RHODE ISLAND
COMPREHENSIVE QUALITY STRATEGY

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Rhode Island's Comprehensive Quality Strategy

I. Introduction

The goal of the Rhode Island Executive Office of Health and Human Services (EOHHS) and of the Rhode Island Medicaid program is to be a catalyst for the Triple Aim and the Department of Health and Human Services (DHHS) National Quality Strategy by providing eligible beneficiaries with services that are ***accessible, of high quality, and promote positive health outcomes in a cost efficient and effective manner.*** The goals and objectives discussed in further detail below demonstrate Rhode Island's quality approach and efforts to advance the following National Quality Strategy priorities:

- Patient Safety
- Person and Family Centered Care
- Effective Communication & Care Coordination
- Prevention and Treatment
- Health and Well Being
- Affordable Care

Rhode Island's *Comprehensive Quality Strategy* (CQS) for its Comprehensive Section 1115 Demonstration (Demonstration) builds on the State's initial framework for continuous quality improvement, *Strategy for Assessing and Improving the Quality of Managed Care Services Offered under RIte Care*. This seminal framework was one of the first of its kind in the United States, was approved by the Centers for Medicare and Medicaid Services (CMS) in April 2005, and focused on Rhode Island's first capitated Medicaid managed care program, RIte Care.

The Comprehensive 1115 Demonstration was built upon the following three fundamental goals:

- Prevent or delay growth in the population eligible for Medicaid
- Reform Rhode Island Medicaid's long-term care system
- Use administrative flexibility to operate more efficiently, through the application of care management systems, and links to "medical homes"

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

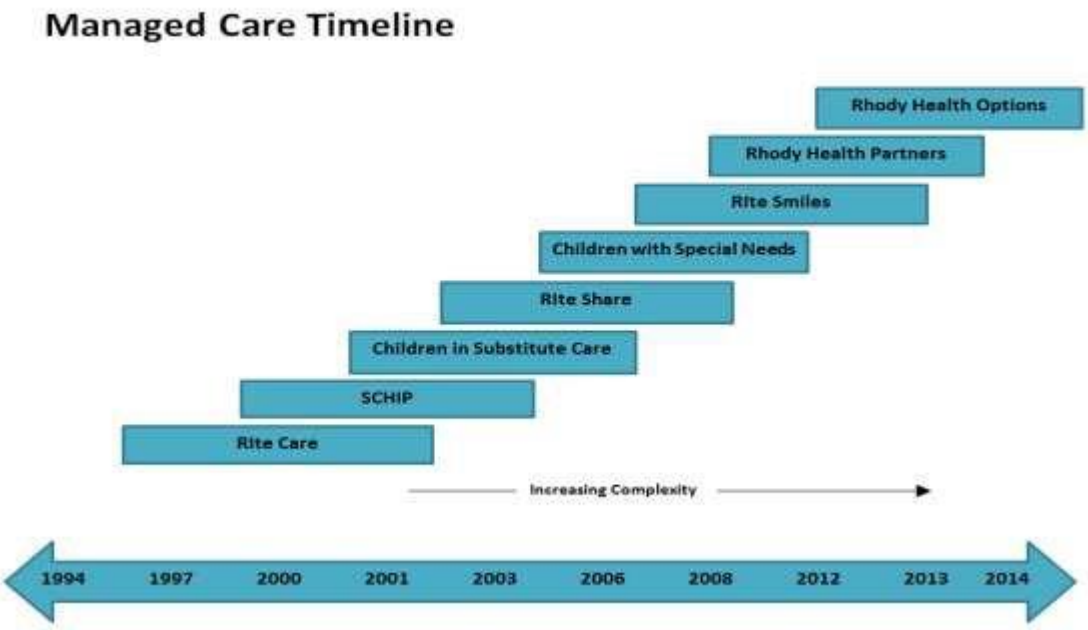
Consumer Empowerment and Choice with the provision of more information about the health care delivery system so that consumers can make more reasoned and cost-effective choices about their health care.
Community-Based Solutions so that individuals may live and receive care in the communities in which they live, a more cost-effective and preferable approach to the institutional setting.
Prevention, Wellness, and Independence initiatives to reduce the incidences of illness and injuries and their associated costs.
Value-Based Purchasing by linking provider reimbursement to the provision of quality and cost-effective care.
Integrated Physical and Behavioral health
Care Coordination and Care Management efforts focused on the highest utilizers of care.
Attention to the Social Determinants of Health
Improved Technology that assists decision-makers, consumers, and providers so that they may make the most informed and cost-effective decisions regarding the delivery of health care.

Through the Comprehensive 1115 Demonstration, Medicaid-funded services on the continuum of care are now organized, financed, and delivered through a single demonstration.[1] This approach provides the infrastructure by which the State can implement a quality strategy that allows for measurement of specific goals and objectives across all Medicaid delivery systems. In effect, the Comprehensive 1115 Demonstration sets forth a strategic approach for reforming the Medicaid program to build a more responsive and a more accountable program that serves Medicaid beneficiaries with the ***right services, in the right setting, and at the right time***.

A. Managed Care Goals and Objectives

Rhode Island has utilized managed care as a strategy for improving access, service integration, quality and outcomes while effectively managing costs. Within this strategy are integral core components, objectives and measurement strategies to ensure a robust oversight and monitoring framework.

As Figure 1 below shows, Rhode Island initiated its Medicaid managed care program twenty years ago (beginning in 1994) with the launch of the RIte Care program, a Medicaid managed care program for children and families and pregnant women. Rhode Island has embraced managed care as a core strategy to meet these goals. Over subsequent years, additional populations with more complex needs have been progressively enrolled in managed care programs.



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

Key Milestones:

- **Initiation of RIte Care**
  The State's initial Medicaid managed care program, RIte Care, began in August 1994, enrolling over 70,000 low-income children and families and pregnant women. A key contractual element was the "mainstreaming" provision, requiring that managed care organizations (MCOs, or Health Plans) must ensure that if a provider accepted enrollees from commercial lines of business, they must also accept RIte Care enrollees without discrimination. The number of providers participating in RIte Care Health Plan networks represented marked expansion with primary care provider participation in Medicaid more than doubling. Physician visits more than doubled by June 1998.

- **SCHIP and Coverage Expansions**
  Effective November 1, 1998, RIte Care expanded to families with children under 18 including parents and relative caretakers with incomes up to 185% of the Federal poverty level (FPL). Effective July 1, 1999, RIte Care expanded to cover children up to age 19 in households with incomes up to 250% of the FPL. The passage of Federal legislation establishing the State Child Health Insurance Program (SCHIP) with enhanced Federal match was key to this expansion.[2]

- **Voluntary Enrollment of Children in Substitute Care Arrangements**
  Beginning in December 2000, the State began to transition children in Rhode Island Department of Children, Youth and Families- (DCYF-) sponsored substitute care arrangements (also referred to as foster care) from fee-for-service (FFS) Medicaid to RIte Care.

- **RIte Share Initiated – Leveraging Employer Sponsored Coverage**
  RIte Share, the State's premium assistance program, was implemented beginning in February 2001 for RIte Care-eligible children and families. Whenever a RIte Care-eligible beneficiary is eligible for other third-party coverage (e.g. employer-sponsored insurance), the case is evaluated for the "cost effectiveness" of the State paying the employee's share of employer coverage rather than enrolling that family in RIte Care.

- **Enrollment of Children with Special Health Care Needs**
  Enrollment of this special needs population into a MCO was initiated in September 2003 on a voluntary basis. In the fall of 2008, enrollment in a MCO became mandatory for Children with Special Health Care Needs (CSHCN) who did not have another source of insurance coverage. Rhode Island defines CSHCN as: The blind and disabled up to the age of twenty-one and eligible for Medical Assistance on the basis of SSI, children eligible under Section 1902(e) (3) of the Social Security Administration (SSA) up to nineteen years of age "Katie Beckett", children up to the age of twenty-one receiving subsidized adoption assistance, children in substitute care "Foster Care".

- **RIte Smiles – Managed Dental Benefit for Children**
  Beginning in May 2006, Rhode Island implemented RIte Smiles, a managed dental benefit for children born on or after May 1, 2000.

- **Rhody Health Partners – Managed Care for "Medicaid-Only" Adults with Disabilities**

[2] As of State Fiscal Year (SFY) 2014 eligibility for parents and relative caregivers in RIte Care was reduced from 175% of the FPL to 138% of the FPL.

In the past, Rhode Island's adult aged, blind and disabled (ABD) populations were provided services through the Medicaid fee-for-service (FFS) system. In 2008, voluntary enrollment in Rhody Health Partners was implemented. In the fall of 2009, all Medicaid-eligible ABD adults without third-party coverage were required to either enroll in a Health Plan through the Rhody Health Partners program, or in the State's FFS Primary Care Case Management (PCCM) program, Connect Care Choice (CCC).

Rhody Health Options and Connect Care Choice Community Partners-Managed Long Term Services and Support for " Medicaid Only" and "Dual Eligible" Beneficiaries

In 2013, Rhode Island Medicaid began the integration of long term services and supports into its managed care delivery systems, including the primary care case management model. Effective November 1, 2013, Medicaid-only adults receiving long term services and supports and Dual Eligibles were given the option to enroll in an MCO. Long term care eligible beneficiaries now have an option to enroll in an MCO, the State's Primary Care Case Management program, PACE (Program All Inclusive for the Elderly) and/or Medicaid FFS.

Table 1: Enrollment (as of September, 2014) in each of these programs has been provided below[3]:

Children & Families					Adults			Adults & LTSS***			
Children < 21 years of age, pregnant woman, and families					Adults with disabilities >21 years of age		Adults >21 years of age	Adults with disabilities < 65 With LTSS*		Adults > 65 years of age with & without LTSS*	
RIte Care	RIte Share	Children with Special Health Care Needs (CSN)	Children in Substitute Care**	RIte Smiles	Rhody Health Partners	Connect Care Choice	Rhody Health Partners (Expansion)	Rhody Health Options	Connect Care Choice Community Partners	Rhody Health Options	Connect Care Choice Community Partners
MCO 133,149	MCO 9,455	MCO 6,882 FFS 2,639	MCO 2,143 FFS 217	MCO 76,215	MCO 13,934	PCCM 4,736	MCO 48,321 FFS 4,105	MCO 466	PCCM 705	MCO 16,696	PCCM 4,259

* Long Term Services and Supports

**Includes Former Foster Children up to 26 years of age "Chafee Children"

***There are a total of 7,987 not enrolled in either program as of 9/30/2014.

The overarching goal of Rhode Island's managed care program is to increase access to and improve the quality of care for Medicaid families eligible for the Demonstration by:

- Providing all enrollees in the Demonstration with a *medical home*
- Increasing the appropriate use of inpatient hospitals and hospital emergency departments
- Improving access to health care for populations eligible for the demonstration
- Reducing infant mortality and improving maternal and child health outcomes
- Expanding access to health coverage to all eligible pregnant women and all eligible uninsured children
- Reducing un-insurance in the expansion population groups eligible for the Demonstration
- Ensuring a high satisfaction level among enrolled populations

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

Table 2: Managed Care Objectives (Abstracted from Rhode Island's Section 1115 Evaluation Design)		
Objective	**Data Source(s)**	**Illustrative Measure(s)**
The rate of un-insurance in the expansion population groups eligible for the Demonstration will be reduced as a result of this Demonstration	• Current Population Survey (CPS) • Behavioral Risk Factor Surveillance Survey (BRFSS)	• Percent of Rhode Island population that is uninsured
All enrollees in the Demonstration will have a *medical home*	• Encounter Data System • HEDIS®	• Practice participation in multi-payer medical home initiative • Primary care practitioner (PCP) assignment • Child and Adolescent to PCPs • Adult Access to Prev./Ambulatory Health Services
Access to health care for populations eligible for the Demonstration will be improved.	• HEDIS®[4]	• Child and Adolescent Use of PCPs • Adult Use of Prev./Ambulatory Health Services • Well-Child Visits • Adolescent Well-Care Visits • Prenatal and Postpartum Care • Frequency of Ongoing Prenatal Care
The appropriate use of inpatient hospitals and hospital emergency departments will increase.	• Encounter Data System	• Use of hospital EDs for ambulatory-sensitive conditions • Potentially preventable re-admissions • Hospital admission rates
The rate of infant mortality in the State will be reduced during the course of this Demonstration.	• Vital Statistics	• Infant mortality rate per 1,000 live births • Post-neonatal mortality rate per 1,000 live births

[4] HEDIS® (Healthcare Effectiveness Data and Information Set) is a registered trademark of the National Committee for Quality Assurance (NCQA). The State expects to follow the annual specifications in HEDIS® for these measures.

Table 2: Managed Care Objectives (Abstracted from Rhode Island's Section 1115 Evaluation Design)		
Objective	**Data Source(s)**	**Illustrative Measure(s)**
Maternal and child health outcomes for populations enrolled in the Demonstration will improve.	• Vital Statistics	• Month of entry into prenatal care • Adequacy of prenatal care • Maternal smoking • Interbirth interval • Percent low birth weight births
Populations enrolled in the Demonstration will have a high level of satisfaction with the Demonstration.	• CAHPS®[5] • Complaints, Grievances and Appeals	• Rating of All Health Care • Rating of Health Plan • Getting Care Quickly • Getting Needed Care • Overall Satisfaction with RIte Care • Satisfaction with Health Plan • Ability to Receive Timely Care • Number of complaints, grievances and appeals by type

In order to meet the objective of increase access and improved health outcomes, Rhode Island's managed care delivery system includes the following:

- Establishment of an Accountable Entity – The State's contract with an MCO establishes a performance-based business relationship and a means of enforcing standards.
- Defined Required Performance Standards through the MCO Contract – This is the means by which the State defines what it believes to be the essential features of an effective health services delivery system for enrolled Medicaid populations.
- Oversight and Monitoring – The State's active oversight and monitoring of performance is critical to understanding and ensuring performance by the MCO.
- Ensure Adequate/Appropriate Funding – Federal regulatory financing requirements and states employ a variety of mechanisms to ensure adequate funding along with responsible stewardship of public funds and a proper alignment of incentives.

In addition to the performance standards outlined in **Sections II** and **III** of this document, Rhode Island has continually used data to drive a number of quality improvements and cost containment efforts. Below are a few examples of efforts implemented by Rhode Island (RI) Medicaid.

Communities of Care Program

Rhode Island received a Federal grant to develop alternatives strategies to reduce avoidable Emergency Room (ER) use. After a thoughtful analytic process, EOHHS developed and implemented the Communities of Care (CoC**)** program. Health Plans are now required to administer a CoC program which is designed to reduce

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

unnecessary and avoidable ER visits for Medicaid recipients with high ER use (i.e., four or more ER visits within a twelve month period). The CoC program consists of three key components: (1) enriched care management and peer navigation supports to educate and assist members to access alternatives to ERs, when appropriate; (2) designated providers to serve members who use multiple providers or have complex medical conditions; and (3) a Healthy Rewards Program to provide incentives that promote members' participation in the health care program. CoC was implemented in November 2010 in the two Health Plans serving Medicaid recipients and in April 2011 in Connect Care Choice. The CoC program can be seen as an initial super utilizer strategy and continues to be an integral part of the Medicaid program's overall approach to super utilizers. In addition to the CoC program, the MCOs have been developing Health Plan-specific super utilizer strategies focused on high cost utilizers, mainly individuals whose annual healthcare costs are equal to $15,000. This includes 6,800 adults enrolled in Rhody Health Partners, 1,299 adults enrolled in RIte Care and 1,388 children enrolled in RIte Care as of June 2014. Most the identified "high utilizers" have a re-occurring behavioral health condition, either primary or secondary diagnosis. EOHHS works collaboratively with the Health Plans to provide all necessary support and technical assistance in the implementation of these efforts.

A preliminary evaluation design for the CoC program includes the following metrics:

- Engagement and Assignment in the CoC program among Continuously Enrolled Members
- Change in ER Utilization Rate Adjusted for Level of Care, Program Engagement, Assignment, and Participation in Care Management as a function of Enrollment
- Change in ER Utilization Rate (Pre vs. Post Enrollment) by Engagement Status[6] among all CoC Enrollees
- Change in Total Medical Expenses (Pre vs. Post Enrollment) by Engagement Status among CoC Members Enrolled in RIte Care and Rhody Health Partners
- Change in ER Utilization Rate (Pre vs. Post Enrollment) by Engagement Status and Population
- Change in ER Utilization Rate (Pre vs. Post Enrollment) by Engagement Status and Level of Care.

Extension of the Generic First Pharmacy Policy and Pharmacy Home Program

Health Plans are required to implement policies and procedures that promulgate the Generic First Policy across all Medicaid populations, including Children with Special Health Care Needs, Children in Substitute Care, Rhody Health Partners, and Rhody Health Options members. In addition, Health Plans are required to establish a Medicaid Pharmacy Home Program for all populations to restrict members whose utilization of prescriptions is documented as being excessive. Members are "locked-in" to a specific pharmacy in order to monitor prescriptions received and reduce unnecessary or inappropriate utilization. This program is intended to prevent members from obtaining excessive quantities of prescription medications through multiple visits to multiple pharmacies.

Medicaid Expenditures

In addition to the above examples of ongoing quality improvement and cost containment efforts, Rhode Island Medicaid produces an annual Medicaid Expenditure report. The data and information included in this annual Medicaid Expenditure report, includes but is not limited to the following:

- Providing an overview of Medicaid Expenditures by eligible population served (elders, adults with disabilities, adults, children and families and children with special health care needs)
- Enrollment and expenditure trends by service type, provider type and delivery mechanism

[6] Engagement status is defined by the proxy measure of a returned emergency room survey.

- Optional services used to reduce expenditure for mandatory services
- Overall utilization rates, including the identification of high cost users

The data and information provided by the Medicaid Expenditure report, in addition to the following reports are examples of how data can be used to identify programmatic opportunities, cost saving initiatives, and ultimately drive system change:

- Medicaid Program Indicator Report[7]
- Monthly operational reports specific to children with special health care needs programs (CEDARRS, Katie Beckett, Respite, RIte Share, Info Line, SSI Recertification and Early intervention)
- Analytic Claims Extract (ACE Report)[8]
- Quarterly Health Plan Reports (Appendix 4: Health Plan Reporting Calendar)

B. RIte Smiles (Dental Benefit Management Program)

RIte Smiles was designed to increase access to dental services, promote the development of good oral health behaviors, decrease the need for restorative and emergency dental care, and decrease Medicaid expenditures for oral health care. To achieve these goals, Rhode Island transitioned from functioning simply as a payer of services to becoming a purchaser of a new oral health delivery system, a dental benefit manager (DBM) program provided by United Healthcare-Dental. Among other responsibilities, the DBM program was charged with:

- Ensuring a robust network beyond safety-net providers and inclusive of specialty providers
- Access to care and services especially for children with special health care needs
- Increased preventive dental care and services
- Increased the number of children between ages 6-9 who received a sealant on a molar

In order to restructure the Medicaid dental benefit for children from fee-for-service to a Dental Benefit Manager (DBM), Rhode Island obtained a Section 1915(b) waiver specifically to implement the RIte Smiles Prepaid Ambulatory Health Plan (PAHP) dental waiver. As proposed, the following categories of children on Medicaid born on or after May 1, 2000 would be enrolled in RIte Smiles on a mandatory basis and receive all their Medicaid dental benefits through the DBM:

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

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

The developmental timeline for RIte Smiles was as follows:

[7] The Medicaid Program Indicator Report is a monthly report comprised of budget, enrollment and utilization indicators across Medicaid Managed Care and components of the Medicaid FFS program such as neonatal intensive care unit (NICU).

