RHODE ISLAND STRATEGY FOR ASSESSING AND IMPROVING THE QUALITY OF MANAGED CARE SERVICES

2012 UPDATE

Rhode Island Executive Office of Health and Human Services
Rhode Island Medicaid, Center for Child and Family Health
Hazard Building #74, 1st Floor
74 West Road
Cranston, Rhode Island 02920
(401) 462-0140
Fax: (401) 462-6353
http://www.eohhs.ri.gov

Revised
October 2012

TABLE OF CONTENTS

INDEX OF TABLES

INTRODUCTION
STRATEGY FOR ASSESSING AND IMPROVING THE QUALITY OF MANAGED CARE SERVICES

In April 2005, the State of Rhode Island submitted to the Centers for Medicare & Medicaid Services (CMS) its *Strategy for Assessing and Improving the Quality of Managed Care Services Offered Under RIte Care.* That document described the State of Rhode Island's strategy for quality assessment and performance improvement for its managed health care programs for low-income populations. First, a brief history of the programs was presented to provide an appropriate context for quality assessment and performance improvement. Second, an overview of Federal requirements for quality improvement and performance assessment was delineated. Third, the components of the State's strategy were described. Finally, the State described the process that it used to obtain the input of recipients and other stakeholders in the development of the strategy and to make the strategy available for public comment.

On February 4, 2008, the State received the following feedback from Jean Moody-Williams at CMS about the quality strategy document:

"*The 55 page Rhode Island Quality Strategy for Assessing and Improving Care Services is comprehensive in addressing access, health care service, regulatory and contractual aspects of implementation of a State Health Quality Strategy. It also encompasses a program approach with clearly outlined strategy components, which is identified as a best practice nationally*."

On July 24, 2009, the State received the following additional comments from Gary Jackson at CMS about the quality strategy document:

"*Given the recent changes in the structure of the state's Medicaid Program, it may be appropriate to consider whether the document needs to be updated*."

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

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

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

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

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

The Global Waiver helps to assure the financial viability, sustainability, and stability of the State's Medicaid program. In effect, the Global Waiver sets forth a strategic approach for reforming the Medicaid program to build a more responsive and a more accountable program that serves Medicaid beneficiaries with the right services, in the right setting, and at the right time.

As is typical for Section 1115 waivers, CMS defines "Special Terms and Conditions" (STCs) for the demonstration. The STCs addressing quality assurance and improvement are as follows:

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

This update, therefore, incorporates relevant changes to RIte Care and adds separate sections for Rhody Health Partners, Connect Care Choice, and RIte Smiles. Enrollment (as of December 31, 2011) in each of these programs has been provided below[1]:

[1] These enrollment figures represent a point-in-time snapshot as of 12/31/2011.

- RIte Care – 125,049
- Rhody Health Partners – 13,424
- Connect Care Choice – 1,749
- RIte Smiles – 56,706

CHAPTER 1

OVERVIEW OF FEDERAL QUALITY ASSESMENT AND PERFORMANCE IMPROVEMENT REQUIREMENTS

This chapter describes the various Federal quality assessment and performance improvement requirements applicable to RIte Care, including:

- Medicaid Managed Care Final Regulations
- Medicaid External Quality Review Final Regulations
- Waivers and Special Terms and Conditions
- Children's Health Insurance Program (CHIP) Quality Requirements

Each set of requirements is described in separate sections below. Detailed descriptions of these requirements are provided in Appendix A to this strategy document.

1.1 Medicaid Managed Care Final Regulations

Except for those Federal legal requirements specifically waived in the *approval letter* for the demonstrations, the State must meet all other applicable, Federal legal requirements. Salient requirements include those contained in the June 14, 2002 *Final Rule* implementing the managed care provisions of the Balanced Budget Act of 1997 (BBA)[2]. States had until June 16, 2003 "to bring all aspects of their managed care programs (that is, contracts, waivers, State plan amendments and State operations) into compliance with the final rule provisions."[3]

This strategy document is essentially a required element of the June 14, 2002 *Final Rule*. Specifically, Subpart D of the *Final Rule* "implements section 1932(c)(1) of the Act and sets forth specifications for quality assessment and performance improvement strategies that States must implement to ensure the delivery of quality health." It also establishes "standards" that States and Health Plans must meet. Section 438.204 of the *Final Rule* delineates the following minimum elements of the State's quality strategy:

- Health Plan "contract provisions that incorporate the standards specified in this subpart"

- Procedures that:

    - Assess the quality and appropriateness of care and services furnished to all Medicaid recipients enrolled in Health Plans

[2] *Federal Register*, 67(115), June 14, 2002, 41094-41116. The BBA also created the State Children's Health Insurance Program (SCHIP).
[3] *Ibid.*, 40989.

