Neighborhood Health Plan of Rhode Island

2024 Quality Improvement Program Description

Approved by Neighborhood's Clinical Affairs Committee:
Supersedes: 5/13, 5/14, 5/15, 5/16, 5/17, 5/18, 5/19, 5/20, 5/21, 5/22, 5/23, 5/24

Approved by Neighborhood's Board of Directors:
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I. Introduction

Neighborhood Health Plan of Rhode Island's (Neighborhood) Quality Improvement (QI) Program strives to ensure that members have access to high quality health care services that are responsive to their needs and result in positive health outcomes. In order to meet this high level goal, Neighborhood's QI Program targets clinical quality of care, member and provider experience and internal operations. The purpose of the Quality Improvement Program Description is to detail the scope, goals, and objectives of the program; to demonstrate how improvement activities are operationalized within Neighborhood; to describe the methodology used within the program; to outline the structure and functions of the committees and subcommittees that support the program; and to delineate the oversight and guidance provided to the program by Neighborhood's senior management and the Neighborhood Board of Directors. Annually, the Quality Improvement Program Description is approved by the Neighborhood Board of Directors.

II. Scope and Philosophy of the Quality Improvement Program

Neighborhood's QI Program covers all its product lines (Medicaid, Exchange and Medicare-Medicaid Plan). Within the scope of its QI Program, Neighborhood monitors and evaluates care and services rendered to members, with particular emphasis on access to care, availability of services, member experience, and health outcomes, as captured through routine health plan reporting, annual HEDIS®, CAHPS®, QHPEES, HOS results, assessment of provider and member experience, accessibility and availability standards, utilization trends, and specially designed quality improvement studies. Neighborhood assesses its performance, including the performance of its contractors and its network providers, against goals and objectives that are evidence-based and align with industry standards.

Neighborhood's QI Program extends to all departments within the organization, at all levels, in the recognition that teamwork and collaboration are essential for quality improvement. Department directors are charged to develop and oversee quality improvement activities aimed at clinical care, services, and organizational efficiency within their own departments as well as coordinate and participate in interdepartmental quality improvement activities, as applicable to their responsibilities.

As one component of its QI Program, Neighborhood annually develops a QI Work Plan to guide the organization's improvement initiatives for the upcoming calendar year. The QI Work Plan lists each planned initiative or ongoing activity with a brief description, the timeframe for completion, the status of the activity and the individual responsible to oversee and facilitate the activity. The Work Plan includes QI activities relevant to the work of Neighborhood's subcontractors as well as those undertaken directly by the Plan.

To assess the effectiveness of the QI Program, including the activities to address the culturally and linguistically appropriate services, Neighborhood produces an annual QI evaluation. The Annual QI Evaluation includes the Plan's measurable performance achievements over the course of the year, with trended data when available. The Quality Improvement Annual Evaluation includes identification of the barriers which made quality improvement difficult to achieve, the interventions recommended to overcome these barriers, and a summary of the overall effectiveness of the program, with consideration given to the adequacy of resources, committee structure, and leadership involvement.

Neighborhood delegates the quality improvement function for behavioral health services to a National Committee for Quality Assurance (NCQA)-accredited Managed Behavioral Healthcare Organization.

Neighborhood provides oversight of the delegated QI activities as described in Section XI of this document.

III. Methodology

Neighborhood's Continuous Quality Improvement (CQI) approach emphasizes the use of "Plan Do Study Act" (also known as the Shewhart or Deming Cycle) as the methodology of choice to achieve and maintain performance excellence. Neighborhood achieves this CQI mission by:

- Creating an organizational culture of continuous quality improvement
- Using data and measurable outcomes to identify opportunities for improvement and to monitor progress toward established goals
- Consistently applying proven QI methods and tools to all quality improvement activities in the areas of clinical practice, service delivery, and internal operations
- Achieving recognition among industry peers as an inspiring model of CQI, and
- Delivering ever improving value to internal and external customers and stakeholders contributing to organizational sustainability.

Neighborhood's CQI initiatives are multi-disciplinary and extend across to all departments within the organization, at all levels, in recognition that teamwork and collaboration are essential for continuous quality improvement. CQI extends beyond the regulatory and contractual requirements and accrediting standards to all aspects of our daily work. Neighborhood's CQI efforts support the Plan's mission, vision and values and reflect the following core principles:

- *Leadership Driven* – Leadership Team involvement is key to the success of CQI. Neighborhood's Leadership Team leads the creation of an organizational culture that supports CQI, model leadership practices that promote and sustain improvement efforts, and create an open and encouraging environment where all staff can use performance improvement to develop their potential for doing the best job they can.

- *Customer Focused* – CQI understands and respects the needs and requirements of internal and external customers, and always strives to exceed their expectations.

- *Employee Empowerment/Involvement* – CQI involves staff at all levels of the organization and takes concrete steps to enable them to make improvement decisions that impact their daily work. CQI supports staff by providing the resources, training and structure necessary to achieve improvement.

- *Results-Based Decision-Making* – CQI identifies opportunities and improves programs and services by using reliable data for decision-making and focusing on measurable outcomes.

The Plan Do Study Act (PDSA) quality improvement methodology is a systematic, data-driven approach that must be employed across all departments to ensure continuous quality improvement in the Plan's clinical and service performance and operational functions and efficiencies.

The following are the steps applied to all quality improvement initiatives undertaken by Neighborhood:

Plan

Neighborhood monitors a variety of performance measures covering clinical care and service delivery to identify opportunities for improvement. Neighborhood uses HEDIS, CAHPS, QHPES and HOS results, program evaluation results, member and provider experience surveys, the Member Services member call logs, claims, utilization data, disease and case management data, medical records and electronic medical records, patient safety data, accessibility and availability surveys, member and provider focus groups, and other sources of data to guide and inform the quality improvement process. The available data are analyzed to assess performance over time, across providers, and among member sub-groups. Root cause analysis is conducted, often in collaboration with network providers and / or member representatives, to better understand trends in the data and identify opportunities for improvement.

Neighborhood's standing QI committee, subcommittees, and ad-hoc QI workgroups are responsible for identifying quality improvement interventions to address the identified opportunities for improvement and prioritizing the work and initiatives to be performed. Priorities are set, and interventions are designed based on the data analysis as well as evidence-based practice, when possible. Operational efficiency and the appropriate and reasonable use of the resources within the organization are considered when prioritizing each activity/intervention. QI workgroups lead individual improvement activities through the PDSA cycle.

For each improvement activity selected, Neighborhood's QI workgroups identify goals and objectives that are specific, measurable, achievable, relevant, and time-bound (SMART). The performance goals and objectives selected often align with local and national benchmark data, including but not limited to Quality Compass® and NCQA Accreditation benchmarks for Medicaid Managed Care organizations.

Do

The QI team leaders, in collaboration with their improvement work groups, carry out the interventions designed based on the analysis of data and evidence-based practice, whenever possible.

Study

The improvement work group monitors the effectiveness of the interventions carried out based on the goals and measures previously identified. The data is collected and analyzed, and the results are reported to the appropriate QI team based on the targets established for each activity using the PDSA methodology, including the identification of barriers and the interventions for overcoming the identified barriers.

Act

The QI team leaders in collaboration with their improvement work groups modify the interventions, as necessary, and identify the next steps. Successful interventions are monitored for sustainability and transferability. To ensure that quality improvement is continuous and the identified goals and/or objectives are being met, each quality improvement activity is reviewed and discussed by the designated committee or subcommittee regularly. Modifications to the initiatives are implemented as necessary and incorporated into the QI Work Plan.

Data Validation Process

Neighborhood monitors and evaluates the care and services provided to its members through collection and analysis of several data sources, including, but not limited to, HEDIS and CAHPS results, provider experience survey results, accessibility and availability standards, and utilization

trends. HEDIS and CAHPS data are collected using NCQA-certified third party vendors and validated by an NCQA-approved auditor contracted by Neighborhood. Surveys performed by external vendors are validated by the vendor according to contract requirements. Data produced internally are validated by business leads and presented at the Medicaid and Commercial and INTEGRITY Quality and Operations Committees.

IV. Program Goals and Objectives

The overall goal of Neighborhood's QI Program is to ensure that members have access to high quality health care services that are responsive to their needs and result in positive health outcomes.

The objectives of the QI Program in support of this goal are to:

- Provide a population health structure across all departments encompassing the clinical care provided to Neighborhood's members
- Assure access to high quality medical and behavioral healthcare that meet the members' needs taking into account the member's cultural and linguistic needs
- Support members with acute and long-term health care needs
- Monitor and improve coordination of care across settings
- Improve member and provider experience
- Ensure the safety of members in all health care settings
- Monitor quality of care in nursing facilities through Minimum Data Set (MDS) data and other data sources
- Engage members in their own care
- Improve HEDIS and CAHPS performance
- Improve Medicare Health Outcomes Survey (HOS) performance
- Ensure all QI initiatives are equity-focused where, to the extent possible, data is analyzed based on race, ethnicity, language and gender in order to identify and address disparities in health care services
- Attain maximum NCQA Star Rating and Accreditation Status
- Support the Medicaid Accountable Entities in achieving maximum performance on their annual Quality Multipliers
- Achieve optimum performance for Quality Withhold under the MMP-INTEGRITY product
- Achieve maximum performance for quality improvement projects required by contracts for Medicaid, INTEGRITY-MMP, and the Exchange products
- Maintain grievance and appeal procedures and mechanisms and assure that members can achieve resolution to problems or perceived problems related to access and other quality issues
- Maintain collaborative relationships with network providers and state agencies
- Improve operational efficiency in the work performed across the organization
- Ensure that Neighborhood's quality improvement structure and processes adhere to NCQA standards and state and federal requirements
- Assess the QI Program annually and make changes as necessary to improve program effectiveness

V. Program Structure, Leadership and Support Committees

A. Board of Directors

Neighborhood's Board of Directors has final authority and responsibility for the care and service delivered to Neighborhood's members. The Board of Directors delegates oversight of the Quality

Improvement Program to the Clinical Affairs Committee. The Board exercises its oversight of the Program by annually approving the Quality Improvement Program Description and Quality Improvement Work Plan, and by annual review of the Quality Improvement Program Evaluation.

