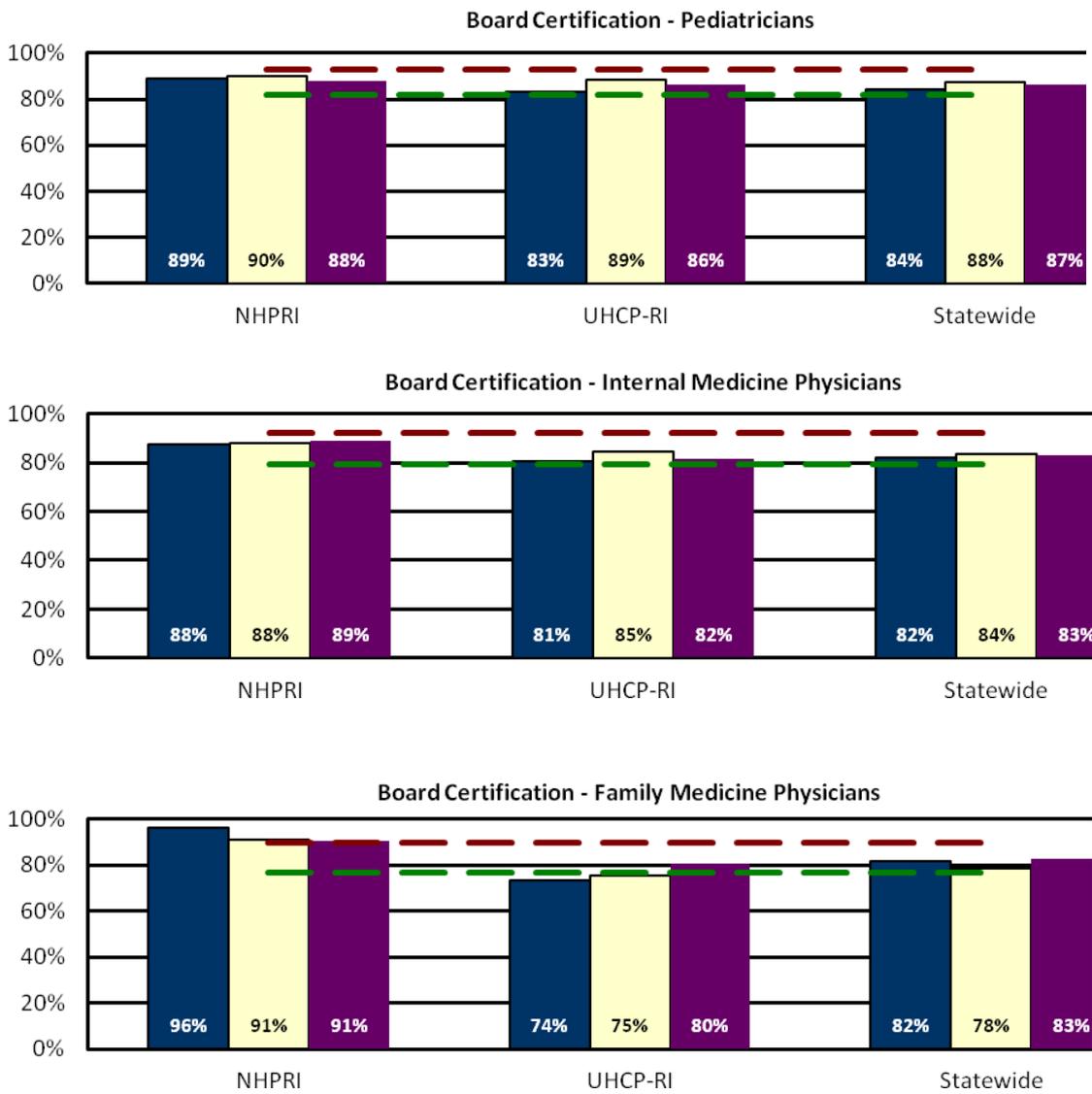
HEDIS[®] **Board Certification** rates illustrate the percentage of physicians in the provider network that are board certified. Figure 13 presents the results and ranking for both Health Plans for years 2009 through 2011.

For the four (4) practitioner types displayed (*Pediatricians, Internal Medicine, Family Medicine, and OB/GYNs*), the statewide rate and both Health Plans' rates exceeded the Medicaid average rate. The statewide rate achieved the 75th percentile for one (1) practitioner type, OB/GYN physicians, and the rates remained stable or improved across all types. NHPRI achieved the 90th percentile and 75th percentile for Family Medicine physicians and Internal Medicine physicians, respectively. UHCP-RI achieved the 75th percentile for OB/GYN physicians.

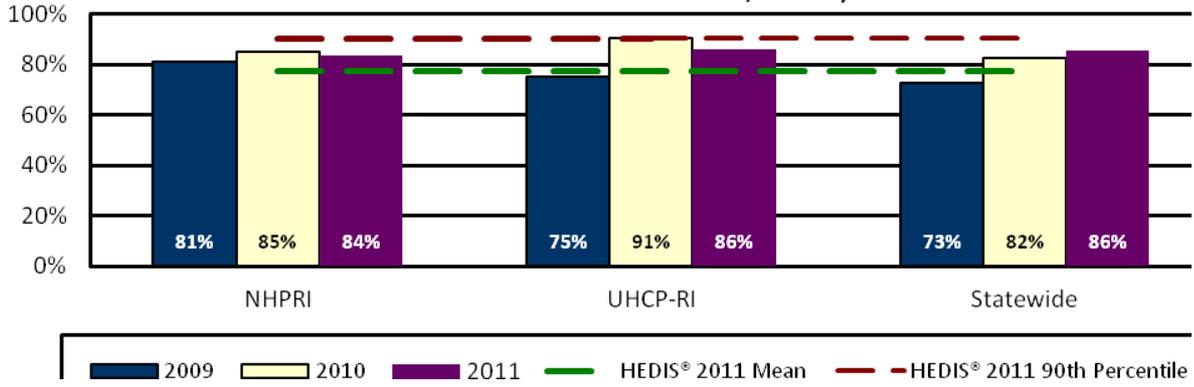
Note that new to this reporting year, the category *Other Physician Specialists* was reported in the Health Plans' individual reports. While these rates are not displayed graphically, NHPRI reported a rate of 89.3%, benchmarking at the 75th percentile, and UHCP-RI reported a rate of 75.7%, benchmarking at the 25th percentile.

This is the first EQR Aggregate Technical Report where statewide rates are calculated based on two (2) Health Plans' performance, rather than three (3), since BCBSRI opted not to seek a renewal of its Medicaid *Contract* in 2010. Care should be taken in interpreting the rate trends for the statewide rates from the interval 2009 through 2011.

Figure 13: HEDIS® Results 2009-2011 Board Certification



Board Certification - OB/GYN Physicians



PROVIDER NETWORK AND GEOACCESS

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

Both Health Plans monitor their provider networks for availability and network capability using the GeoAccess software program. This program assigns geographic coordinates to addresses so that the distance between provider locations and members' homes can be assessed. It can then be determined whether members have adequate access to care within a reasonable distance from their home.

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

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

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

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

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

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

Consequently, the standards against which reasonable distances are assessed are developed by each Health Plan, based upon Health Plan-specific criteria. For NHPRI, the standard was two (2) clinicians within ten (10) miles for both PCP and OB/GYN providers. UHCP-RI's GeoAccess survey differed from NHPRI's in that its results were stratified based on whether members lived in urban, suburban or rural areas. For 2011, UHCP-RI revised its Geo-Access standards so that they were consistent across the three (3) geographic areas. For primary care practitioners, pediatricians and OB/GYNs, the UHCP-RI standard for urban, suburban, and rural members was two (2) providers within fifteen (15) miles. For high volume specialists, the standard for urban, suburban, and rural members measured against two (2) standards for this reporting period: a *single* provider within thirty (30) miles and *two* (2) providers within fifteen (15) miles.

Figure 14 shows the percentage of members for whom the Health Plans' respective geographic access standards were met for three (3) provider types: PCPs, OB/GYNs and high-volume specialists. The results of these surveys revealed that the Health Plan-specified standards were met or exceeded for both Health Plans for all provider types displayed. Additional access indicators are described in each Health Plan's individual report.

Figure 14: GeoAccess Provider Network Accessibility – 2011

Provider Type	Access Standard ¹	Percentage of Members For Whom Access Standard was Met
NHPRI (as of 1/2011)		
Primary Care Practitioners	2 within 10 miles	100%
OB/GYNs	2 within 10 miles	98%
High-volume Specialists ²	1 within 15 miles	98%
UHCP-RI (as of 10/2011)		
Primary Care Practitioners	2 within 15 miles (urban)	100%
	2 within 15 miles (suburban)	100%
	2 within 15 miles (rural)	100%
OB/GYNs	2 within 15 miles (urban)	100%
	2 within 15 miles (suburban)	100%
	2 within 15 miles (rural)	100%
High-volume Specialists ³	1 within 30 miles (urban)	100%
	1 within 30 miles (suburban)	100%
	1 within 30 miles (rural)	100%

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

² High-volume specialists for NHPRI are defined as Allergy, Dermatology, ENT, Ophthalmology, Optometry, Physical Therapy, and Podiatry.