[8] This quarterly report serves as a comprehensive extract of MMIS data across the Medicaid Program

- 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 for dental providers, (2) workforce capacity, and (3) provider education and training. The programmatic strategies used to address these issues are as follows:

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

  It should also be mentioned that to the increase the number of private dentists providing oral health services to children on Medicaid, additional efforts have been taken to address oral health workforce capacity. These efforts include: strengthening the dental services infrastructure of Rhode Island's dental safety net providers; enhancing Medicaid reimbursement for hospital based dental centers; implementing recruitment and retention strategies for dental 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 six. It was recognized that to improve access to dental care for young children, providing training on the topic of delivering oral health care services to very young children would be beneficial to Rhode Island dental professionals. To this end, the Rhode Island Department of Health, St. Joseph's Health

Services, Central Rhode Island Area Health Education Center (criAHEC), and the Samuels Sinclair Dental Center at Rhode Island Hospital partnered to offer an annual "Mini-Residency Series." Each mini-residency within the series featured national expert faculty at two-day continuing education programs targeting Rhode Island's oral health professionals.

Table 3 shows the quality design for RIte Smiles.

Table 3

RIte Smiles Quality Design

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 Work plan developed by the State of NH DHHS, Division of Public Health (May 2006).	UHC Dental
Informal Complaints, Grievances, and Appeals	Informal complaints reports are submitted electronically in a spreadsheet template 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
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	RI Medicaid

	receiving dental treatment services.	
Network Adequacy Assurance	The following measurements will be analyzed to assess access to preventive and specialty dental services: Informal complaints; grievances and appeals; network provider additions & terminations reports; and GeoAccess data.	RI Medicaid
Locus of Care Analysis	Locus of care information (site of care: FQHC; hospital-based practice; solo or group office-based practice) will be analyzed to determine whether ambulatory dental care services have shifted toward solo or group office-based settings.	RI Medicaid
Periodic Medicaid Provider Comparison	Network enrollment by provider type will be compared to the State's pre-RIte Smiles Medicaid participating provider enrollment.	RI Medicaid

C. Primary Care Case Management Goals and Objectives

Connect Care Choice was implemented under Section 1915(a) of the Social Security Act and was incorporated into the 1115 Waiver on January 16, 2009. The goal of CCC is to improve access to primary care, help coordinate health care needs, and serve as a critical link to support services in the community. CCC utilizes three evidence-based tools to assess a member's overall health status and well-being, functional status, and behavioral health needs, particularly depression screening:

- 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.
- Katz Index – 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 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 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.

As discussed in detail in ***Section V***, the opportunity afforded as a result of the Medicaid Adult Quality Grant has provided RI Medicaid with the resources necessary to develop the analytic infrastructure and capacity to produce and validate health care quality measures. A key focus of this grant to produce a set of 15 clinical quality measures that were prioritized by the State for analysis based on the goal of measurement alignment across delivery systems as well as input from various stakeholder. The clinical measures for the CCC measures are part of the selected set of 15 clinical quality measures.

C. Medicaid-Assistance Programs or Alternative Models for Medical Assistance

The goal of alternative models to Medical Assistance is to ensure, maximize and subsidize the employer's contribution to health care coverage. The State shares in the cost of coverage with the employer instead of paying the full cost that would be borne by the State if the family or individual was enrolled in RIte Care. Programmatic success is directly linked to the ability of the State to identify those beneficiaries with access to employer sponsored coverage. EOHHS has proven that public/private partnerships can be successful in ensuring access to high quality, affordable, and comprehensive health insurance while preserving scarce State dollars**.**

RIte Share: RIte Share is Rhode Island's Premium Assistance Program that helps low-income working families obtain and/or maintain affordable health insurance through their employer. RIte Share is an alternative Medical Assistance delivery system for RIte Care eligible families who have access to employer-sponsored health insurance (ESI). The Executive Office of Health and Human Services (EOHHS), RIte Share Unit, reviews the ESI for cost-effectiveness. If it is cost-effective, RIte Share will pay the employee's cost of the ESI premium as well as co-insurance and deductibles.[9] The following information is collected and trended month over month:

- Enrollment
- New Employer Group Mix
- Average Abandonment and Answer Time
- Top 10 Call Reasons for Information Line

Premium Assistance (Market Place Subsidy): Effective January 1, 2014, parents/caretakers of Medicaid-eligible children in households with incomes between 133% and 175% of the FPL, who are not Medicaid-eligible themselves, can apply for financial assistance paying for health insurance coverage accessed through Healthsource RI, Rhode Island's Unified Health Infrastructure Project (i.e., Health Insurance Exchange). Premium assistance is limited to twelve months and/or a change in eligibility has occurred, or monthly payment has not been made. Premium payment is based on family size and income level based upon FPL standards. As reported in Rhode Island's Quarterly 1115 Waiver report to CMS, the following information is collected and trended over time:

- Number of Marketplace Subsidy Program Enrollees: number of policy holders paid.
- Change in Marketplace Subsidy Program Enrollment from Prior Month: difference in the number of policy holders paid in the current month, compared to the previous month.

[9] As of October 1, 2011 RIte Share no longer pays co-payments for RIte Share-enrolled beneficiaries.

- Average Size of Marketplace Subsidy received by Enrollee: Pay Level the state assigned to policy holders most frequently (PA01-PA10) **given in dollar form
- Projected Costs: predicted cost for the month, calculated prior to the pay period
- Actual Costs: Dollar amount paid out each month for all policy holders.

D. Quality Management Structure in RI Medicaid

Serving as the State's Medicaid agency, the Rhode Island Executive Office of Health and Human Services (EOHHS) has responsibility for the State's Comprehensive 1115 Demonstration. The EOHHS is designated as the administrative umbrella that oversees and manages publicly funded health and human services in Rhode Island, with responsibility for coordinating the organization, financing, and delivery of services and supports provided through the State's Department of children, Youth and Families (DCYF), the Department of Health (HEALTH), the Department of Human Services (DHS) including the divisions of Elderly Affairs and Veterans Affairs, and the Department of Mental Healthcare, Developmental Disabilities and Hospitals (BHDDH).

Because EOHHS is an integral partner in a broad array of quality initiatives, a new Office of Health Policy and Innovation was established within the agency in 2013. The goal of this new office is to advance the mission of EOHHS through three major tools: (1) Technology, (2) Policy, and (3) Analytics. With these three tools this office supports the improvement of health and human services throughout EOHHS. This office works closely within EOHHS and across all departments to identify and respond to system issues that require a broader approach.

RI Medicaid continuously monitors and provides oversight to ensure that all contractual standards are met and to make ongoing strategic improvements in the program that will further enhance the goals of improving access to care, promote quality of care and improve health outcomes while containing costs. RI Medicaid staff provide continuous oversight, monitoring and technical assistance to ensure compliance with all contractual requirements and when necessary take corrective action to enhance the provision of high quality, cost-effective care.

On a monthly basis, RI Medicaid conducts oversight and monitoring meetings with all managed care entities. These monthly meetings are conducted separately with each of the Health Plans. Meeting agendas focus upon both standing and emerging items. The following content areas are addressed on a quarterly basis:

- Medicaid managed care operations
- Medicaid program integrity and quality improvement
- Medicaid managed care financial performance

Medicaid program requirements are complex and require reporting and analysis of timely information and data regarding the performance of each MCO. MCOs are required to submit information monthly about financials, operations, and service utilization through the encounter data system. RI Medicaid maintains and operates a data validation plan to assure the accuracy of encounter data submissions. The concept of continuous quality improvement is at the core of the oversight and monitoring and is achieved with ongoing analysis of MCO data as it relates to established standards/measures, industry norms, and trends to identify areas of performance improvement and compliance. When compliance and/or performance is found to be below the established benchmark or contractual requirement a corrective action plan is implemented until demonstrated improvement and contractual compliance is obtained.

In addition to contractual requirements, RI Medicaid conducts monthly internal staff meetings to discuss MCO attainment of performance goals and standards related to access, quality, health outcomes, member services,

network capacity, medical management, program integrity, and financial performance. RI Medicaid staff identifies strategies and develop recommendations for program improvements and assesses the feasibility and impact of potential changes in Medicaid to improve program operations.

RI Medicaid also holds a Quality Improvement Committee meeting on a quarterly basis as well an 1115 Quality and Evaluation Workgroup meeting on a monthly basis. The historical focus of the quarterly Quality Improvement Committee meeting has been on programs and services for children and families such as the Pediatric Respite program, Early Intervention, and outcome of performance and quality initiatives within managed care. The 1115 Quality and Evaluation workgroup is a product of the Global Waiver that was approved by CMS on January 16, 2009 and implemented thereafter through December 31, 2013. This waiver afforded the State greater flexibility in how it delivered and managed services to Medicaid enrollees, enabling the State to provide services with a more cost-effective approach. CMS renewal on December 23, 2013 of the State's Comprehensive 1115 Demonstration included, a specific Special Term and Condition (#128) regarding a Comprehensive Quality Strategy as discussed in this document. The 1115 Quality and Evaluation Workgroup meeting continues to be a venue for EOHHS to monitor various quality improvement efforts occurring within the broad array of Medicaid programming, share lessons learned, and discuss quality and evaluation efforts on the horizon.

E. Development & Review of Quality Strategy

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," started in March 2014 through May 2014, the State used the following process:

- RI Medicaid posted the "final draft" on the RI EOHHS Website.
- RI Medicaid put the "final draft" on the agenda of the Medical Advisory Committee for discussion.
- Public comments were received and reviewed, resulting in minor modifications. Subsequently, the document was finalized and copies were forwarded to CMS Central and Regional Offices.

The State reviews the Comprehensive Quality Strategy periodically with EOHHS' Consumer Advisory Committee (CAC) and the 1115 Quality and Evaluation Workgroup to assess the strategy's effectiveness and to update it, as needed. In addition, Rhode Island updates its Comprehensive Quality Strategy whenever the following significant changes and/or 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.

With respect to planning for the enrollment of new population groups in managed care delivery systems, the State facilitated a series of community stakeholder meetings during the summer of 2012, in preparation for the new coverage opportunities afforded through Rhody Health Options (RHO) and Connect Care Choice Community Partners (CCCCP) as part of Rhode Island's Integrated Care Demonstration. These meetings were sponsored by EOHHS to inform the quality design component of the Integrated Care Initiative (ICI). Please refer to ***Section VI. A.*** for additional information.

Three major policy initiatives have contributed to the update and submission of Rhode Island's *Comprehensive Quality Strategy*:

- The implementation of Phase One of Rhode Island's program for Medicare and Medicaid Eligible (MME) individuals who are eligible for full Medicaid benefits, as approved by CMS for implementation, which began November 1, 2013. Phase One implementation is the incorporation of home and community-based services for Medicaid eligible and MMEs into a managed care delivery system.

- The enrollment in Medicaid, beginning on January 1, 2014, of adults who are age 19 or older and under 65 who are at or below the Federal Poverty Level based on household income using the application of a modified adjusted grow income (MAGI) who are not pregnant, not entitled to or enrolled in Medicare, and not eligible for mandatory coverage under the State's Medicaid Plan. (This group is referred to as Rhode Island's Affordable Care Act Adult Expansion population.) Additional information on this new population is defined further in Chapter 4.
- CMS' renewal on December 23, 2013 of the State's Comprehensive 1115 Demonstration (Project Number 11-W-00242/1) and the Demonstration's associated Special Terms and Conditions (STCs), which include STC 128 (Comprehensive Quality Strategy).

II. Assessment

A. Quality and Appropriateness of Care

RI Medicaid MCOs are required by 42 CFR 438.204(b)(1) to develop and implement a quality management plan that monitors, assures, and improves the quality of care delivered. Quality management incorporates the measurement of performance objectives using quality indicators, system interventions to achieve improved quality of care and health outcomes, evaluation of the effectiveness of said interventions, and demonstrated capacity to sustain such efforts. The MCOs annual quality management plan addresses how the MCOs detect both over- and under-utilization of services, assessment of quality and appropriateness of care provided to members, systematic data collection of performance, provider performance feedback, and the demonstration of ongoing rapid cycle quality improvement methods such as Plan-Do-Study-Act (PDSA).

RI Medicaid requires its participating MCOs to submit a comprehensive series of standing quarterly monitoring reports, which are used for oversight and monitoring of the State's managed care program. In the following series, each report that has been flagged with an asterisk (*) must be disaggregated by the Health Plan to provide program-specific information for each of its various Medicaid enrollment populations (such as Rhody Health Partners and RIte Care for Children with Special Health Care Needs). Appendix 4 provides an example of a reporting calendar that is produced for the MCOs for the beginning of each calendar year.

- Care Management*
- Communities of Care*
- Fraud and Abuse Investigations
- Compliance Dashboard Reporting
- Pharmacy Reports such as Generics First*
- Grievances and Appeals*
- Financial Reports
- Informal Complaints*
- Pharmacy Home*
- Pain Management

The findings from these reports are analyzed on a quarterly basis with each Health Plan during the State's series of Oversight and Monitoring meetings. Receipt of this ongoing series of reports allows RI Medicaid to identify emerging trends, any potential barriers or unmet needs, or quality of care issues.

One of the key features of Rhode Island's Medicaid managed care program is care coordination and care management. The goal of these efforts is to help ensure that members' needs are identified and met as best as possible. This takes a variety of forms, and ranges from supports to members in navigating and accessing

care; assistance in managing complex needs and co-occurring conditions; disease management programs, and prevention and wellness initiatives. The health plans' contract outlines specific care management timelines and expectations, including the specific staff qualifications required at each phase of the care management process (e.g., nurses (RNs), Licensed Independent Clinical Social Workers (LICSW), etc.). These requirements are outlined in the contract specifically for children with special health care needs and members of Rhody Health Partners. The State defines children with special health care needs as blind/disabled individuals up to the age of twenty-one, Katie Beckett children up to age nineteen eligible under Section 1902 (e) (3) of the Social Security Act, individuals up to age twenty-one receiving subsidized adoption, and children in substitute care. The State defines adults with special health care needs as adults twenty one years of age and older who are categorically eligible for Medicaid, not covered by a third-party insurer such as Medicare, and residing in an institutional facility.

Objectives of the care management program include:

- Identification of care management needs that may be present upon Health Plan enrollment
- Provision of short or intensive care management services to those in need of such services
- Shared decision making
- Incorporation of care management into all Health Plan operations
- Identification of strengths as well as risks that may affect the member

Core components of the Care Management program:

1) Initial Health Screen within 45 days: The first step in the care management process is outreach to a new member in order to conduct an Initial Health Screen, or Health Risk Assessment. This screening is intended to identify members with needs that require action. The Health Risk Assessment includes the following domains:

    - Medical/physical needs
    - Behavioral health needs
    - Social service needs
    - The family's cultural and linguistic needs, preferences, or limitations
    - Need for continuity of care
    - Need for assistance in securing appointments/procedures, prior authorizations, medications, or other benefits
    - Satisfaction with PCP selection
    - Determination of current use of out-of-network providers
    - Current involvement with a specialist who may serve as a principal coordinating physician for that member.

2) Level 1 Needs review within 30 days of the Initial Health Screen: The Level 1 needs review identifies if a member is in need of access to care/services or continuity of care that could be responded to with short term case management and/or identify the presence of risk factors that warrant a Level 2 review. This is normally completed simultaneously with the Initial Health Screen.

3) Level 2 Needs review within 30 days of either the Initial Health Screen and/or Level 1 review: The purpose of the Level 2 Needs review is to explore further the circumstances and factors that place a member at risk. The Level 2 review consists of advance care planning, chronic care management, medication management, functional status, and transition from adolescence to adulthood.

4) Care Management Plan: Care Management plans are to be reviewed and updated as needed, but no less than every 6 months. The care management plan should be developed in collaboration with the member, caregiver, provider and other case managers or agencies, if applicable. The Care Management Plan should outline the identified key issues, including medical and social service needs

and involve members and their caregivers in the setting of specific and actionable goals and action steps, including self-management education and techniques.

In addition, specific benchmarks regarding member engagement and care management are included as part of Rhode Island Medicaid's Performance Goal Program. The Initial Health Screens, care management screening and ultimately Care Management Plan development are all components of the RI Medicaid Performance Goal Program discussed further in ***Section III. C.*** As part of the annual Performance Goal Program a team from Rhode Island Medicaid engages in a full desk top review of managed care policies and protocols/procedures, including care management and care coordination. The Rhody Health Options program described in detail in **Section VI**. includes additional components to those listed above.

It is important to note that continuity of care for members with special health care needs, especially those newly enrolled are critical. As such, Medicaid MCOs are required to continue the out-of-network coverage for a period of up to six months, and to pursue bringing that provider into their network and/or offering the member a provider with comparable or greater expertise in treating the needs associated with that member's medical condition.

B. Health Disparities

Cultural Competency
At the time of enrollment individuals are asked to report their race and ethnicity and language. These data are captured in an enrollment file and can be linked to MMIS claims data and analyzed. This data is used to ensure the delivery of culturally and linguistically appropriate services to Health Plan members. For example, Health Plans are required to provide member handbook and other pertinent health information and documents in languages other than English, including the identification of providers who speak a language other than English as well as to provide interpreter services either by telephone or in-person to ensure members are able to access covered services and communicate with their providers. In addition, Health Plans are obligated to adhere to the American Disabilities Act and ensure accessible services for members with a visual, hearing, and/or physical disability.

Analysis by Disability and Gender:
The Health Plans are required to submit their annual HEDIS® submission stratified by Core RIte Care only and for All Populations, including special needs population such as Rhody Health Partners. As part of Rhode Island's External Quality Review process, analysis is completed to identify differences in rates between the Core RIte Care only group and those including All Populations. (The Health Plans utilize internal quality and analytic tools such as CAHPS® which is provided in both English and Spanish as well as informal complaints to identify and monitor for potential health disparities.) In addition, the Health Plans have begun to provide as part of their HEDIS 2014® submission (CY 2013) the following four HEDIS® measures stratified by gender, language, and SSI status:

- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care: HgA1c (CDC)
- Cervical Cancer Screening (CCS)
- Prenatal Postpartum Care (PPC)

C. National Performance Measures

As required by 42 CFR 438.204(c), RI Medicaid collects and reports on the majority of quality measures included in both the voluntary set of core performance measures for children and adults in Medicaid and CHIP.

The *State's CMS 416: Annual EPSDT Participation Report* is produced annually and focuses on Medicaid's Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) program. The CMS 416 includes but is not limited to the following measures:

- Screening Ratio
- Participant Ratio
- Total Eligibles Receiving Any Dental Services
- Total Eligibles Receiving Preventive Dental Services
- Total Eligibles Receiving Dental Treatment Services
- Total Eligibles Receiving a Sealant on a Permanent Molar Tooth
- Total Eligibles Receiving Dental Diagnostic Services
- Total Number of Screening Blood Lead Tests

For each measure, findings are segmented by age : < 1 year; 1 – 2 years; 3 – 5 years; 6 – 9 years; 10 – 14 years; 15 – 18 years; and 19 – 20 years.