B. Clinical Affairs Committee

The Clinical Affairs Committee (CAC) is Neighborhood's Quality Improvement Committee. The CAC provides direction to the Quality Improvement Program and Neighborhood staff for all activities described in the Quality Improvement Program Description, Annual Evaluation and Work Plan, including those quality improvement activities that have been delegated to the health plan's behavioral health vendor and other subcontractors. The CAC recommends approval of Neighborhood's Quality Improvement Program Description and Work Plan to the Board of Directors after review and recommendations. The CAC annually reviews and accepts the QI Program Evaluation. The CAC oversees the credentialing and recredentialing processes for providers and facilities and approves or denies their application to be part of Neighborhood's network. The CAC also reviews and makes network determinations regarding care provided to Neighborhood members for behavioral health providers. The CAC is responsible for quality assurance and peer review to address substantiated complaints and concerns about practitioners who fail to adhere to established standards of care. The CAC meets monthly, reports to the Board of Directors and is chaired by a Board member who is appointed by the Board Chair. The activities of the CAC include but are not limited to the following:

- Reviews and approves the organization's clinical practice and preventive care guidelines.
- Reviews practitioner performance monitoring reports and clinical quality of care issues identified and tracked by the Quality Assurance Committee and Credentialing.
- Reviews and recommends approval of the Quality Improvement Program Description and Quality Improvement Work Plan to the Board of Directors.
- Reviews the Quality Improvement Annual Evaluation.
- Reviews and recommends approval of the quality improvement documents of delegated entities to the Board of Directors.
- Provides input and high-level direction for all activities described in the Quality Improvement Program Description and Quality Improvement Work Plan, including those QI activities that have been delegated.
- Identifies and recommends quality improvement activities and programs for Neighborhood on an ongoing basis as well as within the context of the annual work plan.
- Promotes practitioner and staff participation in the QI Program through planning, design, implementation and/or review.
- Provides insight and recommendations to the Pharmacy and Therapeutics, Medicaid & Commercial Quality and Operations, INTEGRITY Quality and Operations, and Clinical Management Committees for QI activities.
- Maintains written minutes which are approved by the Committee and signed by the Committee Chair.

The Chair of the Board of Directors appoints the Chair of the CAC, and the Nominating Committee appoints its members for voluntary terms. Committee membership includes primary care and specialty care practitioners from the hospital-based practices, private practices, and community health centers in Neighborhood's network. Specialty care practitioners represented include geriatricians, behavioral health providers, and providers with expertise in Long Term Services and Supports (LTSS). Key staff, including the Chief Medical Officer, Medical Director, Director of Quality Improvement, representatives from Neighborhood's behavioral health vendor, and additional Neighborhood staff provide support to CAC and present reports and status updates as necessary.

C. Chief Medical Officer

The Chief Medical Officer (CMO) is a Rhode Island-licensed physician with extensive QI experience in managed care organizations. The Chief Medical Officer guides the direction, delivery, and implementation of Neighborhood's QI Program, including the Population Health Strategy and oversees the functions, responsibilities, planning, design and implementation of activities undertaken by the QI committees and subcommittees. The CMO provides guidance to the CAC, the Medicaid & Commercial Quality and Operations Committee, the Pharmacy & Therapeutics Committee, the Clinical Management Committee and the INTEGRITY Quality and Operations Committee. Additionally, the CMO provides guidance to the internal peer review committee, the Quality Assurance Committee (QAC), and delegates the day-to-day responsibilities to the Medical Director. The CMO or his/her designee is a non-voting member of the CAC and a standing member of other quality improvement committees.

The Chief Medical Officer has responsibility for the oversight, direction, delivery, and implementation of Neighborhood's Quality Improvement Program. The Medicaid and Commercial Quality and Operations Committee and the INTEGRITY Quality and Operations Committee oversee the day-to-day operations of Neighborhood's Quality Improvement Program, including the development of Neighborhood's Quality Improvement Program Description, Annual Evaluation and Work Plan.

The CMO is responsible for the delivery of medical and behavioral healthcare services through operational oversight of the Pharmacy, Medical Management, Medical Director, Behavioral Health and Quality Improvement Departments.

D. Medical Director and Associate Medical Directors

The Medical Director and Associate Medical Directors (MD/AMDs) are Rhode Island-licensed physicians. The AMDs support the MD in assisting the CMO in the role of providing clinical guidance to the organization by directing the development of new clinical programs, evaluating new medical technologies, developing criteria for standards of performance to evaluate individual provider compliance with clinical practice and preventive health guidelines, and providing oversight to physician reviewer and consultant activities and recruitment. The MD/AMDs communicate with practitioners regarding features of the Utilization Management, Clinical Programs and Case Management Programs and on individual cases as necessary. The Medical Director and/or his/her designee chairs the Pharmacy and Therapeutics Committee, the Clinical Management Committee and the Quality Assurance Committee. The Medical Director and/or his/her designee oversees the credentialing and recredentialing processes, manages the quality assurance incident reporting process, facilitates practitioner peer review and disciplinary action, and provides staff support to the Clinical Affairs Committee and is a member of the Medicaid & Commercial Quality and Operations Committee and the INTEGRITY Quality and Operations Committee. The Medical Director and Associate Medical Directors also serve on Quality Improvement Work Groups, as needed.

Support Committees and Staff:

The quality improvement support committees are the Medicaid & Commercial Quality and Operations Committee, the INTEGRITY Quality and Operations Committee, the Clinical Management Committee and the Pharmacy and Therapeutics Committee. Each of these committees performs quality improvement activities within their areas of focus and is accountable to the Chief Medical Officer who provides the day-to-day direction to the QI Program. An organizational chart showing reporting relationships for these committees appears as Appendix A.

E. Medicaid and Commercial Quality and Operations Committee

The Medicaid & Commercial Quality and Operations Committee (M&CQOC) provides direction, guidance, and input to the quality improvement activities undertaken and implemented within the organization to monitor and improve the efficiency and operations of Neighborhood's departments and service to members and providers, with primary focus on quality in the Medicaid and Commercial products. M&CQOC advises the CMO on the quality of clinical care, operational performance and member and provider services provided by Neighborhood. The CMO provides oversight and direction to the M&CQOC and the INTEGRITY Quality and Operations Committees and is responsible for ensuring that the QI Work Plan and Annual Evaluation presented to the Clinical Affairs Committee address all clinical, service and performance improvement activities undertaken by Neighborhood. Optum® and other subcontractors if applicable also report regularly to the M&CQOC on specific QI activities undertaken in their respective areas.

The Medicaid & Commercial Quality and Operations Committee:

- Oversees the development of the Quality Improvement Program Description, Work Plan and Evaluation and submits them for review and approval to the Clinical Affairs Committee
- Ensures that Neighborhood's quality improvement philosophy extends to each department's day-to-day operations
- Identifies and recommends quality improvement opportunities, activities and programs for Neighborhood's clinical performance on an ongoing basis as well as within the context of the annual work plan
- Ensures practitioner and staff participation in the Quality Improvement Program through planning, design, implementation and/or review
- Identifies opportunities to improve departmental and interdepartmental business processes and operational functions
- Serves as a resource for departmental improvement projects
- Addresses opportunities for improvement in the areas of member and provider experience, accessibility of services, and program effectiveness
- Develops and monitors performance and implementation of the HEDIS and CAHPS Improvement Plans
- Establishes and participates in workgroups and subgroups as necessary to address identified opportunities for improvement
- Identifies and monitors departmental metrics
- Maintains written minutes which are approved by the Committee and signed by the Committee Chair.

The Director of Quality Improvement or their designee chairs the Medicaid and Commercial Quality and Operations Committee. The Medicaid and Commercial Quality and Operations Committee is a multidisciplinary committee comprised of key staff, including Chief Medical Officer, Director of Utilization Management, Compliance Officer, Associate Medical Director, Senior Manager of Quality Improvement and Accreditation, the Manager of Grievance and Appeals Unit, Customer Experience Manager and selected other subject matter experts in the organization. The Medicaid and Commercial Quality and Operations Committee meets monthly, and reports on its activities to the Clinical Affairs Committee on a quarterly basis.

F. INTEGRITY Quality and Operations Committee

The INTEGRITY Quality and Operations Committee monitors and reviews the quality improvement and operational activities of the MMP-INTEGRITY product. Findings and issues are presented to the Clinical Affairs Committee for review and approval and shared with the Chief Medical Officer and

the Vice President for Medicare and Medicaid Integration. The CMO and the Vice President for Medicare and Medicaid Integration provide oversight and direction to the INTEGRITY Quality and Operations Committee.

The INTEGRITY Quality and Operations Committee meets monthly to coordinate reporting activities, review selected measures of program effectiveness and identify areas in need of improvement through review of regular reports and facilitating improvements. On a monthly basis, the INTEGRITY Quality and Operations Committee reviews trends for INTEGRITY members to determine if there is over- or under-utilization based on members' demographics, diagnoses and conditions, including review of LTSS operations.

The INTEGRITY Quality and Operations Committee is responsible for establishing workgroups charged with improving performance when measure results are below target. When specific metrics do not meet the established goals and benchmarks, the INTEGRITY Quality and Operations Committee reviews the data with the appropriate business owners and identifies barriers to meeting the goals and possible interventions to overcome the barriers.

Feedback and recommendations from the INTEGRITY Member Advisory Workgroups are shared with the INTEGRITY Quality and Operations Committee.

The Director of Quality Improvement or their designee chairs the INTEGRITY Quality and Operations Committee. The INTEGRITY Quality and Operations Committee is a multidisciplinary committee comprised of key staff, including VP for Medicare and Medicaid Integration, Medical Director, Compliance Officer, Director of Utilization Management, Director of Care Management, Senior Manager of Quality Improvement and Accreditation, the Manager of Grievance and Appeals Unit, and selected other subject matter experts in the organization.

G. Utilization Management Committee

Neighborhood's Utilization Management Committee (UMC) provides direction for clinical services such as new and changing medical and behavioral health technology, clinical medical policies, utilization management procedures, and the assurance of consistent medical review criteria and actions.