- Identify the race, ethnicity, and primary language spoken of each enrollee

- Monitor and evaluate Health Plan compliance with the standards regularly

- Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each Health Plan contract

- Appropriate use of intermediate sanctions, at a minimum, to meet Subpart I of the June 14, 2002 *Final Rule*

- An information system that supports initial and ongoing operation and review of the State's quality strategy

- Standards, at least as stringent as those in Subpart D, for access to care, structure and operations, and quality measurement and improvement

1.2 Medicaid External Quality Review Final Regulations

On January 24, 2003, the Centers for Medicare & Medicaid Services (CMS) published an external quality review (EQR) *Final Rule* in the *Federal Register* to implement Section 4705 of the BBA.[4] The effective date of this *Final Rule* is March 25, 2003 and provides[5]:

> "Provisions that must be implemented through contracts with MCOs, PIHPs, and external quality review organizations (EQROs) are effective with contracts entered into or revised on or after 60 days following the publication date. States have up until **March 25, 2004** to bring contracts into compliance with the final rule provisions." (Emphasis added)

The basic requirements of the January 24, 2003 *Final Rule* are as follows:

- **EQRO Must Perform an Annual EQR of Each Health Plan** – The State must ensure that: "a qualified external quality review organization (EQRO) performs an annual EQR for each contracting MCO."[6]

- **EQR Must Use Protocols** – The January 24, 2003 *Final Rule* stipulates how the EQR must be performed. It should be noted that this includes the requirement[7] that "information be obtained through methods consistent with the protocols established under § 438.352."

[4] Essentially Section 1932(c) of the Social Security Act.
[5] *Federal Register*, 68(16), January 24, 2003, 3586.
[6] 42 CFR 438.350(a).
[7] 42 CFR 438.350(e).

- **EQRO Must Produce A Detailed Technical Report** – The January 24, 2003 *Final Rule* requires[8] that the EQR produce a "detailed technical report" that "describes the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP."

- **States Must Perform Mandatory EQR Activities** – The January 24, 2003 *Final Rule* distinguishes between "mandatory" and "optional" EQR-related activities. Apart from the required "detailed technical report", the "mandatory" activities include[9]:

  - Validation of performance improvement projects
  - Validation of MCO performance measures reported
  - Review to determine the MCO's compliance with standards

  It would appear that, at a minimum, the "detailed technical report" must be prepared by an EQRO. Other "mandatory" EQR activities need not be performed by an EQRO, although enhanced FMAP is not available unless an EQRO performs them[10].

  "Optional" activities[11] include:

  - Validation of encounter data
  - Administration or validation of consumer or provider surveys of quality of care
  - Calculation of additional performance measures[12]
  - Conduct of additional quality improvement projects[13]
  - Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time

Table 1-1 shows these obligations in tabular form.

[8] 42 CFR 438.364.
[9] 42 CFR 438.358(b).
[10] *Federal Register*. *Op. Cit.*, 3611.
[11] 42 CFR 438.358(c).
[12] Any "additional" performance measures must be validated by an EQRO.
[13] Any "additional" performance improvement projects must be validated by an EQRO.

Table 1-1

EXTERNAL QUALITY REVIEW (EQR) ACTIVITIES

Activity	Mandatory Activity[14]	Must Be Performed by EQRO[15]
Prepare detailed technical report	**Yes**[16]	**Yes**
Validation of performance improvement projects	**Yes**	**No**
Validation of MCO performance measures reported	**Yes**	**No**
Review to determine MCO compliance with standards	**Yes**	**No**
Validation of encounter data	**No**	**No**
Administration or validation of consumer or provider surveys of quality of care	**No**	**No**
Calculation of additional performance measures	**No**	**No**
Conduct of additional quality improvement projects	**No**	**No**
Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time	**No**	**No**

1.3 Waivers and Special Terms and Conditions

The *waivers* approved by CMS, which have allowed the State to operate RIte Care (and, now, RIte Share), were actually waivers of specific provisions of the Social Security Act (Act). These waivers include ones to permit the State to receive Federal funds "not otherwise matchable" except under the authority of Section 1115 of the Act. For Medicaid, this provides Federal matching for the expansion populations. For CHIP, this provided Federal matching for eligible parents and relative caretakers as well as eligible pregnant women.

[14] Defined as "mandatory" under the January 24, 2003 *Final Rule*.
[15] According to the provisions of the January 24, 2003 *Final Rule*.
[16] Not listed in the *Final Rule* as a "mandatory" activity in 42 CFR 438.358(b), but "required" by 42 CFR 438.364.

The approval of these waivers and Federal matching was contingent upon the State's compliance with Special Terms and Conditions (STCs). These STCs also delineated the "nature, character, and extent of anticipated Federal involvement" in the **demonstration.** Demonstration has been highlighted because RIte Care was a "demonstration project," according to the DHHS *approval letter*[17].