On an annual basis, findings from the CMS 416 Report are presented to Rhode Island Medicaid's Quality Improvement Committee for discussion by the State's team which oversees the MCOs. Preliminary and final CMS 416 results are also shared with the Health Plans for their input. The CMS 416 is submitted to CMS as required.

Section 401 (a) of the Children's Health Insurance Program reauthorization Act of 2009 (CHIPRA) (Pub.L. 111-3) required the Secretary of Health and Human Services to identify an initial core set of child health care quality measures for voluntary use by State program administered under Titles XIX and XXI. Appendix X provides the initial core set of child health care quality measures and the adult Core Set of Health Care Quality Measures for Adults. The initial core set of child health care quality measures are reported by Rhode Island Medicaid via the annual CHIP report. On June 15, 2012, the Rhode Island was awarded a certificate by the CMS during their 2nd Annual Medicaid & CHIP Quality Conference. The award acknowledged Rhode Island's achievement on reporting on at least 12 (one-half) of the Initial Core Set of measures for both Medicaid and CHIP, and going above and beyond in the first year of voluntary reporting for the Initial Core Set. Rhode Island was one of eight states to be recognized for this honor.

In 2013, Rhode Island was one of 26 States awarded a Medicaid Adult Quality grant from CMS. Through this grant opportunity EOHHS is working to build State capacity in the reporting and analysis of health care quality measures. A key focus of this grant is on building the needed infrastructure and capacity to produce fifteen (15) quality measures that have been prioritized by the State for analysis across Medicaid delivery systems, based on the input of various stakeholders. This process was outlined in the State's first annual report to CMS for the Adult Quality grant, which was submitted on January 31, 2014. Appendix 6 provides an overview of the Core Set of Child Health Care Quality Measures and the Adult Core Set of Quality Measures Medicaid by quality domain and the measure status within a Rhode Island Medicaid program.

D. Monitoring and Compliance

As required by 42 CFR 438.204(b)(3), Rhode Island must outline detailed procedures and protocols to account for the regular oversight, monitoring, and evaluation of its MCOs. The State has endeavored, where possible, to employ the use of standard measures that are nationally endorsed, by such entities as the National Quality Forum (NQF) and which have relevance to Medicaid-enrolled populations, such as the CMS Adult Core

Measure Set and the Children's Core Measure Set. Measurement stewards include the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ), and the American Medical Association-Physician Consortium for Performance Improvement (AMA-PCPI).

The Rhode Island Medicaid program monitors overall quality and access by:

- Defining quality and access standards in Rhode Island's Contracts with the Health Plans
- Conducting annual on-site compliance and record reviews in conjunction with the Performance Goal Program
- Directing monthly contract compliance meetings with each Health Plan
- Contracting with an External Quality Review Organization (EQRO) to perform an independent annual review of the Medicaid managed care program
- Monitoring encounter data to assess trends in service utilization
- Analyzing a series of quarterly reports, including informal complaints, grievances, and appeals
- Conducting member satisfaction surveys
- Analyzing the findings from the Health Plans' four (4) contractually required annual quality improvement projects (QIPs)
- Reinforcing the State's requirement that participating Health Plan's maintain accreditation by the National Committee for Quality Assurance (NCQA)
- Setting a performance "floor" to ensure that any denial of accreditation by NCQA shall be considered cause for termination of the State's Medicaid Managed Care Services Contract and achievement of no greater than a provisional accreditation status by NCQA shall require a Corrective Action Plan within 30 days of the Health Plan's receipt of its final report from the NCQA and may result in the termination of the State's Medicaid Managed Care Services Contract.

In addition, to the oversight and monitoring mechanisms detailed above, modifications or additions to metric development and specification, performance incentives, and additional data and reporting requirements can be made as part of a contract renewal and with the implementation of new programs. Contract amendments as well as contract or benefit clarification can also be utilized as tools to make selected changes or adjustment to quality and performance metrics on a more intermittent basis.

Figure 2 provides a visual depiction of the various qualitative and quantitative measures that are used to monitor the State's Comprehensive 1115 Demonstration. Measures have been bulleted for each of the following areas of analysis:

- Program Oversight and Administration
- Access
- Enrollment, Utilization, and Cost Analysis
- Participant Satisfaction
- Participant Engagement
- Clinical and Functional Quality Measures

Figure 2


Program Oversight & Administration
• Program Administration w/ Health Plans , Coordinating Care Entity & Providers
• Compliance Monitoring
• Pay for Performance
• Financial Oversight
• EQRO
Access
• Geo Access Report
• Informal Complaints
• Provider Network Analysis
• Service Accessibility Reporting
• Grievance & Appeals
• LTSS Monitoring
Enrollment, Utilization & Cost Analysis
• Service Utilization Rates Per 1000
• PMPMs
• NH Transitions
• Enrollment Statistics
• ALOS
• Admission/Readmission rates
Quality
Clinical & Functional Quality Measures
• RI's Priority Adult & Child Core Measure Sets
• HEDIS® Reporting
• Functional Assessment Outcomes
• Adverse Clinical Outcomes
• Critical Incident Reporting
• NH Quality Measures
• QIPs
Participant Satisfaction
• CAHPS Member Satisfaction
• HCBS Survey
• Advisory Committees
• Opt-Out/Health Plan Change Requests
Participant Engagement
• Care Management Reports
• Patient Activation Measure
• Community Health Team Registry
• Member Incentive Programs

Quality Monitoring – HEDIS® Quality Measures

The Healthcare Effectiveness Data and Information Set (HEDIS®) is one of the most widely used sets of health care performance measures in the United States. The HEDIS® methodology was devised in the late 1980s and its oversight was entrusted to NCQA in response to a broad-based demand for standardized, objective information about the performance of a wide range of MCOs (including Health Plans, Preferred Provider Organizations, Point of Service Plans, Accountable Health Organizations, and Management Behavioral Health Organizations).

In the most recent set of HEDIS® spécifications (HEDIS® 2014), there are over eighty (80) HEDIS® measures which span five (5) domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Relative Resource Use
- Health Plan Descriptive Information

The HEDIS Compliance Audit™ is a process that occurs concurrently with HEDIS® Data Collection. These annual Compliance Audits result in audited rates at the individual HEDIS® measure level and indicate if the measures can be publicly reported. All measures selected for public reporting must have a final, audited result. The Compliance Audit™ is required for MCOs that seek to either receive or maintain NCQA accreditation or for reporting by the NCQA in Quality Compass®.

Health Plans must submit their HEDIS® data annually to EOHHS as well as their HEDIS Compliance Audit™ reports as part of their Medicaid contract requirements. The State's EQRO analyzes the Health Plans' HEDIS® final, audited results as well as the reports from the NCQA-certified HEDIS® Compliance Audits. These findings are trended by the EQRO over a three-year period and compared to Quality Compass® benchmarks.

Quality Monitoring – CAHPS® Member Satisfaction Surveys

To maintain their accreditation by NCQA, Rhode Island's Medicaid-participating Health Plan must conduct an annual member satisfaction survey, using the *Consumer Assessment of Healthcare Providers and Systems (CAHPS®)* methodology. The NCQA uses the CAHPS® survey, which is endorsed by the National Quality Forum (NQF), to assess member satisfaction experience with care as a part of the annual HEDIS® measurement process.

CAHPS® results must be collected and reported separately for populations covered by commercial insurance and Medicaid. Both of Rhode Island's Medicaid-participating MCOs engage NCQA-certified external, independent survey vendors to conduct the CAHPS® Health Plan Survey 5.0 using the Adult Medicaid Questionnaire. The CAHPS® Health Plan Survey measures managed care enrollees' satisfaction with:

- Getting needed care
- Getting care quickly
- How well doctors communicate
- Health plan customer service
- Shared decision-making
- Rating of all health care

- Rating of personal doctor
- Rating of specialist

Based on RI Medicaid's analysis of existing member satisfaction survey instruments, a decision was made to use the Agency for Healthcare Research and Quality's CAHPS® survey, which is endorsed by the National Quality Forum (NQF). Selection of the CAHPS® methodology afforded the State with the opportunity to benchmark its findings against the performance of other Medicaid managed care programs, through the use of the NCQA's Quality Compass® for Medicaid. The Quality Compass® for Medicaid analytic tool delineates a count of the number of Medicaid Health Plans nation-wide that had reportable results for various CAHPS® measurement questions and provides comparative percentile rankings, which are set at the 10th, 25th, 50th, 75th, and 90th levels.

Findings from the Health Plans' annual member satisfaction surveys are analyzed by RI Medicaid as part of its programmatic oversight and by the State's EQRO. On an annual basis, each Health Plan presents the findings from its CAHPS® member satisfaction survey process to its own internal Quality Improvement Committee and to RI Medicaid's Oversight and Management Team. Use of the findings from its annual CAHPS® survey is an integral component of a Health Plan's annual quality improvement plan.

In 2011, RI Medicaid undertook a member satisfaction survey process, focusing on the State's Rhody Health Partners (RHP) program. Although each Medicaid-participating Health Plan has included RHP enrollees in its annual CAHPS® survey methodology since the inception of the program, the State was eager to assess the satisfaction of this cohort of disabled adults with a survey focusing exclusively on RHP members. Therefore, RI Medicaid undertook a similar approach in 2012 when it implemented a CAHPS®-like survey focused on Connect Care Choice.

External Quality Review

As required by 42 CFR 438.204(d), an annual External Quality Review (EQR) of Rhode Island's Medicaid managed care program must be conducted by an independent contractor and submitted to the CMS annually. RI Medicaid's commitment to the principle of *external quality review (EQR)* has been a long-standing one, actually predating (beginning in 1995) the promulgation of Federal regulations that govern this important quality improvement process. Island Peer Review Organization, Incorporated (IPRO) is currently under contract with EOHHS to conduct the EQR function for the State. In this role, the EQRO is responsible for the analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that a managed care organization or its contractors furnish to Medicaid enrollees.

On an annual basis, the State's EQRO produces detailed Health Plan-specific technical reports to evaluate quality, timeliness, and access to health services. In addition to producing this annual series of Health Plan-specific reports, Rhode Island has commissioned its EQRO to generate an *aggregate EQR report*. The aggregate report provides the State with an analysis of key findings and recommendations for its Medicaid managed care program based upon the synthesis of information across the participating Health Plans.

In developing its annual EQR reports, the State's EQRO analyzes a rich and diverse set of qualitative and quantitative data, including the following:

- Each Health Plan's accreditation survey findings from NCQA[10]
- Each Health Plan's final, audited annual HEDIS® scores and the report from its independent NCQA-certified HEDIS® auditor
- Provider network analyses: GeoAccess
- Each Health Plan's contractually required Quality Improvement Projects (QIPs)
- Health Plans' performance in Rhode Island's annual Performance Goal Program
- Each Health Plan's annual CAHPS® member satisfaction survey report from the Health Plan's NCQA-certified CAHPS® vendor
- Each Health Plan's Quality Improvement/Quality Management Program Evaluation (which may also be referred to as the Health Plan's annual QI report)*
- The Health Plan's Quality Improvement/Quality Management Plan*
- Any special studies (such as CAHPS® Clinician and Group Surveys or ECHO Surveys)

In conjunction with the State's annual continuous quality improvement cycle, findings from the annual EQR reports are also presented to RI Medicaid's Quality Improvement Committee for discussion by the State's team which oversees the MCOs. The information provided as a result of the EQR process informs the dialogue between the EQRO and the State, part of which is the determination to continue or recommend alternative QIPs. Rhode Island incorporates recommendations from the EQRO into the State's oversight and administration of RIte Care, Rhody Health Partners, and Rhody Health Options. Concurrently, each Medicaid-participating Health Plan is presented with the EQRO's report, in conjunction with the State's annual continuous quality improvement cycle, as well as correspondence prepared by Rhode Island Medicaid which summarizes the key findings and recommendations from the EQRO. Subsequently, during the month of December of each year, each Health Plan must make a presentation at the State's Oversight and Management meeting, outlining the MCO's response to the feedback and recommendations made by the EQRO.

Information gathering for EQR must be consistent with protocols established under 42 CFR 438.352. Table 4 below describes the EQRO activity and the protocol used to guide the activity. In addition, Appendix 1 of Rhode Island's Comprehensive Quality Strategy provides a crosswalk of NCQA's comparability to the regulatory requirements for compliance review as required by 42 CFR 438.360(b)(4).

[10] Rhode Island requires its Medicaid-participating MCOs to maintain accreditation by NCQA. When the State issued its Medicaid Managed Care Services Contract in September 2010, this requirement was reinforced by the establishment of a performance "floor", to ensure that any denial of accreditation by NCQA shall be considered cause for termination of the State's Contract with a Health Plan. In addition, achievement of no greater than a provisional accreditation status by NCQA shall require a Corrective Action Plan (CAP) within thirty (30) days and may result in Contract termination.

Table 4

EXTERNAL QUALITY REVIEW (EQR) ACTIVITIES

Activity	**Mandatory Activity**	**Performed by EQRO**
Prepare detailed technical report	**Yes**	**Yes**
Validation of performance improvement projects	**Yes**	**Yes**
Validation of MCO performance measures reported	**Yes**	**Yes**
Review to determine MCO compliance with standards	**Yes**	**Yes**
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**

The Medicaid program is committed to continuous quality improvement of its programs, including an independent evaluation of the Comprehensive 1115 Demonstration. In addition to the monitoring and compliance activities delineated above, Rhode Island Medicaid has developed a proposed evaluation design for the Medicaid program and its progress in meeting the following objectives:

- Reform the long-term care component of the Rhode Island Medicaid Program
- Use Demonstration expenditure authority to prevent or delay growth in the population eligible for Medicaid
- Use administrative flexibility so that the State may operate its Medicaid program more efficiently, through the application of care management systems and links to “medical homes”

This proposed Evaluation Design outlines specific goals, objectives, evaluation questions, illustrative measures, and data sources for each of the major components of the 1115 Demonstration, including Long-term Care,

RIte Care, RIte Share, Extended Family Planning, Focused Evaluations, and Market Place Subsidy to determine how effective the program has been in meeting the identified objectives.

E. Intermediate Sanctions

As required by 42 CFR 438.204(e) provisions for levying intermediate sanction are a critical component of the RI Medicaid Managed Care Contract. The State's strategies for using intermediate sanction to address quality of care issues is as follows: (1) civil monetary penalties; (2) appointment of temporary management of a Health Plan; (3) granting members the right to terminate enrollment without cause and notifying the affected members of their right to dis-enroll; (4) suspension of new enrollment; or (5) suspension of payment. These strategies can be used in conjunction with a corrective action plan to address quality of care issues. For example, new enrollment can be suspended for a Health Plan until compliance with specific contractual standards have been achieved as a result of a corrective action.

III. State Standards

The following section describes how Rhode Island Medicaid developed and implemented access to care standards, operational standards, and measurement and improvement standards for its managed care entities. Each standard was developed to ensure improved health outcomes in a cost effective manner, improve a beneficiary and family experience of care, and ensure access to right care, in the right setting, and the right time.

A. *Access Standards*

RI Medicaid MCOs are required to meet the following Standards for Access in 42 CFR 438.206-210. For additional detail regarding specific regulatory references, please see Appendix 2, *CMS Quality Strategy Toolkit*. **Table 5** in **Section II.B**. provides additional detail regarding both access and operational standards.

From the beginning of the RIte Care program in 1994, the State has seen the provision of better access to care as a key component and major goal of its implementation of managed care models in Medical Assistance. The State's aims in this area have been to:

- Make available to members across Rhode Island a comprehensive and responsive provider network centered on primary and preventive care and comparable in scope and coverage to that available to commercial MCO members;
- Continue and strengthen the availability of traditional safety-net and other providers with ongoing patient relationships and/or particular expertise in regard to issues of particular concern in the Medicaid population, such as those associated with poverty, disability, or social, linguistic or cultural barriers to care;
- Improve the coordination of services among providers involved with the same patient;
- Develop responsive and well-integrated systems of care as new models emerge.

The State's contract with the MCOs contains a number of provisions to further these aims, as described below.

Promotion of Primary Care

A major objective of managed care is to promote the utilization of primary care services. The primary care provider serves as the recipient's medical home providing primary care services and coordinating the delivery of specialty care as well as other required services.

The Health Plan contracts reinforce the importance of primary care and require Health Plans to:

- **Ensure that Members Select or are assigned a Primary Care Provider (PCP).** Though the role and responsibility of the PCP is broad, the PCP primarily serves as the member's medical home and refers members to require in- and out-of-plan specialty services. No more than 1,500 Medicaid members may be assigned to a single PCP within the team or site.

- **Provide a Comprehensive Array of Primary Care and Preventive Services.** Primary care means all health care services and laboratory services customarily furnished by or through a primary care provider. Health Plans are also required to provide a full range of preventive and comprehensive services.

- **Further the Evolution of Primary Care: Medical Homes.** A primary goal of the State in the current contract period is to enhance the provision of high quality value-based care for Medicaid members. Health Plans are expected to implement programs and a strategy to assure that cost-effective, value-based care is provided to Medicaid members.

Network Adequacy and Timeliness of Care

Across all of its provider relationships, each Health Plan is required by contract to meet specific standards with respect to provider coverage and timeliness of care. Performance of these standards is monitored and reflected in the following ways:

- **Network Adequacy Standards:** The Health Plans must establish and maintain a geographic network designed to accomplish the following goals: (1) offer an appropriate range of services, including access to preventive services, primary care services, and specialty care services for the anticipated number of enrollees in the service area; (2) maintain providers in sufficient number, mix, and geographic area; and (3) make available all services in a timely manner.

- **Meet Service Accessibility Standards.** Health Plans must provide 24 hours, seven days per week coverage to members, either directly or through the PCPs. PCPs are required to have a back-up plan when they are not available. Access to emergency medical services must be available to members twenty-four (24) hours/day, seven (7) days/week. Treatment for an urgent care condition must be provided within twenty-four hours. Treatment or diagnosis of a non-urgent, non-emergent mental health or substance abuse condition must be made available within five (5) days. Treatment for all other non-emergent conditions must be available within thirty (30) days. Women may have direct access to women's health specialists for women's routine and preventive services. Members may also obtain a second opinion by a non-participating network provider at no cost to the member.

- **Coordinate Out-of-Plan and Special Service Needs.** Health Plans are required to coordinate with organizations and service vendors that provide out-of-plan benefits and other services required by members such as, but not limited to: special education, services for the seriously and persistently mentally ill (SPMI) population, home and community based long-term care services, supplemental nutritional services, Adolescent Self-sufficiency Collaborative Support Services, and other necessary supportive services.

Safety-Net Providers and Continuing Care Relationships

Safety-net providers, such as Federally Qualified Health Centers (FQHCs) and Community Mental Health Centers (CMHCs) have traditionally played a crucial role in serving the distinctive needs of underserved populations. Recognizing the expertise associated with this distinctive role, the State has required the Health Plans to contract with these providers, unless it can demonstrate that it has both adequate capacity and an appropriate range of services for vulnerable populations to serve the expected enrollment in a service area without doing so. The Health Plans may designate FQHC sites as PCPs.