The UMC acts in an advisory capacity to the Chief Medical Officer. The UMC:

- Evaluates the development of new medical technology of pertinence to Neighborhood's members, including technology decisions made by Neighborhood's behavioral health vendor.
- Recommends the development of new or the modification of established Clinical Medical Policies, which are reviewed annually. These policies are used for medical necessity decisions.
- Assesses and evaluates reports of under- and over-utilization and reviews Neighborhood's and its delegates' clinical appeals and denials data.
- Reviews and approves Neighborhood's Utilization Management Program Description and Annual Evaluation, including the delegated entities (eviCore, Optum and Evolent Health).
- Monitors and improves members' and providers' experience with Neighborhood's utilization management processes and decision-making.
- Maintains written minutes which are approved by the Committee and signed by the Committee Chair.

The Committee meets at least quarterly, is chaired by the Medical Director or his/her designee and submits minutes of its meetings to the Clinical Affairs Committee. Ad-hoc meetings may be convened

for the expedited assessment of new medical technology or new uses of medical technology as necessary, i.e. on a case-by-case basis. Committee members include: primary care and specialty care practitioners, the Medical Director and/or the designated Associate Medical Director, Director of Utilization Management and Clinical Medical Policy and Medical Review Nurse. External physician reviewers are consulted and/or invited to participate in meetings to provide their expertise on specific new technologies, as needed. Representatives from Neighborhood's behavioral health vendor and additional Neighborhood staff provide support to UMC and present reports and status updates as necessary.

The Neighborhood UMC receives the related documentation of technology review activities conducted by Neighborhood's behavioral health vendor.

H. Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee is comprised of Neighborhood and network pharmacists and providers that act in an advisory capacity to develop and provide clinical input on Pharmacy Benefit design, Medical Pharmacy Benefit HCPCS code coverage design, Drug Utilization Review (DUR), oversight of clinical programs, Utilization Management Criteria review, and oversight of certain regulatory requirements. The P&T Committee is responsible for the creation and maintenance of Neighborhood's Medicaid Pharmacy Benefit and Neighborhood's Medicaid, Commercial and INTEGRITY (MMP) Pharmacy Medical Benefit while having oversight of Neighborhood's Commercial and INTEGRITY Pharmacy Benefits (as CVS Health's Pharmacy and Therapeutics Committee, Neighborhood's Pharmacy Benefit Manager, is delegated to develop the Commercial and INTEGRITY Pharmacy Benefit Formulary).

The Committee meets at least quarterly to assess the safety, efficacy, and unique properties of new to market medications/therapeutic classes that are deemed to need further review. Medication/therapeutic class reviews will consider FDA classification, information from peer-reviewed medical literature, and research monographs prepared by expert consultants in clinical pharmacology. As part of the evaluation process associated with each new drug or drug class, the P&T Committee reviews utilization data to identify trends in drug use. This information is used to help develop and implement specific initiatives to promote appropriate use of drug therapies. The P&T Committee is responsible for:

- Establishing a pharmacy program and benefit that ensures cost-effective therapy.
- Developing pharmacy practice guidelines and performance standards.
- Reviewing and advising on quality improvement activities.
- Providing feedback, summary reports, and notification of formulary changes to network clinicians.
- Maintaining written minutes which are approved by the Committee.

I. Quality Assurance Committee

The Quality Assurance Committee (QAC) is responsible for investigating member complaints about the clinical care received, and concerns that are forwarded by Neighborhood staff. QAC is responsible for making the determination as to whether the care received by the member is standard of care or is a quality of care concern. If a quality of care concern is identified, QAC notifies the provider, requests a corrective action or makes a recommendation(s) for improvement. Cases determined to be a "Quality of Care Concern(s)," with or without a corrective action plan, are presented to the Clinical Affairs Committee for any additional recommendations and/or for inclusion in their re-credentialing decisions.

QAC meets monthly or more frequently as needed, reports to the Clinical Affairs Committee and is chaired by the Medical Director or designee. Members of QAC include the Quality Assurance Specialist, a Registered Nurse who coordinates the QAC activities, the Medical Director, and an Associate Medical Director.

J. Management Team / Staff

In addition to the quality improvement and supporting committees above, the Management Team is critical to the success of the CQI process by leading the creation of an organizational culture that supports CQI. In particular, the Chief Medical Officer or his/her designee is a standing member of the Medicaid & Commercial Quality and Operations and the INTEGRITY Quality and Operations Committees.

Each department Director and Product Vice President is expected to participate and work collaboratively on the quality improvement activities that are undertaken organization-wide and at the departmental level to improve the clinical care and service delivered and improve operations effectiveness and efficiency.

All staff members are given the responsibility and authority to participate in Neighborhood's quality improvement efforts. Success of CQI is dependent on staff members as they drive the day-to-day work for the organization, and they are the individuals who carry out the tasks and are closest to the potential opportunities for continuous quality improvement.

K. Department of Quality Improvement

Reporting to the Chief Medical Officer, the Director of Quality Improvement is accountable for the Plan's performance in the areas of clinical quality and member experience. The Department of Quality Improvement oversees the implementation and the effectiveness of the QI Program by:

- Coordinating the preparation of the Quality Improvement Program Description, Work Plan and Annual Evaluation.
- Monitoring the annual Quality Improvement Work Plan through progress reports by business leads to the Medicaid and Commercial Quality and Operations Committee and INTEGRITY Quality and Operations Committee.
- Conducting the oversight and monitoring of the delegated behavioral quality improvement program through ongoing review of reports including but not limited to HEDIS behavioral health rates, member experience reports, NCQA-MBHO accreditation results and review and approval of annual Behavioral Health Quality Improvement Program Description, Evaluation and Work Plan.
- Leading and chairing the Medicaid and Commercial Quality and Operations Committee and leading and co-chairing the INTEGRITY Quality and Operations Committee, which focus on quality improvement for Medicaid, Marketplace, and INTEGRITY-MMP.
- Leading and chairing the Neighborhood and Optum Quality Oversight Committee which focuses on behavioral health quality improvement.
- Leading and chairing the NCQA Steering Committee including leading the Plan's NCQA Accreditation Survey.
- Collecting and analyzing HEDIS data in support of quality improvement activities.
- Designing, implementing and maintaining supplemental databases certified by the HEDIS Auditor in support of HEDIS data collection efforts.
- Tracking and monitoring HEDIS and other clinical quality data in support of Neighborhood's performance on: 1) NCQA Accreditation programs; 2) NCQA Health Insurance Plan Star Rating; 3) Pay for Performance Program Reporting; 4) Accountable Entities Quality

Reporting; 5) INTEGRITY Quality Withhold; and 6) Quality Improvement Projects.
- Tracking and monitoring HEDIS data in support of quality improvement activities.
- Providing support for measurement and evaluation across Neighborhood to maximize Neighborhood's ability to make data-driven decisions and support day-to-day work to improve the quality of care and service provided to our members.
- Utilizing the existing committees that support quality improvement to better align with the organization's continuous quality improvement Mission, Vision and Core Principles.
- Developing training tools and topics to support the CQI and training Neighborhood staff on using the quality improvement tools, as necessary.
- Developing and driving the Quality Improvement agenda for the Clinical Affairs Committee.
- Providing leadership for the INTEGRITY QIPs and CCIPs required under the TWC with the Center for Medicare and Medicaid Services and the Executive Office of the Health and Human Services.
- Leading Neighborhood's success in the Medicaid Quality Improvement Plan, the INTEGRITY Quality Withhold, and other pay-for-performance programs through leadership of the Quality Withhold and Medicaid Quality Improvement Committees, and their supporting Work Groups.
- Providing leadership and support to Neighborhood's contracted Medicaid Accountable Entities to achieve improved performance on the AE Core Quality Measures, including producing and sharing data analyses, member-level gap reports, and best-practice quality improvement strategies, as well as to meet EOHHS reporting requirements for the AE Program.
- Co-chairing the Neighborhood-United Quality Circle for Accountable Entity quality staff to share understanding of EOHHS directives and guidance and to disseminate best-practice quality improvement strategies.
- Tracking and monitoring the Medicaid Adult and Child CAHPS, the Medicare-Medicaid Plan CAHPS-PDP, Qualified Health Plan Enrollee Survey, HOS, Provider Satisfaction survey data as well as other survey data, in support of quality improvement activities.
- Tracking and monitoring the nursing facility MDS data in support of monitoring the quality of care provided at nursing facilities.
- Participating in the Member Customer Experience Work Group in support of CAHPS improvement.
- Participating in the Provider Customer Experience Work Group in support of improving Provider Satisfaction Survey.
- Participating in and reporting to the Clinical Affairs, Clinical Management, and Utilization Review Committees.
- Respond to the External Quality Review Organization's findings for the Medicaid and the MMP-INTEGRITY products.
- Review and comment on the core Quality Improvement documents submitted by Neighborhood's behavioral health vendor, and facilitate their review by the internal QI Committees.

VI. Behavioral Health Quality

Neighborhood delegates the quality improvement requirements for behavioral health services to Optum, including the involvement of a designated behavioral health practitioner in program implementation and oversight. Neighborhood's Clinical Affairs Committee annually approves Optum's Quality Improvement Program Description and Work Plan and reviews Optum's Quality Improvement Annual Evaluation. These documents encompass the behavioral health aspects of the

QI program. Optum staff participates in the Quality Improvement Workgroups, as needed. Additionally, Neighborhood collaborates with Optum to collect and analyze data to monitor and identify opportunities in several areas including but not limited to:

- Access to care for mental health illness and substance abuse, especially newly diagnosed behavioral health conditions.
- Exchange of information between PCPs and behavioral health specialists;
- Appropriate diagnosis, treatment and referral of members with behavioral health disorders commonly seen in primary care;
- Appropriate uses of psychopharmacological medications;
- Management of treatment and follow up for members with co-existing medical and behavioral health disorders;
- Implementation of primary and or secondary preventive care behavioral healthcare programs; and
- Behavioral health programs to address the special needs of members with severe mental illness.