The STCs contained a number of elements germane to quality assessment and performance improvement, as follows:

- **Encounter Data Requirements** – The State had to have an encounter data "minimum data set," and must perform "periodic reviews, including validation studies, to ensure compliance." The State had to have a "plan for using encounter data to pursue health care quality improvement." This plan had to, at a minimum, focus on:

    - Childhood immunizations
    - Prenatal care and birth outcomes
    - Pediatric asthma
    - One additional clinical condition to be determined by the State based on the population(s) served

- **Quality Assurance Requirements** – The State had to fulfill the following quality assurance requirements:

    - Develop a methodology to monitor the performance of the Health Plans, which, will include, at a minimum, monitoring the quality assurance activities of each Health Plan

    - Contract with an external quality review organization (EQRO) for an independent audit each year of the demonstration

    - Establish a quality improvement process for bringing Health Plans that do not meet State requirements up to an acceptable level

    - Collect and review quarterly reports on complaints and grievances received by the Health Plans, and their resolution

    - Conduct by the EQRO of a focused study of emergency room services, including inappropriate emergency room utilization by RIte Care enrollees

    - Require, by contract, that Health Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required by 42 CFR 438.240 and monitor on a periodic basis each Health Plan's adherence to these standards

[17] The most recent version of the approval letter with both the waivers and the STCs explicated was June 18, 2008.

As noted at the beginning of this update, the STCs[18] for the Global Compact Choice Waiver specified with respect to Quality Assurance and Improvement:

> "The state shall keep in place the existing quality systems for the waivers/demonstrations/programs that currently exist and will remain intact under the Global 1115 Waiver (RIte Care, Rhody Health Partners, Connect Care Choice, RIte Smiles, and PACE).

- **General Administrative/Reporting Requirements** – The State was required to report quarterly and annually in writing to CMS on[19]:

  - Events affecting health care delivery, the enrollment process for newly-eligible individuals, enrollment and outreach activities, access, complaints and appeals, the benefit package, quality of care, access, financial results, and other operational and policy issues

  - Utilization of health services based on encounter data, including physician visits, hospital admissions, and hospital days

These STCs basically remained the same since RIte Care was first implemented in 1994.

1.4 CHIP Quality Requirements

CHIP, too, has quality requirements. Specifically, 42 CFR 457.495 addresses "access to care and procedures to assure quality and appropriateness of care[20]. The State CHIP Plan must describe how it will assure:

- Access to well-baby care, well-child care, well-adolescent care, and childhood and adolescent immunizations

- Access to covered services, including emergency services

- Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition

- That decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after receipt of a request for services, with an extension possible under certain circumstances, and in accordance with State law[21]

[18] STCs dated January 16, 2009.
[19] Three quarterly and one annual report were required to be submitted to CMS. All reports could be combined Medicaid and CHIP reports.
[20] *Federal Register*, 66(8), January 11, 2002, 2666-2688.
[21] *Federal Register*, 66(122), June 25, 2001, 33810-33824.

CHAPTER 2

COMPONENTS OF RITE CARE'S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

From the very beginning of RIte Care, the State has taken to heart the fact that it is a *demonstration* initiative. RI Medicaid developed a plan for monitoring RIte Care Health Plans early on. The plan included the following mechanisms for monitoring 13 areas of Health Plan operations:

- Annual Site Visit Protocol
- Disenrollment Grievance Log
- Informal Complaints and Grievance and Appeals Log
- Primary Care Provider (PCP) Survey
- Enhanced Services Report
- MMIS Special "Runs"
- Member Satisfaction Survey
- Self-Assessment Tool For Health Plan Internal Quality Assurance Plan Compliance With HCQIS
- Access Study Format
- PCP Open Practice Report
- Other Provider Report
- Financial Reporting Requirements
- Third-Party Liability Report

The State also crafted and has implemented an extensive research and evaluation program to determine how well RIte Care has done in accomplishing its goals. In fact, research began before RIte Care was actually implemented in order to have some baseline data for comparison with *demonstration* results.

2.1 Principles Forming The Foundation Of RIte Care's Quality Strategy

As with the earlier monitoring plan, principles have been developed to frame the strategy as follows:

- **Principle 1: The strategy must embrace the unique feature of the program while fulfilling the Federal requirements** – Chapter 2 described the Federal requirements applicable to the *demonstration* with respect to quality assessment and performance improvement. The strategy must incorporate all of the requirements in order to comply fully with the regulations and STCs. Yet, the strategy must make sense given the features

of RIte Care[22], what the State has been attempting to accomplish, and how it has been assessing accomplishments.

