



Neighborhood Health Plan of Rhode Island 2025 Quality Improvement Annual Evaluation

Reviewed by the Clinical Affairs Committee on May 28, 2026

Executive Summary

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Executive Summary

A. Introduction

Neighborhood Health Plan of Rhode Island's (Neighborhood or the Plan) Quality Improvement (QI) Program is committed to ensuring that members receive high-quality, accessible health care services that are responsive to their needs and promote positive health outcomes. The QI Program spans all departments and levels of the organization, recognizing that effective quality improvement relies on collaboration, shared accountability, and a strong team-based approach.

Neighborhood produces the QI Annual Evaluation to assess the effectiveness of its QI Program. During 2025, the QI Program encompassed 59 initiatives covering the broad performance areas of Clinical Quality Improvement (36 initiatives), Service and Operations Quality Improvement (16 initiatives), and Patient Safety and Coordination of Care Quality Improvement (7 initiatives). For each initiative, this Evaluation summarizes the progress and achievements during the year, including:

- A description of the quality improvement activities undertaken;
- Measurable performance achievements, with trended data when available;
- Identification of issues and barriers preventing achievement of the goals;
- Interventions adopted or identified to overcome those barriers;
- Goals identified for the upcoming year;
- Proposed interventions for goal achievement in the upcoming year; and
- Summary of the overall effectiveness of the program.

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, Healthcare Effectiveness Data and Information Set (HEDIS®), Quality Rating System (QRS), Qualified Health Plan Enrollee Experience Survey, Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Health Outcomes Survey (HOS), provider satisfaction survey results, accessibility and availability standards, and utilization trends. HEDIS rates are produced by a third-party vendor certified by the National Committee for Quality Assurance (NCQA) and are validated by an NCQA-approved auditor contracted by Neighborhood. CAHPS data are collected by a third-party vendor certified by NCQA 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 by the Medicaid and Commercial and INTEGRITY Quality and Operations Committees.

The QI Program Annual Evaluation is reviewed by the Clinical Affairs Committee, which serves as Neighborhood's QI Committee, prior to being submitted for review and acceptance by the Board of Directors. The Clinical Affairs Committee and the Board of Directors also review and approve the QI Program Description and Work Plan for the upcoming year.

Note: This evaluation is not meant to take the place of other detailed program evaluations such as the program evaluations for disease and health management programs. However, it will provide a comprehensive overview of outcomes across Neighborhood.

B. Overview of Work in 2025

Operational/Quality Recognition and Achievements

- One of fourteen (out of 212) Medicaid Health Plan in the country to achieve a rating of 4.5 out of a maximum possible rating of 5 in the National Committee for Quality Assurance (NCQA) Health Plan Ratings 2025. Neighborhood was rated in the top 7 percent of all the Medicaid Health Plans that were rated by the NCQA – a testament to Neighborhood’s exceptional network of providers and their strong partnership with Neighborhood to serve Medicaid members.
 - Achieved 5 out of 5 stars in “Prevention and Population” Composite of NCQA’s Health Plan Rating for the following measures: Childhood Immunizations, BMI Percentile Assessment, Prenatal Checkups and Immunizations, Postpartum Care, Breast Cancer Screening, Colorectal Cancer Screening, Race and Ethnicity and Language preference of members.
 - Achieved 5 out of 5 stars in the “Treatment” Composite of NCQA’s Health Plan Rating for the following measures: Patients with diabetes (blood pressure control 140/90, eye exams), Controlling high blood pressure, Adherence to antipsychotic medications for individuals with schizophrenia
- Attained 75% of the CY2024 Quality Withhold for the INTEGRITY product line (MMP Demonstration Year 8), by achieving quality threshold on 8 out of the 12 measures, representing about \$11.6 million of the available QW dollars. Projecting to achieve 75% of the QW for CY2025 (the final demonstration for MMP) by passing seven out of eleven measures resulting in about \$10.7 million of the available QW dollars.
- Successfully led several organization-wide Quality Improvement Work Groups with the goal of closing gaps in care for our members.
- Rating of Health Plan (9+10) remained at the 2025 National Medicaid Quality Compass 90th percentile benchmark for the 21st consecutive year and earned 5 out of 5 Stars in the “Patient Experience” Composite of NCQA’s Health Plan Rating.
- Achieved a +67 Net Promoter Score (NPS), resulting in Neighborhood achieving the 2025 corporate goal of maintaining an overall Medicaid NPS of “Excellent”. (NPS is a metric used in customer experience programs to measure the loyalty of customers to a company.)
- Successfully achieved NCQA Health Outcomes Accreditation in 2025, previously referred to as the Health Equity Accreditation.
- In-sourced behavioral health in-house in September of 2025 to ensure an inclusive and integrated approach to behavioral health services for our members.
- The Population Health and Equity Committee was established to integrate health equity work into the broader organizational population health strategy.
- Implemented the D-SNP Quality and Operations Committee inclusive of elements of the Model of Care.
- Implemented the Stars Governance inclusive of the Director of Stars Strategy, and the Executive and Stakeholders Committees.

Health Management/Preventive Health

- Distributed “Certificate of Recognition” to 13 network Providers that achieved the highest rates for HEDIS quality measures in the Plan’s network.
- Continued to market the Wellness Rewards Program aimed at several screening and prevention HEDIS measures including, but not limited to, well visits, immunizations, lead screening, and routine diabetes care. In addition, two new member rewards were added for completing a

colonoscopy and completing cervical cancer screening. The Plan distributed 1,413 member rewards in 2024.

- Continued to provide members education on the importance of being immunized, as well as the importance of getting preventive screenings and well visits through social media, radio campaigns, automated phone calls and mailings.
- Continued to provide members with education on the Plan's Disease Management and Care Management Programs through Member Newsletters.
- Continued to educate providers on trends related to quality measure improvement and provided best practices via provider newsletter articles.

Patient Safety and Care Coordination

- Credentialed 773 medical practitioner applications and 551 behavioral health practitioner applications for network entry.
- Re-credentialed 2,001 practitioner applications for re-entry into the network.
- Conducted 32 provider site visits to ensure Plan standards are met for safety and patient care.
- Reviewed 156 new cases for quality-of-care complaints and closed 99% of the cases within 60 calendar days. Of the 156 cases, 128 were member complaints and 28 were concerns.
- Reviewed 126 Class I or II drug recalls for potential member impact. A total of 7,189 members were notified of the recalls, all within the required timeframes.
- Conducted 2,855 Comprehensive Medication Reviews across all products as part of Medication Therapy Management, an increase from CY 2023 (2,153).
- For new INTEGRITY enrollees, completed 72% of Health Risk Assessments, 59% of Comprehensive Functional Needs Assessments and 76% of Wellness Assessments within contractual timeframes. All completion rates increased over CY 2023.
- For existing INTEGRITY members, completed 69.5% of the Health Risk Reassessments, 74.4% of the Comprehensive Functional Needs Reassessments, 64.6% of the High-Risk Assessments and 97.7% of the Wellness Reassessments within contractual timeframes. Failed member outreach is a continued barrier to performance.
- Care plans for INTEGRITY members were completed within 15 days of assessment for 99.8% of the 13,581 members enrolled for 90 days or longer.

C. Challenges and Barriers to Quality Improvement

Neighborhood systematically identifies the challenges and barriers encountered within each quality improvement (QI) activity, and these findings are reflected in each respective area of focus. Planning for the upcoming year incorporates these challenges and barriers to guide the development of targeted activities and interventions that support progress and advance Neighborhood's organizational goals. Across multiple QI initiatives conducted throughout 2025, several recurring challenges emerged, including but not limited to the following:

- Multiple, interdependent corporate projects impacting "business as usual" operations.
 - Implemented a new clinical management system, Guiding Care, in April 2025.
 - Fully insourced all Behavioral Health Services and Operations on September 1, 2025.
 - Executed 9 Work Streams in preparation for launching a D-SNP product on January 1, 2026. With the MMP Demonstration ending, all existing and newly enrolled members will move to the D-SNP product on January 1, 2026.
- The Plan continued to restructure the clinical areas of the organization to accommodate for current and potential growth and to achieve better alignment of selected business areas.
- Reliance on HEDIS for outcome measurement and performance improvement activities is disadvantageous for rapid improvement cycles (e.g., Plan, Do, Study, Act). The Plan continues to

assess alternative ways to measure and respond to outcome measures including analyzing prospective HEDIS rates throughout the year.

- Member contact information continues to be limited, making targeted outreach, education and case/disease management difficult or impossible for some members.

D. Overall Program Effectiveness

Neighborhood's QI improvement efforts strive to impact the quality of care and service provided to its members and practitioners. Annually, the Plan assesses the overall effectiveness of its QI Program through the production of the QI Annual Evaluation to ensure that there is adequacy of resources, assesses the QI committee structure, practitioner participation and leadership involvement, and makes changes to its QI program as necessary for the upcoming year.

In 2025, the Plan maintained its focus and commitment to organization-wide quality improvement activities through its QI structure. Participating network practitioners, the Plan's QI staff, the Chief Medical Officer's staff and staff throughout the organization are members of the QI committees and sub-committees contributing to the QI Program. Neighborhood continuously seeks opportunities to enhance how it resources QI activities, inclusive of practitioner participation, and adjusts as needed. Neighborhood successfully submitted final audited HEDIS data for Medicaid, Exchange and Medicare-Medicaid Plan products. The Plan's performance improved in selected HEDIS and CAHPS measures resulting in a 4.5 Health Insurance Plan Rating. Additionally, the Plan achieved a +67 Net Promoter Score (NPS), which is classified as "Excellent" resulting in the achievement of its 2025 corporate goal of maintaining "Excellent" NPS (NPS is a metric used in customer experience programs to measure the loyalty of customers to a company.)

Neighborhood's quality improvement activities include several notable achievements:

- **Accreditation:** Achieved the Accredited status for the Health Outcomes through the National Committee for Quality Assurance.
- **Focus on Preventive Care and Health Management:** Emphasized the importance of preventive care, health management, and accessing appropriate care through initiatives aimed at educating and connecting with members, collaborating with providers, and enhancing internal operations.
- **Health Equity Program:** Implemented initiatives to reduce disparities in maternal health, childhood health and behavioral health.
- **Inter-departmental Quality Improvement:** Promoted awareness and concepts of organizational quality improvement across departments to enhance operational efficiency and capacity.
- **Quality Improvement Work Groups:** Successfully led several organization-wide Quality Improvement Work Groups focused on addressing gaps in care.
- **Medicaid Quality Improvement Projects (QIPs):** Conducted four focused QIPs in areas such as Immunizations for Adolescents, Lead Screening in Children, Follow-Up Care for Children Prescribed ADHD Medication, and Child and Adolescent Well-Care Visits.
- **INTEGRITY-MMP Product QIPs:** Conducted two focused QIPs for the INTEGRITY product, including transitioning members from nursing home facilities to the community and improving performance on Care for Older Adult HEDIS measures.
- **Chronic Care Improvement Project:** All measures of the Chronic Care Improvement Project for the INTEGRITY product improved from the baseline. This CCIP focuses on enhancing diabetes screening measures for this population.

These efforts demonstrate Neighborhood's dedication to continuous quality improvement and its commitment to providing high-quality care to its members.

II. Clinical Quality Improvement Activities

A. Focused Quality Improvement Projects

Immunizations for Adolescents

Opportunity Statement: According to the Centers for Disease Control and Prevention (CDC), on-time vaccination throughout childhood and adolescence is essential because it helps provide immunity before children are exposed to potentially life-threatening disease. The Rhode Island Department of Health noted a decline in statewide vaccinations in recent years. The Rhode Island Executive Office of Health and Human Services (EOHHS) assigned Immunizations for Adolescents as a state-mandated quality improvement topic beginning in 2024. Additionally, the measure was added as a core Accountable Entity measure in 2024.

Goals:

- Achieve or exceed the National Medicaid Quality Compass 90th percentile for HEDIS Immunizations for Adolescents measure.

Measure/Methodology:

The HEDIS measure for Adolescent Immunization is measured annually and compared to Medicaid Quality Compass benchmarks. This measure assesses adolescents 13 of years of age who had one dose of meningococcal vaccine, one Tdap vaccine, and the complete human papillomavirus (HPV) vaccine series by their 13th birthday.

Interventions:

- **Member Interventions:**
 - Posted messaging about the importance of well visits and immunizations on social media channels.
 - Published an article on the Member Newsletter entitled “How to protect yourself from cold, flu, and COVID-19”.
 - Added flu information and resources on accessing vaccine for members on Neighborhood’s website.
 - Automated reminder to all Medicaid and Exchange members (age 3-21) who needed a well visit including a vaccination reminder.
 - Deployed targeted mailing of HPV Flyer to households with children starting at age 9 who may be due for the HPV vaccine.
- **Provider Interventions:**
 - Sent member gap-in-care reports to all PCPs.
 - Developed specific HPV gap-in-care reports and sent to the Accountable Entities.
 - Sent member gap in care reports to School-Based Health Centers.

Analysis of Performance: The Plan’s rate (48.44) for MY2024 improved compared to MY2023 rate (46.39), achieving the 2025 National Medicaid QC 90th (47.16) percentile for HEDIS Immunizations for Adolescents measure. HPV vaccination rate is the key driver to performance for the Combo 2 - Adolescent Immunizations measure.

Immunizations for Adolescents				
Immunization	HEDIS MY2021	HEDIS MY2022	HEDIS MY2023	HEDIS MY2024
Meningococcal	85.01	85.17	86.41	85.82
Tdap/Td	85.76	85.47	86.71	86.33
HPV	46.44	46.49	47.16	49.54
Combo 2	45.08	45.64	46.39	48.44

Analysis of Adolescent Immunization rates by Race and Ethnicity show that the African American population performed 6.63% below the Plan rate while the Hispanic population performed 3.22% better.

Analysis of Barriers to Performance and Planned Interventions:

- The COVID-19 pandemic continues to be a system-level barrier impacting the following:
 - With the availability of COVID-19 vaccines, members experienced vaccination fatigue and changed vaccination habits.
- HPV vaccines are highly effective and work best when given before adolescents become sexually active but vaccinating preteens and teens to protect them against a sexually transmitted infection is a bridge parents have been reluctant to cross.
- Many parents have a lack of knowledge about HPV and the HPV vaccine. They also have fears about the safety and efficacy of the HPV vaccine.
- Changes to the national recommended vaccine schedule could have major impact to rates in 2026.

The Prevention and Screening Workgroup is committed to educating members on the importance of all immunizations.

Social Determinant of Health: Lead Screening in Children

Opportunity Statement: Social determinants of health are economic and social conditions that affect health outcomes and the quality of life. A well-established health risk that is strongly associated with social determinants is childhood lead poisoning. According to the World Health Organization, young children are particularly vulnerable to the toxic effects of lead and can suffer profound and permanent adverse health effects, particularly affecting the development of the brain and nervous system. In general, children who live in older and poorly maintained housing and who reside in neighborhoods where lead dust has contaminated the soil are at higher risk for poisoning.

Neighborhood chose improving the Lead Screening (LSC) HEDIS rate, encouraging timely follow up for all children whose lead screening results are ≥ 3.5 mcg/dL. and poverty level/geographic location as measures for social determinants of health. Children enrolled in Medicaid often live in substandard housing and are at a higher risk of having elevated blood lead levels than commercially insured children.

Improving LSC is a Quality Improvement Project (QIP) for the Plan. Neighborhood believes that collaborating with the Rhode Island Department of Health (RIDOH) to prevent lead poisoning and promote screening will benefit members' overall health.

Goal: Achieve the National Medicaid Quality Compass 90th percentile for LSC, encourage follow up care for children whose lead screening results are ≥ 3.5 mcg/dL and outreach to parents of children with high blood lead levels who refused services from the RIDOH based on poverty level/geographic location.

Measure/Methodology: The percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning prior to their second birthday, per the HEDIS Technical Specifications for *Lead Screening* measure. This measure is not reported for the Exchange population and the QIP focuses on the Medicaid population.

Interventions:

- **Member Interventions:**

- Offered the \$25 incentive gift cards to members who received a lead screening.
- Partnered with Thundermist Community Health Centers and Wood River Health to distribute teddy bears to children completing on-site lead screenings. The incentive encourages parents/guardians to complete the additional lab visit while providing comfort to the child.
- Provided member education on the importance of lead screening through social media platforms.
- Care Management team continued to provide lead screening education and developed goals for members that met the screening age criteria.

- **Provider Interventions:**

- Neighborhood met with several high and low performing provider sites to review performance, discuss barriers to performance and best practices.
- Distributed provider gap-in-care reports in April, June and October of 2025, inclusive of a list of members in need of lead screening. The Plan included reminder letters to providers with the gap-in-care reports about the importance of LSC, how providers can help and what Neighborhood is doing to help increase LSC.
- Distributed a rolling gap-in-care report inclusive of lists of members ages 9 months to 22 months that have not had a lead screening test completed to Accountable Entities monthly.
- Published a provider newsletter article titled “National Lead Poisoning Prevention Week”, which included information on the importance of lead screening/well visits and follow up for patients with blood levels greater than or equal to 3.5 mcg/dL.

Analysis of Performance:

The LSC MY2024 rate (79.81) decreased compared to MY2023 rate of (80.65) and missed the QIP goal of the Medicaid 2025 QC 90th percentile (82.86) and remained below the baseline rate (82.90, MY2015). The LSC rate for MY2024 performance rated at National Medicaid 2025 QC 75th percentile.

In terms of social determinants related to the Lead Screening measure, Neighborhood is focusing on poverty level and geographic location. Due to staffing issues at RIDOH and COVID-19, Neighborhood did not receive quarterly data from the RIDOH that identifies members with blood levels ≥ 3.5 mcg/dL who are lost to follow up. Once the data is received from RIDOH, the Quality Improvement Department will meet with the Care Management Department to determine if outreach to members identified by RIDOH can continue.

Analysis of Lead Screening rates by race and ethnicity show that Black/African American members were screened at a rate 9.5% lower than the Plan rate, while the rate of screening for Hispanic members was 2.36% higher than the Plan rate. This is a difference of almost 12% between the two race ethnicity categories which had the highest and lowest rates.

Analysis of Barriers to Performance and Planned Interventions:

- Parents do not understand the importance of lead screening, or the risks involved with high blood lead levels.
 - **Planned Interventions:**
 - Restart the monthly birthday postcards inclusive of language about lead screening.
 - Continue to provide the \$25 member reward through the Plan's Member Rewards Program.
 - Publish information regarding the importance of lead screening on Neighborhood's social media sites.
 - Publish an article about the importance of lead screening and well visits in the provider newsletter.
 - Continue the teddy bear partnership with Community Health Centers.
 - Explore administering automated calls specifically targeting members that meet the lead screening age criteria.

Follow-up Care for Children Prescribed ADHD Medication

Opportunity Statement: For children six years of age and older with ADHD, the American Academy of Pediatrics (AAP) recommends both behavior therapy and medication as good treatment options, preferably together. For young children (under 6 years of age) with ADHD, behavior therapy is recommended as the first line of treatment, before medication is tried. In 2016, 62% of children (2-17 years of age) diagnosed with ADHD were taking medication, and 47% of children ages 2-17 years with ADHD received behavioral health therapy.

In December 2017, the Office of the Health and Human Services assigned the Follow-up Care for Children Prescribed ADHD Medication (ADD) measure as a Quality Improvement Project.

Goal: Achieve the National Medicaid QC 90th percentile for both components of the measure.

Measure/Methodology: The eligible population for this measure includes Medicaid members who are 6-12 years of age as of the Index Prescription Start Date with an ambulatory prescription dispensed for ADHD medication (newly prescribed). Although this measure is reported for the Medicaid and the Exchange product lines, this QIP focuses on the Medicaid population.

The ADHD HEDIS measure is collected via administrative claims data and is reported based on the following two components:

1. **Initiation Phase:** The number of Medicaid members 6-12 years of age as of the earliest prescription dispensing date (Index Prescription Start Date) with an ambulatory prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30 days following the Index Prescription Start Date.
2. **Continuation and Maintenance Phase:** The number of members 6-12 years of age as of the earliest prescription dispensing date (Index Prescription Start Date) with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least seven months (210 days) and, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner within nine months (270 days) after the Initiation Phase has ended.

Interventions:

- Neighborhood quality staff completed telephone calls to practitioners who treated members with newly prescribed ADHD medication to confirm that the members have a follow-up appointment scheduled and if not, encourage them to schedule a follow-up appointment.
- Optum educated parents of enrollees about ADHD symptom management, medication compliance, and the importance of timely follow-up with their practitioner by providing a link on their website to the enrollees' section of the website. (discontinued 8/31/25 due to termination of contract with Optum).
- Optum educated behavioral health practitioners through an educational email blast. Providers targeted were those that had treated one or more children/adolescents diagnosed with ADHD within the past 12 months. The email content included ADHD best treatment practices, the HEDIS measure specifications, and practitioner resources. (discontinued 8/31/25 due to termination of contract with Optum).
- Published an article in Neighborhood's provider newsletter for educational purposes.
- Social media postings to Neighborhood's social media platforms for member awareness and educational purposes.
- Neighborhood continued to provide an ADHD follow up tracking form that includes educational information for starting an ADHD medication. This form is available in English, Spanish and Portuguese.

Analysis of Performance: Neighborhood's HEDIS MY2024 rate (49.82) for ADHD Initiation Phase increased compared to MY2023 HEDIS rate (46.71). The HEDIS MY2024 rate (53.91) for ADHD Continuation and Maintenance Phase decreased compared to the MY2023 HEDIS rate (56.09). Both the Initiation and Continuation Phases fell short of meeting the QIP goal of 2025 National Medicaid QC 90th percentiles.

Measure	HEDIS MY2017 Rate Baseline	HEDIS MY2018 Rate MY #1	HEDIS MY2019 Rate MY #2	HEDIS MY2020 Rate MY #3	HEDIS MY2021 Rate MY #4	HEDIS MY2022 Rate MY # 5	HEDIS MY2023 Rate MY # 6	HEDIS MY2024 Rate MY # 7	2025 QC Percentile	Goal (Rate)
ADD: Initiation Phase	47.23	47.58	46.91	50.83	48.39	47.57	46.71	49.82	66th	QC 90th (57.29)
ADD: Continuation & Maintenance Phase	58.30	61.19	56.19	61.79	59.15	54.40	56.09	53.91	33rd	QC 90th (65.18)

Analysis of rates by prescribing physician type for the Initiation phase revealed that medical providers had a lower rate (44.86) compared to behavioral health providers (72.40). Of note, the medical providers had a higher denominator (622) compared to behavioral health providers (207). For the Continuation and Maintenance phase, medical providers had a lower rate (46.94) compared to behavioral health providers (72.60).

	Medical			Behavioral Health			Unknown		
	Den	Num	Rate	Den	Num	Rate	Den	Num	Rate
ADD: Initiation Phase	622	279	44.86	192	139	72.40%	41	8	19.51%
ADD: Continuation & Maintenance Phase	147	69	46.94%	73	53	72.60%	10	2	20.00%

Analysis of Barriers to Performance and Planned Interventions: The Neighborhood Quality Improvement Oversight Committee as well as the Behavioral Health Strategic Quality Collaborative Work

Group met to review and discuss all behavioral health and medical quality initiatives, inclusive of the ADD measure. The Committee and the BH Work Group reviewed the HEDIS MY2024 results for ADD and identified the following barriers to performance and planned interventions:

- Parents of members may not be aware of the importance of medication compliance and the importance of timely follow-up.
 - **Planned Intervention:** Continue to develop and distribute educational materials for parents about the importance of medication adherence and following up with visits with their primary care practitioners.
 - **Planned Intervention:** Continue adding ADHD content to Neighborhood social media platforms in collaboration with the marketing department.
 - **Planned Intervention:** Continue to meet with low performing providers and provide education and analysis specific to their practice.
- Providers may not be aware of measures/best practices and may not provide members with all the information regarding ADHD treatment.
 - **Planned Intervention:** Continue meeting with providers and providing education and analysis specific to their practice and identified barriers.
 - **Planned Intervention:** Published an article in Neighborhood's provider newsletter for educational purposes (completed July 2025)
 - **Planned Intervention:** Continue to encourage primary care providers to coordinate with Behavioral Health providers to complete follow-up.
- Providers may not be aware of the HEDIS ADHD measure timeframes; thus, a follow-up visit within 30 days of a new prescription is not scheduled.
 - **Planned Intervention:** Neighborhood staff will continue to make telephone calls and send faxes to practitioners treating members with newly prescribed ADHD medication to confirm that the members have a follow-up appointment scheduled and if not, encourage them to schedule a follow-up appointment.
- Members and their guardians may be unaware of the importance of following up for a new medication within 30 days of a new prescription.
 - **Planned Intervention:** Mail medication adherence educational/reminder regarding the importance of follow up, medication adherence, and communication with the child's provider. Medication adherence flyers have been submitted for review and will be included in interventions for members falling into this measure once approved and initiated.

Child and Adolescent Well Care Visit

Opportunity Statement: The Executive Office of Health and Human Services (EOHHS) requires Quality Improvement Projects (QIPs) for the Medicaid Product. Neighborhood has chosen to improve the Child and Adolescent Well-Care Visits (WCV) rates. The WCV measure focuses on children and adolescents 3 to 21 years of age who had at least one comprehensive well visit with a Primary Care Practitioner or an Obstetrician-Gynecologist during the measurement period.

According to NCQA, well care visits provide an opportunity for providers to influence health and development, which is a critical opportunity for screening and counseling. High-quality primary care services have been found to significantly reduce children's non-urgent Emergency Room (ER) visits (Bloom et al., 2012). A consistent source of primary care can fill the need for screening, appropriate treatment, and preventive services for children and adolescents.

The focus of this QIP is to improve Neighborhood's HEDIS rates for the WCV measure by identifying the members who are due for a visit with their PCP. Neighborhood will analyze the HEDIS data to identify

barriers to performance for the WCV measure and identify and implement interventions to address those barriers. Neighborhood anticipates that improving the WCV measure will positively impact several of the early childhood measures such as Developmental Screening, Lead Screening in Children, and Childhood Immunization Status.

Goal: Achieve the National Medicaid Quality Compass 90th percentile for all measures.

Measure/Methodology: The percentage of members 3-21 years of age who had at least one comprehensive well-care visit with a Primary Care Practitioner or an Obstetrician-Gynecologist during the measurement year, per the HEDIS Technical Specification for *Child and Adolescent Well-Care Visit* measures.

Interventions:

- **Member Interventions:**

- Continued to offer the \$25 incentive gift cards to members who received an annual well visit at 18 months and between the ages of three and twelve.
- Continued to raise member awareness through social media platforms.
- Conducted automated phone calls October-November 2025 to promote the importance of well visits and immunizations to non-compliant members 3-21 years old.

- **Provider Interventions:**

- Neighborhood met with several high and low performing provider sites to review performance, discuss barriers, and share best practices.
- Distributed provider gap-in-care reports inclusive of a list of non-compliant members in August 2025.
- Provided an incentive-based program to Accountable Entities to address opportunities for improvement on selected HEDIS measures including Well Child Visits.

Analysis of Performance: Neighborhood's HEDIS MY2024 WCV (ages 3-11) rate is 71.07% and is in the 2025 National Medicaid QC 75th percentile. The rate for WCV (ages 12-17) is 65.01% and is in the 2025 National Medicaid QC 75th percentile. The WCV (ages 18-21) rate is 44.03% and is in the 2025 National Medicaid QC 75th percentile. The Total rate (ages 3-21 years) is 64.97% and is in the 2025 National Medicaid QC 75th percentile. All rates were higher than both the baseline and previous year but fell short of meeting the QIP goal of National Medicaid QC 90th percentile.

Age in Measurement Year:	Baseline 2020 Admin Rate	MY #1 2021 Admin Rate	MY #2 2022 Admin Rate	MY #3 2023 Admin Rate	MY #4 2024 Admin Rate
3-11 years	60.12%	68.48%	70.18%	68.56%	71.07%
12-17 years	52.60%	63.12%	64.08%	62.39%	65.01%
18-21 years	34.75 %	39.00 %	41.35 %	40.35 %	44.03%
Ages 3-21 years	53.46 %	61.26 %	62.57 %	61.19 %	64.97%

Analysis of WCV Total rates by Race and Ethnicity show that the American Indian or Alaskan Native members were seen at a rate 10.43% lower than the Plan rate, while the rate for Hispanic members was 1.44% higher than the Plan rate. This is a difference of almost 12% between the two race ethnicity categories that had the highest and lowest rates. There was a disparity among the American Indian or Alaskan Native population across all individual age groups except for ages 18-21 years where the rate was 4% higher than the Plan.

Analysis of Barriers to Performance and Planned Interventions:

- Access to primary care in Rhode Island has decreased in recent years. There is a primary care practitioner shortage with many pediatric practices closing in 2024 and 2025.
- Parents may not understand the importance of well visits and only take their children to see a provider when they are sick or injured.
 - **Planned Interventions:**
 - Provide the \$25 member incentive, for completing a well visit, through Neighborhood's Member Rewards Program.
 - Distribute reward forms to School Based Health Centers.
 - Advertise the availability of School Based Health Centers across Rhode Island.
 - Publish information regarding the importance of well visits on Neighborhood social media sites.
 - Publish an article in the provider newsletter on the importance of well visits.
 - Explore administering automated calls in early 2026 targeting members 3-21 years old that did not have a well visit the year prior.
 - Distribute educational materials at marketing events.
 - Continue to distribute gap-in-care reports to Accountable Entities.

The Plan will continue to meet with low-performing sites to understand barriers and share best practices learned from high-performing sites and distribute gap -in-care reports to facilitate timely follow-up with members. The Prevention and Screening Workgroup will continue to analyze data, identify barriers to performance, and design and implement interventions to address those barriers, when possible.

Increase Percentage of Transitions from the Nursing Home to the Community

Opportunity Statement: The Executive Office Health and Human Services (EOHHS) chose transitions from the nursing home to the community as a QIP in 2018. Studies show that members have a better quality of life and health when living in the community versus living in an institutional setting. Living in the community provides members with the autonomy and control needed to make their own decisions. According to the Rhode Island Long-Term Care AARP Survey, a large majority consider “very important” the plan's components that would enable them to be able to choose and receive services at home (84%) and have high-quality nursing home care if needed (81%) (Katherine Bridges, 2002).

According to AARP surveys, about nine out of ten seniors have a stated desire to remain in their homes. This is likely due to an attachment to their homes, as well as preference to remain with friends and family in the community. According to the U.S. Department of Health and Human Services, home care options are often less expensive than a permanent facility stay which averages approximately \$6,500 per month (Watts et.al, 2015).

Goal: Transition 35% of all INTEGRITY members from the nursing home to the community.

Measure/Methodology: All INTEGRITY members in nursing facilities are assessed within 30 days of enrollment and annually thereafter, to determine if they have an opportunity to discharge back into the community. If an opportunity exists and the member agrees to the transition, Neighborhood staff work with the member, the facility, and family members to plan for and arrange a discharge. If the member has been at a custodial level of care for at least 90 consecutive days, he/she qualifies for the Rhode to Home Program (RTHP). The member must agree and sign consent to enroll and participate in the RTHP. However, if a member transitions prior to 90 days or declines RTHP, they are transitioned through the Nursing Home Transition Program (NHTP). Data for 2025 was extracted using the Comprehensive Functional Needs Assessment (CFNA) in Neighborhood's Care Management system.

Interventions:

- Neighborhood continued to reassess members that had chosen to stay in the nursing facility after the first 60 days and encourage these members to transition back into the community.
- Neighborhood's Skilled Nursing Facility (SNF) Care Managers continue to utilize Welcome Calls for new enrollees and passive enrollments to help identify INTEGRITY members for transition.
- Neighborhood continues to ensure that members admitted to nursing homes for short-term rehabilitation are assessed within ten (10) days for opportunity to return to community.

Analysis of Performance: Of the 712 members identified for transition to the community, Neighborhood transitioned 53.37% (380) of INTEGRITY members from nursing facilities into the community in 2025, exceeding the goal of 35%.

Neighborhood's Care Management Team continued in-person nursing homes visits. The Plan re-assessed members that had chosen to stay in the nursing facility after the first ninety (90) days to encourage transition back into the community. Approximately 48.39% (15/31) of eligible Rhode to Home Program INTEGRITY members were transitioned to the community through the Rhode to Home Program in CY2025.

Analysis of Barriers to Performance and Planned Interventions:

- Neighborhood to identify opportunities for transition through re-assessment.
 - **Planned Interventions:**
 - Continue to work with facilities to gain additional access to nursing homes' electronic medical record systems for the remaining homes.
 - Continue to cross-train all Case Managers to manage transitions.
- Some members who are eligible for transfer choose to stay in the nursing facility.
 - **Planned Intervention:** Provide education to the member and/or members' representative about the services available to them once transitioned. Neighborhood continues to provide education via on-site visits as well as telephonic outreach to impacted members.
- Lack of housing and use of housing vouchers.
 - **Planned Intervention:** Neighborhood continues to collaborate with the State to use subsidized/waiver-housing vouchers targeted for the RTHP. Property owners are reluctant to accept the vouchers.
- Neighborhood is not always notified of potential candidates for transition.
 - **Planned Intervention:** Neighborhood Lead Case Managers will continue to submit Section Q forms from the Minimal Data Set (MDS) on Neighborhood members at each facility to ensure Neighborhood is identifying as many potential transitions as possible. If the facility did not administer Section Q form, Neighborhood Case Management initiates and sends to the State.
 - **Planned Intervention:** Medical Management will continue to conduct welcome calls to identify potential candidates for transition.

Care for Older Adults

Opportunity Statement: As the population ages, physical and cognitive function can decline, and pain becomes more prevalent. Older adults may also have more complex medication regimens. Consideration should be given to members' own choices about end-of-life care; advance care plans should be in place. Screening of elderly members is effective in identifying functional decline. The HEDIS Care for Older Adults (COA) measure is a set of measures that ensures older adults receive the care they need to optimize

their quality of life. The HEDIS COA measure includes four components: advance care planning, medication review, functional status assessment and pain assessment.

The Plan's MY2017 rates for three of the four components of the COA measure were well below the Medicare-Medicaid Plan (MMP) Quality Withhold benchmarks. As such, Neighborhood proposed and received approval from EOHHS/CMS in January 2019, to include COA as a QIP for INTEGRITY members.

The focus of this QIP is to improve Neighborhood's HEDIS rates for all COA components for INTEGRITY members. Neighborhood anticipates that improving COA measures will positively influence the health outcomes for older adults.

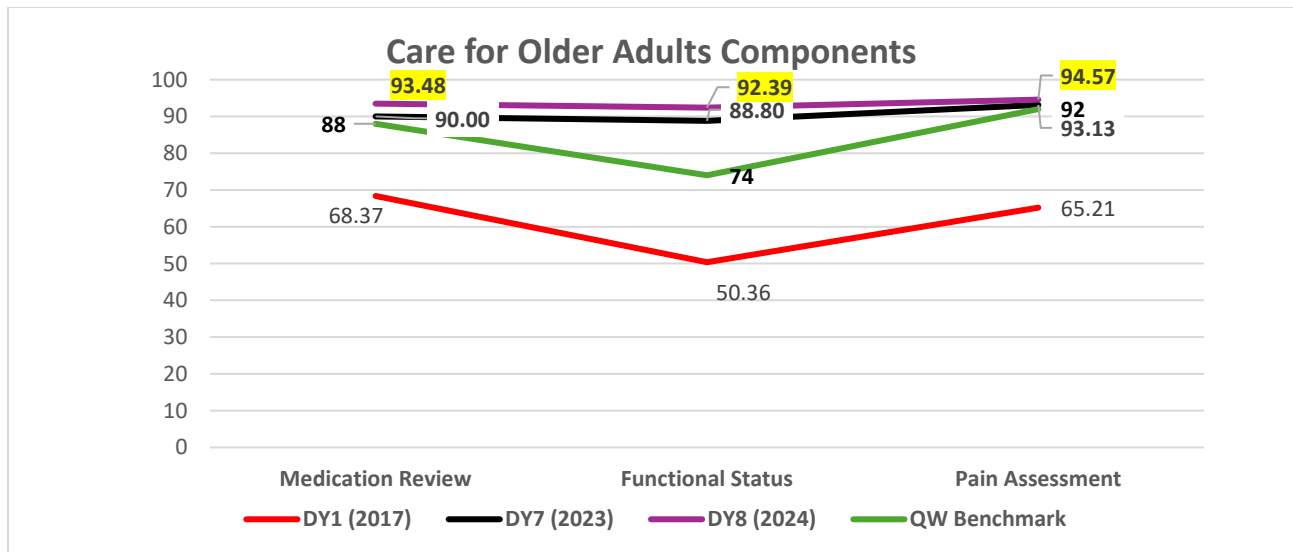
Goal: Meet or exceed the DY 8 Quality Withhold benchmark for two components of the COA measure: Medication review (88%) and Functional Status Assessment (74%). The Pain Assessment measure was retired.

Measure/Methodology: COA is a HEDIS measure collected using both administrative (claims) information and medical record information. The administrative data is monitored on a quarterly basis, and the medical record data is collected and analyzed on an annual basis during the HEDIS data collection period, which occurs in the spring of each year. The medical record review is conducted on a systematic sample of 388 members from the eligible population of the COA measure per the NCQA HEDIS Technical Specifications.

Interventions:

- Distributed Gap in Care Reports inclusive of a list of members who resided in Nursing Home facilities and were without advanced care plans. The Plan's Care Management Team collaborated with the Nursing Home facilities to collect data on advance care plans.
- Collected data for all components of the COA measure year-round to augment the COA HEDIS data collection cycle.
- Continued to utilize the Care Management system as a supplemental database for all COA measures apart from Medication Review as this data is derived from the Outcomes MTM system.
- Continued to leverage Health Risk Assessment (HRA) to collect data for Activities of Daily Living (ADL) for the Functional Status Assessment measure.
 - Nursing staff have been trained on the HRA to ensure the data for the ADL is collected and documented.
- Continued to provide a list of members who required Medication Reviews to the Pharmacy team for outreach.

Analysis of Performance: The Medication Review rate for MY2024 (93.48%) maintained performance above the baseline rate (68.37%). The MY2024 Functional Status Assessment rate (92.39%) also improved compared to the baseline rate (50.36%) and exceeds the MY2024 MMP Quality Withhold benchmark of 74%. The MY2024 Pain Assessment rate (94.57%) substantially increased compared to the baseline rate (65.21%); and like the other measures, has surpassed MY2024 MMP Quality Withhold benchmark of 92%.



Analysis of Barriers to Performance and Planned Interventions:

- Neighborhood’s focus continues to be on building a supplemental database and using the Case Management system to capture data during member interactions.
 - **Planned Intervention:** Continue to conduct off-season medical record review as well as collaborate with Care Management to ensure pain assessments are conducted appropriately and timely.
- Providers may be unaware of the measure requirements and lack education on the requirements needed to make a member compliant.
 - **Ongoing Intervention:** Continue to focus provider education/outreach efforts (e.g., on rates, peer-to-peer sharing etc. through meetings, mail, email) on sites that are not meeting the benchmark, have a higher denominator and cross multiple measures.
 - **Planned Intervention:** Initiate provider education on the COA requirements and assistance in improving provider EMRs to facilitate performance reminders on data collection for COA.

Opioid Program

Opportunity Statement: The opioid epidemic affects the state of Rhode Island and by promoting appropriate opioid utilization, Neighborhood will work to improve inappropriate opioid utilization amongst its population.

Goal: Improve the performance rate by 1% from baseline (to below 3.55% as the 2019 baseline was 4.55%) for Exchange members for the HEDIS measure “Risk of Continued Opioid Use,” which will support safe, effective, and appropriate pain management with opioids among Neighborhood members.

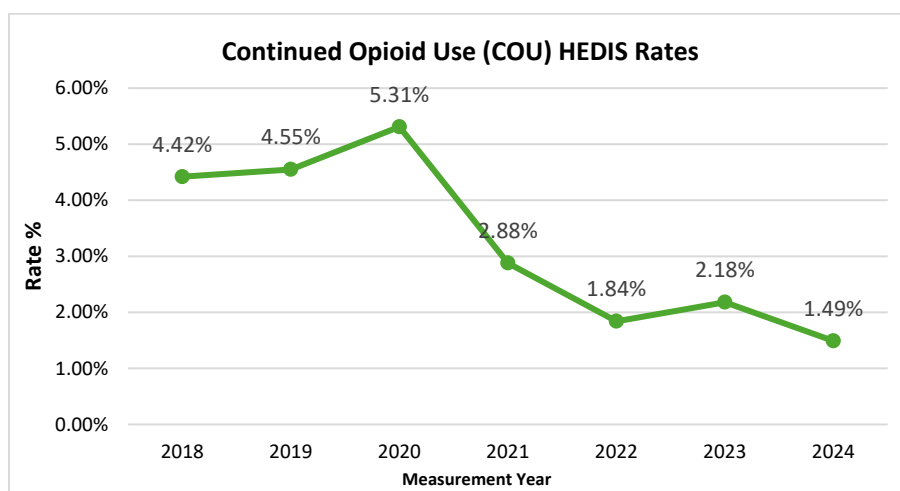
Measure/Methodology: The measure is defined as the proportion of members 18 years and older, receiving prescription opioids for ≥ 15 days during the measurement year at a high dosage (average milligram morphine dose (MME) > 120 mg).

Interventions:

- Implemented prior authorization requirement on all formulary long-acting opioids to ensure appropriate use for chronic pain.

- Implemented prior authorization requirement on opioid daily doses of 90 MME **OR** a lower MME that requires dose consolidation
- Implemented quantity limitations for all formulary short-acting opioids for initial prescriptions when a member's prescription claims utilization does not support if a member has had opioid exposure (member is opioid naïve) within the last 30 days.
 - Quantity limitations on initial short-acting opioid prescriptions include both of the following:
 - No more than 20 doses; AND
 - No more than 30 morphine milligram equivalents (MME) per day.
- Implemented point of sale rejections that occur if Ibuprofen, Acetaminophen or Aspirin are above their FDA recommended dosing limit.
- In 2021, implemented coding that restricts opioid naïve members to only receive 7 days of an IR opioid in a 90-day period. If a greater amount of opioid is required, then PA is required.

Analysis of Performance: Neighborhood's rate for Continued Opioid Use (COU) was 1.49% (18/1,206) in MY2024. The rate continued to show improvement from 2.18% in MY2023 and remains well below the baseline rate of 4.42%.



Planned Interventions:

- Continue to ensure that coding and rejections are in place and working appropriately via quarterly oversight.

Chronic Care Improvement Program: Standardizing HbA1c Screening, HbA1c Control <8%, Diabetic Eye Exams, and Blood Pressure Control (140/90) Among Diabetic Health@Home Members

Opportunity Statement: The Centers for Medicare and Medicaid Services (CMS), per the Three-Way Contract, requires one Chronic Care Improvement Program (CCIP) for the INTEGRITY (MMP) line of business as part of the Quality Improvement Program. The CCIP is required to: 1) promote effective management of chronic disease, 2) improve care and health outcomes for enrollees with chronic conditions; and 3) be conducted over a three-year period. Effective management of chronic disease is expected to slow disease progression, prevent complications and development of comorbidities, reduce preventable emergency department (ED) encounters and inpatient stays, improve quality of life, and save costs.

- Neighborhood's selected CCIP, Standardizing HbA1c Screening, HbA1c Control (<8%), Diabetic Eye Exams, and Blood Pressure Control (140/90) among Diabetic Health@Home (H@H) Members, addresses comprehensive diabetes care among INTEGRITY Health@Home participants through: 1) facilitating and monitoring HbA1c screening and HbA1c control (<8%); 2) facilitating diabetic eye exams; and 3) screening and monitoring members for high blood pressure. The CCIP target population is INTEGRITY Health@Home patients diagnosed with diabetes.
- The objective of Neighborhood's CCIP is to improve the health status of the 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 condition or illness.

Goal: The goal of this CCIP is to improve rates for HbA1c screenings, HbA1c control (< 8%), diabetic eye exams, and blood pressure control (140/90) for all Health@Home members with diabetes. Rate improvements on the four measures specified indicate improved health and quality of care.

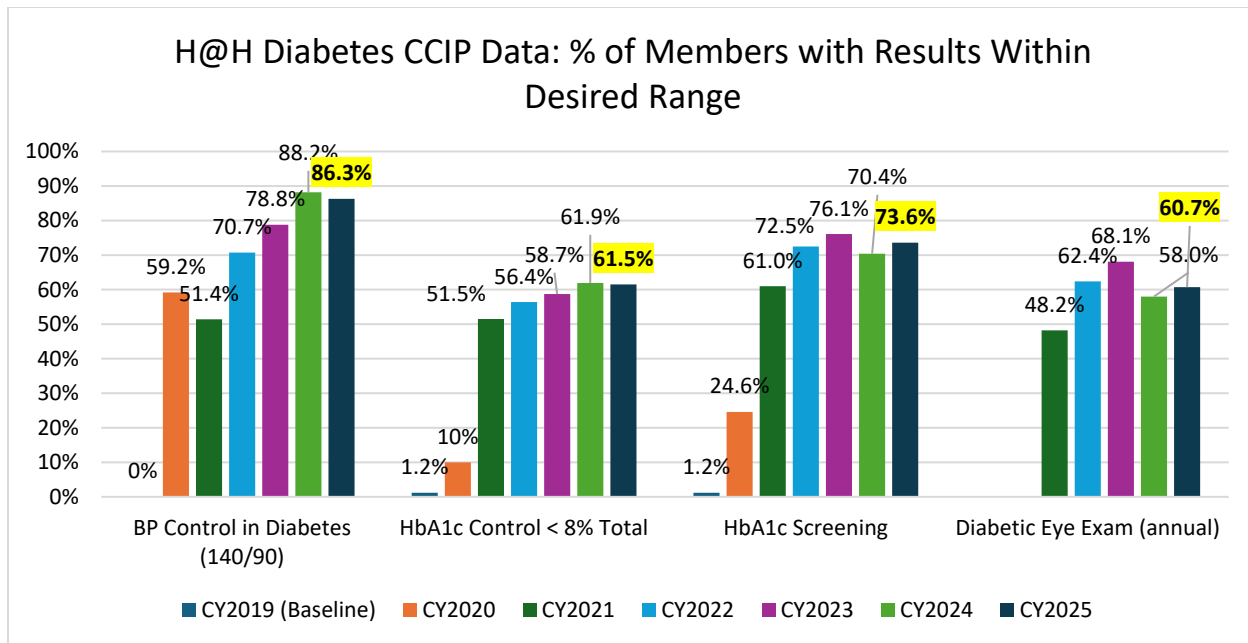
Measure/Methodology: Neighborhood's H@H Primary Care Team serves the eligible diabetic MMP population via the Health@Home Program. Within this program, staff visit the members' homes and facilitate or coordinate HbA1c screening, HbA1c control (< 8%), diabetic eye exams, and blood pressure control (140/90).

- Health@Home nursing staff has incorporated and standardized the facilitation or coordination of the following into the processes set forth within the existing Health@Home Program: HbA1c screening, HbA1c control (<8%), diabetic eye exams, and blood pressure control (140/90) to ensure the eligible population have documented results.
- In Q3 2021, Athena, Health@Home's electronic medical record system, retired the Nephropathy Screening measure, which is no longer reported. The Diabetic Eye Exam measure replaced the Nephropathy Screening measure in the CCIP as of Q3 2021 and beyond. CCIP performance is measured on a quarterly basis using the electronic medical record software, Athena. The annual analysis includes data for the INTEGRITY Health@Home patients in Neighborhood's Health@Home Program.

Interventions: H@H nursing staff standardized the facilitation or coordination of HbA1c screenings, HbA1c control (< 8%), diabetic eye exams (Q3 2021 and beyond), and blood pressure control (140/90) to ensure the eligible population receive high-quality care and better health outcomes to manage diabetes. Results are reviewed with applicable members and education is provided as appropriate. H@H nursing staff has incorporated these measures into the existing processes of the Health@Home Program.

Analysis of Performance: The following tables and charts represent the CY2019 baseline data as well as data from CY2020 to CY2025.

- Baseline data reflects all measure results, both satisfied and out of range of the desired outcome.
- CY2020 through CY2025 data illustrates the impact the process improvements established from program implementation. CY2025 data points are highlighted below.