The Department of Quality Improvement conducts the oversight and monitoring of the delegated quality improvement program through ongoing review of reports including but not limited to HEDIS behavioral health rates, member experience reports, NCQA-MBHO accreditation results and review and approval of annual Behavioral Health Quality Improvement Program Description, Evaluation and Work Plan. The Quality Improvement Department leads the monthly Optum/Neighborhood Quality Oversight Committee meetings including development of the committee's agenda topics. The goal of the Neighborhood/Optum Quality Oversight Committee is to provide direction, guidance, and input to the behavioral health quality improvement activities undertaken and implemented by Optum in support of Neighborhood's quality improvement program.

VII. Program Staffing and Resources

Each of Neighborhood's departments contributes to the QI Program and is represented in the Medicaid & Commercial Quality and Operations and the INTEGRITY Quality and Operations Committees. Through the leadership of the department directors and their Executive Leadership Representatives, each department is expected to participate and work collaboratively on the quality improvement activities that are undertaken organization-wide and at the departmental level to improve the clinical care and service delivered to members. Below are some of the responsibilities of the departments and staff who support the organization's QI Program:

Analytics Staff

- Support the Continuous Quality Improvement Work Groups, facilitated by the Quality Improvement Department, with analysis of claims and nursing home data in support of Quality Withhold efforts.
- Collaborate with Medical Management to analyze and summarize population segments and the effectiveness of population health interventions for care and disease management programs.
- Collaborate with the Grievances and Appeals Unit to conduct analysis and trending of complaints, grievances and appeals and provide monthly, quarterly and annual reports and analysis internally and to appropriate committees and regulatory agencies.
- Collaborate with the Pharmacy Department to analyze and summarize pharmacy cost and utilization and support pharmacy reporting and initiatives as needed.
- Produce actionable data dashboards and other visualization tools for departments within

Neighborhood to maximize Neighborhood's ability to make data-driven decisions.
- Support Neighborhood's contracted Medicaid Accountable Entities to reduce medical expenses and improve performance on EOHHS' designated Outcome Measures, including producing and sharing data analyses, member-level utilization data, and best-practice strategies for efficient medical care costs and utilization.

Care Management Staff
- Oversee care management, both internally and with our external agency partners, for high-risk members including those identified through Neighborhood's disease management programs.
- Track clinical program outcomes.
- Conduct assessment, outreach and care coordination activities for members who have been identified as being at high clinical and social risk to ensure quality, and cost-effective member-centered care.
- Develop materials and resources with the input of network providers to impart the importance of positive health behaviors to members.
- Implement health education programs for individual Neighborhood members, populations, and/or other community needs.
- Educate members and work with them toward healthy lifestyle behaviors.
- Plan and evaluate health education programs and program activities for Neighborhood members, populations, and/or other community needs.

Credentialing Staff
- Process provider applications for network entry and recredentialing according to Neighborhood's established credentialing standards.
- Notify providers of the status of their applications and the credentialing committee's decisions.
- Conduct continuous monitoring of the provider network through internal and external sources to ensure that providers continue to meet standards for network participation.
- Conduct onsite quality assessment at patient care facilities for network entry and recredentialing and to address environment of care concerns.
- Maintain the credentialing database with current provider information including state license and board certification information.
- Conduct the oversight of the delegated credentialing activities, including auditing of delegated activity.
- Coordinate hearings for providers denied network participation and for restriction of network privileges.

Grievance and Appeals Unit
- Address, resolve, and trend member complaints (grievances).
- Review administrative and clinical appeals according to member contracts, CMS, EOHHS and OHIC regulatory standards and mandates, NCQA accreditation survey standards, and established policies and procedures.
- Communicate with members and providers regarding the status of appeals, process of appealing, and appeal outcomes.
- Collaborate with cross-functional areas as required to ensure appropriate and consistent decision-making.
- Collaborate interdepartmentally to educate staff about the appeals and grievances processes.
- Collaborate interdepartmentally to identify and implement ways to improve member experience.

- Identify potential quality of care and member safety issues (critical incidents) for review by Quality Assurance staff.
- Conduct analysis and trending of complaints, grievances and appeals and provide monthly, quarterly, and annual reports and analysis internally and to appropriate committees and regulatory agencies.
- Oversee appeal processes delegated to vendors for behavioral health services, high-end radiology services, physical medicine services and prescriptions.
- Participates in the quarterly Utilization and Appeal Review Committee.
- Participates in the Medicaid and Commercial Quality and Operations Committee.
- Participates in the INTEGRITY Quality and Operations Committee.

Marketing Staff

- Facilitate member communications and serve as the primary point of contact for regulatory submissions.
- Oversee translation of member communications that are delegated to vendors.
- Educate all member and potential members on health plan offerings.
- Oversee Member Rewards Program.
- Support implementation of new, and revisions to, federal, state, contractual and product projects, programs, and products.
- Report new member understanding data to the Medicaid and Commercial Quality and Operations Committees.
- Facilitate quarterly, Member Advisory Committee meetings for Medicaid and INTEGRITY members.
- Facilitate Member Advocate functions to ensure the interests of members are understood, promoted, and addressed by the organization and the larger health care system.
- Lead the Customer Experience work in collaboration with business owners throughout the organization to ensure Neighborhood continues to advance how it delivers services to members and providers in ways that matter.
- Facilitate and chair the Member Customer Experience Work Group.
- Facilitate the Provider Customer Experience Work Group in collaboration with Provider Relations Director.
- Collect, analyze, and report the Medicaid CAHPS, Medicare-Medicaid CAHPS-PDP, HOS, and Provider Satisfaction survey data as well as other journey and touchpoint survey data, to inform quality and process improvement activities led by other business areas.
- Working in collaboration with the behavioral health business partner lead, support the oversight of the behavioral health member and provider experience survey process conducted by the behavioral health vendor.
- Report regulatory survey data to the Clinical Affairs, Clinical Management, INTEGRITY Quality and Operations and Medicaid and Commercial Quality and Operations Committees.

Member Services Staff

- Field all member inquiries regarding eligibility, benefit coverage, claims, special programs and access to care and interact with appropriate staff to achieve resolution.
- Educate members on how to file a grievance, complaint or an appeal.
- Arrange interpreter services for members.
- Log member complaints and requests for appeals in accordance with established policies and procedures.
- Identify potential quality of care and member safety issues for review by Grievance and Appeals Unit staff and Case Management.

Pharmacy Staff

- Oversight of the Pharmacy Benefit Formularies and the Pharmacy Medical Benefit HCPCS codes for all Lines of Business.
- Conduct pharmacy benefit coverage determinations to ensure members have access to high quality and cost effective medications for Medicaid and Commercial line of business. Conduct oversight of delegated coverage determination reviews for INTEGRITY line of business to ensure all reviews meet CMS Part D regulations and State contracts.
- Conduct coverage determinations to ensure appropriate therapy for Pharmacy Medical Benefit related HCPCS codes for all lines of business.
- Ensure all coverage determination reviews meet NCQA standards, CMS and State regulatory requirements, including but not limited to, appropriate clinical UM decision making, timeliness, accuracy of denial notices and appeal rights.
- Oversight of Pharmacy Benefit and Pharmacy Medical Benefit Prior Authorization Criteria.
- Promote operational excellence for members and providers by supporting Member Services, Provider Services, UM, GAU and AMD teams with pharmacy benefit and pharmacy medical benefit related initiatives and questions.
- Develop, lead, and conduct the functions necessary to ensure the P&T Committee meets on a recurrent basis, has the appropriate materials to review, and makes sound clinical decisions.
- Support Care Management, Medical Management and Health@Home teams in answering drug information questions or providing medication-related recommendations (examples: Transitions of Care Rounds, INTEGRITY Rounds, Medicaid Rounds, etc.).
- Maintain a robust First-Tier, Downstream and Related Entities (FDR) oversight program of all PBM delegated functions e.g., Transition, Formulary and Benefit Administration, Coverage Determinations and Appeals, Member notification and materials, and claim adjudication) to ensure compliance with CMS regulations.
- Oversight of Prior Authorization (PA) systems to ensure both manual and electronic PA submission channels capture accurate information as submitted by the prescriber.
- Oversight of website to inform members about their pharmacy benefit, financial responsibility for medications, and list network pharmacies.
- Oversight of Evolent Health's holistic oncology management program that includes medical oncology, radiation oncology and genomic testing to ensure members have access to the appropriate medications at the appropriate time in their disease state.
- Inform and notify members and providers of medication safety alerts and formulary updates.
- Work interdepartmentally and with external providers/members to improve medication adherence, HEDIS rates, Quality Withhold measures and other metrics to improve member health. (Program examples include: Hemophilia/Immune Globulin Dosing Programs, Site of Care Initiative, Psoriasis Treatment Pathway, HIV Medication Adherence Program, Antidepressant Education and Adherence Program, etc.)
- Initiate Drug Utilization Reviews and conduct outreach to providers and members to ensure appropriate utilization/enhance patient safety.
- Provide Accountable Entity partners with insight into their population with spend/trend/individual member reporting while also providing targeted interventions to improve the lives of their members and lower total cost of care.
- Maintain a Specialty Pharmacy Limited Network for Neighborhood's Medicaid and Commercial Lines of Business (this includes coding, contracting, claims oversight, etc.).

Provider Contracting Staff

- Contract implementation and oversight including, but not limited to, rate implementation, oversight of contract terms and oversight of provider adherence to contract terms.

- Field provider inquiries regarding Provider Agreements.
- Lead in the implementation of alternative payment mechanisms, including, but not limited to, incentives to providers for achieving improved quality of clinical care and patient experience, shared savings models, and bundled payment arrangements.
- Maintain network adequacy requirements as defined by Centers for Medicare and Medicaid Services (CMS), Executive Office of Health and Human Services (EOHHS) and Office of the Health Insurance Commissioner (OHIC).
- Recruit and expand the medical and durable medical equipment provider network.
- Develop programs and reimbursement structures that align with federal and state requirements and meet Neighborhood's mission to offer high quality, affordable health care.

Provider Relations Staff

- Develop and maintain strong professional relationships with the provider network, their key staff and providers, and function as liaison to research and resolve issues and strategic objectives.
- Monitor the accessibility standards at physician offices, including after-hours patient instruction systems.
- Manage communications and serve as the primary point of contact for network providers.
- Field provider inquiries regarding provider manual policies and procedures.
- Work to implement collaborative quality improvement activities with network providers.
- Act on improvement efforts as necessary and as identified during the annual provider experience survey and Community Health Center survey.
- Support implementation of new, and revisions to, federal, State, contractual and product projects, programs, and products.