- **Principle 2: The strategy must build on, not duplicate or supplant, other requirements –** The service delivery system for RIte Care does not exist in isolation. The State made a policy decision[23] in the very beginning that only State-licensed health maintenance organizations (HMOs) would be allowed to participate in RIte Care. HMOs in the State are overseen by the Division of Facility Regulation (DFR) within the Rhode Island Department of Health (DOH) and by the Department of Business Regulation (DBR). In Rhode Island, this also means that the HMOs are accredited by the National Committee for Quality Assurance (NCQA), since this is a requirement of State law[24]. So, the strategy should build on, not duplicate or supplant these requirements.

- **Principle 3: The strategy must recognize and not interfere with the relationships between the Health Plans and their networks and between the networks and their patients** – Failure to do so could undermine these relationships, thereby jeopardizing the Health Plans' ability to maintain viable operations and RIte Care as a whole. Nonetheless, quality assessment needs to include these relationships to assure they are working well and meet all legal requirements.

- **Principle 4: The strategy must include, among other things, the requirements levied on the Health Plans through the contracts between the Health Plans and the State** – Health Plans cannot be held accountable for operations or performance for which they are not contractually obligated (or obligated as a matter of law, ethics, or sound business practice) to meet.

2.2 The Components Of Rhode Island's Quality Strategy for Managed Care

[22] The focus here is RIte Care and not RIte Share, because RIte Care is the mandatory managed care program. RIte Share, while there is mandatory enrollment, does **not** have mandatory enrollment into a *managed care plan*.

[23] When Blue Cross and Blue Shield of Rhode Island (BCBSRI) made a decision to give up its HMO license for CHIP effective January 1, 2005, the State changed its requirements that non-HMO RIte Care Health Plans had to meet, including NCQA accreditation and certain HMO requirements that plans had to meet under Rhode Island Department of Health regulations. These requirements were incorporated into the *RIte Care Health Plan Contract* effective January 1, 2005. BCBSRI ceased participating in Medicaid managed care in December 2010, when it declined to bid on the State's new Medicaid managed care procurement.

[24] All three MCOs which were participating in RIte Care during Reporting Year 2010 (the most recent EQR period) had full, three-year accreditation from NCQA. All three Health Plans – BCBSRI, Neighborhood Health Plan of Rhode Island (NHPRI), and United HealthCare of New England (UHCNE) – received an "excellent" designation from NCQA. Both BCBSRI and UHCNE had their Medicaid product lines accredited separately by NCQA and both were Medicare Advantage participating plans (and had their Medicare product lines separately accredited by NCQA).

Using the above principles as a backdrop, the following will constitute the various components of the strategy for quality assessment and performance improvement. Table 2-1 shows the various components of RIte Care's CMS-approved quality strategy. In order to track compliance with Federal requirements, the table is organized first according to those minimum elements delineated in the June 14, 2002 *Final Rule* and then according to the applicable STCs for the RIte Care waivers.

In this update to the quality strategy, the State has set forth its quality design for Rhody Health Partners, Connect Care Choice, and RIte Smiles, building upon the core principles that have been previously approved by CMS for RIte Care. Table 4–1 delineates the components of the quality design for Rhody Health Partners, the State's MCO-based Medicaid managed care program for disabled adults; Table 5-1 outlines the quality design for the State's primary care case management program for disabled adults, Connect Care Choice[25]. The quality design for RIte Smiles, the State's dental managed care program for Medicaid-enrolled children born on or after May 1, 2000, has been provided in Table 6-1.

[25] Rhody Health Partners and Connect Care Choice serve disabled adults whose only source of health insurance coverage is Rhode Island Medicaid.

Table 2-1

COMPONENTS OF RITE CARE'S QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT STRATEGY

QUALITY/PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
1. Assess the quality and appropriateness of care and services to enrollees	• Performance incentive program • Encounter Data System • NCQA information • Member Satisfaction Survey • Complaint, grievance and appeals reporting • EQRO studies • Special studies • Contract compliance review	
2. Identify the race, ethnicity, and primary language spoken of each enrollee	• MMIS data	
3. Arrange for annual, external independent reviews of the quality and timeliness of, and access to, the services covered under each Health Plan contract	• Performance incentive program • Encounter Data System • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO studies • Special studies • Contract compliance review	The State's EQRO is responsible for preparing an annual, plan-specific detailed technical report that assesses the quality, timeliness, and access to the care furnished by each Health Plan.
4. Appropriate use of intermediate sanctions	• Contract compliance review	Provisions for levying intermediate sanctions have always been a part of the RIte Care Health Plan Contract. Contracts were amended to incorporate Subpart I of the June 14, 2002 *Final Rule* requirements.