For newly enrolled members who are Children with Special Health Care Needs or members of Rhody Health Partners, and who are in ongoing care relationships with out-of-network medical providers, the RI Medicaid Managed Care Contract requires the Health Plan to continue the out-of-network coverage for a period of up to six months, pursue bringing that provider into their network and/or offer the member a provider with comparable or greater expertise in treating the needs associated with that member's medical condition. Related provisions associated with behavioral health providers require the Health Plans to have written policies and procedures for transitioning members from non-network to network providers including paying for one or more transition visits with the non-network provider.

Mainstreaming

The State considers "mainstreaming" of members into the broader health delivery system to be an important program objective. Since 1994, each Health Plan has been contractually required to have all of its network providers accept members for treatment. Additionally, the Health Plans must have policies and procedures in place such that any provider in its network who refuses to accept a Medicaid member for treatment cannot accept non- Medicaid members for treatment and remain in the network. The contract further directs the Health Plans to ensure that network providers do not intentionally segregate members in any way from other persons receiving services.

Behavioral Health Continuum of Services

Health Plans are required to provide a robust continuum of mental health and substance abuse services to members of both the RIte Care and Rhody Health Partners programs. The Health Plan contract also specifically requires that the Health Plan's network include providers experienced in serving low-income populations, subspecialists or specialty providers experienced in sexual abuse, domestic violence, rape and dual diagnosis (mental health and substance abuse) in sufficient numbers to meet the needs of its members in a timely manner. The contract further requires the MCO to have defined methods to promote access to behavioral health care and for early identification of those with behavioral health needs.

Specialty, Pharmacy and Ancillary Providers Networks

In order for the Health Plans to provide the services to meet the needs of their members, the Health Plans' networks must include a comprehensive array of Specialty, Pharmacy and Ancillary providers that foster access and choice. Each Health Plan contracts with a Pharmacy Benefit Manager to process the point-of-sale pharmacy claims, send alerts to the pharmacists for possible harmful drug interactions and dispense medicine according to the clinical guidelines. The Specialty and Ancillary provider networks are required to be linguistically and culturally competent in breadth to deliver the health care services to the RIte Care and Rhody Health Partners membership. As each program has evolved to serve additional populations with more complex medical needs, the health plans have expanded their provider networks to support the new populations.

RIte Smiles Network Requirements

Network requirements under the State's managed dental care contract are broadly similar to those for medical and behavioral health care. The dental benefits manager (DBM) is contractually required to establish and maintain a geographically accessible statewide network of general and specialty dentists in numbers sufficient to meet specified accessibility standards for its membership. Accessibility standards are as follows: (1) every member must have a dental provider available within a 20 minute drive; (2) treatment services available within 48 hours for an urgent dental condition; (3) preventive services available within 60 days of a member's request or of new enrollment; and (4) members have a choice of dental providers accepting new patients. The DBM is also required to contract with all FQHCs providing dental services, as well as with both hospital dental clinics in Rhode Island.

B. Structure & Operations

Table 5 presents a detailed description of each targeted focus area, required standard, and the mechanism by which the standard is monitored and overseen. Note: This table is applicable to all managed care programs, including the most recent addition of Rhody Health Options.

Table 5: Managed Care Performance & Contract Oversight

Access

Aims	Standard	Mechanism
Promotion of Primary Care **Behavioral Health Continuum of Services** **Specialty, Pharmacy and Ancillary Provider Networks** **Ensure Network Adequacy and Timeliness of Care**	**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 surveys ▪ Findings from Health Plans' after-hours access surveys ▪ Performance incentive program ▪ Encounter Data System ▪ MMIS data ▪ Risk-share reporting ▪ NCQA accreditation information ▪ EQRO activities ▪ Special studies ▪ Contract compliance review ▪ Audited HEDIS® submissions ▪ Program management meetings with each RIte Care-participating Health Plan

	Assurance of 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 ▪ 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	▪ Provider network reporting ▪ Informal complaints reporting ▪ Encounter Data System ▪ GeoAccess™ reporting
	Coordination & Continuity of Care: • Safety-Net Providers & Continuing Care Relationships • Care Management& Care Coordination Protocols • Disease Management, Health Promotion and Wellness	▪ NCQA information ▪ Contract compliance review ▪ Complaint, grievance, and appeals reporting ▪ Care management reporting ▪ NCQA information ▪ EQRO activities ▪ Special studies ▪ Contract compliance review
	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	▪ On-site review ▪ Member satisfaction survey ▪ Complaint, grievance, and appeals data ▪ Care management reporting ▪ Encounter Data System ▪ MMIS data ▪ Risk-share reporting ▪ NCQA information ▪ EQRO activities ▪ Contract compliance review

		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 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

Structure and Operations

Robust Operational System, Credentialing Determination, and Compliance Program	**Provider selection**	▪ Provider network data ▪ NCQA information ▪ Complaint, grievance, and appeals reporting ▪ Contract compliance review
	Enrollee Information	▪ Performance incentive program ▪ On-site reviews ▪ NCQA information ▪ Complaint, grievance, and appeals reporting ▪ Special studies ▪ Contract compliance review
	Confidentiality	▪ NCQA information

		▪ Complaint, grievance, and appeals reporting ▪ Contract compliance review
	Enrollment & Disenrollment	▪ MMIS data ▪ NCQA information ▪ Complaint, grievance, and appeals reporting ▪ Health Plan change requests ▪ Contract compliance review
	Grievance Systems	▪ NCQA information ▪ Annual member satisfaction survey ▪ Complaint, grievance, and appeals, reporting ▪ Special studies ▪ Contract compliance review
	Sub-contractual Relationships	▪ NCQA information ▪ Complaint, grievance, and appeals reporting ▪ Special studies ▪ Contract compliance review ▪ Program management meetings with each RIte Care-participating Health Plan

C. Measurement and Improvement

Practice/Clinical Guidelines

RI Medicaid MCOs are contractually required to establish clinical practice guidelines that are based on evidence based guidelines, member-centric, are reviewed on an annual basis. The clinical programs offered by the Health Plans are planned and monitored with the goal of achieving positive health outcomes for members and focus largely on preventive health, health promotion, disease management and patient safety. Disease management programs focus on the identification of populations with, or at risk for, established medical conditions. The programs strive to: support the relationship between practitioners and their patients, reinforce the established plan of care, and emphasize the prevention of exacerbations and complications with the goal of improving overall health.

Program implementation of disease management and health promotion programs require the development of health risk assessments, member and provider education materials and ongoing interaction and outreach to members. These voluntary programs are staffed by teams of registered nurses, behavioral health clinicians, and social workers to help members get the care they need when they need it. Some of the programs offered by the Health Plans are outlined in Table 6.

Table 6: Chronic Care Management Programs

Health Condition	Disease Management/Care Management Program
Asthma	Breathe Easy
Chronic Obstructive Pulmonary Disease	Take a Breath
Congestive Health Failure	Healthy Heart
Coronary Artery Disease	Don't Skip a Beat
Diabetes	Control for Life
Pregnancy/Prenatal	Healthy First Steps Bright Start
Tobacco Cessation	Quit for Life
Attention Deficit/Hyperactivity Disorder (ADHD)	ADHD Tool Kit
Adults and Children Behavioral Health Intensive Interventions	Mobile Case management
Behavioral Health Post-Partum Health	Pregnancy Enhanced Services
Depression	Depression Medical Compliance Outreach

Quality Program Description

As indicated in section II D. Rhode Island's MCOs are required to have a quality assurance program to monitor the performance of its MCOs, which includes the annual External Quality Review.

The QA/QM plan shall include:
- Measurement of performance, using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of interventions
- Planning and initiation of activities for increasing or sustaining improvement

The Quality Assurance Plan also shall:
- Be developed and implemented by professionals with adequate and appropriate experience in QA
- Detect both under-utilization and over-utilization of services
- Assess the quality and appropriateness of care furnished to enrollees
- Provide for systematic data collection of performance and patient results
- Provide for interpretation of this data to practitioners
- Provide for making needed changes when problems are found

Quality Improvement Projects

Based on Federal managed care regulations, Medicaid MCOs must conduct a series of Performance Improvement Projects (also known as *Quality Improvement Projects* or "QIPs") on an annual basis and submit these to Rhode Island Medicaid. In conformance with Rhode Island's *Comprehensive Quality Strategy*, IPRO analyzes each Health Plan's QIPs. Subsequently, IPRO's feedback is presented in its series of annual EQR technical reports to RI Medicaid, the Health Plans, and CMS.

When RI Medicaid and its participating Health Plans entered into the 2010 *Medicaid Managed Care Services Contract*, requirements that focus on the mandatory QIPs were enhanced. Rhode Island Medicaid set several new requirements:

- Each Health Plan must conduct four (4) Quality Improvement Projects annually
- At least one QIP must address each of the following populations of interest:
    - Children with Special Health Care Needs (CSHCN)
    - Disabled adults who are enrolled in Rhody Health Partners
    - Members who are enrolled in the Communities of Care initiative

RI Medicaid requires that each Health Plan organize its QIPs using a template that was developed by NCQA for accreditation and certification purposes. The Quality Improvement Activity (QIA) form, Appendix 5, provides a robust set of standards and guidance for summarizing quality improvement activities.

As noted previously, on an annual basis the State requires each Health Plan to present its feedback to the annual EQR technical report and its plan for addressing recommendations set forth by the State's EQRO. This meeting takes place during the month of December of each year and the agenda also focuses on the Health Plans' year-end report of the outcomes of their four (4) QIPs. Findings from the QIPs are also provided to the State's EQRO for validation purposes.

RI Medicaid sets forth the areas of focus for the Health Plans' annual QIPs, based upon the synthesis of qualitative and quantitative measures, such as HEDIS® and CAHPS® results and findings from the State's annual Performance Goal Program, as well as the recommendations put forward by the EQRO. For CY 2014, the State has established the following areas of focus for the QIPs that will be conducted by its participating Health Plans.

QIP Measure	**Measure Steward**
Initial Health Screenings Are Conducted with New RHP and RIte Care for CSHCN within 45 Days of Enrollment	RI EOHHS
Follow-up After Hospitalization for Mental Illness	NCQA/HEDIS®
Follow-up Care for Children Prescribed ADHD Medication	NCQA/HEDIS®
Antidepressant Medication Management	NCQA/HEDIS®

Annual Performance Goal Program

In 1998, RI Medicaid established a performance-based system that provides financial incentive awards to the MCOs that meet or exceed established quality metrics. Rhode Island was the 2nd state in the Nation to establish a performance-based system that promotes value purchasing.

A significant number of the measures which are included in the State's Performance Goal Program are from standardized measurement sets: (a) HEDIS® and (b) CAHPS®. Inclusion of these measures affords RI Medicaid with the opportunity to benchmark its performance against Medicaid health plans nationwide, using the Quality Compass for Medicaid® methodology. For each HEDIS® and CAHPS® measure, Quality Compass for Medicaid® delineates a count of the number of Medicaid health plans nationwide that had reportable results and provides comparative percentile rankings.

Currently, Rhode Island Medicaid's Performance Goal Program has eight (8) major domains, which focus on the following:

- Member Services: Four (4) State-specified measures
- Medical Home/Preventive Care: Eighteen (18) measures[11]
- Women's Health: Two (2) HEDIS® measures
- Chronic Care: Four (4) HEDIS® measures
- Behavioral Health: Three (3) HEDIS® measures
- Cost Management: One State-specified measure
- Initial Health Screenings Are Completed within Contractual Timeframes: For new RIte Care for Children with Special Health Care Needs (CSHCN) and Rhody Health Partners Enrollees
- Care Management Plans Are Evaluated and Updated within Contractual Timeframes: For RIte Care for CSHCN and Rhody Health Partners Enrollees

Table 7 delineates these measures, their source, and benchmarks for performance.

Table 7: Managed Care Performance Goal Program (An outline of performance goals, benchmark and source of measure for the above 8 domains)

PERFORMANCE GOALS

Area	MEASURE	BENCHMARK	SOURCE OF MEASURE
Member Services	Member identification cards were distributed within ten (10) calendar days of being notified of enrollment.	98%	Health Plan
	Member handbooks were distributed within ten (10) calendar days of being notified of enrollment.	98%	Health Plan
	Two member welcome	98%	Health Plan

[11] In the Medical Home/Preventive Care domain, there are two State-specified measures and the remainder are HEDIS® and CAHPS® measures.

Area	MEASURE	BENCHMARK	SOURCE OF MEASURE
	calls attempts are documented within the first thirty (30) days of enrollment.		
	Grievances and appeals were resolved within Federal (Balanced Budget Act) timeframes.	97%	Health Plan
Medical Home/Preventive Care	Members were satisfied with access to urgent care.	Medicaid Quality Compass® 90th percentile	CAHPS®
	Rate of ED visits for ambulatory care sensitive conditions.	Five (5) Percentage Point Decrease Annually	Encounter Data
	Adult members had an ambulatory or preventive care visit.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Child members had an ambulatory or preventive care visit.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Child members had well-child visits in their first 15 months of life	Medicaid Quality Compass® 90th percentile	HEDIS®
	Child members had well-child visits in their 3rd through 6th years of life	Medicaid Quality Compass® 90th percentile	HEDIS®
	The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine and one tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) or one tetanus, diphtheria toxoids vaccine (Td) by their 13th birthday	Medicaid Quality Compass® 90th percentile	HEDIS®
	The percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps, and rubella (MMR); two H influenza type B (HiB); three	Medicaid Quality Compass® 90th percentile	HEDIS®

Area	MEASURE	BENCHMARK	SOURCE OF MEASURE
	Hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. [12]		
Medical Home/Preventive Care (continued	Child members had a visit with a Health Plan PCP (HEDIS Access): • 12 – 24 Months • 25 Months – 6 Years • 7 – 11 Years • 12 – 19 Years	Medicaid Quality Compass® 90th percentile	HEDIS®
	Children received at least one age appropriate blood lead screen prior to their second birthday.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Members 18 years of age and older received advice to quit smoking.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Adult BMI Assessment (ABA): The percentage of members 18 – 74 years of age who had an outpatient visit and who had their body mass index (BMI) documented during the measurement year or the year prior to the measurement year.	Medicaid Quality Compass® 75th percentile	HEDIS®
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): The percentage of members 2 – 17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile	Medicaid Quality Compass® 75th percentile	HEDIS®

[12] Specific to Combo 3 and 10

Area	MEASURE	BENCHMARK	SOURCE OF MEASURE
	documentation, counseling for nutrition and counseling for physical activity during the measurement year.		
Medical Home/Preventive Care (continued	Frequency of On-going Prenatal Care (FPC): The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits: ≥ 81 percent of expected visits.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Pregnant RIte Care members received timely prenatal care and timely postpartum care • Prenatal • Postpartum	Medicaid Quality Compass® 90th percentile	HEDIS®
	Adolescent Well-care Visits (AWC): The percentage of enrolled members 12 – 21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Annual Monitoring for Patients on Persistent Medications (MPM): The percentage of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one	Medicaid Quality Compass® 90th percentile	HEDIS®

Area	MEASURE	BENCHMARK	SOURCE OF MEASURE
	therapeutic monitoring event for the therapeutic agent in the measurement year. Report each of the four rates separately and as a total rate: • Annual monitoring for members on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) • Annual monitoring for members on digoxin • Annual monitoring for members on diuretics • Annual monitoring for members on anticonvulsants Total rate (the sum of the numerators divided by the sum of the four denominators		
Medical Home/Preventive Care (continued)	Use of Imaging Studies for Low Back Pain (LBP): The percentage of members with a primary diagnosis of low back pain who **DID NOT** have an imaging study (plain X-Ray, MRI, CT scan) within 28 days of the diagnosis.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Initial Health Screens for the Plan's special enrollment populations – 95% completion rate within 45 days from the effective date of enrollment.	95%	Health Plan
	Active Care Management plans are evaluated and updated as needed, no less frequently than every six (6) months.	95%	Health Plan

Area	MEASURE	BENCHMARK	SOURCE OF MEASURE
Women's Health	Women enrolled 18 – 64 years received cervical cancer screening.	Medicaid Quality Compass® 90th percentile	HEDIS®
	The percentage of women 16-20 and 21-24 years of age who were identified as sexually active and who had at least one test for Chlamydia during the measurement year.	Medicaid Quality Compass® 90th percentile	HEDIS®
Chronic Care	The percentage of members between five and 64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Members 18 – 75 years of age with diabetes had HbA1c testing	Medicaid Quality Compass® 90th percentile	HEDIS®
	Controlling High Blood Pressure (CBP): The percentage of members 18 – 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (< 140/90) during the measurement year.	Medicaid Quality Compass® 90th percentile	HEDIS®
	Pharmacotherapy Management of COPD Exacerbation (PCE): The percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter between January 1 – November 30 of the measurement year and who were dispensed appropriate medications.	Medicaid Quality Compass® 90th percentile	HEDIS®

Area	MEASURE	BENCHMARK	SOURCE OF MEASURE
Behavioral Health	The percentage of discharges for members six years of age or older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner: ○ Follow-up within thirty (30) days of discharge ○ Follow-up within seven (7) days of discharge	Medicaid Quality Compass® 90th percentile	HEDIS®
	Antidepressant Medication Management (AMM): The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication for at least 84 days (Effective Acute Phase Treatment).	Medicaid Quality Compass® 75th percentile	HEDIS®
	Follow-up Care for Children Prescribed ADHD Medication (ADD): The percentage of members 6 – 12 years of age as of the 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-day Initiation Phase.	Medicaid Quality Compass® 90th percentile	HEDIS®

Area	MEASURE	BENCHMARK	SOURCE OF MEASURE
Resource Maximization	Health Plans notified DHS of any potential source of third party liability within five (5) business days of such source becoming known to contractor.	90%	Health Plan

An on-site review is conducted at each Health Plan by representatives of EOHHS. This process includes interviews with Health Plan staff as well as the review of random sample of care management records, grievance and appeal files, and documents, such as policies and procedures, call logs, and Member Handbooks.

Findings from the annual Performance Goal Program are shared internally with RI Medicaid's Quality Improvement Committee, to foster discussion by the State's team which oversees the MCOs. In addition to providing the measure-specific findings from the sentinel year, results are trended over a three-year period in order to help discern changes over time.

Detailed written summaries are also presented to the Health Plans. Any areas warranting performance improvement are highlighted, both within the summary report and in the accompanying cover correspondence. As noted previously, four (4) of the twelve (12) monthly Oversight and Monitoring meetings that are conducted with each Health Plan focus on quality improvement. At a subsequent Health Plan Oversight meeting, each Health Plan must present its action plan for remediation for any of the Performance Goal Program's HEDIS® or CAHPS® measures that do not meet the contractually-mandated Quality Compass for Medicaid® thresholds. Subsequently, each Health Plan must outline the interventions that it will undertake to address any areas of low performance on any of the Performance Goal Program's State-specified measures.

On an annual basis, a summary from the annual Performance Goal Program is posted on EOHHS' Website. This document provides three years' worth of trended HEDIS® findings as well as an update about the annual ranking of Medicaid Health Plans NCQA.