³ High-volume specialists for UHCP-RI are defined as OB/GYN, Cardiology, ENT, General Surgery, Ophthalmology, and Orthopedics.

MEMBER SATISFACTION: Adult CAHPS® 4.0H²⁵

The Rhode Island EOHHS requires as part of its *Medicaid Managed Care Services Contract* that each Health Plan collect member satisfaction data through an annual survey of a representative sample of its members. In 2011, the **Consumer Assessment of Healthcare Providers and Services Health Plan Survey 4.0H (CAHPS® 4.0H)** for adult Medicaid members was conducted on behalf of each Health Plan by NCQA-certified survey vendors. Figure 15 presents the survey item/composite and each Health Plan's 2011 statistical rating and the statewide rate compared to *Quality Compass*® 2011 Medicaid national benchmarks. New to the 2011 EQR Annual Technical reports is the composite measure *Shared Decision Making*²⁶. Due to insufficient data points for this measure, it is not included in Figure 15; however rates for this measure for the reporting year 2011 were 64.5% for NHPRI and 59.9% for UHCP-RI and the statewide rate was calculated as 61.7%. One Health Plan, NHPRI, exceeded the *Quality Compass*® 2011 Medicaid average as well as the 75th percentile for this measure.

Performance for CAHPS® 2011 revealed a generally high degree of member satisfaction across both Health Plans and for statewide rates. Collectively, both Health Plans and the statewide rate exceeded the *Quality Compass*® 2011 Medicaid average rate for seven (7) of the eight (8) measures displayed. NHPRI met or exceeded the *Quality Compass*® 2011 average rate for all eight (8) measures and met or exceeded the 75th or 90th percentiles for five (5) of eight (8) measures. Measures that did not perform as well included: *Getting Care Quickly* (25th percentile), *How Well Doctors Communicate* (50th percentile), and *Rating of Personal Doctor* (50th percentile). UHCP-RI exceeded the average rate for seven (7) of eight (8) measures and achieved the 75th percentile for four (4) measures. Of the remaining measures, three (3) (*Getting Needed Care*, *How Well Doctors Communicate*, and *Rating of Health Plan*) ranked at the 50th percentile and one (1) measure, *Customer Service*, ranked below the 10th percentile.

This is the first EQR Aggregate Technical Report where statewide rates are calculated based on two (2) Health Plans' performance, rather than three (3), since BCBSRI opted not to seek a renewal of its *Medicaid Contract* in 2010. Care should be taken in interpreting the trends for the statewide rates from 2009 and 2010 to 2011. As noted above, the statewide rates for seven (7) of eight (8) measures exceeded the Medicaid average. Additionally, four (4) measures (*Rating of Health Care*, *Rating of Health Plan*, *Rating of Personal Doctor*, and *Rating of Specialist*) attained the 75th or 90th percentiles. The statewide rates remained relatively stable from HEDIS® 2010 to HEDIS® 2011; rates for five (5) measures increased between one (1) and two (2) percentage points, and of the two (2) measure rates that declined, neither declined by more than three (3) percentage points. It is notable that the statewide rate for one (1) measure, *Rating of Specialist*, increased by over seven (7) percentage points.

²⁵ NHPRI and UHCP-RI 's rates for all Medicaid Adult CAHPS® 2010 and 2011 measures include RHP members, as they were included in the random survey sample of adult members.

²⁶ The CAHPS® *Shared Decision Making* composite is comprised of two (2) survey questions: Q10 "In the last 6 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?" and Q11 "In the last 6 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice you thought was best for you?".

Figure 15: CAHPS® Results 2009 – 2011 Member Satisfaction Measures^{1,2}

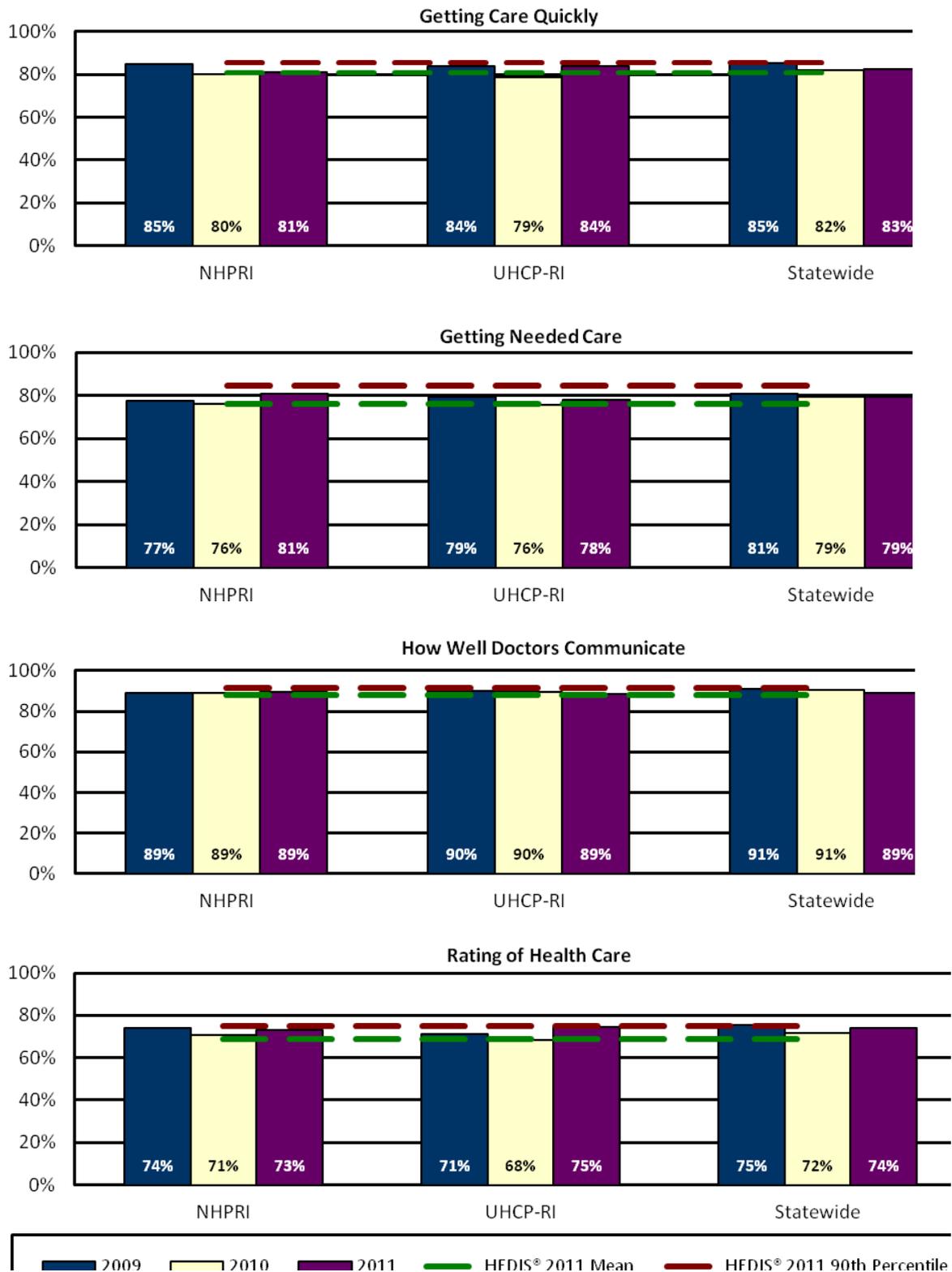
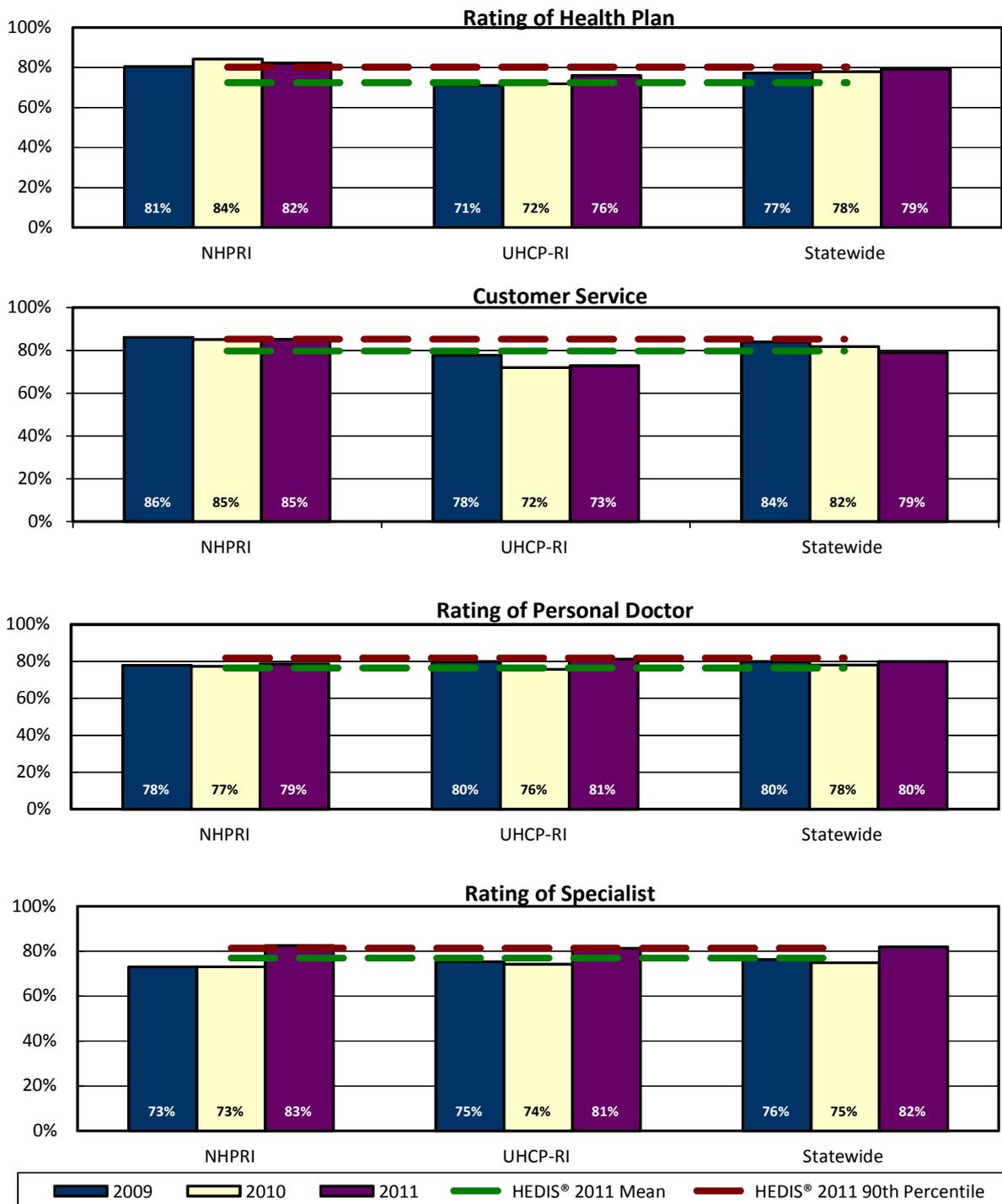