5. Standards for Access to Care, Structure and Operations, and Quality Measurement and Improvement		
5.a. Access Standards 5.a.1 Availability of services	• Performance incentive program • Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Special studies • Contract compliance review	As Table 2-2 shows, the State has quantitative access standards and has since 1994.
5.a.2 Assurances of adequate capacity and services	• Provider network reporting • NCQA information • Contract compliance review	As Table 2-2 shows, the State has quantitative capacity standards and has since 1994.
5.a.3 Coordination and continuity of care	• Complaint, grievance, and appeals reporting • NCQA information • EQRO activities • Special studies • Contract compliance review	The State defers principally to NCQA standards in this area.
5.a.4 Coverage and authorization of services	• Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Contract compliance review	The State defers principally to NCQA standards in this area.
5.b. Structure and Operation Standards		
5.b.1 Provider selection	• Provider network data • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review	The State defers principally to NCQA standards in this area.
5.b.2 Enrollee information		The State defers to NCQA

	• Performance incentive program • On-site reviews • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review	standards in this area, except for certain State-specific requirements to be met in the contract.
5.b.3 Confidentiality	• NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review	The State defers principally to NCQA standards in this area.
5.b.4 Enrollment and disenrollment	• MMIS data • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review	State requirements must be met as specified in the contract.
5.b.5 Grievance systems	• NCQA information • Annual Member Satisfaction Survey • Complaint, grievance, and appeals, reporting • Special studies • Contract compliance review	The State defers to NCQA standards in this area, except for certain requirements that must be met under State law.
5.b.6 Subcontractual relationships and delegation	• NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review	The State defers principally to NCQA standards in this area.
5.c. Quality Measurement and Improvement Standards		
5.c.1 Practice guidelines	• NCQA information • Special studies • Contract compliance review	The State defers principally to NCQA standards in this area.
5.c.2 Quality assessment and performance improvement program	• Performance incentive program • Encounter Data System • Complaint, grievance, and appeals reporting • NCQA information • Special studies • Contract compliance review	The State defers to NCQA standards in this area, except for certain State-specific requirements to be met under the contract.
5.c.3 Health information systems	• Encounter Data System • Risk-share reporting	The State defers to NCQA standards in this area, except for

	• NCQA information • EQRO activities • Special studies • Contract compliance review	certain State-specific requirements to be met under the contract.
6. Encounter Data Requirements	• Encounter Data System • EQRO activities • Special studies • Contract compliance review	The Encounter Data System has been used to produce reports since 1998. It is supplemented by EQRO studies and special studies in areas of access and clinical care interest.
7. Quality Assurance Requirements		
7.a. Methodology to monitor performance	• All mechanisms	Previously, the State had a *Plan for Monitoring RIte Care Health Plans*. That plan is superseded by this strategy document with respect to quality.
7.b. Contract with EQRO	• EQRO activities	The State's EQRO contract was reprocured in 2003, 2006, and 2012[26].
7.c. Quarterly reports on complaints and grievances	• Complaint, grievance, and appeals reporting • Contract compliance review	Complaint, grievance, and appeals reporting have been in place since 1994.
7.d. EQRO focused study of emergency room services	• EQRO study	Study report was submitted to CMS (HCFA) in 1998.
7.e Require that Health Plans meet certain quality assurance requirements	• NCQA information • Contract compliance review	Contracts were amended to conform to the *Final Rule*.
8. General Administrative/Reporting Requirements – quarterly and annual reports	• All mechanisms	

[26] In 2012, Rhode Island issued its Request for Proposals (RFP) for the managed care EQR functions.

Table 2-2 shows those areas where the State has established quantitative standards for access.

Table 2-2

RIte Care's Quantitative Standards for Access and Mechanisms for Measuring Them

Area	Quantitative Standard	Mechanism for Measuring It
Availability of services	• Emergency services are available 24 hours a day, 7 days a week • Make services available immediately for an "emergent" medical condition including a mental health or substance abuse condition • Make treatment available within 24 hours for an "urgent" medical problem including a mental health or substance abuse condition • Make services available within 30 days for treatment of a non-emergent, non-urgent medical condition, except for routine physical examinations or for regularly scheduled visits to monitor a chronic medical condition for visits less frequently than once every 30 days • Make services available within five business days for diagnosis or treatment of a non-emergent, non-urgent mental health or substance abuse condition	• Complaint, grievance, and appeals data • Contract compliance review • Member Satisfaction Survey
Adequate capacity and services	• No more than 1,500 RIte Care members for any single PCP in a Health Plan network • No more 1,000 RIte Care members per single PCP within the team or site • No more than 4,000 members per	• Provider network reporting • Informal complaints reporting