In CY2025, 86.3% of members in the program had results within the desired range in Athena for blood pressure control in diabetes (140/90), a substantial increase compared to the baseline rate (0%) but a decrease in CY2024 rate (88.2%). Similar results occurred for HbA1c control <8% in CY2025, 61.5% of members had results within the desired range compared to the baseline rate (1.2%) but a decrease in CY2024 rate (61.9%). Results for HbA1c screenings in CY2025 increased to 73.6% in CY2025 compared to the baseline rate (1.2%) and an increase from the CY2024 rate (70.4%). Diabetic eye exams replaced nephropathy screenings as of Q3 2021, and in CY2025, 60.7% of members had results within the desired range with an increase compared to 58% in CY2024.

Analysis of Barriers to Performance and Planned Interventions:

- Limited resources due to staffing shortages/losses are a notable barrier to performance. There was a shift in priorities in terms of program initiatives for Health@Home in CY2025, which pulled focus to increasing Wellness Visits for risk adjustment purposes in this population. The shift in focus in addition to the staffing shortage resulted in a decrease in some rates.
 - **Planned Intervention:** The Plan will continue to focus efforts on hiring staff to handle the workload of multiple priorities from the organization.
- Another barrier to performance was new clinical staff were hired with less experience than in the past resulting in an increased need for training. Many of those newly hired were recent graduates that lacked experience, and more efforts were needed to train these new employees.
 - **Planned Intervention:** The Plan will work to develop on-the-job training to ensure newly hired clinical staff have all the resources to be able to do their job effectively and efficiently.

B. Quality Incentive Programs

INTEGRITY-Medicare Medicaid Plan Quality Withhold

Overview: A percentage of Neighborhood's per member, per month (PMPM) revenue for INTEGRITY product is held back each Demonstration Year and is returned to the Plan based on the Plan's performance on a set of quality measures during that year. The number of measures and the percentage withheld changed

during the first three years of the Demonstration. The percentage withheld is applied to both Medicare revenues, excluding Part D (i.e., pharmacy revenues), and Medicaid revenues.

To systematically address performance on the INTEGRITY quality withhold measures, Neighborhood implemented an INTEGRITY Quality Withhold Committee responsible for reviewing the Quality Withhold performance, identifying priority measures and Work Groups, and facilitating getting needed resources identified by the Work Groups.

Priority Measures / Quality Withhold Work Groups: Nine of the twelve Quality Withhold measures were identified as priority measures for improvement. The flu measure was incorporated into the Prevention and Screening Work Group which focuses on all immunizations. The Nursing Home Work Group continues to focus on improving the Nursing Home Transitions measures. The Care for Older Adults (COA) Work group was put on hold as performance for these measures continued to exceed the QW benchmarks.

Measure	Work Group
Annual flu vaccine	Prevention and Screening
Follow-up after hospitalization for mental illness within 30-days of discharge (FUH)	Behavioral Health
Controlling blood pressure (CBP)	Treatment and Utilization
Care for Older Adults (COA) - Medication Review - Functional Status Assessment	Work Group Paused
Nursing Home Measures - Skilled Nursing Facility Hospital Admissions - Skilled nursing facility discharges to the community	Nursing Home Workgroup
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Behavioral Health
Plan all-cause readmissions (PCR)	Transitions of Care
Medication Adherence for Oral Diabetes Medications	N/A
Encounter Data	N/A

The data for priority measures are collected via the following data sources:

- The set of nursing home measures are collected through the Minimum Data Set (MDS) and monitored monthly.
- COA and PCR measures are annually collected via the HEDIS data collection process. All components of the three measures are monitored throughout the measurement year.
- The Annual Flu Vaccine measure is annually collected through the Consumer Assessment of Healthcare Providers and Systems- Prescription Drug Pan (CAHPS-PDP).

The Quality Withhold Work Groups reviewed data, identified barriers to performance for the priority measures and developed and implemented interventions in 2025 to address low performance measures.

Neighborhood projects achieving 75% of the Quality Withhold by passing seven out of the eleven measures, resulting in payment of about \$10.7 million for CY 2025, the final demonstration year for MMP.

Barriers to performance include:

- Challenges in receiving MDS data that impacted the Plan's ability to accurately calculate nursing home measures.

- Vaccine hesitancy continues to widen impacting flu and other immunization measures. The flu immunization rate (67%) fell below the QW benchmark (69%).

The Quality Withhold incentive program will change in 2026 based on the State Medicaid Agency Agreement Contract for the Dually Eligible Special Needs Plans (D-SNPs).

Certified Behavioral Health Community Centers (CCBHC) Quality Improvement Program

Overview: To systematically improve performance on CCBHC quality measures, Neighborhood has established quarterly quality collaboration meetings with each of the eight CCBHCs. These meetings are designed to provide performance feedback and to partner on targeted interventions to support each CCBHC in achieving its goals.

The purpose of these collaborative sessions extends beyond maximizing quality bonus payments as outlined in the CCBHC Quality Manual. They also serve to communicate performance on all CCBHC HEDIS measures, analyze barriers to performance, and assist in developing individualized strategies to reach target rates. Neighborhood is responsible for reviewing HEDIS performance for each measure, identifying priority areas for each CCBHC, and facilitating discussions to guide the implementation of effective interventions that align with identified objectives.

Priority Measures: Priority measures (Quality Bonus Payment Measures or QBPs) for the CCBHCs are defined within the CCBHC Quality Manual. Of those measures, Neighborhood is responsible for calculating performance on the following Quality Bonus Payment measures:

- Follow-Up After Hospitalization for Mental Illness (FUH-CH and FUH-AD)
- Hemoglobin A1c (HbA1c) Control for Patients with Diabetes
- Plan All Cause Readmission (PCR)
- Initiation and Engagement of Substance Use Treatment (IET-AD)

Additionally, the following HEDIS measures are also calculated by Neighborhood and shared with CCBHCs for analysis and intervention, though they are considered “reporting only” and do not have associated quality bonus payments for performance on the measures:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)
- Antidepressant Management (AMM-AD- *retired in 2026)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)
- Follow-Up After Emergency Room Visits for Substance Use (FUA-CH and FUA-AD)
- Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH)
- Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD).

The data for both priority and reporting only measures are collected via the following data source:

- HEDIS data collection process. This information is reported on a quarterly basis to each CCBHC for review and intervention. All components of each measure are monitored throughout the performance period.

Throughout 2024, the Behavioral Health Strategic Quality Collaborative Work Group conducted a comprehensive review of performance data for all CCBHC quality measures. This process included a detailed analysis of trends and outcomes, identification of systemic and operational barriers impacting

performance, and prioritization of measures tied to quality bonus payments. The Work Group engaged in collaborative discussions to understand root causes of underperformance, assess resource needs, and develop actionable strategies aimed at improving results on these priority measures.

Result: In 2024, all Neighborhood contracted CCBHC providers were able to meet or exceed the threshold targets for the following Quality Bonus Payment (Priority) HEDIS measures:

- Follow-Up After Hospitalization for Mental Illness (7 day)- Children
- Follow-Up After Hospitalization for Mental Illness (30 day)- Children
- Plan All Cause Readmission
- Initiation of Substance Use Treatment

Neighborhood Members at 6 of the 8 CCBHCs met or exceeded the threshold target for Follow-Up After Hospitalization for Mental Illness (Adults, 7 day). Neighborhood members at 7 of the 8 CCBHCs met or exceeded the threshold target for Follow-Up After Hospitalization for Mental Illness (Adults, 30 day) and Engagement of Substance Use Treatment.

None of the CCBHCs met the threshold target for HbA1c control during this measurement year. In response to this, Neighborhood has begun to provide member level data to each CCBHC regarding this measure set. The Executive Office of Health and Human Services in Rhode Island has subsequently proposed a change in the target rates for these measures, given performance and barriers for CCBHCs in this area.

Accountable Entity Program

Overview: The Rhode Island Executive Office of Health and Human Services (EOHHS), through its contracted Medicaid Managed Care Organizations (MCOs), designed and implemented an Accountable Entity (AE) structure of the RI Medicaid Program. The AE Program goal is to provide the framework for transforming the structure of RI Medicaid's delivery and payment system as envisioned by the Reinventing Medicaid Workgroup that was convened by Governor Raimondo in March 2015. An Accountable Entity is RI Medicaid's version of an Accountable Care Organization (ACO) in which a provider organization is accountable for quality health care outcomes and the total cost of care of its population. The AE Program is a shared savings program. AEs must meet quality standards to ensure that savings are achieved through improving care coordination and providing care that is appropriate, safe, and timely. EOHHS has established quality and outcome measures on care coordination, appropriate use of preventive health services, and improved care for at-risk populations. Neighborhood is currently contracted with seven Accountable Entities across the state of Rhode Island that include approximately 77% of Neighborhood's Medicaid membership and 65% of total membership.

Total Cost of Care: The Total Cost of Care (TCOC) calculation is a fundamental element in any shared savings and/or risk arrangement. It includes a historical baseline cost of care specifically tied to an AE's attributed population projected forward to the performance period. Actual costs during the performance period are then compared to those projections to identify a potential shared savings or risk pool, depending on the terms of the arrangement.

In Program Year 7, AEs were eligible to retain up to 50% of the Shared Savings Pool. AEs assuming downside risk were eligible for up to 60% of the Shared Savings Pool and were responsible for up to 30% of the Shared Loss Pool. Of the seven Accountable Entities in operation, three assumed downside risk and four were contracted with Neighborhood for Shared Savings Only during Quality Performance Year 7 (MY2024). The shared savings/loss pool is adjusted based on the assessment of quality performance. An

overall Quality Multiplier is calculated for each AE based on the Overall Quality Score and is applied as a percentage to the shared savings/loss pool. For Shared Savings the overall quality score is adjusted upwards by 0.10 for each AE contract with a quality multiplier cap of 1. For Shared Losses the Overall Quality Score is divided by four for each AE contract to mitigate losses.

Quality: A fundamental element of the EOHHS AE program is a focus on quality. Measuring and rewarding quality as part of a value-based model is vital to ensuring that quality is maintained and improved while cost efficiency is increased. That payment model is designed to both recognize and reward historically high-quality AEs while also creating meaningful opportunities and rewards for quality improvement. Quality performance measurement is based on the Medicaid Comprehensive AE Common Measure Slate.

For QPY7 (MY2024), 14 core measures were required to be reported to EOHHS. Of the 14 core measures, 9 were pay-for-performance measures and the rest were reporting only. Benchmarks were selected by EOHHS and agreed upon by the MCO and AE with two benchmarks for each measure (Threshold and Upper Target). Each measure was assessed and scored based on performance relative to the benchmark targets. AEs could receive up to 1 point per pay for performance measure towards their Overall Quality Score. AEs began earning partial points once the threshold benchmark was met based on the following formula: $(\text{rate} - \text{threshold}) / (\text{high target} - \text{threshold})$. AEs could also earn 1 full point if the rate showed a 3-percentage point improvement from the EOHHS determined baseline. The table below shows the performance of each AE on each quality measure, plus the final computed Overall Quality Score.

QPY7 (MY2024) Accountable Entity Quality Measure Performance							
Measure	BVCHC	Coastal	IHP	Integra ***	PCHC	Prospect	Thundermist
Breast Cancer Screening*	57.47	72.32	56.73	67.70	70.97	67.67	58.22
Controlling Blood Pressure*	68.26	77.65	69.40	75.11	67.20	72.17	66.93
Chlamydia Screening**	62.68	65.15	49.11	74.38	64.97	63.81	61.55
Colorectal Cancer Screening**	49.19	65.18	44.85	54.68	53.63	58.30	45.77
Diabetic Eye Exam*	66.74	68.31	64.44	68.96	73.97	68.73	69.69
Depression Screening and Follow Up*	77.69	56.93	66.06	60.13	68.64	56.76	28.08
Developmental Screening**	90.42	83.93	67.11	81.08	57.36	84.29	34.20
Follow Up After Hospitalization for Mental Illness*	44.83	68.66	51.47	60.36	44.41	40.91	51.10
A1c <8%*	51.13	66.90	57.88	61.80	58.20	60.59	60.14
Adolescent Immunizations Combo 2**	35.98	43.09	34.25	53.86	40.72	61.19	56.25
Lead Screening*	75.93	92.67	71.56	79.32	82.70	70.83	69.70
Patient Engagement**	75.69	90.16	77.05	89.07	80.48	86.36	82.67
SDOH Screening*	38.42	27.59	19.80	45.53	60.56	38.09	11.59
Well Child Visits*	54.09	70.00	57.50	74.51	58.55	64.46	66.28
Overall Quality Score	49.55	82.79	72.10	100	81.55	81.33	53.28

* Indicates Pay for Performance Measure

** Indicates Reporting Only Measure

*** Integra does not publicly report rates

Outcome Measures Incentives: Through the Medicaid Infrastructure Incentive Program, AEs are eligible to receive funding from the Accountable Entity Incentive Pool. One of the determinants of funding eligibility is submission of and performance on a few outcome metrics related to utilization of health services. There are two outcome measures that are reported: Potentially Avoidable Emergency Department Visits and Plan All-Cause Readmissions. For OPY7, AEs needed to demonstrate attainment of a set of graduated targets set by EOHHS. The outcomes measures were weighed equally at 32.5%. EOHHS calculated targets for all measures based on an AE's total population across all MCOs, which is also how final performance was calculated. The table below shows the performance of each AE for OPY7 across both MCOs. Cells shaded in red indicate performance below the threshold to earn any incentive funds and cells shaded in green indicate performance above the 100% target. There were no instances of performance between the 25% and 100% targets.

OPY7 (CY2024) Accountable Entity Outcome Measure Performance							
Measure	BVCHC	Coastal	IHP	Integra*	PCHC	Prospect	Thundermist
Potentially Avoidable ED Visits	39.13%	33.1%	35.2%	36.5%	39.3%	37.5%	36.7%
Plan All-Cause Readmissions	0.8133	1.3563	1.3263	1.4859	1.4493	1.3261	1.2827

C. Health Equity Program

Analysis of Health Disparities by Race/Ethnicity

Opportunity Statement: According to the Kaiser Family Foundation, health and healthcare disparities have been documented for decades and reflect longstanding structural and systemic inequities rooted in racism and discrimination.

Goal: Identify areas of inequities for specific populations based on HEDIS measures, research and implement evidence-based interventions to address the identified inequities and move towards a more equitable healthcare system.

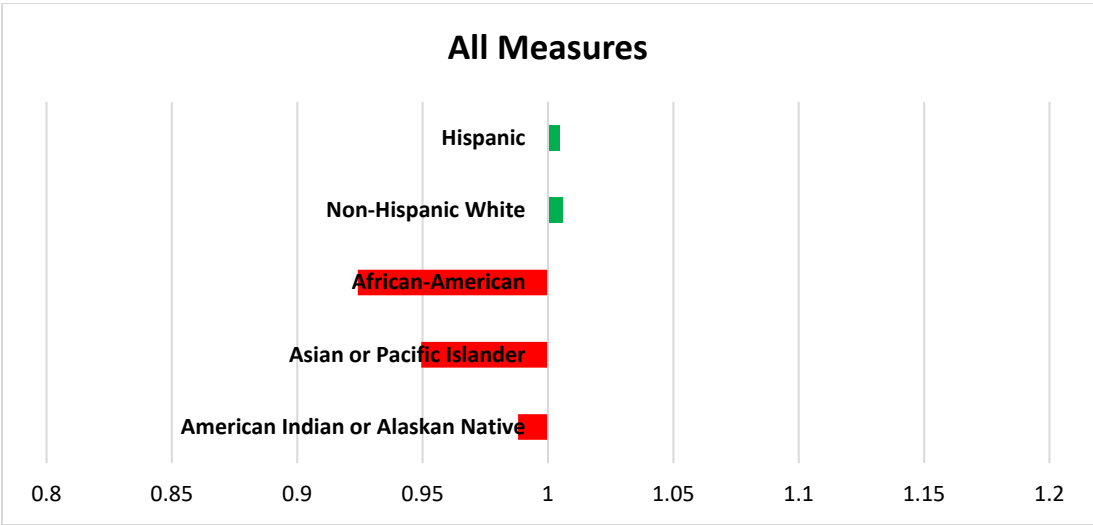
Measure/Methodology: Health care disparities within Neighborhood's Medicaid membership was assessed by producing rates for five-member race and ethnicity (R/E) groups for 85 measures collected in HEDIS MY2024. The R/E groups used in the analysis are American Indian or Alaskan Native, Asian or Pacific Islander, Black or African American, Non-Hispanic White, and Hispanic. For each measure, the rates for individual race/ethnicity groups were compared against the Plan average rate for Medicaid, excluding rates calculated on fewer than 30 members per cell. Summary indices of relative disparity were computed for all 86 measures together and for these five combinations of measures ("components of care")

- Access and Utilization (20 measures)
- Prevention and Screening (27 Measures)
- Treatment (14 Measures)
- Behavioral Health (17 Measures)
- Overuse/Appropriateness of Care (7 Measures)

The summary indices were calculated by first computing for each R/E group the ratio of the group's rate for a measure divided by the plan rate for that measure, then averaging those ratios across all the measures in the measure combinations representing components of care. A similar summary index was computed for

each R/E group based on all 86 measures (excluding measures with denominators <30). The summary indices can be interpreted as indicators combining information on both the extent of disparity (i.e., number of measures showing disparities) and the magnitude of the disparities experienced by the R/E group, with an index of less than 1.00 showing an average deficit in quality of care received relative to the overall experience of Medicaid members and an index of greater than 1.00 showing better-than average quality of care received. As the summary index gets farther away from 1.00, the greater the level of disparity.

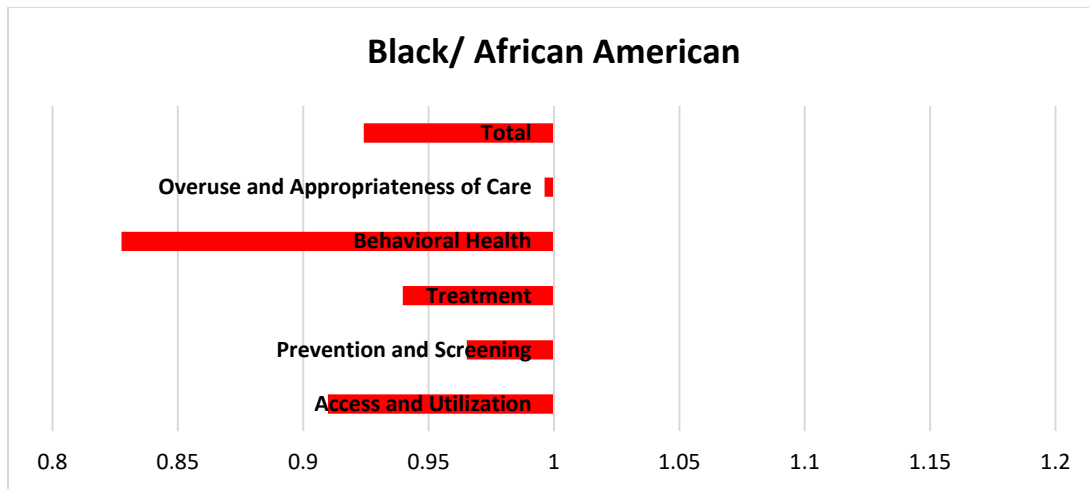
Analysis of Performance: The following graphs present the level and pattern of disparity experienced by each race/ethnicity group, based on all HEDIS measures for MY2024 for which the group has a denominator of 30 or greater.



Based on values for the summary index comprised of all measures, there are two R/E groups receiving quality of care that are just slightly better than Neighborhood’s membership as a whole and three R/E groups whose care falls below the average, in some cases well below. The index for Non-Hispanic White members is at the Plan average with an index above by 0.58% while the index for Hispanic members is above by approximately 0.44%. American Indian or Alaskan Natives experience a deficit of 1.19%; Asians experience a deficit of 5.05% (was 5.85% in MY2023), and African Americans experience a deficit of 7.59% (was 4.2 % in MY2023).

Note that the values of the total index for Asians and Pacific Islanders and American Indians and Alaska Natives are based on a subset of the individual quality measures because of the exclusion of measures for which there are fewer than 30 members in the denominator. For American Indians and Alaska Natives, only 30 of the 85 measures had denominators of 30 or greater, and for Asians and Pacific Islanders, only 33 of the 85 measures had denominators of 30 or greater. Please also note that the total index for African American members is using 84 of the 85 measures for the same denominator size exclusion.

There is a slight difference in the level of disparities compared to MY2023. The Asian population had the largest disparities across all measures in MY2023. As shown above, the African American population is now experiencing the largest disparity.



African Americans experienced the largest deficit in overall quality, at 7.59% below the average for all members. Within that performance, there was a wide range of disparities in the components of care, with quality deficits in the areas Overuse and Appropriateness of Care (0.38%), Prevention and Screening (3.48%), Treatment (6.03%), Access and Utilization (9.02%), and Behavioral Health (17.25%). Overuse and Appropriateness of Care and Treatment both moved from enhanced care to a deficit of care in relation to overall Plan performance compared to MY2023. The changes between the two measurement years are as follows: Total deficit increased by 3.39%, Overuse and Appropriateness of Care moved from 3.3% better than the Plan to 0.38% below, Behavioral Health deficit increased by 6.65%, Treatment moved from 0.8% better than the Plan to a 6.03% deficit, Prevention and Screening deficit increase by 0.58%, and Access and Utilization deficit increased by 1.82%. The most significant difference is in the Behavioral Health component of Care.

Within the components of care, rates for specific measures often drive the overall values in a positive or negative direction. For African Americans, some examples include:

- **Prevention and Screening:** The African American rate for Chlamydia Screening in Women is 12% above the Plan rate.
- **Treatment:** The African American rate for the Statin Therapy for Patients with Cardiovascular Disease - Adherence is lower than the corresponding Plan rate (21%).
- **Behavioral Health:** Rates for African American members on many behavioral health measures fell below the Plan average. The most extreme deficits were seen in these measures –
 - Antidepressant Medication Management: Continuation – 12% below Plan average
 - Follow-Up Care for Children Prescribed ADHD Medication: Initiation – 19% below Plan average
 - Follow-Up after High-Intensity Care for Substance Use Disorder: Within 7 Days and Within 30 Days are 14% below Plan average
 - Follow-Up after Emergency Department Visit for Substance Use: Within 7 Days and Within 30 Days are 11% below Plan average

The following is a list of possible priority areas for further analysis and intervention based on the findings presented above:

- Disparities in behavioral health care quality among all BIPOC R/E groups
- Disparities among African American members and Asian members across almost all the quality-of-care components
- Disparities in Treatment among African American and Hispanic members

- Disparities in Access and Utilization among all BIPOC R/E groups
- Disparities in Prevention and Screening among Non-Hispanic White, American Indian or Alaskan Native, Asian, and African American members
- Disparities in Overuse and Appropriateness of Care among Non-Hispanic White, African American, and Asian members
- Disparities in Colorectal Cancer Screening among English speakers

These priority areas identify the inequities in quality of care for the Plan to focus its intervention work.

Health Equity Initiatives

Opportunity Statement: Neighborhood's Health Equity initiatives identified by national trends, Rhode Island State trends, analysis of HEDIS measures, and claims data aim to reduce health care disparities that disproportionately affect marginalized and underserved communities.

In 2024, to address health care disparities among the Rhode Island population, Neighborhood formed three health equity work groups focused on behavioral health, maternal health and childhood health. Each work group developed goals to address disparities within behavioral health, maternal and childhood health and reports on the progress of these measures to the Population Health and Equity Committee.

In Q4 2025, a new Population Health and Equity Review Committee was established to enhance the integration of the Health Equity work into broader organizational strategy and discussions. This newly formed committee replaced the internal Health Equity Advisory Committee and the three individual Health Equity Workgroups, consolidating leadership and expertise. This Committee meets quarterly and serves as a collaborative forum for reviewing Population Health and Equity reporting and includes representatives from Clinical Strategy, Operations and Integration, Medical Leadership, Quality Improvement, Behavioral Health, Pharmacy, Product, and Analytics. Its purpose is to ensure that data, evaluations, and insights are shared across departments, enabling the development of coordinated, data-driven strategies to improve health outcomes and reduce disparities across all populations served.

Goals:

- Behavioral Health
 - Increase follow-up care for Black/African American and Hispanic members in Alcohol and Other Drug Abuse or Dependence Treatment and Initiation and Engagement of Substance Use Disorder Treatment HEDIS measures by 5% by end of 2026, with the baseline year being MY2023.
 - Increase follow-up care for Black/African American and Hispanic members in Follow Up After High-Intensity Care for Substance Use Disorder (FUI) HEDIS measure by 5% by end of 2026, with the baseline year being MY2023.
- Maternal Health
 - Decrease disparities in preterm birth rates, as measured by claims data, among Black/African American, Asian/Pacific Islanders, and Hispanic members by 5% by end of 2026, with the baseline year being MY2022.
 - Decrease disparities in very-low birthweight rates among Black/African American members by 5% by end of 2026, with the baseline year being MY2022.

- Childhood Health
 - Increase counseling for Nutrition and Physical Activity in Black/African American and Hispanic children, Weight Assessment and Counseling for Nutrition and Physical Activity in Children and Adolescents HEDIS measure by 5%, each year

In 2025, the Plan implemented several activities focused on decreasing the health care disparities noted above.

Maternal Health

- The team launch the Maternal Health Equity Designation with Women & Infants Hospital, which is the largest birthing center in the state, delivering approximately 80% of babies born in RI. The Designation includes components that recognize and support hospital facilities that provide inclusive, affirming, and equitable care to all birthing people. The Designation identifies the criteria for the core components of designation, the rationale behind each, and the operational strategies hospitals can adopt to meet the criteria and improve maternal health outcomes. The Maternal Health Equity Designation is more than a recognition—it is a roadmap for systemic change. By meeting these criteria, hospitals and obstetric facilities and community health centers can transform maternal care, reduce disparities, and build trust.
 - The Plan finalized the application process and awarded Women & Infants Hospital the first Maternal Health Designation partner after meeting all criteria and establishing Best Practices in November. Neighborhood will announce the Designation publicly in March 2026 to showcase this Best-in-Class model.
- Partnered with Blackstone Valley Community Health Care with their Perinatal Care Management program that provides resources and care management guidance for gestational hypertension patients to drive better health outcomes for both mother and baby. The Plan provides automatic blood pressure cuffs to members who stay adherent to the program to decrease emergency room visits for gestational hypertension.
 - Seven (7) automatic blood pressure cuffs have been provided to BVCHC for members identified in the program.
- Launched a Women's Health web page ([Women's Health – NHPRI.org](https://www.nhpri.org/women-health)) that includes information on benefits, plan coverage, immunizations, and pregnancy health programs with links to resources.

Childhood Health

- In response to disparities in obesity rates, declining well-visits and immunizations in children, the Plan prioritized education on the importance of well visits, vaccinations, and healthy activities in at-risk communities through annual Back to School Events throughout the state.
 - In August 2025, 9 colleagues attended four of the Back-to-School events along with our Marketing teams to distribute educational materials on nutrition, healthy eating and the importance of well visits. Nearly 1,800 community members were reached during these events. The team distributed 800 Women's Health Passports to drive better health outcomes, 500 CDC MyPlate activity sheets to drive nutritional education, and nearly 1000 flu shot reminder stickers. A trackable QR code that links to Neighborhoods website with a new Community Resource page was also displayed. This QR code produced a 5% Click rate (Goal was 3%).
- Published article in Provider Newsletter on coding best practices for the WCC (Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents) HEDIS Measure to ensure providers use appropriate codes and avoid missed opportunities.

- Included additional community resource links to our resource web page including RI Community Food Bank for food assistance programs, food pantries and meal sites, SNAP, WIC links and RIDE Free or Reduced-price School Meals application.
- Partnered with RIDOH to launch Pediatric Home Asthma Response Program to work directly with families during home visits to provide education and formulate goals, conducts an environmental home walk-through to identify potential asthma triggers, and instruct families on how to utilize strategies and supplies to remediate triggers within the home. Resources and referrals for other needs are provided, as needed.
 - 51 members received their 1st visit, 47 members 2nd visit, 24 members 3rd visit, 14 members 4th visit and 2 members so far have had the 5th visit completed.

Behavioral Health

- To address disparities identified in the Follow-Up After High Intensity Treatment (FUI) measure for Black/African American members, the Behavioral Health Equity Work Group launched a targeted three-step intervention strategy.
 - Step 1: High Intensity Treatment Facility Scorecard. In Q1 2025, Score cards were developed to understand performance on the FUI measure. These score cards highlight follow-up rates by race/ethnicity to show gaps.
 - Step 2: Peer Learning and Best Practice Sharing. Score cards were used to identify the highest-performing facility, which was engaged to share best practices. These insights were then disseminated through structured calls with lower-performing facilities, fostering peer learning and promoting equitable best in class strategies to improve FUI outcomes across the network. The Provider meetings began in Q3 2025 and will continue through Q4 2025. These meetings were an opportunity to share best practices and partner with providers to address barriers unique to their practice.
 - Step 3: Behavioral Health Transitions of Care Program offers targeted support for members discharged from inpatient behavioral health settings.
 - In 2025, the team met with several high intensity treatment facilities to review their scorecards, ensure they were aware of disparities in their follow-up care and discussed opportunities to address performance. Internally, the Plan's Behavioral Health Transitions of Care program successfully connected 263 members to Care Coordination, created 70 Care Plans, and provided members with health transitions assessments, self-management plans, connections to SDOH resources, educational resources and enrolled over 133 members into Care Management. The team will continue to monitor the disparities and rely on the Behavioral Health Transitions of Care (TOC) program for ongoing outreach to members.
- The Plan launched an Access to Care partnership with an Affordable Housing Development to create engagement events for the plan's Care Management/Care Coordinators to provide residents with connections to primary care facilities and social need resources.
 - At the October event, 20 members requested information on medical/behavioral health needs or connection to a PCP accepting new patients.

Analysis of Performance:

Dashboards were developed to measure performance against baseline metrics for each priority HEDIS measure.

Behavioral Health

- Follow-up care for Black/African American and Hispanic members in Alcohol and Other Drug Abuse or Dependence Treatment was not prioritized for intervention but was acknowledged in both CHC and CCBHC discussions as a measure currently not meeting performance goals.
- Prospective rate for MY2025 measure for Black/African American members showed a slight decrease for 7 day Follow Up (21.9% 2024 to 21.21% 2025) but a slight increase in 30 day Follow Up (48.2% 2024 to 49.2% 2025). Hispanic members had decreased follow up rates for both 7 day (37.8% 2024 to 28.3% 2025) and 30 day (62.2% 2024 to 52.6% 2025).

Maternal Health

- Timeliness of care for Black/African American pregnant members improved in 2025, with 94.5% receiving timely prenatal visits and 91.1% completing postpartum visits. Key birth outcomes also improved: the preterm birth rate for Black/African American members decreased to 7.4%. Additionally, low birthweight rate declined to 6.8% among Black/African American members and among Hispanic members dropped to 0.9%, indicating notable progress in maternal and infant health outcomes across these groups.

Childhood Health

- The MY2024 HEDIS rates for WCC decreased for Hispanic members for both Counseling for Nutrition and Physical Activity. The Population Health & Equity team will continue to drive education on nutrition and physical activities to continue to decrease these disparities.

Planned Interventions:

The Population Health and Equity Committee will continue to track the goals identified above. In addition, the Committee added a new goal to increase follow-up care for Black/African American children prescribed medication for ADHD as measured by ADD HEDIS Measure by 5% by end of 2028, with the baseline year being MY2024 (18.79% disparity).

In 2026, the following interventions will continue or be developed:

Behavioral Health

- To address disparities in follow-up care for Black/African American children prescribed ADHD medication, develop an intervention for direct outreach to Black/African American members newly prescribed an ADD medication to drive attendance to follow up appointments.
- Expand the Affordable Housing Access to Care intervention by partnering with a new housing development in southern Rhode Island to reach additional members to Behavioral Health needs and needed resources.

Maternal Health

- Continue to work with our Maternal Health Equity Designation partner (Women & Infants Hospital) to build on health equity best practices to share throughout the state.
- Develop the criteria for the OBGYN Designation and identify a Community Health Center partner.
- Continue the partnership with Blackstone Valley Community Health Care Perinatal Care Management program that provides resources and care management guidance for gestational hypertension patients.

- Continue to add additional links and resources to the Women's Health web page to ensure members have the resources and links to drive better health outcomes. ([Women's Health – NHPRI.org](https://www.nhpri.org)).

Childhood Health

- Continue to focus on the importance of well visits, vaccinations, and healthy activities in at-risk communities through annual Back to School Events throughout the state.
- Continue the partnership with RIDOH on the Pediatric Home Asthma Response Program to drive better asthma control for our pediatric members.

Culturally and Linguistically Appropriate Services (CLAS) Initiatives

Opportunity Statement: Neighborhood monitors and annually assesses utilization and experience with language services provided to its members to identify opportunities for improvement and prioritize and implement interventions to address those opportunities.

Goals: Improve Culturally and Linguistically Appropriate Services (CLAS) by implementing interventions identified through annual analysis of utilization reports and experience surveys.

Measure/Methodology: Neighborhood uses several mechanisms to evaluate members' and staff's experience with language services provided by the Plan.

- Utilization Reports
 - Utilization of Neighborhood's Language Line providing translation and oral interpretation services: A report is generated annually by Member Services.
 - Utilization of interpreter request e-form: A report is generated annually by Member Services to track utilization of the request form.
 - Utilization of Translation Services: A report is generated annually by Marketing to track the total amount spent on translation of materials for members.
- Member Experience
 - After call survey: Survey data are collected ongoing for any member who utilized Neighborhood's language services. A report is generated annually by Member Services.
 - Member Complaints: Neighborhood analyzes complaints data annually to assess any dissatisfaction with materials translated by the Plan's vendor.
 - QHP CAHPS Survey: Survey question related to experience with obtaining language services during medical appointments.
 - Supplemental Medicaid CAHPS Survey: New survey question related to experience with language services will be included in 2025.
- Staff Experience
 - Staff Survey: Neighborhood Staff are surveyed annually via email. A report is generated annually by Human Resources.

Interventions: In 2025, the Plan continued or implemented the following initiatives to improve CLAS.

- Conduct Staff Experience with Language Services Survey
- Track complaints data by language and conduct additional analysis into complaint types and resolution.
- Implement a survey for members who submit an interpreter request form to obtain experience with interpreter services.

- Monitor call volume by language to identify trends and continue oversight of Language Line vendor to ensure adequate capacity.
- Provide Annual Training to new Providers on identifying and serving LEP members

Analysis of Performance: Neighborhood evaluates the CLAS program through analysis of survey data and utilization data.

Language Services Survey

The 2025 Staff Experience with Language Services survey results showed an increase in use of Language Services with Daily use at 41% compared to 36% in 2024. Staff who reported “never” using language services decreased from 21% in 2024 to 13% in 2025, showing an increase in language services utilization.

The survey identified the following as strengths:

- Overall experience with language services increased from 70% (2024) to 72% (2025), with positive feedback relative to staffs’ experience.
- Access and ability to meet needs improved slightly. Favorability for accessing services and meeting member needs both increased 2 percentage points from 77% to 79%.
- Staff experience with wait-time perception improved from 61% in 2024 to 79%, the largest gain year-over-year.

The survey identified the following as opportunities:

- Overall quality declined from 62% in 2024 to 56%. Comments cite inconsistent interpreter proficiency, medical terminology gaps, and messages shortened or not fully relayed, especially in Spanish or specific dialects. These themes appear in both years and remain prominent in 2025.
- Multiple comments describe interpreters disconnecting mid-call, staticky connections, and needing to reconnect multiple times, which burdens staff and members.
- Staff noted inability to transfer calls with an interpreter already engaged, causing members to wait for a new interpreter after transfer; others request email confirmation with agency contact details for scheduled in-person interpreters to avoid on-site uncertainty.
- While wait times generally improved, several comments still mention long waits or unavailability for less common languages.

Member Complaints by Language

Neighborhood analyzed member complaints data from CY2024 and CY2025 to identify potential trends by language. The total number of complaints decreased in Medicaid while Exchange complaints increased.

Medicaid Complaints by Language:

- Medicaid member complaints for English as a primary language decreased by 21% (175 CY2024 to 137 in CY2025).
- There was a 24% decrease in complaints for Spanish as a primary language (52 CY2024 to 44 CY2025).
- No Medicaid complaints for Portuguese or Arabic as a primary language in CY2025.

Exchange Complaints by Language:

- There was an 18% increase in member complaints for English as a primary language, (81 CY2024 to 104 CY2025).

- A 2% increase in complaints for Spanish as a primary language (10 CY2024 to 12 CY2025).
- Member complaints for Other as a primary language had a 5% increase (4 CY2024 to 10 CY2025).
- There were no Exchange complaints for Portuguese or Arabic as a primary language in CY2025.

Total Number of Complaints Submitted				
Primary Language	Medicaid CY 2024	Medicaid CY 2025	Exchange CY 2024	Exchange CY 2025
English	175 (75%)	137 (75%)	81 (85%)	104 (83%)
Spanish	52 (22%)	44 (24%)	10 (10%)	12 (10%)
Other	3 (1%)	2 (1%)	4 (4%)	10 (8%)
Portuguese	2 (1%)	0	1 (1%)	0
Arabic	1 (<1%)	0	0	0
TOTAL	233	183	96	126

Member Services After Call Survey Results

There is a survey given to members after they contact Member Services to rate their experience. The survey includes two questions about experience with interpreter and language services.

1. Rate experience of utilizing interpreter or language services = 77.2% Best Possible Experience
2. Obtained interpreter when needed = 34.6% Always, 11.5% Usually, 23.1% Sometimes, 30.8% Never

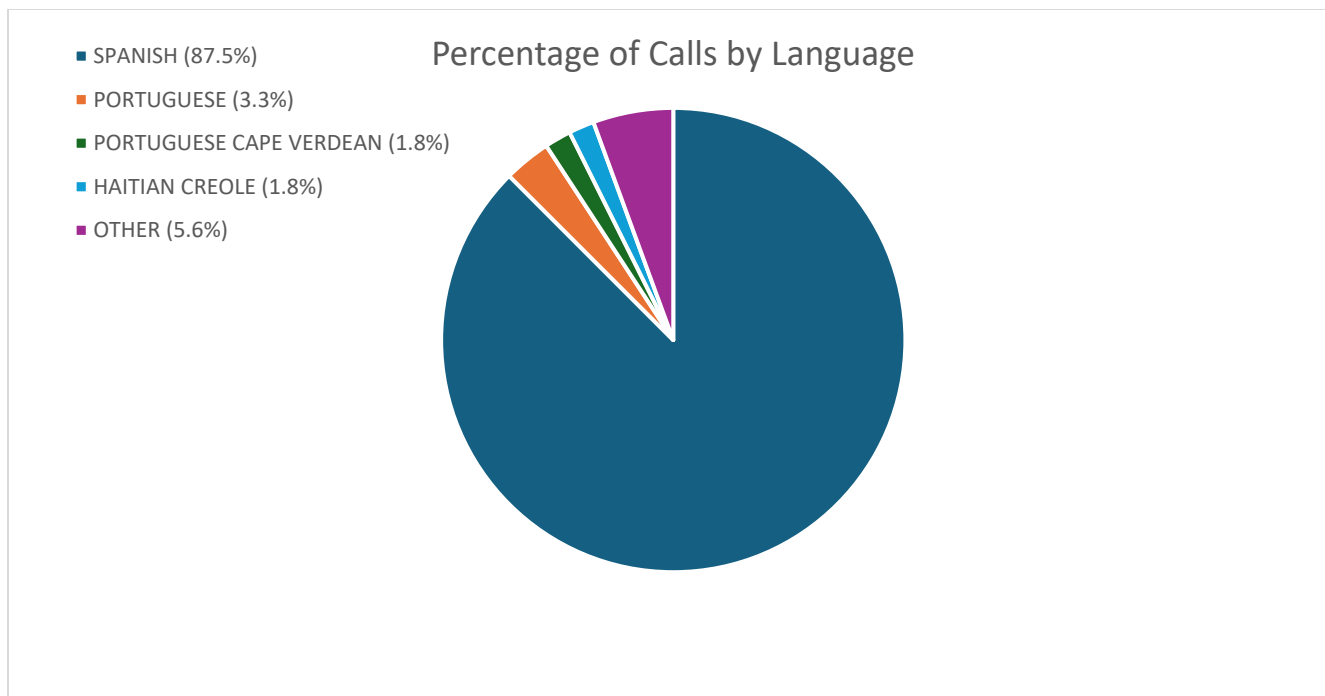
Opportunities for 2026

- Ability to work with interpreters in my preferred language decreased from 45.5% in 2024 to 34.6% in 2025. Further analysis is needed to evaluate barriers in obtaining interpreters.

2025 Call volume by language

Neighborhood utilizes a Language Line to meet the needs of members. A total of 30,159 members calls amounting to 326,103 minutes were utilized in 2025. The top languages requested were Spanish, Portuguese, Portuguese Cape Verdean, and Haitian Creole.

Neighborhood has a high volume of calls from the Spanish (26,390 calls), Portuguese (991 calls), Portuguese Cape Verdean (556 calls), Haitian Creole (537 calls) populations.



2026 Opportunities:

- Language Services Survey: While wait times have improved overall, staff still experience delays or unavailability for less common languages, signaling the need for stronger vendor coordination and resource allocation.
- The total number of Member complaints by language decreased in Medicaid CY2025 while Exchange complaints increased. Additional review is needed to understand the increase in Exchange complaints.
- Ability to work with interpreters in my preferred language decreased from 45.5% in 2024 to 34.6% in 2025. Need to evaluate barriers in obtaining interpreter when needed.

In 2026, Neighborhood will continue with the ongoing interventions noted above as well as evaluate how to strengthen end-to-end language access consistency across all touchpoints and specifically for members in the Exchange product.

D. HEDIS Performance for Priority Measures

1. Prevention and Screening Measures

Childhood Immunization Status

Opportunity Statement: According to the CDC, on-time vaccination throughout childhood is essential because it helps provide immunity before children are exposed to potentially life-threatening disease. The Rhode Island Department of Health noted a decline in statewide vaccinations in recent years.

Goals:

- Achieve the National Medicaid Quality Compass 90th percentile for HEDIS Childhood Immunization measure for two-year-old children.

Measure/Methodology:

The HEDIS measure for Childhood Immunization is measured annually and compared to Medicaid Quality Compass benchmarks. This measure is the percentage of children 2 years of age who had the following vaccines by their second birthday:

- 4 doses of diphtheria, tetanus, and acellular pertussis (DTaP)
- 3 doses of polio (IPV)
- 1 dose of measles, mumps, and rubella (MMR)
- 3 doses of haemophilus influenza type B (HiB)
- 3 doses of hepatitis B (HepB)
- 1 dose of chicken pox (VZV)
- 4 doses of pneumococcal conjugate (PCV)
- 1 dose of hepatitis A (HepA)
- 2 or 3 doses of rotavirus (RV)
- 2 doses of influenza

Interventions: The Immunization Workgroup focused on improving rates for all immunizations with the goal of analyzing available data, researching best practices and designing and implementing interventions to improve performance. The Immunization Workgroup combined with the Prevention and Screening Workgroup in July 2025. The workgroup monitored Childhood Immunization rates as performance has been in the National Medicaid QC 95th percentile for the last ten years. However, we continue with the following interventions to ensure high performance.

- **Social media:** Posted messaging about the importance of well visits and immunizations on social media channels.
- **Member Newsletters:** Published an article on how to protect yourself from cold, flu, and COVID-19.
- **Website:** Added flu information and resources on accessing a vaccine for members.
- **Incoming Call Reminder:** Medicaid and Exchange members received a general well visit and immunizations reminder.
- **Automated Phone Call:** Automated reminder to all members who needed a well visit including a vaccination reminder.
- **Provider Reports:** Member gap-in-care reports were sent to all PCPs.
- **Community Partnership:** Participated in the RI Medicaid Immunization Workgroup.

Analysis of Performance: The Plan exceeded the 2025 National Medicaid QC 90th (34.79) percentile for HEDIS Childhood Immunization measure for Age 2 with a final rate of 48.31. However, this is a 4.52 percentage points decrease from the previous year's performance (52.83). The Influenza rate continues to be the key driver to the low performance for Combo 10, followed by DTaP.

Childhood Immunization Status				
Immunization	HEDIS MY2021	HEDIS MY2022	HEDIS MY2023	HEDIS MY2024
DTaP	80.01%	83.93%	80.92%	81.28%
IPV	91.80%	93.62%	92.48%	93.22%
MMR	90.84%	92.35%	90.97%	91.77%
Hib	85.24%	87.76%	86.92%	92.68%
Hepatitis B	93.86%	94.39%	94.28%	94.87%
VZV	90.21%	92.09%	90.63%	91.57%

Pneumococcal	82.01%	86.48%	82.74%	83.13%
Hepatitis A	86.77%	90.05%	88.15%	89.30%
Rotavirus	87.52%	88.78%	88.43%	88.26%
Influenza	72.82%	69.64%	60.69%	56.21%
Combo 10	61.33%	59.95%	52.83%	48.31%

Analysis of Childhood Immunization rates by Race and Ethnicity show that the Black or African American members rate was 6.95% lower than the Plan rate, while the immunization rate for Hispanic members was 3.26% higher than the Plan rate. This is a difference of 10% between the two race ethnicity categories that had the highest and lowest rates.

Analysis of Barriers to Performance:

- Since the COVID-19 pandemic, members have experienced increased vaccination fatigue and changed vaccination habits. Members who routinely received a flu shot chose not to in the 2023-2024 flu season.
 - Two doses of the influenza vaccine are required before the age of two to meet the measure requirements. The rates for the influenza component in the measure showed a significant decline from MY2021 (72.82 to 56.21) and is the key driver in the lower overall rate.
- Vaccine hesitancy continues to grow both locally and nationally.
- Changes to the national recommended vaccine schedule could impact rates in 2026.

The Prevention and Screening Workgroup is committed to educating members on the importance of all immunizations.

Adult Immunization Status

Opportunity Statement: Immunizations are recommended for everyone to prevent serious disease, hospitalization, and death. The CDC Advisory Committee on Immunization Practices (ACIP) recommends that adults ages 19 and older receive an annual influenza vaccine and a dose of tetanus and diphtheria (Td) or tetanus, diphtheria, and pertussis (Tdap) vaccine every 10 years. The ACIP also recommends routine herpes zoster vaccination for adults 50 and older and pneumococcal vaccination for adults 65 and older. This measure addresses public health issues that impact our community.

The Immunization Workgroup focused on improving rates for all immunizations. The goal of the workgroup was to analyze available data as well as design and implement interventions to increase the number of adults who receive recommended immunizations based on their age. The Immunization Workgroup was combined with the Prevention and Screening Workgroup in July of 2025.

The Prevention and Screening Workgroup goal is to develop and implement interventions to achieve maximum performance on the prevention and screening priority measures.

Goals:

- Achieve the National Medicaid Quality Compass 90th percentile and the Medicaid Health Insurance Plan 5 Star Rating on all four components of the HEDIS Adult Immunization Status measure.

Measure/Methodology:

The HEDIS measure for Adult Immunization Status (AIS) is measured annually and compared to National Medicaid Quality Compass benchmarks.

Interventions:

- **Community Partnerships:** Leveraged partnerships to communicate flu reminders throughout the community.
- **Pharmacy Partnership:** CVS and Walgreens provided verbal flu reminders during point-of-sale.
- **Social media:** Posted messaging about the importance of well visits and immunizations on social media channels.
- **Postcards:** Flu reminder postcards were mailed by CMS to Neighborhood's MMP members.
- **Birthday Cards:** In December 2025, launched birthday cards for members turning 50 to remind them about the Zoster vaccine and members turning 65 to remind them about the Pneumococcal vaccine.
- **Member Newsletters:** Published an article on how to protect yourself from cold, flu, and COVID-19.
- **Television Interviews:** Trusted staff members appeared on Telemundo's Health Minute featuring a reminder to stay up to date on flu and COVID vaccines in Spanish.
- **Radio Ads:** Flu shot reminders on English, Spanish, and Portuguese-speaking radio stations.
- **Neighborhood Website:** Added flu information and resources on accessing a vaccine for members.
- **Incoming Call Reminder:** Medicaid and Exchange members received a general well-visit reminder.
- **Automated Phone Call:** Automated reminder to all members who needed a well visit including a vaccination reminder.
- **Flu Shot Flyer:** Distributed flu shot reminder flyer to members in the community and distributed via mail/email with electronic versions shared on the website and social media.
- **Health@Home:** The Health@Home team immunized members for influenza, pneumococcal, and zoster using targeted lists produced by the Quality Measurement and Analytics team.
- **Community Partnership:** Participated in the RI Medicaid Immunization Workgroup.