Quality Improvement Staff

- Coordinate the preparation of the Quality Improvement Program Description, Work Plan, and Annual Evaluation.
- Monitor the annual Quality Improvement Work Plan through progress reports by business leads to the Medicaid and Commercial Quality and Operations and INTEGRITY Quality and Operations Committees.
- Conduct the oversight and monitoring of the delegated behavioral quality improvement program through regular oversight meeting between Neighborhood and Optum quality staff, ongoing review of reports including but not limited to HEDIS behavioral health rates, member survey reports, NCQA-MBHO accreditation results, and review and approval of the annual Behavioral Health Quality Improvement Program Description, Evaluation and Work Plan.
- Lead and chair the Medicaid and Commercial Quality and Operations Committee, lead and chair the INTEGRITY Quality and Operations Committee, and lead and chair the Neighborhood and Optum Quality Oversight Committee.
- Lead and chair the NCQA Steering Committee, including leading the Plan's NCQA Accreditation Survey.
- Collect and analyze HEDIS data in support of quality improvement activities.
- Design, implement and maintain supplemental databases certified by the HEDIS Auditor in support of HEDIS data collection efforts.
- Tracking and monitoring HEDIS and other clinical quality data in support of Neighborhood's performance on: 1) NCQA Accreditation programs; 2) NCQA Health Insurance Plan Star Rating; 3) Pay for Performance Program Reporting; 4) Accountable Entities Quality Reporting; 5) INTEGRITY Quality Withhold; and 6) Quality Improvement Projects.

- Track and monitor HEDIS data in support of quality improvement activities.
- Provide support for measurement and evaluation across Neighborhood to maximize Neighborhood's ability to make data-driven decisions and support day-to-day work to improve the quality of care and service provided to our members.
- Utilize the existing committees that support quality improvement to better align with organization's continuous quality improvement Mission, Vision and Core Principles.
- Develop training tools and topics to support the CQI and train Neighborhood staff on using the quality improvement tools, as necessary.
- Develop and drive the Quality Improvement agenda for the Clinical Affairs Committee.
- Provide leadership for the QIPs and CCIPs as assigned by the Center for Medicare and Medicaid Services and the Executive Office of the Health and Human Services and as identified internally.
- Leading Neighborhood's success in the Medicaid Quality Improvement Plan, the INTEGRITY Quality Withhold, and other pay-for-performance programs through leadership of the Quality Withhold Committee, Medicaid Quality Improvement Committee, and their supporting Work Groups.
- Track and monitor the Medicaid Adult and Child CAHPS, Medicare-Medicaid CAHPS-PDP, Qualified Health Plan Enrollee Experience Survey, HOS, Provider Satisfaction survey data as well as other survey data in support of quality improvement activities.
- Track and monitor the nursing facility MDS data in support of monitoring the quality of care provided at nursing facilities.
- Provide leadership and support to Neighborhood's contracted Medicaid Accountable Entities to achieve improved performance on the AE Core Quality Measures, including producing and sharing data analyses, member-level gap reports, and best-practice quality improvement strategies, as well as to meet EOHHS reporting requirements for the AE Program.
- Co-chair the Neighborhood-United Quality Circle for Accountable Entity quality staff to share understanding of EOHHS directives and guidance and to disseminate best-practice quality improvement strategies.
- Participate in the Member Customer Experience Work Group in support of improving CAHPS performance.
- Participate in the Provider Customer Experience Work Group in support of improving Provider Experience Survey results.
- Participate in and report to the Clinical Affairs, Clinical Management and Utilization and Review Committees.
- Respond to the External Quality Review Organization's findings for the Medicaid and the MMP-INTEGRITY products.
- Review and comment on the core Quality Improvement documents submitted by Neighborhood's behavioral health vendor and facilitate their review by the internal QI Committees.

Utilization Management Staff – Medical Services

- Conduct pre-certification, concurrent, and retrospective analysis of appropriateness of care.
- Provide an annual evaluation of the medical management and utilization management activities to the Clinical Management Committee for the identification of improvement opportunities.
- Track and trend key utilization data.
- Review Utilization policies annually.
- Work with the AMD to identify and develop the organization's Clinical Medical Policies, which detail the medical necessity criteria for coverage of conditional benefits.

VIII. Advisory Groups / Committees

In addition to employing and supporting the quality improvement committees mentioned previously, Neighborhood utilizes the following committees and forums to obtain additional information to guide the organization's quality improvement efforts. Activities and work undertaken by each of the following groups is reported to the Medicaid and Commercial Quality and Operations Committee.

A. Member Advisory Committees

The Neighborhood Member Advisory Committees (Medicaid and INTEGRITY) offer Neighborhood an avenue for the voice of the member to be heard and to ensure that the organization's initiatives and program materials are always member-centric. These advisory committees provide important assistance to Neighborhood in the identification of members' issues and concerns regarding health care at the individual, organizational, and systemic levels. Advisory committee members work closely with staff on the creation and implementation of quality improvement initiatives addressing member concerns. Committee members also provide valuable input in reviewing and improving the health plan's member materials and in testing new systems to ensure member usability. Beyond their role within Neighborhood, advisory committee members are invited to speak on behalf of our members at the State and Federal level regarding legislation and budget issues.

Each advisory committee is comprised of members and community partners representing the various product lines that Neighborhood serves. The committees meet on a quarterly basis and communicate and document issues and concerns that are within the scope of Neighborhood's operational responsibilities. The Member Advisory Committees are facilitated by Neighborhood's Member Advocate. The Member Advisory Committee reports to the Medicaid and Commercial Quality and Operations Committee and the INTEGRITY Member Advisory Committee reports to the INTEGRITY Quality and Operations Committee.

B. Member Customer Experience Work Group

The Member Customer Experience (CX) Work Group identifies opportunities for and barriers to improvement with the health care delivery system, and with the health plan overall based on survey feedback from all listening posts. The Work Group is comprised of management from member-facing teams such as Product, Member Call Center, Inside Sales, Marketing, Outreach, Pharmacy, Quality Improvement, Grievance and Appeals, Population Health, Behavioral Health, Provider Contracting, Member Advocate, and Care Management. Neighborhood uses the results from its annual CAHPS member experience surveys as well as member feedback gathered from CX listening posts, member journey map workshop findings, member complaints and appeals, and member advisory committees to identify opportunities for improvement for member experience. Data is shared with Member CX Work Group participants, as well as cascaded through the organization, to inform business areas what is performing well and where interventions may be needed. In 2024, the Work Group formed subcommittees focused on initiatives to address opportunities identified as key drivers of Net Promoter Score. Additionally, the Work Group meets regularly to review current survey data, progress on prioritized initiatives and monitor member experience metrics against specific goals. An update of Member CX Work Group activities is reported annually to INTEGRITY Quality and Operations, Medicaid and Commercial Quality and Operations Committee, the Clinical Affairs and Planning committees of the Board of Directors.

C. Provider Customer Experience Work Group

The Provider Customer Experience (CX) Work Group identifies opportunities to improve the overall provider experience when doing business with the health plan. The Provider CX Work Group is comprised of management from provider-facing areas including Claims, Provider Services, Operations Support, Quality Improvement, Grievance and Appeals, Pharmacy, Provider Relations, Marketing, Behavioral Health, Contracting, Product Management, Clinical, Credentialing and Business Development. Results of the annual Provider Satisfaction Survey and Community Health Center Satisfaction Survey, provider pulse surveys as well as additional feedback gathered by Provider Relations, Provider Call Center, and other provider-facing teams, are reviewed, and utilized to develop recommendations for areas of improvement by the business owners. In 2024, the Work Group formed subcommittees focused on initiatives to address opportunities identified as key drivers of Net Promoter Score. Additionally, the Work Group meets regularly to review current survey data, progress on prioritized initiatives and monitor provider experience metrics against specific goals. An update of the Provider CX Work Group activities is reported annually to Medicaid and Commercial Quality and Operations Committee and the Planning Committee of the Board of Directors.

D. INTEGRITY Quality Withhold Committee

The goal of the INTEGRITY Quality Withhold Committee is to develop and implement interventions that will achieve the maximum Quality Withhold payment based on Neighborhood's performance on the measures identified in the Three-Way Contract. These activities are critical to achieving financial stability for the INTEGRITY product, and to ensuring that high quality services are delivered to Neighborhood's dual eligible members. The INTEGRITY Quality Withhold Committee is responsible for reviewing the Quality Withhold performance, identifying priority measures and associated Work Groups, and obtaining needed resources identified by the Work Groups. The Quality Withhold Work Groups are interdisciplinary and include organization-wide representation, and they are led by the Department of Quality Improvement. The Work Groups focus on specific high-priority measures, analyze data specific to the priority measures, and develop and implement interventions to achieve maximum performance on the Quality Withhold. The INTEGRITY Quality Withhold Committee is a multidisciplinary Committee which meets quarterly, or more frequently if needed, and is co-chaired by the VP of Medicare-Medicaid Integration and the Director of Quality Improvement.

E. Medicaid Quality Improvement Committee

The goal of the Medicaid Quality Improvement Committee is to develop and implement interventions that will achieve: 1) the maximum performance on the measures identified by the Rhode Island Executive Office of the Health and Human Services contract; and 2) maximum Star Rating in the NCQA Health Insurance Plan Rating in the areas of Prevention and Treatment. The Medicaid Quality Improvement Committee is responsible for reviewing the performance in the Medicaid clinical measures for quality initiatives, NCQA Star rating, identifying priority measures and Work Groups, and facilitating getting needed resources identified by the Work Groups. The Medicaid Quality Improvement Committee is interdisciplinary and includes organization-wide representation, and is co-chaired by the Director of Quality Improvement and Grievance and Appeals the Senior Manager of Quality Improvement and Accreditation.