	network mental health provider • No more than 10,000 members per network psychiatrist • Members may self-refer for up to four GYN/family planning (FP) visits annually or for FP services, without obtaining a referral from the PCP	• Encounter Data System
Coverage and authorization of services	• Assignment of a PCP within 20 days of enrollment, if none selected by the enrollee • For children with special health care needs, completion of an Initial Health Screen within 45 days of the effective date of enrollment • For children with special health care needs for whom it is applicable, completion of a Level I Needs Review and Short Term Care Management Plan within 30 days of the effective date of enrollment • Provide initial assessments of RIte Care members within 90 days of enrollment • Provide initial assessments of pregnant women and members with complex and serious medical conditions within 30 days of the date of identification • Allow women direct access to a women's health care specialist within the Health Plan's network for women's routine and preventive services • Resolution of a standard appeal of an adverse decision within 14 days • Resolution of an expedited appeal of an adverse decision within three days	• On-site review • Member Satisfaction Survey • Complaint, grievance, and appeals data

The State's "standards" are "at least as stringent" as required by 42 CFR 438.204(g).

As noted in Chapter 2, information gathering for EQR must be consistent with *protocols* established under 42 CFR 438.352. Table 3-3 describes the entity that will perform each EQRO activity and the *protocol* used/to be used to guide the activity.

Table 2-3

Protocols Used/To Be Used for EQR

Activity	Who Has, Will, or May Perform	Protocol Used/To Be Used
Prepare detailed technical report	EQRO	No protocol specified by CMS
Validation of performance improvement projects	• EQRO • Xerox State Healthcare, LLC • State staff •	Methods consistent with CMS protocols
Validation of MCO performance measures reported	NCQA auditors	NCQA audit standards and protocols, which the State has found to be consistent with CMS protocols
Review to determine MCO compliance with standards	• State staff • Xerox State Healthcare, LLC	State-specific protocols consistent with CMS protocols
Validation of encounter data	• Xerox State Healthcare, LLC • May be the EQRO	Validate against bills and/or Against medical records
Administration or validation of consumer or provider surveys of quality of care	• Xerox State Healthcare, LLC • State staff • MCH Evaluation	State-specific consumer survey consistent with CMS protocols and CAHPS® standards
Calculation of additional performance measures	• Xerox State Healthcare, LLC • MCH Evaluation	Methods consistent with CMS protocols
Conduct of additional quality improvement projects	• State staff • Xerox State Healthcare, LLC • MCH Evaluation	Methods consistent with CMS protocols
Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time	EQRO	EQRO's methods consistent with CMS protocols

Xerox State Healthcare, LLC, (formerly ACS) is the State's management assistance contractor. MCH Evaluation is the State's research and evaluation contractor. IPRO, Incorporated is the State's EQRO.

CHAPTER 3

PROCESS FOR INVOLVING RECIPIENTS AND OTHER STAKEHOLDERS

To fulfill the requirements of 42 CFR 438.202(b) to "obtain the input of recipients and other stakeholders in the development of the strategy and make the strategy available for public comment before adopting it in final," the State used the following process:

- RI Medicaid posted the "final draft" on the RI Medicaid Website.
- RI Medicaid put a notice in English and Spanish in *The Providence Journal*, the newspaper of widest circulation in the State, making the public aware that the "final draft" was available for review and how to obtain a copy of it. RI Medicaid had a 30-day comment period.
- RI Medicaid put the "final draft" on the agenda of the Child and Family Health Consumer Advisory Council for discussion.
- With there being no comments received from the public, the document was finalized and copies were forwarded to CMS Central and Regional Offices.

The State will review the Quality Strategy periodically with the EOHHS' Consumer Advisory Committee (CAC) and the Global Waiver's Quality and Evaluation Workgroup to assess the strategy's effectiveness and to update it, as needed. In addition, Rhode Island will review its Quality Strategy whenever the following temporal events occur: a) new population groups are to be enrolled in managed care delivery systems; and b) Medicaid managed care re-procurement takes place.

CHAPTER 4

RHODY HEALTH PARTNERS

The option to enroll in a managed care organization (MCO)[27] was extended to adult Medicaid beneficiaries with disabilities in 2008. At that time, adults with disabilities without third-party coverage were given the option to enroll in an MCO with the provision that they could choose to return to fee-for service (FFS) Medicaid ("opt out") at any time. Effective September 1, 2010, all adults residing in the community without third-party coverage were required to either enroll in a Health Plan (i.e., MCO) through Rhody Health Partners or in the State's FFS programs, which are Connect Care Choice and Connect Care. The Connect Care Choice program is a primary care practice-based model that includes care coordination and nurse care management. Connect Care is not a focus of the quality strategy, given that it is not a managed care product.

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

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

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

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

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

[27] Prior to the State's *Medicaid Managed Care Services* re-procurement in September of 2010, NHPRI and UHCNE were the MCOs available to adults with disabilities in which to enroll; BCBSRI never made itself available to this population.