Analysis of Performance per Immunization:

- **Influenza:** The Plan did not meet the 2025 National Medicaid QC 90th (26.60) percentile for HEDIS AIS Influenza measure with a final rate of 21.59 (75th percentile). This is an increase from the previous year's performance (15.53).
- **Tdap/Td:** The Plan did not meet the 2025 National Medicaid QC 90th (61.22) percentile for HEDIS AIS Tdap/Td measure with a final rate of 44.50 (50th percentile). This is an increase from the previous year's performance (36.35).
- **Zoster:** The Plan did not meet the 2025 National Medicaid QC 90th (24.04) percentile for HEDIS AIS Zoster measure with a final rate of 12.29 (33rd percentile). This is an increase from the previous year's performance (5.91).
- **Pneumococcal:** The Plan did not meet the 2025 National Medicaid QC 90th (71.90) percentile for HEDIS AIS Pneumococcal measure with a final rate of 52.20 (50th percentile). This is an increase from the previous year's performance (42.22).

Except for the Influenza measure which was rated a 4-stars, Tdap/Td, Zoster and Pneumococcal measures were all rated 3-stars for the 2025 Medicaid Health Insurance Plan Rating; however, all four measures fell short of achieving the 5-star rating.

Immunization	HEDIS MY2021	HEDIS MY2022	HEDIS MY2023	HEDIS MY2024
Influenza	13.09%	16.02%	15.53%	21.59%
Tdap/Td	23.95%	33.79%	36.35%	44.50%
Zoster	0.90%	3.82%	5.91%	12.29%
Pneumococcal	18.99%	28.10%	42.22%	52.20%

Analysis of Adult Immunization rates by Race and Ethnicity show differences between the major race ethnicity categories. The American Indian Alaskan Native population performed much higher for flu (32.67) than the Plan with a rate 11 percentage points higher while the Asian Pacific Islander population had the lowest flu immunization rate (18.20) which was 3.39% lower than the Plan. That is a 14.5% difference between the lowest and highest performing race ethnicity categories. For zoster immunization, the Non-Hispanic White population performed 1.44% better than the Plan rate at 13.72% and the African American Population performed 2.36% below the Plan rate at 9.93%. The pneumococcal immunization rate was lowest in the African American population (49.76) and highest in the American Indian Alaskan Native population (54.51) with a difference of 4.75% between the two populations.

Analysis of Barriers to Performance:

- With the availability of COVID-19 vaccines, members experienced vaccination fatigue and changed vaccination habits.
- Many people are not aware that the newest version of the zoster vaccine is a two-dose series and have only had one dose.
- Adult vaccine history data is not robust in Rhode Island and work is needed to get the Adult Immunization Registry with more accurate and timely data.
- Vaccine hesitancy continues to grow both locally and nationally.

The Prevention and Screening Workgroup is committed to educating members on the importance of all immunizations.

Breast Cancer Screening

Opportunity Statement: Nearly 1 in 8 U.S. women (12.4%) will develop invasive breast cancer over the course of her lifetime. According to the American Cancer Society early detection is key to breast cancer survival. If detected when it is still local (Stages I and II), the five-year survival rate for breast cancer is over 99% (Cancer Facts & Figures 2018, American Cancer Society). The corresponding rates of five-year survival for cancer detected at the regional (Stage III) or distal (Stage IV) stages are 85% and 27% respectively.

Goal:

- Achieve the National Medicaid Quality Compass 90th percentile for the Medicaid product; and
- Achieve the National Quality Compass 90th percentile for the Exchange product.

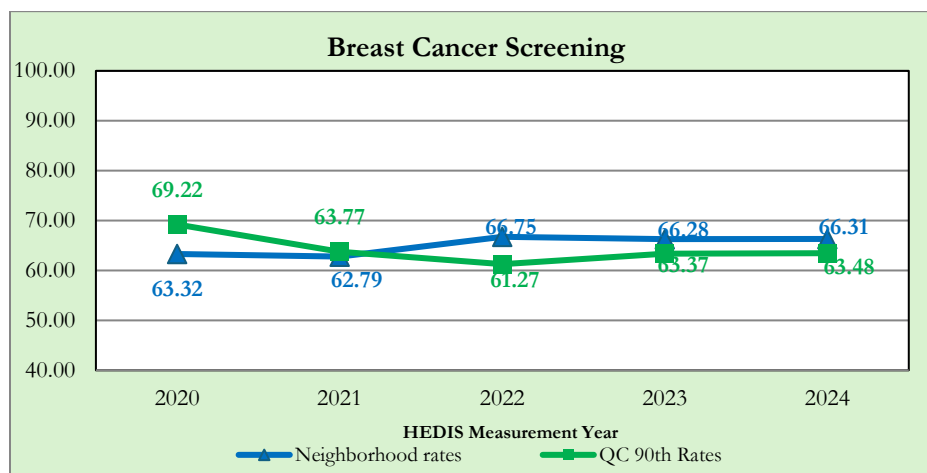
Measure/Methodology: The percentage of women 50-74 years of age who had a mammogram at any time between October 1st two years prior to the measurement year and December 31st of the measurement year, per the HEDIS technical specification for the *Breast Cancer Screening* measure.

Interventions:

- **Member Interventions:**

- Published information regarding the importance of breast cancer screening on Neighborhood's social media sites.
- Continued to offer \$25 incentive gift cards to members who received a mammogram.
 - The number of members receiving a reward decreased from 201 in 2024 to 155 in 2025.
- Women's Preventive Screening automated phone call reminder campaign for breast and cervical cancer screening.
 - The automated call reminder was sent to X members with X voicemail messages successfully delivered.
- Distributed the Women's Guide to Health Living Passport at marketing events.
 - Passports were distributed at the Back to School Summer event which is attended by thousands of families.
- **Provider Interventions:**
 - Distributed provider gap-in-care reports inclusive of a list of members in need of screening. These reports were distributed in March and August of 2025.
 - Provided an incentive-based program to Accountable Entities to address opportunities for improvement on selected HEDIS measures including the Breast Cancer Screening measure.
 - Gathered provider feedback during an Accountable Entity Quality Circle meeting to understand barriers and how to improve performance.
- **Measurement Intervention:**
 - Continued year-round chart review to gather historical mammogram results and mastectomy information and store it in a registry to augment the HEDIS seasonal data collection.
 - Continued to gather supplemental data on breast cancer screening from the Health Risk Assessments.

Analysis of Performance: The Plan's Medicaid HEDIS MY2024 rate (66.31) increased slightly compared to MY2023 rate (66.28), rating at the 2025 National Medicaid QC 90th percentile target (66.31).



Neighborhood's Medicaid MY2024 rate reflects a total eligible population of 8,490 members with 5,630 numerator events.

The Plan's MY2024 rate (76.92) for the Exchange product increased compared to MY2023 rate (74.42) rating at the 2025 National Medicaid QC 66th percentile, below the goal of the 90th QC percentile (80.39).

The Plan's MY2024 rate (70.62) for the MMP product increased slightly compared to MY2023 (69.05), rating at the 90th MMP National Percentile.

Analysis of BCS rate by Race and Ethnicity for Medicaid show that the rate for Hispanic members was 9.5% higher than the Plan rate, while the rate for Asian or Pacific Islander members was 10.76% lower than the Plan rate. This is a difference of 20% between the two race ethnicity categories that had the highest and lowest rates.

Analysis of Barriers to Performance and Planned Interventions:

- According to the Centers for Disease Control and Prevention, the fear of screening being uncomfortable is a common barrier.

The Plan will continue the following interventions:

- Conduct year-round chart review to gather historical mammogram results and mastectomy information for the supplemental database.
- Gather supplemental data on breast cancer screening from Health Risk Assessments
- Air radio ads during Breast Cancer Awareness Month to promote screening.
- Provide provider gap-in-care reports to identify women who are due for a screening.
- Offer \$25 incentive gift card to members for receiving a mammogram.
- Publish information regarding the importance of breast cancer screening on Neighborhood's social media sites.
- Continue to provide an incentive-based program to Accountable Entities to address opportunities for improvement on selected HEDIS measures including the Breast Cancer Screening measure.
- Women's Preventive Screening automated phone call campaign for breast and cervical cancer screening.
- Distribute the Women's Guide to Health Living Passport at marketing events.

The Plan will continue to meet with low-performing sites to understand barriers and share best practices learned from high-performing sites and distribute gap-in-care reports to facilitate timely screenings for members. The Prevention and Screening Workgroup will continue to analyze data, identify barriers to performance, and design and implement interventions to address those barriers, when possible.

Chlamydia Screening

Opportunity Statement: According to the Rhode Island Department of Health (RIDOH), in the last 10 years, there has been a 174% increase in reported cases of infectious syphilis, a 176% increase in reported cases of gonorrhea, and a 9% increase in reported cases of chlamydia in Rhode Island. Chlamydia cases have increased 21% among individuals 24 years and younger since 2015. If left untreated, chlamydia can cause pelvic inflammatory disease, which can lead to serious health problems, including infertility.

Goal:

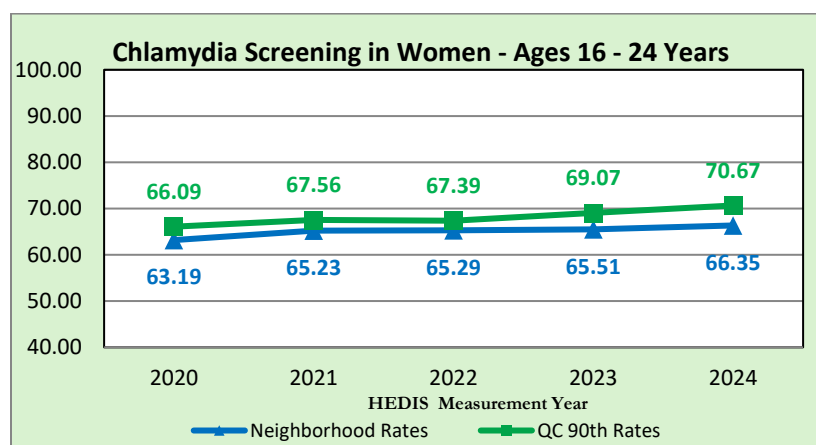
- Achieve the National Medicaid Quality Compass 90th percentile for Medicaid product.
- Achieve the National Exchange Quality Compass 90th percentile for Exchange product.

Measure/Methodology: The eligible population is all female members aged 16-24 as of December 31 of the measurement year who are identified as sexually active via claims or pharmacy data during the measurement year, per the HEDIS technical specification for the *Chlamydia Screening* measure. The measure (rate) is the percentage of these members having a claim for a chlamydia test in the year.

Interventions:

- Continued to conduct data exchange and reconciliation with the Department of Health (RIDOH) Laboratory to ensure receipt of all evidence of chlamydia screenings.
- Continued to distribute provider gap-in-care reports inclusive of a list of all non-compliant members. The provider gap-in-care reports were distributed to provider offices in March and August of 2025.
- With the addition of the measure to the Accountable Entities measures slate, added distribution of provider gap-in-care reports for the Accountable Entities monthly beginning in April 2024.
- Published an article in the provider newsletter in collaboration with RIDOH.
- Distributed the Women's Guide to Health Living Passport at marketing events.
- Worked with School-based Health Centers to get members screened while at school.

Analysis of Performance: The Plan's Medicaid Chlamydia Screening (CHL) total rate (16-24 years) for MY2024 (66.35) increased slightly compared to the MY2023 rate (65.51), remaining in the 2025 National Medicaid QC 75th percentile, missing the goal of achieving the 2025 National Medicaid QC 90th percentile (70.67).



Neighborhood's MY2024 rate reflects a total eligible population of 6,455 members with 4,283 numerator events.

In terms of the Exchange population, the Plan's HEDIS MY2024 rate (59.70) increased compared to MY2023 rate (56.21), landing in the 2025 Exchange Quality Compass 75th percentile.

Analysis of CHL Medicaid rates by Race and Ethnicity reveal that the screening rate for Hispanic members was 4.65% higher than the Plan rate, while the screening rate for Non-Hispanic White members was lowest at 5.79% below the Plan rate. The difference between the highest and lowest performing race ethnicity categories was roughly 10%.

Barriers to Performance and Planned Interventions:

- Inconsistent screening practices among providers, leading to missed opportunities while the member is at the provider office.
 - **Planned Intervention:** Collaborate with the Rhode Island Department of Health (RIDOH) to increase Chlamydia Screening rates in Rhode Island.
- Providers only screening members they believe need screenings and do not have a universal screening policy.

The Plan will continue the following member and provider interventions in 2026:

- Encourage providers to screen all members ages 16-24 for Chlamydia, regardless of evidence of sexual activity.
- Distribute gap reports to provider offices with a list of members in need of screening.
- Distribute the Women's Guide to Health Living Passport at marketing events.
- Conduct data exchange and reconciliation with the Rhode Island Department of Health Laboratory to ensure receipt of all evidence of Chlamydia screenings.
- Conduct site visits to learn best practices and barriers to aid in designing targeted interventions.
- Publish an article in the provider and member newsletters in collaboration with RIDOH.
- Continue to support an incentive-based program to Accountable Entities with addition of the measure to the measure slate.

The Plan will continue to meet with low-performing sites to understand barriers and share best practices learned from high-performing sites and distribute gap-in-care reports to facilitate timely screenings for members. The Prevention and Screening Workgroup will continue to analyze data, identify barriers to performance, and design and implement interventions to address those barriers, when possible.

Cervical Cancer Screening

Opportunity Statement: Cervical cancer is one of the most preventable forms of cancer, according to the American Cancer Society, yet it continues to claim thousands of women's lives annually. According to the CDC, each year in the United States, about 13,000 new cases of cervical cancer are diagnosed about 4,000 women die of this cancer. Hispanic women have the highest rates of developing cervical cancer, and Black women have the highest rates of dying from cervical cancer.

Goal:

- Achieve the National Medicaid Quality Compass 90th percentile for the Medicaid product; and
- Achieve the Quality Compass 90th percentile for the Exchange product.

Measure/Methodology: Percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human pap.

Interventions:

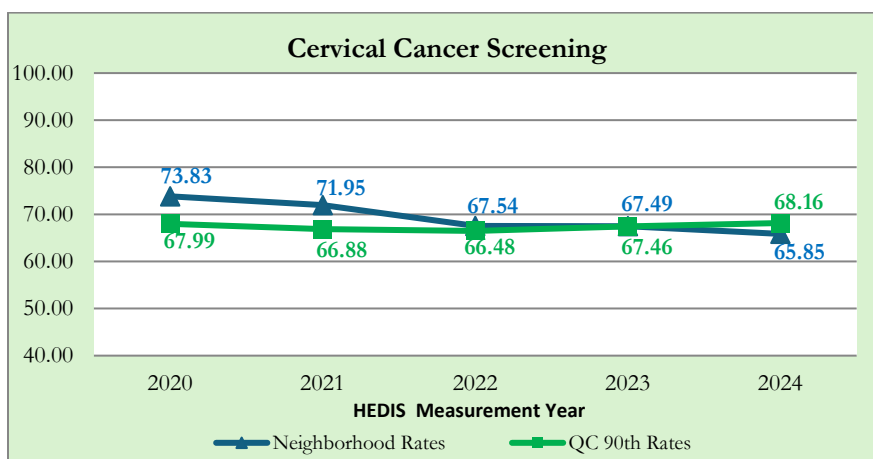
- **Member Interventions:**
 - Case Management provided screening reminders based on the member's last cervical cancer screening.
 - Social media messaging on the importance of cervical cancer screening and other screenings.
 - Distributed the Women's Guide to Health Living Passport at marketing events.
 - Women's Preventive Screening automated phone call reminder campaign for breast and cervical cancer screening.
- **Provider Interventions:**
 - Distributed provider gap-in-care reports inclusive of a list of members in need of CCS.
 - Published provider newsletter on the importance of screening members for cervical cancer.
 - Mailed CCS Measure Description & Age Timeline Grid- Mailing letters with grid to all OBGYN Offices.

- **Measurement Intervention:**

- Continued year-round chart review to gather historical CCS results and hysterectomy information and store it in a supplemental database to augment the HEDIS seasonal data collection.
- Continued to gather supplemental data on Cervical Cancer Screening from the Health Risk Assessments.

Analysis of Performance:

The Plan's hybrid Medicaid HEDIS MY2024 rate (65.85) decreased compared to MY2023 rate (67.49), rating at the 2025 National Medicaid QC 75th percentile (67.46) and below the 90th percentile (68.16) target.



Neighborhood's MY2024 rate reflects a total eligible population of 366 members with 241 numerator events.

The Plan's MY2024 rate (61.62) for the Exchange product decreased compared to MY2023 rate (71.34), rating at the 2025 National Exchange QC 50th percentile and below the 90th percentile target (72.22).

Analysis of CCS Medicaid administrative rates by Race and Ethnicity show that the rate for American Indian or Alaskan Native members was 10% lower than the Plan rate and the Hispanic members rate was 7% higher than the Plan rate. This is a difference of 17% between the two race ethnicity categories that had the highest and lowest rates.

Analysis of Barriers to Performance and Planned Interventions:

- According to the Centers for Disease Control and Prevention, the fear of screening being uncomfortable is a common barrier for lack of screening.
- The Cervical Cancer Screening hybrid method was retired and replaced with the electronic version for MY2025 which may result in lower rates based on historic performance.
- Newly approved at-home screening kits may increase screening rates but have not yet been added to measure specifications and may have impact on already decreasing rates in 2026.

The Plan will also continue the following interventions:

- Case Management providing member education based on the member's last cervical cancer screening.
- Social media messaging on the importance of cervical cancer screening and other screenings.
- Distribute the Women's Guide to Health Living Passport at marketing events.

- Women's Preventive Screening automated phone call campaign for breast and cervical cancer screening.
- Distributing provider gap-in-care reports inclusive of a list of members in need of CCS.
- Publishing provider newsletter on the importance of screening members for cervical cancer.
- Mailing CCS Measure Description & Age Timeline Grid- Mailing letters with grid to all OBGYN Offices.
- Continue year-round chart review to gather historical CCS results and hysterectomy information and store it in a registry to augment the HEDIS seasonal data collection.
- Continue to gather supplemental data on Cervical Cancer Screening from the Health Risk Assessments.

The Plan will continue to meet with low-performing sites to understand barriers and share best practices learned from high-performing sites and distribute gap-in-care reports to facilitate timely screening for members. The Prevention and Screening Workgroup will continue to analyze data, identify barriers to performance, and design and implement interventions to address those barriers, when possible.

Colorectal Cancer Screening

Opportunity Statement: According to the American Cancer Society, in the United States, colorectal cancer is the third-leading cause of cancer-related deaths in men and the fourth-leading cause in women, but it is the second most common cause of cancer deaths when numbers for men and women are combined.

The death rate from colorectal cancer has been dropping in older adults for several decades. Screening results in many colorectal cancers being found earlier, when they are likely to be treated easier. However, more than a third of adults 50–75 do not get recommended screenings. In addition, treatments for colorectal cancer have improved over the last few decades. In people under 55, however, death rates have been increasing about 1% per year since the mid-2000s.

Although Neighborhood rate in the QC 90th percentile, the absolute rates of screening remain low.

Goal:

- Achieve the National Medicaid Quality Compass 90th percentile for the Medicaid product;
- Achieve the National Quality Compass 90th percentile for the Exchange product; and
- Achieve the 90th MMP National Percentile for the MMP product.

Measure/Methodology: Percentage of patients aged 45-75 who had an appropriate screening for colorectal cancer.

- Colonoscopy – measurement year or 9 years prior
- Flexible Sigmoidoscopy – measurement year or 4 years prior
- CT Colonography – measurement year or 4 years prior
- Stool DNA (sDNA) with FIT Test – measurement year or 2 years prior
- iFOBT, gFOBT, FIT – measurement year

Per the HEDIS technical specification for the *Colorectal Cancer Screening* measure.

Interventions:

- **Member Interventions:**
 - Women's Guide to Health Living Passport distributed at Marketing events.

- Social media messaging on the importance of Colorectal Cancer Awareness Month in March.
- **Provider Interventions:**
 - Distributed provider gap-in-care reports inclusive of a list of members in need of colorectal cancer screening. The gap-in-care reports were distributed to provider offices in 2023 and 2024.
- **Measurement Intervention:**
 - Continued year-round chart review to gather historical COL results and Colectomy information and store it in a registry to augment the HEDIS seasonal data collection.
 - Continued to gather supplemental data on Colorectal Cancer Screening from the Health Risk Assessments.

Analysis of Performance: The Plan's Medicaid HEDIS MY2024 rate (55.04) increased from MY2023 (52.14) and rated at the 2025 National Medicaid QC 90th percentile target (53.31).

The Plan's MY2024 rate for the Exchange product decreased from 62.90 in MY2023 to 60.05. Colorectal Cancer Screening is not a measure included in the 2025 Quality Compass for Exchange.

The Plan's MY2024 rate for the MMP product decreased from 66.38 in MY2023 to 64.85, rating at the 90th MMP National Percentile. Both reported rates from MY2023 for MMP and Exchange were not the ECDS version of the measure.

Analysis of Medicaid COL rates by Race and Ethnicity show that Hispanic members rate was 7.72% higher than the Plan rate, while the rate for Asian members was 7.86% lower than the Plan rate. This is a difference of 15.57% between the two race ethnicity categories that had the highest and lowest rates.

Analysis of Barriers to Performance and Planned Interventions:

- According to the Centers for Disease Control and Prevention, the fear of screening being uncomfortable is a common barrier.
 - **Planned Intervention:** Explore partnering with a CHC and lab to collaborate on distributing noncompliant members a FOBT/FIT kit.
- Colonoscopy takes a day for prep and a day to complete the screening. It is a barrier for members to have to take time off from work. Also, members would need a ride to and from the procedure that is not a taxi/rideshare.

The Plan will also continue the following interventions:

- Distribute the Women's Guide to Health Living Passport at marketing events.
- Social media messaging on the importance of Colorectal Cancer Awareness Month in March.
- Distributing provider gap-in-care reports inclusive of a list of members in need of screening.
- Continued year-round chart review to gather historical COL results and Colectomy information and store it in a registry to augment the HEDIS seasonal data collection.
- Continued to gather supplemental data on Colorectal Cancer Screening from the Health Risk Assessments.

The Plan will continue to meet with low-performing sites to understand barriers and share best practices learned from high-performing sites and distribute gap-in-care reports to facilitate timely screenings for members. The Prevention and Screening Workgroup will continue to analyze data, identify barriers to performance, and design and implement interventions to address those barriers, when possible.

2. Treatment and Utilization Measures

Avoidance of Antibiotic Treatment in People with Acute Bronchitis

Opportunity Statement: According to the National Committee for Quality Assurance (NCQA), viruses cause approximately 90% of acute bronchitis cases, while bacteria account for less than 10%. Most cases of acute bronchitis are viral and do not require antibiotic therapy. Inappropriate antibiotic treatment is a public health concern and misuse and overuse may contribute to antibiotic resistance, Clostridium Difficile infections, and other side effects. The Plan's HEDIS rate for this measure has been trending below the national Medicaid Quality Compass 90th percentile. Avoidance of Antibiotic Treatment in People with Acute Bronchitis (AAB) is a priority measure for the Plan.

Goal:

- Achieve the National Medicaid Quality Compass 75th percentile for Medicaid product; and
- Achieve the National Exchange Quality Compass 90th percentile for the Exchange product.

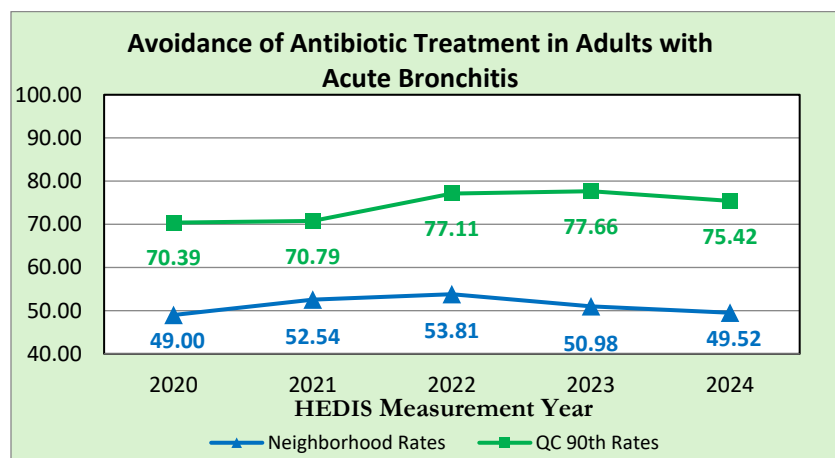
Measure/Methodology: The percentage of members 3 months-65 years old with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic prescription, per the HEDIS technical specification for the *Avoidance of Antibiotic Treatment in People with Acute Bronchitis/ Bronchiolitis* measure.

Interventions:

- Published information regarding the importance of avoidance of antibiotics through the social media platform Facebook.
- Published an article in the provider newsletter titled “Appropriate Antibiotic Use” outlining Neighborhood’s performance and recommendations on how to improve the rate.
- Distributed provider educational materials about antibiotic use for bacterial infections and non-viral infections during provider site meetings at Urgent Care Center.

Analysis of Performance: The Plan’s Medicaid HEDIS MY2024 rate (49.52) decreased compared to MY2023 rate (50.98), rating in the 2025 National Medicaid QC 10th percentile and below the goal of achieving the 2025 QC 90th percentile (75.42).

The Plan’s Exchange rate (34.93) for MY2024 decreased compared to MY2023 rate (35.79), landing in the 2025 Exchange Quality Compass 10th percentile.



*Neighborhood’s MY2024 rate reflects a total eligible population of 2,603 members with 1,314 numerator events.
Note: Measure is an inverse rate.*

Analysis of Medicaid rates by Race and Ethnicity show that the White member rate was 14.31% lower than the Plan rate, while rate for Black or African American members was 6.49% higher than the Plan rate. This is a difference of about 20% between the two race ethnicity categories that had the highest and lowest rates.

Barriers to Performance and Planned Interventions:

- Members may be unaware that antibiotics are not an effective way to treat Bronchitis/Bronchiolitis.
 - **Planned Intervention:** Create and disperse a poster to provider offices that displays the appropriate treatment course for bronchitis/bronchiolitis.

The Plan will continue the following member and provider interventions in 2026:

- Raise awareness through social media platforms.
- Educate CHCs and AEs on effective over-the-counter medications to treat illnesses in lieu of an antibiotic.
- Fax letters to low-performing Urgent Care Centers highlighting performance and helpful tips on how to improve.
- Publish a provider newsletter article highlighting Neighborhood's AAB performance and Centers for Disease Control and Prevention helpful tips for prescribing antibiotics.
- Publish a member newsletter article highlighting the facts about overuse of antibiotics.

The Quality Improvement Workgroup for Treatment and Utilization will continue to analyze data, identify barriers to performance, and design and implement interventions to address those barriers, when possible.

HIV Program: Viral Load Suppression <200 Viral Load

Opportunity Statement: In conjunction with evidence-based guidelines and patient-specific factors, there are opportunities to develop a collaborative and effective management program between Neighborhood and the Rhode Island Department of Health (RIDOH) relating to patients with HIV. By partnering with the RIDOH, Neighborhood will work to improve HIV medication therapy adherence, decrease gaps in care, and help to return HIV members to care who may have been considered "lost to care."

Goal: The goal of this partnership is to help the RIDOH meet the state's 90/90/90 campaign goal. This campaign is to reach the following goals:

- 90% of patients with HIV are aware of their HIV diagnosis
- 90% of patients who are aware of their HIV diagnosis are receiving treatment
- 90% of patients who are receiving treatment for HIV have an undetectable viral load

Measure/Methodology: Neighborhood will utilize its pharmacy claims system to collect medication adherence data and use this information to target specific individuals who are determined to be non-adherent to their medication or "lost to care."

Interventions:

60 Day Intervention

- Neighborhood runs a claims data report on a weekly basis to identify members that have not filled their medication within 60 days of when their next calculated fill should have occurred.
- Neighborhood will notify the member's prescriber of the gap in prescription fill history and provide information to the prescriber regarding the RIDOH's Lost to Care referral program.
- After referral by the provider, the RIDOH will work closely with the identified members to re-enroll them in care if the member is lost to follow up by engaging them in the Lost-To-Care-Program.

- The RIDOH will re-engage a member by reaching out to them via telephone, text messages, field visits in the community and sending letters. Once contact is made, the RIDOH will assess what barriers to care the member has and work with the provider and member to provide them with resources to re-enter care. For example, if the barrier to care is transportation, the RIDOH will provide to the member taxi services and bus tickets.

To improve provider contact, a process was implemented where the Pharmacy Department contacts the Infectious Disease Nurse Care Manager or Office Pharmacist directly.

Analysis of Performance:

60-Day Intervention (Data: January 1st, 2025 through December 31st, 2025)

- Neighborhood's Pharmacy Department attempted outreach to the providers of 119 members who had not filled their medication within 60 days of when the medication was due for refill. Outreach to the prescriber's office was successful for 92 of these cases.
 - The intervention led to 1 member being referred to RIDOH.

Analysis of Barriers to Performance and Planned Interventions:

- Inability to see member's claims that are not adjudicated through Neighborhood's system.
- Members can be difficult to reach due to phone numbers not being in service or incorrect contact information.

Kidney Health Evaluation for Patients with Diabetes

Opportunity Statement: Diabetes is the leading cause of chronic kidney disease (CKD), with approximately one in three adults with diabetes diagnosed with CKD. The disease occurs when an individual's kidneys are damaged and unable to filter blood effectively. As many as 90% of those with CKD are not aware they have it because it often has no symptoms. CKD can worsen over time, leading to severe complications such as heart disease, stroke, and kidney failure. Thus, annual monitoring of kidney health is crucial for people with diabetes to prevent these outcomes and mitigate further kidney damage.

The new Healthcare Effectiveness Data Information Set (HEDIS®) Kidney Health Evaluation for Patients with Diabetes (KED) measure tracks the percentage of adults with diabetes (age 18-85) who received an annual kidney health evaluation. This includes tests for both an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR). The National Kidney Foundation-developed "kidney profile" amplifies testing that combines the eGFR, which assesses kidney function, with the uACR, which assesses kidney damage.

Goal:

- Achieve or exceed the National Medicaid Quality Compass 90th percentile; and
- Achieve the National Exchange Quality Compass 90th percentile.

Measure/Methodology:

Percentage of patients 18–85 years of age with diabetes (type 1 and type 2) who had a kidney health evaluation in the measurement year. Both eGFR and a uACR are required on the same or different dates of service.

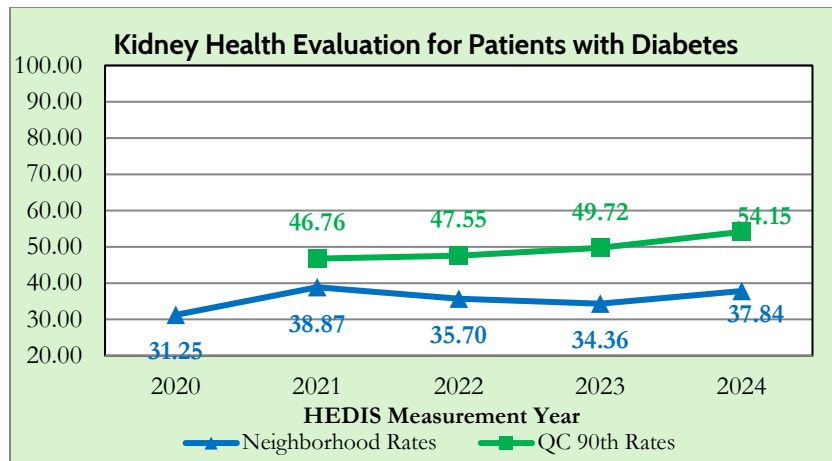
- At least 1 estimated glomerular filtration rate (eGFR); AND
- At least 1 urine albumin-creatinine ratio test identified by one of the following:
 - A quantitative urine albumin test AND a urine creatinine test 4 or less days apart

- A uACR test

Interventions:

- Distributed non-compliant provider Gap Reports for uACR and eGFR in August 2025
- Distributed the Women's Guide to Health Living Passport at marketing events
- Published a provider newsletter article on kidney health and screenings
- Social Media postings on National Kidney Month in March
- Met with low- and high-performing provider sites to discuss barriers and shared best practices.

Analysis of Performance: The Plan's Medicaid HEDIS MY2024 rate (37.84) increased compared to MY2023 rate (34.36), rating in the 2025 QC 25th percentile, below the Plan's goal of 2025 National Medicaid QC 90th percentile (54.15).



Neighborhood's MY2024 rate reflects a total eligible population of 9,051 members with 3,425 numerator events.

The Plan's Exchange rate (35.78) for MY2024 increased compared to MY2023 rate (33.27) landing at the 2025 Exchange Quality Compass 10th percentile.

Analysis of Medicaid rates by Race and Ethnicity show that the Asian or Pacific Islander member rate was 8.11% higher than the Plan rate, while rate for Non-Hispanic White members was 2.92% lower than the Plan rate. This is a difference of 11% between the two race ethnicity categories that had the highest and lowest rates. The highest performing age group is 45-64 with a rate of 41.38% and is 3.54% higher than Neighborhood's overall rating.

Barriers to Performance and Planned Interventions:

- Practitioner's not ordering the uACR lab test.
 - **Planned Intervention:** Educate providers on the lab data sets to include for proper testing.

The Plan will continue the following member and provider interventions in 2026:

- Distribute non-compliant provider Gap Reports for uACR and eGFR in August 2026
- Distribute the Women's Guide to Health Living Passport at marketing events.
- Publish a provider newsletter article
- Social Media Postings on National Kidney Month in March 2026
- Meet with provider sites to discuss barriers and share best practices.
- Educate CHC and AEs on the importance of ordering the uACR along with the eGFR lab test for their diabetic panel.

The Quality Improvement Workgroup for Treatment and Utilization will continue to analyze data, identify barriers to performance, and design and implement interventions to address those barriers, when possible.

Statin Therapy for Patients with Cardiovascular Disease

Opportunity Statement:

According to NCQA, cardiovascular disease is the leading cause of death in the United States. It is estimated that 92.1 million American adults have one or more types of cardiovascular disease (Benjamin et al., 2017). People with diabetes also have elevated cardiovascular risk, thought to be due in part to elevations in unhealthy cholesterol levels. Having unhealthy cholesterol levels places people at significant risk for developing atherosclerotic cardiovascular disease (ASCVD).

Goal:

- Achieve the National Medicaid Quality Compass 90th percentile; and
- Achieve the National Exchange Quality Compass 90th percentile.

Measure/Methodology:

The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1. **Received Statin Therapy.** Patients who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year.
2. **Statin Adherence 80%.** Patients who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

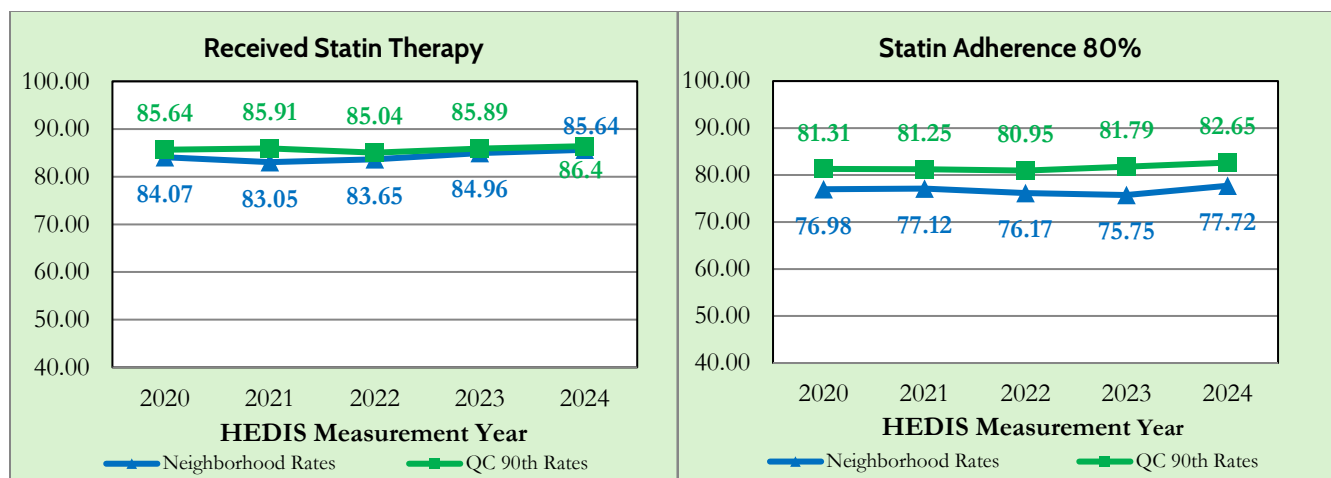
Interventions:

- Pharmacy Team modified several statin medications to be 90-day refills from 30-day refills to promote medication continuation of a statin
- Social Media postings on American Heart Month in February.

Analysis of Performance:

The Plan's Medicaid HEDIS rate for prescribing at least one statin medication during the year increased to 86.40% in MY2024 from 84.96% in MY2023, rating at the 2025 QC 75th percentile. The Plan's Medicaid rate of members who remained on a statin medication for at least 80% of the treatment period increased to 77.72% in MY2024 from 75.75% in MY2023 and rating at the 2025 QC 75th percentile.

Exchange Quality Compass percentiles were not published for this measure.



Neighborhood's MY2024 rate reflects a total eligible population of - Statin Received: 933 members with 799 numerator events. Statin Adherence: 799 members with 621 numerator events.

Analysis of Medicaid rates by Race and Ethnicity show that for the Statin Received component of the measure, the rate for Black/African American members was 7.07% lower than the Plan rate while the rate for Hispanic members was 5.03% above the Plan rate. For the Statin Adherence component of the measure, Black or African American was 20.09% lower than the Plan rate while the Non-Hispanic White members was 6.86 lower than the Plan rate. This is a difference of 12.10% for received statin and 25.97% for statin adherence between the two race ethnicity categories that had the highest and lowest rates with a denominator above 30.

Barriers to Performance and Planned Interventions:

- Patients not consistently picking up or taking statin medications:
 - **Planned Intervention:** Add medication delivery of statins as a covered and advertised benefit.

The Plan will continue the following member and provider interventions in 2026:

- Promote provider and member education to diabetic patients about the importance of taking medications regularly to manage cholesterol levels effectively.
- Continue the 90-day refill policy for statins to promote medication continuation of a statin
- Social Media postings on American Heart Month in February.

The Quality Improvement Workgroup for Treatment and Utilization will continue to analyze data, identify barriers to performance, and design and implement interventions to address those barriers, when possible.

Statin Therapy for Patients with Diabetes

Opportunity Statement:

For individuals with diabetes, managing cholesterol is crucial due to their increased risk of atherosclerotic cardiovascular disease (ASCVD), a leading cause of health complications in this group. Effective cholesterol management can significantly reduce morbidity and mortality associated with diabetes.

- **Statin Therapy for Patients with Diabetes (Ages 40-75 without ASCVD)**
 - The Plan's Medicaid rate for prescribing at least one statin medication during the year decreased to 69.02% in MY2024, down from 70.03% in MY2023.

- **Statin Adherence 80% for Patients with Diabetes**

- The Plan's Medicaid rate assessing members who maintained a statin medication for at least 80% of the treatment period saw an improvement to 71.85% in MY2024 from 67.61% in MY2023.

Goal:

- Achieve or exceed the 2025 National Medicaid Quality Compass 90th percentile; and
- Achieve the 2025 National Exchange Quality Compass 90th percentile.

Measure/Methodology:

Per the HEDIS technical specification for the *Statin Therapy for Patients with Diabetes* measure. The percentage of patients 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

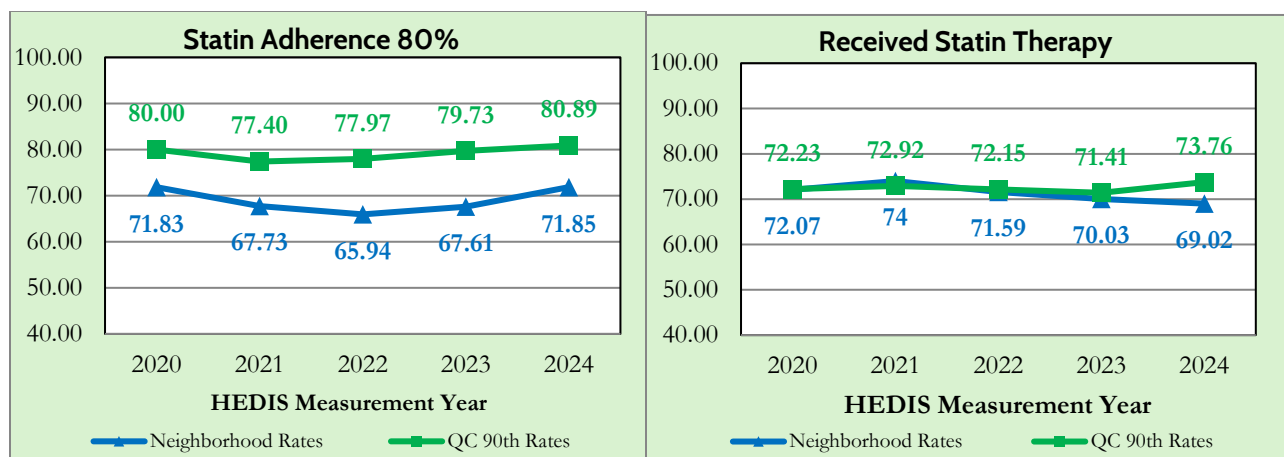
1. Received Statin Therapy. Patients who were dispensed at least one statin medication of any intensity during the measurement year.
2. Statin Adherence 80%. Patients who remained on a statin medication of any intensity for at least 80% of the treatment period.

Interventions:

- Pharmacy Team modified several Statin Medications to be 90-day refills from 30-day refills to promote medication continuation of a Statin.
- Published a provider newsletter article.

Analysis of Performance: The Plan's Medicaid HEDIS rate for prescribing at least one statin medication during the year decreased to 69.02% in MY2024, down from 70.03% in MY2023, rating at the 2025 National Medicaid QC 75th percentile. The Plan's Medicaid rate of members who maintained a statin medication for at least 80% of the treatment period improved to 71.85% in MY2024 from 67.61% in MY2023 and rating at the 2025 National Medicaid QC 50th percentile.

Exchange Quality Compass percentiles were not published for this measure.



Neighborhood's MY2024 rate reflects a total eligible population of Statin Received: 5,332 members with 3,680 numerator events. Statin Adherence: 3,680 members with 2,644 numerator events.

Analysis of Medicaid rates by Race and Ethnicity show that for the Statin Received component of the measure, the rate for Black or African American members was 1.41% lower than the Plan rate while the rate for American Indian or Alaskan Native members was 12.42% higher than the Plan rate. The difference

between the highest and lowest race ethnicity categories is 13.83%. For the Statin Adherence component of the measure, Black or African American was 2.27% lower than the Plan rate while the Non-Hispanic White members was 9.07% higher than the Plan rate. This is a difference of 11.34% between the two race ethnicity categories that had the highest and lowest rates.

Barriers to Performance and Planned Interventions:

- Patients not consistently picking up or taking statin medications:
 - **Planned Intervention:** Add medication delivery of statins as a covered and advertised benefit.

The Plan will continue the following member and provider interventions in 2026:

- Promote provider and member education to diabetic patients about the importance of taking medications regularly to manage cholesterol levels effectively
- Continue the 90-day refill policy for statins to promote medication continuation of a statin
- Social Media postings on American Heart Month in February

The Quality Improvement Workgroup for Treatment and Utilization will continue to analyze data, identify barriers to performance, and design and implement interventions to address those barriers, when possible.

3. Behavioral Health Measures

Antidepressant Medication Management

Opportunity Statement: The HEDIS rate for the Antidepressant Medication Management (AMM) measure for Medicaid continues to rate below the National Medicaid Quality Compass 90th percentile. The AMM HEDIS measure is one of the high-priority measures identified in the “Medicaid Quality Improvement Plan.” According to the World Health Organization (WHO), depression is the 4th leading cause of disability. Depression contributes to the worsening of medical illnesses and often co-occurs with other chronic conditions.

Goal: Achieve the 2025 QC National Medicaid 75th percentile for Effective Acute Phase Treatment and 75th percentile for the Effective Continuation Phase Treatment.

Measure/Methodology: The eligible population for this measure is members who were 18 years of age and older as of April 30th of the measurement year, who were treated with antidepressant medication, had a diagnosis of major depression, and remained on an antidepressant medication treatment. The AMM measure is collected via administrative data (claims data) and is reported in the following two components:

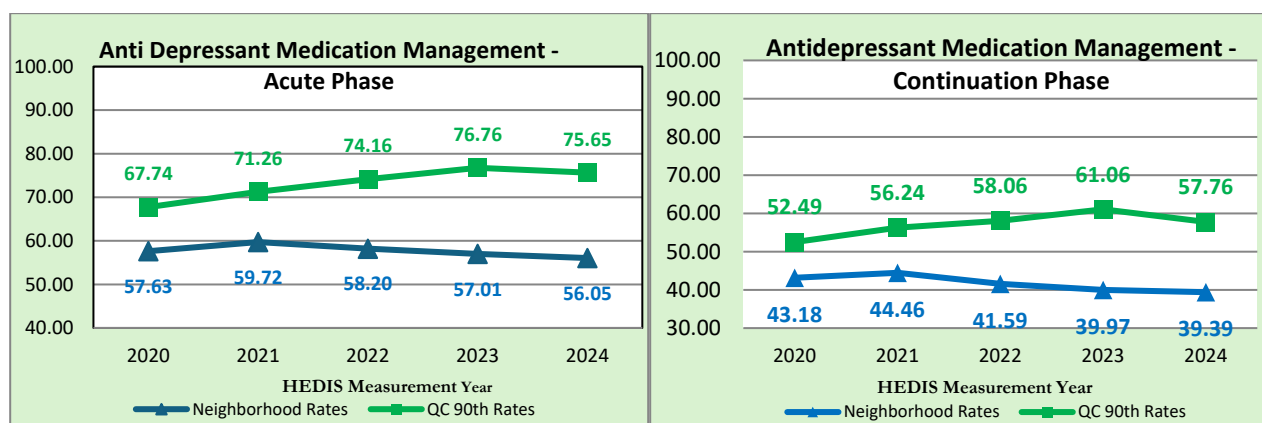
1. **Effective Acute Phase Treatment.** The percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks).
2. **Effective Continuation Phase Treatment.** The percentage of members who remained on an antidepressant medication for at least 180 days (6 months).

Interventions:

- Optum continued to educate outpatient behavioral health prescribing practitioners, targeted for having treated five or more adult members within the past 12 months, through an educational email titled "Best Practice for the Treatment of Depression and Bipolar Disorder." (Discontinued on 8/31/25 due to termination of Neighborhood's contract with Optum)

- Optum distributed “Behavioral Health Toolkit for Medical Providers” via the Provider Express website. (Discontinued on 8/31/25 due to termination of Neighborhood’s contract with Optum)
- Neighborhood obtained a weekly automated report using Caremark’s claim system identifying Thundermist members new to therapy. Neighborhood pharmacists initiated telephonic intervention and reached out to the members at 3-, 6-, and 12-weeks post filling of the initial prescription to encourage medication adherence and provider follow up.

Analysis of Performance: The Plan’s Medicaid HEDIS MY2024 rate (56.05) for the AMM Effective Acute Phase decreased compared to HEDIS MY2023 rate (57.01), rating in the 2025 National Medicaid QC 10th percentile, below the goal of Medicaid QC 75th percentile. The HEDIS MY2024 AMM Effective Continuation Phase rate (39.39) decreased slightly compared to HEDIS MY2023 rate (39.97), rating at the 2025 Medicaid QC 10th percentile, below the goal of Medicaid QC 75th percentile.