F. Health Equity Committee

The purpose of the Health Equity Committee is to 1) Provide guidance on how Neighborhood can champion equitable healthcare services and reduce health disparities among at risk populations; 2) Position Neighborhood as a resource in the Rhode Island community; 3) Influence public policies that address health and social disparities and obstacles to achieve health equity; 4) Identify and

influence changes to policies, laws, systems, environments and practices to eliminate inequities in opportunities and resources needed to "achieve full health potential." and 5) Establish a platform to fully consider the range of systemic racial and ethnic inequities of health care.

The Health Equity Committee is comprised of multi-disciplinary staff across the organization and reports up to the Chief Medical Officer through the Vice President Clinical Strategy and Implementation. The Health Equity Committee provides regular updates to the Medicaid and Commercial Quality and Operations and INTEGRITY Quality and Operations committees. The Health Equity Committee meets at minimum quarterly.

G. Neighborhood and Optum Quality Oversight Committee

The Neighborhood and Optum Quality Oversight Committee (NOQOC) provides direction, guidance, and input to the behavioral health quality improvement activities undertaken and implemented by Optum in support of Neighborhood's quality improvement program. The Director of Quality Improvement provides oversight and direction to the Committee and is responsible to ensure that the behavioral health Quality Improvement Work Plan and Quality Improvement Annual Evaluation presented to the Clinical Affairs Committee encompasses all clinical, service, and performance improvement activities undertaken by Optum for Neighborhood members and providers. The Neighborhood and Optum Quality Oversight Committee:

- Reviews and recommends for approval Optum's behavioral health Quality Improvement Program Description, Work Plan and Evaluation to the Clinical Affairs Committee and Board of Directors.
- Identifies and recommends behavioral health quality improvement activities and programs for Optum in support of Neighborhood's products within the context of the annual behavioral health quality work plan.
- Addresses opportunities for improvement in the areas of quality of care, member and provider experience, accessibility of services, and program effectiveness.
- Reviews HEDIS rates for behavioral health measures and identifies potential barriers to performance and interventions to address those barriers.
- Reviews member and provider experience survey report for behavioral health services and identifies potential barriers to performance and interventions to address those barriers.
- Reviews reports in support of Neighborhood's NCQA accreditation survey for Standards and Guidelines related to behavioral health services.

The Neighborhood and Optum Quality and Oversight Committee membership is comprised of quality improvement and behavioral health staff from Neighborhood and key staff from Optum, and is chaired by Neighborhood's Director of Quality Improvement. The committee meets quarterly or more often if necessary, and reports to Neighborhood's Clinical Affairs Committee through review of the meeting minutes and to Neighborhoods Quality and Operations Committees on at least semi-annual basis via updates by the Chair of the Committee.

IX. Role of Participating Practitioners

The expertise and input of participating practitioners at each of Neighborhood's Community Health Centers, private primary care practices, hospital-based primary care practices, specialty care practices, hospitals and other facilities are critical to the development, delivery, and success of Neighborhood's

Quality Improvement Program. As part of their commitment and contribution to the QI Program, Neighborhood's contracted practitioners, hospitals, and provider sites:

- Commit to abide by the policies and procedures of Neighborhood.
- Demonstrate active involvement and participation in Neighborhood's disease and preventive health management programs.
- Review and adhere to Neighborhood's Clinical Practice Guidelines, preventive health guidelines, and Clinical Medical Policies and offer recommendations for improvement based on community standards.
- Participate on various standing and ad-hoc quality improvement committees.
- Participate and cooperate with medical chart review activities, quality assurance policies and procedures, and audits.
- Work with Neighborhood's Case Managers, Member Services Staff, and Provider Contracting Management and Provider Relations staff to ensure optimal delivery of care and service to members through communication.
- Partner with Neighborhood in quality improvement collaboratives organized at the state-level.

X. Quality Improvement Activities

Clinical Quality Performance Indicators: HEDIS and QRS

The purpose of HEDIS and QRS is to ensure that health plans collect and report quality, cost and utilization data in a consistent way so that purchasers can compare performance across health plans. Neighborhood uses the annual HEDIS and QRS measures to provide network providers with a standardized assessment of their performance in key areas in comparison to plan-wide findings and national benchmarks. Neighborhood conducts analysis of HEDIS and QRS results by race and ethnicity, language spoken, gender, age group, primary care provider type, and line of business to better understand clinical outcome patterns and identify areas for improvement. Neighborhood shares and discusses site-specific HEDIS results with high-volume primary care provider sites to encourage collaboration to improve members' clinical outcomes and improve HEDIS performance annually.

Member Experience Surveys: CAHPS and QHP Enrollee Experience Surveys

Surveying member experience provides Neighborhood with information on our members' experience with the plan and their practitioners. Neighborhood participates in CAHPS Medicaid Adult, CAHPS Medicaid Child, CAHPS Medicare-Medicaid Prescription Drug Plan, and the Qualified Health Plan Enrollee Experience to identify areas of member satisfaction and opportunities for improvement. Results are benchmarked against Quality Compass and Book of Business percentiles. Activities to address member experience feedback, which are led by the appropriate business area in the organization, are supported by the Member CX Work Group. To strengthen the cross functional work to address member satisfaction, in 2024, the Member CX Work Group formed subcommittees focused on three CAHPS key drivers for Net Promoter Score based on review of the top key drivers across all lines of business. This work is informed by additional feedback collected at Member Advisory Committee meetings and supplemental member and provider experience surveys such as those described below.

Member Experience Surveys: After Service Experience Surveys

Neighborhood introduces after service experience surveys to better understand members' experience with services throughout their journey with Neighborhood. Examples include: Care Management (CM) survey on a rolling monthly basis with members receiving services in the last 30 days; and Member Services Call Center survey on a daily basis with members who spoke to a representative the

day before. Closed loop follow up is directed to identified individuals in business area for follow up on low scoring surveys and reports are compiled on a quarterly and annual basis. This survey is designed to evaluate member experience with Neighborhood's CM programs. As areas are identified for assessment to better understand CAHPS feedback and/or to measure effectiveness of an improvement initiative, surveys are designed and implemented to inform business areas on member satisfaction or areas of improvement.

Provider Experience Survey: Annual Provider Satisfaction

Neighborhood conducts an Annual Provider Satisfaction survey to measure primary care and specialty providers' experience with Neighborhood's administrative and clinical processes. This survey assesses satisfaction with functional areas within Neighborhood and its network, as well as overall satisfaction and health plan loyalty. Results are benchmarked against the survey vendor's Medicaid health plans' and Book of Business results. Feedback is used to develop quality improvement initiatives across the organization to improve providers' experience with Neighborhood and to ensure high quality care for Neighborhood members. As areas are identified for assessment to better understand providers' feedback and/or to measure effectiveness of an improvement initiative, surveys are designed and implemented to inform business areas on provider satisfaction or areas of improvement.

Provider Experience Surveys: Supplemental Experience Surveys

Neighborhood conducts an Annual Community Health Center Satisfaction Survey recognizing the federally qualified health centers serve half of Neighborhood's membership and as founders of the health plan. Survey results are compared to the Annual Provider Satisfaction Survey to assess differences across provider types. Examples of supplemental provider listening includes qualitative listening tours with targeted provider groups and web intercept surveys to measure ease of using digital forms and the online provider directory. Neighborhood introduces supplemental experience surveys to better understand a specific group of providers' experience and/or the ease of using specific services throughout their journey with Neighborhood.

Clinical Practice Guidelines

Neighborhood's Medical Director's Office develops and/or adopts and maintains clinical practice guidelines consisting of current, peer-reviewed, evidence-based standards of care. The clinical practice guidelines identify the Plan's expectations of its network and serves as a clinical resource to providers. Clinical practice guidelines for behavioral health are developed by Neighborhood's behavioral health vendor. The Clinical Affairs Committee reviews and approves the organization's clinical practice and preventive care guidelines. The guidelines complement and reinforce the established medical philosophy and benefit coverage offered by the Plan. Clinical Practice Guidelines are updated no less than every two (2) years and are accessible to network practitioners via the Neighborhood website. Providers are notified of the availability of the Clinical Practice Guidelines via the quarterly Provider Newsletter postcards.

Disease Management and Wellness

Neighborhood's Care Management staff work collaboratively with community partners including, but not limited to Neighborhood's provider network, the Rhode Island Department of Health, the Executive Office of Health and Human Services, and the Rhode Island Health Center Association, to identify health program and project opportunities that align with the health needs of our members and the community. Programs are planned, implemented and monitored with the goal of achieving positive health outcomes for members and focus largely on preventive health, health promotion, disease management, and patient safety. Program implementation requires the development of member and provider educational materials and ongoing interaction and outreach to members.

Neighborhood's disease management programs strive to support the relationship between practitioners and their patients and reinforce the established plan of care; emphasize the prevention of exacerbations and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management and patient education and outreach; and continuously evaluate clinical and financial outcomes with the goal of improving overall health and efficient plan performance. Neighborhood's current programs include asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure and coronary artery disease.

Peer Review Activity

The Chief Medical Officer (CMO) manages the peer review process internally for presentation and review by the Clinical Affairs Committee. Cases requiring peer review are identified through member or provider complaints, utilization review and other sources. The CMO and Medical Director staff directly perform peer reviews and will engage external specialty peer review when indicated, in accordance with Neighborhood's Policies and Procedures. When quality of care concerns are identified, they are reported to the Clinical Affairs Committee for review and recommendations. In accordance with Neighborhood's Professional Review Action policies and procedures, any required remedial and disciplinary action is taken in a timely manner per policy guidelines and as directed by Neighborhood's Clinical Affairs Committee.

Actions to Address Quality of Care Complaints

All complaints and/or concerns received from members, providers, Neighborhood staff, state agencies, and other entities relative to the quality of care or clinical services rendered to members are forwarded directly to the Quality Assurance Specialist who coordinates the investigation and prepares the findings to be reviewed with the Medical Director or other staff physician assigned to the case. The physician and the Quality Assurance Specialist collaborate to complete the investigation, make determinations, and when required, notify external entities such as the Rhode Island Department of Health about cases. As needed, the physician and the Quality Assurance Specialist also create and monitor corrective action plans, which are shared with and guided by the Clinical Affairs Committee (CAC). Complaints deemed to be issues of quality of care by the QAC are reported to the CAC on a regular basis. The CMO reviews the quality of care complaints and concerns in accordance with Neighborhood's established policies and procedures.