- Initial Adult Health Screen – completed within forty-five (45) days of enrollment in the Health Plan

- Level I Needs Review – completed within thirty (30) days of completion of the Initial Health Screen

- Level II Needs Review – within thirty (30) days of completion of the Initial Health Screen or Level I Review, including development of an Intensive Care Management Plan as needed

- Short-Term Care Management – completed within thirty (30) days of completion of the Initial Health Screen

- Intensive Care Management – as deemed necessary

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

Table 4-1 shows the quality design for Rhody Health Partners.

Table 4-1

Rhody Health Partners Quality Design

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

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

CHAPTER 5
CONNECT CARE CHOICE

Connect Care Choice is a Primary Care Case Management (PCCM) option for adults who have Medical Assistance coverage and are 21 year old or older. The goal of Connect Care Choice (CCC) is to improve access to primary care, help coordinate health care needs, and link to support services in the community. Connect Care Choice was implemented under Section 1915(a) of the Social Security Act and was incorporated into Global Compact Consumer Choice Waiver on January 16, 2009.

To be eligible for Connect Care Choice a beneficiary must be eligible for Medical Assistance and:

- Be a Rhode Island resident
- Be 21 years old or older
- Live in the community (at home, in assisted living, or a group home)
- Not be covered by Medicare or other health insurance

Participating primary care sites include:

Name	**Locations**
Anchor Medical Associates	Providence, Warwick, Lincoln
Aquidneck Medical Associates	Newport, Portsmouth
Blackstone Valley Community Health Care	Pawtucket, Central Falls
Coastal Medical Inc.	Providence
Cranston Comprehensive Community Action Program (CCAP)	Cranston
East Bay Community Action Program	East Providence, Newport
Hillside Family Medicine	Pawtucket, Scituate
The Immunology Clinic at Miriam Hospital	Providence
Memorial Hospital Center for Primary Care and Prevention	Pawtucket
The Miriam Hospital Primary Care Clinic	Providence
Providence Community Health Centers: Central Health Center Capitol Hill Health Center Allen Berry Health Center Fox Point Health Center Chafee Health Center Olneyville Health Center	Providence
Rhode Island Hospital Ambulatory Clinic	Providence
Thundermist Health Center	Woonsocket, West Warwick, South County
TriTown Community Action Program (CAP)	Johnston
St. Joseph's Ambulatory Clinic	Providence
University Medical Group	Providence, Cranston, Lincoln

Roger Williams Ambulatory Clinic	Providence
University Medicine Foundation-Governor St. Primary Care Center	Providence

Table 5-1 shows the quality design for Connect Care Choice.

Table 5-1
Connect Care Choice Quality Design

Date Collection Method	Type of Method	Performed By
SF-36™	The SF-36™ is a multi-purpose, short-form survey with 36 questions. It yields an 8-scale profile of functional health and well-being scores as well as psychometrically-based physical and mental health summary measures and a preference-based health utility index.	The CCC nurse case manager in conjunction with the Connect Care Choice enrollee
The Index of Independence in Activities of Daily Living (Katz Index of ADL)	The Katz Index assesses basic activities of daily living and ranks adequacy of performance in six functions: bathing, dressing, toileting, transferring, continence, and feeding. Clients are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.	The CCC nurse case manager in conjunction with the Connect Care Choice enrollee
The PHQ-9 Patient Health Questionnaire	The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is based directly on the diagnostic criteria for major depressive	The CCC nurse case manager in conjunction with the Connect Care Choice enrollee

	disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV). There are two components of the PHQ-9: Assessing symptoms and functional impairment and deriving a severity score to help monitor treatment.	
Selected HEDIS®-like clinical measures which focus on Coronary Artery Disease, Depression, Diabetes, and Smoking & Tobacco Use Cessation	The following HEDIS®-like measures are analyzed by RI Medicaid for the Connect Care Choice Program. Coronary Artery Disease: *Persistence of Beta-blocker Therapy After a Heart Attack.* Depression: *Antidepressant Medication Management (Effective Acute Phase Treatment*). Diabetes: The following components of the *Comprehensive Diabetes Care* measure: Hemoglobin A1c with poor control (<9.0%), LDL control (<100 mg/dL), Eye (retinal) exam performed, Blood Pressure control (<130/80). For all enrollees: *Advising Smokers & Tobacco Users to Quit*.	RI Medicaid
Access to Health Care for Adults with Disabilities on Medicaid Survey	Telephone survey of a sample of Rhode Island's ABD population, including Connect Care Choice enrollees.	Independent Contractor

CHAPTER 6

RITE SMILES

RIte Smiles is designed to increase access to dental services, promote the development of good oral health behaviors, decrease the need for restorative and emergency dental care, and decrease Medicaid expenditures for oral health care.