Note: HEDIS Medicaid MY2024 data reflects a total eligible population of 3,097 members with 1,736 numerator events for the Acute Phase and 1220 numerator events for the Continuation Phase.

Analysis of performance by prescribing provider shows that medical providers had a lower rate (55.49) for the Effective Acute phase compared to behavioral health providers (57.39). A lower performance is seen for the medical providers for the Effective Continuation phase with a rate (39.14) compared to the behavioral health providers (40.08).

The Plan’s Exchange HEDIS MY2024 rate (77.17) for the AMM Effective Acute Phase decreased compared to the HEDIS MY2023 rate (80.52). The AMM Effective Continuation Phase rate (55.02) also decreased when compared to HEDIS MY2023 rate (64.76). There is no Exchange benchmark available for this measure. Analysis shows that for the Exchange Effective Acute phase, the medical providers had a lower rate (76.21) compared to behavioral health providers (79.31). For the Medicaid Effective Continuation phase, the medical providers also had a lower rate (53.79) compared to behavioral health providers (57.93).

The Plan’s INTEGRITY HEDIS MY2024 rate for the AMM Effective Acute Phase is 77.56 and the rate for the AMM Effective Continuation Phase is 64.27. Analysis shows that medical providers had a lower rate (76.56) for Effective Acute phase, compared to behavioral health providers (80.58). For the Effective Continuation phase, the medical providers had a higher rate (65.55) compared to behavioral health providers (64.75).

Analysis of Barriers to Performance and Planned Interventions:

- The rates for Medicaid and Exchange for prescribers who are primary care practitioners are lower than the rates for prescribers who are behavioral health providers.

- Members are not remaining on the medication treatment regimen and therefore impacting the rates of the continuation phase of the measure.
 - **Planned Intervention:** Continue to collaborate with Thundermist to implement the following: Neighborhood obtains a weekly automated report set up using Caremark's claim system identifying members new to medication therapy. Neighborhood pharmacists will initiate the telephonic intervention and will reach out to the members at 3-, 6-, and 12-weeks post filling of the initial prescription. This intervention was concluded as of 4/1/25 due to the retirement of the AMM Measure.

While Neighborhood will continue to monitor and support members in taking their antidepressant medications as prescribed and following up with their providers, the HEDIS Measure AMM is retired for 2026. As such, ongoing reporting for interventions will no longer be continued.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

Opportunity Statement: According to the Center for Disease Control (CDC), heart disease and diabetes are among the top ten leading causes of death in the United States. The use of antipsychotic medications can impair glucose regulation by decreasing insulin action, increasing the likelihood of developing diabetes. Regular screening for diabetes in people who are using antipsychotic medication will allow for early identification and treatment of diabetes in people with schizophrenia or bipolar disorder. The HEDIS rate for the Diabetes Screening for People with Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) measure for Medicaid continues to rate below the National Medicaid Quality Compass 90th percentile. The SSD HEDIS measure continues to be one of the high-priority measures identified in the "Medicaid Quality Improvement Plan".

Goal: Achieve the National Medicaid QC 90th percentile for Diabetes Screening for People with Schizophrenia, Schizoaffective Disorder, or Bipolar Disorder Who Are Using Antipsychotic Medications.

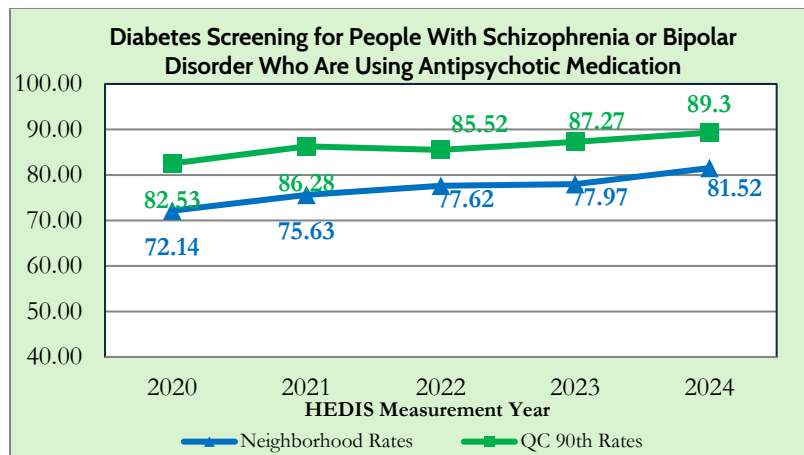
Measure/Methodology: The eligible population for this measure is members who are between 18 years of age and 64 years of age as of December 31st of the measurement year who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

Interventions:

- Optum updated a training tool for use by health plans to educate the medical providers on the importance of care coordination.
- Optum educated medical providers via the 'Behavioral Health Toolkit for Medical Providers' accessed on Optum's website. The Toolkit includes a flyer titled "Care for Individuals Diagnosed with Schizophrenia and/or Prescribed Antipsychotic Medications".
- Optum educated behavioral health practitioners through an educational e-mail blast. Prescribing practitioners were targeted for having treated more than two members diagnosed with schizophrenia and/or bipolar disorder within the past 12 months. The e-mail content included best practices, the need for metabolic screening, as well as the HEDIS measure specifications.
- Neighborhood provided gap-in-care reports to medical providers with a list of non-compliant members.
- Neighborhood held meetings with provider sites to educate providers on the measure and targeted sites that had a high number of members in the SSD measure.

Analysis of Performance: The Plan's Medicaid HEDIS MY2024 rate (81.52) for SSD increased compared to HEDIS MY2023 rate (77.97), rating at 2025 Medicaid QC 33rd percentile, below the goal of Medicaid QC 90th percentile. In terms of rate by gender, the rate for female members (83.69) is 2.17 percentage points higher compared to the male rate of (81.52). Analysis shows that medical providers had a higher rate (82.44) compared to behavioral health providers (80.79).

In terms of performance by language spoken, members whose primary language is English had a lower rate (81.15) compared to members whose primary language is Spanish (85.71). There was a noted difference in population sizes with English speakers having a denominator of 2260 and Spanish speakers having a denominator of 154. The 45-64 age group has a higher rate (84.80) compared to the 21-44 age group (80.08).



Neighborhood's MY2024 data reflects a total eligible population of 2,435 members with 1,985 numerator events.

Analysis of Barriers to Performance and Planned Interventions:

- Practitioners may lack information regarding diabetic screening for patients who are taking antipsychotic medications. To address this opportunity, the Plan deployed the following ongoing interventions:
 - **Planned Intervention:** Continue to distribute gap-in-care reports of members that are non-compliant and require outreach.
 - **Planned Intervention:** Publish articles in the Plan's provider newsletter to inform providers on the SSD measure.
- Members may be unaware of the importance of diabetes screening relative to taking antipsychotic medications.
 - **Planned Intervention:** Continue to post on Neighborhood social media platforms on the importance of diabetes screening for people with schizophrenia or bipolar disorder while taking antipsychotic medication.
 - **Planned Intervention:** Neighborhood Care Managers will reach out to members that are enrolled using approved call scripts to educate members on the importance of testing and to encourage non-compliant members to complete testing.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Opportunity Statement: The HEDIS rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) measure for MMP-INTEGRITY Plan continue to rate below the MMP Quality Withhold benchmark and below the National Medicaid Quality Compass 90th percentile. The

IET HEDIS measure is one of the high-priority measures identified in the “Medicaid Quality Improvement Plan” and is an MMP-INTEGRITY Quality Withhold priority measure.

Goal:

Achieve the INTEGRITY MMP Quality Withhold benchmark for Demonstration Years 2-8; and achieve the National Medicaid QC 90th percentile for both the Initiation and the Engagement phases of the IET measure.

Measure/Methodology: The eligible population for this measure is members who are 13 years of age and older as of December 31 of the measurement year, who had a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

- **Initiation of AOD Treatment.** The percentage of members who initiate treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
- **Engagement of AOD Treatment.** The percentage of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

Interventions:

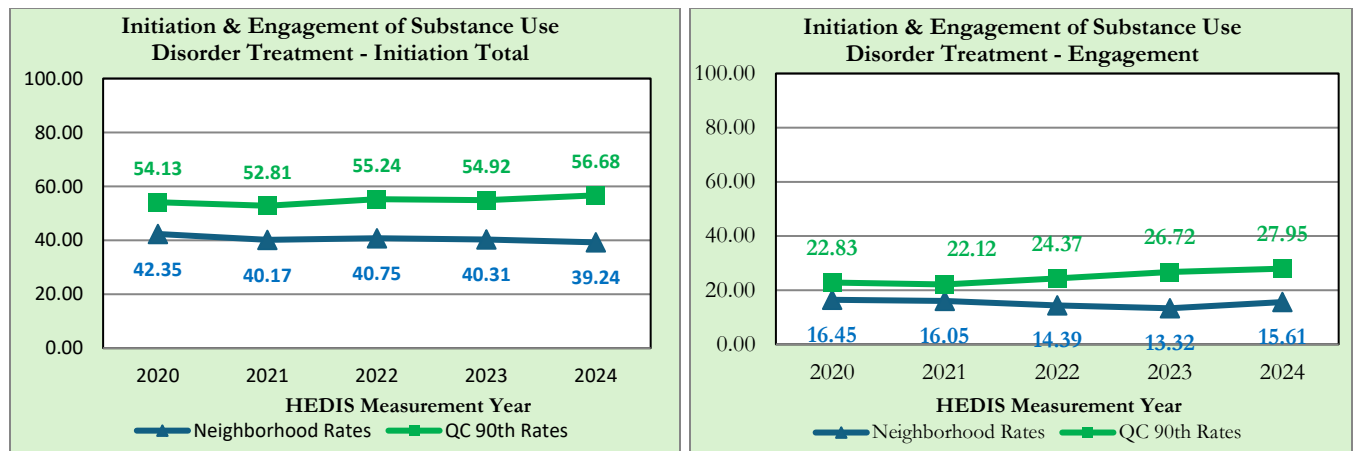
- Neighborhood published 2 provider newsletter articles educating providers on the IET measure specifications and how providers can help improve the measure.
- Optum continued to offer a confidential Substance Use Disorder Helpline, which is managed by highly specialized licensed clinicians who are experts in connecting members with getting the most appropriate and timely treatment services (discontinued on 8/31/25 due to termination of Neighborhood’s contract with Optum).
- Optum educated outpatient behavioral health providers through an email titled “Treatment for Individuals with Substance Use Disorder (SUD)”. The content included best treatment practices for substance use, treating co-occurring diagnoses, and suggested tips on how to help patients with SUD. The email was targeted at behavioral health providers that have treated two or more members ages 13 and older. (discontinued on 8/31/25 due to termination of Neighborhood’s contract with Optum).
- Optum published an educational module for providers on the topic of substance-use disorders in primary care. (discontinued on 8/31/25 due to termination of Neighborhood’s contract with Optum)

Analysis of Performance: The Plan’s Medicaid HEDIS MY2024 rate (39.24) for IET Initiation of AOD Treatment decreased compared to HEDIS MY2023 rate (40.31), rating in the 2025 National Medicaid QC 10th percentile. The IET Engagement of AOD Treatment HEDIS MY2024 rate (15.61) increased compared to HEDIS MY2023 rate (13.32), rating at the 2025 National Medicaid QC 50th percentile. Both rates fell below the goal of meeting the Medicaid QC 90th percentile. In terms of performance by age, members between the ages of 21-44 had a higher rate (41.19) for the Initiation of AOD treatment compared to the rate of 38.07 for members between the ages of 45-64. For the Engagement of AOD Treatment, members between the ages of 21-44 had a higher rate (18.51) compared to the rate (12.69) for members between the ages of 45-64.

The Plan’s INTEGRITY HEDIS MY2024 rate (37.16) for IET Initiation of AOD treatment decreased when compared to the HEDIS MY2023 rate (38.31), remaining below the MMP Quality Withhold target of 45%. The IET Engagement of AOD treatment HEDIS MY2024 rate (9.98) increased when compared to HEDIS MY2023 rate (7.06), remaining below the MMP Quality Withhold target of 16%.

The Plan's Exchange HEDIS MY2024 rate (31.07) for Initiation of AOD treatment increased compared to HEDIS MY2023 rate (30.63), while the HEDIS MY2024 Engagement rate (12.02) decreased compared to HEDIS MY2023 rate (13.21). There are no Exchange benchmarks available for this measure.

The following charts reflect the performance of the Medicaid product.



Note: For HEDIS MY2024, data in the graphs reflect a total eligible population of 4,009 members with 1,573 numerator events for Initiation of AOD Treatment and 4,009 members with 626 numerator events for Engagement of AOD Treatment.

Analysis of Barriers to Performance and Planned Interventions:

- Members may be placed into the IET measure unintentionally or inappropriately through coding in EMRs:
 - **Ongoing Intervention:** Neighborhood HEDIS team will continue to conduct chart audits to determine if active dependence diagnosis codes are being used erroneously and improperly pulling members into the IET measure denominator.
- Members may be placed into the IET Measure incorrectly through an unfounded diagnosis of an active Cannabis Use Disorder.
 - **Ongoing Intervention:** Neighborhood will provide education to providers regarding the proper diagnosis of Cannabis Use Disorder through both provider newsletter article(s), education regarding validated diagnostic tools for diagnosis of Cannabis Use Disorder, and education during provider meetings.
- Providers may be unaware that they have members in this measure and lack information about the IET measure in general:
 - **Ongoing Intervention:** Neighborhood will continue to meet with low-performing high-volume behavioral health providers in the IET measure to discuss technical specifications of the IET Measure, present provider data, and educate/provide resources regarding best practices and resources.
- Providers may be unaware of the documented benefits of use of a peer recovery support specialist in engaging a patient with substance use disorder treatment.
 - **Ongoing Intervention:** Neighborhood will meet with providers to provide education and promote the use of peer support specialists in the care for the patients who fall into the IET denominator.
- Providers may not be aware of Neighborhood resources available to them.
 - **Ongoing Intervention:** Neighborhood will continue to publish provider newsletter articles to educate providers on the IET measure, the Plan's performance, how providers can improve the measure, and how Neighborhood can help them refer their patients to treatment.

- Increasing demand of members seeking in-person interventions in PCP offices.
 - **Ongoing Intervention:** Neighborhood will continue to encourage members to utilize telehealth options and/or Community Mental Health Center or other behavioral health providers to engage in treatment.
- Providers may be coding members as having an active substance use disorder when the member may be in remission.
 - **Ongoing Intervention:** Neighborhood will collaborate with provider sites to provide education about proper remission coding and implement a cleanup process to ensure providers are using correct diagnosis codes for members.

Follow-Up After Emergency Department Visit for Substance Use Disorder

Opportunity Statement: The HEDIS rate for the Follow-Up After Emergency Department Visit for Substance Use (FUA) measure for Medicaid continues to rate below the National Medicaid Quality Compass 90th percentile.

Goal: Achieve the National Medicaid QC 90th percentile for Follow-Up After Emergency Department Visit for Substance Use.

Measure/Methodology: The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, who had a follow up visit for SUD. Two rates are reported:

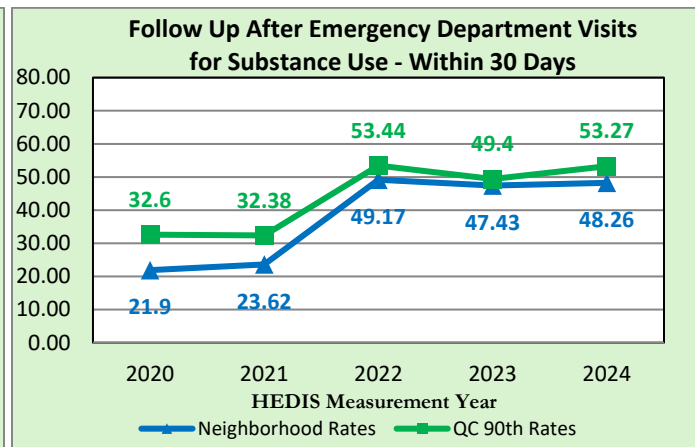
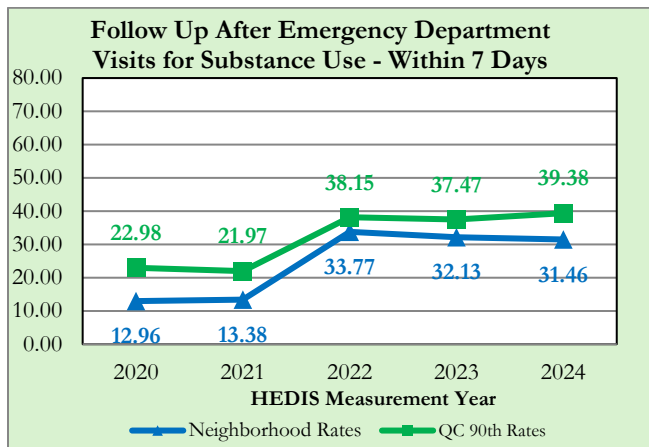
1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Interventions:

- Optum distributed a flyer to PCPs regarding the importance of timely follow up for members after a substance use presentation to the emergency department and posted this to the network - Provider Express section of the website.
- Optum distributed a flyer for behavioral health practitioners on the importance of members having a 7 day follow up appointment after an ED visit.
- Optum published an educational module for providers on the topic of substance-use disorders in primary care.
- Neighborhood met with providers to provide education about FUA technical specifications, present them with their performance data, and provide education regarding best practices.

Analysis of Performance: The Plan's Medicaid HEDIS MY2024 rate for follow-up within 30 days (48.26) increased compared to the HEDIS MY2023 rate (47.43), rating at the 2025 National Medicaid QC 75th percentile. The follow-up within 7 days rate (31.46) decreased compared to HEDIS MY2023 rate (32.13), rating at the Medicaid QC 66th percentile. Both rates fell below the goal of meeting the 2025 National Medicaid QC 90th percentile.

In terms of performance by age, members aged 21-44 had a lower rate (31.73) for follow-up within 7 days compared to the rate (32.95) for members aged 45-64. For follow-up within 30 days, members aged 20-44 had a lower rate (46.65) than members aged 45-64 (52.11). In both measures, the age group of 65+ had a significantly smaller population size and had lower rates of 23.08 for follow-up within 7 days and 51.28 for follow-up within 30 days. The following charts depict the Medicaid product line trends.



Note: For HEDIS MY2024, data in the graphs reflect a total eligible population of 1,494 members with 470 numerator events for Follow-up within 7 days and 721 numerator events for Follow-up within 30 days.

Analysis of Barriers to Performance and Planned Interventions:

- Providers may not be aware of Neighborhood and community resources available to them.
 - Ongoing Intervention:** Neighborhood will continue to publish provider newsletter articles to educate providers on SUD measures, the Plan's performance, how providers can improve the measures, the resources available through Neighborhood, and how Neighborhood can help them refer their patients to treatment.
 - Ongoing Intervention:** Neighborhood will continue to meet with Certified Community Behavioral Health Centers and other high-volume providers to provide education about FUA technical specifications, present them with their performance data, and provide education regarding best practices.
 - Ongoing Intervention:** Neighborhood will meet with highest volume providers and present a scorecard demonstrating Neighborhood and provider performance on this measure and facilitate a discussion around barriers and opportunities for improvement on the provider performance.
- Increasing demand of members seeking in-person interventions in PCP offices.
 - Ongoing Intervention:** Neighborhood will continue to encourage members to utilize telehealth options and/or Community Mental Health Center resources/ behavioral health providers to engage in treatment.
- Providers may be unaware of the documented benefits of use of a peer recovery support specialist in engaging a patient with substance use disorder treatment.
 - Ongoing Intervention:** Neighborhood will meet with providers to provide education and promote the use of peer support specialists in the care for the patients who fall into the FUA denominator.

Follow-Up After High-Intensity Care for Substance Use Disorder

Opportunity Statement: The HEDIS rate for the Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) measure for Medicaid continues to rate below the National Medicaid Quality Compass 90th percentile. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2020 National Survey, "In 2020, 40.3 million people aged 12 or older (or 14.5 percent) had an SUD in the past year, including 28.3 million who had alcohol use disorder, 18.4 million who had an illicit drug use disorder, and 6.5 million people who had both alcohol use disorder and an illicit drug use disorder." With a growing

percentage of the population experiencing SUD, it is important that there is an expansion of high-intensity care utilization and follow-up.

Goal: Achieve the National Medicaid QC 90th percentile for Follow-Up After High-Intensity Care for Substance Use Disorder.

Measure/Methodology: The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:

1. The percentage of discharges for which the member received follow-up for substance use disorder within the 30 days after the visit or discharge.
2. The percentage of discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.

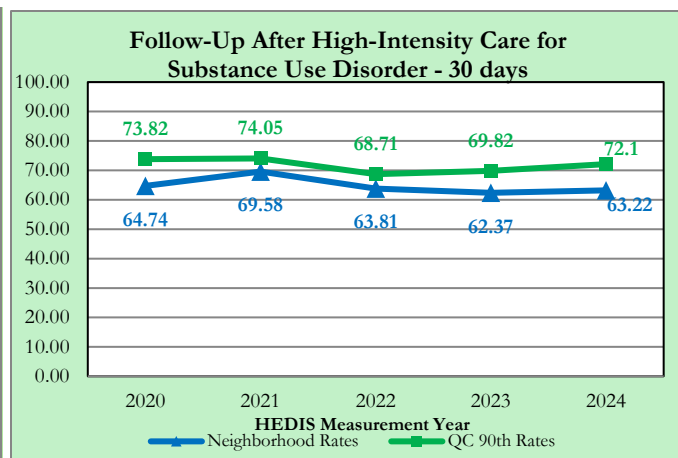
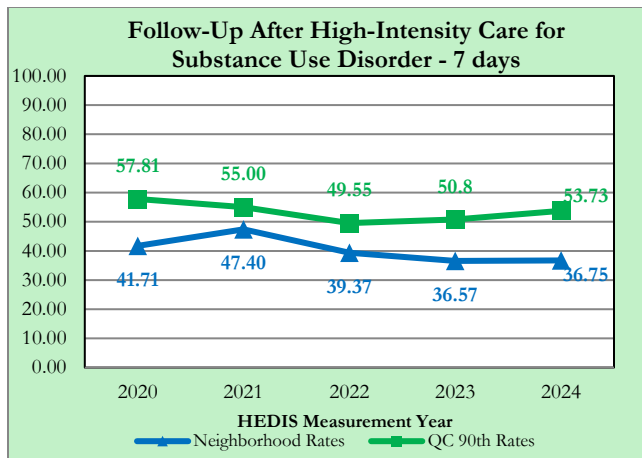
Interventions:

- Optum educated outpatient behavioral health practitioners on the importance of members having a 7-day follow-up appointment after an emergency department (ED) visit or inpatient hospitalization, through an educational email 'blast' titled "Follow-Up Care after Discharge."
- Optum educated practitioners via an on-demand webcast titled "Substance-use Disorders in Primary Care." The content is available online at [Optumhealtheducation.com](https://www.optumhealtheducation.com) and focuses on screening, diagnosis, and treatment for substance use disorders, as well as the importance of follow-up after hospitalization or emergency department visit.
- Neighborhood met with providers to provide education about FUI technical specifications, present them with their performance data, and provide education regarding best practices.

Analysis of Performance: The Plan's Medicaid HEDIS MY2024 rate (63.22) for follow-up within 30 days increased when compared to HEDIS MY2023 rate (62.37), rating at the 2025 National Medicaid QC 66th percentile. The follow-up within 7 days rate (36.75) also increased when compared to HEDIS MY2023 rate (36.57), rating at the 2025 National Medicaid QC 50th percentile. Both rates fell below the goal of meeting the Medicaid QC 90th percentile.

In terms of performance by age, members aged 21-44 had a higher rate (39.79) for follow-up within 7 days compared to the rate (33.39) for members aged 45-64. For follow-up within 30 days, members aged 20-44 had a higher rate (65.67) than members aged 45-64 (61.26). In both measures, the age group of 65+ had a significantly smaller population size and had lower rates of 13.33 for follow-up within 7 days and 36.67 for follow-up within 30 days.

The following charts depict the Medicaid product line trends.



Note: For HEDIS MY2024, data in the graphs reflect a total eligible population of 2,939 members with 1,080 numerator events for Follow-up within 7 days and with 1,858 numerator events for Follow-up within 30 Days.

Analysis of Barriers to Performance and Planned Interventions:

- Providers may not be aware of Neighborhood and community resources available to them.
 - **Ongoing Intervention:** Continue to publish provider newsletter articles to educate providers on SUD measures, the Plan's performance, how providers can improve the measures, the resources available through Neighborhood, and how Neighborhood can help them refer their patients to treatment.
 - **Ongoing Intervention:** Continue to Meet with highest volume providers and present a scorecard demonstrating Neighborhood and provider performance on this measure and facilitating a discussion around barriers and opportunities for improvement on the provider performance.
 - **Ongoing Intervention:** Continue to meet with Certified Community Behavioral Health Centers and other high-volume providers to provide education about FUA technical specifications, present them with their performance data, and provide education regarding best practices.
- Increasing demand of members seeking in-person interventions in PCP offices.
 - **Ongoing Intervention:** Continue to encourage members to utilize telehealth options and/or Community Mental Health Center resources/ behavioral health providers to engage in treatment.
- Providers may be unaware of the documented benefits of use of a peer recovery support specialist in engaging a patient with substance use disorder treatment.
 - **Ongoing Intervention:** Neighborhood will meet with providers to provide education and promote the use of peer support specialists in the care for the patients who fall into the FUI denominator.

Follow-Up After Hospitalization for Mental Illness

Opportunity Statement: The HEDIS rate for the Follow-Up After Hospitalization for Mental Illness (FUH) measure for Medicaid continues to rate below the National Medicaid Quality Compass 90th percentile. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) 2020 National Survey, "Among adults aged 18 or older in 2020, 21.0 percent (or 52.9 million people) had any mental illness (AMI), and 5.6 percent (or 14.2 million people) had serious mental illness (SMI) in the past year." With an increasing percentage of the population utilizing the hospital to treat serious and emergent behavioral health issues, access to appropriate care and follow-up is imperative.

Goal: Achieve the National Medicaid QC 90th percentile for Follow-Up After Hospitalization for Mental Illness - 7 and 30 Days.

Measure/Methodology: The percentage of inpatient discharges for members 6 years of age and older who were hospitalized for a diagnosis of mental illness or intentional self-harm and who had a follow-up visit with a mental health provider. Two rates are reported:

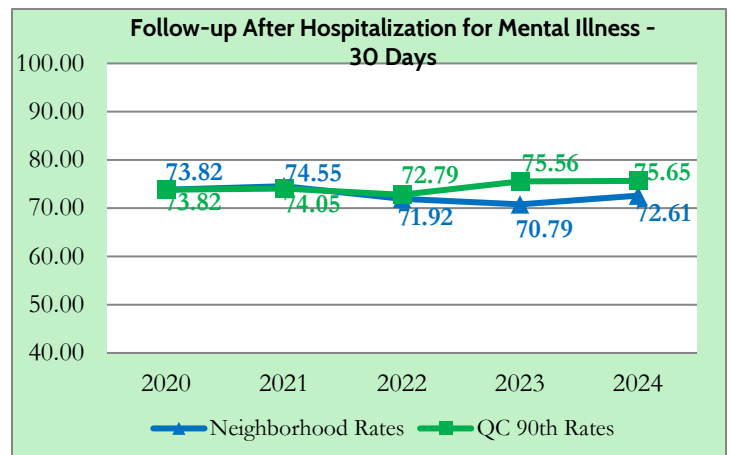
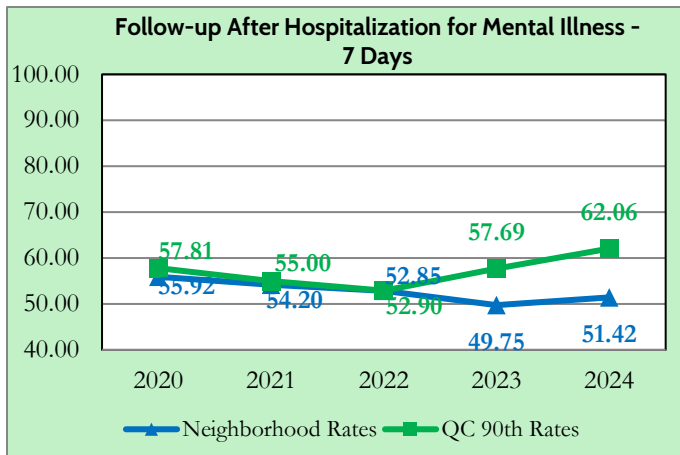
- The percentage of discharges for which the member received follow-up within 30 days after discharge.
- The percentage of discharges for which the member received follow-up within 7 days after discharge.

Interventions:

- Neighborhood distributed an automated report daily to Accountable Entities (AE) of all behavioral health inpatient authorizations to assist with AE awareness of members who will need post discharge follow up.
- Neighborhood Behavioral Health Care Management team outreached members post discharge to assist in care coordination.
- Neighborhood Behavioral Health Care Management team used discharge outreach as an opportunity to complete a Comprehensive Functional Needs Assessment (CFNA), either as the annual assessment or updated due to inpatient stay. The CFNA identifies needs the members may have and provides resources for follow-up.
- Neighborhood's Quality staff provided education on the specifications of the FUH measure and Neighborhood's resources available to them in facilitating appointments for their patients.
- Optum educated outpatient behavioral health practitioners on the importance of members having a 7-day follow-up appointment after an ED visit or inpatient hospitalization, through an educational email 'blast' titled "Follow-Up Care after Discharge." (discontinued 8/31/2025 due to termination of contract with Optum)
- Optum educated practitioners via an on-demand webcast titled "Mental Health Disorders and Follow-Up After Higher Levels of Care." The content was available online at [Optumhealtheducation.com](https://optumhealtheducation.com) and focuses on screening, diagnosis, treatment and medication adherence for depression, as well as the importance of follow-up after hospitalization or emergency department visit for mental health. (discontinued 8/31/2025 due to termination of contract with Optum)

Analysis of Performance: The Plan's Medicaid HEDIS MY2024 rate (72.61) for follow-up within 30 days increased compared to the HEDIS MY2023 rate (70.79), rating at the 2025 National Medicaid QC 75th percentile. The follow-up within 7 days rate (51.42) also increased compared to the HEDIS MY2023 rate (49.75), rating at the 2025 National Medicaid QC 75th percentile. Both rates fell below the goal of meeting the Medicaid QC 90th percentile.

In terms of performance by age, members aged 21-44 had a higher rate (49.25) for follow-up within 7 days compared to the rate (43.38) for members aged 45-64. For follow-up within 30 days, members aged 21-44 had a higher rate (70.91) than members aged 45-64 (65.81). In both measures, the age group of 65+ had a significantly smaller population size but higher rates for both 7-day (55.77) and 30-day (75.00) follow-ups. The following charts depict the Medicaid product line trends.



Note: For HEDIS MY2024, data in the graphs reflect a total eligible population of 2,143 members with 1,102 numerator events for Follow-up within 7 Days and 1556 numerator events for Follow-up within 30 Days.

Analysis of Barriers to Performance and Planned Interventions:

- Providers may not be aware of Neighborhood and community resources available to them.
 - **Ongoing Intervention:** Continue to publish provider newsletter articles to educate providers on the FUH measure, the Plan's performance, how providers can improve the measures, the resources available through Neighborhood, and how Neighborhood can help them refer their patients to treatment.
 - **Ongoing Intervention:** Meet with highest volume providers and present a scorecard demonstrating Neighborhood and provider performance on this measure and facilitating a discussion around barriers and opportunities for improvement on the provider performance.
 - **Ongoing Intervention:** Continue to meet with Certified Community Mental Health Centers and other high-volume providers to provide education about FUH technical specifications, present them with their performance data, and provide education regarding best practices.
- Increasing demand of members seeking in-person interventions in PCP offices.
 - **Ongoing Intervention:** Continue to encourage members to utilize telehealth options and/or Community Mental Health Center resources/ behavioral health providers to engage in treatment.
- Providers may be unaware of the documented benefits of use of a peer recovery support specialist in engaging a patient with a mental health diagnosis.
 - **Ongoing Intervention:** Neighborhood will meet with providers to provide education and promote the use of peer support specialists in the care for the patients who fall into the FUH denominator.
- Members may lack the knowledge of the importance of scheduling and keeping the follow-up appointment post discharge.
 - **Ongoing Intervention:** Neighborhood Behavioral Health Care Management team continues to outreach to members post discharge to assist in care coordination.

- **Ongoing Intervention:** Neighborhood Behavioral Health Care Management team uses discharge outreach as an opportunity to complete a Comprehensive Functional Needs Assessment (CFNA), either as an annual assessment or updated due to inpatient stay.
- Providers may lack timely information for inpatient facilities.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

Opportunity Statement: According to the study Provider Specialty and Receipt of Metabolic Monitoring for Children Taking Antipsychotics, published in the National Library of Medicine, “Children taking antipsychotic medication are at risk for obesity, impaired glucose metabolism, and hyperlipidemia. Yet <40% of children receive recommended metabolic monitoring.” The Medicaid HEDIS rate for the Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) measure continues to rate below the National Medicaid Quality Compass 90th percentile. The APM HEDIS measure continues to be one of the high-priority measures identified in the “Medicaid Quality Improvement Plan”.

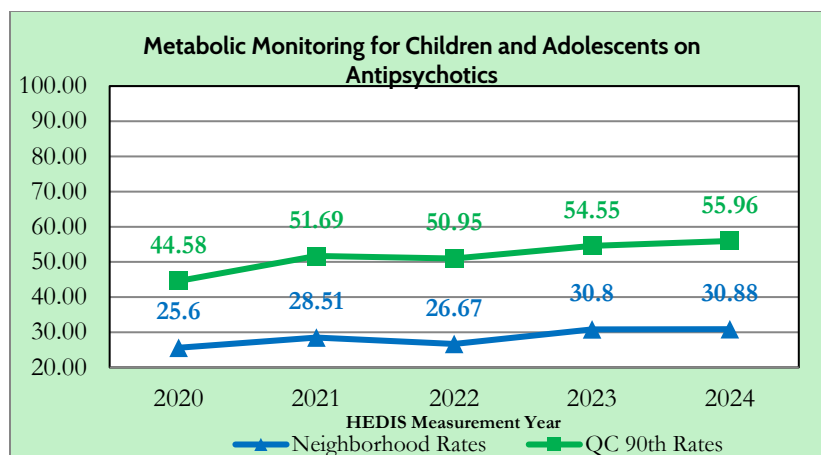
Goal: Achieve the 2025 National Medicaid QC 90th percentile for Metabolic Monitoring for Children and Adolescents on Antipsychotics.

Measure/Methodology: The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three stratifications of rates are reported as follows:

- The percentage of children and adolescents on antipsychotics who received:
 - Blood glucose testing.
 - Cholesterol testing.
 - Glucose and cholesterol testing.

Interventions:

- Optum updated a training tool for use by health plans to educate medical providers on the importance of care coordination.
- Optum educated medical providers via the ‘Behavioral Health Toolkit for Medical Providers’ accessed on Optum’s website. The Toolkit includes a flyer titled “Care for Individuals Diagnosed with Schizophrenia and/or Prescribed Antipsychotic Medications”.
- Optum educated behavioral health practitioners through an educational e-mail blast. The target of the outreach was prescribing practitioners that treated more than two members diagnosed with schizophrenia and/or bipolar disorder within the past 12 months. The e-mail content included best practices, the need for metabolic screening, as well as the HEDIS specifications.
- Neighborhood provided gap-in-care reports to medical providers with a list of non-compliant members.
- Neighborhood published an article in Neighborhood’s provider newsletter titled “Metabolic Monitoring for Children and Adolescents on Antipsychotics.”
- Neighborhood held meetings with provider sites to educate providers on the measure, specifically targeting sites that had a high number of members in the APM measure.
- Neighborhood Behavioral Health Care Management team outreached members in the SUB care line of business to encourage completion of annual labs.



Note: For HEDIS Reporting year 2024, data in graph reflects a total eligible population of 625 members with 193 numerator events

Analysis of Performance: The Plan's Medicaid HEDIS MY2024 rate (30.88) for APM increased compared to the HEDIS MY2023 rate (30.80), rating at the 2025 National Medicaid QC 25th percentile and below the goal of National Medicaid QC 90th percentile. In terms of rate by gender, the rate for female members (37.68) is 10.17 percentage points higher compared to the male rate of (27.51). Analysis shows that medical providers had a lower rate (16.02) compared to behavioral health providers (40.11). Some claims for the measure could not be assigned and are classified as unknown provider type.

In terms of performance by Race Ethnicity, Hispanic/Latino members had the highest rate (34.13), while White members had the lowest rate (29.21). Black or African American members had a rate of 30.95. The Black or African American denominator (42) is significantly smaller compared to the Hispanic (126) and White (202) populations.

Analysis of Barriers to Performance and Planned Interventions:

- Practitioners may lack information regarding required screening for children or adolescent patients on antipsychotic medications.
 - **Ongoing Intervention:** Neighborhood will continue to distribute gap-in-care reports of members that are prescribed antipsychotics and require screening outreach.
 - **Ongoing Intervention:** Continue to publish articles in Neighborhood's provider newsletter to continue to educate providers on the APM measure.
 - **Ongoing Intervention:** Neighborhood will continue to engage in meetings with providers to educate and provide feedback focused on adherence to best practices relative to this measure.
- Members may be unaware of the importance of metabolic screening, particularly regarding taking antipsychotic medications.
 - **Ongoing Intervention:** Neighborhood Behavioral Health Care Management team will continue the outreach program for members in the SUB care line of business to encourage completion of annual labs
 - **Planned Intervention:** Neighborhood will establish a behavioral health partner to conduct on site testing with immediate results for glucose and cholesterol testing.

E. Pregnancy and Prenatal Care

Bright Start Program

Goal: Promote compliance with prenatal and post-partum care to improve birth and health outcomes and achieve the 2025 Medicaid National Quality Compass 90th percentile for timeliness of prenatal care and post-partum care visits.

Measure/Methodology: The Plan's Care Management Software system, Acuity, and Guiding Care beginning of April 2025, is used for data collection for the Bright Start Program.

In addition, the Plan assess the Timeliness of Prenatal Care and Post-partum Care HEDIS measures as well as analysis of CY 2025 claims to analyze performance.

Interventions:

- Continued to distribute the prenatal passbook with associated incentives to improve the rate of prenatal and postpartum visits with providers. In CY 2025 a total of 50 incentives were distributed.
- Continued to send a bi-weekly Provider Gap Report inclusive of members with recent delivery to improve the rate of post-partum visits.
- Continued to utilize the Maternal Health Work Group to focus on improving health disparities among Neighborhood members.

Analysis of Performance:

HEDIS Performance

The Plan's Medicaid HEDIS rate for Timeliness of Prenatal Care decreased from 96.35% in MY2023 to 95.97% in MY2024, rating at the 2025 National Medicaid QC 95th percentile. The rate for Postpartum Care decreased from 90.02% in MY2023 to 88.76 in MY2024, rating at the 2025 National Medicaid QC 90th percentile.

The Plan's Exchange rate for Timeliness of Prenatal Care decreased from 97.67% in MY2023 to 96.74 in MY2024, remaining in the QRS 95th percentile. The rate for Postpartum Care increased from 90.70% in MY2023 to 98.91% in MY2024, rating in the QRS 95th percentile.

Birth Rates

The Plan had more births 2025 (3,294) than in 2024 (3157) across all lines of business. Neighborhood calculates fertility and birth rates, and both measures use the total live births as the numerator. The fertility rate is based on a denominator of all female members who are between the ages of 15 and 44 during 2025. The birth rate is based on all female members aged 10 or older. Each rate is expressed as number of births per 1000 members.

Measurement	2022	2023	2024	2025
Fertility Rate*	48.51	50.04	43.45	47.45
Birth Rate**	23.53	24.50	21.81	23.49
*Fertility Rate = (total live births/ female members aged 15-44) X 1000				
**Birth Rate = (total live births/ female members age 10+) X 1000				

Birth Outcomes

The percentage of “very low birth weight” decreased in 2025. The “low birth weight” decreased in 2025. The percentage of newborns requiring admission to the neonatal intensive care unit (NICU) immediately following delivery was 3.27% and NICU re-admissions were 5.05%, an increase compared to prior year. The rate for preterm birth decreased in 2024 from 9.06% to 8.68%. The rates for primary caesarean section increased from 16.60% to 17.09%. While repeat caesarean decreased slightly from 15.27% in 2024, to 14.69% in 2025.

Outcome	Measurement	2023	2024	2025
1a	Birth weight: Very low (<1500g)	1.34%	1.27%	1.12%
1b	Birth weight: Low (1500-2499 g)	7.00%	7.76%	7.44%
2	Multiple births/1,000 total births	20.54%	32.93%	30.05%
3	NICU admissions	8.20%	5.62%	3.27%
4	NICU re-admissions	6.28%	4.35%	5.05%
5	Preterm births (<37 weeks gestation)	10.21%	9.06%	8.68%
6a	Normal vaginal delivery	68.43%	68.13%	68.21%
6b	Primary caesarean section	16.44%	16.60%	17.09%
6c	Repeat caesarean section	15.13%	15.27%	14.69%

Care Management and Care Coordination for Pregnant Members:

Members are identified for the Bright Start Program based on the members’ pregnancy status. Members are then stratified further based on risk factors identified from the Neighborhood Prenatal Risk Assessment (PRA) tool. Bright Start participating obstetrics provider sites are required to complete and submit the PRA for every pregnant Neighborhood patient/member receiving prenatal care. If a risk is not present at the initial prenatal screening visit, but develops later in the pregnancy, the participating OB provider is required to fax an additional PRA to the Health Plan indicating the change in risk.

In addition, all members identified as being pregnant are sent a Bright Start Newsletter. The Bright Start Newsletter consists of prenatal and postnatal care information as well as information about choosing a pediatrician.

A total of 3,255 members were identified for the Bright Start Program in 2025 and received educational materials.

- Neighborhood received 132 referrals for the high-risk program from completion of the PRA. Of the 132 referrals, 36 members were enrolled (27.27%).
- Neighborhood received 220 referrals for the care coordination program and enrolled 181 (82.27%). Many of these members were identified as needing postpartum follow-up or care coordination during pregnancy due to very low or low birth weights, and/or previous postpartum risks such as history of post-partum depression and current depression.

Analysis of Barriers to Performance and Planned Interventions:

- PRAs continue to be sent to the health plan with no risks early in the pregnancy and if risks develop OB providers do not consistently send an updated PRA.

- Due to staffing constraints, we were unable to expand criteria and moderate-risk referrals were not processed.
 - **Planned Intervention:** Research and identify interventions to improve the pregnancies/birth outcomes of the African American/Latino population.
 - Continue to work with OB/GYN provider sites on sending in Prenatal Risk Assessment form early in pregnancy to assist with identifying members with risk and enrollment into the program.
 - Continue to identify members who have been in the Emergency Room for a pregnancy-related visit and refer to the Bright Start prenatal program.

The Plan will also continue to monitor data (birth outcomes and rates) to identify any new negative birth outcome trends using birth analysis data. Further analysis will be completed to determine potential reasons for the increase in preterm/low birth weight babies by obtaining birth outcome data.

F. Disease Management

Asthma Management (“Breathe Easy”)

Goals:

- Improve the rates for HEDIS asthma performance measure by one percentage point.
- Decrease utilization for ER visits/1,000 for asthma exacerbations by 1% for all members.
- Decrease inpatient admissions/1,000 for asthma exacerbations by 1% for all members.
- Increase the percentage of persistent asthmatic members that are appropriately managing their asthma through regular outpatient visits for asthma management (at least two visits per year) by 1%.

Measure / Methodology: HEDIS MY2024 measures for Asthma Medication Ratio (AMR) as well as analysis of calendar year 2025 claims.

Neighborhood adopted the Clinical Practice Guideline (CPG) based on national guidelines developed by the National Heart, Lung, Blood Institute (NHLBI) for the diagnosis and management of asthma. The CPG is posted on the health plan’s website and is available as a hard copy to practitioners upon request. The health plan’s annual evaluation of the Asthma Disease Management Program aligns with the recommendations detailed in the CPG, as measured by the HEDIS AMR asthma measure and regular follow-up treatment for asthma, defined as no less than two outpatient visits each year for asthma management.

Interventions:

- Continued to improve the process of connecting asthma patients to their specialists. All members enrolled had a scheduled specialist appointment coordinated by a care manager.
- Encouraged the importance of two or more outpatient visits each year for asthma management. A care manager assisted members in coordinating their outpatient visits.
- Created the Asthma Enhancement Program to identify members with emerging risk.
- Continued to offer a Member Reward for completing an asthma action plan.
- Expansion of the transition of care (TOC) criteria, adult members with diagnosis of asthma upon discharge will be referred to the TOC program.

Program Participation:

The Plan members identified as having asthma, using HEDIS criteria, do not need to enroll in the disease management program; members are automatically enrolled upon identification through claims. Participation

and membership in the program are voluntary, and members may opt out at any time by calling the Plan. Participation in the program can also result from referrals made by Care Management, Utilization Management, Pharmacy, Behavioral Health, and Member Service staff. Referrals are also identified outside the Plan through member or caregiver self-referrals, practitioners, and community partners.

All members identified as having asthma receive a welcome letter introducing the program and informing them of the services and educational materials they can expect to receive. Members identified for the program are stratified into two risk levels. Assignment of risk level helps determine the level of intervention received, and are designed to support condition monitoring, adherence, lifestyle, and other health issues.

- Low-Risk (Well Controlled) - A member is in the low-risk category when they meet the identification criteria. These members receive a welcome packet with educational materials and a QR code to access the Be Well, Stay Well newsletter.
- High-Risk (Poorly Controlled) - A member is considered high risk when they meet the identification criteria of being discharged home after an inpatient stay with an asthma diagnosis. Additionally for our Pediatric Neighborhood Medicaid members (ages 2-17 years).
 - 1+ emergency department visits
 - and/or an inpatient hospitalization for asthma within the past 12 months

Year	Member's Participation (Numerator)	Enrolled Members (Denominator)	Participation Rate	Triggered for High DM	Enrolled in High DM	High DM Participation Rate
2023	13,506	13,506	100%	118	56	47%
2024	13,052	13,052	100%	66	32	48%
2025	11,095	11,095	100%	109	52	48%

The Plan’s asthma population decreased in 2025. The overall participation rate in educational outreach efforts was 100% with no members opting out in 2025. The number of members triggering for the high-risk disease management telephonic disease management intervention increased from 66 to 109 members. All high-risk members were identified through the hospital discharge process. The participation (enrollment) rate of members that triggered for high-risk disease management remained the same from 2024 to 2025 (48%).

In 2025 Our High DM Members were enrolled into the TOC Program as part of our transition of care initiative for asthma. In 2025 21 members were identified, and 6 were enrolled into the Transitions of Care Program (29%).

Year	Members Identified (Denominator)	Members Enrolled (Numerator)	Enrolled Rate
2025	21	6	29%

Analysis of Performance: The Plan’s HEDIS rate for Asthma Medication Ratio is used to assess the effectiveness of the Asthma Disease Management Program “Breathe Easy.” The Asthma Medication Ratio for ages 5-64 years decreased from 54.64 to 48.69. The goal of improving by 1 percentage point was not met.

Medicaid HEDIS Asthma Program Measures	HEDIS MY2022	HEDIS MY2023	HEDIS MY2024	Goal Met
Asthma Medication Ratio (total)	62.82 (QC 33rd)	54.64 (QC 10th)	48.69 (QC 10th)	No

The rates of inpatient hospital admissions per 1000 member years increased from 9.92 in 2024 to 13.08 in 2025. The rate of ER visits per 1000 member years with a primary, secondary, or tertiary diagnosis of asthma decreased from 186.05 to 181.92 in 2025. The proportion of members having at least two outpatient visits for asthma management during the year increased from 1.35% to 5.11%

Program Measures	2023 Outcomes	2024 Outcomes	2025 Outcomes	Change	Goal Met
Acute inpatient admissions per 1000 member years	9.24/1000	9.92/1000	13.08/1000	↑	No
Emergency room visits per 1000 member years	170.61/1000	186.05/1000	181.92/1000	↓	Yes
Evidence of two (2) or more outpatient visits each year for asthma management	8.97%	1.35%	5.11%	↑	Yes

Analysis of Barriers to Performance and Planned Interventions:

- The high-risk disease management program remains small as program enrollment criteria are based on hospital discharges and certain criteria for our Pediatric population. Of those members identified for high-risk disease, a significant number of members were not enrolled due to failed outreach and members declining the program. Due to staffing constraints, the program was placed on hold for 2025 except for members identified for the Pediatric population and Transition of Care program.