Quality Improvement Projects

Neighborhood conducts Quality Improvement Projects (QIPs) in compliance with the Executive Office of the Human and Health Services (EOHHS), HealthSource RI and the Centers for Medicare & Medicaid Services (CMS) requirements. The QIPs are presented to Medicaid and Commercial Quality and Operations Committee and the INTEGRITY Quality and Operations Committee and annually reported to the appropriate agencies. QIPs are usually focused on one or more clinical and/or non-clinical areas with the goal of improving members' health outcomes and experience. The QIPs are generally conducted over a three-year period.

Chronic Care Improvement Programs (CCIP) – MMP-INTEGRITY

Neighborhood is required to conduct a CCIP based on the Centers for Medicare & Medicaid Services requirement. The objective of Neighborhood's CCIP is to improve the health status of its eligible members who are at risk for multiple chronic conditions. This objective is achieved through member education as well as assisting members in managing their conditions or illnesses. The result of the CCIP is annually presented at the INTEGRITY Quality and Operations Committee.

Activities to Improve Patient Safety

The following activities are undertaken as a demonstration of Neighborhood's commitment to improve clinical quality of care and ensure the safety of its members:

- Comprehensive site assessments during the credentialing and recredentialing process for those providers who meet the designated criteria to ensure that patient care sites meet Neighborhood's standards for safety and cleanliness.
- Additional site visits for any complaint about site environment including those about safety, physical access, and cleanliness.
- Continuous monitoring of entire network's licensing status and exclusion listings.
- Notification to the GAU and Quality Assurance Specialist of any potential quality or safety cases (e.g., significant provider errors including pharmaceutical errors, unexpected deaths, missed diagnoses or treatments, missed follow-up, or insufficient discharge planning).
- Investigation and tracking of quality of care complaints, identification of trends, institution of increased monitoring as appropriate.
- Monitoring of Provider-Preventable Conditions ("Never Events") and Healthcare Acquired Conditions in inpatient facilities.
- Monitoring of critical incidents including but not limited to hospitalizations, suspected abuse, medication error resulting in ER visits and /or hospitalization, severe injury, theft against member and unexpected death.
- Clinical Management Committee reviews and considers new technology, new uses of existing technology, and new pharmaceuticals to ensure the safety, efficacy, and effectiveness of each.
- Safety and Monitoring Solutions/Enhanced Safety and Monitoring Solutions (SMS/ESMS) – targets members with high risk dispensing patterns (anabolic steroids, anxiety medications, opioids, muscle relaxants, sleep medications, stimulant drugs, other controlled substances, and gabapentin products). The SMS/ESMS program provides the framework for Neighborhood's comprehensive approach to the opioid crisis which grants the plan the opportunity to lock in "at risk members" to a specific pharmacy and/or prescriber.
- Notification to patients and providers of medications recalled by the FDA and other risks related to pharmaceuticals.
- Drug Utilization Reviews targeting members and prescribers who meet specified criteria involving antipsychotic, narcotic and other medication classes.
- Medication Refill Too Soon rates were increased to prevent members from having extra medications in the home or "stock-piling".
- Care coordination discharge planning to ensure safe transitions, medication reconciliation, and follow up.
- Case and utilization managers have access to data across the continuum of care including inpatient, outpatient, and pharmacy. Care is also coordinated with onsite behavioral health clinicians.
- Care Coordination High Risk outreach programs for ER, readmissions, and poly-pharmacy.
- Educational outreach to targeted and general member (Member Newsletters or telephonic outreach).

Neighborhood's annual work plan encompasses additional patient safety activities planned for each upcoming year.

Objectives to Enhance Service to a Culturally Diverse Membership

Neighborhood's membership is comprised of people from diverse cultures with differing needs. Neighborhood is committed to equitable healthcare that affords everyone a fair and just opportunity to achieve the best health outcome. Neighborhood serves low-income families, recent immigrants,

diverse racial and ethnic groups, people of all ages, people with disabilities, and people who may identify as gender-fluid and/or as Lesbian, Gay, Bisexual, Transgender and Queer. Its stated mission is to secure access to high quality, cost-effective health care for Rhode Island's at-risk populations. Neighborhood's focus on equity prompted the development and implementation of the "4 Report – Equity 4 People and People 4 Equity" which focuses on the following four commitments with each commitment having specific areas of focus:

1. Build a stronger workforce by broadening our diverse and inclusive environment.
2. Ensure everyone has a seat and a voice at the table.
3. Use data to advocate for equity and achieve measurable impact.
4. Accelerate health equity by supporting and working in underserved communities.

To improve its ability to serve its culturally and linguistically diverse membership, Neighborhood undertakes the following measurable efforts and initiatives:

- Works to improve the completeness and accuracy of the information on members' race, ethnicity, language spoken, disability status, and geographic location, to understand and respond to the diversity in its membership.
- Works to improve the completeness and accuracy of the information on practitioners' race, ethnicity, language spoken, and geographic location to understand and respond to the diversity in its membership.
- Analyzes its HEDIS and CAHPS data, and other data as appropriate, to identify gaps in access and quality of care based on race, ethnicity, language spoken, age and other characteristics, and design and implement initiatives to address the gaps.
- Presents the results of data analyses identifying disparities in access and quality of care and in services to members to the Medicaid and Commercial Quality and Operations Committee and/or to the INTEGRITY Quality and Operations Committee, Neighborhood's internal quality improvement committees to identify opportunities for improvement.
- Decrease maternal health disparity ratios for Neighborhood members by 50% by Q4 2025.
- Assesses the language spoken by its network practitioners and Member Service staff, as well as the adequacy of the telephonic interpreter services available, to identify and address any gaps relative to the language needs of its membership.
- Assesses the geographic adequacy of its physician network for groups who speak languages other than English.
- Includes members that are representative of the diversity of its membership's culture and language in all advisory committees and ad hoc work groups to help assure that all members' needs are being considered by these groups.
- Conducts marketing efforts that outreach to culturally and linguistically diverse populations to maintain and expand its market share among these populations.
- Makes an organizational-wide commitment to diversity of staff, management, and committees.
- Develops member materials that are targeted to the expected reading level and the languages spoken by its members.
- Ensures the availability and accessibility of cultural linguistic services such as 24/7 interpreting services including the American Sign Language.
- Training and education to better serve members of the LGBT community.

Objectives to Enhance Services to Members with Complex Health Needs

Neighborhood's membership is comprised of people with differing health and social needs. The Plan's mission is to be a catalyst for improved access and better health in Rhode Island, especially for vulnerable populations. Neighborhood works to ensure the delivery and coordination of services for

members with complex health needs including those receiving Long Term Services and Supports (LTSS) through integrated care management and complex case management that address their needs. Members identified for the Programs include those with multiple chronic conditions, physical or developmental disabilities, and members with severe mental illnesses. The Plan's care managers assess the needs of these members and work with practitioners, members and their care givers to support the physical, social and emotional aspects of chronic illness to help them regain optimum health. The objectives for serving our members with complex health needs include but are not limited to:

- Ensure that needed services identified through the assessment processes are obtained and that any existing gaps or barriers to necessary services are addressed and/or eliminated.
- Assist members in achieving an optimal level of wellness and function by facilitating timely and appropriate health care services.
- Improve access to primary and specialty care by facilitating timely and appropriate health care services, thus helping members with complex health needs achieve an optimal level of wellness and function.
- Coordinate community services for members with complex needs living in the community.
- Pursue the integration of medical and behavioral health services.
- Provide home-based care through Health@Home as appropriate.
- Provide transitions of care support to members with multiple chronic conditions.
- Collaborate with members' providers to ensure continuity and coordination of care.
- Educate members in self-advocacy and self-management.
- Improve the members' and their families/caregivers' experience with the health care delivery system.

Population Health Management Strategy (PHMS)

Neighborhood's Population Health Management Strategy (PHMS) is based on comprehensive analysis of its entire population and is reviewed and updated annually by the Director of Population Health. The PHMS is presented to the Plan's Medicaid and Commercial Quality and Operations Committee and the Committee's input is incorporated into the PHMS.

Neighborhood's PHMS includes an integrated approach that addresses the members' needs across the various demographic continuum. The objectives of the Plan's PHMS are to provide high quality, cost-effective integrated medical and behavioral health services that are culturally and linguistically appropriate for each member and responds to feedback obtained through member experience surveys. Additionally, PHMS helps to identify gaps in care in current health programs and create cross-functional opportunities to effectively use internal and external resources to address those gaps. The PHMS defines how the health services are identified, offered, and delivered to the members across all risk levels. The PHMS addresses the following key areas along the continuum of care:

- Keeping Members Healthy;
- Management of Members with Emerging Risk;
- Patient Safety and Outcomes Across Settings; and
- Management of Multiple Chronic Conditions

Neighborhood's population health management services are provided by interdisciplinary teams that include care management, disease management, social services, behavioral health, data analytics, and community resources. The PHMS is inclusive of coordination and collaboration of programs across the Plan including but not limited to complex case management, care management, community outreach, disease management, utilization management and quality improvement.

Annual Evaluation and Work Plan Development
Neighborhood conducts an annual evaluation of its QI Program, inclusive of the activities undertaken and monitored by Neighborhood's QI committees, subcommittees and workgroups. Neighborhood uses the annual evaluation as an opportunity to make program revisions and identify work plan objectives and activities for the upcoming year. Annually, all contributors, Quality Improvement staff and the Chief Medical Officer review the draft annual Quality Improvement Program Evaluation, Program Description and Work Plan in whole or in part. The Director of Quality Improvement and/or his/her designee presents the Annual Evaluation, Program Description, and resulting Work Plan to the Clinical Affairs Committee for review and recommendation to the Board of Directors for final review and approval. The status of all Work Plan items are reviewed and updated quarterly. The Work Plan is a fluid document and subject to ongoing revisions and updates throughout the year.