In addition as part of the annual EQR and the evaluation of care provided to special enrollment population, a subset of HEDIS® measures utilized for the annual Performance Goal Program is analyzed to make comparison between the HEDIS® and CAHPS® measure rates for Core RIte Care Only members and the rates for All Populations (Core RIte Care, RIte Care for CSHCN, RIte Care for SC (NHPRI only) and RHP members). Performance is considered similar if the rates ranked within the same percentile band and dissimilar if the rates ranked in different percentile bands.

Health Information Systems

Table 5 in Section II.B of this document highlights the various health information systems utilized to oversee and monitor quality, structure, and operations of the Medicaid managed care programs. In addition as required by 42 CFR 438.204(f) the encounter data system has been used to produce reports since 1998. Encounter data are supplemented by EQRO and special studies in areas of access and clinical care.

IV. Home and Community-Based Services (HCBS) Programs

RI Medicaid is responsible for ensuring that the following six (6) assurances that pertain to 1915(c) home and community-based waiver services are met:

1) Level of Care Determination: Person enrolled has needs consistent with the designated level of care evaluation
2) Service Plan: Participants have a service plan that is appropriate to their need and receive the services and supports outlined in their plan
3) Qualified Providers: Providers are qualified to deliver services and supports
4) Health and Welfare: Beneficiaries' health and welfare are safeguarded and monitored
5) Financial Accountability: Claims for waiver services are paid according to State payment methodologies
6) Administrative Authority: Medicaid agency is involved in the oversight of the waiver and overall responsibility of the program.

The current methods utilized by each HCBS program for ongoing monitoring and performance measurement include, but are not limited to the following elements:

- Case Records Reviews
- Provider monitoring, including BCI (Background Criminal Investigation)
- Fiscal and eligibility review, including utilization reviews
- Functional Status Assessments

Rhode Island is currently in the process of revamping its quality and oversight of HCBS to ensure alignment and compliance with the recent modification to the §1915(c) HCBS waivers and recently promulgated rules regarding person-centering planning and HCBS settings. In 2015, Medicaid will engage in an annual audit of all HCBS programs, both FFS and managed care. As part of this process, a random sample of records from each program or of combined populations will be evaluated to assess and identify baseline performance of Home and Community-Based Services for each assurance across all HCBS. Table 9 below provides an overview of the Home and Community Based Services Quality Assurances, Methods, and Benchmarks.

Table 8.Home & Community Based Services Quality Framework

Level of Care

Assurances	CMS Expectations	Method/Outcomes/Benchmarks
Initial evaluation for Level of Care is provided to all applicants for whom there is a reasonable indication that services may be needed in the future.	The state will submit evidence that it has reviewed applicant files to verify that initial individual Level of Care evaluations are conducted.	Via quarterly audits Baseline to be set and benchmark to be determined
Level of care for enrolled beneficiaries is reevaluated at least annually.	The state will submit evidence that it regularly reviews beneficiary files to verify that reevaluations of Level of Care are conducted at least annually.	Via quarterly audits Baseline to be set and benchmark to be determined
Process and instruments described in the approved waiver are applied	The state will submit that it regularly review beneficiary files to verify that the instrument described in the approved	Via quarterly audits

appropriately and according to the approved description to determine beneficiary Level of Care.	waiver is used in all Level of Care redeterminations, the person(s) who implement Level of Care determinations are those specified in the approved waiver, and the process/instruments are applied appropriately.	Benchmark: 100%

Service Plans

Assurances	CMS Expectations	Method/Outcomes/Benchmarks
Service Plan addresses all beneficiary assessed needs and personal goals (includes health and safety risk factors).	The state demonstrates that service plans are reviewed periodically to assure all of beneficiary needs are addressed and preferences are considered.	Via quarterly audits Person-centered planning policy to be developed and vetted Benchmark to be determined
Monitor service plan development in accordance with State's policy and procedures.	The state submits evidence of its monitoring process for service plan development and any corrective action taken when service plans were not developed according to policy and procedure.	Via quarterly audits Person-centered planning policy to be developed and vetted Benchmark to be determined
Service plans are updated and revised at the minimum on an annual basis. (Sooner if warranted by changes in beneficiary needs).	The state submits evidence of its monitoring process for service plan update/revision including service plan updates taken when service plans were not in compliance according to policies and procedures.	Via quarterly audits Baseline to be set and benchmark to be determined
Services are delivered in accordance with the service plan and the type, scope, amount, and frequency must be specified in the service plan.	The state submits evidence of the results of its monitoring process for ensuring the services identified in the service plan are implemented.	Via quarterly audits Baseline to be set and benchmark to be determined
Participants are afforded a choice: 1. Between waiver services and institutional care; and 2. Between waiver services and providers	The state submits evidence that that beneficiaries are afforded a choice between waiver services and institutional care, and between waiver services and providers.	Via quarterly audits Revised Informed Consent form to be developed and vetted Benchmark to be determined

Qualified Providers

Assurances	CMS Expectations	Method/Outcomes/Benchmarks
Verify that providers initially and continually meet required licensure and/or	The state provides documentation of periodic review by licensing/certification entity.	Ongoing The RI Dept. of Health has statutory

certification standards. Verify that providers adhere to other state standards prior to their furnishing waiver service.		responsibility for licensing all home care providers. The RI Dept. of Behavioral Healthcare, Developmental Disabilities and Hospitals license Habilitation Group Homes. Benchmark: 100%
The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	The state provides documentation that non-licensed/non-certified providers are monitored on a periodic basis sufficient to provide protections to waiver participants.	Via quarterly audits Baseline to be set and benchmark to be determined
The state implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.	The state provides documentation of monitoring of training and actions it has taken when providers have not met requirements (e.g. technical assistance, training).	To be determined

Health and Welfare

Assurances	CMS Expectations	Method/Outcomes/Benchmarks
The state, on an ongoing basis, identifies addresses and seeks to prevent the occurrence of abuse, neglect, and exploitation.	The state demonstrates that on an ongoing basis abuse, neglect and exploitation are identified, appropriate actions have been taken when the health or welfare of a beneficiary has not been safeguarded, and an analysis is conducted of abuse, neglect, and exploitation trends and strategies it has implemented for prevention.	Via Critical Incident reporting and procedure (as known) Monthly review Benchmark: 100%

Administrative Authority

Assurances	CMS Expectations	Method/Outcomes/Benchmarks
The state Medicaid agency retains the ultimate administrative authority and responsibility for the operation of the waiver program. The state Medicaid agency exercises oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.	The state submits evidence of monitoring of all delegated functions, and implementation of policies/procedures related to its administrative authority over the waiver program, including: memoranda of agreements, and description of roles and responsibilities relative to program operations, monitoring, and remediation or system improvements instituted when	To be determined by the Executive Office of Health and Human Services leadership

	problems are identified in the operation of the waiver program.	

Financial Accountability

Assurances	CMS Expectations	Method/Outcomes/Benchmarks
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	The State submits results of its financial monitoring process for verifying maintenance of appropriate financial records as specified in the approved waiver	Via quarterly audits HP assists through the Service Utilization Review Surveillance Unit staffed by Registered Nurses
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	The State submits results of its review of waiver participant claims to verify that they are cod ed and paid in accordance with the waiver reimbursement methodology.	Via quarterly audits HP – MMIS – Service Utilization Review Surveillance
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	The State demonstrated that the interviews with State staff and providers are periodically conducted to verify that any identified financial irregularities are addressed.	Ongoing HP and dedicated state staff
State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.	The State demonstrates that site visits are conducted with providers to verify that they maintain financial records according to provider agreement/contract.	Program Integrity audits

The following is a snapshot of metrics that are currently submitted to CMS on a quarterly basis:

- Level of Care Determinations stratified by the following categories (Highest, High, Preventive)
- Percentage of Nursing Home Transition Referrals and Placements
- Percentage of Medicaid beneficiaries in Institutional and HCBS LTC settings, inclusive of cost and utilization of service units
- Percent distribution of expenditures for LTC Institutional and HCBS by population, including elders 65 and older, adults with disabilities, and children with special health care needs
- Number of Medicaid beneficiaries on a waiting list for any LTC service
- Percentage of individuals in a non-Medicaid funded LTC co-pay program by type, unit of service, and expenditures

V. Quality Improvement via Cross-Cutting Initiatives

A. All Payer Claims Database

Rhode Island's All Payer Claims Database (APCD) was initiated in 2008. Rhode Island's APCD is an interagency initiative to develop a central repository of all membership, medical, behavioral health and pharmacy claims

from all commercial insurers, the self-insured, Medicare, and Medicaid. The purpose of APCD is to build a robust database that helps identify areas for improvement, growth, and success across Rhode Island's health care system. The production of actionable data and reports that are complete, accessible, trusted, and relevant will allow for meaningful comparison and help inform decisions made by consumers, payers, providers, researchers, and state agencies.

APCD data will also be used to:

- Provide data on disease prevalence and healthcare costs, trends, and utilization
- Expand ability to analyze population health
- Understand the effects of new initiatives/payment reforms on Rhode Island's health care system
- Review peer-comparisons and give provider feedback for quality improvement
- Provide transparency in cost and quality to inform healthcare decision-making

Rhode Island's All Payer Claims Database (APCD) was initiated in 2008. Rhode Island's APCD is an interagency initiative to develop a central repository of all membership, medical, behavioral health and pharmacy claims from all commercial insurers, the self-insured, Medicare, and Medicaid. The purpose of APCD is to build a robust database that helps identify areas for improvement, growth, and success across Rhode Island's health care system. The production of actionable data and reports that are complete, accessible, trusted, and relevant will allow for meaningful comparison and help inform decisions made by consumers, payers, providers, researchers, and state agencies.
APCD data will also be used to:

- Provide data on disease prevalence and healthcare costs, trends, and utilization
- Expand ability to analyze population health
- Understand the effects of new initiatives/payment reforms on Rhode Island's health care system
- Review peer-comparisons and give provider feedback for quality improvement
- Provide transparency in cost and quality to inform healthcare decision-making

As a co-convener of APCD, EOHHS was one of the drivers of the project, and has and continues to be actively involved in its design, selection of vendors and its implementation. EOHHS will have access to, and the ability to analyze APCD data including Medicaid and Medicare data in the APCD via a business intelligence tool supported by the APCD analytic Vendor (3M previously Treo Solutions). APCD data will be able to be used to report quality measures derived from claims data across the various Medicaid delivery systems. EOHHS anticipates 3 years of historical data (2011-2014) will begin to be available for use in the Spring of 2015. The types of reports that will be available from the APCD will be phased in.

<u>Phase one</u>

- Total cost of care
- Readmission comparisons
- Inpatient and outpatient cost of care by county

<u>Phase two</u>

- Trend/total cost of care data for various sites and providers of care
- Payment variations (by carrier, by discharge and risk-adjusted for inpatient discharges)
- Estimates for out-of-pocket expenditures
- Churn reports
- High utilizer reports
- Rate/cost of preventive procedures

The time frame for the report packages are as follows:
Package 1: 12/9/2014
Package 2: 4/30/2015
Package 3: 6/30/2015
Package 4: 9/30/2015
Package 5: 12/30/2015

B. Chronic Care Sustainability Initiative

The Chronic Care Sustainability Initiative (CSI) is Rhode Island's all-payer patient-centered medical home program. CSI currently includes 48 practice sites, with over 300 primary care providers serving 220,000 Rhode Islanders (approximately 20% of the State's population.) CSI recently announced its fifth expansion and plans to add 20 new practices serving an additional 100,000 Rhode Islanders. With the expansion, approximately 30% of the State's population (and approximately 40% of the adult population) will have access to high-performing patient-centered medical homes through CSI.

One of the contractual requirements of the CSI program is the quarterly production and reporting of a set of standardized quality metrics from Electronic Health Record (EHR). FQHCs, some of which are also CSI sites, have submitted emergency visit rates to Medicaid. Practices submit these reports (numerators and denominators) to a central program management entity for aggregation, feedback, and display. A website available only to program participants displays each practice's measures over time, along with CSI aggregate totals. CSI has also established a "measure harmonization" process by which all of the payers participating in the program agree upon the metrics, their specifications, and the benchmarks for achieving contractual requirements. Currently, the following metrics are reported by type of payer (commercial, Medicare Advantage, RIte Care and Rhody Health Partners) in aggregate and by practice site:

- All Cause Admission (Number of Inpatient Admissions in three year rolling average per 1,000 member months)
- Ambulatory Care Sensitive Conditions (ACSC) Admissions(Number of ACSC in rolling year per 1,000 member months)
- All Cause ER Visit Rate (Number of ER visits in rolling year per 1,000 member months)
- Preventive ER Visit Rate (Number of Preventable ER visits in rolling year per 1,000 member months)
- Readmission Percent (Percent of Discharges in rolling year resulting in 30-day readmission)
- Observation Stay Rate (Percent of Observation Stays in rolling year per 1,000 member months)

In addition to the utilization metrics described above the CSI practices collect a set of clinical quality measures as shown in Appendix 3.

CSI-RI is one RI Medicaid delivery system that is designed to provide beneficiaries with the right services, in the right setting, and at the right time. The program is structured to care for beneficiaries with complex healthcare needs. The data analytic functions of CSI-RI will enable Medicaid to measure whether there is increased access to and improved quality of care for Medicaid recipients enrolled in the program, and compare rates to recipients receiving care via other delivery systems.

C. Medicaid EHR Incentive Program

In 2011, Rhode Island's Medicaid EHR Incentive Program (Meaningful Use) began providing incentive payments to eligible Medicare and Medicaid professionals and hospitals which adopt and become meaningful users of certified EHR technology. Meaningful Use encourages providers to utilize technology within their operations and monitor the quality of care for their patients. For example a provider may incorporate electronic prescribing into their operations and review clinical quality measures of their patients by monitoring Body Mass Index (BMI) levels. In the coming years the clinical quality measures will be expanding into six National Quality Strategy domains which represent the Department of Health and Human Services' NQS priorities for health care quality improvement:

1. Patient and Family Engagement
2. Patient Safety
3. Care Coordination
4. Population/Public Health
5. Efficient Use of Healthcare Resources
6. Clinical Process/Effectiveness

In 2013, 51% of Rhode Island physicians adopted an EHR. Of the 447 eligible Medicaid providers participating in Meaningful Use, 52% have attested to Stage 1 Meaningful Use and all 809 eligible Medicare providers have attested to Stage 1 Meaningful use. Rhode Island's hospitals are also actively engaged in the program. Providers and hospitals are able to obtain technical assistance from Rhode Island's Regional Extension Center (REC), administered by the Rhode Island Quality Institute (RIQI). Of the 1,221 primary care providers assisted by the REC, 69% have attested to Stage 1 Meaningful Use.

Meaningful Use increases providers' capacity to use data to improve quality of care and health outcomes for their Medicare and Medicaid patients. Rhode Island providers have attested to applying EHR to the use of various quality measures including screenings for breast and cervical cancer, chlamydia, and adult BMI, patients participating in smoking cessation strategies, and patients with chronic conditions like high blood pressure, diabetes and asthma.

D. Adult Medicaid Quality Grant

Rhode Island was one of 26 states to be awarded a CMS Adult Medicaid Quality (AMQ) grant in 2012. The purpose of this grant is to assist states in developing their ability to gather, analyze, and report on a number of Adult Core Quality Measures of the Medicaid healthcare system. EOHHS used this opportunity to establish an Analytics and Evaluation unit, charged with the longer term task of more generally building the analytic capabilities of EOHHS through:

- Assessing current infrastructure (including the EOHHS data warehouse)
- Standardizing data definitions and reporting methods
- Centralizing and optimizing data management and reporting
- Interfacing between policy, operations and IT
- Facilitating cross-departmental analytic collaboration
- Turning data into meaningful information

Once operationalized, this augmentation of analytic capabilities will enable EOHHS to report on a defined set of quality measures across all Medicaid delivery systems and use this data to identify opportunities for performance improvement in a more specific and timely manner.

Additionally, EOHHS has engaged three community partners to conduct two QIPs and one EHR Initiative:

- Healthcentric Advisors (RI's Medicare Quality Improvement Organization) is assisting with the development and implementation of a Transitions of Care QIP. A key aim of this QIP is to increase the percentage of hospital discharges associated with the timely and complete transmission of quality discharge information to the appropriate community provider.
- The University of Rhode Island, College of Pharmacy is assisting with the development and implementation of an Antidepressant Medication Management QIP. The goal of this QIP is to increase the percentage of adults diagnosed with major depression who remain on an antidepressant medication treatment. The intervention focuses on providers, who are responsible for large volumes of anti-depressant prescriptions and will also engage the local pharmacy community.
- The Brown University School of Public Health has been engaged to analyze the feasibility and validity of collecting some of the Adult Core Measures directly from EHRs.

VI. Delivery System Reforms

A. Integration of Home & Community Based Services/Long Term Services and Supports

Rhody Health Options (RHO)

For currently enrolled populations, particularly those in Rhody Health Partners, the integration of long-term care services and supports (LTCSS) into the MCO's scope of benefits will enhance continuity of care for the member, provide for improved care transition management, and extend the MCO's accountability of member outcomes. Presently, when a Medicaid-only member (or "non-dual") enrolled in Rhody Health Partners is admitted to a nursing facility for greater than 30 days, the member is dis-enrolled from managed care and the MCO care management service ceases which can lead to higher costs and poorer outcomes. At their most vulnerable moments, *dual eligible* beneficiaries often face a confusing and fragmented system of care, leading to otherwise avoidable nursing home stays and hospital admissions. One approach to address this need is the inclusion of LTSS in an integrated managed care arrangement.

The goal of the State's Integrated Care Initiative (ICI) is to build on the Rhody Health Partners and Connect Care Choice programs through the integration of acute care services, primary care, and long term services and supports (LTSS). LTSS includes nursing home care as well as home and community-based supports that allow members to live independently in the community. Rhody Health Options (RHO) is the integration of these LTSS services into a managed care delivery system. The Connect Care Choice Community Partners (CCCCP) program is the State's Primary Care Case Management (PCCM) model which serves adult populations with complex medical and behavioral needs, and offers extensive care management services through seventeen (17) comprehensive medical home practice sites throughout the State.

The following safeguards have been implemented to ensure access and continuity of care:

- All newly enrolled members have access to out-of-network providers for six months post enrollment,
- The MCO must honor all prior authorizations, including long-term services and supports (LTSS) authorizations, and

- Members residing in an out-of-network nursing facility can remain in that facility if and when the member chooses to change nursing homes.

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

- Age twenty-one (21) or older
- Categorically eligible for Medicaid-only
- Not covered by other third-party insurance
- Residents of Rhode Island

Effective through RHO, on November 1, 2013 Medicare-Medicaid eligible beneficiaries and Medicaid-only beneficiaries receiving long-term services and supports (LTSS) were given the option to enroll in an MCO with the provision that they could "opt-out" to fee-for-service or enroll in the Primary Care Case Management Program (PCCP). The Medicaid-only members represent a small number of Rhody Health Partners (RHP) members who have already been enrolled in managed care, but who had been receiving their long term services and supports (i.e., HCBS) via Medicaid fee-for-service. These Medicaid-only members who have been receiving home and community-based services through the State's fee-for-service program are now given the option to stay in managed care and receive LTSS as an in-Plan benefit or otherwise opt in to CCCCP or fee-for-service delivery systems. For both delivery systems, Medicare services will continue to be administered by the Medicare program.