Planned interventions to improve the program and corresponding goals include:

- Increase identification of members needing asthma coordination (moderate/high)
- Review prescription fills for controller vs rescue inhaler to gauge red flags in asthma condition management.
- Engage specialists and PCPs to encourage members to enroll in the program for when members decline.
- Continue to connect asthma patients to their specialists. All members enrolled will have a scheduled specialist appointment coordinated by a care manager.
- Continue to encourage the importance of two or more outpatient visits each year for asthma management by Care Management staff coordination of outpatient visits.
- Obtain utilization data for members with two or more outpatient visits each year for asthma management to understand any gaps.
- Continue to expand the transition of care (TOC) criteria, adult members with diagnosis of asthma upon discharge will be referred to the TOC program versus High Disease Management. Members who do not qualify for TOC will be referred to the High Disease Management program.
- Continue the Pediatric Asthma At-Home Program, which is a joint effort between Neighborhood, the Rhode Island Department of Health, the Care Transformation Collaborative. This program is a collaborative, evidence-based initiative designed to provide asthma intervention at home.

Diabetes Management (“Control for Life”)

Goals:

- Improve rates by one percent (1%) for all HEDIS® Diabetes measures.
 - Increase *Blood Pressure Control (<140/90)* rate
 - Increase *Eye Exam* rate
 - Increase Hemoglobin A1c Control for Patients with Diabetes - HbA1C Control (<8.0%)

Measure / Methodology: HEDIS diabetes measures and measures of hospital and emergency room (ER) utilization from 2024 medical claims.

Interventions:

- Expansion of the transition of care (TOC) criteria, adult members with diagnosis of diabetes upon discharge will now be referred to the new TOC program versus High Disease Management. Members who do not qualify for TOC will be referred to the High Disease Management program.
- Continued to offer a Member Reward for completing diabetic screenings.

Program Participation: Members with diabetes, using HEDIS criteria, are automatically enrolled upon identification through claims. Participation in the program is voluntary, and members may opt out at any time by calling the health plan. Participation in the program can also result from referrals made by Care Management, Utilization Management, Pharmacy, Behavioral Health and Member Services staff. Referrals are also identified outside the health plan through member or caregiver self-referrals, practitioners, and community partners.

All members identified as having diabetes receive a welcome letter introducing the program and informing them of the services and educational materials they can expect to receive. Members identified for the program are stratified into one of two risk levels. Assignment of risk level determines the level of intervention they receive to support condition monitoring, adherence, lifestyle, and other health issues.

- **Low-Risk (*Well Controlled*)** - A member is in the low-risk category when they meet the identification criteria for diabetes and do not meet the high-risk criteria (below). These members receive a welcome packet with educational materials and a QR code to access the Be Well, Stay Well newsletter.
- **High-Risk: (*Poorly Controlled*)** - A Medicaid or Exchange member is considered high-risk if they have an inpatient admission with diabetes as one of the first three diagnoses. These members receive the same educational mailing as those at low risk but also receive telephonic outreach attempts from a Care Manager to offer high-risk disease management (health coaching) and assistance in meeting service milestones such as PCP/endocrinologist visits, HbA1c testing, diabetic foot exam, and nephrology testing.

Year	Members Identified (Denominator)	Members Enrolled (Numerator)	Participation Rate	Triggered for High DM	Enrolled in High DM	High DM Participation Rate
2021	17,084	17,082	99.98%	26	13	50.00%
2022	18,165	18,164	99.99%	31	18	58.06%
2023	19,282	19,280	99.99%	18	8	44.44%
2024	19,446	19,444	99.99%	19	10	52.63%
2025	19,913	19,913	100%	0	0	0

The Plan's diabetic population increased by 83 members in 2025. The participation rate in the diabetes program was 100%. In 2025 due to staffing constraints, the High DM Members were enrolled into the TOC Program as part of our transitions of care initiative for Diabetes. In 2025, 54 members were identified and 9 were enrolled into the Transitions of Care Program (17%).

Year	Members Identified (Denominator)	Members Enrolled (Numerator)	Enrolled Rate
2025	54	9	17%

Analysis of Performance: Below is an overview of the selected performance measures used to assess the effectiveness of the Plan's Diabetes Disease Management Program "Control for Life."

- Blood pressure control (<140/90): The rate (79.56) for HEDIS MY2024 increased from HEDIS MY2023 (79.08).
- HbA1C Control (<8.0%): The rate (64.96) for MY2024 increased from HEDIS 2023 (64.23).
- Eye Exam for Patients with Diabetes: The rate (74.29) for HEDIS MY2024 increased from MY2023 (69.59).

HEDIS Diabetes Program Measures	HEDIS MY2022 Rate	HEDIS MY2023 Rate	HEDIS MY2024 Rate	Goal Met (Yes/No)
Blood Pressure Control (<140/90)	75.67 (QC 90th)	79.08 (QC 90th)	79.56 (QC 90th)	Yes
Hemoglobin A1c Control for Patients with Diabetes - HbA1C Control (<8.0%)	59.37 (QC 75th)	64.23 (QC 90th)	64.96 (QC 75th)	No
Eye Exam for Patients with Diabetes	71.11 (QC 95th)	69.59 (QC 95th)	74.29 (QC 95th)	Yes

Analysis of Barriers to Performance and Planned Interventions:

- Criteria for high-risk disease management is limited and based on availability of resources.
 - **Planned Intervention:** Reinforce the importance of testing and medication adherence by monitoring members enrolled in high-risk disease management and if they are non-adherent, coordinate care with the PCP or specialist.
 - Continuing expansion of the transition of care (TOC) criteria, adult members with diagnosis of diabetes upon discharge will be referred to the TOC program versus High Disease Management. Members who do not qualify for TOC will be referred to the High Disease Management program.
 - Utilized Guiding Care system to actively monitor high-risk disease management member medication compliance (for all medications) and intervene (by calling the member) if compliance becomes problematic based on the case manager's clinical judgment.

In addition to the "Control for Life" mailings and telephonic outreach, home visits will be completed as applicable.

G. Transitions of Care

Transitions of Care Programs

Goals:

- Support members discharged from hospital to drive positive outcomes.
 - Increase engagement in Behavioral Health Outpatient treatment 30 days following discharge.
 - Increase in PCP visits within 30 days following discharge.
 - Increase enrollment of members in all Transition of Care Programs.

Measure / Methodology:

Starting in Q4 of 2024, Neighborhood expanded the reach of their Transitions of Care (TOC) programming to include members with behavioral health admissions. Following an inpatient discharge, Medicaid and Commercial members were triaged to be outreached for a 30-day Case Management intervention focused on coordinating services for those at high risk for readmission. This approach supports smoother transitions from hospitals to community, enhances care coordination and quality, and contributes to overall cost efficiency. Improved management of the population will result in:

- Improved outcomes as measured by HEDIS/STARS and other metrics
- Reduced hospitalizations
- Reduced re-admissions
- Reduced emergency department visits
- Improved medication adherence
- Improved continuity of care
- Increasing patient engagement
- Better use of community resources
- Lower total cost of care for the population
- Improved patient satisfaction

Member Identification:

Transitions of Care:

The Transitions of Care (TOC) team identifies discharged members using RI Quality Institute (RIQI) CurrentCare data, Utilization Management (UM) notifications, and hospital notifications through collaborative meetings. Member who transition to residential treatment, Crisis Stabilization Unit (CSU) or Skilled Nursing Facility (SNF) placement are not outreached for the TOC program. Priority is given to members who are high risk including those members readmitted within the same month, who were discharged Against Medical Advice (AMA), and who are newly enrolled in the health plan.

Enhanced Transitions of Care:

The Enhanced Transitions of Care (ETOC) program identifies members while admitted to an inpatient medical setting. Neighborhood utilizes all available data and the LACE Index Tool to identify members most at risk for readmission, and those who would most likely benefit from focused assistance and additional services in support of their transition from hospital to home. Identifying members who require intensive transition services enables Neighborhood to target resources effectively. Members admitted for routine deliveries or elective procedures are not screened unless their history or provider indicates a need for additional discharge support.

Interventions: The TOC programs provide the following interventions to reduce likelihood of readmission.

- Review of discharge instructions for thorough understanding

- Medication review with emphasis on medication adherence
- Medication reconciliation with health plan or community pharmacist as needed
- Address SDOH barriers, including housing, food, transportation
- Assist with making follow up appointments as recommended
- Coordinate with service providers to close gaps in care
- Educate on importance of engaging with PCP
- Collaboration with Certified Community Behavioral Health Center teams or other Behavioral Health (BH) Providers
- Individualized, member-centric care plan

Program Participation:

Identified members are contacted for consent to participate in the voluntary Transitions of Care program and may decline or opt out at any time. Consenting members are enrolled and assessed at discharge and receive follow-up calls weekly or as needed. Members and the Neighborhood team collaborate on goal achievement. For ETOC, outreach begins during hospitalization in coordination with inpatient case management to address early gaps in care. After 30 days, members requiring continued support transition to long-term Neighborhood case management.

Q4 2024	Members Identified (Denominator)	Enrolled Members (Numerator)	Participation Rate
ETOC	123	50	41%
Medical TOC	458	178	39%
Behavioral Health TOC	131	112	85%
Total	712	340	48%

Analysis of Performance: The following analysis is based on the 340 members who were enrolled in the TOC programs as of Q4 2025.

Behavioral Health Transitions of Care (BH- TOC)

Members who completed the program had a lower all-cause readmission rate (28%) compared to members who were identified as eligible for TOC but did not participate in the program (43%). Some members have been identified that require advocacy for alternate discharge planning and even placement in a supporting living environment. The BH TOC team has engaged with facilities as well as community teams to help best support members with frequent readmissions. Changes were made throughout 2025 to examine which members would benefit from the support of the TOC program. Some changes include considering members that are enrolled in high acuity community treatment a lower priority for Neighborhood's TOC program.

BH - TOC	30-day readmission	90-day readmission
Completed	28%	43%
Did not complete	43%	56%

Outpatient treatment is positive driver to help members maintain stability in the community and prevent readmissions. The BH TOC Program strives to connect members to the most appropriate level of care including Intensive Outpatient, Partial Hospital Programs, and Certified Community Behavioral Health

Centers. Contacting members within 72 hours or less of their discharge provided the TOC team an opportunity to eliminate barriers that prevent members from keeping their follow-up appointments.

BH TOC	Outpatient Enrollment 30 days post Discharge	Outpatient Enrollment 90 days post Discharge
Completed Program	82%	93%
Did not complete	70%	91%

Medical Transitions of Care (TOC)

Members who completed the program had a lower all-cause readmission rate (11%) compared to members who were identified as eligible for TOC but did not participate in the program (24%). Members who completed the TOC program stayed out of the hospital for nearly twice as long (43 days) as those who did not complete the program (23 days).

Compared to members who did not complete the program, members who participated and completed the TOC program had lower 30-, 60-, and 90- day readmission rates:

Medical TOC	30-day Readmission Rate	60-day Readmission Rate	90-day Readmission Rate
Completed Program	6%	9%	8%
Did not complete	21%	21%	22%

PCP appointments following an inpatient admission for medical reasons did not show a significant difference between the members enrolled in the TOC program as compared to those that did not. This will remain a goal that will be tracked.

Medical TOC	PCP visit within 30 days of Discharge	PCP visit within 60 days of Discharge	PCP visit within 90 days of Discharge
Completed	45%	55%	56%
Did not complete	44%	52%	57%

Enhanced Transitions Of Care (ETOC)

Members who completed the program had a lower all-cause readmission rate (20%) compared to members who were identified as eligible for ETOC but did not participate in the program (59%). Members who completed the ETOC program stayed out of the hospital for an average of 50 days compared to those who did not complete the program and averaged 33 days before their next inpatient admission.

Compared to members who did not complete the program, members who participated and completed the ETOC program had lower 30-, 60-, and 90- day readmission rates:

ETOC	30-day readmission	60-day readmission	90-day readmission
Completed	4%	13%	18%
Did not complete	36%	45%	58%

Overall, the Transitions of Care Program participation in Q4 2024 yielded positive results. As planned, program participation grew in 2025 with 821 additional members enrolled in the program through 2025. Evaluation of the 2025 program results is underway.

2025	Members Identified (Denominator)	Enrolled Members (Numerator)	Participation Rate
ETOC	451	224	50%
Medical TOC	1737	598	34%
BH-TOC	1088	339	31%
Total	3,276	1,161	35%

Analysis of Barriers to Performance and Planned Interventions:

The Transition of Care program benefited from access to the RI Quality Institute (RIQI) Admission, Discharge, and Transfer feed; however, a system transition in May 2025 temporarily limited Neighborhood's ability to receive timely discharge data. While many issues have since been resolved, gaps remain due to incomplete census reporting from some facilities.

Planned interventions to improve the program and corresponding goals include:

- Develop new payment policy requiring facilities to share admission and discharge information, allowing Neighborhood to receive more timely information to expedite member outreach.
- Establish more standardized processes for members who are readmitted while enrolled in the Transition of Care programs.
- Enhance data analysis to support informed decision-making and targeted interventions.
- Utilize data to inform how to prioritize members that the TOC team may have more of an impact on.
- Expand collaboration with facilities to include facilities we are not currently collaborating with on a regular basis.
- Increase from National Medicaid QC 75th percentile to QC 90th percentile for FUH Measure.
- Expand collaboration with AE and CCBHC teams.
- Work with Department of Children Youth and Families (DCYF) to develop a process to work more collaboratively with their new initiatives targeting children in BH Inpatient settings including a warm hand off for ongoing support from TOC Program.

H. Nursing Home Quality

Nursing Home Quality Monitoring

Opportunity Statement: Nursing homes are required by the Centers for Medicare and Medicaid Services (CMS) to collect and report nursing assessment results called the Minimum Data Set (MDS). The MDS provides a wealth of data that is used to assess facility quality as well as member characteristics and needs.

Goal: The Plan analyzes MDS data to monitor and report on the quality of care received by Neighborhood nursing home residents.

Neighborhood is responsible for reporting on two¹ MDS-derived INTEGRITY MMP nursing home quality measures as part of the state Quality Withhold (QW) program:

- RI 4.5 Skilled nursing facility discharges to the community.
- RI 4.6 Skilled nursing facility hospital admissions.

Neighborhood is also responsible for reporting on one additional MDS-derived MMP nursing home core reporting measure that is not a QW measure: RI 4.3 Nursing facility residents experiencing one or more falls with a major injury.

Measure details for the MMP Nursing Home quality measures are included in the following table:

Measure Name	Element A (Denominator)	Element B (Numerator)
RI 4.3 Nursing facility residents experiencing one or more falls with a major injury	Total number of long-stay nursing home residents	Total number of long-stay nursing home residents with one or more look-back scan assessments that indicate one or more falls that resulted in major injury
RI 4.5 Skilled nursing facility discharges to the community	Total number of members admitted to a skilled nursing facility (SNF) from an acute hospital during the prior 12 months who did not have a stay in a nursing facility in the 100 days prior to the SNF admission	Total number of members who were discharged back to the community alive from a SNF within 100 days of admission <u>and</u> remained out of any SNF for at least 30 days
RI 4.6 Skilled nursing facility hospital admissions	Total number of members admitted to a SNF from an acute hospital who had an MDS admission assessment during the prior 12 months	Total number of members readmitted to any hospital from the SNF within 30 days of admission

Measure/Methodology: The MDS is a standardized, federally mandated screening and assessment tool that facilitates comprehensive assessment of nursing home residents, including items that measure cognitive patterns; communication, hearing, and vision patterns; continence; psychosocial well-being; mood and behavior patterns; disease diagnoses and other health conditions; nutritional and dental status; skin conditions; medication use; and treatments and procedures.

¹ Two measures, RI 4.9 Nursing facility residents with Low Care Needs and RI 4.10 Nursing facility residents who received an antipsychotic medication, were retired in CY2021 and are no longer being reported. RI 4.2 High-risk nursing facility residents with pressure ulcers was suppressed for CY2024 reporting because of material changes made by CMS to the MDS assessment that rendered the measure incalculable.

EOHHS forwards an extract of Neighborhood member MDS data monthly to Neighborhood, and the extract is loaded into Neighborhood's internal data system. Neighborhood Analytics staff runs an annual report for submission to CMS and EOHHS four months after the end of the calendar year. Interim updates are provided to Neighborhood's internal nursing home quality workgroup throughout the year on a monthly or bi-monthly basis to facilitate intervention and monitor metric progress.

Interventions:

- Ongoing, Neighborhood's case managers complete a Transition assessment for all members who meet one Medicaid day criteria. Case Management staff completes and submits the Section Q form to the State.
- Ongoing, case managers attend care plan and discharge planning meetings at facilities (virtually, telephonically or on site) and conduct interdisciplinary case team meetings as needed.
- Ongoing, care management continues weekly care coordination with members admitted to nursing homes for short-term rehabilitation to assist with discharge planning as needed to ensure a safe return to community.
- Ongoing, care management continues to leverage service calculator (ADL assessment tool), resulting in a functional assessment that ensures appropriate in-home services are authorized to prevent or delay institutionalization.
- Custodial members are now assessed biannually for discharge opportunity. (as per contractual requirements). Our rehabilitation specialists provide recommendations as appropriate for additional oversight and guidance, including attendance at interdisciplinary care team meetings.
- Ongoing, care management continues to leverage census reports including tracking and trending of inpatient acute admissions for opportunities to proactively mitigate/improve patient outcomes. The Neighborhood Nursing Home Care Management team worked with RI nursing home industry leadership to increase electronic medical records (EMR) access. Allowing Neighborhood's care management team to review members' nursing home medical records has allowed greater oversight of members' care.

Analysis of Performance:

CY2025 findings to date indicate that Neighborhood is not likely to achieve success against benchmark for:

- RI4.5 Discharges to community: The current year-to-date rate is 64.31%, is better than last year's rate of 64.08%, but below the benchmark of 69% and short of the gap closure benchmark of 65.5%.

Neighborhood is very likely to achieve success against the gap closure target for:

- RI4.6 Hospital admissions: The current year-to-date rate of 12.6% is significantly better than the state and national averages of 25.1% and 23.9% respectively. This year's rate is considerably lower than CY2024 performance of 19.2%. While it misses the benchmark of 12.0%, it clears the gap closure target of 16.9%.

The following table provides Neighborhood CY 2023- CY 2025 nursing home quality measure performance vs. Quality Withhold benchmarks:

Measures	Neighborhood MMP Performance			Rhode Island Average*	National Average*	Notes
	2023	2024	2025**			
4.3 Falls with Injury	3.31%	2.56%	3.75%	3.64%	3.26%	Lower is better
Benchmarks	-	-	-			
4.5 Discharges to Community	67.81%	64.08%	64.31%	N/A	N/A	Higher is better
Benchmarks	69%, gap closure 63.89%	69%, gap closure 68.8%	69%, gap closure 65.5%			
4.6 Hospitalizations	9.28%	19.18%	12.62%	25.10%	23.87%	Lower is better
Benchmarks	12%, gap closure 13.70%	12.00%***	12%, gap closure 16.9%			

*Note: RI and National data are from the CMS Nursing Home Compare website, <https://data.cms.gov/provider-data/dataset/xcdc-v8bm>. Last modified 01/27/2026, released 02/05/2026, processing date 01/01/2026. N/A= not available as a comparable metric in NH Compare.

**2025 Neighborhood findings are considered preliminary as of the time of this report as data are formally submitted 4/30 (RI4.5 and RI 4.6) and 6/30 (RI4.3) and then go through final review by CMS and EOHHS before being considered final. Data here reflects January-September 2025 assessments, as of January 2026, for all metrics. Two metrics, Discharges to Community and Hospitalizations have follow-up periods extending beyond one month and will not have complete data until the final run in June.

***No gap closure option because we met and exceeded the benchmark in the prior year

Analysis of Barriers to Performance and Planned Interventions:

- Frequent management turnover and shifts in facility leadership/ownership.
- New contract requirements with shortened completion timelines.
- Electronic medical record access fluctuates due to continued management turnover.

III. Service and Operational Quality Improvement Activities

A. Access to the Health Plan

Call Abandonment Rate and Call Answer Timeliness

Opportunity Statement: The Plan tracks call performance to ensure that members are receiving the highest quality of service resulting in greater member satisfaction and retention.

Goal: Meet or exceed the contractual requirement for call timeliness goal of 80% of incoming calls answered within 30 seconds. Meet or exceed the requirement for abandoned calls to occur in 5% or less of member calls.

Measure/Methodology: Call Abandonment (<5%) and the Call Answer Timeliness (80%/30 sec) data are tracked and reported through the Plan's call management systems, Ring Central which tracks all inbound and outbound calls.

Interventions:

- Commercial Product team provided annual training to update staff on upcoming product changes with the goal of helping employees become more familiar with the new information and ultimately improve efficiency and reduce the time required to respond to member inquiries.

- A new-hire Medicaid class started in July which consisted of 8 new reps. Out of the 8 new hires, 5 are bilingual.
- Implemented Eforms to eliminate manual entry, improve data integrity, and turnaround time – these included: Interpreter Internal Eform, Member Address Change Eform, Member Appeal Eform, and the PCP Eform.
- Continued cross-training additional staff across multiple lines of business to enhance flexibility during peak hours.
- Continued promoting the member portal as a convenient tool for accessing self-service features, including PCP changes, Explanation of Benefits (EOBs) requests, ID card replacements, and mailing address updates Support staff in developing strategies to enhance both individual and overall call handling times, increasing availability for incoming calls.

Analysis of Performance: Overall, the Plan met both the abandonment rate goal for the Medicaid and INTEGRITY lines of business in 2025, the timeliness goal was also met for both lines of business.

Product	Number of Calls	Average Speed to Answer	% Abandoned	% Answered in 30 seconds
Medicaid	105,210	00:17	1%	90%
Exchange	55,655	02:22	8%	59%
Integrity	28,553	00:17	2%	91%

***Note:** Information listed only includes member calls.*

Call Performance (80% of calls answered within 30 Seconds)

- The call performance goal for the Medicaid product was met for all 12 months in 2025, resulting in an overall average of 90%.
- The call performance for the Exchange product did not meet the goal in 2025, resulting with an overall average score of 59%.
- The call performance goal for the INTEGRITY product (MMP) was met for all 12 months in 2025, ending the year with an overall average of 91%.

% in 30	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicaid	93%	90%	84%	89%	91%	91%	93%	96%	91%	94%	85%	83%
Exchange	33%	53%	71%	85%	87%	70%	69%	40%	27%	64%	68%	63%
Integrity	83%	90%	92%	95%	94%	92%	93%	87%	85%	95%	93%	91%

Abandonment Rate (no more than 5%)

- The Medicaid product met the performance goal for CY2025, resulting in an overall score of 1%.
- The Exchange product did not meet the performance goal in four of the 12 months in 2025, resulting in an overall abandonment rate of 7.25% for the year.
- The INTEGRITY product met the performance goal for CY2025, resulting in an overall average of 2%.

Abandon %	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicaid	1%	2%	2%	1%	1%	1%	1%	1%	1%	1%	2%	2%
Exchange	15%	9%	3%	1%	1%	4%	4%	14%	22%	5%	4%	5%
Integrity	3%	2%	1%	1%	1%	1%	1%	2%	3%	1%	1%	2%

Analysis of Barriers to Performance and Planned Interventions:

- Staff attrition and increased call volumes affected our ability to meet the required metrics from June through December for the Exchange line of business.
 - **Planned Intervention:** Continue to cross train additional staff on multiple lines of business to provide greater flexibility for covering peak hours.
 - **Planned Intervention:** Promote the member portal via email as a means for all members to access the many self-service functions such as; PCP changes, requesting EOB's, ID cards and changing their mailing address changes.
 - **Planned Intervention:** Launched a self-service member portal for the Medicaid line of business in Q4 2025.
 - **Planned Intervention:** Hired a new Medicaid training class in May and a Medicaid temp training class in November 2025 to support progression of staff trained on other lines of business.

Timely Distribution of Member Handbooks and Identification Cards

Goals:

- **Medicaid:** 98% of Identification (ID) cards and member handbooks are mailed to members, new to the health plan, within ten calendar days of notification from EOHHS.
- **Exchange:** 98% of ID cards and member handbooks are mailed to members new to the health plan, within ten calendar days of notification from Healthsource Rhode Island (HSRI).
- **Medicare-Medicaid Plan (MMP):**
 - INTEGRITY Voluntary Enrollment:
100% of enrollment materials are mailed within 8 days of the 834 file EOHHS Run Date or/the last day of month prior to the Effective Date (whichever allots more time).
 - INTEGRITY Passive Enrollment:
Note: 1st and 2nd Mailings are sent together at time of Enrollment.
 - 1st Mailing- 100% of enrollment materials are mailed 30 days prior to the effective date.
Enrollment materials include: Welcome Letter, Summary of Benefits, Combined EOC/Provider/Formulary Insert.
 - 2nd Mailing- 100% of enrollment materials are received 1 day prior to the effective date.
Enrollment materials include: List of Durable Medical Equipment (DME) and Authorization of Representative Form.
 - Annual Notification of Change (ANOC) Mailing: 100% of ANOC enrollment materials are mailed by the last day of the member's effective date month. ANOC Enrollment Materials include: ANOC, evidence of coverage, DME list, benefit summary, formulary, and provider directory.

Measure/Methodology: The Manager of Enrollment and/ or Enrollment Analysts receive fulfillment files from HealthRules and Amisys daily and reconcile the daily member additions received by way of EOHHS, Center for Medicare and Medicaid Services (CMS) and HSRI. Once files are confirmed to be complete and accurate, they are sent to the fulfillment vendor. The fulfillment vendor processes the file and returns a response that includes mail dates of the member/ enrollment materials. That response file is analyzed to ensure all required materials have been sent in a timely manner.

Analysis of Performance:

- **Medicaid:** Met the goal of 98% of ID cards and member handbooks mailed to newly enrolled members within ten calendar days of notification from EOHHS, except for July 2025 which was at 97%. This was due to a HealthEdge data warehouse issue regarding delays in data replication.
- **Exchange:** Met goal of 98% of ID cards and member handbooks mailed to newly enrolled members within ten calendar days of notification from HSRI, except for November and December 2025, which were at 93% and 91% respectively. This was directly related to a defect in the print fulfillment file that was identified during our Commercial Annual Enrollment Period corporate project.
- **INTEGRITY:** Met the goal of 100% of member mailings within required timeframes.

	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Medicaid	100%	100%	100%	99%	100%	100%	97%	100%	99%	100%	100%	100%
Exchange	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	93%	91%
Medicare-Medicaid Plan	100%	100%	100%	100%	100%	100%	100%	100%	100%	N/A	N/A	N/A

Analysis of Barriers to Performance and Planned Interventions:

- **Medicaid:** Barriers to performance typically include timeliness of transactions received and quality of data received from EOHHS, however the barrier in 2025 was an isolated incident regarding a data replication issue in the HealthRules Data Warehouse.
 - **Planned Intervention:** Collaboration with EOHHS regarding continuous process improvement and data quality.
 - **Planned Intervention:** Escalating issues by way of reported JIRA tickets and leadership awareness for timely resolution.
- **Exchange:** Barriers to performance typically include timeliness and accuracy of transactions received from HSRI, however the barrier in 2025 was an isolated incident related to the corporate project: Commercial Annual Enrollment Period (AEP) in which precursor tasks and milestones were not completed prior to go-live, including remediation of a member material fulfillment file defect. As a result, erroneous member materials were continually extracted to the file and correct member materials were not extracted to the file. These could not be sent to the print vendor for fulfillment.
 - **Planned Intervention:** Enrollment performs daily reconciliation to identify new members as soon as they are received to manually trigger materials.
 - **Planned Intervention:** To remediate the issue of the file defect, Business Services manually produced a member material fulfillment file. Long term resolution of defect remains outstanding. Recommendations have been made to the project team inclusive of enhanced project plan and playbook for go-live activities during the next AEP.
- **MMP:** Barriers to performance include dependency on receipt of matching enrollment transactions from EOHHS and CMS. The Plan is also dependent on the Business Processing Organization (BPO) being able to load members into the Market Prominence system. Enrollment has a work-around in place with SS&C to address Service Level Agreement (SLA) misses.
 - **Planned Intervention:** Enrollment will continue to perform daily reconciliation to identify new members as soon as the Plan receives notification of their enrollment, so that materials are manually triggered as needed. With sunset of MMP and transition to D-SNP, there will be a reduced risk of barrier.

Overall Interventions:

- The Enrollment Team will continue to collaborate with EOHHS, HSRI, and CMS to identify areas of concern and process improvements for enhanced resolution of data integrity and data delivery issues.
- The Enrollment Team will continue with ongoing departmental training regarding reconciliation.
- Collaborate with Production Support so they can appropriately prioritize and establish service level agreements regarding resolution of enrollment-reported issues.

Nurse Advice Line

Opportunity Statement: The Nurse Advice Line is available to all Neighborhood members. The toll-free service allows a registered nurse to respond to a broad range of health-related questions 24 hours a day, seven days a week. The Nurse Advice Line helps members identify and access the appropriate level of care to improve their health. The service provides education and resources to members, allowing the members to make informed medical decisions.

Goals:

- Decrease non-emergent use of emergency room.
- Use Carenet data daily to follow-up and/or intervene with members, as appropriate.

Measure/Methodology: Carenet, the Plan's nurse advice line vendor, provides Neighborhood with member level detail of calls by line of business daily, as well as a monthly summary of all the call activity by line of business. Medical Management staff reviews the data to ensure Carenet appropriately directed members and to assess if there is an opportunity for follow up by Neighborhood. In addition to monitoring the Carenet data for member impact, the data is also reviewed for contractual compliance such as call wait times and call back metrics.

Interventions:

- Daily, Care Management monitored the data in the fields "Presenting Problem" and "Care Advice" and identified those member calls for which the standard of complete and actionable data is not met. A full copy of the members' call data from the Carenet Triage report was sent to Carenet along with an explanation of discrepancies.
- Carenet re-educated staff based on feedback received. In addition, monthly touchpoint meetings were held to ensure that these standards are met.
- Monthly, Care Management monitored the summary data for contractual compliance such as call wait times and call back metrics. Touchpoint meetings were held to ensure that standards are met.

Analysis of Performance: The total number of calls made to the Nurse Advice Line increased from the prior year with 2,494 total calls in 2025 compared to 2,336 in 2024. The total number of member calls continues to trend upwards yearly. The total number of triaged calls in 2025 was 434 compared to 391 in 2024. The calls not triaged were directed to customer service and in some cases, the caller was not a Neighborhood member. The following table contains the call volume data from 2020-2025.

	Total Calls	Total Triage
2020	1,651	461
2021	1,811	461
2022	1,753	443
2023	2,013	419
2024	2,336	391
2025	2,494	434

The 2025 call volume displays that most calls continue to occur during the day (1,749 calls or 70.1%). This trend was also true for 2023 and 2024.

2023	Q1	Q2	Q3	Q4	Total
# Calls during day (9AM-5PM)	414	320	380	350	1,464
# Calls during night (5PM-9AM)	126	160	139	124	549
2024	Q1	Q2	Q3	Q4	Total
# Calls during day (9AM-5PM)	414	427	449	442	1,732
# Calls during night (5PM-9AM)	131	159	159	155	604
2025	Q1	Q2	Q3	Q4	Total
# Calls during day (9AM-5PM)	555	365	426	403	1,749
# Calls during night (5PM-9AM)	191	192	195	167	745

The following table shows data comparing the Nurse Advice Line recommendation for level of care and the member's original inclination from 2020 to 2025. The percentages for each triage recommendation were consistent with the results for 2024 with a slight increase/decrease. Of the members triaged, the nurse advice line was successful in diverting 4% of members from the emergency room and recommending 24% of members to less acute care. In contrast, 45% of members triaged were recommended sooner and/or more acute care. Of note, members calling for information or advice increased from 5% to 6% in 2025.

Triage Recommendation	2020 Calls	2021 Calls	2022 Calls	2023 Calls	2024 Calls	2025 Calls
Nurse recommended sooner and/or more acute care than member inclination	108 (26%)	82 (18%)	132 (30%)	127 (30%)	169 (44%)	192 (45%)
Nurse recommended later and/or less acute care than member inclination	44 (11%)	66 (14%)	99 (22%)	84 (20%)	87 (23%)	104 (24%)
Member was going to ER and nurse recommended alternative (ER Diversion)	29 (6%)	12 (3%)	52 (12%)	23 (5%)	21 (5%)	19 (4%)
Nurse recommendation and member initial inclination similar	177 (43%)	158 (34%)	91 (21%)	33 (8%)	53 (13%)	57 (13%)
Member called for information or advice only	30 (7%)	25 (5%)	16 (4%)	68 (16%)	22 (5%)	26 (6%)
Other (No contact after many attempts or no service provided, transfer)	63 (15%)	116 (25%)	104 (23%)	84 (20%)	39 (10%)	36 (8%)

In 2025, the Neighborhood Care Management team monitored the Nurse Advice Line call abandonment rate, average speed to answer, and average call back times to ensure it continuously meets Neighborhood Standards.

- Call abandonment rate was 3.57%, within the Plan's goal of less than 5%. This was an improvement compared to the 2024 call abandonment rate of 4.98%.
- The average speed answered by a live person was 20 seconds, within the Plan's goal of less than 30 seconds. This was an improvement compared to the 2024 average speed of 25 seconds.
- The average call back time was 17.82 minutes, which was below the Plan's goal of 30 minutes. This was an improvement compared to the 2024 average call back time of 18.5 minutes.

Barriers to Performance and Planned Interventions:

- Neighborhood is working to improve member experience with Carenet by evaluating on-call services provided by Carenet.
 - **Planned Intervention:** Neighborhood Care Management will continue to monitor Carenet to ensure the transcribed information is complete and actionable by Neighborhood internal staff.

Member Email Access to the Health Plan

Opportunity Statement: To meet member communication preferences, the Plan offers an email form via the website to provide members with an alternate mode of contacting the health plan.

Goals:

- 100% of email inquiries are responded to within one business day.
- Achieve an average quality score of at least 95%.

Measure/Methodology: Members access the Plan's "Contact Us" portion of the website and follow the instructions to create a unique username and password. By clicking on the "Contact Us" link, members can submit their inquiries to Neighborhood using the "Contact Us" template. A dedicated Member Services Representative (MSR) responds to the email. A Quality Analyst audits a minimum of five email responses for quality and accuracy monthly.

Analysis of Performance: Between January and December 2025, the Plan received 1,124 web email inquiries, representing a decrease of 183 inquiries (14%) compared to 2024. Turnaround time continued to improve significantly, with 99% of inquiries responded to within one business day, up from 90% in 2024, placing performance just 1% below the 100% goal.

Interventions

- Ongoing Process Monitoring: Continued daily check-ins, status updates, and real-time guidance ensured consistent oversight and immediate issue resolution.
- Maintaining Adequate Staffing Levels: Ensured sufficient staff coverage with team members trained specifically on the email inquiry workflow.
- Leveraging Extended and Weekend Shifts: Utilized staff working later hours and weekends to manage volume and maintain timely responses.
- Inquiry Tracking for Trends and Resolution: Monitored inquiry types and trends to ensure that issues were addressed promptly and recurring problems were minimized.
- Promotion of Self-Service Options: Encouraged members to use self-service tools on the member portal. With the launch of the Medicaid Member Portal in Q3, further reductions in inquiries are expected in 2026.

Analysis of Performance: Analysis of email received showed that Medicaid members submitted the highest volume of inquiries, totaling 515 (46%), followed by Exchange with 448 inquiries (40%) and MMP with 134 inquiries (12%). Overall inquiries decreased by 183, driven primarily by a reduction of 133 inquiries from Commercial members.

Product	Total Inquiries 2024	Total Inquiries 2025	+/-
Medicaid	650	515	-135
Exchange	506	448	-58
MMP	137	134	-3
Misdirected	14	27	+13
Total	1307	1124	-183

The top five inquiry types for the period were as follows:

1. **Reimbursement Requests – 203 inquiries** - Reimbursement requests moved to the top position in 2025, increasing by only five compared to 2024. Of these, 99 were submitted by Medicaid members, 89 by Commercial members, 14 by Integrity members, and 1 by a non-member. These requests typically involve members submitting supporting documentation for out-of-pocket expenses.
2. **Consent Form Inquiries – 128 inquiries** - The team received 31 inquiries from Medicaid, 74 from Integrity, and 22 from Commercial members related to consent form processing. One inquiry was submitted on behalf of a non-member and could not be completed.
3. **Benefit Questions – 128 inquiries** - Benefit-related inquiries included 57 from Medicaid, 56 from Commercial, and 13 from Integrity members.
4. **ID Card Requests – 111 inquiries** - ID card requests included 84 from Medicaid members, 21 from Commercial, 4 from Integrity, and 2 without sufficient member information. This reflects a notable decrease from the 194 ID card requests received in 2024.
5. **Billing and Claims Questions – 110 inquiries**
Billing and claims inquiries totaled 41 from Medicaid, 63 from Commercial, and 4 from Integrity members.

The following table shows the types and number of inquiries received in 2025 compared to 2024. The inquiry types have not changed significantly over the past three years.

Category	2024 Inquires	2025 Inquiries	+/-
ID Card	194 (15%)	111(10%)	-83
Benefit	138 (11%)	128(11%)	-10
Requesting Forms & Materials	42 (3%)	56(5%)	+14
PCP/Address Change	70 (5%)	65(6%)	-5
Billing/Claims Question	146 (11%)	110(10%)	-36
Verifying Eligibility	102 (7%)	100(9%)	-2
Reimbursement/DMR	198 (15%)	203(18%)	+5

Finding a doctor	45 (3%)	35(3%)	-10
Dis-enrollment Requests	24 (2%)	20(2%)	-4
Case Management/Programs	2 (0.2)	6(1%)	+4
Grievances, complaints and appeals	16 (1%)	17(2%)	+1
Behavioral health and substance abuse treatment	14 (1%)	10(1%)	-4
Website	11 (.8%)	20(2%)	+9
Inquiry submitted by Provider	0	4	+4
Authorization Inquiry	10 (1%)	7(1%)	-3
Consent/CertApp/POA	199 (15%)	128(11%)	-71
Pharmacy	38 (3%)	40(4%)	+2
Rewards	58 (4%)	64(5%)	+6
Total	1307	1124	-183

Quality Tracking

The quality of email responses is measured using the following criteria:

- Introduction/Closing
- Verification
- Grammar/Professionalism/Communication
- Research/Effective Use of Resources
- Inquiry Accuracy and Completeness
- Documentation

The average monthly quality score for 2025 was 99%, consistent with the 2024 score (99%) and exceeding the goal of 95%.

	2025											
Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Average Score	100%	96%	98%	100%	98%	96%	100%	98%	100%	100%	100%	98%
Goal	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Analysis of Barriers to Performance and Planned Interventions:

- The number of inquiries responded to in one business was 99%, slightly below the 100% target. Despite staff attrition and an increase in inbound call volume for all lines of business, the improvements allowed us to respond timely to the majority email requests.

Planned Intervention:

- **Shift “Contact Us” to Member Portals:** Relocate the Contact Us function for Commercial, Medicaid and D-SNP to their respective member portals. This change will highlight available self-service options and is expected to reduce both email inquiries and call volume related to tasks that can be completed online.

- **Direct Submission of Consent Forms:** Continue providing members with the direct email address for returning completed consent forms to the processing team. This bypasses the Contact Us workflow and removes the associated triage responsibilities from this team.
- **Leverage RingCentral Email Functionality:** Utilize Email functionality via Ring Central to allow for easier tracking and task coordination.
- **Further Evaluation of Operational Impact:** Initial assessments are complete; however, further review is needed to ensure revised workflows do not negatively impact call availability.
- **Reduce Manual Tracking and Improve Oversight:** These interventions will decrease the time spent on manual tracking, support more accurate performance evaluation, and strengthen overall staff management.

B. Accessibility of Services

Access to Health Care Appointments and Needed Care

Opportunity Statement: Access to medical services rendered by network practitioners is a critical measure of Neighborhood's mission to deliver high quality, cost-effective health care for Rhode Island's residents. The primary care provider (PCP) is the central access point for Neighborhood's members and serves as the member's medical home, affording each member the coordination and continuity of care that are hallmarks of a quality health care system. Access to specialty care is an integral part of supporting the member in their medical home.

Goal: Neighborhood's goal is 100% of primary care and select high-volume and/or high-impact specialty sites surveyed meet the following standards:

- Urgent care appointments within 24 hours.
- Routine care appointments within 30 days.
- New provider appointments within 30 days.

Measure/Methodology: In quarters 1 and 3 each year, surveys are conducted telephonically, via provider attestation, of the next available appointment type to assess the network's compliance with Neighborhood's access to care standards. In quarters 2 and 4 each year, secret shopper scenarios are utilized. Surveyors will role-play as new members to Neighborhood and using scripted scenarios, they will attempt to make an appointment for routine care and urgent care. Surveyors will aim to obtain appointments within the EOHHS specified timeframes by requesting the earliest possible appointment.

Sampling for each quarter includes the following provider types:

Q1 and Q3 Provider Attestation:

- Eighty adult and pediatric PCPs; and
- Six specialty care providers were selected for each type, including high-volume/high-impact specialty types. The entire universe of specialty care practices was selected when fewer than six were available. Behavioral health providers are included however oversight and reporting are done by a contracted vendor, Optum, and results are not included in this report.

Q2 and Q4 Secret Shopper:

- Sixty adult and pediatric PCP's, pediatricians, and OB/GYNs

- Six specialty care types including adult dermatology, endocrinology, gastroenterology, pulmonology and cardiovascular disease and pediatric allergy/immunology, gastroenterology, neurology, orthopedics, and otolaryngology.

To represent a reliable cross-section of Neighborhood's provider network, samples were randomly selected directly from Neighborhood's Provider Directory, and include a mix of small private practices, Community Health Centers, large multi-specialty practices, and hospital-based groups. Regarding specialty group selection, Neighborhood defines **high-volume providers** as the top five provider types by utilization, always to include OB/GYN. Neighborhood defines **high-impact providers** as oncology.

Data collection is done in two principal areas:

1. Appointment Rates: Number of appointments made compared to number of providers surveyed.
2. Timely Appointment Rates: Number of appointments made that meet compliance standards compared to total number of appointments made.

In addition to the survey, a review and analysis of member complaint data is conducted.

Analysis of Performance:

Provider Attestation: Compared to the prior period, appointment rates did not vary very significantly. In Q1 2024, 276 (or 99%) of the 280 providers surveyed offered appointments. In Q1 2025, 272 (or 97%) of the providers surveyed offered appointments.

Primary care appointment rates decreased slightly from 100% in Q1 2024 to 98% in Q1 2025. For the five specialty categories that remained the same for both quarters, Adult Cardiology, Adult Oncology, Adult Optometry, Pediatric Optometry and Pediatric Otolaryngology/ENT, percentages remained at 100%.

In Q1 2024, of the 276 appointments made, 219 (or 79%) met access standards. In Q1 2025, 221 of the 272 appointments made (or 81%) met access standards.

Timely appointment rates decreased in the following areas: Adult Urgent Cardiology, Adult Urgent Oncology, Adult Urgent Optometry and Pediatric Routine Otolaryngology/ENT.

Timely appointment rates increased for Family Medicine Urgent, Adult Routine Cardiology, Adult Routine Oncology, Pediatric Routine and Urgent Optometry and Pediatric Urgent Otolaryngology/ENT.

Rates remained the same for Adult Routine Optometry.

In summary, average timely appointment rates remained the same for Routine Primary Care. Timely rates for Urgent Primary Care increased from 78% to 96%. Timely rates on average decreased for both Routine and Urgent Specialty Care.

Table 1 – Q1 2025 Provider Attestation

Q1 2025 Provider Attestation Survey							
Provider Type	Appointment type	Minimum Required Sampling	Total number of providers surveyed	Total number of appointments made	Appointment Rate	Total number of appointments meeting timeframe standard	Timely Appointment Rate
Family Medicine, Internal Medicine, and Pediatrics	Routine	80	80	79	98%	74	94%
	Urgent	80	80	79	98%	68	86%
Cardiology	Routine	6	6	6	100%	4	67%
	Urgent	6	6	6	100%	3	50%
Gastroenterology	Routine	6	6	6	100%	5	83%
	Urgent	6	6	6	100%	3	50%
Neurology	Routine	6	6	6	100%	5	83%
	Urgent	6	6	6	100%	3	50%
Oncology	Routine	6	6	6	100%	5	93%
	Urgent	6	6	6	100%	3	50%
Optometry	Routine	6	6	6	100%	5	83%
	Urgent	6	6	6	100%	6	50%
Pediatric Dermatology	Routine	6	6	6	100%	2	33%
	Urgent	6	6	6	100%	5	83%
Pediatric Optometry	Routine	6	6	6	100%	6	100%
	Urgent	6	6	6	100%	6	100%
Pediatric Orthopedics	Routine	6	6	6	100%	4	67%
	Urgent	6	6	6	100%	0	0%
Pediatric Otolaryngology/ENT	Routine	6	6	6	100%	4	67%
	Urgent	6	6	6	100%	5	83%
Pediatric Speech Therapy	Routine	6	6	6	100%	5	83%
	Urgent	6	6	6	100%	0	0%
Totals		280	280	272	97%	221	81%

Table 2 – Comparison Q1 2024 Q1 2025 Provider Attestation

	Q1 2024 Q1 2025 Comparisons Provider Attestation					
Category	Provider Type	Appointment type	2024 Q1 Appointment Rate	2025 Q1 Appointment Rate	2024 Q1 Timely Appointment Rate	2025 Q1 Timely Appointment Rate
Primary Care	Family Medicine, Internal Medicine, and Pediatrics	Routine	100%	98%	94%	94%
		Urgent	100%	98%	78%	86%
Specialty Care - Adults	Cardiology	Routine	100%	100%	17%	67%
		Urgent	100%	100%	67%	50%
	Gastroenterology	Routine	N/A	100%	N/A	83%
		Urgent	N/A	100%	N/A	50%
	Neurology	Routine	N/A	100%	N/A	83%
		Urgent	N/A	100%	N/A	50%
	Oncology	Routine	100%	100%	83%	93%
		Urgent	100%	100%	67%	50%
	Optometry	Routine	100%	100%	83%	83%
		Urgent	100%	100%	67%	50%
Specialty Care - Pediatrics	Pediatric Dermatology	Routine	N/A	100%	N/A	33%
		Urgent	N/A	100%	N/A	83%
	Pediatric Optometry	Routine	100%	100%	83%	100%
		Urgent	100%	100%	50%	100%
	Pediatric Orthopedics	Routine	N/A	100%	N/A	67%
		Urgent	N/A	100%	N/A	0%
	Pediatric Otolaryngology/ENT	Routine	100%	100%	83%	67%
		Urgent	100%	100%	50%	83%
	Pediatric Speech Therapy	Routine	N/A	100%	N/A	83%
		Urgent	N/A	100%	N/A	0%
Total	Primary Care	Routine	100%	98%	94%	94%
		Urgent	100%	98%	78%	96%
	Specialty Care	Routine	97%	100%	80%	76%
		Urgent	97%	100%	63%	52%
Specialty Categories highlighted in Yellow were the same for Q1 2024 and Q1 2025 and therefore comparisons could be made						

Secret Shopper: In Q2 of 2024, 80 of the 180 providers surveyed (or 44%), offered an appointment. In Q2 of 2025 69 of the 180 providers surveyed (or 38%) offered an appointment.

Appointment rates decreased in all areas except Routine Pediatrics, Adult Urgent Cardiology, Adult Urgent Dermatology, Adult Urgent Endocrinology, Adult Routine Gastroenterology, Adult Urgent Pulmonary and

Pediatric Routine Otolaryngology/ENT. Rates remained the same for Urgent Pediatrics, Adult Routine Dermatology, Adult Routine Endocrinology and Pediatric Routine Gastroenterology.