Figure 15: CAHPS® Results 2009 – 2011 Member Satisfaction Measures (continued)



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

² The measure *Shared Decision Making* was not displayed due to insufficient data points (2011 was the first year this survey item is being included in the EQR Technical Reports).

CONCLUSIONS AND RECOMMENDATIONS

IPRO's external quality review concludes that, in 2010, the Rhode Island Medicaid managed care program and both of the participating Health Plans have had a positive impact on the accessibility, timeliness and quality of services for Rhode Island Medicaid recipients. This is supported by the fact that both Health Plans consistently receive an *Excellent* NCQA accreditation status. Both Health Plans were ranked in the top twenty (20) of Medicaid Health Plans nationally by the NCQA based on HEDIS[®] results, CAHPS[®] scores and NCQA accreditation results, with NHPRI ranked at 8th and UHCP-RI ranked at 16th.

With the exception of those shown for the Performance Goal Program, (PGP), the Medicaid benchmarks and HEDIS[®] percentiles cited in this Annual EQR Technical Report originated from the NCQA's *Quality Compass*[®] 2011. Scoring benchmarks for the 2011 Performance Goal Program were derived from *Quality Compass*[®] 2010.

Also, it should be noted that this is the first EQR Aggregate Technical Report where statewide rates are calculated based on two (2) Health Plans' performance, rather than three (3), since BCBSRI opted not to seek a renewal of its Medicaid *Contract* in 2010. Therefore, care should be taken in interpreting the rate trends for the statewide rates which span the interval from 2009 through 2011.

Strengths

This section provides a description of the many strengths exhibited by both Health Plans and the Medicaid managed care program overall.

NCQA Accreditation

As noted above, both Health Plans achieved *Excellent* NCQA accreditation status consistently. Both received *Excellent* ratings for the NCQA accreditation domains related to *Access and Service* and *Qualified Providers*, and received five of five (5 of 5) stars for the NCQA Health Plan Rankings category *Prevention*.

Performance Goal Program

The Health Plans performed well overall in the **Medical Home/Preventive Care** domain with rates exceeding the *Quality Compass*[®] 2010 90th or 75th percentiles for several measures. Related to children's and adolescents' preventive care, both Health Plans achieved the 75th or 90th percentile for each of the following measures: *Children's Access to PCPs* (all age groups), *Well Child Visits* (all age categories), *Childhood Immunization Status: Combo 3*, and *Lead Screening in Children*. Both Health Plans also exceeded either the 50th or 75th percentile goal for two of three (2 of 3) of the *Weight Assessment & Counseling for Children and Adolescents* (ages 3 – 17 years) numerators: *Counseling for Nutrition* and *Counseling for Physical Activity*. Related to adult preventive care, both Health Plans achieved the 75th or 90th percentile goal for the measure *Adults' Access to Preventive/Ambulatory Care* (both the 20 – 44 Years and 45 – 65 Years age groups).

HEDIS[®] 2011

In the **HEDIS® Effectiveness of Care** domain both Health Plans and the statewide rate met or exceeded the *Quality Compass®* 2011 75th percentile for the two measures: *Childhood Immunizations: Combo 3* and *Follow-up after Hospitalization for Mental Illness - 30 Days*.

Within the **Access to/Availability of Care** domain, both Health Plans and the statewide rate ranked above the *Quality Compass®* 2011 Medicaid average rate for seven of eight (7 of 8) measures presented: *Children's Access to Primary Care* (all four (4) age groups) and the two (2) *Adults' Access to Preventive/Ambulatory Health Services* (both 20 – 44 years and 45 – 64 years) and *Timeliness of Prenatal Care*. For these same measures, the statewide rates exceeded the 75th or 90th percentiles and have remained relatively stable.

As for the **Use of Services** measures, the two (2) Health Plans and the statewide rate met or exceeded the *Quality Compass®* 2011 90th percentile for *Well Child in the First 15 Months of Life: 6+ Visits* and *Adolescent Well Care Visits*, with the statewide rate achieving the 75th percentile for *Well Child in the Third, Fourth, Fifth, and Sixth Years of Life*.

GeoAccess monitoring of the availability and network capability of each Health Plan's provider network demonstrated that each of the Health Plan's specified standards were met or exceeded for primary care physicians.

Performance on the 2010 **Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS® 4.0H)** measures showed a generally high degree of member satisfaction in several areas between the two (2) Health Plans and statewide. The Health Plans' and the statewide rates exceeded the *Quality Compass®* 2011 Medicaid average rate for five of eight (5 of 8) measures. Specifically, NHPRI achieved the 75th or 90th percentile for the following five (5) survey items: *Getting Needed Care*, *Rating of All Health Care*, *Rating of Health Plan*, *Customer Service*, and *Rating of Specialist*, while UHCPRI achieved the 75th percentile for four (4) measures: *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist*. Statewide rates attained the 75th or 90th percentile for four (4) measures: *Rating of Health Care*, *Rating of Health Plan*, *Rating of Personal Doctor*, and *Rating of Specialist*.

In addition to the overall strengths of the State's Medicaid managed care program, both Health Plans demonstrated various strengths. These are described in detail in each Health Plan's individual Annual External Quality Review Technical Report, and are presented in summary form by Health Plan, as follows.²⁷

Neighborhood Health Plan of Rhode Island, Inc. Strengths

IPRO's external quality review concludes that the Rhode Island Medicaid managed care program and NHPRI, specifically, have had a positive impact on the accessibility, timeliness and quality of services for Medicaid recipients that its *Excellent* NCQA Accreditation status would imply. In October 2011, NHPRI was ranked 8th nationally among all Medicaid Health Plans in the NCQA's Health Plan Rankings, based upon its HEDIS® and CAHPS® results and NCQA Accreditation standards scores. Furthermore, 2011 marked the seventh consecutive year that NHPRI has ranked within the top ten Medicaid Health Plans nationally as evaluated by the NCQA.

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

NHPRI's overall strong performance in the level of member satisfaction was proven by the Health Plan's CAHPS® results where five of eight (5 of 8) measures displayed exceeded the *Quality Compass*® 90th or 75th percentiles for Medicaid Health Plans. Most notably, members' ratings of the Health Plan exceeded the *Quality Compass*® 2011 90th percentile for the sixth consecutive year.

NHPRI also consistently exhibited strong performance in relation to timeliness and access to care.