XI. Delegation

Contractual agreements between Neighborhood and any delegated group, agency, or organization specify the responsibilities of both parties; the functions or activities that are delegated; the frequency of reporting on those responsibilities and functions to Neighborhood; the process by which performance is evaluated; corrective action plan expectations, when identified as necessary; and lastly, termination for cause language in the event expectations are not fulfilled. Ultimate responsibility for the oversight of delegated activities lies with designated business areas within Neighborhood. Delegates are monitored according to a regular reporting schedule overseen by the responsible business areas. Additionally, Neighborhood's committees assist in the oversight process, as indicated:

- Monthly, Neighborhood's Clinical Affairs Committee (CAC) reviews and accepts practitioners credentialed and recredentialed by its delegates. Neighborhood retains the ultimate authority to approve, terminate, or suspend individual practitioners or providers when warranted.
- Annually, Neighborhood's Clinical Management Committee reviews and recommends modifications to each delegate organization's Utilization Management Program Description, Annual Evaluation, and Work Plan.
- Annually, the delegate's Quality Improvement Program Description and Work Plan are reviewed and approved by the Plan's Clinical Affairs Committee, after review and comment by the Plan's Medicaid and Commercial Quality and Operations Committee and the INTEGRITY Quality and Operations Committee.
- Annually, the delegate's Quality Improvement Annual Evaluation is reviewed by the Plan's Clinical Affairs Committee, after review and comment by the Plan's Medicaid and Commercial Quality and Operations Committee and/or the INTEGRITY Quality and Operations Committee.

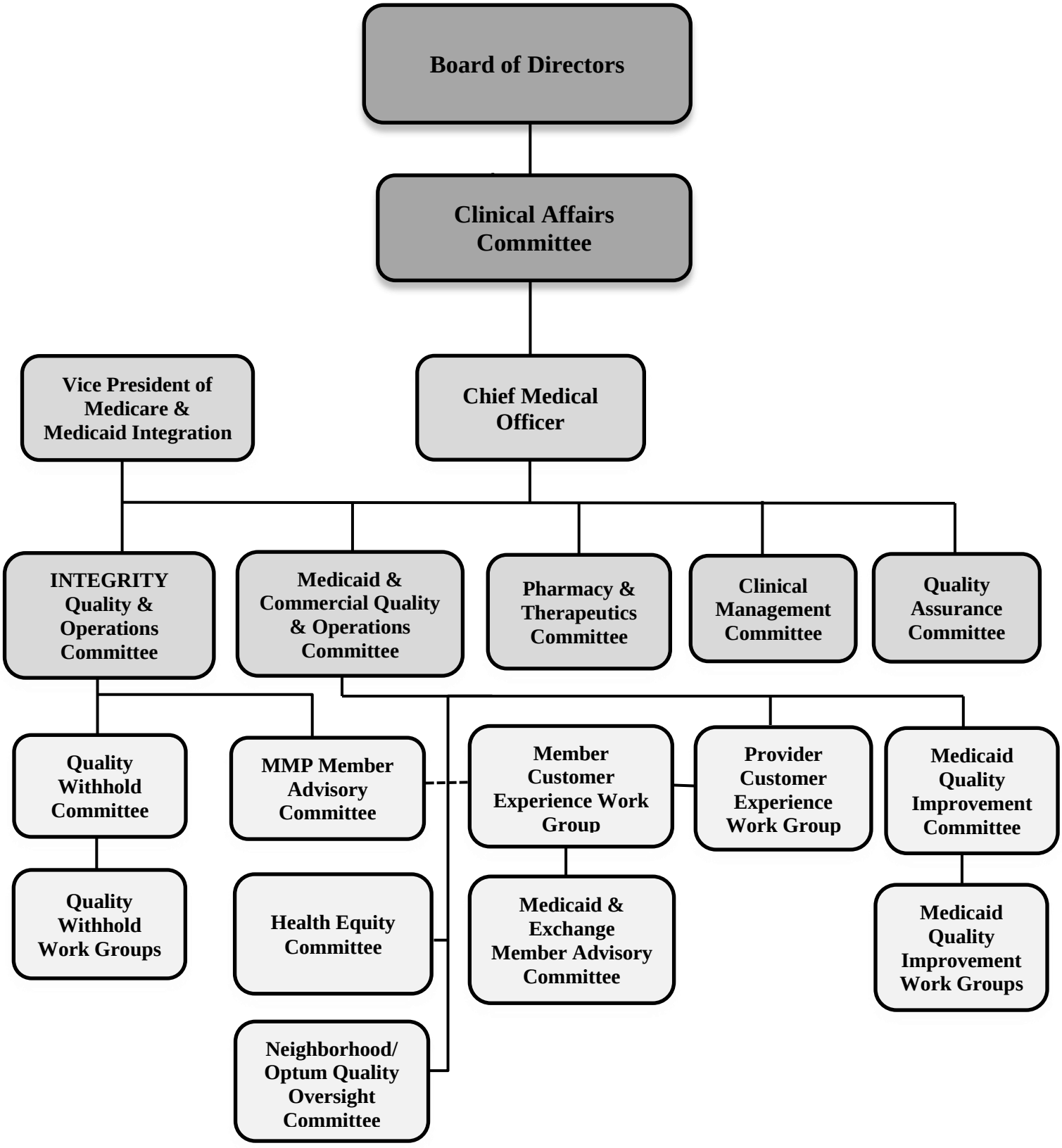
In the event that oversight activities reveal opportunities for improvement, Neighborhood's responsible business area, Account Manager, and Compliance Officer works with the delegate to develop a corrective action plan and monitor the delegate's activities to fulfill the corrective expectations.

XII. Confidentiality / Conflict of Interest / Compliance

Confidentiality / Conflict of Interest

Neighborhood's QI Program maintains the confidentiality of members and providers as required by federal and state law and regulation. Electronic and paper reports, minutes, phone logs, medical records or and any other information generated are specifically excluded from release or discoverability except as allowed by federal or state laws and regulations. All information is protected in accordance with current peer review privacy and confidentiality acts and access to member information is granted on a need-to-know basis. All Neighborhood employees are responsible to read and sign a Confidentiality Agreement and Code of Conduct at the start of their employment or assignment with Neighborhood, and thereafter on an annual basis. To avoid potential conflict of interest, all internal staff, Physician Reviewers, and Physician Consultants involved in the planning or delivery of a treatment plan do not participate in medical review decisions. Medical review decisions are not made with regard to financial incentives.

Neighborhood Health Plan of Rhode Island
Quality Improvement Structure
Appendix A



Appendix B
Quality Committee Reports

Overview: The Clinical Affairs Committee, the Plan's Board-designated Quality Improvement Committee, and the Quality Improvement supporting committees follow a monthly calendar of standard reporting to facilitate Quality Improvement throughout the organization. The reports listed under each Committee represent a sample of the standard reports presented annually. Additional reporting is added as needed to meet the Neighborhood's needs.

Clinical Affairs Committee Reports	Medicaid & Commercial Quality & Operations Committee Reports	INTEGRITY Quality & Operations Committee Reports	Pharmacy & Therapeutics Committee Reports	Clinical Management Committee Reports
Clinical Practice Guidelines	Access and availability Reports	Member Assessment Report	Class Reviews (including utilization trends)	UM Program Description
Quality of Care Issues	Network Adequacy Reports	Critical Incident Report	Review of Delegated Exchange and MMP/INTEGRITY Formulary Changes	UM Program Evaluation
Performance Monitoring	CAHPS & QHP Results	Nursing Home Transitions Report	New Drug Reviews	UM Program Work Plan
Disciplinary Action	HEDIS Results	Nursing Home Quality Report	Meeting Minutes	Clinical Medical Policies
QI Program Description, Work Plan & Evaluation including those of delegates	QI Program Description, Work Plan & Evaluation including those of delegates	Denials / Appeals Reports	DUR Reporting	Clinical Necessity Decision Criteria
HEDIS, HOS, CAHPS QHP & CAHPS-PDP Results	Provider Satisfaction Survey Results	Complaints (Grievances) Report		Delegated Entities Utilization Reports
Provider Satisfaction Survey Results	Call Performance Reports	QW Performance Dashboard		Technology Assessment
HEDIS Medical and Behavioral Health Measures Opportunity	BH Reports (Surveys, call performance, HEDIS results)	QI Projects Reports (Progress & Intervention)		Inter-rater Reliability Reports
Pharmacy Updates	Denial / Appeals Reports	MMP Call Performance Report		Utilization Reports
M&C QOC Quarterly Report of Activities	Member & Provider Complaints Reports	Pharmacy Clinical Program Review & Utilization Reporting		Clinical Appeals & Denials
INTEGRITY QOC Quarterly Report of Activities	Credentialing / Recredentialing TAT Report	Member Screening (Fall Risk) Report		Member and Provider Satisfaction with UM Reports
	QI Projects (Progress & Interventions)	CAHPS MAPDP Results		
	Claims Report	MMP HEDIS Results		
	EOHHS PGP and QW Dashboard	INTEGRITY Member Advisory Com Report		

Appendix C

Neighborhood's Mission, Vision & Values

Mission

Neighborhood Health Plan of Rhode Island, an innovative health plan in partnership with the Community Health Centers, secures access to high quality, cost effective health care for Rhode Island's at-risk populations

Vision

To advance its mission, Neighborhood is working to create a world where:

- Everyone in Rhode Island has comprehensive health care coverage and access to high-quality health care.
- Community Health Centers are models for high quality, cost-effective integrated medical and behavioral health services and are the building blocks of community health.
- As the essential partner to the state's Medicaid program, Neighborhood transforms the health care delivery system through value-based purchasing with primary care as the focus.
- Neighborhood is differentiated by outstanding customer service and members who actively engage in their own health and health care.

Values

Ardently Advocate for Members: Neighborhood treats members with dignity and respect and strives to create access to needed services and social supports.

Foster Partnerships: Neighborhood works collaboratively at all levels of the organization and with its external partners to improve the member experience.

Innovate to Improve the Health Care System: Neighborhood is a catalyst for the delivery of better and more efficient health care.

Demonstrate Value: Neighborhood must use its health care financing position to improve health outcomes, lower costs and ensure access to care.

Passionately Promote Health Equity: Neighborhood cares about those who are disenfranchised from the health care system and works to ensure more equitable access to care and improved health outcomes.

Create an Exceptional Workplace: Neighborhood is an employer of choice and works to attract and advance a culturally competent and diverse workforce to better serve our members.