In 2024 of the 180 providers surveyed 80 were able to offer appointments. 38 of those appointments met timely standards or 47.5%. In 2025 of the 180 providers surveyed, 69 offered appointments and of those 69, 43 of those appointments met timely standards or 61%.

Accessibility, as defined by timely appointment rates, increased in most areas of routine care including Family/General Practitioners and Internal Medicine, Urgent Pediatrics and Routine OB/GYN care. Rates remained the same for Routine Pediatric care and decreased slightly for Urgent OB/GYN care.

Timely appointment rates for Adult Specialty Care appointments increased for Dermatology Routine appointments, Endocrinology Urgent appointments, Gastroenterology Routine appointments and Pulmonary Routine appointments. Rates decreased for urgent Pulmonary and remained the same for all other categories.

Specialty Care appointments for children increased for Allergy/Immunology Routine, Neurology Routine and Urgent, and Orthopedics Urgent. Rates decreased for Gastroenterology Urgent, Orthopedics Routine, Otolaryngology/ENT Routine and Urgent. Rates remained the same for Allergy/Immunology Urgent and Gastroenterology Routine.

In summary, average timely appointment rates increased for all areas of Primary Care and decreased slightly from 80% to 78% for Routine Specialty care for children.

Areas identified with exceptionally low rates of both appointment availability as well as timely appointment rates are Pediatric Urgent Care, Adult Routine Cardiology, Adult Urgent Dermatology Adult Urgent Gastroenterology, Pediatric Urgent Allergy/Immunology, Pediatric Urgent Gastroenterology and Pediatric Urgent Otolaryngology/ENT.

Table 3- Q2 2025 Secret Shopper

2025 Q2 Secret Shopper Survey								
Category	Provider Type	Appointment type	Minimum Required Sampling	Total number of providers surveyed	Total number of appointments made	Appointment Rate	Total number of appointments meeting timeframe standard	Timely Appointment Rate
Primary Care	Family/General Practitioners and Internal Medicine	Routine	10	10	4	40%	4	100%
		Urgent	10	10	5	50%	4	80%
	Pediatricians	Routine	10	10	5	50%	5	100%
		Urgent	10	10	2	20%	1	50%
	OB/GYNs	Routine	10	10	6	60%	6	100%
		Urgent	10	10	4	40%	1	25%
Specialty Care - Adults	Cardiology	Routine	6	6	0	0%	0	N/A
		Urgent	6	6	2	33%	1	50%
	Dermatology	Routine	6	6	3	50%	2	67%
		Urgent	6	6	5	83%	0	0%
	Endocrinology	Routine	6	6	2	33%	1	50%
		Urgent	6	6	4	67%	1	25%
	Gastroenterology	Routine	6	6	3	50%	2	67%
		Urgent	6	6	0	0%	0	NA
	Pulmonary	Routine	6	6	2	33%	2	100%
		Urgent	6	6	4	67%	0	0%
Specialty Care - Pediatrics	Pediatrics Allergy/Immunology	Routine	6	6	3	50%	2	67%
		Urgent	6	6	1	17%	0	0%
	Pediatric Gastroenterology	Routine	6	6	3	50%	3	100%
		Urgent	6	6	0	0%	0	NA
	Pediatric Neurology	Routine	6	6	1	17%	1	100%
		Urgent	6	6	1	17%	1	100%
	Pediatric Orthopedics	Routine	6	6	2	33%	1	50%
		Urgent	6	6	2	33%	2	100%
	Pediatric Otolaryngology	Routine	6	6	4	67%	3	75%
		Urgent	6	6	1	17%	0	0%
TOTALS			180	180	69	38%	43	61%

Table 4– Comparison of Q2 2024 and Q2 2025 – Secret Shopper

Category	Provider Type	Appointment type	2024 Q2 Appointment Rate	2025 Q2 Appointment Rate	2024 Q2 Timely Appointment Rate	2025 Q2 Timely Appointment Rate
Primary Care	Family/General Practitioners and Internal Medicine	Routine	50%	40%	80%	100%
		Urgent	60%	50%	50%	80%
	Pediatricians	Routine	20%	50%	100%	100%
		Urgent	20%	20%	0%	50%
	OB/GYNs	Routine	70%	60%	43%	100%
		Urgent	70%	40%	29%	25%
Specialty Care - Adults	Cardiology	Routine	17%	0%	0%	0%
		Urgent	0%	33%	N/A	50%
	Dermatology	Routine	50%	50%	33%	67%
		Urgent	17%	83%	0%	0%
	Endocrinology	Routine	33%	33%	50%	50%
		Urgent	33%	67%	0%	25%
	Gastroenterology	Routine	33%	50%	0%	67%
		Urgent	50%	0%	0%	0%
	Pulmonary	Routine	50%	33%	67%	100%
		Urgent	33%	67%	50%	0%
Specialty Care - Pediatrics	Pediatric Allergy/Immunology	Routine	67%	50%	25%	67%
		Urgent	50%	17%	0%	0%
	Pediatric Gastroenterology	Routine	50%	50%	100%	100%
		Urgent	67%	0%	75%	0%
	Pediatric Neurology	Routine	67%	17%	75%	100%
		Urgent	33%	17%	0%	100%
	Pediatric Orthopedics	Routine	67%	33%	100%	50%
		Urgent	50%	33%	0%	100%
	Pediatric Otolaryngology/ENT	Routine	50%	67%	100%	75%
		Urgent	33%	17%	100%	0%
Average of all	Primary Care	Routine	47%	50%	74%	100%
	Primary Care	Urgent	50%	37%	26%	52%
	Specialty Care Adult	Routine	37%	33%	30%	57%
	Specialty Care Adult	Urgent	27%	50%	13%	28%
	Specialty Care Children	Routine	60%	33%	80%	78%
	Specialty Care Children	Urgent	47%	17%	35%	40%

Analysis of Barriers to Performance and Planned Interventions:

- Provider Attestation:**
 - While appointment rates were extremely high for all areas with no appointment types identified with a decrease, there were many timely appointment types with decreases in 2024.
 - Many specialty care providers do not have routine care outside of follow-up care for which they provide the next necessary appointment (e.g., annual GYN appointments which are equal to 365 days). Therefore, providers reported available days greater than 30 as routine follow-up is not typically needed within 30 days.
 - Urgent care appointments to specialty providers are based on the acuity of symptoms and referral requests by primary care providers and/or upon discharge from an inpatient or outpatient facility. Therefore, the urgent care appointments do not always align with Neighborhood standards.
- Secret Shopper:** An ongoing challenge with the secret shopper survey is that it is not a reasonable expectation for a new patient to receive a routine or urgent appointment within 30 days. It is also not a reasonable industry expectation for a new patient to receive an urgent appointment within 24 hours. These patients are not known to the PCP and are referred to urgent care.

In both secret shopper and provider attestation survey, examination of the non-responding providers revealed data accuracy impacting response rate including inaccurate telephone numbers, Providers with closed panels, Closed practices, and retired practitioners. In some cases, where providers had left practices, appointments were offered with other providers in the practice. It should be noted that providers who could not be reached, who had retired or who had closed panels are not removed from the group denominators. A process improvement was put in place in 2025 adding panel status to the report used to

identify providers to survey. Any providers who had submitted a closed panel status update, were eliminated from the sample used.

Another identified challenge involves practices that require referrals and/or questionnaires be completed prior to appointments being made. This is very prevalent in most areas of specialty care.

In general, Rhode Island is experiencing a provider crisis due to shortages of physicians and other healthcare professionals. Factors contributing to this include provider retirements, burnout, and insufficient availability of new providers.

Planned Interventions

- Provider Relations to conduct outreach and education for non-compliant providers, including but not limited to the discussion of access standards, issues of responsiveness, and to better understand how Neighborhood and providers can work together to reduce barriers impacting care.
- Provider Relations will send a letter to non-compliant providers educating them on access standards for which they are contractually obligated.
- If a provider needs to update their information e.g. No Longer Accepting New Patients, the providers are instructed to complete the necessary eforms.
- Provider Relations has worked closely with our Business Intelligence Team and Salesforce to develop process improvements in Provider Training and Tracking which will in turn lead to increased communication and education with providers regarding access standards and compliance.
- Provider Relations created a new position titled Provider Relations Associate Representative who will be able to outreach providers and follow-up with education regarding Access Standards as needed.
- Provider Relations is working with Product to standardize Access measures for all lines of business and improve the current method of surveying and reporting.

Access to Health Care Services After Business Hours

Opportunity Statement: Access to medical services rendered by network practitioners is a critical measure of Neighborhood's mission to deliver high-quality, cost-effective health care for Rhode Island's residents. Neighborhood surveys the primary care network, on an annual basis, to ensure member access to care outside of normal hours of operation.

Goal: Participating primary care providers are required to provide Neighborhood's members with a mechanism to access coverage twenty-four hours per day, seven days per week, and three-hundred-sixty-five days per year. Additionally, it is Neighborhood's expectation that primary care practices provide a call back within one (1) hour not to exceed two (2) hours, from the primary care or covering provider.

Measure/Methodology: Neighborhood engaged a vendor to conduct telephonic surveys of primary care providers outside of normal business hours. The vendor, from all available practices in Neighborhood's Provider Directory, randomly selected eighty (81) primary care providers. The sample included multi-specialty groups, small independent practices, hospital based primary care, community health centers, and community mental health centers to assess the following:

- Presence and type of coverage mechanism.
- Linguistic considerations.
- If emergency instructions were provided.
- The average wait time to access an on-call provider.

Interventions:

- Provider Relations provided Behavioral Health Orientation Webinars, as part of Behavioral Health in-sourcing, with 771 attendees.
- Provider Relations scheduled three webinars for providers to log on to complete the annual mandatory training. 753 attendees have completed the training and a third training is scheduled.

Analysis of Performance: Overall response rate:

A total of eighty-one out of eighty-one or 100% of providers responded to the after-hours survey. This is an increase from 2024 when 95% of providers responded.

Table 1:

Mechanism	2024 Respondents	2024 Membership Total	2025 Respondents	2025 Membership Total	2025 Membership Adult	2025 Membership Pediatric
Answering machine	13 (17%)	3,393	30 (37%)	22191	19752	2439
Answering machine with answering service option	33 (43.5%)	36,271	29 (36%)	16030	13591	2439
Call forwarding to answering service	24 (31.5%)	8,757	16 (20%)	5670	4034	1636
Direct to Provider	6 (8%)	5,284	6 (7%)	3473	3473	0

Table 1 displays the mechanism by which a member could access a primary care provider after normal business hours, as follows:

- Traditional answering machine(s) with the option to leave a message increased from 17% in 2024 to 37% in 2025.
- Answering machine(s), with a call forwarding option to an answering service decreased from 43.5% in 2024 to 36% in 2025.
- Call forwarding direct to the answering service decreased from 31.5% in 2024 to 20% in 2025.
- Providers offering after-hours direct to the on-call provider decreased slightly from 8% in 2024 to 7% in 2025.

Table 2:

Alt Languages and Emergency Directions	2024 Respondents	2024 Membership Total	2025 Respondents	2025 Membership Total	2025 Membership Adult	2025 Membership Pediatric
Answering service with alternate language	52/57 (91%)	22,226	24/45 (53%)	21700	19796	1904
Emergency medical directions provided	44/46 (95%)	41,597	52/59 (88%)	12823	7975	4848

Table 2 displays alternate language capabilities available via answering services and if emergency medical directions are provided via answering machines options, as follows:

- The percent of answering services who reported having the ability to communicate in languages other than English decreased from 91% in 2024 to 53% in 2025.
- Emergency directions (call 911 or go to the emergency department), via either answering machine option, decreased from 95% in 2024 to 88% in 2025.

Table 3:

Call Back Time	2024 Respondents	2024 Membership Total	2025 Respondents	2025 Membership Total	2025 Membership Adult	2025 Membership Pediatric
Less than/equal to measure	55/57 (96.5%)	20,994	45/45 (100%)	21700	19796	1904
Greater than measure	0	N/A	0	N/A	N/A	N/A

Table 3 displays the call-back measure results. Eighty-seven percent (87%) of the answering services gave a call-back time of 30 minutes or less. Thirteen percent (13%) confirmed a call back within 60 mins or less. Neighborhood expects that primary care practices provide a call back within one (1) hour not to exceed two (2) hours, from the primary care or covering provider. In all, 100 % of the providers that were contacted, not including those providers who answered directly, would meet Neighborhood’s standards.

Barriers to Performance and Planned Interventions:

The total survey response rate was 100% which was a slight increase from the 95% rate for the 2024 survey. There were no instances of incorrect provider information or difficulty contacting providers.

The areas of concern are outlined in Table 2 with significant decreases in the percentage of answering services with alternative language capabilities from 91% in 2024 to 53% in 2025. There was also a decrease in Emergency Medical information being provided, via answering machines, decreasing from 95% in 2024 to 88% in 2025.

- **Planned Intervention:** Through monthly, quarterly, biannual, and ad hoc meetings with provider groups, Provider Relations discusses Neighborhood’s access standards. This allows an organic conversation around access to care and if Neighborhood could help with any barriers providers are facing that could impact our members’ care.
- **Planned Intervention:** Continue to include access standards as part of the mandatory provider training. The training was updated to include 2026 standards that coincide with the implementation of D-SNP programs as well as the insourcing of the Behavioral Health Network.
- **Planned Intervention:** Share results with providers to better understand changes or barriers with alternative language capabilities.

Availability of Network Providers and Alternate Language Capacity of Network

Opportunity Statement: The availability of network providers is a key driver to fulfilling Neighborhood promise of “making health care easy”. Neighborhood annually assesses the geographic availability of its

provider network for the purpose of developing, maintaining, and improving the network as necessary so that members may access care “close to home.”

Neighborhood recognizes that the provider network’s ability to meet members’ linguistic needs or preferences is an important consideration or starting point for understanding the network’s ability to address the membership’s cultural and ethnic needs and preferences. To ensure that members’ language accessibility needs are met, Neighborhood annually assesses language availability for the membership as it relates to languages spoken by contracted practitioners and Member Services staff, as well as the telephonic interpreter services available to supplement languages spoken by Member Services staff.

Neighborhood continues its efforts to obtain a better understanding of its members’ cultural, ethnic, and racial preferences to ensure that its network meets the members’ needs.

Goal:

- Geo-Access: 95% of members have access to providers that speak their language within the geographic distances indicated below.
- CAHPS: 90% of the membership do not feel that they have been treated differently at their personal doctor's office because of race, culture or economic status.

Interventions: Neighborhood will continue to monitor and provide oversight of; member and provider language data, network adequacy (sufficient numbers and types of providers), member and provider race and ethnicity data, and Medicaid adult CAHPS survey results in effort to better understand the provider networks’ ability to meet cultural, linguistic, racial and ethnic preferences of Neighborhood members.

- Initiate contracting efforts, to ensure network adequacy, as applicable and as possible, including but not limited to member and/or internal requests to contract based on provider language, race, ethnicity, or culture.
- Require the network to complete cultural competency training and provide the relevant materials.
- Initiate the collection and subsequent reporting of provider race and ethnicity data.

Section 1 Member and Provider Language

Table 1 provides the breakdown of the top languages (>5%) spoken by Neighborhood’s members and providers, as of Q4 2024.

Total Medicaid membership decreased by 3.64% over the prior period. The percentage of English-speaking members, in Medicaid Products, decreased by 5.26%, while the percentage of Spanish-speaking members increased by 0.40%. Total Commercial membership increased by 53.77%, with English-speaking members increasing 50.51% and by Spanish-speaking members by 64.78%. Neighborhood’s provider network increased by 9.72%. English-speaking providers increased by 9.64% and Spanish-speaking providers increased by 11.14%.

Table 1: Member and Provider Languages

		Q4 2023		Q4 2024	
Product	Language	Member Count	Percentage	Member Count	Percentage
Medicaid	English	159,859	76.86%	151,448	75.57%
	Spanish	44,435	21.36%	44,613	22.26%
	Portuguese	2,033	0.98%	2,075	1.04%
	Other	1,662	0.80%	2,276	1.14%
	Total	207,989		200,412	
Commercial	English	24,545	77.77%	36,944	76.12%
	Spanish	6,366	20.17%	10,490	21.61%
	Portuguese	384	1.22%	577	1.19%
	Other	267	0.85%	524	1.08%
	Total	31,562		48,535	
Provider	Language	Provider Count	Percentage	Provider Count	Percentage
All	English	6,348	90.08%	6,960	90.02%
	Spanish	296	4.20%	329	4.26%
	Other	403	5.72%	443	5.73%
	Total	7,047		7,732	

* Data notes – 2023 data revised to include all professional provider types, including ancillary specialty providers. Providers who spoke more than one language were counted multiple times.

Section 2 Geographic Availability

Methodology:

Neighborhood utilized geographic mapping software to calculate the estimated drive time/distance from unique member to provider addresses, for the following provider types; adult and pediatric primary care, and high-volume/high-impact specialty care providers. The period of the data collection was Q1 2025.

Measurement Standard:

Geographic availability is measured in accordance with the lesser of time or distance standards, for Medicaid and Commercial Products, displayed in Tables 2.1 and 2.2.

Goal:

At least 95% of members within the service area can access a provider within the lesser of time/distance.

Analysis:

Table 2.1 displays the geographic availability of Neighborhood's Medicaid primary care and high volume/high impact specialty provider networks.

The provider network is robust, demonstrating compliance above Neighborhood's goal (95%) for all provider types. The provider network is stable, displaying no change in provider availability between reporting periods. There were no barriers, or deficiencies, noted in the prior or current reporting period.

Table 2.1: Medicaid Geographic Availability

Provider Type	Population	Standard	Goal	2024	2025	Goal
PCP-Family Medicine	All	1 in 20 Miles	95%	100%	100%	Met
PCP-Family Medicine	All	1 in 20 Minutes	95%	100%	100%	Met
PCP-Internal Medicine	18 Years of Age and Older	1 in 20 Miles	95%	99.9%	99.9%	Met
PCP-Internal Medicine	18 Years of Age and Older	1 in 20 Minutes	95%	99.9%	99.9%	Met
PCP-Pediatrics	Up to 17.99 Years of Age	1 in 20 Miles	95%	99.9%	99.9%	Met
PCP-Pediatrics	Up to 17.99 Years of Age	1 in 20 Minutes	95%	99.9%	99.9%	Met
Cardiology	Adult	1 in 30 Miles	95%	100%	100%	Met
Cardiology	Adult	1 in 30 Minutes	95%	100%	100%	Met
Gastroenterology	Adult	1 in 30 Miles	95%	100%	100%	Met
Gastroenterology	Adult	1 in 30 Minutes	95%	100%	100%	Met
Neurology	Adult	1 in 30 Miles	95%	100%	100%	Met
Neurology	Adult	1 in 30 Minutes	95%	100%	100%	Met
Oncology	Adult	1 in 30 Miles	95%	100%	100%	Met
Oncology	Adult	1 in 30 Minutes	95%	100%	100%	Met
Optometry	Adult	1 in 30 Miles	95%	100%	100%	Met
Optometry	Adult	1 in 30 Minutes	95%	100%	100%	Met
Orthopedic Surgery	Adult	1 in 30 Miles	95%	100%	100%	Met
Orthopedic Surgery	Adult	1 in 30 Minutes	95%	100%	100%	Met
OB/GYN	Adult-Female	1 in 30 Miles	95%	100%	100%	Met
OB/GYN	Adult-Female	1 in 45 Minutes	95%	100%	100%	Met

Table 2.2 displays the geographic availability of Neighborhood's Commercial primary care and high volume/high impact specialty provider networks.

The provider network is robust, demonstrating compliance above Neighborhood's goal (95%) for all provider types. The provider network is stable, displaying no changes in provider availability between reporting periods. There were no barriers, or deficiencies, noted in the prior or current reporting period.

Table 2.2: Commercial Geographic Availability

Provider Type	Population	Standard	Goal	2024	2025	Goal
PCP-Family Medicine	All	1 in 20 Miles	95%	100%	100%	Met
PCP-Family Medicine	All	1 in 20 Minutes	95%	100%	100%	Met
PCP-Internal Medicine	18 Years of Age and Older	1 in 20 Miles	95%	99.9%	99.9%	Met
PCP-Internal Medicine	18 Years of Age and Older	1 in 20 Minutes	95%	99.8%	99.8%	Met
PCP-Pediatrics	Up to 17.99 Years of Age	1 in 20 Miles	95%	99.2%	99.2%	Met
PCP-Pediatrics	Up to 17.99 Years of Age	1 in 20 Minutes	95%	99.2%	99.2%	Met
Cardiology	Adult	1 in 30 Miles	95%	100%	100%	Met
Cardiology	Adult	1 in 30 Minutes	95%	100%	100%	Met
Gastroenterology	Adult	1 in 30 Miles	95%	100%	100%	Met
Gastroenterology	Adult	1 in 30 Minutes	95%	100%	100%	Met
Neurology	Adult	1 in 30 Miles	95%	100%	100%	Met
Neurology	Adult	1 in 30 Minutes	95%	100%	100%	Met

Provider Type	Population	Standard	Goal	2024	2025	Goal
Oncology	Adult	1 in 30 Miles	95%	100%	100%	Met
Oncology	Adult	1 in 30 Minutes	95%	100%	100%	Met
Ophthalmology	Adult	1 in 30 Miles	95%	100%	100%	Met
Ophthalmology	Adult	1 in 30 Minutes	95%	100%	100%	Met
Orthopedic Surgery	Adult	1 in 30 Miles	95%	100%	100%	Met
Orthopedic Surgery	Adult	1 in 30 Minutes	95%	100%	100%	Met
OB/GYN	Adult-Female	1 in 30 Miles	95%	100%	100%	Met
OB/GYN	Adult-Female	1 in 45 Minutes	95%	100%	100%	Met

Section 3 Member to Provider Ratios

Methodology:

Neighborhood utilizes geographic mapping software to calculate the ratio of members to providers within the service area, for the following provider types; adult and pediatric primary care, and high-volume/high-impact specialty care providers.

Measurement Standard:

Member to Provider ratios were measured in accordance with the standards, for Medicaid and Commercial Products, displayed in Tables 3.1 and 3.2.

Goal:

Member to provider ratios less than the standard.

Analysis:

Table 3.1 displays the ratio of Medicaid members to providers within the service area.

The provider network met Neighborhood's standard(s) for member to provider ratios, for all provider types.

The provider network is stable, with incremental change in member to provider ratios between reporting periods. Upon further investigation the ratios to nine (9) of ten (10) provider types improved, while one (1) worsened. Member eligibility appeared to be the leading driver of change.

- The ratio to family medicine PCPs improved, from 375:1 to 337:1; decrease in membership (-18,022) was the primary driver of change followed by an increase in providers (+1).
- The ratio to internal medicine PCPs improved over the prior period, from 271:1 to 269:1; decrease in membership (-18,147) was the primary driver of change followed by a decrease in providers (-64).
- The ratio to pediatric PCPs worsened over the prior period, from 384:1 to 404:1; decrease in providers (-12) was the primary driver of change followed by an increase in membership (+1,000).
- The ratio to cardiologists improved over the prior period, from 868:1 to 730:1; decrease in membership (-18,147) was the primary driver of change followed by a decrease in providers (-1).
- The ratio to gastroenterologists improved over the prior period, from 1,542:1 to 1,383:1; decrease in membership (-18,147) was the primary driver of change followed by a decrease in providers (-5).
- The ratio to neurologists improved over the prior period, from 1,351:1 to 1,217:1; decrease in membership (-18,147) was the primary driver of change followed by a decrease in providers (-6).
- The ratio to OB/GYNs improved over the prior period, from 384:1 to 268:1; decrease in membership (-10,797) was the primary driver of change followed by a decrease in providers (-22).

- The ratio to oncologists improved over the prior period, from 1,955:1 to 1,522:1; decrease in membership (-18,147) was the primary driver of change followed by an increase in providers (+4).
- The ratio to optometrists improved over the prior period, from 555:1 to 468:1; decrease in membership (-18,147) was the primary driver of change followed by a decrease in providers (-2).
- The ratio to orthopedic surgeons improved over the prior period, from 855:1 to 837:1; decrease in membership (-18,147) was the primary driver of change followed by a decrease in providers (-19).

Table 3.1: Medicaid Member to Provider Ratios

Provider Type	Population	Standard	Member ct. 2024	Prov ct. 2024	Ratio 2024	Mem ct. 2025	Prov ct. 2025	Ratio 2025	Goal
PCP-Family Medicine	All	1,500:1	184,127	491	375:1	166,105	492	337:1	Met
PCP-Internal Medicine	>18 Yrs.	1,500:1	109,488	403	271:1	91,341	339	269:1	Met
PCP-Pediatrics	< 17 Yrs.	1,500:1	75,764	197	384:1	74,764	185	404:1	Met
Cardiology	Adult	10,000:1	109,488	126	868:1	91,341	125	730:1	Met
Gastroenterology	Adult	10,000:1	109,488	71	1,542:1	91,341	66	1,383:1	Met
Neurology	Adult	10,000:1	109,488	81	1,351:1	91,341	75	1,217:1	Met
OB/GYN	Adult Female	5,000:1	63,477	218	291:1	52,680	196	268:1	Met
Oncology	Adult	10,000:1	109,488	56	1,955:1	91,341	60	1,522:1	Met
Optometry	Adult	10,000:1	109,488	197	555:1	91,341	195	468:1	Met
Orthopedic Surgery	Adult	10,000:1	109,488	128	855:1	91,341	109	837:1	Met

Table 3.2 displays the ratio of Commercial members to providers within the service area.

The provider network met Neighborhood's standard(s) for member to provider ratios, for all provider types.

The provider network is stable, with incremental change in member to provider ratios between reporting periods. Upon further investigation the ratios of member to ten (10) of ten (10) provider types worsened. Member eligibility appeared to be the leading driver of change.

- The ratio to family medicine PCPs worsened, from 54:1 to 82:1; increase in membership (+13,543) was the primary driver of change followed by an increase in providers (+1).
- The ratio to internal medicine PCPs worsened over the prior period, from 63:1 to 114:1; increase in membership (+12,957) was the primary driver of change followed by a decrease in providers (-64).
- The ratio to pediatric PCPs worsened over the prior period, from 5:1 to 9:1; increase in membership (+586) was the primary driver of change followed by a decrease in providers (-12).
- The ratio to cardiologists worsened over the prior period, from 204:1 to 309:1; increase in membership (+12,957) was the primary driver of change followed by a decrease in providers (-1).
- The ratio to gastroenterologists worsened over the prior period, from 363:1 to 586:1; increase in membership (+12,957) was the primary driver of change followed by a decrease in providers (-5).
- The ratio to neurologists worsened over the prior period, from 318:1 to 516:1; increase in membership (+12,957) was the primary driver of change followed by a decrease in providers (-6).
- The ratio to OB/GYNs worsened over the prior period, from 63:1 to 113:1; increase in membership (+8,412) was the primary driver of change followed by a decrease in providers (-22).

- The ratio to oncologists worsened over the prior period, from 460:1 to 645:1; increase in membership (+12,957) was the primary driver of change followed by an increase in providers (+4).
- The ratio to ophthalmologists worsened over the prior period, from 373:1 to 634:1; increase in membership (+12,957) was the primary driver of change followed by a decrease in providers (-8).
- The ratio to orthopedic surgeons worsened over the prior period, from 201:1 to 355:1; decrease in providers (-19) was the primary driver of change followed by an increase in membership (+12,957).

Table 3.2: Commercial Member to Provider Ratios

Provider Type	Population	Standard	Member ct. 2024	Prov ct. 2024	Ratio 2024	Mem ct. 2025	Prov ct. 2025	Ratio 2025	Goal
PCP-Family Medicine	All	1,500:1	26,902	491	54:1	40,445	492	82:1	Met
PCP-Internal Medicine	>18 Yrs.	1,500:1	25,776	403	63:1	38,733	339	114:1	Met
PCP-Pediatrics	< 17 .99 Yrs.	1,500:1	1,126	197	5:1	1,712	185	9:1	Met
Cardiology	Adult	10,000:1	25,776	126	204:1	38,733	125	309:1	Met
Gastroenterology	Adult	10,000:1	25,776	71	363:1	38,733	66	586:1	Met
Neurology	Adult	10,000:1	25,776	81	318:1	38,733	75	516:1	Met
OB/GYN	Adult Female	5,000:1	13,808	218	63:1	22,220	196	113:1	Met
Oncology	Adult	10,000:1	25,776	56	460:1	38,733	60	645:1	Met
Ophthalmology	Adult	10,000:1	25,776	69	373:1	38,733	61	634:1	Met
Orthopedic Surgery	Adult	10,000:1	25,776	128	201:1	38,733	109	355:1	Met

Section 4 Race and Ethnicity (R&E)

Neighborhood utilizes the CAQH standard application, which requires languages spoken but does not require providers to enter race or ethnicity information. Neighborhood continues to explore ways to obtain provider R&E data.

Data Notes:

Membership R&E data was obtained from Neighborhoods operational data store. The reader should be aware that member race and ethnicity (Hispanic/Latino and Not Hispanic/Latino) did not total to race without ethnicity due to members only answering one part of the two-part race and ethnicity question(s).

In the absence of network provider R&E data, Neighborhood leveraged the U.S. Census Bureau's Microdata Analysis Tool (MDAT) as a supplementary source, albeit at a statewide level vs. contracted network level. The MDAT allows users to create a variety of population estimates based on data derived from the American Community Survey (ACS). The ACS is an annual survey, administered by the U.S. Census Bureau, representing approximately 1% of the population of the United States. The survey data vintage utilized for this report was derived from the 1/year Public Use Microdata Sample v2023 files. Other publicly available reports were considered, and some even utilized ACS data but did not drill down to the extent that was available via the MDAT.

Analysis:

Table 4 displays R&E data for Neighborhood's membership and Rhode Island providers (physicians, surgeons, physician assistants, nurse; practitioners, anesthetists, and midwives).

When examining race, providers identified as White (72.37%), Asian and Pacific Islander (15.24%), and belonging to two or more races (9.61%), in greater percentages than members. Whereas a significantly higher proportion of members identified as some other race (49.37%), Black or African American (10.35%), and American Indian and Alaska Native (0.94%).

With the inclusion of ethnicity (Hispanic or Latino vs not Hispanic or Latino), no providers identified as Hispanic or Latino in the 2023 ACS. Hispanic or Latino members identified predominantly as Some Other Race (75.08%), White (19.18%), Black or African American (4.91%). White, Not Hispanic or Latino members identified as White (51.36%), Some Other Race (31.31%) and Black or African American (14.32%).

Table 4: Race & Ethnicity

	Neighborhood Members		Rhode Island Providers	
Race	Count	Percent	Count	Percent
White	80,433	38.16%	3,907	72.37%
Black or African American	21,818	10.35%	62	1.14%
American Indian and Alaska Native	1,988	0.94%	0	0.00%
Asian and Pacific Islander	2,462	1.17%	823	15.24%
Some Other Race	104,061	49.37%	87	1.61%
Two or More Races	34	0.02%	519	9.61%
Total	210,796	100%	5,398	100%
Ethnicity: Hispanic or Latino				
White alone	15,611	19.18%	0	0.00%
Black or African American alone	4,001	4.91%	0	0.00%
American Indian and Alaska Native alone	239	0.29%	0	0.00%
Asian and Pacific Islander alone	427	0.52%	0	0.00%
Some Other Race alone	61,123	75.08%	0	0.00%
Two or More Races	5	0.01%	0	0.00%
Total	81,406	100%	0	0.00%
Ethnicity: Not Hispanic or Latino				
White alone	61,076	51.36%	3,907	72.37%
Black or African American alone	17,035	14.32%	62	1.14%
American Indian and Alaska Native alone	1,690	1.42%	0	0.00%
Asian and Pacific Islander alone	1,859	1.56%	823	15.24%
Some Other Race alone	37,235	31.31%	87	1.61%
Two or More Races	29	0.02%	519	9.61%
Total	118,924	100%	5,398	100%

National data helps to provide prospective when trying to understand the underrepresentation of physician minorities. The Association of American Medical Colleges (AAMC) compiled race/ethnicity data for U.S. medical school matriculants. For the 2024-2025 year, students identified, alone or in combination (multiple races and/or ethnicities selected) as follows; White (50.7%), Asian/Pacific Islander (32%), Hispanic/Latino (11.2%), Black or African American (8.8%), Some Other Race (4.3%) American Indian and Alaska Native (0.9%). Medical school enrollment, like Rhode Island provider data, skews whiter and more Asian/Pacific Islander than other race or ethnicities. Should all matriculants go on to graduate, and be accepted into a residency program, it will be interesting to see which states benefit from the increased provider diversity.

In order to make Rhode Island a more attractive destination for providers the legislature passed a budget (SFY26) which included the following enhancements:

- Primary Care Rates (Medicaid): Increase primary care rates to 100% of Medicare rates, effective October 1, 2025.
- Primary Care Provider Rates: OHIC to provide a one-time report on primary care reimbursement rates due September 1, 2026.
- Federally Qualified Health Care Center Rates: Increase reimbursements to the FQHCs, effective July 1, 2025.
- Prior Authorization (Medicaid): Within the Medicaid Resolution, seeks Federal approval to establish a three-year pilot program to eliminate prior authorization requirements for any service, treatment, or procedure ordered by a primary care provider in the normal course of treatment (excludes pharmacy benefits). Pilot start date is October 1, 2025, and sunsets October 1, 2028. Providers include family medicine, geriatrics, internal medicine, obstetrics and gynecology, or pediatrics.
- Hospital-Rates at Current Law: Increase the hospital rate to 3.48%.
- Nursing Home Minimum Staffing Enhanced Rate: 2.3% increase for Nursing Homes.

To address the underrepresentation of physician minorities, Neighborhood requires providers to comply with the American with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of Neighborhood's members. This includes mandatory training, and materials, to assist providers in rendering culturally competent care. Cultural competence enables providers to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients. Neighborhood prioritizes requests from members and/or member facing departments to contract with providers who meet member's expressed language, race/ethnicity or cultural need, and is working to obtain R&E data on its contracted network in accordance with Health Equity Standards (HE4).

Section 5 Language Services Available Through Neighborhood

Neighborhood makes telephonic interpreter services available to all members and arranges for in-person interpretation at doctor appointments for all Products. In addition, Neighborhood's Member Services Department boasts an impressive multilingual staff (n=41) that helps meet members' language needs. Broken down as follows; 41.4% speak Spanish, with one (1) staff member who speaks Cabo Verdean-Creole, one (1) Portuguese, one (1) Hmong, one (1) Khmer, and one (1) Haitian Creole.

Section 6 Members' Expressed Cultural Preferences

Neighborhood has one network for its Medicaid and Exchange Product lines and adjusts to meet cultural needs based on data collected. Neighborhood uses the annual CAHPS survey of Medicaid adults to identify potential gaps, as this product line represents more than 70% of Neighborhood's membership.

Methodology:

Neighborhood assesses its members' cultural, linguistic, racial and ethnic preferences to ensure that its practitioner network meets the needs and expressed preferences of its membership. The Plan assessed its members' preferences by asking the following custom questions on its annual CAHPS survey of Medicaid adult members.

Measurement Standard:

Members have not been treated differently at their personal doctor's office because of race, culture or economic status.

Goal:

90% of the membership do not feel that they have been treated differently at their personal doctor's office because of race, culture or economic status.

Based on 2025 CAHPS Medicaid adult survey results, Neighborhood has exceeded its goal.

Overall, the 2025 survey results are like the 2024, with no significant differences to the prior year. Results confirm that a majority of adult Medicaid members' cultural, linguistic, racial and ethnic preferences are being met by Neighborhood's provider network.

- The proportion of survey respondents speaking a language other than English increased slightly from 34.7% in 2024 to 35.0% in 2025.
- Most members (84.1%) never had a hard time speaking with or understanding their personal doctor because they spoke different languages.
- The proportion of members saying they prefer a doctor of the same ethnic group decreased from 41.8% to 37.0%.
 - In 2025, members aged 55 years or older (43.2%) were significantly more likely than their counterparts in the age groups of 35-44 (25.9%) to prefer a doctor of the same ethnic group.
 - In 2025, members reporting having a high school level of education or less (40.2%) were significantly more likely than members reporting having at least some college education (29.6%) to prefer a doctor of the same ethnic group.
 - In 2025, Hispanic members (50.4%) were significantly more likely than White members (35.0%) and Black/African American members (30.8%) to prefer a doctor of the same ethnic group.
- In 2025, there was an increase of members (86.7%) compared to 2024 (80.8%) who were able to find an in-network doctor who met their ethnic preference.
 - In 2025, Hispanic members (91.8%) were significantly more likely than non-Hispanic members (82.1%) who were able to find an in-network doctor who met their ethnic preference.

Survey Question	2024 Results	2025 Results
What language do you mainly speak at home?	Number of respondents: 411	Number of respondents: 423
English	65.3%	65.0%
Spanish	30.3%	30.7%
Some other language	4.4%	4.3%
In the past 6 months, how often did you have a hard time speaking with or understanding your personal doctor because you spoke different languages?	Number of respondents: 332	Number of respondents: 346
Never	87.7%	84.1%
Sometimes	5.4%	10.1%
Usually	3.9%	2.0%
Always	3.0%	3.8%
Do you prefer to have a doctor that is of the same ethnic group as you?	Number of respondents: 366	Number of respondents: 387
Yes	41.8%	37.0%
No	58.2%	63.0%

Survey Question	2024 Results	2025 Results
Was this preference met by the health plan's network?	Number of respondents: 172	Number of respondents: 218
Yes	80.8%	86.7%
No	19.2%	13.3%

Neighborhood asks two additional NCQA-approved custom questions added to the CAHPS Medicaid Adult survey to capture additional member feedback on how well members' cultural, racial or other needs are met by the Plan's provider network. These custom questions were added in 2020.

For the fourth consecutive year, over nine in ten Medicaid survey respondents said they were “never” treated differently at a doctor's office because of their race, culture, or economic status (94.8% in 2025). About the same proportion (92.9% in 2025) said finding a physician they were comfortable with based on cultural, personal, or religious beliefs was “not a problem.”

Survey Question	2024 Results	2025 Results
In the last 6 months, how often have you been treated differently at your personal doctor's office because of your race, culture or economic status?	Number of respondents: 389	Number of respondents: 427
Never	94.1%	94.8%
Sometimes	4.4%	3.5%
Usually	1.0%	0.5%
Always	0.5%	1.2%
When selecting your health provider(s), did you have any problems finding a physician you were comfortable with based on your cultural, personal, or religious beliefs?	Number of respondents: 387	Number of respondents: 424
A big problem	2.8%	2.1%
A small problem	5.4%	5.0%
Not a problem	91.7%	92.9%

Provider Directory Accuracy Assessment

Opportunity Statement: The Provider Directory Accuracy Assessment Survey response rate increased from 20.1% in 2024 to 25.7% in 2025.

- Responding PCPs reported that 100% of their address and phone number data is accurately listed in our online physician directory.
- Overall accuracy rates among responding providers decreased slightly from 2024 to 2025 for Medicaid Network Participation awareness.
- The overall accuracy rate of the address, telephone and “accepting new patient” information listed in the online physician directory increased significantly for both PCPs and Specialists in 2025, achieving both the primary and secondary goal for each category in the process.
- The number of terminated providers reported during this 2025 assessment decreased from 14 in 2024 to 11 in 2025.
- The 2025 survey featured new questions inquiring about the availability of Telehealth appointments.

Neighborhood conducts an annual physician directory accuracy assessment to validate the information listed in its online physician directory. Neighborhood is committed to providing members with accurate information on in-network physicians to avoid barriers to access. The annual assessment also helps determine if there is a lack of awareness on the part of physician office staff or if the organization has incorrectly listed a physician as being in-network.

Goal:

- To achieve 95% accuracy of information listed in Neighborhood's online physician directory to ensure members' ability to successfully access needed healthcare.
- If 95% accuracy cannot be achieved, then the accuracy rate should improve by at least two (2) percentage points compared to the prior year's result.

Measure/Methodology: A random sample of 1,042 active PCPs and Specialists from a population of 22,065 active practitioners in Neighborhood's provider directory were selected to be surveyed in 2025 to allow for a 95% confidence level in the results. Any prior survey respondents from last year were excluded from the eligible population for sample selection.

- In 2025, the survey was sent in two halves – one portion of the sample in July 2025 and a second portion of the sample in November 2025.
- A personalized cover letter and a one-page, fourteen-question survey was mailed on July 14th, 2025 to a sample of 507 practitioners (124 PCPs and 383 specialists) for the first half of the sample. On November 19th, 2025, these materials were mailed to the second sample of 535 practitioners (116 PCPs and 419 Specialists). Total sample of 1,042 practitioners (240 PCPs and 802). Either the practitioner or the Office Manager were asked to complete the survey. In most cases, an Office Manager completed the survey.
- Eight of the fourteen survey items were pre-populated with the following information contained in Neighborhood's online physician directory for Medicaid and Marketplace members as of July 1st, 2025 for the first portion and November 1st, 2025 for the second portion:
 - Office location (address, city, state, zip code) and phone number
 - Hospital affiliations
 - Accepting new patients (Yes or No)
- Respondents were asked to validate if the listed information was accurate, and if not, to provide updated information.
- Practitioners were also asked to verify the following additional information:
 - Neighborhood products in which they participate
 - Presence of bilingual staff in the office
 - Have they worked with an interpreter in the last year
 - Does the office offer video, phone or onsite interpreter services
 - Does the practice offer Telehealth appointments or exclusively Telehealth appointments
- Practitioners were also asked to provide their race/ethnicity as an optional question. A disclaimer was added to this question letting the practitioner know that if provided, their race/ethnicity information would be available to members upon request.

Analysis of Performance: A total of 268 practitioners responded via email or desktop fax of the 1,042 surveyed. The total response rate for the 2025 assessment is 25.7%, which is higher than the 2024 response rate of 20.1%. The 2025 response rate increasing could be tied to a change in delivery of the survey. Typically, the survey is sent in one batch, but to comply with the NCQA requirement changes for 2025, surveys were sent out in two batches.

- The rate of terminated providers reported during this assessment decreased from 14 or 4.7% in 2024 to 11 or 4.1% in 2025. Ten of the reported provider terminations were specialty providers, one was a PCP.

The tables on the following pages present the results of the 2025 physician directory accuracy assessment compared to the 2024 and 2023 results.

Verification of Office Location, Phone Number, Hospital Affiliation, and Accepting New Patients:

Table 1: Correct Address Information Listed in the Directory (Address, City, State, and Zip Code)

	Total Respondents			PCPs			Specialists		
	2025	2024	2023	2025	2024	2023	2025	2024	2023
Numerator	261	283	173	62	63	44	199	220	129
Denominator	268	301	246	62	67	62	206	234	184
Rate	97.4%	94.0%	70.3%	100%	94.0%	70.9%	96.6%	94.0%	70.1%

- The overall accuracy rate of the address information listed in the online physician directory increased from 94.0% in 2024 to 97.4% in 2025, therefore meeting the primary and secondary accuracy goal.
- 100% of responding PCPs confirmed their address data is correct in our directory, which is a 6% increase from 2024.
- All information was corrected in our system in less than 7 business days.

Table 2: Rate of Correct Phone Number Information Listed in the Directory

	Total Respondents			PCPs			Specialists		
	2025	2024	2023	2025	2024	2023	2025	2024	2023
Numerator	256	273	189	62	63	37	194	210	152
Denominator	268	301	246	62	67	62	206	234	184
Rate	97.7%	90.7%	76.8%	100%	94.0%	59.6%	94.2%	89.7%	82.6%

- Improving significantly from last year, once again dating back to 2018, this is the highest percentage of accurately reported directory phone number information for all three categories (total, PCPs and specialists).
- The overall level of accurate office phone numbers reported by responding physicians increased significantly from 90.7% in 2024 to 97.7% in 2025, achieving both the primary and secondary accuracy goals.
- 100% of responding PCPs reported accurate phone numbers, which is a 6% increase from 2024. This was the main cause of the significant increase in overall accuracy.
- For specialists, the accurate office phone numbers reported increased from 89.7% in 2024 to 94.2% in 2025, achieving the secondary goal.
- All information was corrected in our system in less than 7 business days.

Table 3: Rate of Correct Hospital Affiliation Information Listed in the Directory

	Total Respondents			PCPs			Specialists		
	2025	2024	2023	2025	2024	2023	2025	2024	2023
Numerator	246	280	228	53	60	55	193	220	173
Denominator	268	301	246	62	67	62	206	234	184
Rate	91.8%	93.0%	92.7%	85.5%	89.6%	88.7%	93.7%	94.0%	94.2%

- The overall level of accurate hospital affiliation information reported by responding providers decreased slightly from 93.0% in 2024 to 91.8% in 2025.
- The rate of correct hospital affiliation data among responding PCPs decreased by 4.1% from 89.6% in 2024 to 85.5% in 2025.
- The rate of correct hospital affiliation data among responding Specialists decreased by 0.3% from 94.0% in 2024 to 93.7% in 2025.

Table 4: Rate of Correct “Accepting New Patients” Information Listed in the Directory

	Total Respondents			PCPs			Specialists		
	2025	2024	2023	2025	2024	2023	2025	2024	2023
Numerator	260	277	238	58	57	61	202	227	179
Denominator	268	301	246	62	67	62	206	234	184
Rate	97.0%	94.4%	96.7%	93.5%	85.1%	98.4%	98.1%	97.0%	97.2%

- The overall accuracy rate of the “accepting new patients” indicator increased from 94.4% in 2024 to 97% in 2025, achieving both the primary and secondary accuracy goals.
- The accuracy rate of the “accepting new patients” information for Specialists increased slightly from 97.0% in 2024 to 98.1% in 2025.
- The accuracy rate of the “accepting new patients” information for PCP’s increased significantly from 85.1% in 2024 to 93.5% in 2025. This was likely the main driver of the increase in overall accuracy.
- All information was corrected in our system in less than 7 business days.

Product Participation Awareness:

Table 5: Rate of Awareness of Medicaid Product Participation

	Total Respondents			PCPs			Specialists		
	2025	2024	2023	2025	2024	2023	2025	2024	2023
Numerator	254	289	234	61	65	60	193	224	174
Denominator	268	301	246	62	67	62	206	234	184
Rate	94.8%	96.0%	95.1%	98.4%	97.0%	96.8%	93.7%	95.7%	94.6%

- The overall rate of responding providers or office staff citing awareness of participating in Neighborhood’s Medicaid network decreased slightly from 2024 to 2025.
- Only 1 PCP and 13 Specialists responding were unaware of their Medicaid network participation.
- The rate of PCPs reporting being aware of participating in Medicaid increased from 97.0% in 2024 to 98.4% in 2025.
- The rate of Specialists reporting being aware of participating in Medicaid decreased slightly from 95.7% in 2024 to 93.7% in 2025.

Table 6: Rate of Awareness of Commercial Product Participation

	Total Respondents			PCPs			Specialists		
	2025	2024	2023	2025	2024	2023	2025	2024	2023
Numerator	263	282	242	61	63	61	201	219	181
Denominator	268	301	246	62	67	62	206	234	184
Rate	98.1%	93.7%	98.4%	98.4%	94.0%	98.4%	97.6%	93.6%	98.4%

- The overall rate of responding providers or office staff citing awareness of participating in Neighborhood’s Commercial network increased significantly from 93.7% in 2024 to 98.1% in 2025.
- The rate of PCPs reporting being aware of their Commercial network participation increased from significantly from 94.0% in 2024 to 98.4% in 2025.
- The rate of Specialists reporting being aware of their Commercial network participation increased from 93.6% in 2024 to 97.6% in 2025.

Additional Information Gathered from Providers:

This year we leveraged the accuracy survey to collect additional information about our providers. The tables below depict the information that was requested as well as the percentage of responses to each inquiry. All Race/Ethnicity data inquiries were listed as optional.