Metrics related to preventive, acute and chronic care also demonstrated strong performance overall. NHPRI achieved *Excellent* ratings on the components of the NCQA Accreditation survey related to *Staying Healthy* and *Living with Illness*. Similarly, the NCQA granted the Health Plan five of five (5 of 5) stars for the Health Plan Rankings' metrics *Prevention* and *Treatment*. In contrast, however, though the Health Plan received only two of four (2 of 4) stars for the NCQA accreditation domain *Getting Better*.

Strengths of NHPRI's quality management program for 2010/2011 include its systematic, data-driven and comprehensive nature; cross-departmental, multidisciplinary, collaborative teams; allocation of staff resources from across all levels of the organization and active participation from practitioners.

UnitedHealthcare Community Plan - Rhode Island Strengths

IPRO's external quality review concludes that the RIte Care and Rhody Health Partners programs and UHCP-RI, specifically, have had a generally positive impact on the accessibility, timeliness and quality of services for Medicaid recipients that its continued *Excellent* NCQA Accreditation status would imply. In October 2011, UHCP-RI was ranked 16th nationally among all Medicaid Plans in the NCQA Health Plan Rankings, based on HEDIS® and CAHPS® results and NCQA Accreditation standards scores. This is a substantial improvement from the prior year's ranking of 26th. Despite this, there are a number of areas where improvement is warranted and other areas consistently identified as opportunities. Additionally, some quality and access measures ranked in the lower percentiles, and/or did not meet the expectations of EOHHS.

UHCP-RI's performance related to member satisfaction was varied, with four (4) measures attaining the 75th percentile and *Rating of Health Plan* ranked at the 50th percentile and *Customer Service* below the 10th percentile.

The Health Plan's performance also varied in relation to measures of preventive and chronic care. In its annual Medicaid Health Plan Ranking, the NCQA granted the Health Plan five of five (5 of 5) stars for the metric *Prevention* and four of five (4 of 5) stars for *Treatment*, though the Health Plan received only two of four (2 of 4) stars for the NCQA accreditation domain *Getting Better*. PGP and HEDIS® measures related to preventive and chronic care exhibited mixed results, with several ranking in the top percentiles and achieving *Contract* goals and others not.

In general, UHCP-RI performed well in relation to access and availability of care. UHCP-RI received an *Excellent* rating for both *Access and Service* and *Qualified Providers* components of the NCQA Accreditation survey, exceeded the established standards for its GeoAccess survey, and ranked at the 90th percentile for six of seven (6 of 7) primary and ambulatory care access measures. Performance on the HEDIS® Use of Services measures further demonstrated UHCP-RI's reliable access, with rates for the three (3) pediatric well-care metrics exceeding the 90th percentile.

UHCP-RI's quality management program continues to evolve, with use of national programs and resources; continued efforts to utilize dedicated, local staff; oversight at the local, regional and national

levels and participation in regional best practices meetings; and a continued transition to intervention strategies focused on more proactive efforts rather than relying primarily on passive, mailed educational materials.

Previous Year's Recommendations

Health Plan-specific recommendations were made in the 2010 Annual External Quality Review Technical Reports. In relation to these areas, the performance for reporting year 2011 improved in a number of areas for NHPRI and UHCP-RI.

Neighborhood Health Plan of Rhode Island, Inc.

Recommendations were made to NHPRI in the 2010 Annual External Quality Review Technical Report. Improvements seen in this year's evaluation included:

- **Percentage Change in Rate of ED Visits for Ambulatory Care Sensitive Conditions**
- **CAHPS[®] Getting Needed Care**
- **CAHPS[®] Rating of Specialist**
- **Notify the State of Third Party Liability**

UnitedHealthcare Community Plan-Rhode Island

Recommendations were made to UHCP-RI in the 2010 Annual External Quality Review Technical Report. Improvements seen in this year's evaluation included:

- **Percentage Change in Rate of ED Visits for Ambulatory Care Sensitive Conditions (for 2 of 3 populations)**
- **CAHPS[®] Getting Care Quickly**
- **CAHPS[®] Rating of Personal Doctor**
- **CAHPS[®] Rating of Specialist**
- **CAHPS[®] Rating of All Health Care**
- **HEDIS[®] Follow-Up after Hospitalization for Mental Illness – 30 Days**
- **HEDIS[®] Antidepressant Medication Management**

Recommendations

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

The following recommendations are made:

- Both of the Health Plans should evaluate performance related to the new Performance Goal Program measures in anticipation of the 2012 PGP: *Childhood Immunizations: Combo 10, Adolescent Immunization Status, Monitoring of Persistent Medication, Use of Imaging for Low Back Pain, Controlling High Blood Pressure, Pharmacotherapy for COPD Exacerbation, and Members 6 Years and Older Get Follow-Up by 7 Days Post-Discharge.*
- In the **Member Services** domain of the PGP, neither Health Plan performed well, with NHPRI meeting only one (1) *Contract* goal and UHCP-RI meeting no goals for the four (4) measures. Both Health Plans would benefit from continuing to examine the processes and procedures currently in place, make changes where needed, and re-assess at frequent intervals to determine effectiveness.

- With regard to **Medical Home/Preventive Care**, neither Health Plan met the *Contract* goal for the CAHPS[®] measure *Members Were Satisfied with Access to Urgent Care* or the HEDIS[®] measure *Chlamydia Screening* (both 16 – 20 years and 21 – 24 years). The Health Plans should continue their current efforts, evaluate the effectiveness of each intervention, and seek out best practices to emulate.
- In the **Chronic Care** domain, neither NHPRI nor UNCP-RI met the PGP goal for the measure *Members with Persistent Asthma Prescribed Appropriate Medications (5 – 11 Years)* and both Health Plans earned only two of five (2 of 5) stars for the NCQA accreditation domain *Getting Better*. Interventions to improve the delivery of services to members with chronic conditions might include: targeting interventions at both providers and members, tracking and conducting outreach for members who do not fill needed prescriptions, and issuing provider performance feedback. The Health Plans should also evaluate the effectiveness of the existing interventions.
- In the **CSHCN** domain, neither Health Plan met the goal for *Initial Health Screen Completed within 45 Days*. The Health Plan should take note of the observations and recommendations of the State’s Site Visit Team. Additionally, both Health Plans should assess performance for any HEDIS[®] measure where the rates for All Populations (including special enrollment population members) rank in a lower *Quality Compass*[®] percentile band than those for Core Rite Care members only.
- In relation to **Member Satisfaction**, an opportunity for improvement exists for both Health Plans for the CAHPS[®] measure *How Well Doctors Communicate*. Soliciting direct feedback from members, particularly the special enrollment populations may provide some insight into the reasons for members’ lack of satisfaction and provide a direction for targeted interventions.

In addition to the overall opportunities for improvement for the Medicaid managed care program, each Health Plan was provided with individual recommendations for improvement which are described in detail in each Health Plan’s individual EQR Technical Report, and are presented here in summary form.²⁸

Neighborhood Health Plan of Rhode Island, Inc.

Some recommendations are made for improving the delivery of health care and services to members in the following areas: member services, preventive and screening services, member satisfaction, chronic care and QIPs.

Within these areas, IPRO recommends that NHPRI augment its current initiatives and continue working to improve the following measures:

- ***Member Handbook Sent within 10 Days***
- ***Two New Member Call Attempts within 30 Days***
- ***Timely Grievances and Appeals Processing***
- ***The NCQA Accreditation domain Getting Better***
- ***CAHPS[®] Member Satisfaction with Access to Urgent Care***
- ***HEDIS[®] Chlamydia Screening***
- ***HEDIS[®] Adults’ Access to Preventive and Ambulatory Health Services (members ages 65+ years)***
- ***HEDIS[®] Antidepressant Medication Management***
- ***HEDIS[®] Use of Appropriate Medications for Members with Persistent Asthma, and***
- ***CAHPS[®] Getting Care Quickly***
- ***CAHPS[®] Rating of Personal Doctor***
- ***CAHPS[®] How Well Doctors Communicate***

²⁸ For further information, refer to each Health Plan’s Annual External Quality Review Technical Report.

- **Opportunity for improvement remains for each of the Quality Improvement Projects (QIPs), as NHPRI did not achieve its goals for any of the four (4) QIPs. Specific recommendations for each of the QIPs are provided in the Health Plan-specific report.**

Additionally, the State-specific measures for special enrollment populations (Rite Care for Children with Special Health Care Needs, Rite Care for Children in Substitute Care, and Rhody Health Partners), *Initial Health Screen within 45 Days* and *Active Care Management Plans are Evaluated and Updated No Less than Every 6 Months*, present opportunities for improvement.

UnitedHealthcare Community Plan-Rhode Island

Some recommendations are made for improving the delivery of health care and services to members in the following areas: member services, preventive and screening services, member satisfaction, chronic care and QIPs.