To achieve these goals, Rhode Island transitioned from functioning simply as a payer of services to becoming a purchaser of a new oral health delivery system, a dental benefit manager (DBM) program provided by United Healthcare Dental. Among other responsibilities, the DBM program was charged with:

- Increasing reimbursement rates paid to private dentists
- Ensuring there are enough dentists who participate in the network
- Assisting members with finding dentists

In order to restructure the Medicaid dental benefit for children from fee-for-service to a Dental Benefit Manager (DBM), Rhode Island sought a Section 1915(b) waiver of the Social Security Act (the Act) specifically to implement the RIte Smiles Prepaid Ambulatory Health Plan (PAHP) dental waiver. This would allow Rhode Island Medicaid to have the following sections of the Act waived:

- Section 1902(a)(10) – Comparability of Services
- Section 1902(a)(23) – Freedom of Choice
- Section 1902(a)(4) – Mandatory enrollment in a single PAHP

As proposed, the following categories of children on Medicaid born on or after May 1, 2000 would be enrolled in RIte Smiles on a mandatory basis and receive all their Medicaid dental benefits through the DBM:

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

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

- December 2005 – The State submitted Section 1915(b) Waiver Application to CMS

- December 23, 2005 – The State issued Bid Specifications Document (RFP # B05923) for Dental Benefit Management (DBM)

- February 2, 2006 – State issued Addendum #1 to RFP # B05923

- February 17, 2006 – The State set the due date for submittal of proposals in response to RFP # B05923; two proposals were received

- April 1, 2006 – Section 1915(b) waiver authority was received from CMS

- May 2006 – State's contract with United Healthcare Dental/RIte Smiles was effective

- September 1, 2006 – After determining adequate DBM readiness, the initial group of 10,000 children was enrolled statewide into RIte Smiles

- October 1, 2006 – A second geographic group was enrolled

- November 1, 2006 – The third and final region with active waiver-eligible Medicaid recipients were enrolled

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

Reimbursement and Workforce Capacity - Prior to RIte Smiles the number of Medicaid-participating providers was very limited. The State reasoned that if the Medicaid reimbursement level were increased that it would increase the likelihood that more dental providers would participate in Medicaid. Therefore, the DBM was charged with increasing Medicaid reimbursement rates to be closer to commercial preferred provider organization (PPO) rates. Under RIte Smiles, the DBM is also required to establish and maintain a network of participating dental providers.

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

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

Table 6-1 shows the quality design for RIte Smiles.

Table 6-1

RIte Smiles Quality Design

Date Collection Method	Type of Method	Performed By
Administrative data, as set forth annually by the NCQA.	The HEDIS® methodology: *Annual Dental Visit (ADV)* measure.	UHC Dental
One Quality Improvement Project (QIP)	PDSA (Plan->Do->Study->Act) Methodology developed by RI Medicaid, based upon the Performance Improvement Workplan developed by the State of New Hampshire, DHHS, Division of Public Health (May 2006).	UHC Dental
Informal Complaints, Grievances, and Appeals	Informal complaints reports are submitted electronically in a spreadsheet template established by RI Medicaid.	UHC Dental
Member Satisfaction Survey	Mailed survey written in English and Spanish focusing on access to services, use of services, customer service, and satisfactions with service.	RI Medicaid
Independent Assessment	Five Oral Health Indicators are tracked:	MCH Evaluation

	(1) Percentage of Medicaid-enrolled children with at least one dental visit; (2) Annual dental visit rate/1,000 Medicaid-enrolled children; (3) Percentage of Medicaid-enrolled children with at least one preventive oral health visit; (4) Percentage of Medicaid-enrolled children with at least one restorative dental visit; and (5) Percentage of Medicaid-enrolled children with at least one sealant.	
Dental-specific components of the CMS 416	Analysis of paid claims and enrollment data for beneficiaries through the 20th year of life, to address the following: (1) Total eligibles receiving any dental services; (2) Total eligibles receiving preventive dental services; (3) Total eligibles receiving dental treatment services.	RI Medicaid
Network Adequacy Assurance	The following measurements will be analyzed to assess access to preventive and specialty dental services: Informal complaints; grievances and appeals; network provider additions & terminations reports; and GeoAccess data.	RI Medicaid
Locus of Care Analysis	Locus of care information (site of care: FQHC; hospital-based practice; solo or	RI Medicaid

	group office-based practice) will be analyzed to determine whether ambulatory dental care services have shifted toward solo or group office-based settings.	
Periodic Medicaid Provider Comparison	Network enrollment by provider type will be compared to the State's pre-RIte Smiles Medicaid participating provider enrollment.	RI Medicaid