Presence of Bilingual Staff, and Availability of Interpreters or Interpretation Services:

2024	Presence of Bilingual Staff in Office			Office Has Worked with an Interpreter in the Last Year			Offers Remote Video or Telephone Interpreters			Office Offers Onsite Interpreters		
	Total	PCP	Spec.	Total	PCP	Spec.	Total	PCP	Spec.	Total	PCP	Spec.
Numerator	144	43	101	94	27	67	76	31	45	59	15	44
Denominator	301	67	234	301	67	234	301	67	234	301	67	234
Rate	47.8%	64.2%	43.2%	31.2%	40.3%	28.6%	25.2%	46.3%	19.2%	25.2%	46.3%	19.2%

2025	Presence of Bilingual Staff in Office			Office Has Worked with an Interpreter in the Last Year			Offers Remote Video or Telephone Interpreters			Office Offers Onsite Interpreters		
	Total	PCP	Spec.	Total	PCP	Spec.	Total	PCP	Spec.	Total	PCP	Spec.
Numerator	124	37	87	66	21	45	57	26	31	44	12	32
Denominator	268	62	206	268	62	206	268	62	206	268	62	206
Rate	46.3%	59.7%	42.2%	24.6%	33.9%	21.8%	21.3%	41.9%	15.0%	16.4%	19.4%	15.5%

- 46.3% of responding providers or office staff indicated that there is a presence of bilingual staff in the office compared to 47.8% in 2024
- 24.6% of responding providers or office staff indicated that they have worked with an interpreter in the last year compared to 31.2% in 2024.
- 21.3% of responding providers or office staff confirmed that they have remote or telephone interpreters available to our members compared to 25.2% in 2024.
- 16.4% of responding providers or office staff confirmed that they have onsite interpreters available to our members compared to 25.2% in 2024.

Practitioner Provided Their Race/Ethnicity:

2024	Practitioner Provided Their Race/Ethnicity			Practitioner Would Like Their Race/Ethnicity Published in the Directory		
	Total	PCP	Spec.	Total	PCP	Spec.
Numerator	20	7	13	27	8	19
Denominator	301	67	234	301	67	234
Rate	6.6%	10.4%	5.6%	9.0%	11.9%	8.1%

2025	Practitioner Provided Their Race/Ethnicity		
	Total	PCP	Spec.
Numerator	42	11	33
Denominator	268	62	206
Rate	15.7%	17.7%	16.0%

- In 2025 the survey question was updated, adding a disclaimer letting the practitioners know that if provided, their race/ethnicity information would be available to members upon request. This is different from 2024 when providers were asked if they would like this information published.
- 15.7% of the responding providers or office staff shared their race or ethnicity with Neighborhood compared to only 6.6% in 2024.

Practitioner Offers Telehealth Appointments, or are Exclusively Telehealth:

2025	Practitioner Offers Telehealth Appointments			Practitioner is Exclusively Telehealth		
	Total	PCP	Spec.	Total	PCP	Spec.
Numerator	27	10	17	0	0	0
Denominator	268	62	206	268	62	206
Rate	10.1%	16.1%	8.3%	0.0%	0.0%	0.0%

The telehealth questions were added to the survey for 2025.

- 10.1% of responding providers or office staff indicated that their practice offers Telehealth appointments.
- None of the 268 responding providers or office staff indicated that their practice offers Telehealth appointments exclusively.
- We are anticipating that we will have responses in 2026 for practices offering Telehealth appointments exclusively as Behavioral Health providers will be part of the survey population.

Analysis of Barriers to Performance and Planned Interventions:

- Bilingual staff and interpreter/interpreter service availability survey questions had lower percentages than most other questions on the survey.
 - **Planned Intervention:** Provider Data Integrity team will increase the frequency in which this data is being collected to increase the amount of provider demographic information we have available to our members. Additionally, further engagement from other departments to our provider groups encouraging language service/interpreter availability for members could assist in increasing these percentages.
- Overall accuracy rate of the Hospital Affiliation listed in the online physician directory decreased slightly.
 - **Planned Intervention:** Share results with Credentialing and coordinate next steps to improve hospital affiliation accuracy.
- Overall level of product participation awareness by responding physicians decreased slightly.
 - **Planned Intervention:** Share results with Provider Relations to ensure education to providers on product participation.

Next Steps:

In 2026, the Provider Data Integrity team will work with Configuration Services to begin storing the additional information gathered from providers specific to the presence of interpreters and interpretation services in HealthRules. Once we have established where this information will be stored, we will collaborate with other internal areas on how this information can be shared, when available, with our members.

C. Member Experience

Monitoring Member Complaints

Goals: The Plan's goal is to meet or exceed members' expectations. If a Plan-related experience does not meet the members' expectations, members are encouraged to notify the Plan.

- Medicaid: The Plan has thirty (30) calendar days to research and provide verbal response and resolution to members. Clinical Quality of Care complaints processed by the Medical Director's office or Grievances (Access to Care or '2nd level informal complaints', handled by GAU) are allowed ninety (90) calendar days for resolution in written format.
- Exchange/Commercial: The Plan has thirty (30) calendar days to research and provide resolution to members. There is only one level of complaint. Verbal complaints are responded to verbally on a recorded line in accordance with OHIC requirements (effective 2019). Written complaints are responded to in writing. Clinical Quality of Care complaints are processed by the Medical Director's office within same 30 calendar day timeframe, and resolution is in written format.
- INTEGRITY/MMP: The Plan has thirty (30) calendar days to research and provide members with written resolution for Grievances (GAU) and Clinical Quality of Care grievances (Medical Director's office). There is only one level of complaint.

The Plan strives to:

- Identify and understand the sources of member dissatisfaction and minimize or remove these sources of dissatisfaction.
- Develop and implement service improvements/interventions.
- Provide network providers fair opportunity to respond to member complaints about their office/staff to ensure that our members' experiences are positive.
- Encourage members to become involved and actively participate in health plan initiatives and member advisory committees.
- Offer members the opportunity to advocate for high quality health care services.

Measure/Methodology: The Plan utilizes the COGNOS environment as a reporting tool to determine the number and type of complaints received and reported on a quarterly basis to EOHHS (Medicaid) and annually to OHIC (Exchange/Commercial). MMP Reporting utilizes Acuity data and reported monthly to CMT and annually to CMS.

When necessary, interdepartmental collaboration occurs during the investigation and resolution of member complaints as well as with external parties including, but not limited to, delegated entities and contracted providers. Complaint reports are created and reviewed internally on a monthly basis and submitted to appropriate agencies on a quarterly or annual basis, as described above.

Plan member complaint data allows for and includes feedback from the EOHHS Child and Family Consumer Advisory Committee (CAC), member focus groups, annual CAHPS and member satisfaction survey performance data, and any other pertinent member satisfaction related data available.

Medicaid

- The Medicaid member complaints and grievances are logged in HealthRules.
- Quality of Care complaints are logged in HealthRules and processed in Acuity.

Exchange/Commercial

- Member complaints and quality of care complaints are logged in AWD-CS and processed in Acuity.

INTEGRITY/MMP

- Member grievances are logged in AWD-CS when initiated verbally at the Plan’s Member Services Call Center.
- Written grievances received directly in GAU are documented only in Acuity. GAU and Quality of Care document the substance, research, and resolution in Acuity.

Interventions:

- GAU continued to collaborate with Member Services, Pharmacy Department, QOC and Product to identify and implement process improvements. The following process improvements were made as a result of this collaboration:
 - Ongoing feedback to Member Services regarding grievance documentation to improve call handling and the ability of GAU/QOC to research complaints/grievances.
 - Presentations to new Member Services Call Center staff about grievances and complaints.
 - Reference sheets previously created for new/existing staff for complaints/grievances are kept up to date.
- Staffing vacancies (resignation and movement within Neighborhood) in GAU attributed to increase in the claims dispute backlog and shift in responsibilities. This was resolved by Q4 2023
 - Five positions were vacant in 2023, including the GAU Clinical Manager position, Two Senior GAU Specialist positions, GAU Specialist and a GAU Coordinator position. GAU Management continued to implement strategies to decrease the backlog including obtaining OT. The Claim Dispute backlog was resolved in September of 2023.
- Focused on cross training all department staff on the documentation of all workflows to ensure timeliness, consistency, and efficiency.

Analysis of Performance: The total complaints received for 2025 was 822, an increase of 34.75% compared to the 610 received in 2024. The average rate of complaints per 1,000 members in 2025 was 2.22/1000 compared to 1.66/1,000 in 2024. The average number of receipts for calendar year 2025 was 205 per quarter. Q1 2025 (173 receipts) the lowest number of receipts and was lower than the quarter average by 15.61% or 32 complaints. Q2 2025 (203 receipts) was lower than the quarter average by 0.98% or 2 complaints. Quarters Q3 2025 & Q4 2025 incurred higher than average receipts with Q4 2025 being the highest at 235 receipts.

Complaints Received in 2025				
Q1	Q2	Q3	Q3	Total
173	203	211	235	822

Attitude and Service Complaints

Attitude and Service complaints include both provider service issues and Neighborhood Customer Service complaints. The attitude and service complaints represent the second largest percentage of complaints with 341 received in 2025, an increase compared to 198 received in 2024, and representing 41.0% of the total numbers of complaints. Most of these complaints were related to member perception of rude or disrespectful treatment by a physician or his/her staff and disrespectful rude or demeaning treatment by Neighborhood staff. Complaints about physicians/office staff and facilities accounted for 239 or 70.0% of the attitude and service complaints. Complaints about the Plan accounted for 102 or 30% of the attitude and service complaints.

Quality-Related Complaints

167 Quality-related complaints were received in 2025 representing 20% of all complaints. Most of these complaints reflect member perception of inappropriate treatment, inappropriate diagnosis, and denial of medical treatment by a physician or his/her staff resulting in allegations of poor quality of care.

The Plan reviews member concerns and medical records against standards of care. If quality of care is not present from a clinical perspective, the complaint process allows the Plan to assure the member that the complaint has been investigated and to work with a provider if the treatment received was not acceptable/appropriate. If quality of care issue is suspected or identified when researching member concerns, the issue is researched by a clinician to verify that treatment plans are appropriate.

Access to Care Complaints

Access to Care Complaints represent the highest percentage of complaints alongside Attitude & Service complaints, with 225 Access to Care Complaints received in 2025 representing 27% of all complaints. Most of these complaints reflect member perception about provider availability and difficulty reaching the provider, problems receiving medications, and accessibility of services.

The following table shows the total number of complaints and the complaints per thousand, broken down by quarter and complaint category.

	Member Complaint /1,000	Total # Complaint	Access to Care	Quality of Care	Attitude/ Service	Interpreter Service	Billing	Enrollment	Environment of Care
Q1 2025	1.85	173	14%	38%	40%	2%	5%	1%	0%
Q2 2025	2.16	203	25%	21%	46%	1%	6%	0%	1%
Q3 2025	2.28	211	33%	18%	38%	1%	7%	2%	0%
Q4 2025	2.59	235	34%	9%	41%	2%	11%	3%	0%

	Member Complaint /1,000	Total # Complaint	Access to Care	Quality of Care	Attitude/ Service	Interpreter Service	Billing	Enrollment	Environment of Care
Q1 2024	1.42	131	31%	30%	35%	1%	2%	0%	1%
Q2 2024	1.31	120	28%	23%	39%	2%	6%	1%	1%
Q3 2024	1.98	182	29%	24%	35%	2%	8%	3%	0%
Q4 2024	1.93	177	24%	34%	23%	2%	16%	1%	0%

Analysis of Barriers to Performance and Planned Interventions:

- Confirming if member complaints against providers are true or false continues to be a challenge as perception often cannot be replicated between member and provider statements. The complaint process often serves as a means of member education, communication, and a reminder of member rights to advocate their needs to providers.
 - **Planned Intervention:** Continue to reinforce Grievance and Appeals training for all Neighborhood staff on how to properly identify a member complaint and to ensure that complaints properly directed to the GAU for complete investigation. Brainshark training is incorporated into new hire orientation. Take GAU ‘on the road’ – providing presentations to interdepartmental staff meetings as requested or needed.

Timeliness of Complaint Resolution

Goal: 100% of all member complaints are resolved within the required timeframes.

Medicaid: The Plan has thirty (30) calendar days to research and provide verbal response and resolution to our members. Clinical Quality of Care complaints processed by the Medical Director’s office or Grievances (Access to Care or ‘2nd level informal complaints’, handled by GAU) are allowed ninety (90) calendar days for resolution in written format.

Exchange/Commercial: The Plan has thirty (30) calendar days to research and provide resolution to our members. Verbal complaints are responded to verbally on a recorded line in accordance with OHIC requirements (effective 2019). There is only one level of complaint and one turnaround timeframe. Written complaints are responded to in writing. Clinical Quality of Care complaints processed by the Medical Director’s office are within same 30 calendar day timeframe and resolutions are in written format.

INTEGRITY/MMP: The Plan has thirty (30) calendar days to research and provide members with written resolution for Grievances (GAU) and Clinical Quality of Care grievances (Medical Director’s office). There is only one level of complaint.

Measure/Methodology: The Plan determines the number of days for completed resolution by calculating the number of days between the date the complaint was filed by the member and the date the member was notified with a resolution. This information is logged in the system of record by line of business/complaint type. The Plan utilizes the COGNOS environment as a reporting tool to determine the number and type of complaints received and to report on a quarterly basis to appropriate agencies. MMP reporting is based on data entered in Acuity.

Intervention:

- GAU continued to enhance the complaint process from intake to resolution to ensure that GAU maintains control of case investigation, resolution, and turnaround times. Collaboration is key to enhancing the process and GAU collaborated with internal departments to emphasize the importance of the complaints process and how it ties to member satisfaction, member rights and potential for process improvement.

Analysis of Performance: In 2025, overall timeliness for all complaints from all lines of business was 99%. Of the 822 complaints received, 815 were completed within the regulatory timeframes. Timeliness of resolving complaints continues to improve year after year, hovering above 99%. The following chart depicts percent of timeliness of complaint resolution by product lines:

	Q1 2025	Q2 2025	Q3 2025	Q4 2025
MEDICAID	100%	100%	100%	100%
MMP	100%	99%	96%	100%
Exchange	100%	100%	100%	100%
% Per Quarter	100%	100%	100%	100%

Barriers to Performance and Planned Interventions:

GAU Continued to experience some staffing challenges during CY 2025. Three positions were vacant in 2025, the GAU Specialist, A GAU Clinical Nurse and a GAU Coordinator position.

Planned Intervention: Continue to focus on cross training all department staff on documentation of all workflows/DTPs to ensure timeliness, consistency, and efficiency.

Cross- training all departments mitigates risk in the future and more easily onboard new staff should the need occur.

- Most quality-of-care concerns cannot be substantiated despite the Plan’s best efforts and continue to be a barrier to assessing the performance of network providers.
- Ensuring all internal staff follow documented processes for intake of member complaints and grievances.
 - **Planned Intervention:** Ongoing training for Member Services staff, including new staff, to ensure consistency, member focused approach as well as how to identify the appropriate time to offer the complaint process. GAU continues to conduct Member Services and GAU Leadership Monthly Collaboration meeting.

CAHPS 2025 Adult Medicaid Member Experience Survey

Opportunity Statement: Surveying members provides Neighborhood with information on members’ experience with the Plan and their practitioners. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Adult Medicaid survey is one of the key measurement tools used to assess member experience.

Goals:

- Achieve the 2025 National Medicaid Quality Compass 90th percentile on survey measures.
- Maintain an overall Net Promoter Score of “Excellent” (scoring +50 or higher) in 2025.
- Achieve 4 out of 5 stars on NCQA Star Rating Patient Experience measures.

Measure/Methodology: Neighborhood contracted with Press Ganey (PG), a National Committee for Quality Assurance (NCQA) certified survey vendor, to administer the CAHPS 5.1H Adult Medicaid survey between March and June 2025. The oversampling rate remained high in 2025 at 150% to ensure sufficient survey response rates. Using a mixed (mail, phone, and internet) survey methodology, PG collected 441 responses from the eligible member population of 3,375 for a response rate of **13.1%** which increased from 12.2% the previous year. Of the completed surveys, 121 (64 mail, 29 phone, 28 internet) were completed in Spanish for non-English Spanish-speaking members.

Medicaid Expansion (RHE) members continued to account for the largest proportion (39%) of all survey respondents. Traditional Rite Care MED members accounted for 15% of the total respondents and RHP adults with disabilities accounted for 14%. Children with Special Health Needs, which include children and youth up to age 26 years who are in the care of Department of Children, Youth and Families (DCYF)

account for less than 1% of total respondents. Since 2019, NCQA has mandated the inclusion of Medicare-Medicaid Plan (MMP) members (INTEGRITY) in both the Medicaid Adult and Medicare CAHPS samples resulting in members potentially being surveyed twice. INTEGRITY members accounted for 31% of the total survey respondents in 2025. Satisfaction is presented as Summary Rates, which represent the percent of respondents who chose the most positive combination of question responses as specified by NCQA.

Product	Number of Respondents
Medicaid Expansion (RHE)	173
INTEGRITY (MMP)	139
Rite Care (MED)	66
Rhody Health Partners (RHP)	61
Children with Special Health Care Needs (CSN)	1

Interventions:

- Experience Management (XM) leaders established quarterly XM Summits for Member, Provider, and Employee Experience Workgroups to enhance their knowledge of XM principles and foster cross-collaboration between the XM workgroups to bolster execution of interventions.
- CX Team engaged workgroup participants individually to establish deeper understanding of the data and what improvement opportunities are possible within each business area. This will replace the provider and member workgroup's subgroup strategy with a monthly review of operational data and a cadence of department report-outs to increase capacity for implementations and ensure information about interventions related to key drivers is shared across departments.
- The Provider Relations team, in collaboration with the CX Team, shared CAHPS 2024 results with the provider network. The initiative aims to establish awareness of opportunities identified in Neighborhood's CAHPS results related to provider interactions with members/patients. The goal is through better understanding of their patients' satisfaction; providers will make necessary adjustments in their service delivery and/or partner with Neighborhood on potential adjustments.
- Established an internally developed Medicaid Member Portal to encourage member use of self-service features and access to benefit information. This initiative aims to enhance the member experience while driving operational efficiencies through system-to-system integration with various requests such as (Mailed Materials Requests, ID Cards, PCP Changes, etc.).
- CX team in collaboration with the Provider CX Workgroup introduced additional pulse listening to gain timely insights into provider satisfaction throughout the year. New listening posts will help measure effectiveness of planned interventions, as applicable.

Analysis of Performance: Highlights of the 2025 survey results are as follows:

- Rating of Health Plan (8+9+10) remains high in 2025 and above the 2025 National Medicaid QC 90th percentile for the 22nd consecutive year.
- Getting Care Quickly, improved by over 5 percentage points and rated at the 2025 National Medicaid QC 95th percentile.
- Neighborhood met the 2025 corporate goal of maintaining an overall Medicaid Net Promoter Score (NPS) of "Excellent" (scoring +50 or higher), by scoring +67.

The Plan performance rates for 2025 CAHPS Adult Medicaid satisfaction are displayed in the table below.

CAHPS Survey Measure Adult Medicaid 5.1H	2025 CAHPS Rate	2025 QC Percentile	2024 CAHPS Rate	2024 QC Percentile
Getting Needed Care (<i>% usually or always</i>)	86.3%↑	86 th	83.8%	67 th
Getting Care Quickly (<i>% usually or always</i>) *	87.9%↑	94 th	82.6%	65 th
How Well Doctors Communicate (<i>% usually or always</i>)	94.4%↑	67 th	93.0%	53 rd
Customer Service (<i>% usually or always</i>)	92.4%↑	87 th	91.7%	86 th
Coordination of Care (<i>% usually or always</i>)	89.2%↓	82 nd	90.2%	85 th
Rating of Health Care (8+9+10)	77.9%↑	64 th	76.5%	55 th
Rating of Health Care (9+10)	60.7%↓	77 th	62.1%	84 th
Rating of Personal Doctor (8+9+10)	87.2%↑	80 th	81.0%	26 th
Rating of Personal Doctor (9+10)	71.8%↑	59 th	67.4%	34 th
Rating of Specialist (8+9+10)	84.3%↓	62 nd	85.9%	85 th
Rating of Specialist (9+10)	67.2%↓	43 rd	72.3%	84 th
Rating of Health Plan (8+9+10) *	86.6%↑	98 th	88.5%	99 th
Rating of Health Plan (9+10) *	73.0%↓	98 th	75.3%	99 th
Advising Tobacco Users to Quit *	83.1%↓	94 th	84.8%	96 th

Arrows indicate comparison to prior year's performance.

*Measures meeting or exceeding the performance goal of achieving the 90th percentile in 2025.

Analysis of Barriers to Performance and Planned Interventions:

The identified barriers to performance during the reporting period were related to competing organizational priorities. Significant focus in 2025 was directed toward the insourcing of the Behavioral Health Provider Network and the transition from MMP to Dual Eligible Special Needs Plan (D-SNP) model of care. These initiatives required substantial cross-functional resources, which temporarily limited the organizations capacity to implement interventions during this period.

Additionally, a major data breach of the Rhode Island Bridges (RIBridges) system in December 2024 affected over 600,000 individuals in the state of Rhode Island. This may have contributed to a decrease in member trust. Although the breach occurred within the Department of Human Services (DHS) system, the health plan's association with DHS may have influenced member perception. This external event may have indirectly impacted performance.

- **Planned Intervention:** Pharmacy team in partnership with CVS will establish a Smart Prior Authorization Code Logic (Smart PA) to streamline approvals, reduce unnecessary delays, decrease administrative burden and ensure members can access the care they need faster.
- **Planned Intervention:** Provider Data Integrity team will implement automation on provider roster to ingest rosters from Providers to increase accuracy and efficiency for Neighborhoods provider directory and leverage its live intercept survey to determine opportunities for improvement.
- **Planned Intervention:** Care Management team made enhancements to Health Risk Assessment's (HRA) with the implementation of Guiding Care which allows for HRAs to be mailed in multiple languages (English, Spanish, and Portuguese), an auto dialer feature, in the event a member answers the phone they will be auto connected to a care manager to complete their HRA. Lastly, health equity questions were incorporated such as race, ethnicity, languages, sexual orientation, and gender identity to improve quality of care.
- **Planned Intervention:** The Health Equity Manager will track trends for member experience with interpreter services and identify areas of opportunity.

- **Planned Intervention:** Provider Contracting is in the process of contracting with additional hospitals such as Yale-New Haven Health and Boston Children’s Hospital to reduce the rate of out-of-network (OON) requests and ensure access to needed specialty care.
- **Planned Intervention:** Pharmacy team in partnership with CVS will determine if any non-formulary drugs should be added to the Medicaid formulary and/or if any prior authorization (PA) requirements can be removed or relaxed to help ensure members can access necessary medications without barriers or delays in treatment.
- **Planned Intervention:** Information Systems and Member Services implemented a member portal to access self-service options and improve member understanding of benefits, coverage, claims status, and other health plan information. Additionally, both teams will relaunch a member portal feedback survey to make future enhancements in partnership with Customer Experience.
- **Planned Intervention:** Provider Relations (PR) will educate non-compliant providers on access standards, support updates to provider information by encouraging use of the necessary e-forms. Work with Business Intelligence and Salesforce to develop improvements in provider training tracking. Onboard PR Associate dedicated to outreach and education regarding Access Standards as needed.

CAHPS 2025 Adult QHP (Exchange) Enrollee Experience Survey

Opportunity Statement: Neighborhood annually contracts with a Health and Human Services-approved survey vendor to conduct the Qualified Health Plan (QHP) Enrollee Experience Survey (EES). The survey is designed to capture accurate and reliable information from Marketplace members about their experience with the health care they received. Centers for Medicare and Medicaid Services (CMS) developed the QHP EES to collect data for three main purposes: to inform consumer decision-making in choosing a QHP; to inform quality improvement efforts for QHPs; and to allow for effective oversight.

Goal: Achieve “above average” performance on member satisfaction measures when compared to the CMS National Average.

Measure/Methodology: Neighborhood contracted with Press Ganey (PG), a National Committee for Quality Assurance (NCQA) certified survey vendor, to administer the QHP EES between February and May 2025. A mixed (mail, phone, and internet) survey methodology per CMS protocol was executed, and PG surveyed a sample of 1,690 Marketplace adult members who were active members July to December 2024. The final 2025 survey response rate was 16.5% with 146 completed (57 mail, 40 phone, 49 Internet), slight decline from 189 responses in 2024 with a 21.5% response rate. A total of 32 surveys were completed in Spanish (5 mail, 16 phone, 11 Internet).

Interventions:

- Experience Management (XM) leaders to establish quarterly XM Summits for Member, Provider, and Employee Experience Workgroups to enhance their knowledge of XM principles and foster cross-collaboration between the XM workgroups to bolster execution of interventions.
- CX Team to engage workgroup participants individually to establish deeper understanding of the data and what improvement opportunities are possible within each business area. This will replace the provider and member workgroup’s subgroup strategy with a monthly review of operational data and a cadence of department report-outs to increase capacity for implementations and ensure information about interventions related to key drivers is shared across departments.
- The Provider Relations team, in collaboration with the CX Team, will work together to share CAHPS 2024 results with the provider network. The initiative aims to establish awareness of opportunities identified in Neighborhood’s CAHPS results related to provider interactions with

members/patients. The goal is through better understanding of their patients' satisfaction; providers will make necessary adjustments in their service delivery and/or partner with Neighborhood on potential adjustments.

- Continued development and rollout of the newly established internal Exchange Member Portal, designed to encourage member use of self-service features and access to benefit information. This initiative aims to enhance the member experience while driving operational efficiencies through system-to-system integration with various requests such as (Mailed Materials Requests, ID Cards, PCP Changes, etc.).
- CX team in collaboration with the Provider CX Workgroup to introduce additional pulse listening to gain timely insights into provider satisfaction throughout the year. New listening posts will be prioritized to measure effectiveness of planned interventions as possible.
- Insource Behavioral Health Provider Network and measure onboarding and overall experience of these providers with Neighborhood.

Analysis of Performance: Highlights of the 2025 survey results are listed below:

- Neighborhood's Quality Rating System (QRS) summary indicator score for Enrollee Experience maintained its overall rating of 5 out of 5 possible Stars.
- Neighborhood's performance on all but four measures rated **"Average"** compared to the national CMS average score
- Neighborhood's performance rated **"Below average"** when compared to the national CMS average among the following measures:
 - Enrollee Experience with Cost
 - Pay out of pocket for care you thought health plan would pay for
 - Ease of filling out forms
 - Doctor offered telephone/video appts

2025 Qualified Health Plan Enrollee Experience Survey Measures	Neighborhood Scaled Mean Score		CMS 2025	
	2025	2024	CMS National Average	Neighborhood Compared to the National Average
Getting Care Quickly	71	71	71	average
Getting Needed Care	64↓	68	69	average
Ease of getting care, tests, or treatment	71↓	76	75	average
Getting specialist appointment	58↓	60	62	average
Care Coordination	84↑	80	82	average
Get test results	86↑	85	86	average
Access to Information	57↑	52	53	average
Plan Administration (Customer Service)	74↑	72	75	average
Getting info/help from Customer Service	63↑	62	65	average
Treated with courtesy and respect	85↑	83	84	average
Longer than expected wait time to speak with CS	63↓	66	67	average
Ease of filling out forms	62	62	70	below average
Rating of Health Care	77↓	80	80	average
Rating of Personal Doctor	87↑	86	88	average
Rating of Specialist	84↓	85	86	average

2025 Qualified Health Plan Enrollee Experience Survey Measures	Neighborhood Scaled Mean Score		CMS 2025	
	2025	2024	CMS National Average	Neighborhood Compared to the National Average
Rating of Health Plan	72↑	71	73	average
Enrollee Experience with Cost	72↓	78	78	below average
Paying for care I thought was covered	63↓	71	74	below average
Doctor offered telephone/video appts	34↓	38	40	below average

Analysis of Barriers to Performance and Planned Interventions:

The identified barriers to performance during the reporting period were related to competing organizational priorities. Significant focus in 2025 was directed toward the insourcing of the Behavioral Health Provider Network and the transition from Medicare-Medicaid Plan (MMP) to Dual Eligible Special Needs Plan (D-SNP) model of care. These initiatives required substantial cross-functional resources, which temporarily limited the organizations capacity to implement interventions during this period.

Additionally, a major data breach of the Rhode Island Bridges (RIBridges) system in December 2024 affected over 600,000 individuals in the state of Rhode Island. This may have contributed to a decrease in member trust. Although the breach occurred within the Department of Human Services (DHS) system, the health plan's association with DHS may have influenced member perception. This external event may have indirectly impacted performance.

- **Planned Intervention:** Commercial Product team implemented a new member welcome email to provide timely information to new members related to ID cards, member services number, and the member portal which includes access to benefit/coverage information. The team will now monitor for increased member understanding within pulse survey results and a decrease in grievances and complaints.
- **Planned Intervention:** Commercial Product team will implement a change to 2026 Individual market plan names to be aligned with industry standards, by categorizing plan names by metal tier and add deductible/ HSA indicator. Providing cost information on member materials and plan names will improve members' understanding of their financial responsibility and support informed decision-making when accessing care.
- **Planned Intervention:** Pharmacy team in partnership with CVS will establish a Smart Prior Authorization Code Logic (Smart PA) to streamline approvals, reduce unnecessary delays, decrease administrative burden and ensure members can access the care they need faster.
- **Planned Intervention:** Provider Data Integrity team will implement automation on provider roster to ingest rosters from Providers to increase accuracy and efficiency for Neighborhoods provider directory and leverage its live intercept survey to determine opportunities for improvement.
- **Planned Intervention:** Quality Improvement team in partnership with the Health Equity Manager will track trends for member experience with interpreter services and identify areas of opportunity.
- **Planned Intervention:** Information Systems and Member Services implemented a member portal to access self-service options and improve member understanding of benefits, coverage, claims status, and other health plan information. Additionally, both teams will relaunch a member portal feedback survey to make future enhancements in partnership with Customer Experience.
- **Planned Intervention:** Provider Relations (PR) will educate non-compliant providers on access standards, support updates to provider information by encouraging use of the necessary e-forms. Work with Business Intelligence and Salesforce to develop improvements in provider training

tracking. Onboard PR Associate dedicated to outreach and education regarding Access Standards as needed.

CAHPS 2025 Medicaid Child with CCC Member Experience Survey

Opportunity Statement: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Medicaid Child with Children with Chronic Conditions (CCC) survey aims to measure how well plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on overall satisfaction; and to identify areas of opportunity for improvement, which can aid plans in increasing the quality of provided care to children.

Goal: Achieve the 2025 National Medicaid Quality Compass 90th percentile on survey measures.

Measure/Methodology: The 2025 CAHPS 5.1H Medicaid Child with CCC survey was administered by Press Ganey, an NCQA-certified survey vendor. Neighborhood employed a 50% oversample to ensure actionable results and surveyed parents of 4,315 eligible Neighborhood members using mail survey methodology with one set of reminder phone calls per NCQA protocol between March and June 2025. The 2025 survey containing 53 questions with total of 228 surveys collected yielded a 9.2% response rate in 2025, which increased from 7.7% the previous year. Of the total surveys, 121 were completed in Spanish (68 mail, 53 phone), compared to 63 responses from the previous year.

Interventions:

- Experience Management (XM) leaders to establish quarterly XM Summits for Member, Provider, and Employee Experience Workgroups to enhance their knowledge of XM principles and foster cross-collaboration between the XM workgroups to bolster execution of interventions.
- CX Team to engage workgroup participants individually to establish deeper understanding of the data and what improvement opportunities are possible within each business area. This will replace the provider and member workgroup's subgroup strategy with a monthly review of operational data and a cadence of department report-outs to increase capacity for implementations and ensure information about interventions related to key drivers is shared across departments.
- The Provider Relations team, in collaboration with the CX Team, will work together to share CAHPS 2024 results with the provider network. The initiative aims to establish awareness of opportunities identified in Neighborhood's CAHPS results related to provider interactions with members/patients. The goal is through better understanding of their patients' satisfaction, providers will make necessary adjustments in their service delivery and/or partner with Neighborhood on potential adjustments.
- Establish an internally developed Medicaid Member Portal which will be designed to encourage member use of self-service features and access to benefit information. This initiative aims to enhance the member experience while driving operational efficiencies through system-to-system integration with various requests such as (Mailed Materials Requests, ID Cards, PCP Changes, etc.).
- CX team in collaboration with the Provider CX Workgroup to introduce additional pulse listening to gain timely insights into provider satisfaction throughout the year. New listening posts will be prioritized to measure effectiveness of planned interventions as possible.
- Insource Behavioral Health Provider Network and measure onboarding and overall experience of these providers with Neighborhood.

Analysis of Performance: Highlights of the 2025 survey results are as follows:

- 2025 Medicaid Child Net Promoter Score (NPS) = +67 - Meets and exceeds 2025 Corporate Goal of maintaining overall Medicaid NPS of "Excellent" (+50).

- **Rating of Health Plan (8+9+10) = 89.2%** is a slight increase from 88.6% in 2024, rating at the QC 76th percentile.
- **Rating of Health Care (8+9+10) = 83.7%** a decrease from 91.2% in 2024, rating at the bottom 12th percentile.
- **How well doctors communicate (A+U) = 91.1%** a decrease from 97.2% in 2024 a statistically significant decline, rating at the bottom 9th percentile.
- **Getting Care Quickly (A+U) = 85.4%** a decrease from 92.0% in 2024, rating in the 37th percentile.
- **Rating of Personal Doctor (8+9+10) = 90.0%** a slight decline from 91.5% in 2024, rating in the 38th percentile.

2025 CAHPS Medicaid Child Results

Survey Measures	General Population				
	2025	2025 QCPctile	2024	2024 QCPctile	2025 90 th QCPctile
Getting Needed Care	83.4%↓	40 th	88.5%	87 th	89.5%
Ease of getting care, tests or treatment	86.8%↓	19 th	91.9%	69 th	94.6%
Getting Care Quickly	85.4%↓	37 th	92.0%	89 th	92.0%
Obtain appointment for routine care	82.2%↓	43 rd	88.1%	83 rd	88.9%
How Well Doctors Communicate	91.1%↓	9 th	97.2%	97 th	96.5%
Doctor listened carefully	94.9%↓	36 th	98.4%	96 th	97.6%
Doctor showed respect	96.8%↓	41 st	97.6%	71 st	98.7%
Rating of Personal Doctor (8+9+10)	90.0%↓	38 th	91.5%	73 rd	93.3%
Rating of Specialist (8+9+10)	87.8%↓	59 th	93.8%	97 th	92.3%
Rating of Health Care (8+9+10)	83.7%↓	12 th	91.2%	93 rd	91.4%
Rating of Health Plan (8+9+10)	89.2%↑	76 th	88.6%	72 nd	90.7%

Arrows indicate comparison to prior year's performance.

*Measures meeting or exceeding the performance goal of achieving the 90th percentile in 2025.

Analysis of Barriers to Performance and Planned Interventions:

The identified barriers to performance during the reporting period were related to competing organizational priorities. Significant focus in 2025 was directed toward the insourcing of the Behavioral Health Provider Network and the transition from Medicare-Medicaid Plan (MMP) to Dual Eligible Special Needs Plan (D-SNP) model of care. These initiatives required substantial cross-functional resources, which temporarily limited the organizations capacity to implement interventions during this period.

Additionally, a major data breach of the Rhode Island Bridges (RIBridges) system in December 2024 affected over 600,000 individuals in the state of Rhode Island. This may have contributed to a decrease in member trust. Although the breach occurred within the Department of Human Services (DHS) system, the health plan's association with DHS may have influenced member perception. This external event may have indirectly impacted performance.

- **Planned Intervention:** Pharmacy team in partnership with CVS will establish a Smart Prior Authorization Code Logic (Smart PA) to streamline approvals, reduce unnecessary delays, decrease administrative burden and ensure members can access the care they need faster.
- **Planned Intervention:** Provider Data Integrity team will implement automation on provider roster to ingest rosters from Providers to increase accuracy and efficiency for Neighborhoods provider directory and leverage its live intercept survey to determine opportunities for improvement.

- **Planned Intervention:** Care Management team made enhancements to Health Risk Assessment's (HRA) with the implementation of Guiding Care which allows for HRAs to be mailed in multiple languages (English, Spanish, and Portuguese), an auto dialer feature, in the event a member answers the phone they will be auto connected to a care manager to complete their HRA. Lastly, health equity questions were incorporated such as race, ethnicity, languages, sexual orientation, and gender identity to improve quality of care.
- **Planned Intervention:** Quality Improvement team in partnership with the Health Equity Manager will track trends for member experience with interpreter services and identify areas of opportunity.
- **Planned Intervention:** Provider Contracting is in the process of contracting with additional hospitals such as Yale-New Haven Health and Boston Children's Hospital to reduce the rate of out-of-network (OON) requests and ensure access to needed specialty care.
- **Planned Intervention:** Pharmacy team in partnership with CVS will determine if any non-formulary drugs should be added to the Medicaid formulary and/or if any prior authorization (PA) requirements can be removed or relaxed to help ensure members can access necessary medications without barriers or delays in treatment.
- **Planned Intervention:** Information Systems and Member Services implemented a member portal to access self-service options and improve member understanding of benefits, coverage, claims status, and other health plan information. Additionally, both teams will relaunch a member portal feedback survey to make future enhancements in partnership with Customer Experience.
- **Planned Intervention:** Provider Relations (PR) will educate non-compliant providers on access standards, support updates to provider information by encouraging use of the necessary e-forms. Work with Business Intelligence and Salesforce to develop improvements in provider training tracking. Onboard PR Associate dedicated to outreach and education regarding Access Standards as needed.

Health Outcomes Survey (MMP-INTEGRITY)

Opportunity Statement: The purpose of the Medicare Health Outcomes Survey (HOS) was designed to assess the health function of Medicare Advantage (MA) beneficiaries aged 65 and older, and the program expanded to include dual-eligible Medicare-Medicaid members aged 65 and older covered under Neighborhood's INTEGRITY plan. The intent is to assess Neighborhood's ability to maintain or improve the physical and mental health of its INTEGRITY (MMP) members over time.

Goal: Two-year change scores are estimated from a regression model that case-mix adjusts for baseline function. Contract-level change scores are on a 0-100 scale, with 100 equivalents to all beneficiaries retaining 100% of baseline function over two years and 0 corresponding to every beneficiary in the contract experiencing maximum decline. Health maintenance, rather than improvement, is a realistic clinical goal for many beneficiaries. Plan results are compared to the national HOS average performance results, which include mostly MA health plans.

Measure/Methodology: The HOS 3.0 survey is administered to a random sample of members from the health plan at the beginning of a two-year period, and Baseline survey respondents are mailed a Follow-Up survey two years later. For each member who completes a Baseline and Follow-Up survey, a two-year change score is calculated and, taking risk factors into account, the member's physical and mental health status is categorized as better, the same, or worse than expected. Members who are deceased at Follow-Up are included in the "worse than expected" physical outcome category at the contract level.

CMS released the final 2022-2024 Cohort 25 Performance Measurement Report in July 2025 to the health plans for use in quality improvement activities.

Survey Timing:

- Cohort 25 Baseline survey fielded in 2022
- Cohort 25 Baseline Report in November 2023
- Cohort 25 Follow-Up survey fielded in 2024
- Cohort 25 final performance results calculated and reported in 2025

Analysis of Performance:

Baseline 2022-Cohort 25

- Neighborhood’s CMS-approved survey vendor, Press Ganey/SPH Analytics, reported in 2022 that 162 MMP members responded of the 1,200 members surveyed, yielding a 14.0% response rate.
- Upon receipt and case-mix adjustment of the results, CMS officially reported that **205** members responded, yielding a final CMS response rate of 17.4%.
- CMS separates HOS survey respondents into two groups by age:
 - **Analytic sample (Age >= 65) N=104 (50.7%)**
 - Disabled sample (Age < 65) N=101 (49.3%)

CMS does not include any of the responses from the disabled sample (Age < 65) in its analysis.

Follow-Up 2024-Cohort 25

- Of the 104 Baseline respondents age 65 or older, 28 voluntarily disenrolled and 10 died.
- The remaining 66 were included in the 2024 Follow-Up survey population.
 - 28 members did not respond
 - 38 members age 65 or older responded to the Follow-Up survey and their survey responses are examined in this analysis.
 - Follow-Up survey response rate: 57.6%; this is lower compared to the national MA average response rate of 64.6%.

The HOS national average, also referred to in this report as the HOS total, is based on all Medicare Advantage Organizations (MAOs) that participated in the performance measurement. Outliers are those MAOs that performed significantly better or significantly worse than expected when compared to the national average. MAOs may be outliers on a measure of physical health, mental health, or both. The overall measure of change in physical health is calculated by combining death status and the Physical Component Score (PCS). Change in mental health is calculated using the Mental Component Score (MCS).

Physical and Mental Health Scores

The primary physical and mental health status measures for the HOS are the PCS and the MCS. Table 1 presents the trend in the physical health performance measurement results for Neighborhood (Medicare contract H9576), BlueCHiP for Medicare (H4152), the state total, and HOS total. Six out of 10 (67.52%) of the responding MMP members reported their physical health status was better or the same after two years. Neighborhood performed as expected (↔), or the same as the national MAO average (differed by less than two standard deviations from the HOS national average).

Table 1: Trend in Physical Health Results for 2022-2024 Cohort 25

	Percent Better	Percent Same	Percent Worse	Percent Better + Same	Performance Results
H9576 Neighborhood	11.41%	56.11%	32.48%	67.52%	↔
H4152 BlueCHiP	16.26%	54.25%	29.49%	70.51%	↔
Rhode Island	14.71%	56.53%	28.76%	71.24%	
HOS Total	16.26%	54.70%	29.04%	70.96%	

Table 2 presents the trend in the mental health performance measurement results for Neighborhood (H9576), BlueCHiP (H4152), the state total, and HOS total. Eight out of 10 (85.76%) of the responding MMP members reported their mental health status was better or the same after two years. Neighborhood performed as expected (↔), or the same as the national MAO average.

Table 2: Trend in Mental Health Results for 2022-2024 Cohort 25

	Percent Better	Percent Same	Percent Worse	Percent Better + Same	Performance Results
H9576 Neighborhood	24.00%	61.76%	14.24%	85.76%	↔
H4152 BlueCHiP	20.11%	67.18%	12.71%	87.29%	↔
Rhode Island	17.92%	69.86%	12.23%	87.77%	
HOS Total	15.13%	68.91%	15.95%	84.05%	

General Health and Comparative Health

Table 3 describes baseline and follow-up results for the general and comparative health status of beneficiaries in Neighborhood (H9576), Rhode Island, and the HOS total. Populations with greater increases between Baseline and Follow-Up in the proportion of beneficiaries who indicated that their general health was “Fair” or “Poor” or that their physical or mental health compared to one year ago was “Slightly worse” or “Much worse” may assume greater risk for mortality.

Table 3: Distributions of Self-Rated General and Comparative Health Status for 2022-2024 Cohort 25

	General Health Fair or Poor		Comparative Physical Slightly Worse or Much Worse		Comparative Mental Slightly Worse or Much Worse	
	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
H9576 Neighborhood	47.4%	52.6%↑	21.1%	13.5%↓	13.2%	10.8%↓
Rhode Island	14.2%	15.7%↑	18.7%	21.2%↑	7.7%	8.0%↑
HOS Total	21.5%	23.9%↑	24.6%	27.3%↑	11.5%	12.2%↑

- The rate of Neighborhood respondents reporting worsening comparative physical or mental health status outcomes decreased from Baseline (2022) to Follow-Up (2024).
- Neighborhood’s MMP respondents were more than twice as likely as Rhode Island respondents age 65 or older overall (most of whom are MA) to report their general health was “Fair” or “Poor” compared to one year ago.

Chronic Medical Conditions

Table 4 shows the percentage of beneficiaries with multiple (i.e., two or more) chronic medical conditions at Baseline (2022) and Follow-Up (2024) for Neighborhood (H9576), Rhode Island, and the HOS total. Research demonstrates that having a greater number of chronic conditions increases the risks of the following outcomes: mortality, poor functional status, unnecessary hospitalizations, adverse drug events, duplicative tests, and conflicting medical advice.

Table 4 shows the rate of self-reported multiple chronic conditions decreased from Baseline (2022) to Follow-Up (2024) among Neighborhood’s MMP respondents.

Table 4: Multiple Chronic Medical Conditions for 2022-2024 Cohort 25

	Baseline	Follow-Up
H9576 Neighborhood	75.0%	81.1%
Rhode Island	56.8%	60.1%
HOS Total	61.0%	63.6%

Note: Multiple chronic medical conditions are defined as having two or more conditions.

Note: Removal of three conditions in 2022 will affect comparability between the baseline and follow up results in this report and reports from prior years.

Healthy Days Measures

Table 5 illustrates the percentage of beneficiaries with 14 or more days of poor physical health, poor mental health, and days of activity limitations in the past 30 days for Neighborhood, Rhode Island, and the HOS total. In general, 14 or more days of poor health or activity limitations are considered indicative of poor well-being. These measures help identify vulnerable sub-populations with the greatest risk for disease or injury (See Next Page).

Table 5: Healthy Days Measures for 2022-2024 Cohort 25

	14 or More Days of Poor Physical Health		14 or More Days of Poor Mental Health		14 or More Days of Activity Limitations	
	Baseline	Follow-Up	Baseline	Follow-Up	Baseline	Follow-Up
H9576 Neighborhood	28.1%	27.8%↑	21.9%	10.8%↓	25.8%	11.1%↓
Rhode Island	11.8%	14.1%↑	6.5%	5.5%↓	7.4%	7.2%↓
HOS Total	16.7%	18.3%↑	9.5%	10.1%↑	11.5%	12.9%↑

Next Steps:

- Customer Experience team to obtain the beneficiary-level data file from Compliance via CMS and share it with Neighborhood's Medical Management staff for the purpose of informing case management activities.
- Neighborhood to access opportunities in running simulated Health Outcome Surveys via external vendor or internally via Qualtrics platform, as organizations pivots to D-SNP product.
- Quality Improvement team to review trends, determine areas of improvement, and establish interventions to improve health outcomes.

CAHPS 2025 Prescription Drug Plan (MMP-INTEGRITY) Survey

Opportunity Statement: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Prescription Drug Plan (PDP) survey is conducted annually to assess the experiences of beneficiaries in Medicare Advantage (MA) and Prescription Drug Plans, including Medicare-Medicaid Plans (MMPs). The goals of the Medicare CAHPS survey are to help health plans identify opportunities to improve quality of care and enhance Centers for Medicare and Medicaid Services' (CMS) ability to monitor quality of care and performance.

Goals:

- Annual Flu Vaccine rate to meet or exceed the MMP Quality Withhold benchmark of 67%.

- Meet or exceed the average performance of the national Medicare Advantage or MMP populations as presented in the case-mix-adjusted CMS reporting.

Measure/Methodology: Press Ganey, a CMS-certified survey vendor, was selected by Neighborhood to conduct its 2025 MMP CAHPS Survey. A total of 1,200 INTEGRITY MMP members, inclusive of a 50% oversample, were surveyed via mail or telephone between March and June 2024. The 2025 survey instrument contained 80 questions, which included the ten CMS-mandated MMP supplemental questions and a question measuring members likelihood to recommend – Net Promotor Score (NPS). CMS calculated Neighborhood’s 2025 survey response rate to be 24.4%, which is higher than the 2024 response rate (22.6%), and higher than the 20.3% average response rate for all MMP contracts nationally in 2025. This rate represents about 286 MMP members responding.

Interventions:

- The Prevention and Screening Workgroup continued to review and update its multi-channel campaign to maintain awareness of flu and vaccine immunizations.
- The CX Team support work to transition MMP members to FIDE-SNP and established FIDE-SNP Personas as a tool to educate staff of the FIDE-SNP member populations experience with Neighborhood.

Analysis of Performance: Highlights of the 2025 survey results are as follows:

- Rating of Health Plan increased its adjusted mean score to 8.9 in 2025, from 8.8 in 2024
 - Exceeded the national MMP average (8.8)
 - Exceeded the National Medicare Advantage (MA) average (8.7)
- The Annual Flu Vaccine rate decreased from 70% in 2024 to 67% in 2025
 - Did not meet the goal of exceeding the MMP Quality Withhold benchmark of 69%
- Getting appointments and Care Quickly and Getting Needed Care measures both rose and met or exceeded the national MMP average
- Getting needed Prescription Drugs, Reminder to Fill Prescription and Reminder to take medication all saw increases from 2024

Measures	2025			2024	Statistical Significance
	Neighborhood	National MA Average	National MMP Average	Neighborhood	
Overall Health Plan Ratings					
Health Plan	8.9↑	8.7	8.8	8.8	above average
Health Care Quality	8.6↑	8.7	8.7	8.8	below average
Personal Doctor	N/A	9.2	9.2	N/A	N/A
Specialist	N/A	9.0	9.0	N/A	N/A
Health Plan Composite Measures					
Getting Needed Care	3.42↑	3.45	3.42	3.39	no difference
Getting Appointments and Care Quickly	3.55↑	3.51	3.51	3.47	above average
Doctors Who Communicate Well	N/A	3.78	3.77	N/A	N/A
Customer Service	3.73↑	3.70	3.69	3.64	above average
Care Coordination	3.62↓	3.64	3.62	3.64	no difference
Clinical Measure					
Annual Flu Vaccine	67%↓	69%	60%	70%	below average

Arrow indicates if Neighborhood’s 2025 performance improved or declined compared to 2024.