Those who do not select an option are automatically assigned to either model. Eligible clients are auto-assigned to either Rhody Health Options (RHO) or Connect Care Choice Community Partners (CCCCP) using an algorithm established by the State. The algorithm takes into account whether a member currently receives primary care from one of the seventeen (17) Connect Care Choice patient-centered medical homes (PCMH) using a primary care attribution methodology established by the Medicare program. These 17 practices are also part of the RHO managed care delivery option. Seventy-five percent (75%) of eligible members currently receiving primary care services from one of the 17 Connect Care Choice patient-centered medical homes received an auto-assignment letter. The remainder of the eligible population received an RHO auto-assignment letter. This auto-assignment approach preserves existing patient and provider relationships. Members also have an opportunity to change delivery systems monthly.

Enrollment began through a staged approach starting on November 1, 2013. The target population for the ICI was enrolled over a six-month period which began in November 2013 and concluded in April of 2014. Each enrollment "wave" assumed that a certain percentage of ICI eligible members would opt out and choose to remain in the fee-for-service delivery system. Enrollment estimates did not include individuals for whom the State received returned or undeliverable mail.

Services for individuals with intellectual/developmental disabilities and individuals with severe and persistent mental illness continue to be funded and managed by the Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals.

The following populations are exempt from enrollment in an MCO:

- Medicare beneficiaries who are not eligible for full Medicaid benefits (i.e., Qualified Medicare Beneficiaries, QMBs)
- Specified Low-Income Beneficiaries (SLMBs)
- Qualified Individuals (QIs)

- Individuals who are eligible for partial Medicare benefits (Part A only or Part B/D)
- Individuals residing at Tavares[13], Eleanor Slater[14] Hospital or out-of-State hospitals
- Individuals who are incarcerated (adjudicated and in prison)
- Individuals who are in hospice on the enrollment start date

RHO members have a comprehensive benefit package, which now includes all home and community-based services (e.g., homemaker services, environmental modification, home-delivered meals, supportive living arrangements, adult companion services, respite services, and assisted living.)

A key component of Rhody Health Options is the Care Management Program for which the Health Plan must comply with the *Executive Office of Health and Human Services Care Management Protocols for Rhody Health Options.* The goal is to have a person-centered system of care focused on improving health outcomes, coordination of care and services, access to timely health care, LTSS, and other community-based services, and optimizing resources.

Care Management Program elements include:

- For community non-LTSS members, an Initial Health Screen (IHS) is to be completed within 45 days of enrollment and every 180 days thereafter.
- For LTSS members, the Comprehensive Functional Needs Assessment (CFNA) and Discharge Opportunity Assessment must be completed by a licensed clinician in person, face-to-face, at either the member's residence or chosen location.
- For a Community non-LTSS member determined to be "at-risk", the CFNA must be completed within 15 days of completion of the IHS. A reassessment must be completed within 180 days or sooner depending on the member's condition.
- For a Community LTSS member, the CFNA must be completed within 15 days of enrollment and a reassessment completed every 90 days or sooner depending on the member's condition.
- For Members living in a Nursing Facility, the Discharge Opportunity Assessment must be completed within 30 days of enrollment and every 180 days or sooner depending on the member's condition.
- A home re-assessment is to be completed for all RHO members post-hospitalization within five (5) days of hospital discharge.
- A plan of care is to be developed in collaboration with a member and/or identified caregiver within 5 days of completion of the CFNA. The plan of care is to be re-evaluated and modified as needed and in collaboration with the member and/or identified caregiver after the completion of a reassessment, change in the member's condition or need, acute care episode, or critical incident.

The qualitative oversight of the newly integrated home and community based LTSS services, long-term care services, and nursing home transitions are paramount areas of focus.

Table 9 and 9-1 show the quality design for RHO. This quality design was informed by community stakeholders through a series of three (3) public forums which were held during the Summer of 2012. These forums were held to obtain input and recommendations on the focus of the RHO and CCCCP quality design, and specifically quality of care domains. The input obtained through the stakeholder process was then cross-walked against

[13] Tavares Pediatric Center is an intermediate care facility for the Developmentally Disabled.

[14] Eleanor Slate Hospital is a State hospital providing care and treatment to patients with acute and long term medical illnesses as well as patients with psychiatric disorders. This hospital is operated by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals.

national benchmarks such as HEDIS® and CAHPS® measures as well as National Quality Forum (NQF)-endorsed measures.

Table 9

Rhody Health Options (RHO) 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 Plan(s)[15] serving Rhode Island's RHO enrollees
Identify the race, ethnicity, and primary language spoken of each enrollee.	MMIS data	EOHHS
State Specific Quality Measures (See Table 7-2).	On-site audit, reporting, and MDS data.	Medicaid-participating Health Plans serving Rhode Island's RHO 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 RHO enrollees
Annual External Quality Review	Elements as mandated by 42 CFR 438.350(a).	Rhode Island's designated External Quality Review Organization (IPRO, Incorporated)
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 RHO enrollees
Health Plan Member Satisfaction Survey	The CAHPS® 5.0 Survey Methodology for Adults in Medicaid.	NCQA-certified CAHPS® vendor (2015 cycle)
Care Management Report for RHO	Care management reports are submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Long Term Services and Supports Operational Report	Long Term Services and Supports Operational Reports are submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Critical Incident Report	The Critical Incident Report is submitted electronically in a	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees

[15] As of 11/01/2013, Rhode Island has contracted with one Health Plan, Neighborhood Health Plan of Rhode Island (NHPRI), for Rhody Health Options (RHO).

	spreadsheet template established by RI Medicaid.	
Nursing Home Transitions Report	The Nursing Home Transitions Report is submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Nursing Home Quality Report[16]	The Nursing Home Quality Report is submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
24 hour Emergency Back-Up report	The 24 hour Emergency Back-Up Report is submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHO enrollees
Care Transitions Report	The Care Transitions Report (numerator: Number of hospital readmission within 30 days, denominator: Number of identified hospital discharges) is submitted electronically in a spreadsheet template established by RI Medicaid.	Medicaid-participating Health Plans serving Rhode Island's RHO 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 RHO enrollment population

Table 9-1

Nursing Home Quality Measures		
% of LTC patients with a hospital admission	Percent of long-stay nursing facility residents (i.e., residing in a nursing facility continuously for 100 days prior to the second quarter of the calendar year) who were hospitalized within six (6) months of baseline assessment.	CMS, MEDPAR Administrative Claims
% of High Risk Residents with Pressure Ulcers	Percent of all long-stay residents in a nursing facility with an annual, quarterly, significant change or correction MDS assessment during the selected quarter who were identified at high risk and	CMS MDS Data

[16] Please see table 9-1 for specified nursing home quality measures.

(Long Stay) 5 star	who have one more stage 2-4 pressure ulcers.	
% of LTC patients with a Urinary Tract Infection (UTI) (Long Stay)	Percent of all long-stay residents with a selected target assessment that indicates a urinary tract infection within the last thirty (30) days.	CMS MDS Data
% of long stay residents who received an antipsychotic medication	Percentage of all long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received .	CMS MDS Data
% of long-stay residents who report either (1) almost constant or frequent moderate to severe pain in the last 5 days or (2) any very severe/horrible in the last 5 days**.**	Percent of long-stay residents with a selected target assessment where the target assessment meets ***either*** *or* ***both*** of the following two conditions: 1. Resident report almost constant or frequent moderate to severe pain in the last five (5) days. ***Both*** of the following conditions must be met: Almost constant or frequent pain ***and*** at least one episode of moderate to severe pain. 2. Resident reports very severe/horrible pain of any frequency.	CMS MDS Data

In addition to national benchmarks such as HEDIS® and CAHPS® measures, the State's Performance Goal Program for RHO has established a set of State-specific quality and operational standards in three main focus areas: Member Services, Beneficiary Protection, Care Management and Nursing Home Quality of Care and Transitions to Community as shown in Table 9-2.

Table 9-2

Performance Goal Program for Rhody Health Options

Area	**Goal**
Member Services	Identification cards are distributed within ten (10) calendar days of Plan receipt of enrollment information.
	During standard hours of operation, Member Service calls are answered by a live voice in thirty (30) seconds average speed to answer.
	Grievance and appeals are resolved within Federal Balanced Budget Act time frames.
Care Management	Non-LTSS members receive an initial telephonic assessment within forty-five (45) days of enrollment.
	Non-LTSS members who are identified for a comprehensive needs assessment will have a face to face visit assessment completed within thirty (30) days of the initial telephonic assessment.
	A comprehensive face-to-face visit assessment is completed within fifteen

	(15) days for recipients of Community Long Term Care Services and Supports (LTSS); within thirty (30) days for nursing home residents.
	Care plans clearly demonstrate adequate and appropriate care and service plan, including social and environmental supports, shared decision making, involvement of the member and/or caregiver in plan development, and assessment of member goals and preferences.
Nursing Home Transitions (NHT)	Members have a risk assessment (as defined per NHT protocol) prior to transition to the community.
	Members have a home visit within one (1) calendar day of their transition to the community.

The State-specified quality measures listed above are a critical component to monitoring the quality and oversight of this new integrated care delivery system. These quality measures are used to capture critical process and structural data elements from several key domains to monitor the ongoing viability of key functions and operations, and ensure high quality care and outcomes. In addition to the State-specified quality measures, the Health Plan will be required to conduct a QIP. Baseline data will be used to identify target areas for improvement. By conducting performance improvement projects, the MCO will be able to implement interventions that lead to improved processes and therefore outcomes.

Connect Care Choice Community Partners (CCCCP)

The Connect Care Choice Community Partners (CCCCP) program is the State's PCCM model which serves adults 21 years or older with complex medical and behavioral services, and offers extensive care management services through seventeen (17) comprehensive medical home practice sites throughout the State. The CCCCP program addresses the needs for greater integration of primary care, acute care, specialty care, behavioral health and long-term care services through high touch care coordination via a contracted Coordinating Care Entity (CCE). The CCE[17] coordinates the collection of performance data, quality assurance and quality improvement activities. A key feature of the CCE is that it provides a Community Health Team (CHT) that coordinates the social supports and services for both Medicaid-only and MME members.

Table 10 shows the quality design for CCCCP. This quality design was informed by community stakeholders through a series of three public forums which were held during the Summer of 2012. These forums were held to obtain input and recommendations on the RHO and CCCCP quality design, and specifically quality of care domains. The input obtained through the stakeholder process was then cross-walked against national benchmarks such as the NCQA's HEDIS® and the AHRQ's CAHPS® measures as well as National Quality Forum (NQF)-endorsed measures.

Table 10

Connect Care Choice Community Partners Quality Design

Date Collection Method	Type of Method	Performed By
Administrative data and hybrid measures	Based on HEDIS® methodology (See table 10-	The CCE serving Rhode Island's Connect Care Choice Community Partners

[17] As of 11/01/2013, Rhode Island has contracted with Care Link, Incorporated, to be the CCE.

	2B)	enrollees
State Specific Quality Measures (See Table 8-2).	On-site audit, reporting, and MDS data.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Informal Complaints	Informal complaints reports are submitted electronically in a spreadsheet template established by RI Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Health Plan Member Satisfaction Survey	The CAHPS® 5.0 Survey Methodology for Adults in Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Care Management Report	Care management reports are submitted electronically in a spreadsheet template established by EOHHS.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Long Term Services and Supports Operational Report	Long Term Services and Supports Operational Report are submitted electronically in a spreadsheet template established by RI Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Critical Incident Report	Critical Incident Report is submitted electronically in a spreadsheet template established by RI Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Nursing Home Transitions Report	Nursing Home Transitions Report is submitted electronically in a spreadsheet template established by RI Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Nursing Home Quality Report	Nursing Home Quality Report is submitted electronically in a spreadsheet template established by RI Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
24 hour Emergency Back-Up report	24 hour Emergency Back- Up Report is submitted electronically in a spreadsheet template established by RI Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Care Transitions Report	Care Transitions Report is submitted electronically in a spreadsheet template established by RI Medicaid.	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees
Claims and/or Encounter Data Analysis	MMIS is designed to identify services provided to an individual and track utilization over time and	The CCE serving Rhode Island's Connect Care Choice Community Partners enrollees

	across service categories, provider types, and treatment facilities.	

The State has established a set of State-specific quality and operational standards in four main focus areas: Member Services, Beneficiary Protection, Care Management and Nursing Home Quality of Care and Transitions to Community. Table 10-1 below outlines each of these four focus areas and accompanying goals within each area.

Table 10-1

CCCCP Quality and Operational Standards

Member Services	Member materials are distributed within ten (10) calendar days of Plan receipt of enrollment notification.
	During standard hours of operation, Member Service calls are answered by a live voice in 30 seconds average speed to answer.
	Grievances (Informal Complaints) are resolved within 30 days.
Beneficiary Protection	For members that report a critical incident, the Care Management Plan must demonstrate the completion of an updated risk assessment and mitigation plan.
	Member and/or caregivers receive education and information, annually at a minimum, about how to identify and report instances of abuse and neglect.
Care Management	Level I and Level II members with LTSS receive an initial telephonic assessment within thirty (3) days of enrollment. Level II Non-LTSS Members receive an initial telephonic assessment within sixty (60) days of initial start-up enrollment and 45 days thereafter.
	Members identified as "At Risk" during the initial telephonic assessment will receive an in-person Health Risk Assessment within sixty (60) days during initial start-up enrollment and fourteen (14) days thereafter.
	Based on a risk profile, members identified as Level I and Level II with LTSS will receive an in-person Health Risk Assessment within sixty (60) days during the initial start-up enrollment and thirty (30) days thereafter.
	Based on a risk profile, member identified as Level II Non LTSS will receive an in-person Health Risk Assessment within one hundred and eighty (180) days during initial start-up enrollment and ninety (90) days thereafter.
	All Health Risk Assessments must be received within two (2) business days of the in-person visit.
	All comprehensive needs assessments conducted by the CCE and/or care manager should include documentation of completed home safety evaluations and appropriate follow up thereafter.
	Members are screened for clinical depression using a standardized tool and follow up is documented.
Nursing Home Quality Measures	Percent of long-stay nursing facility residents (i.e., residing in a nursing facility continuously for one hundred (100) days prior to the second quarter of the calendar year) who were hospitalized within six (6) months of baseline assessment.

	Percent of all long-stay[18] residents in a nursing facility with an annual, quarterly, significant change or correction MDS assessment during the selected quarter who were identified at high risk and who have one more stage 2-4 pressure ulcers.
	Percent of all long-stay residents with a selected target assessment that indicates a urinary tract infection within the last thirty (30) days.
	Percentage of all long-stay residents with a selected target assessment where the following condition is true: antipsychotic medications received.
	Percent of long-stay residents who report either (1) almost constant or frequent moderate to severe pain in the last 5 days or (2) any very severe/horrible pain in the last 5 days.

The CCCCP primary care practice network consists of practices that have adopted the "chronic care model" and are certified as a "patient-centered medical home" by NCQA. In addition, these practices must meet a high standard of performance, provide evidenced-based chronic disease management, nurse care management, primary and preventive care while encouraging self-management supports and education. The design of this health delivery system is quality focused, holistic in its approach to achieve and maintain wellness as well as to improve access to primary and specialty care. The ability to monitor clinical quality is critical to measuring practice based performance and outcomes. Table 10-2 below provides a list of clinical measures being used to monitor practice based performance on chronic care management and patient self-management.

Table 10-2

CCCCP Clinical Quality Measures based on Selected HEDIS®-like Clinical Measures		
Measure Name	**Measure Description**	**Measure Steward and Data Source**
Persistence of Beta-Blocker Treatment After a Heart Attack	Percent of Members 18+ during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to the measurement year to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six (6) months after discharge.	NCQA Administrative Claims Chart Review

[18] All residents in an episode whose cumulative days in the facility is greater than or equal to 101 days at the end of the target period. An episode is a period of time spanning one or more stays, beginning with an admission and ending with either a discharge or the end of the target period (whichever comes first). A target period is the span of time that defines the QM reporting period (e.g., a calendar quarter).

Adult BMI Assessment	Percent of members 18-74 years of age who had an outpatient visit and who's BMI was documented during the measurement year or the year prior to the measurement year.	NCQA Administrative Claims and Hybrid
Anti-depressant Medication Management (Effective Acute Phase Treatment)	Percent of members 18 + who were diagnosed with a new episode of major depression and treated with anti-depressant medication, and who remained on anti-depressant medication.	NCQA Administrative Claims
Comprehensive Diabetes Care	Hemoglobin A1c with poor control (> 9.0%), LDL control (< 100 mg/dL), Eye (retinal) exam performed, Blood Pressure control (< 140/80).	NCQA Administrative Claims & Hybrid
Advising Smokers and Tobacco Users to Quit	The percentage of members 18 years of age and older who are current smokers or tobacco users and who received cessation advice during measurement year.	NCQA/AHRQ

VII. Lessons Learned (Conclusions and Opportunities)

State policymakers further define "all-payer" approaches that align incentives within the health care system to strengthen the primary care infrastructure and promote positive incentives for providers, such elements need to be integrated with Medicaid managed care. Alignment of quality measurement and reporting strategies is a critical component. In addition to integration of LTSS into the MCOs, other opportunities for service integration exist. For example, dental services are a covered Medicaid benefit but for adolescents and adults are administered outside of the MCOs. Integration of dental services for all populations into a MCO would provide better access to care and improved health outcomes. The importance of dental services is illustrated by that fact that, currently the diagnosis of dental pain is the second leading cause for Emergency Room visits for the Medicaid population.

Other promising quality improvement efforts include a QIP with Brown University as part of Rhode Island's Medicaid Adult Quality grant. Through this QIP, Brown University is analyzing the feasibility and validity of collecting some of the Adult Core Measures directly from EHRs. As part of this process, Brown has developed a Qualitative Plan to conduct interviews with clinicians and data managers at identified sites to assess challenges to EHR data entry and extraction as well as to help understand the reasons for potential discrepancies between claims analysis and the data extracted from the electronic health record and/or obtained from manual chart review. The outcome of this QIP and the ability to derive clinical quality measures from an EHR will help the Medicaid program produce quality of care measures that can be utilized to measure care being provided to Medicaid beneficiaries at a provider level of aggregation in addition to what is currently produced at an MCO and programmatic level.

Another opportunity afforded to Rhode Island is the submission of a proposal as part of the State Innovative Model Initiative (SIMS). A critical component of the proposal includes the establishment of a Rhode Island Health Care Quality Measurement, Reporting and Feedback system. This new reporting system would enable Rhode Island to obtain, analyze, benchmark, and produce outcomes on various health care quality measures directly submitted from providers and their various practice settings. This type of data reporting could help to inform quality improvement efforts, health care purchasing, and consumer choice. Rhode Island is currently awaiting its receipt of SIMS funding.

Opportunities exist with relation to Medicaid's current analytic infrastructure. The capacity offered via the Medicaid Adult Quality grant to focus efforts on improving the process of extracting and analyzing data for this grant has uncovered major limitations to Medicaid data systems. The MMIS has developed into a complex, and at times counterintuitive system that is not conducive to quality measurement activities. Some of the limitations include the following:

- Claims data being parsed out over four (4) separate databases, which do not all share the same format
- The tools available to access, extract, and analyze data are antiquated and need updating.