Within these areas, IPRO recommends that UHCP-RI evaluate and augment its current initiatives and work to improve performance related to the following:

- ***ID Cards Sent within 10 Days***
- ***Member Handbook Sent within 10 Days***
- ***Two New Member Call Attempts within 30 Days***
- ***Timely Grievances and Appeals Processing***
- ***HEDIS[®] Chlamydia Screening***
- ***HEDIS[®] Cervical Cancer Screening***
- ***HEDIS[®] Adult BMI Assessment***
- ***HEDIS[®] Weight Assessment and Counseling for Nutrition and Physical Activity - BMI percentile component***
- ***CAHPS[®] Member Satisfaction with Access to Urgent Care***
- ***HEDIS[®] Timely Prenatal Care***
- ***HEDIS[®] Timely Postpartum Care***
- ***HEDIS[®] Frequency of Ongoing Prenatal Care***
- ***HEDIS[®] Use of Appropriate Medications for Members with Persistent Asthma***
- ***HEDIS[®] Comprehensive Diabetes Care – HbA1c Testing***
- ***HEDIS[®] Follow-Up for Children Prescribed ADHD Medications – Initiation Phase***
- ***The NCQA Accreditation domain Getting Better***
- ***CAHPS[®] Getting Needed Care***
- ***CAHPS[®] How Well Doctors Communicate***
- ***CAHPS[®] Shared Decision-Making***
- ***CAHPS[®] Customer Service***
- ***CAHPS[®] Rating of Health Plan***
- ***The NCQA Health Plan Ranking domain Consumer Satisfaction***
- **Opportunities for improvement remain for each of the Quality Improvement Projects (QIPs), as UHCP-RI achieved its goals for only one of five (1 of 5) QIPs (*Antidepressant Medication Management – Effective Acute Phase Treatment*). In the past, the Health Plan has relied primarily on passive initiatives such as newsletter articles and mailings. In general, UHCP-RI implemented stronger intervention strategies for this reporting period. Specific recommendations for each QIP are detailed in the Health Plan-specific report.**

Additionally, the State-specified measures for special enrollment populations (CSHCN and RHP), *Initial Health Screen within 45 Days*, *Active Care Management Plans Are Evaluated and Updated No Less than*

Every 6 Months, and Reduction in Emergency Department Visits for ACSCs – CSHCN Population, present substantial opportunities for improvement.

EOHHS Responses and Follow-Up to Recommendations

As required by Federal regulations, the EQR must annually assess the degree to which the Health Plan effectively addressed the previous year's recommendations. In order to ensure that the Health Plans had the information required to achieve this, EOHHS used the Annual EQR Technical Reports as a quality improvement tool and provided feedback to each Health Plan regarding its HEDIS[®] and CAHPS[®] scores, PGP outcomes, State Monitoring Visit findings, as well as the EQR Technical Report.

EOHHS issues the results of both its annual *Contract* compliance review and the EQR Technical Reports to each Health Plan accompanied by cover letters that include commendations for Health Plan accomplishments and improvements and delineating key recommendations requiring a plan of action and/or response. EOHHS also includes follow-up to these recommendations as an agenda item in its monthly *Contract*-oversight meetings with the Health Plans. Key findings and planned improvement efforts related to the EQR Technical Reports were a focus of the December 2011 *Contract* meetings with both of the Health Plans.

REFERENCES

Introduction

- Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Federal Register, Part II, 42 CFR Parts 433 and 438, Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule*; §438.320, page 3635.
- Department of Health and Human Services, Centers for Medicare & Medicaid Services, *Rhode Island Global Consumer Choice Compact Section 1115 Demonstration (Project No. 11-W-00242/1) Special Terms and Conditions*, December 9, 2009.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island's 2011 Performance Goal Program – Preliminary HEDIS[®] and CAHPS[®] Rates: Core Rlte Care Only and All Populations*, NHPRI, June 3, 2011.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island's 2011 Performance Goal Program – Preliminary HEDIS[®] and CAHPS[®] Rates: Core Rlte Care Only and All Populations*, UHCNE, June 3, 2011.
- Rhode Island Executive Office of Health and Human Services, *Medicaid Managed Care Services Contract*, September 1, 2010.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island's Strategy for Quality Assessment and Performance Improvement*, April 2005.
- Rhode Island Executive Office of Health and Human Services, *Code of Rules, Medical Assistance, § 0300 Medical Assistance Program Overview, § 0348 Rlte Care Program, § 0374 Managed Care Program Options for Adults*, available at: <https://www.policy.ri.gov/0300.htm> (accessed June 18, 2012).

Corporate Profile

- NCQA, *Health Insurance Plan Rankings 2011 – 2012*, available at www.ncqa.org (accessed January 27, 2012).
- Updated enrollment information provided by State of Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health.

Accreditation Summary

- NCQA, *Health Insurance Plan Rankings 2011 – 2012, Methodology Overview*, October 20, 2011, available at: www.ncqa.org, (accessed January 27, 2012).
- NCQA, *Health Insurance Plan Rankings 2011 – 2012, Medicaid Plans*, NHPRI ranking data, page 8, available at www.ncqa/portals/0/health%20plan%20rankings/2011/HPR2011_NCQA_Plan_Ranking_Details_Medicaid.pdf, (accessed January 27, 2012).
- NCQA, *Health Insurance Plan Rankings 2011 – 2012, Medicaid Plans*, UHCNE ranking data, page 16, available at www.ncqa/portals/0/health%20plan%20rankings/2011/HPR2011_NCQA_Plan_Ranking_Details_Medicaid.pdf, (accessed January 27, 2012).
- NCQA, *Health Plan Report Card, Rhode Island Medicaid, Neighborhood Health Plan of Rhode Island*, available at: <http://reportcard.ncqa.org/plan/external/PlanSummary.aspx?WipsPlanId=178>, (accessed January 27, 2012).

- NCQA, *Health Plan Report Card, Rhode Island Medicaid, UnitedHealthcare of New England*, available at <http://reportcard.ncqa.org/plan/external/PlanSummary.aspx?WipsPlanId=432> (accessed January 27, 2012).
- Rhode Island Executive Office of Health and Human Services, *Medicaid Managed Care Services Contract*, September 1, 2010.

Enrollment and Provider Network

- NCQA, HEDIS[®] 2009, 2010, 2011, *Interactive Data Submission System – Medicaid, NHPRI*.
- NCQA, HEDIS[®] 2009, 2010, 2011, *Interactive Data Submission System – Medicaid, UHCNE*.
- NCQA, HEDIS[®] 2010 *Quality Compass[®] Measure Benchmarks for Medicaid*.
- NCQA, HEDIS[®] 2011 *Quality Compass[®] Measure Benchmarks for Medicaid*.
- NHPRI, *NHPRI Members - Managed Care Accessibility Analysis: A report on the accessibility of NHPRI Providers: PCPs, OBGYNs & Specialists for Members of NHPRI as of January 31, 2011*, February 14, 2011.
- UHCNE, Memorandum: *Geo Access Analysis – Executive summary for the Service Quality Improvement Subcommittee (SQIS)*, Pillsbury, Joan. October 3, 2011 (updated April 30, 2012)
- Updated enrollment information provided by the Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health.

Rhode Island Performance Goal Program 2011

- NCQA, HEDIS[®] 2009, 2010, 2011 *Interactive Data Submission System – Medicaid, NHPRI*.
- NCQA, HEDIS[®] 2009, 2010, 2011 *Interactive Data Submission System – Medicaid, UHCNE*.
- NCQA, HEDIS[®] 2010 *Quality Compass[®] Measure Benchmarks for Medicaid*.
- Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health, *Medicaid Managed Care Services Contract*, September 1, 2010.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island's 2011 Performance Goal Program, Measurement Period: Calendar Year 2010*.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island's 2011 Performance Goal Program - Summary of Findings for Calendar Year 2010. Neighborhood Health Plan of Rhode Island (NHPRI), Site Visit conducted, May 3, 2011 and May 4, 2011*.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island's 2011 Performance Goal Program, Summary of Findings for Calendar Year 2010. UnitedHealthcare of New England (UHCNE), Site visit conducted April 27, 2011 and April 28, 2011*.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island's 2011 Performance Goal Program, Summary of Findings for CSHCN and Substitute Care Calendar Year 2010, Neighborhood Health Plan of Rhode Island*.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island's 2011 Performance Goal Program, Summary of Findings for Rhody Health Partners, Measurement Period: Calendar Year 2010, Neighborhood Health Plan of Rhode Island*.
- Rhode Island Executive Office of Health and Human Services, *Rhode Island's 2011 Performance Goal Program, Summary of Findings for CSHCN, Calendar Year 2010, UnitedHealthcare of New England*.
- *Rhode Island's Performance Goal Program (2009 and 2010 Results)*.
- UHCP-RI, *UnitedHealthcare Community Plan, Rhode Island - HEDIS[®] Action Plan Summary*, 6/27/2011.
- UHCP-RI, *UnitedHealthcare Community Plan, Rhode Island - HEDIS[®] Action Plan Summary*, 8/15/2011.
- UHCP-RI, *UnitedHealthcare Community Plan, Rhode Island - HEDIS[®] Action Plan Summary*, 9/15/2011.