Analysis of Barriers to Performance and Planned Interventions:

Significant focus in 2025 was directed toward the insourcing of the Behavioral Health Provider Network and the transition from MMP to Dual Eligible Special Needs Plan (D-SNP) model of care. These initiatives required substantial cross-functional resources, which temporarily limited the organizations capacity to implement interventions during this period.

- **Planned Intervention:** Customer Experience in collaboration with Member Services will add D-SNP members to the Member Services After Call Survey to identify opportunities to improve their experience.
- **Planned Intervention:** Continue to support Prevention and Screening Workgroup in executing multi-channel flu immunization campaign.

Member Reward (Wellness) Program

Opportunity Statement: Preventing illness and disease conditions before they start is critical to helping the Plan’s members live longer and healthier lives. Engaging members in preventive health services can also help those members with early stages of disease from getting sicker.

Goal:

- Encourage members to become involved in their healthcare and engage in preventive care by offering rewards for healthy behaviors.
- Increase participation in the Member Rewards Program by 5% annually.

Measure/Methodology: The number of members who participated in the Member Rewards Program by completing healthy behaviors and submitting documentation to the Plan.

Interventions:

- Promoted the Member Rewards Program on social media, Neighborhood’s website, and through Marketing community presentations.
- Published an article in the Healthy You member newsletter regarding the rewards program.
- Promoted the Member Rewards program through the Well Visit Automated Call Campaign to members in need of an annual well visit.

Analysis of Performance: In CY 2025, there was a total of 1,435 reward requests from individual members with 1,220 requests approved and 215 denied. This is an increase in member rewards requests, but also a significant increase in the number of denials. There was an increase in the total number of member rewards distributed in 2025 (1,220) compared to 2024 (1,108). The goal of increasing participation in the Member Rewards Program by 5% was achieved. Some members submitted requests for multiple rewards which is why the total number of healthy behaviors completed, and rewards requests submitted is different. The following table details the types of healthy behaviors completed in 2025.

Healthy Behavior	2022 Total Rewards Distributed	2023 Total Rewards Distributed	2024 Total Rewards Distributed	2025 Total Rewards Distributed
40+ Mammogram	127	163	201	155
19-year-old + well exam	277	336	377	358
13–18-year-old well exam	76	141	60	110
3–12-year-old well exam	300	600	304	354

18-month-old well exam	30	59	25	35
Completed all recommended immunizations by 2 nd birthday	22	30	42	27
Had a lead screening test by 2 nd birthday	39	49	20	24
Asthma Action Plan	67	70	58	69
Diabetes screenings	40	81	53	69
3-month gym membership	127	198	202	207
Colonoscopy				1
Pap test				4
Total	1105	1727	1342	1413

There were 215 denials for member rewards in 2025, a significant increase from 83 denials in 2024. Member reward denials were triggered for the following reasons:

- Provider information not included on the rewards form.
- Reward request was for behavior completed many years ago.
- Member reward requested for same behavior within the year.
- Reward forms not filled out completely.
- Access/Trust member not enrolled for three consecutive months.
- Members are terminated from the Plan.
- No name on gym receipts/no gym receipts included.

The following table shows the number of reward requests by product. Most rewards requested are from the Medicaid population, specifically MED (675). The number of Exchange members receiving rewards increased with 414 rewards in 2025 compared to 329 in 2024.

Reward Requests	Exchange	MED	RHE	CSN	RHP	SUB	MMP	EFP
2022	207	455	135	30	43	3	4	1
2023	228	939	168	63	61	7	11	0
2024	329	515	174	34	50	3	3	0
2025	414	675	178	49	73	9	4	0

Analysis of Barriers to Performance and Planned Interventions:

- There was an increase in the number of rewards denied in 2025.
 - **Planned Intervention:** Marketing team will continue to conduct health presentations to educate members and providers about the Member Rewards Program.
 - **Planned Intervention:** Continue to publish an article in the Healthy You and Be Well Stay Well member newsletters regarding the rewards.
 - **Planned Intervention:** Continue to advertise the Member Rewards Program on social media.
 - **Planned Intervention:** Continue to educate members and community partners regarding the member rewards program at marketing events and presentations as well as highlighting the importance of carefully reading the instructions on the form to avoid denials.

D. Provider Experience

2025 Provider Satisfaction Survey

Opportunity Statement: Neighborhood annually administers the Provider Satisfaction Survey to assess and identify opportunities to improve providers' experience with health plan services and operations, with the goal of influencing members' care experience.

Goals:

- Achieve a -25 or better overall Net Promoter Score in 2025.
- Achieve an overall provider satisfaction score of 65% or higher.
- Meet or exceed the survey vendor's current Medicaid Book of Business benchmark, where available, for survey items measured by the annual Provider Satisfaction Survey.

Measure/Methodology: Neighborhood contracted with the survey vendor Press Ganey, to administer its 2025 Provider Satisfaction Survey. The 24-question survey was designed to align with the 2025 instrument to maintain consistency in measuring satisfaction. To maximize participation, Neighborhood in partnership with Press Ganey implemented an enhanced outreach approach, beginning with an initial blast email invitation followed by a second blast email reminder near the end of the survey period, as well as mail and phone follow-ups. The survey was conducted from September to November 2025. The sampling methodology was consistent with prior years and included 1,500 participants in 2025.

- A total of 1,488 Primary Care (PCP), Specialist, and Ancillary providers who had visits with at least 100 or more unique members between March and September 2024 were surveyed.
- A total of 123 surveys were completed (58 mail, 32 Internet, and 33 phone), yielding a response rate of 8.3%.
- Where possible, Neighborhood results are compared to the 2024 Press Ganey Medicaid Book of Business benchmarks which consists of data from 108 Medicaid health plans representing 17,393 respondents.

Interventions:

- Experience Management (XM) leaders to establish quarterly XM Summits for Member, Provider, and Employee Experience Workgroups to enhance their knowledge of XM principles and foster cross-collaboration between the XM workgroups to bolster execution of interventions.
- CX Team engaged workgroup participants individually to establish deeper understanding of the data and what improvement opportunities are possible within each business area. This will replace the provider and member workgroup's subgroup strategy with a monthly review of operational data and a cadence of department report-outs to increase capacity for implementations and ensure information about interventions related to key drivers is shared across departments.
- Provider Data Integrity/Coding hosted a cross-functional workshop applying the Kaizen methodology for continuous improvement. The goal is to modify current processes for request to modify provider-related coding based on philosophy of "measure twice, cut once" with goal to reduce finance/claims issues.
- Provider Relations to conduct prior authorization training, improve education resources, simplify forms, assess effectiveness of provider communications, and develop search capabilities for payment policies on Neighborhood website page that houses payment policies.

- CX team in collaboration with the Provider CX Workgroup to introduce additional pulse listening to gain timely insights into provider satisfaction throughout the year. New listening posts will be prioritized to measure effectiveness of planned interventions as possible.
- Payment Integrity department established new payment policies in 2025 based on review of industry standards.
- Insourced Behavioral Health Provider Network and measure onboarding and overall experience of these providers with Neighborhood.

Analysis of 2025 Survey Performance: Highlights of the 2025 survey results include:

- Met the overall Net Promotor Score (NPS) goal of NPS -25 or better with a score of NPS -5.
- For rating of Neighborhood Health Plan compared to all other contracted health plans, 70.9% of PCPs (n=56) are highly satisfied (T2B: % completely or somewhat satisfied); and 71.0% of Specialists (n=72) are highly satisfied.
- For the 11th consecutive year in a row, responding providers were most satisfied with Blue Cross Blue Shield of Rhode Island (BCBSRI) when examining the combined percentage of “completely” and “somewhat” satisfied (81.2%).
- Comparatively, Neighborhood overall satisfaction score of 69.2% exceeded Tufts Health Plan, which increased from 49.5% in 2024 to 56.8% in 2025 and UnitedHealthcare satisfaction score which decreased from 50.5% in 2024 to 50.0% in 2025.

The following composite areas are included in the survey: Overall Satisfaction, Finance Issues (includes claims processing), Utilization and Quality Management, Network/Coordination of Care, Pharmacy, Health Plan Call Center Service Staff, and Provider Relations.

Provider Satisfaction Levels by Category

Composite/Attribute	Summary Rate Definition	Neighborhood TOTAL		Provider Type Summary Rate 2025		2024 PG Medicaid Book of Business Summary Rate
		Summary Rate 2024	Summary Rate 2025	Primary Care	Specialist	
Overall Satisfaction ¹	Well /Somewhat Above Average	57.7%	69.2%	70.9%	71.0%	72.3%
Finance Issues		28.2%	26.6%	22.4%	28.4%	35.7%
Utilization and Quality Management		26.4%	30.0%	32.6%	27.5%	36.3%
Network/Coordination of Care		18.0%	27.1%	27.4%	26.3%	32.9%
Pharmacy		16.3%	25.2%	25.2%	26.4%	27.2%
Health Plan Call Center Staff ²		36.6%	33.5%	30.5%	35.4%	38.9%
Provider Relations		34.2%	37.8%	44.1%	30.4%	34.5%

Underlining indicates statistically significant difference, (p < 0.05).

¹Proportions represent percentage Completely or Somewhat Satisfied.

²Health Plan Call Center Staff represents Provider Services.

Analysis of Barriers to Performance and Planned Interventions:

The identified barriers to performance during the reporting period were related to competing organizational priorities. Significant focus in 2025 was directed toward the insourcing of the Behavioral Health Provider Network and the transition from Medicare-Medicaid Plan (MMP) to Dual Eligible Special Needs Plan (D-SNP) model of care. These initiatives required substantial cross-functional resources, which temporarily limited the organizations capacity to implement interventions during this period.

Planned Interventions:

- Pharmacy team in partnership with CVS will establish a Smart Prior Authorization Code Logic (Smart PA) to streamline approvals, reduce unnecessary delays, decrease administrative burden and ensure members can access the care they need faster.
- Provider Data Integrity team will implement automation on provider roster to ingest rosters from Providers to increase accuracy and efficiency for Neighborhoods provider directory and leverage its live intercept survey to determine opportunities for improvement.
- Provider Contracting is in the process of contracting with additional hospitals such as Yale-New Haven Health and Boston Children's Hospital to reduce the rate of out-of-network (OON) requests and ensure access to needed specialty care.
- Pharmacy team in partnership with CVS will determine if any non-formulary drugs should be added to the Medicaid formulary and/or if any prior authorization (PA) requirements can be removed or relaxed to help ensure members can access necessary medications without barriers or delays in treatment.
- Provider Relations will educate non-compliant providers on access standards, support updates to provider information by encouraging use of the necessary e-forms. Work with Business Intelligence and Salesforce to develop improvements in provider training tracking. Onboard PR Associate dedicated to outreach and education regarding Access Standards as needed.

Timeliness of Claims Adjudication

Goals:

- Medicaid: 95% of clean claims submitted by Rhode Island health care providers are paid within:
 - 30 days from receipt for electronic claims
 - 40 days from receipt for paper claims
- INTEGRITY and Commercial: 100% of clean claims received either electronic or by paper are processed within the following timeframes:
 - 95% processed within 24 calendar days of Receipt
 - 97% processed within 34 calendar days of Receipt

Measure/Methodology:

The Plan's Medicaid and Commercial claims are processed in the Health Edge system called Health Rules while INTEGRITY claims are processed by Securities Software & Consulting (SS&C) in the system called Amisys. SS&C is responsible for meeting the same turnaround times as indicated in the RI Prompt Pay Act. SS&C also processes claims in a first in, first out manner.

In 2025, total receipts for all lines of business combined amounted to 3.8 million, compared to 3.5 million in the previous year, reflecting an increase of 8.5%. The breakout between the two systems is 2.9 million claims for Health Rules and 900 thousand claims for SS&C. We upheld our performance with claims settled within 30 days at 98.5%, surpassing the expected rate of 95%. Additionally, the auto adjudication rate stood at 92%, exceeding the anticipated 85%.

Interventions:

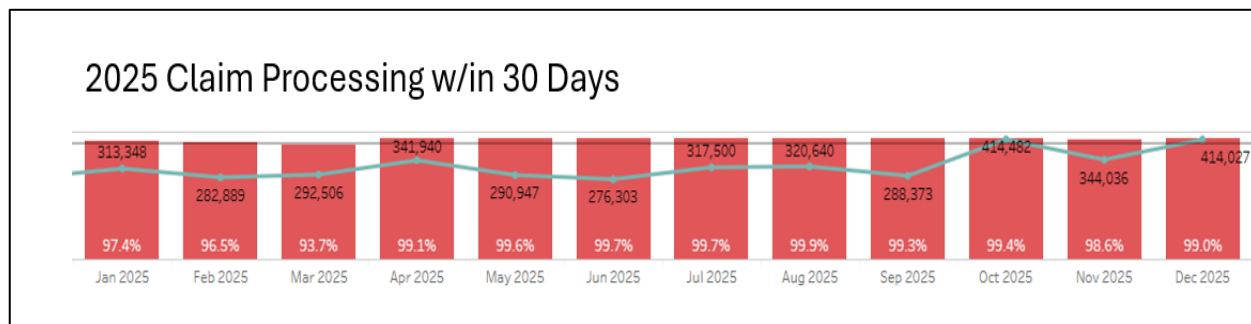
- Supported the tail end of the commercial migration.
- Performed UAT to ensure a successful implementation to our DSNP plan that went live 1/1/2026. This is the last stage of the plan to our single system organization goal.
- In late 2024 administrative appeals for contracted providers transitioned to the Claims department with a significant backlog of over 2000 appeals. In August of 2025 the backlog

was completed and now we maintain completion at 100% within 60 days. The work that took place to accomplish this was

- Created training plans for claims associates
- Developed a triage process
- Development of a determination letter with accurate nomenclature to clearly communicate with providers
- Staffed the team to support the growth
- The quality of claims processing transitioned to the Payment Integrity team as part of a restructuring to better align compliance with our state contract.

Analysis of Performance:

Throughout the year, all lines of business-maintained consistency, achieving the objective of 95% of claims being paid within 30 days. The charts below illustrate the prompt adjudication and receipt of claims across both systems and all lines of business.



Analysis of Barriers to Performance and Planned Interventions:

- The most prominent barrier to claims' performance continued with having two different claims systems for our products. With the Plan moving into a single transactional system, this barrier should ameliorate.
- **Planned Intervention:**
 - Continue work towards the migration of Behavioral Health line of business from stabilizing the claims processing.
 - Continue migration work to single system processing by conducting User Acceptance Testing to bring live a Fully Integrated Dual Eligible (FIDE) and Dual Special Needs Plan (D-SNP) in the Health Rules Processing System for 1/1/2026.

E. Credentialing / Re-credentialing and Site Assessment

Timeliness of Practitioner Credentialing / Re-credentialing

Goal:

- Render the credentialing decision of an application within 45 calendar days after the date of receipt of a complete application.
- Render a decision within 120 calendar days from the date the application was received in credentialing for processing.
- 100% of applicants will be provided with status updates every 15 calendar days.

- 100% of applicants will be informed within five business days that the credentialing application is deemed complete.
- 100% recredentialing applications are processed within 36 months.
- 100% of organizational providers are reassessed within 36 months, including onsite visits for those providers that are not accredited by a national accrediting body.

Measure/Methodology: The Plan's credentialing staff uses the credentialing system, sProvider, to calculate the turnaround time for provider credentialing and recredentialing. Days in process were measured from the date the application was received in credentialing for processing.

Monitoring Practitioner and Provider Quality: All contracted providers are monitored during the interval between formal recredentialing cycles to ensure the highest quality care and services to members. Monthly, Neighborhood credentialing staff monitors for suspension and/or sanction from the professional licensure board, Medicaid/Medicare sanctions, including exclusion and preclusion, and member complaint information. Providers with license suspension and/or sanctions are reviewed by the Medical Director or the physician designee and presented to the Clinical Affairs Committee (CAC) for further remedial and/or disciplinary actions as appropriate.

Interventions:

- HEDIS nurse assisted with onsite visits for facility credentialing and recredentialing.
- Site visits conducted by Department of Health, Facility regulations were considered in lieu of Neighborhood's site visit.
- One vacant position was filled.
- Two temporary staff were hired to assist with increased workload.
- Additional meetings were held for clean files review.
- Revision of unclean files criteria to streamline file review process.

Analysis of Performance of Approved Applications - Medical:

Practitioners	Initial Credentialing		Recredentialing	
# Days to render decision	773	Performance	# Applications	Performance
Within 45	629	81%	2001	99.5%
Within 60	125	16%	--	--
Within 90	19	3%	1	.05%

100% of applications were completed within 120 days of the date the application was received in credentialing for processing and met NCQA standard.

Practitioners Initial Credentialing Application:

A total of 779 applications were received for initial credentialing. The total number of applications include files approved by the Associate Medical Director and CAC. Of the 779 applications, 772 were approved, 1 was denied, and 6 were returned due to no response to requests for information to complete the applications.

Practitioners' Recredentialing Application:

A total of 2,002 applications were presented to CAC for review and were all approved.

22 network practitioners submitted requests for status change, 1 was denied for not meeting credentialing criteria.

Behavioral Health Insourcing:

Goal:

- Render credentialing decisions within 90 days on providers credentialed by Optum.
- Credential 100% of providers within 180 days from the delegation termination date.
- Render credentialing decisions within 45 days for applicants not credentialed by Optum
 - Provide status updates every 15 calendar days as applicable.
 - Inform providers within 5 business days that the credentialing application is deemed complete as applicable.

Analysis of Performance:

4012 requests for credentialing were received, of which 2,352 required full credentialing.

- 1,801 applicants were credentialed by Optum
 - 1,794 had decisions rendered within 90 days (99.6%)
 - 7 had decisions rendered within 120 days (.4%)
- 551 applicants were not credentialed by Optum
 - 527 had decisions rendered within 45 days (95%)
 - 22 had decisions rendered within 90 days (4%)
 - 2 had decisions rendered within 120 days (1%)
- 100% of applications credentialed by Optum were completed within 180 days.
- 100% of applications not credentialed by Optum had decisions made within 120 of the date received in credentialing for processing.

Organizational Provider Credentialing and Recredentialing - Medical:

A total of 135 applications were presented for review, and all were approved. 48 facilities were not accredited and required onsite visits:

- 32 visits were conducted by credentialing staff
- 16 facilities DOH site visit were accepted in lieu of Neighborhood's site visit

Application turnaround performance

Facilities	Initial Credentialing			Recredentialing	
# of Days	# Applications	Performance		# Applications	Performance
Within 45	19	100%		115	99%
Within 60	--	--		1	1%

Organizational Provider Credentialing – Behavioral Health

23 facilities were credentialed; all were credentialed by Optum and required a 90-day application turnaround. 100% met the 90-day turnaround. 7 facilities were not accredited and required site visits. Visits conducted by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) were accepted in lieu of Neighborhood's site visits.

Monitoring of Provider Network Quality:

- 18 providers were presented to CAC for review of action against their licenses, two resulted in network termination due suspension or surrender of license to practice.
- 7 providers were reviewed for meeting the complaint/concern threshold, no further action was required.
- 8 providers were reviewed for substantiated quality of care cases and three for sentinel events, no further action was recommended by CAC.

- 1 provider was terminated due to exclusion.

Analysis of Barriers to Performance:

- Increased workload due to behavioral health insourcing.

Practitioner / Provider Site Assessment Results

Goal:

- 100% of organizational providers requiring onsite visits for re-credentialing are assessed within 36 months timeframe.

Methodology: Onsite assessments are conducted to ensure patient care site(s) meet the Plan standards for safety and cleanliness, medical record keeping, patient education, access to care, and patient satisfaction. A national accreditation is accepted in lieu of the site assessment for network entry and re-credentialing. The site assessment report serves as a mechanism for provider's education and continuous improvement of patient care and service.

A passing site assessment score is 90%. Network providers that do not achieve a passing score are required to submit a plan to improve the area of deficiencies and are re-evaluated within six months of the initial assessment. After 12 months of the initial assessment, if the provider continues to be deficient, they are reviewed by the Medical Director and submitted to CAC for further review and recommendation, and if deemed appropriate, action is initiated to terminate the provider agreement with the Plan. An overall score of 90% or above is required for network entry.

Interventions:

- HEDIS nurse assisted with site visits for recredentialing.
- Site visits conducted by Department of Health Facility regulations were considered in lieu of Neighborhood conducting the visit.

Analysis of Performance: A total of 48 medical facilities required site visits, 32 visits were conducted and all received a passing score. Results of Department of Health, Facility regulations site visits in lieu of Neighborhood's site visit were accepted for 16 medical facilities.

Analysis of Barriers to Performance:

- Increase in workload due to BH insourcing.

IV. Initiatives to Improve Patient Safety and Coordination of Care

A. Patient Safety Activities

Quality Assurance Case Review

Goal:

- 100% of all clinical quality complaints and concerns involving INTEGRITY and Exchange/Commercial members will be resolved within 30 calendar days, according to CMS and OHIC requirements.
- 100% of all clinical quality complaints and concerns involving Medicaid members will be resolved within 90 calendar days.

Measure/Methodology: The Quality Assurance Committee (QAC) is comprised of the Plan's Medical Director, Associate Medical Directors (AMDs), and Clinical Quality Assurance Specialist (CQAS). Medical consultants and outside specialist reviewers are consulted, as needed. The Plan's Chief Medical Officer (CMO) provides oversight and guidance.

- All member complaints and staff concerns that include potential quality-of-care issues are referred to the Clinical Quality Assurance Specialist (CQAS) for review. The CQAS obtains medical records and any additional information as needed and presents each case to the Quality Assurance Committee (QAC) for determination regarding the quality of care provided. Cases determined to involve Moderate or Serious Quality of Care issues require the provider to submit a Corrective Action Plan (CAP) and are subsequently presented at the monthly Clinical Affairs Committee, where additional actions or follow-up may be recommended.
- Complaints may be submitted by members, their legal guardians, or legal representatives regarding care received and may include, but are not limited to, concerns related to accessibility of services, availability of clinicians, care not meeting standards, clinician behavior or communication, confidentiality, coordination of care, delays in care or referrals, inappropriate prescribing or treatment, insufficient discharge planning, medical or medication errors, incomplete medical records or documentation, premature discharge, and other related issues.
- Concerns may also be submitted by external providers or internal staff when potential clinical quality issues are identified. In general, clinical quality issues involve either errors of commission (an action taken that should not have been taken) or errors of omission (a failure to take an action that should have been taken), resulting in actual or potential harm. These concerns are categorized using the same clinical quality categories as member complaints.

2025 Interventions:

- An overview of the Quality Assurance process was forwarded to Medical Management.
- Ongoing training and mentoring were conducted to ensure role coverage and continuity for the CQAS function.
- The CQAS continued to provide consultation regarding administrative cases, as needed.
- Medicaid and HBE Quality of Care cases were transitioned to the Guiding Care platform.
- The criteria threshold for case classification was tightened to ensure only appropriate quality-of-care cases were referred to the CQAS. This refinement streamlined the process and resulted in a decrease in overall case volume.

Analysis of Performance:

A total of 156 cases (128 member complaints and 28 concerns) were reviewed in 2025, representing a decrease compared to 187 cases investigated in 2024. Of the 156 cases reviewed:

- 99% of cases met established timeline requirements.
- One case missed established timelines due to delayed receipt from Member Services.
- One case was identified as a Sentinel Event; however, no quality of care issue was identified.

Complaint/Concern Outcome Data

Complaint/Concern Outcome Category	2024
Level 0: No quality-of-care issue identified	90%
Level 1: Minor quality of care issue identified	8%
Level 2: Moderate quality of care issue identified	1%
Level 3: Serious quality of care issue identified	1%

Complaint/Concern Outcome Category	2025
Unable to Determine	1%
Level 0: No quality-of-care issue identified	88%
Level 1: Minor quality of care issue identified	5%
Level 2: Moderate quality of care issue identified	6%
Level 3: Serious quality of care issue identified	0%

Unable to Determine: One case was classified as Unable to Determine due to insufficient information available within required review timelines, and efforts are ongoing to obtain the necessary information.

In addition, Level 2 & 3 cases were reviewed at the monthly Clinical Affairs Committee Meeting.

2026 Planned Interventions:

- Transition of all D-SNP quality-of-care referrals to the Guiding Care platform.

Pharmacy and Therapeutics Committee Activities for Patient Safety

Goal: Neighborhood's Pharmacy Department provides oversight of each of the following program elements that support the appropriate use of pharmaceuticals and ensure our members have access to a variety of safe, cost-effective pharmaceuticals, including over the counter medications while providing:

- Appropriate identification of patients requiring drug therapy
- Prudent prospective selection of drugs and drug therapies used to treat patients
- Thoughtful application of prior authorization and other benefit limitations intended to avoid sub-optimal and/or unsafe drug use
- Comprehensive drug utilization review (both concurrent and retrospective)
- Accurate delivery of drugs to patients
- Proper administration of drugs

Measure/Methodology: Neighborhood's Pharmacy and Therapeutics (P&T) Committee guides the Pharmacy Department in Formulary management and provides oversight and guidance on clinical pharmacy programs. 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.

Interventions: The following activities directly impacted patient safety in 2025.

- Completed 80 individual new drug reviews.
- 308 Pharmacy Benefit Policies were reviewed and approved.
- 188 medical policies were reviewed and approved.
- 304 oncology clinical medical policies were reviewed and approved.
- 26 administrative policies were reviewed and approved.
- 766 changes were made to the Medicaid Pharmacy Benefit Formulary (adding/removing medication from formulary, adding/removing prior authorization requirement, adding/removing quantity limit, adding/removing step therapy requirement, specific NDC coding, and excluding inflationary products or medications excluded by Medicaid).
- Maintained oversight of Drug Utilization Review (DUR) Programs in compliance with regulatory and contractual reporting/notification.
 - a. Completed and sent letters to providers regarding five DURs on a quarterly basis.
 - b. Completed five ad hoc retrospective DUR projects
- Conducted oversight of an oncology/hematology pathway solution with Evolent, formerly New Century Health, which helps to ensure members have access to the appropriate oncology/hematology medications at the appropriate time in their disease state.
- Continued the HIV Medication Adherence Pilot Program with the RIDOH.
- Continued to support the MMP Quality Withhold and Medicare Stars measures by
 - a. Providing targeted telephonic outreach to 681 members identified quarterly on oral diabetic medications.
 - i. The percentage of members adherent to oral diabetic medications declined from 87% (2024) to 86% (2025)
 - b. Provided targeted telephonic outreach to 287 members discharged with a primary diagnosis of COPD, CHF, or diabetes with the goal to decrease readmissions.
 - c. Provided telephonic outreach to members to educate on fracture risk reduction and outreach to providers as needed to recommend BMD testing or osteoporosis therapy. This program began in September 2025.
 - d. Engaged in CVS's program which outreaches to providers and/or pharmacies to convert eligible members with 30-day supply prescriptions to 90-day supply prescriptions to support adherence to diabetes, hypertension, and hyperlipidemia medications. This program began in Q3 2025.
- Continued to support the HEDIS measures by:
 - a. Expanding an antidepressant medication adherence and education program with Thundermist Health Center to improve the AMM measure. 11 members were targeted in 2025. The AMM outreach program was discontinued after Quarter 1 2025.
 - b. Continuing an asthma medication program focused on (1) identifying members with high rescue inhaler utilization and notifying their provider that the member may benefit from a chronic inhaler and (2) identifying members at risk of hitting the AMR measure and educating them on proper chronic inhaler use.
- Provided Accountable Entity partners with:
 - a. Quarterly Review of important topics, pharmacy spend, drug utilization trends, and high-cost member review
- Maintained a searchable formulary for the pharmacy benefit and pharmacy medical benefit for all lines of business.
- Translated the INTEGRITY formulary to all prevalent languages (Spanish, Portuguese, and Khmer)

- Supported Health at Home members by participating in interdisciplinary team rounds and conducting Transition of Care reviews.
- Supported INTEGRITY care management by participating in interdisciplinary team rounds.
- Maintained and had oversight of the immune globulin and hemophilia clinical review programs with Prime Therapeutics, which decreases medication waste.
- Provided oversight for soft DUR rejections on drug-drug interactions and therapeutic duplications for the Medicaid and Commercial Lines of Business.
- Analyzed duplicate Claims Across Pharmacy and Medical Benefits via reporting and retracted claims as appropriate.
- Continued to implement and maintain a Specialty Pharmacy Limited Network for Medicaid and Commercial Lines of Business to allow for greater oversight, improved safety/quality of care, and rate setting.
- Conducted root cause analysis and supported operations/benefits in identification and correction of clinical trial coding within the medical benefit system.
- Conducted root cause analysis and supported operations in identification and correction of coding and system set-up within the medical benefit system (authorization to claim matching).
- Completed an ad hoc analysis to ensure members with overlapping fills of both a sulfonylurea and glucagon-like peptide-1 (GLP-1) agonist or dual glucagon-like peptide-1/glucose-dependent insulintropic polypeptide (GLP-1/GIP) agonist were not using them concomitantly to mitigate and prevent adverse effects.
- Completed an ad hoc analysis to identify prescribing patterns for long-acting stimulant utilization in pediatric patients under 6 years of age to monitor changes in prescribing based on updated warnings for this age group.
- Completed an ad hoc analysis to ensure members with overlapping fills of maintenance NSAIDs were not using more than one concomitantly to mitigate and prevent adverse effects.
- Completed an ad hoc analysis to ensure members with a diagnosis of Multiple Myeloma were receiving a bone modifying agent in accordance with American Society of Clinical Oncology (ASCO) recommendations.
- Completed an ad hoc analysis to ensure members with overlapping fills of pregabalin and gabapentin were not using them concomitantly to mitigate and prevent adverse effects.

The Plan will continue ongoing interventions in 2026 and cost savings from 2025 strategies will be seen in the 2026 plan year.

Timely Notification of Drug Recalls, Withdrawals and Adverse Drug Event Monitoring

Opportunity Statement: Timely notification of those who have had a recall on their medication is imperative. Timely notification allows members to assess and discuss with their provider if they should stop or continue their medication.

Goal: Provide notices to members and providers within a timely manner of each FDA notice of drug recall/withdrawal.

- **Class I recalls:** Neighborhood members affected by a Class I recall are identified within three business days and prompt notice is provided to members and their prescribing provider(s) to alert both to the nature of the recall.
- **Class II recalls or market withdrawals:** Neighborhood members affected by a Class II recall or market withdrawal for safety concerns are identified within thirty (30) calendar days of the FDA

notification. Notice is provided to the affected members and their prescribing provider(s) to alert both to the nature of the recall and/or market withdrawal.

Measure / Methodology: The Food and Drug Administration (FDA) notices of drug recalls and/or withdrawals are delegated to Neighborhood's Pharmacy Benefit Manager (PBM), CVS/Caremark, with Neighborhood providing oversight. After identifying impact, Neighborhood's PBM will notify members of the medication recall.

Information in the notification includes the following:

- Name of the drug(s) included in the recall/withdrawal
- Drug manufacturer
- Affected lots
- Date of the recall
- A brief description of the reason for the recall (as specified in FDA notice)
- Information to encourage the patient to contact his/her practitioner
- FDA or manufacturer specific recommendation for affected patients and healthcare providers
- Information on how to access additional information related to the recall/withdrawal from the FDA and/or drug manufacturer
- CVS/Caremark's Member Service telephone number for assistance.

Intervention:

- Continued to provide oversight of the PBM recall/withdrawal monitoring processes.

Analysis of Performance: A total of 126 Class I or Class II drug recalls reviewed during 2025 warranted member notification, an increase compared to 64 recalls in 2024. Of the 126 recalls that warranted member notification, 7,189 members were notified within required timeframes.

Analysis of Barriers to Performance and Planned Intervention:

- Obtaining notification on a quicker cadence from CVS/Caremark that member notifications have occurred.
 - **Planned Intervention:** Ongoing oversight and conversations to improve the submission of timely data.

Medication Therapy Management

Opportunity Statement: Medication Therapy Management (MTM) reviews of drug therapy regimens are conducted to optimize health outcomes through enhanced medication use including but not limited to medication adherence, appropriateness of therapy, risk reduction of adverse events/office visits/hospitalizations, and education for the avoidance of drug interactions.

Goal: The Plan's goal was to complete greater than 76% of the Comprehensive Medication Reviews (CMRs) for eligible members in 2025.

Methodology: INTEGRITY MMP members eligible for enrollment in MTM are identified by the Plan's PBM and OutcomesMTM using the following metrics:

1. Multiple (3+) chronic conditions; and
2. Taking at least 8 covered chronic/maintenance Part D drugs; and

3. Must have incurred ¼ of the specified annual cost threshold of \$1,623 in the previous three months;
or
4. Identified by the Drug Management Program as having a high risk for dependence and/or abuse.

Comprehensive Medication Reviews (CMRs) are completed by pharmacists. CMRs are offered and completed via telephone, mail, or in person for the Plan's members. Three attempts are made to contact members to offer a CMR. Detailed voicemails are left after the first call to promote returned calls.

During each MTM review with a member, the following interventions may be conducted:

• Additional therapy needed • Adverse drug reaction check • Change in drug therapy • Discontinuation of therapy	• Dose adjustment • Drug interaction alert • Drug-disease interaction • Duplicate therapy • Formulary management • Medication adherence	• Medication monitoring opportunity • Plan referral • Provider education • Other
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Interventions:

- OutcomesMTM provided a retail/community-based program where community pharmacists in a retail pharmacy can provide MTM.
- Provided OutcomesMTM with additional phone numbers housed within Neighborhood's systems in May and October to increase member telephonic reach rate.
- CVS/Caremark utilized their retail pharmacy database to provide accurate phone number records for outreach. In addition, their internal call center increased the number of calls for CMR offers.
- Requested Community Health Centers and Accountable Entities (AE) sign up for OutcomesMTM.
- Requested partner pharmacies to take on greater telephonic member outreaches for OutcomesMTM.

Analysis of Performance: The number of successful CMRs increased in 2025 (2,855) compared to 2024 (2,153). In 2025 there was an increase in the number of members eligible for CMR with 3,641 eligible in 2025 compared to 2,550 in 2024.

The CMR completion rate decreased in 2025 (78.4%) from 2024 (84.4%). The performance was driven by an increase in the access to accurate or preferred phone numbers, and the ability of retail pharmacies to conduct reviews. The Plan met its goal (76%) of completed CMRs for 2025.

Barriers to Performance and Planned Interventions:

- Neighborhood does not have appropriate phone numbers for members being targeted and therefore delegated entities are unable to make successful outreaches.
 - **Planned Intervention:** Neighborhood will continue to provide OutcomesMTM with additional phone numbers for members identified for MTM.
- Community Health Center pharmacists have not signed up to provide MTM currently.
- Partner pharmacies cannot take on extra telephonic outreach at this time due to limited bandwidth.

Neighborhood's Pharmacy Department will continue to monitor CMR data on a quarterly basis to ensure the completion rate is on track to meet the goal and follow CMS standards.

Critical Incidents

Goal: The Plan is contractually required to collect, track, and report critical incidents and report quarterly to EOHHS and the Rhode Island Office of Healthy Aging, depending on the nature of the incident. A critical incident is defined as any actual or “alleged event” or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or well-being of INTEGRITY members including falls, hospitalizations, financial exploitation, police-involved incidents, and disasters.

Measure/Methodology: Neighborhood systematically tracks all critical incidents reported by members, caregivers, or those identified by the care manager. Critical incidents are documented in the Clinical software system Acuity.

All team managers are responsible for INTEGRITY product reviews of all critical incidents. Critical incidents are reported to the Grievance and Appeals Unit (GAU) if an incident is a grievance. Quality of Care concerns are reported to the Quality Assurance Specialist. Critical Incidents are also reviewed to determine if the incident needs to be reported to an outside agency.

Interventions:

- Annual review of critical incident policies and procedures to reflect system documentation and expectations for reporting workflow and management responsibilities. Retraining of staff as needed.

Analysis of Performance: In 2025, there were 23 critical incidents reported, a decrease compared to 43 incidents reported in 2024. During 2025, there was one hospitalization, 3 exploitations, 11 abuse/self-neglect, two falls, two thefts against the member, 1 care giver absence and 3 “other” critical incidents reported. The “other” critical incidents reported were related to CNA complaints such as CNA displaying aggression and CNA coercion to change agencies. There were no reported deaths due to a critical incident in 2025 which is a 100% reduction in comparison to the 4 deaths reported in 2024. The number of exploitations reported has also decreased significantly but continues to occur. There were 10 instances in 2024 but this was reduced to 3 in 2025.

	2024				2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
# of Members Receiving LTSS	2,857	2,918	2,905	2,919	2,881	3,096	3,117	3,085
# of Critical Incidents	4	7	11	21	5	6	6	6

CY 2024-2025 Critical Incidents by Type

Type of Critical Incidents Reported	CY 2024	CY2025
Total # of reported Hospitalizations	2	1
Total # of reported deaths	4	0
Total # of reported Exploitation	10	3
Total # of reported Abuse & Self-neglect	13	11
Total # of ER	1	0
Total # of Falls	3	2
Total # of Other	10	3
Total # of Attempted Suicide	0	0
Total Number of Theft Against the Member	0	2

Care Giver Absence	0	1
Total Number of Pressure Ulcers	0	0
Total	43	23

Analysis of Barriers to Performance and Planned Interventions:

- Critical incidents are not always reported.
 - **Planned Intervention:** The Plan will continue to re-train staff to identify and document critical incidents.
- There can be lag time between the reporting of a critical incident and the review by a Care Manager.
 - **Planned Intervention:** Managers continue to review real-time incidents reported; staff are provided with direct feedback and appropriate follow-up.
 - **Planned Intervention:** Continue Quality monthly review of critical incident reporting

The Plan will continue to provide care management intervention for INTEGRITY members who experience a critical incident.

B. Coordination of Care Activities

New and Repeat Assessment Completion (Medicare-Medicaid Plan INTEGRITY)

Goal: Neighborhood is contractually required to reach 100% of the newly enrolled INTEGRITY members to complete either a Comprehensive Functional Needs Assessment (CFNA) or Health Risk Assessment (HRA), depending on the member's capitation code, within 90 days of enrollment for all Long-Term Services and Supports (LTSS) members and Moderate-/Low-Risk Non-LTSS members and 45 days for all High-Risk Non-LTSS members.

The goal for repeat assessments is to complete at least one reassessment annually; however, most members receive multiple assessments per year based on contractual requirements.

Measure/Methodology: Data is extracted from the care management system on all INTEGRITY members in CY 2025 to determine who had an assessment within 90 days of enrollment. This data also includes the members unwilling to participate and those the Plan was unable to reach.

Interventions:

- The Assessment and Care Planning (ACP) team were absorbed back into the PODs due to staff shortages. Integrated Care Managers (ICM) continued to take on the following: Initial CFNAs, assessments for new high-risk Milliman Advanced Risk Adjusters (MARA), members managed by community care coordinators (CCC), CFNAs that trigger from a high-risk HRA, and reassessment HRAs.
- Established a dedicated scheduling team to ensure that there was consistent/timely member outreach.
- Assessment completion oversight continued to be managed by individual ICMs and CCCs receive their own daily case list reports for tracking. This allowed for daily completion statistics and follow up as needed.

Analysis of Performance:

Initial Assessments (HRA)

	2024	2025	% Change
Total	1,079	1,023	
Complete	847	739	
% Complete	78.5%	72.2%	-6.3%
Declined	35	22	
% Declined	3.2%	2.2%	-1%
Failed Outreach	193	257	
% Failed Outreach	17.9%	25.1%	+7.2%

Initial Assessments (CFNA)

	2024	2025	% Change
Total	595	642	
Complete	473	377	
% Complete	79.5%	58.7%	-20.8%
Declined	49	70	
% Declined	8.2%	10.9%	+2.7%
Failed Outreach	68	190	
% Failed Outreach	11.4%	29.6%	+18.2%

Initial Assessments (Wellness)

	2024	2025	% Change
Total	90	42	
Complete	79	32	
% Complete	87.8%	76.2%	-11.6%
Declined	1	1	
% Declined	1.1%	2.4%	+1.3%
Failed Outreach	1	4	
% Failed Outreach	1.1%	9.5%	+8.4%

Re-assessments (HRA)

	2024	2025	% Change
Total	7,300	6,403	
Complete	5,075	4,220	
% Complete	69.5%	65.9%	-3.6%
Declined	144	70	
% Declined	2.0%	1.1%	-0.9%
Failed Outreach	2,080	2,113	
% Failed Outreach	28.5%	33.0%	+4.5%

Re-Assessments (CFNA LTSS)

	2024	2025	% Change
Total	5,653	5,892	
Complete	4,203	4,156	
% Complete	74.3%	70.5%	-3.8%
Declined	845	1,182	
% Declined	14.9%	20.1%	+5.2%
Failed Outreach	603	532	
% Failed Outreach	10.7%	9.0%	-1.7%

Re-Assessments (High Risk)

	2024	2025	% Change
Total	5,610	4,614	
Complete	3,619	2,842	
% Complete	64.5%	61.6%	-2.9%
Declined	1,306	1,227	
% Declined	23.3%	26.6%	+3.3%
Failed Outreach	683	534	
% Failed Outreach	12.2%	11.6%	-0.6%

Re-Assessments (Wellness)

	2024	2025	% Change
Total	866	836	
Complete	846	818	
% Complete	97.7%	97.8%	+0.1%
Declined	11	15	
% Declined	1.3%	1.8%	+0.5%
Failed Outreach	3	1	
% Failed Outreach	0.3%	0.1%	-0.2%

New enrollees:

In CY 2025, there were 1,707 INTEGRITY members that were enrolled for at least 90 days by the end of the reporting period. Of those members enrolled, 93 members were unwilling to participate in the assessment and 451 were unable to be reached following three attempts. There was a total of 739 members with a completed HRA (72.2%), 377 members with a completed CFNA (58.7%), and 32 members with a completed wellness assessment (76.2%).

In 2025, the number of completed initial assessments decreased compared to 2024. This decline was primarily due to the large passive enrollment that occurred in June 2025. Although all contractual outreach requirements were met, many members had incorrect demographic information, and outreach attempts - including phone calls and mailed letters - did not result in returned contacts. This unusually high volume of unsuccessful outreach during June significantly lowered the overall completion rate for the year.

Conversely, failed outreach initial assessments increased in 2025 compared to 2024. This issue continues to stem from inaccurate member demographic information and was further exacerbated by the June 2025

passive enrollment surge. Despite completing all required outreach attempts and issuing a CML, many members did not respond to Neighborhood to complete their assessments.

Reassessments:

In CY 2025, a total of 4,220 members had a HRA reassessment completed (65.9%), 4,156 LTSS members had a CFNA reassessment completed (70.5%), 2,842 members had a high-risk reassessment completed (61.6%), and 818 had a wellness reassessment completed (97.8%).

In 2025, there was a slight decrease in the number of completed reassessments, except for wellness assessments, compared to 2024. This modest reduction was impacted by staffing shortages, which led to rescheduled assessments and delays in completion.

There was a slight increase in the number of CFNA declines in 2025. This was largely driven by the implementation of the new clinical system, which temporarily reduced staff availability due to required trainings. Additionally, as part of the rollout of the new FIDE line of business in December, some members were contacted for preliminary check-ins and were scheduled for full outreach in January 2025, contributing to year-end declines.

The number of failed outreaches for CFNAs increased in 2025 compared to 2024 as well. This continues to be primarily driven by inaccurate or outdated member demographic information, which limits successful contact attempts.

Analysis of Barriers to Performance and Planned Interventions:

- High Caseloads/Staff Turnover.
 - **Planned Intervention:** ACP and Clinical Engagement Teams were brought back under the case management department for better cross-coverage of assessments to help reduce workloads.
- Heavy assessment workload due to staff turnover
 - **Planned Intervention:** All Transitions of Care (TOC) members except for Skilled Nursing Facility (SNF) discharges or members in SNF were assigned to the TOC Utilization Management (UM) team to complete a CFNA.

Care Plan Completion (MMP- INTEGRITY)

Goal: Complete 100% of Care Plans within 15 days of completed assessment and 15 days from discharge for all transitions events. Integrated Care Managers (ICM) attempt to conduct Comprehensive Functional Needs Assessments (CFNAs) on all Long-Term Services and Supports members and on high-risk non-LTSS members. All transitions events are assigned to an ICM to attempt to conduct the CFNA. Following the CFNA, a Plan of Care (POC) is developed which is person-centered and focused on the needs of the individual member. The goal is to send the POC to the member for approval and signature within 15 days of completion of the CFNA or 15 days from discharge for transitions events.

Measure/Methodology: Plans of Care are populated using information captured in the Care Management System from conducting CFNAs and HRAs. Based on the CFNA assessment and collaboration with the member's identified Care Team, an individualized Plan of Care (POC) is developed. The POC is printed and mailed to the member and identified care team members within 15 days of a completed CFNA or 15 days from discharge for transition events. It is also faxed to the providers for collaboration and signature.

Population	Assessment	Care Plan
Community-based, non-LTSS or not otherwise high risk	IHS (Initial Health Screen) also known as an HRA	Community Care Plan
Community-based, receiving LTSS or otherwise high risk	CFNA	Interdisciplinary Care Plan
Facility-based, do not wish to return to community	Wellness Assessment	Wellness Plan
Facility-based, wish to return to community	Discharge Opportunity Assessment	Community Transition Plan

Interventions:

- Assigned all Transition of Care (TOC) members except for Skilled Nursing Facility (SNF) discharges or members in a SNF to new TOC Utilization Management (UM) team to complete a CFNA.
- Reviewed timelines with staff to ensure Plans of Care are completed within 15 days from CFNA completion except for transitions, which are completed within 15 days from discharge.
- Plan of Care completion continues to be monitored for timeliness using the Integrity case list report and sent to staff/Managers to monitor daily.

Analysis of Performance: The following tables show INTEGRITY Members with a Care Plan completed for CY 2025.

Not High Risk	2023	2024	2025
Total number of CFNAs completed	6,205	6,093	5,103
Total number of ICP completed within 15 days	99.9%	99.9%	100%
Total number of ICP completed	100%	100%	100%

High Risk	2023	2024	2025
Total number of CNFAs completed	8,950	8,364	7,442
Total number of ICP completed within 15 days	99.6%	99.8%	99.8%
Total number of ICP completed	100%	100%	100%

Wellness	2023	2024	2025
Total number of CNFAs completed	1,164	1,176	1,036
Total number of ICP completed within 15 days	99.8%	99.9%	99.8%
Total number of ICP completed	100%	100%	100%

The following are Plan of Care completion rates for members enrolled for 90 days or longer:

- Of the 5,103 Not High-Risk members with a completed assessment, 100% had a care plan completed within 15 days resulting in a 0.1% increase from 2024.
- Of the 7,442 members with a completed assessment, 99.8% had a care plan completed within 15 days. This was consistent with the completion rate in 2024.

- Of the 1,036 members with a completed assessment, 99.8% had a care plan completed within 15 days resulting in a 0.1% decrease from 2024.

Analysis of Barriers to Performance and Planned Interventions:

- Staff training and lack of consistent reporting and oversight continue to be an opportunity for improvement.
- **Planned Interventions:**
 - Complete training on care plan completion for all staff and managers.
 - Training and retraining as needed for staff on areas identified as needing improvement.
 - Case list report to clearly note if any POCs are coming due which are sent to both managers and individual ICMs daily.
 - Re-education on the case list report for managers and staff.
 - Monitor KPI reports and case list reports daily to ensure processes and procedures are on track.
 - Conduct root cause analysis with staff by managers on reason for untimeliness.
 - Case Management will follow up for trends and retrain as necessary.