The Adult Quality Grant team is now in the process of compiling alternative avenues to address these concerns, with the ultimate goal of having a fully functioning claims-based quality data set and analytic tools capable of mining this big data for performance monitoring and improvement. Other identified areas of opportunity in relation to data collection and analytics exist with the receipt of Medicare data in a complete and timely encounter data set and data submitted for Meaningful Use that is currently not available to Medicaid. Both types of data-related issues pose a challenge for Medicaid to be able to conduct the type of analytical work necessary to embark on a robust and transparent quality measurement and improvement

strategy across the entire Medicaid program.

In conclusion, a Medicaid Quality Strategy can achieve the goals of timely access to necessary health care services, quality outcomes and cost-effectiveness. Fuller integration of service scope can better align incentives for MCOs and providers. This can more fully promote Payment Reform implementation and provide for financial sustainability of the Medicaid program. As enhanced models of care continue to emerge (e.g. patient centered medical homes; co-located medical and behavioral health services; new methods of reimbursement that encourage greater coordination of care and reward outcomes) these innovations will continue to be integrated into the current managed care delivery systems. In addition, the initiatives currently under-way such as the All Payer Claims Database and Adult Quality Grant enable the Rhode Island Medicaid program to accomplish its goals by:

- Increasing the capacity to analyze Medicaid data and identify trends based on utilization, cost, and population health
- Maximize the use of measure reporting, allowing the ability to report quality measures across delivery systems, and
- Use data to drive performance improvement.

Appendix 1: Crosswalk of National Committee for Quality Assurance (NCQA) & Regulatory Requirements

QUALITY/PERFORMANCE IMPROVEMENT AREA	STATE OVERSIGHT & MONITORING MECHANISM	FEDERAL REGULATION	NCQA STANDARD
5. Standards for Access to Care, Structure and Operations, and Quality Measurement and Improvement **5.a. Access Standards** 5.a.1 Availability of services 5.a.2 Assurances of adequate capacity and 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	§438.206 .	QI 3: Health Services Contracting • Element A: Practitioner Contracts QI 4: Availability of Practitioners • Element A: Cultural Needs and Preferences • Element B: Practitioners Providing Primary Care • Element C:Practitioners Providing Specialty Care QI 5: Accessibility of Services • Element A: Assessment Against Access Standards MED 1: Medicaid Benefits and Services • Element A: Direct Access to Women's Health Services • Element B: Second Opinions • Element C: Out-of-Network Services • Element D: Out-of-Network Cost to Member • Element E: Hours of Operation Parity RR 3: Subscriber Information
		§438.207	QI 4: Availability of Practitioners • Element B: Practitioners Providing Primary Care • Element C: Ensuring Availability of SCPs
			QI 4: Availability of Practitioners • Element B: Practitioners Providing Primary Care

5.a.3 Coordination and continuity of care 5.a.4 Coverage and authorization of services	• Provider network reporting • NCQA information • Contract compliance review • Complaint, grievance, and appeals reporting • NCQA information • EQRO activities • Special studies • Contract compliance review • Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Contract compliance review	§438.208	QI 5: Accessibility of Services • Element A: Assessment Against Access Standards Using valid methodology
		§438.210	UM 2: Clinical Criteria for UM Decisions • Element C: Consistency in Applying Criteria UM 4: Appropriate Professionals • Element A: Licensed Health Professionals • Element B: Use of Practitioners for UM Decisions • Element F - Affirmative Statement about Incentives UM 5: Timeliness of UM Decisions • Element A: Timeliness of Non-BH UM Decision Making • Element B: Notification of Non-BH Decisions: • Element C: Timeliness of BH UM Decision Making • Element D: Notification of BH Decisions UM 7: Denial Notices • Element A: Notification of Reviewer Availability • Element C: Reason for Non-BH Denial • Element F: Reason for BH Denial

5.b. Structure and Operation Standards 5.b.1 Provider selection 5.b.2 Enrollee information 5.b.3 Confidentiality 5.b.4 Enrollment and disenrollment	• Provider network data • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review • Performance incentive program • On-site reviews • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review	§438.214	CR 1: Credentialing Policies • Element A: Practitioner Credentialing Guidelines • Element B: Practitioner rights
		§438.218	UM 2: Clinical Criteria for UM Decisions • Element C: Consistency in Applying Criteria UM 4: Appropriate Professionals • Element A: Licensed Health Professionals • Element B: Use of Practitioners for UM Decisions • Element F - Affirmative Statement about Incentives UM 5: Timeliness of UM Decisions • Element A: Timeliness of Non-BH UM Decision Making • Element B: Notification of Non-BH Decisions: • Element C: Timeliness of BH UM Decision Making • Element D: Notification of BH Decisions UM 7: Denial Notices • Element A: Notification of Reviewer Availability • Element C: Reason for Non-BH Denial • Element F: Reason for BH Denial 438.204 • States can use NCQA's accreditation reports to monitor MCO compliance • HEDIS® Measures can be used to measure and evaluate plan performance • The annual review can incorporate information obtained from HEDIS® measures and accreditation standards
		§438.224	RR 5 Privacy and Confidentiality • Element A: Adopting Written Policies • Element C: Protection for PHI Sent to Plan

5.b.5 Grievance systems	• MMIS data • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review		Sponsors • Element D: Authorization • Element E: Communication of PHI Use and Disclosure
		§438.226	NCQA Standards are not applicable; please refer to the State Oversight and Monitoring Mechanism
	• NCQA information • Annual Member Satisfaction Survey • Complaint, grievance, and appeals, reporting • Special studies • Contract compliance review • Specific to §438.226, analysis by the Rhode Island EOHHS Member Dis-enrollment Request Review Team • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance	§438.228	RR 2: Policies for Complaints and Appeals • Element A: Policies and Procedures for Complaints • Element B (and C): Preservice (and Postservice) Appeals UM 2 Element C: Consistency in Applying Clinical Criteria UM 5: Timeliness of UM Decisions • Element B: Notification of Non-BH Decisions UM 8: Policies for Appeals • Element B: Preservice Appeals • Element C: Postservice Appeals • Element E: External Reviews in States With Laws UM 7: Denial Notices • Elements C and F: Reason for Non-Behavioral Health and Behavioral Health Denial • Elements D and G: Non-BH and Behavioral Health Notice of Appeals Rights/Process UM 9 Appropriate Handling of Appeals • Element A: Preservice and Postservice Appeals • Element D - Notification of Appeal Decision/Rights • Element F: Appeals Overturned by the IRO

5.b.6 Sub contractual relationships and delegation	review		RR 2B: Member notification
		§438.230	Delegation Standards: CR 12, RR 7, UM 15 and QI 12: Delegation of Credentialing, Rights and Responsibilities, Utilization Management and Quality Improvement • Element A: Written Delegation Agreement • Element D: Predelegation Evaluation • Element F: Reporting • Element G: Opportunities for Improvement
5.c. Quality Measurement and Improvement Standards 5.c.1 Practice guidelines 5.c.2 Quality assessment and performance improvement program 5.c.3 Health information systems	• NCQA information • Special studies • Contract compliance review • Performance incentive program • Encounter Data System • Complaint, grievance, and appeals reporting • NCQA information • Special studies • Contract compliance review • Encounter Data System • Risk-share reporting • NCQA information	§438.236	QI 9: Clinical Practice Guidelines • Element A: Adoption and Distribution of Guidelines
		§438.240	QI 1: Program Structure • Element A: Quality Improvement Program Structure HEDIS® Measures: HEDIS® clinical measures account for 32.86 out of 100 points for HP accreditation. CAHPS 4.0H Survey: CAHPS survey results account for 13.00 out of 100 points for HP accreditation
		§438.242	A plan's ability to report HEDIS® indicated that these required systems are in place HEDIS® Compliance Audit A copy of the plan's HEDIS® Data Submission Tool (DST) could be submitted to the state

	• EQRO activities • Special studies • Contract compliance review		

Appendix 2: CMS Quality Strategy Toolkit

Regulatory Reference	DESCRIPTION	Page Reference or Comment
Section I -- INTRODUCTION		
Managed Care Goals, Objectives & Overview *This section should provide a brief description of managed care in the State, as well as the goals/guiding principles and objectives of the managed care program.*		
	Include a brief history of the State's Medicaid and CHIP managed care programs.	This information can be found on pgs. 5-8 of the Comprehensive Quality Strategy
	Include an overview of the quality management structure that is in place at the State level. *For example, what does the leadership team look like, are there any quality task forces, collaboratives, etc.?*	A new Office of Policy and Innovation was recently established within the RI EOHHS. The Office was designed to centralize oversight of policy and development, health information technology initiatives (including lead on the All Payer Claims Database and EHR incentive program), data systems (including MMIS, UHIP – the new enrollment system,

		and the data warehouse), and analytics and evaluation across Rhode Island's 1115 Waiver. Please refer to pg. 53 in Rhode Island's proposed *Comprehensive Quality Strategy*.
	Include general information about the State's decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the State believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.	The State's goals for its Section 1115 Demonstration Waiver have been described on pgs. 5-10 in Rhode Island's proposed *Comprehensive Quality Strategy*.
	Include a description of the goals and objectives of the State's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the State's priorities and areas of concern for the population covered by the MCO/PIHP contracts. *For example, "the State will demonstrate a 10% improvement in childhood immunization rates over the next three years" or "through expansion of the primary care network, as evidenced by geographical reporting, the State will demonstrate a 5% improvement in enrollee access to primary care".*  Attachment M September 2010 Con	Please refer to Table 3-1, (pgs. 18-23), Table 4-1 (pg. 28), Table 5-1 (pgs. 30-31), Table 6-1 (pgs. 32-33), Table 7-1 (pgs. 37-39), & Table 8-1 (pgs. 42-43). Also, RI's current *Managed Care Services Contract,* which was approved by CMS in 2010, delineates performance goals in Attachment M (please refer to the

	 Attachment J Performance Goals R	embedded document). RI's current *Contract for Medicaid Managed Integrated Adult Care Services in the Rhody Health Options Program*, which was approved by CMS in 2013, lists performance goals in Attachment J (please refer to the document that has been embedded in the center column).
Development & Review of Quality Strategy *This section should describe how the State initially developed the quality strategy, subsequently reviews the strategy for effectiveness, and the timeline/process for revision.*		
	Include a description of the formal process used to develop the quality strategy.	This information can be found on pgs. 17-19 in Rhode Island's proposed *Comprehensive Quality Strategy*.
§438.202(b)	Include a description of how the State obtained the input of beneficiaries and other stakeholders in the development of the strategy.	This information can be found on pgs. 18-19 in Rhode Island's proposed *Comprehensive Quality Strategy*.

§438.202(b)	Include a description of how the State made (or plans to make) the strategy available for public comment before adopting it in final.	This information can be found on pg. 19 in Rhode Island's proposed *Comprehensive Quality Strategy*.
§438.202(d)	Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	Please refer to pg. 19 in Rhode Island's proposed *Comprehensive Quality Strategy* for the discussion about Rhode Island's periodic review of its Quality Strategy.
§438.202(d)	Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant changes", include the State's definition of "significant changes".	Please refer to pg. 19 in Rhode Island's proposed *Comprehensive Quality Strategy* for this content.
Section II -- ASSESSMENT		
Quality & Appropriateness Of Care		
§438.204(b)(1)	Address procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts and to individuals with special health care needs.	Please refer pgs. Island's proposed *Comprehensive Quality Strategy*. (This requirement does not apply to the State's PCCM (Connect Care Choice) or to the State's PAHP dental managed care program (RIte

		Smiles).)
§438.204(b)(1)	Include the State's definition of special health care needs.	The State's definition of special health care needs is included on pgs. 7 of the proposed *Comprehensive Quality Strategy*.
§438.204(b)(2)	Detail the methods or procedures the State uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. *States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.*	This information can be found on page 22 of the proposed *Comprehensive Quality Strategy*.
	Document any efforts or initiatives that the State or MCO/PIHP has engaged in to reduce disparities in health care.	Since 2011, the State has required its Medicaid MCOs to report preliminary findings for a subset of HEDIS® measures, which are included in the State's Performance Goal Program. Health Plans disaggregate their preliminary HEDIS® results for the core RIte Care population versus all populations, which would include either CSHCN or Rhody Health Partners members as well as the Core RIte Care

		cohort (depending on the measure). This information is analyzed for quality monitoring purposes by the RI EOHHS and also by the State's External Quality Review Organization (EQRO) in its annual EQR report. In 2013, the Rhode Island Executive Office of Health and Human Services (EOHHS) was one of twenty-six (26) States to be awarded a Medicaid Adult Quality grant from the Center for Medicare and Medicaid Services (CMS). A component of this grant opportunity is to focus on a subset of measures for health disparities reporting.
National Performance Measures *At this time, CMS has not identified any required performance measures.*		
§438.204(c)	Include a description of any national performance measures and levels identified and developed by CMS.	
	Indicate whether the State plans to require the collection of any CMS core performance measures for children and adults in Medicaid/CHIP. Many of these measures have already been in widespread use as part of the HEDIS® data	This information can be found on pgs. 22-

	set and have readily available national and regional benchmarks. *For a list of these measures, refer to http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-—-Performance-Measurement.html.* CMS Award to RI Medicaid 2012 for CH	34 and Appendix 6 Rhode Island's proposed *Comprehensive Quality Strategy*. Please note that RI received a commendation from CMS in 2012 for its reporting on the voluntary core measures for children enrolled in Medicaid and CHIP.
Monitoring and Compliance		
§438.204(b)(3)	Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). Some examples of mechanisms that may be used for monitoring include: • Member or provider surveys; • HEDIS results; • Report Cards or profiles; • Required MCO/PIHP reporting of performance measures; • Required MCO/PIHP reporting on performance improvement projects; • Grievance/Appeal logs, etc.	This information can be found on pgs. 23-30. (This requirement does not apply to the State's PCCM (Connect Care Choice) or to the State's PAHP dental managed care program (RIte Smiles).)
External Quality Review (EQR) *Instructions: This section must specify what entity will serve as the State's External Quality Review Organization and for what period of time.*		
§438.204(d)	Include a description of the State's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract.	This information can be found on pgs. 27-29
	Identify what, if any, optional EQR activities the State has contracted with its EQRO to perform.	Rhode Island's

	The five optional activities include: 1. Validation of encounter data reported by an MCO or PIHP; 2. Administration or validation of consumer or provider surveys of quality of care; 3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; 4. Conduct of PIPs in addition to those conducted by an MCO or PIHP and validated by an EQRO; and 5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.	contract with its EQRO includes language permitting the State to request that any optional EQR activities be conducted.
§438.360(b)(4)	Identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the standards are duplicative.	This information can be found on pgs. 27-29 in Rhode Island's proposed *Comprehensive Quality Strategy* and in Appendix 1 (*NCQA Crosswalk*).
Section III ---STATE STANDARDS		
Access Standards *This section should include a discussion of the standards that the State has established in the MCO/PIHP contracts for access to care. These standards should relate to the overall goals and objectives listed in the introduction. States may either reference the access to care provisions from the State's managed care contracts or provide a summary description of the contract provisions. If the State chooses the latter option, the description must be sufficiently detailed to offer a clear picture of the specific contract provisions.*		
§438.206 -Availability of Services		
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	Please refer to Section 2.08.01 (pgs. 47-49) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section

		2.09.01 (pgs. 46-48). Please refer to Section 2.09.01 (pgs. 36-38) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.206(b)(2)	Female enrollee direct access to a women's health specialist	Please refer to Section 2.09.06 (pg. 57) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.10.06 (pg. 57). Please refer to Section 2.10.06 (pg. 57) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	Please refer to Section 2.06.04 & 2.06.05 (pgs. 42-43) of the State's *Medicaid Managed Care Services*

		contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.6.2 & 2.6.3 (pgs. 41-42). Please refer to Section 2.06.02 & Section 2.06.03 (pgs. 31-32) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.206(b)(4)	Adequately and timely coverage of services not available in network	Please refer to Sections 2.08.01 (pgs. 47-48) and 2.09 (pgs. 55-57) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.09.01 (pgs. 46-48) & Section 2.10 (pgs. 55-58). Please refer to Section 2.09.01 (pgs. 36- 38) & Section 2.10 (pgs. 45-49) of the State's *Medicaid*

		Managed Integrated Adult Care Services (Rhody Health Options) contract.
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	Please refer to Section 2.08.01 (pgs. 47-49) of the State's *Medicaid Managed Care Services* contract *and in Attachment W: ACA Adult Expansion Population*, Section 2.09.01 (pgs. 46-48). Please refer to Section 2.09.01 (pgs. 36-38) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.206(b)(6)	Credential all providers as required by §438.214	Please refer to Section 2.12.04 (pg. 65) of the State's *Medicaid Managed Care Services* contract *& Attachment W: ACA Adult Expansion Population*, Section 2.13.4 (pgs. 66-68). Please refer to

		Section 2.13.04 (pgs. 57-58) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.206(c)(1)(i)	Providers meet State standards for timely access to care and services	Please refer to Section 2.08.01 (pgs. 47-49) and Section 2.09 (pgs. 55-57) of the State's *Medicaid Managed Care Services* contract *and in Attachment W: ACA Adult Expansion Population*, Section 2.09.01 (pgs. 46-48) & 2.10 (pgs. 55-58). Please refer to Section 2.09.01 (pgs. 36-38) & Section 2.10 (pgs. 45-49) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service	Please refer to Section 2.08.01 (pgs. 47-49) of the State's *Medicaid Managed Care Services* contract and in

		Attachment W: ACA Adult Expansion Population, Section 2.09.01 (pgs. 46-48). Please refer to Section 2.09.01 (pgs. 36-38) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.206(c)(1)(iii)	Services included in the contract available 24 hours a day, 7 days a week	Please refer to Section 2.09.01 (pg. 55) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.10.1 (pg. 55). Please refer to Section 2.10.01 (pg. 45) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.206(c)(1)(iv)-(vi)	Mechanisms to ensure compliance by providers	Please refer to Section 2.09.08 (pg. 57) of the State's

		Medicaid Managed Care Services contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.10.8 (pg. 57). Please refer to Section 2.10.08 (pg. 48) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.206(c)(2)	Culturally competent services to all enrollees	Please refer to Section 2.10.04 (pg. 59) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.11.4 (pg. 60). Please refer to Section 2.11.04 (pg. 51) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.

§ 438.207 - Assurances of Adequate Capacity and Services		
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	Please refer to Section 2.08.10 (pg. 53) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.9.9 (pg. 54). Please refer to Section 2.9.10 (pg. 44) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	Please refer to Section 2.08.01 (pgs. 47-49) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.09.01 (pgs. 46-48). Please refer to Section 2.09.01 (pgs. 36-38) of the State's *Medicaid Managed*

		Integrated Adult Care Services (Rhody Health Options) contract.
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	Please refer to Section 2.08.01 (pgs. 47-49) of the State's *Medicaid* Managed *Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.09.01 (pgs. 46-48). Please refer to Section 2.09.01 (pgs. 36-38) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§ 438.208 - Coordination and Continuity of Care		
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs	Please refer to Section 2.08.02.01 (pg. 49) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.9.2.1 (pg. 48).