- UHCP-RI, *UnitedHealthcare Community Plan, Rhode Island - HEDIS® Action Plan Summary*, 10/15/2011.
- UHCP-RI, *UnitedHealthcare Community Plan, Rhode Island - HEDIS® Action Plan Summary*, 12/30/2011.
- UHCP-RI, *HEDIS® 2012 Interim Report, Medicaid Effectiveness of Care, UnitedHealthcare of New England, Claim Period 01/01/2011 – 8/31/2011*. Updated: 9/18/2011.
- UHCP-RI, *HEDIS® 2012 Interim Report, Medicaid Effectiveness of Care, UnitedHealthcare of New England, Claim Period 01/01/2011 – 9/31/2011*. Updated: 10/19/2011.
- UHCP-RI, *HEDIS® 2012 Interim Report, Medicaid Effectiveness of Care, UnitedHealthcare of New England, Claim Period 01/01/2011 – 11/30/2011*. Updated: 12/19/2011.

HEDIS® Performance Measures

- Attest Health Care Advisors, LLC, NCQA Certified *HEDIS® Compliance Audit™ Final Audit Report: HEDIS® 2011, Neighborhood Health Plan of Rhode Island*, July 8, 2011.
- Attest Health Care Advisors, LLC, *HEDIS® 2011 Final Rates: Audit Review Table, Neighborhood Health Plan of Rhode Island*, 2011.
- Attest Health Care Advisors, NCQA Certified *HEDIS® Compliance Audit™ of 2011 HEDIS® Reports, Final Audit Findings, UnitedHealthcare of New England*, July 7, 2011.
- Attest Health Care Advisors, LLC, *HEDIS® 2011 final Rates: Audit Review Table, UnitedHealthcare of New England, Medicaid Managed Care Operations*, 2011.
- NCQA, *HEDIS® 2009, 2010, 2011 Interactive Data Submission System – Medicaid, NHPRI*.
- NCQA, *HEDIS® 2009, 2010, 2011 Interactive Data Submission System – Medicaid, UHCNE*.
- NCQA, *HEDIS® 2011 Quality Compass® Measure Benchmarks for Medicaid*.

Member Satisfaction: Adult CAHPS® 4.0

- NCQA, *HEDIS® 2010 Quality Compass® Measure Benchmarks for Medicaid*.
- NCQA, *HEDIS® 2011 Quality Compass® Measure Benchmarks for Medicaid*.
- *Survey Research Solutions Report, UnitedHealthcare of New England, Inc. Consumer Assessment of Healthcare Providers and Systems, CAHPS® 4.0H, Adult Medicaid Consumer Satisfaction Survey, prepared by Center for the Study of Services*, August 2011.
- The Myers Group, *Neighborhood Health Plan of Rhode Island CAHPS® 2011 Medicaid Adult Survey Project Number 48745 and 48746 Final Report*, June 30, 2011.

Conclusions and Recommendations

- IPRO, on behalf of the Rhode Island Executive Office of Health and Human Services, *Annual External Quality Review Technical Report for Neighborhood Health Plan of Rhode Island (NHPRI)*, Reporting Years 2009-2011.
- IPRO, on behalf of the Rhode Island Executive Office of Health and Human Services, *Annual External Quality Review Technical Report for UnitedHealthcare of New England (UHCNE)*, Reporting Years 2009 – 2011.
- NHPRI, *Neighborhood Health Plan of Rhode Island: 2010 Quality Improvement Annual Evaluation*.
- NHPRI, *Neighborhood Health Plan of Rhode Island, Beacon Health Strategies Quarterly Report to: Operations and Service Committee*, September 2011.
- NHPRI, *Neighborhood Health Plan of Rhode Island Presentation to: Department of Human Services, 2011 Rite Care Performance Goal Program (CY 2010) Improvement Plan for HEDIS® Measures*, September 2011.

- NHPRI, *Neighborhood Health Plan of Rhode Island: Quality Improvement Program Description 2011*, May 12, 2011.
- NHPRI, *Quality Improvement Activity, (QIA) Form: Quality Improvement Activity: Antidepressant Medication Management: Acute Phase*, December 2011.
- NHPRI, *Quality Improvement Activity (QIA) Form: Quality Improvement Activity: Getting Needed Care*, December 2011.
- NHPRI, *Quality Improvement Activity (QIA) Form: Quality Improvement Activity: Improving Childhood Immunization Rates for Children 2 years of age*, December 2011.
- NHPRI, *Quality Improvement Activity (QIA) Form: Quality Improvement Activity: Initial Health Screens for Specified Populations (CSNSC, RHP)* November 2011.
- Rhode Island Executive Office of Health and Human Services, Center for Child and Family Health, *Medicaid Managed Care Services Contract*, September 1, 2010.
- UHCNE, *2011 United Healthcare Community Plan of Rhode Island Quality Improvement Program Description, Contract Period beginning September 1, 2010*.
- UHCNE/Medicaid, *Quality Improvement Activity (QIA) Summary: Improving Effective Acute Phase Treatment for Major Depression*, January 10, 2012.
- UHCNE, *Quality Improvement Activity (QIA) Summary: Improving Follow-up Care after Hospitalization for Mental Illness*, January 10, 2012.
- UHCNE/Medicaid, *Quality Improvement Activity (QIA) Summary: Initial Health Screens for Special Populations*, January 10, 2012.
- UHCNE/Medicaid, *Quality Improvement Activity (QIA) Summary: Member Satisfaction with Getting needed Care (CAHPS®)*, January 10, 2012.
- UHCNE/Medicaid, *Quality Improvement Activity (QIA) Summary: Prenatal and Post Partum Care*, January 10, 2012.

APPENDIX 1: Rite Care Background Information

Rite Care: Medicaid Managed Care for Children and Families In Rhode Island¹

1. Background Information

In November of 1993, the State of Rhode Island was granted a Section 1115 Waiver (11-W-00004/1) to develop and implement a mandatory Medicaid managed care demonstration program called Rite Care. Rite Care, implemented in August 1994, has the following general goals:

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

Rite Care was designed for the following groups to be enrolled in licensed health maintenance organizations (HMOs, or Health Plans):

- Family Independence Program (FIP)² families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

Over time, the populations eligible for Rite Care have expanded, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective November 1, 1998, to expand to families with children under age 18 including parents and relative caretakers with incomes up to 185³ of the FPL (expansion under Section 1931 of the Social Security Act through a State Plan Amendment (SPA))
- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL
- Effective December 1, 2000, to maximize enrollment of children in foster care placements⁴ from fee-for-service Medicaid to Rite Care
- Effective November 1, 2002, to establish a separate child health program to cover unborn children with family income up to 250 percent of the FPL

¹ The Quality Strategy included in this appendix was approved by CMS in 2005. An updated Quality Strategy was submitted in 2012 and is pending approval.

² Originally Aid to Families with Dependent Children (AFDC) and then Temporary Assistance to Needy Families (TANF). FIP is Rhode Island's program for the TANF-eligible population.

³ This eligibility category was reduced to 175 percent of the FPL when the Rite Care demonstration was extended effective October 1, 2008.

⁴ Children in foster care are enrolled in Rite Care on a voluntary basis.

- Effective January 29, 2003, to enroll the following categories of children with special health care needs (CSHCN) into Rite Care Health Plans on a mandatory basis⁵:
 - Blind/disabled children, and related populations (eligible for Supplemental Security Income, or SSI, under Title XVI of the Social Security Act)
 - Children eligible under Section 1902(e)(3) of the Social Security Act (“Katie Beckett” children)
 - Children receiving subsidized adoption assistance

The May 1, 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualified as eligible Medicaid expansions under Title XXI (State Children’s Health Insurance Program, or SCHIP) of the Social Security Act. By Section SCHIP 1115 waiver approval (21-W-00002/1-01), effective January 18, 2001, Section 1931 parents and relative caretakers between 100 and 185 percent of the FPL, and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI. Approved April 17, 2003, the separate child health program allows the State to provide comprehensive coverage for pregnant aliens who would not be otherwise eligible for Federal financial participation (FFP). These women are enrolled in Rite Care Health Plans.

It should be noted that the State received approval from the, then, Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services, or CMS) on January 5, 1999 to expand SCHIP coverage to children under age 19 in households with income up to 300 percent of the FPL. The State has not yet implemented the approved amendment and has no immediate plans to do so due to ongoing budgetary constraints.

The SCHIP demonstration ended September 30, 2008 and the Medicaid demonstration was extended until December 31, 2014 as part of the State’s Section 1115 Global Consumer Choice Compact Waiver (Project No. 11W-00242/1). Subsequent to approval of the Global Consumer Choice Compact Waiver, two changes have occurred regarding Rite Care.

- Effective July 1, 2009, CMS approved coverage under CHIP of lawfully residing children up to 250 percent of the FPL.⁶
- Effective December 9, 2009, CMS approved coverage under CHIP to provide pregnancy-related services for women between 185 and 250 percent of the FPL (the population previously covered under the Section 1115 SCHIP demonstration).

⁵ Children with special health care needs (CSHCN) were enrolled on a voluntary basis effective January 29, 2003, as only NHPRI had been willing to enroll this population. As of October 1, 2008, managed care enrollment became mandatory for all Rite Care-eligible CSHCN who do not have another primary health insurance coverage; both NHPRI and UHCNE accept this population. NHPRI is the only Health Plan which currently enrolls children in foster care.

⁶ This population is also covered under a Title XIX State Plan Amendment (SPA).

2. Demonstration Evaluation Design

A new requirement under the waiver extension is for the State to prepare an evaluation design. The State submitted its *Draft Evaluation Design* to CMS on November 18, 2005 and submitted its *Final Evaluation Design* to CMS on July 20, 2006 after receiving CMS' comments on the draft on May 8, 2006. Table 1 shows the objectives and hypotheses for the demonstration.

Table 1
Objectives and Hypotheses for the Demonstration

Demonstration Objectives	Demonstration Hypotheses
To reduce uninsurance in the expansion population groups eligible for the demonstration	The rate of uninsurance in the expansion population groups eligible for the demonstration will be reduced as a result of this demonstration.
To provide all enrollees in the demonstration with a <i>medical home</i>	All enrollees in the demonstration will have a <i>medical home</i> .
To improve access to health care for populations eligible for the demonstration	Access to health care for populations eligible for the demonstration will be improved.
To increase the number of physicians participating in the State's Medical Assistance Program	The number of physicians participating in the State's Medical Assistance Program will increase as a result of this demonstration.
To increase preventive and other primary care provided to populations enrolled in the demonstration	Preventive and other primary care services provided to populations enrolled in the demonstration will increase.
To shift the locus of preventive care and other primary care from hospital emergency departments to other service delivery locations	The locus of preventive care and other primary care will shift from hospital emergency departments to other service delivery locations.
To increase the appropriate use of inpatient hospitals and hospital emergency departments	The appropriate use of inpatient hospitals and hospital emergency departments will increase.
To reduce infant mortality	The rate of infant mortality in the State will be reduced during the course of this demonstration.
To improve maternal and child health outcomes	Maternal and child health outcomes for populations enrolled in the demonstration will improve.
To improve the quality of care provided to populations enrolled in the demonstration	The quality of care provided to populations enrolled in the demonstration will improve.
To have a high satisfaction level with the demonstration project among enrolled populations	Populations enrolled in the demonstration will have a high level of satisfaction with the demonstration project.
To have the demonstration project be budget neutral	The cost to the Rhode Island Medical Assistance Program with the demonstration will be no greater than the cost would have been without the demonstration, adjusted for increases in inflation and population.

The heart of the evaluation design is the State's quality strategy described in the next section.

3. Quality Strategy

A *quality strategy document* is a required element of the June 14, 2002 *Final Rule* implementing the managed care provisions of the Balanced Budget Act of 1997 (BBA). Specifically, Subpart D of the *Final Rule* “implements section 1932(c)(1) of the Act and sets forth specifications for quality assessment and performance improvement strategies that States must implement to ensure the delivery of quality health.” Table 2 summarizes Rhode Island’s quality strategy to comply with Section 438.204 of the *Final Rule*.

Table 2

COMPONENTS OF RHODE ISLAND’S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY - April 2005

QUALITY/ PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
1. Assess the quality and appropriateness of care and services to enrollees	<ul style="list-style-type: none"> • Performance incentive program • Encounter Data System • NCQA information • Member Satisfaction Survey • Complaint, grievance and appeals reporting • EQRO studies • Special studies • Contract compliance review 	
2. Identify the race, ethnicity, and primary language spoken of each enrollee	<ul style="list-style-type: none"> • MMIS data 	
3. Arrange for annual, external independent reviews of the quality and timeliness of, and access to, the services covered under each Health Plan <i>Contract</i>	<ul style="list-style-type: none"> • Performance incentive program • Encounter Data System • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO studies • Special studies • Contract compliance review 	IPRO, the State’s EQRO is responsible for preparing an annual, plan-specific detailed technical report that assesses the quality, timeliness, and access to the care furnished by each Health Plan.

QUALITY/ PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
4. Appropriate use of intermediate sanctions	<ul style="list-style-type: none"> • Contract compliance review 	Provisions for levying intermediate sanctions have always been a part of the <i>Rite Care Health Plan Contract</i> . Contracts were amended to incorporate Subpart I of the June 14, 2002 <i>Final Rule</i> requirements.
6. Standards for Access to Care, Structure and Operations, and Quality Measurement and Improvement 6.a. Access Standards 6.a.1 Availability of services 6.a.2 Assurances of adequate capacity and services 6.a.3 Coordination and continuity of care 6.a.4 Coverage and authorization of services	<ul style="list-style-type: none"> • Performance incentive program • Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Special studies • Contract compliance review <ul style="list-style-type: none"> • Provider network reporting • NCQA information • Contract compliance review <ul style="list-style-type: none"> • Complaint, grievance, and appeals reporting • NCQA information • EQRO activities • Special studies • Contract compliance review <ul style="list-style-type: none"> • Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Contract compliance review 	<p>As Table 3-2 shows, the State has quantitative access standards and has since 1994.</p> <p>As Table 3-2 shows, the State has quantitative capacity standards and has since 1994.</p> <p>The State defers principally to NCQA standards in this area.</p> <p>The State defers principally to NCQA standards in this area.</p>

QUALITY/ PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
<p>6.b. Structure and Operation Standards</p> <p>6.b.1 Provider selection</p> <p>6.b.2 Enrollee information</p> <p>6.b.3 Confidentiality</p> <p>6.b.4 Enrollment and disenrollment</p> <p>6.b.5 Grievance systems</p> <p>6.b.6 Subcontractual relationships and delegation</p>	<ul style="list-style-type: none"> • Provider network data • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review <ul style="list-style-type: none"> • Performance incentive program • On-site reviews • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review <ul style="list-style-type: none"> • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review <ul style="list-style-type: none"> • MMIS data • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review <ul style="list-style-type: none"> • NCQA information • Annual Member Satisfaction Survey • Complaint, grievance, and appeals, reporting • Special studies • Contract compliance review <ul style="list-style-type: none"> • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review 	<p>The State defers principally to NCQA standards in this area.</p> <p>The State defers to NCQA standards in this area, except for certain State-specified requirements to be met in the <i>Contract</i>.</p> <p>The State defers principally to NCQA standards in this area.</p> <p>State requirements must be met as specified in the <i>Contract</i>.</p> <p>The State defers to NCQA standards in this area, except for certain requirements that must be met under State law.</p> <p>The State defers principally to NCQA standards in this area.</p>

QUALITY/ PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
<p>6.c. Quality Measurement and Improvement Standards</p> <p>6.c.1 Practice guidelines</p> <p>6.c.2 Quality assessment and performance improvement program</p> <p>6.c.3 Health information systems</p>	<ul style="list-style-type: none"> • NCQA information • Special studies • Contract compliance review <ul style="list-style-type: none"> • Performance incentive program • Encounter Data System • Complaint, grievance, and appeals reporting • NCQA information • Special studies • Contract compliance review • • Encounter Data System • Risk-share reporting • NCQA information • EQRO activities • Special studies • Contract compliance review 	<p>The State defers principally to NCQA standards in this area.</p> <p>The State defers to NCQA standards in this area, except for certain State-specified requirements to be met under the <i>Contract</i>.</p> <p>The State defers to NCQA standards in this area, except for certain State-specified requirements to be met under the <i>Contract</i>.</p>
<p>7. Encounter Data Requirements</p>	<ul style="list-style-type: none"> • Encounter Data System • EQRO activities • Special studies • Contract compliance review 	<p>The Encounter Data System has been used to produce reports since 1998. It is the heart of RItE Care’s performance incentive program. It is supplemented by EQRO studies and special studies in areas of access and clinical care interest.</p>
<p>8. Quality Assurance Requirements</p> <p>8.a. Methodology to monitor performance</p>	<ul style="list-style-type: none"> • All mechanisms 	<p>Previously, the State had a <i>Plan for Monitoring Health Plans</i>. That plan is superseded by this strategy document with respect to quality.</p>

QUALITY/ PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
8.b. Contract with EQRO	<ul style="list-style-type: none"> EQRO activities 	EQRO contract was reprocured, with a contract effective date of September 1, 2003.
8.c. Quarterly reports on complaints and grievances	<ul style="list-style-type: none"> Complaint, grievance, and appeals reporting Contract compliance review 	Complaint, grievance, and appeals reporting has been in place since 1994.
8.d. EQRO focused study of emergency room services	<ul style="list-style-type: none"> EQRO study 	Study report was submitted to CMS (HCFA) in 1998.
8.e Require that Health Plans meet certain quality assurance requirements	<ul style="list-style-type: none"> NCQA information Contract compliance review 	<i>Contracts</i> were amended to conform to the <i>Final Rule</i> .
9. General Administrative/ Reporting Requirements – quarterly and annual reports	<ul style="list-style-type: none"> All mechanisms 	

The entire *quality strategy document* may be found at:
http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/Reports/Rhode_Island_Strategy_For_Assessing_Quality.pdf

4. Administrative Improvements

The State has made a number of improvements over time to make the application and enrollment processes less burdensome, to stimulate enrollment, and to deter *crowd-out* (i.e., substituting public coverage for private coverage). Among these administrative improvements have been the following:

- *October 1998* – Implemented a streamlined mail-in application with minimal documentation requirements and eliminated face-to-face requirements to confirm eligibility
- *April 1999* – Initiated a Rite Care community-based enrollment outreach project, encompassing school-based outreach combined with contracts with 32 community-based organizations using performance-based incentives for locating and enrolling eligible children. This outreach project ended in June 2000.
- *January 2002* – Implemented monthly premiums at up to three percent of income for expansion enrollees over 150 percent of the FPL
- *August 2002* – Increased the monthly premiums but not to exceed five percent of income for expansion enrollees over 150 percent of the FPL
- *May 2004* – Made the Rite Care application available on-line in both English and Spanish

5. Delivery System Changes

As noted at the beginning of this appendix, the State of Rhode Island made a policy decision to only allow State-licensed HMOs to participate in Rite Care. There were originally five Rite Care-participating Health Plans: Coordinated Health Partners (CHP, or BlueCHiP), Harvard Community Health Plan (HCHP), Neighborhood Health Plan of Rhode Island (NHPRI), Pilgrim Health Care (PHC), and United HealthCare of New England (UHCNE). There have been several important changes to the Rhode Island HMO marketplace since then. First, HCHP and PHC merged in 1995, becoming Harvard Pilgrim Health Care (HPHC). Second, HPHC left⁷ the Rhode Island market without warning in 1999. Finally, Blue Cross and Blue Shield of Rhode Island (BCBSRI) voluntarily gave up its State HMO license at the end of 2004.

In order to assure the availability of choices for Rite Care-eligible individuals, the State changed its policy to allow other than State-licensed HMOs to participate in Rite Care effective January 1, 2005. Non-HMOs must meet the following requirements:

- Be licensed as a Health Plan in the State
- Be accredited⁸ by the National Committee for Quality Assurance (NCQA) as a Medicaid managed care organization (MCO)
- Meet certain State regulatory requirements⁹ that HMOs must meet:
 - Have professional services under the direction of a medical director who is licensed in Rhode Island and performs the functions specified in regulation (e.g., oversight of quality management)
 - Make certain enrollees are only liable for co-payments and to have this provision in its provider contracts
 - Meet “preventive health care services” requirements and provide them within time frames set by the HMO, according to accepted standards specific to age and gender
 - Have a quality management program that is accredited

6. Rite Share

Rite Share, the State of Rhode Island’s premium assistance program for Medicaid-eligible individuals who have access to employer-sponsored insurance (ESI), had the following implementation timelines:

- *February 2001* – Initiated voluntary enrollment in Rite Share
- *April 2001* – Began transitioning Rite Care enrollees with access to ESI to Rite Share
- *February 2002* – Began mandatory enrollment in Rite Share of eligibles with access to qualified ESI

Under Rite Share, Medicaid pays all or a part of an eligible family’s monthly premium, based upon income and family size, for an employer’s DHS-approved ESI. Rite Share provides for coverage of all Medicaid benefits as wrap-around coverage to ESI as well as co-payments and deductibles.

⁷ Tufts Health Plan of New England also left the Rhode Island market about the same time, although it had never participated in Rite Care.

⁸ In Rhode Island, all HMOs must be accredited by NCQA. All three Health Plans have full three-year accreditation and received an “Excellent” designation from the NCQA. Of all the Medicaid plans in the nation, BCBSRI ranked first, UHCNE ranked third, and NHPRI ranked sixth in 2005. Both BCBSRI and UHCNE have their Medicaid product lines accredited, as well as their Medicare product lines.

⁹ *Rules and Regulations for the Certification of Health Plans (R23-17.13-CHP).*

Rlte Share is not a focus of the quality strategy, given that it is not a managed care product. Rlte Share has been described herein because of its overall role in addressing health care access in the State and is, as such, an important contextual element.

APPENDIX 2: Rhody Health Partners Background Information

Rhody Healthy Partners: Medicaid Managed Care for Children and Adults with Disabilities In Rhode Island¹

1. Background Information on the State's Section 1115 Global Consumer Choice Compact Waiver

As noted in Appendix 1, the Medicaid demonstration has been subsumed under the State's Section 1115 Global Consumer Choice Compact Waiver (Project No. 11W-00242/1). Approved January 16, 2009 and extending through December 31, 2014, the Global Waiver provides the State with substantially greater flexibility to redesign the Medicaid program than was available previously. Rhode Island is using this additional flexibility to provide more cost-effective services and care in the least restrictive and most appropriate setting.

The State operates its entire Medicaid program under the Global Waiver, with an aggregate budget ceiling for Federal reimbursement with the exception of disproportionate share hospital (DSH) payments, administrative expenses, phased Medicare Part D contributions, and payments to local education agencies (LEAs).

The Global Waiver is built upon three fundamental goals:

- Rebalance the State's long-term care system
- Integrate care management across all Medicaid populations
- Complete the transition from a payer to a purchaser of care

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 healthcare delivery system so that consumers can make more reasoned and cost-effective choices about their health care.
- **Personal Responsibility** in choosing treatment options, living healthy lifestyles, and having a financial stake in the care provided.
- **Community-Based Solutions** so that individuals may live and receive care in the communities in which they live and work, 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.
- **Competition** among health care providers to ensure that care is provided at the best price and with the highest quality.
- **Pay for Performance** by linking provider reimbursement to the provision of quality and cost-effective care.
- **Improved Technology** that assists decision-makers, consumers, and providers make the most informed and cost-effective decisions regarding the delivery of health care.

¹ An updated Quality Strategy, which includes Rhody Health Partners, was submitted to CMS in 2012 and is pending approval.

The Global Waiver helps to assure the financial viability, sustainability, and stability of the State's Medicaid program. In effect, the Global Waiver 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.

2. Background Information on Rhody Health Partners

The option to enroll in a managed care organization (MCO)² 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. Effective September 1, 2010, all adults residing in the community without third-party coverage are required to either enroll in a Health Plan (i.e., MCO) through Rhody Health Partners or in the State's FFS Primary Care Case Management (PCCM) programs, which are Connect Care Choice and Connect Care. The Connect Care Choice program is a primary care practice-based model that includes care coordination and nurse care management. Neither Connect Care nor Connect Care Choice is a focus of the quality strategy, given that it is not a managed care product. They have been described herein because of its overall role in addressing health care access in the State and are, as such, an important contextual element.

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

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

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

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

² NHPRI and UHCNE were MCOs available to adults with disabilities in which to enroll.

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

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

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

The State’s quality strategy is in the process of being updated to include a section on Rhody Health Partners³. As already noted in the body of this report, Rhody Health Partners was included in this external quality review where applicable.

3. Demonstration Evaluation Design

A requirement under the Global Waiver is for the State to prepare an evaluation design. The State submitted its *Draft Evaluation Design* to CMS on July 17, 2009. Table 1 shows what was included in the design for Rhody Health Partners.

Table 1: Rhody Health Partners Evaluation Design

Date Collection Method	Type of Method	Performed By
Administrative data and hybrid measures, as set forth annually by the NCQA.	The HEDIS [®] methodology.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Quality Improvement Project (QIP)	NCQA's Quality Improvement Assessment (QIA) methodology that meets CMS protocol requirements.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Annual External Quality Review	Elements as mandated by 42 CFR 438.350(a).	Rhode Island's designated External Quality Review Organization (IPRO)
Informal Complaints, Grievances, and Appeals	Informal complaints reports are submitted electronically in a spreadsheet template established by the RI DHS.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Health Plan Member Satisfaction Survey	The CAHPS [®] 4.0 Survey Methodology for Adults in Medicaid.	NCQA-certified CAHPS [®] vendor

³ As noted on page 1, footnote 1, an updated Quality Strategy, which includes Rhody Health Partners, was submitted to CMS in 2012, and is pending approval.

Table 1: Rhody Health Partners Evaluation Design (cont'd.)

Date Collection Method	Type of Method	Performed By
Care Management Report for RHP	Care management reports are submitted electronically in a spreadsheet template established by the RI DHS.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollees
Encounter Data Reporting and Analysis	The managed care encounter dataset is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities.	Medicaid-participating Health Plans serving Rhode Island's RHP enrollment population
Access to Health Care for Adults with Disabilities on Medicaid Survey	Telephone survey of a sample of Rhode Island's ABD population, including RHP enrollees.	Independent Contractor