		Please refer to Section 2.09.02.01 (pg. 38) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP	Please refer to Section 2.08.02.01 (p. 49) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.9.2.1 (pg. 48). Please refer to Section 2.09.02.01 (pg. 38) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.208(b)(3)	Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	Please refer to Section 2.08.02.01 (pg. 49) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion*

		Population, Section 2.9.2.1 (pg. 48). Please refer to Section 2.09.02.01 (pg. 38) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.208(b)(4)	Protect enrollee privacy when coordinating care	Please refer to Section 2.08.02.01 (pg. 49) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.9.2.1 (pg. 48). Please refer to Section 2.09.02.01 (pg. 38) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	Please refer to Sections 2.04.01.05 (pg. 15) and 2.05.02 (pgs. 20-21) of the State's *Medicaid*

		Managed Care Services contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.5.2 (pg. 25) & 2.10.9 (pgs. 57-58) Please refer to Section 2.05.02 (pg. 19) & Section 2.10.09 (pg. 48) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	Please refer to Section 2.09.07 (pg. 57) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.10.7 (pg. 57). Please refer to Section 2.10.07 (pg. 47) & Section 2.10.09 (pg. 48) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody*

		Health Options) contract.
§438.208(c)(3)	If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with State standards	Please refer to Section 2.06.02.04 (pg. 38) and Attachments Q & R of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.7 (pgs. 42-44) & Appendix G (pg. 154). Please refer to Section 2.07 (pg. 32-34) & Attachment L (pg. 211) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	Please refer to Section 2.09.09 (pg. 57) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.10.0 (pg.48)

		Please refer to Section 2.10.09 (pg. 48) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§ 438.210 - Coverage and Authorization of Services		
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	Please refer to Section 2.06 (pg. 32) of the State's *Medicaid Managed Care Services* contract and in Attachment A (pg. 144) & *Attachment W: ACA Adult Expansion Population*, Section 2.6 (pgs. 32-41) & Appendix A (pg. 126). Please refer to Section 2.06 (pgs. 29-31) and in Attachment A (pg. 150) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	Please refer to Section 2.06 (pg. 32)

		of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.6 (pgs. 32-41). Please refer to Section 2.06 (pgs. 29-31) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	Please refer to Section 2.12.03.07 (pg. 65) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.03.07 (pg.66). Please refer to Section 2.13.03.07 (pg. 57) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)*

		contract.
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	Please refer to Section 2.12.03.07 (pg. 65) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.03.07 (pg. 66). Please refer to Section 2.13.03.07 (pg. 57) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.210(a)(3)(iii)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	Please refer to Section 2.12.03.02 (pg. 63) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.02 (pgs. 63-64). Please refer to Section 2.13.03.02 (pgs. 54-55) of the

		State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.210(a)(4)	Specify what constitutes "medically necessary services"	Please refer to Section 1.30 (pg. 5) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 1.30 (pg. 15). Please refer to Section 1.35 (pg. 7) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	Please refer to Section 2.12.03.02 (pg. 63) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.02 (pgs. 63-64). Please refer to

		Section 2.13.03.02 (pgs. 54-55) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.210(b)(2)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	Please refer to Section 2.12.03.01 (pgs. 62-63) & Section 2.12.03.02 (pg. 63) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.1 (pg. 63) & Section 2.13.3.02 (pgs. 63-64). Please refer to Section 2.13.03.01 (pgs. 53-54) & Section 2.13.03.02 (pgs. 54-55) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	Please refer to Section 2.12.01 (pgs. 60-61) of the State's

		Medicaid Managed Care Services contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.1 (pg. 61). Please refer to Section 2.13.01 (pg. 52) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.210(c)	Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	Please refer to Section 2.12.03.02 (pg. 63) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.02 (pgs. 63-64). Please refer to Section 2.13.03.02 (pgs. 54-55) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health*

		Options) contract.
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	Please refer to Section 2.12.03.02 (pgs. 62-63) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.02 (pgs. 63-64). Please refer to Section 2.13.03.02 (pgs. 54-55) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.210(e)	Compensation does not provide incentives to deny, limit, or discontinue medically necessary services	Please refer to Section 2.12.03 (pg. 63) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.02 (pgs.63-64). Please refer to Section 2.13.03.02

		(pgs. 54-55) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
Structure and Operations Standards *This section should include a discussion of the standards that the State has established in the MCO/PIHP contracts for structure and operations. These standards should relate to the overall objectives listed in the introduction. States may either reference the structure and operations provisions from the State's contracts, or provide a summary description of such provisions. If the State chooses the latter option, the description must be sufficiently detailed to offer a clear picture of the specific contract provisions.*		
§ 438.214 – Provider Selection		
§438.214(a)	Written policies and procedures for selection and retention of providers	Please refer to Section 2.12.04 (pgs. 65-66) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.4 (pgs. 66-68). Please refer to Section 2.13.04 (pgs. 57-58) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.214(b)(1)	Uniform credentialing and re-credentialing policy that each MCO/PIHP must follow	Please refer to Section 2.12.04 (pgs. 65-66) of the State's *Medicaid Managed*

		Care Services contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.4 (pgs. 66-68). Please refer to Section 2.13.04 (pgs. 57-58) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.214(b)(2)	Documented processes for credentialing and re-credentialing that each MCO/PIHP must follow	Please refer to Section 2.12.04 (pgs. 65-66) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.4 (pgs. 66-68). Please refer to Section 2.13.04 (pgs. 57-58) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.

§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	Please refer to Section 2.12.04 (pgs. 65-66) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.4 (pgs. 66-68). Please refer to Section 2.13.04 (pgs. 57-58) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	Please refer to Section 2.12.04 (pgs. 65-66) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.4 (pgs. 66-68). Please refer to Section 2.13.04 (pgs. 57-58) of the State's *Medicaid Managed Integrated Adult Care*

		Services (Rhody Health Options) contract.
§438.214(e)	Comply with any additional requirements established by the State	Please refer to Section 2.12.03.05 (pg. 65) State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 3.13.3.5 (pg. 66). Please refer to Section 2.13.03.05 (pg. 56) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.218 – Enrollee Information		
§438.218	Incorporate requirements of §438.10	Please refer to Sections 1.14 (pg. 3), 1.37 (pg. 6), 2.04.05 (pg. 16), 2.05.01 (pg. 20), 2.05.06 (pg. 23) 2.05.10 (pg. 25), 2.05.10.03 (pg. 29) and 2.10.01 (pg. 58) of the State's *Medicaid Managed Care Services* contract.

		A*ttachment W: ACA Adult Expansion Population*, Sections 1.18 (pg. 13), 2.5.1 (pg. 25), 2.5.6 (pgs. 26-27), 2.5.10 (pg. 29), 2.5.10.3 (pg. 33) and 2.11.1 (pg. 58). Please refer to Section 1.19 (pg. 4), 1.34 (pg. 6), 1.56 (pg. 10), 2.04 (pgs. 17-19), 2.05.01 (pg. 19), 2.05.06 (pg. 21), 2.05.10 (pg. 23), 2.05.10.03 (pg. 27) and 2.11.01 (pg. 49) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.224 – Confidentiality		
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	Please refer to Section 2.12.03.04 (pg. 64) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section

		2.13.3.4 (pg. 66). Please refer to Section 2.13.03.04 (pg. 56) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.226 – Enrollment and Disenrollment		
§438.226	Each MCO/PIHP contract complies with the enrollment and disenrollment requirements and limitations set forth in §438.56	Please refer to Sections 2.04.10 (pg. 18), 2.05.02 (pgs. 20-21), 2.05.10.01 (pgs. 26-29), 2.05.12 (pgs. 30-31), 2.10.0 (pgs. 58-59), & 2.14.01 (pgs. 69-72) of the State's *Medicaid Managed Care Services* contract. *Attachment W: ACA Adult Expansion Population*, Sections 2.4.8 (pg. 24), 2.5.2 (pgs. 25-26), 2.5.10.1 (pgs. 29-33), 2.5.12.2 (pgs. 34-35), 2.11 (pgs. 58-60), & 2.15 (pgs. 71-76). Please refer to Sections 2.04.10 (pg.

		18), 2.05.02 (pg. 19), 2.05.10.01 (pgs. 23-27), 2.05.12.03 (pgs. 28-29), 2.11 (pgs. 49-51), & 2.15 (pgs. 61-66) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.228 – Grievance Systems		
§438.228(a)	Grievance systems meet the requirements of Part 438, subpart F	Please refer to Sections 1.17 (pg. 3), 2.05.10.01 (pgs. 26-29), Section 2.10.3 (pgs. 58-59), 2.13.03 (pg. 68), & 2.14.01 (pgs. 69-72) of the State's *Medicaid Managed Care Services* contract. *Attachment W: ACA Adult Expansion Population*, Sections 1.20 (pg. 13), 2.5.10.11 (pgs. 29-33), 2.11.3 (pgs. 59-60), 2.14.3 (pg. 69), & 2.15 (pgs. 71-76). Please refer to Sections 1.21 (pg. 4), 2.05.10.01 (pgs. 23-

		27), 2.11.03 (pgs. 49-51), 2.14.03 (pg. 60), & 2.15 (pgs. 61-66) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.228(b)	Random State reviews of notice of action delegation to ensure notification of enrollees in a timely manner	Please refer to the following Sections 2.05.08 (p. 25), 2.06.02.02 (p. 35-37), 2.08.14 (p. 54), 2.10.04 (p. 60), & 2.13.03 (p. 68), and Attachment M of the State's *Medicaid Managed Care Services* contract. *Attachment W: ACA Adult Expansion Population*, Sections 2.5.10.1 (pgs. 31-32), 2.11.3 (pg. 60), 2.14.3 (pg. 69) & 2.15.1 (pgs. 71-75). Please refer to Sections 2.05.08 (pg. 22), 2.06.04 (pg. 32), 2.09.13 (pgs. 44-45), 2.11.05 (pg. 51), & 2.14.03 (pg. 60) of the State's *Medicaid*

		Managed Integrated Adult Care Services (Rhody Health Options) contract. In addition to the NCQA audit process and State review, MCOs are required to submit quarterly Appeals & Grievance reports. A measure on the timely notification to enrollees is also included as a state specific measure in the Performance Goal Program (please refer to Attachment M) of the State's *Medicaid Managed Care Services* contract.
§438.228 – Subcontractual Relationships and Delegation		
§438.228(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	Please refer to Section 3.05.05 (pg. 95) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 3.5.5 (pgs. 99-100).

		Please refer to Section 3.05.05 (pgs. 88-89) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.228(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	Please refer to Section 3.05.05 (pg. 95) of the State's *Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 3.5.5 (pgs. 99-100). Please refer to Section 3.05.05 (pgs. 88-89) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.228(b)(2)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	Please refer to Section 3.05.05 (pg. 95) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion*

		Population, Section 3.5.5 (pgs. 99-100). Please refer to Section 3.05.05 (pgs. 88-89) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.228(b)(3)	Monitoring of subcontractor performance on an ongoing basis	Please refer to Section 3.05.05 (pg. 95) of the State's *Medicaid Managed Care Services* and in *Attachment W: ACA Adult Expansion Population*, Section 3.5.5 (pgs. 99-100). Please refer to Section 3.05.05 (pgs. 88-89) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.228(b)(4)	Corrective action for identified deficiencies or areas for improvement	Please refer to Section 3.05.05 (pg. 95) of the State's *Medicaid Managed Care Services* contract and in

		Attachment W: ACA Adult Expansion Population, Section 3.5.5 (pgs. 99-100). Please refer to Section 3.05.05 (pgs. 88-89) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
Measurement and Improvement Standards *This section should include a discussion of the standards that the State has established in the MCO/PIHP contracts for measurement and improvement. These standards should relate to the overall objectives listed in the introduction. States may either reference the measurement and improvement provisions from the State's contracts, or provide a summary description of such provisions. If the State chooses the latter option, the description must be sufficiently detailed to offer a clear picture of the specific contract provisions.*		
§ 438.236 – Practice Guidelines		
§438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	Please refer to Section 2.12.03.06 (pg. 65) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.6 (pg. 66). Please refer to Section 2.13.03.06 (pg. 56) of the State's *Medicaid Managed Integrated Adult Care*

		Services (Rhody Health Options) contract.
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees	Please refer to Section 2.12.03.06 (pg. 65) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.6 (pg. 66). Please refer to Section 2.13.03.06 (pg. 56) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§ 438.240 – Quality Assessment and Performance Improvement Program		
§438.240(a)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program	Please refer to Section 2.12.03.03 (pgs. 63-64) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.3 (pgs. 64-65). Please refer to

		Section 2.13.03.03 (pgs. 55-56) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.240(b)(1)	Each MCO and PIHP must conduct performance improvement projects *List out performance improvement projects in the quality strategy*	Please refer to Section 2.12.03.03 (pgs. 63-64) & 2.13.04 (pg. 68) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.3 (pgs. 64-65) & Section 2.14.4 (pg. 70). Please refer to Section 2.13.03.03 (pgs. 55-56) & Section 2.14.04 (pg. 60) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.240(b)(2)	Each MCO and PIHP must submit performance measurement data as specified by the State *List out performance measures in the quality strategy*	Please refer to Section 2.13.04 (pg. 68) of the State's *Medicaid Managed*

		Care Services contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.14.4 (pg. 70). Please refer to Section 2.14.04 (pg. 60) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.240(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	Please refer to Section 2.12.03.03 (pgs. 63-64) of the State's *Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.3 (pgs. 64-65). Please refer to Section 2.13.03.03 of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.240(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs	Please refer to Section 2.12.03.03

		(pgs. 63-64) of the State's *Medicaid Managed Care Services* contract and in *Attachment W: ACA Adult Expansion Population*, Section 2.13.3.3 (pgs. 64-65). Please refer to Section 2.13.03.03 (pgs. 55-56) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.240(e)	Annual review by the State of each quality assessment and performance improvement program *If the State requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.*	Please refer to Section 2.12.03.03 (pgs. 63-64) & Section 2.15.10 (pg. 79) of the State's *Medicaid Managed Care Services* contract and Section 2.13.3 (pgs. 64-65) *Attachment W: ACA Adult Expansion Population*. Please refer to Section 2.13.03.03 (pgs. 55-56) and Section 2.16.10 (pg. 72) of the State's

		Medicaid Managed Integrated Adult Care Services (Rhody Health Options) contract.
§ 438.242 - Health Information Systems		
§438.242(a)	Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data	Please refer to Section 2.13 (pg. 66) of the State's *Medicaid Managed Care Services* contract and in Section 2.14 (pg. 68) of *Attachment W: ACA Adult Expansion Population*. Please refer to Section 2.14 (pg. 58) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.242(b)(1)	Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees	Please refer to Section 2.13 (pg. 66) of the State's *Medicaid Managed Care Services* contract and in Section 2.14 (pg. 68) of *Attachment W: ACA Adult Expansion Population*.

		Please refer to Section 2.14 (pg. 58) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
§438.242(b)(2)	Each MCO and PIHP must ensure data received is accurate and complete	Please refer to Section 2.15.07 (pg. 78) of the State's *Medicaid Managed Care Services* contract and in Section 2.16.07 (pg. 81) of *Attachment W: ACA Adult Expansion Population*. Please refer to Section 2.16.07 (pg. 71) of the State's *Medicaid Managed Integrated Adult Care Services (Rhody Health Options)* contract.
Section IV –IMPROVEMENT/INTERVENTIONS		
	Describe, based on the results of assessment activities, how the State will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to: • Cross-State agency collaborative; • Pay-for-performance or value-Based purchasing initiatives; • Accreditation requirements;	Please refer to the following page citations in Rhode Island's proposed *Comprehensive*

	• Grants; • Disease management programs; • Changes in benefits for enrollees; • Provider network expansion, etc.	*Quality Strategy*: pgs. 19-46, 50-65 and Appendix 4. Quality improvement strategies and specific interventions are addressed through the State's annual Performance Goal Program and in the annual cycle of External Quality Review (EQR) reports. Please note that in addition to the Health Plan-specific EQR reports that RI's EQRO produces that the State also has the EQRO produce an annual Aggregate report, which is submitted to CMS.
	Describe how the State's planned interventions tie to each specific goal and objective of the quality strategy.  Attachment M September 2010 Con  Attachment J Performance Goals R  Measuring Quality and Access in RIte Ca	As noted previously, performance goals are outlined in Appendix M of the State's *Medicaid Managed Care Services* contract. Rhode Island's current *Contract for Medicaid Managed Integrated Adult Care*

		Services in the Rhody Health Options Program, which was approved by CMS in 2013, lists performance goals in Attachment J (please refer to the document that has been embedded in the center column). We have also provided a copy of a document that is produced annually and posted on the RI EOHHS Web-site, showing trended results from the Performance Goal Program.
Intermediate Sanctions		
§438.204(e)	For MCOs, detail how the States will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, subpart I. Specify the State's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	This information can be found on pg.30 Island's proposed *Comprehensive Quality Strategy*.
Health Information Technology		
§438.204(f)	Detail how the State's information system supports initial and ongoing operation and review of the State's quality strategy.	This information can be found on pg.46 Rhode Island's proposed *Comprehensive Quality Strategy*.

	Include any health information technology (HIT) initiatives that will support the objectives of the State's quality strategy.	Please refer to pgs. 50-53 in Rhode Island's proposed *Comprehensive Quality Strategy*.
Section V -- CONCLUSIONS AND OPPORTUNITIES		
	Identify any successes that the State considers to be best or promising practices.  Measuring Quality and Access in RIte Ca  CMS Award to RI Medicaid 2012 for CH	CMS may wish to review the appended document, which is updated annually and posted on the RI EOHHS Web-site. In addition, Rhode Island was commended in 2012 by CMS for its quality measures reporting in the State's annual CHIP report.
	Include a discussion of the ongoing challenges the State faces in improving the quality of care for beneficiaries.	Please refer to pg.65 in the *Comprehensive Quality Strategy* for discussion about efforts to harmonize quality measures and reduce duplication of effort. (As CMS noted on pg. 1 of the *Quality Strategy Toolkit for States*, there is no current Federal regulatory requirement that stipulates that this

		content must be addressed in a quality strategy.)
	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support State HIT/EHR development or enhancement, etc.	Please refer to pg. 50-53 and 64-65 in Rhode Island's proposed *Comprehensive Quality Strategy* for discussion about the establishment of the RI EOHHS' Office of Policy and Innovation. (As CMS noted on pg. 1 of the *Quality Strategy Toolkit for States*, there is no current Federal regulatory requirement that stipulates that this content must be addressed in a quality strategy.)
	Include recommendations that the State has for ongoing Medicaid and CHIP quality improvement activities in the State. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable.	Rhode Island is one of 26 States that has been awarded a CMS Adults in Medicaid Quality grant: *Measuring and Improving the Quality of Care in Medicaid*. The State's first Annual Report was submitted to CMS on

		January 31, 2014.
Section VI – EXPANSION POPULATIONS		
Managed Care Long Term Services and Supports *This section should be completed by States that have either incorporated the aged, blind, and disabled population into managed care or that have transitioned a State's 1915(c) program into an 1115 waiver.*		
	Describe the reasons for incorporating this population into managed care. Include a definition of this population and methods of identifying enrollees in this population.	The Rhode Island Executive Office of Health and Human Services recognized the need to improve the Medicaid program through the integration of services, and thereby ensure that care is delivered in the most appropriate setting based on a person's medical, behavioral and social service needs. An EOHHS goal is to provide the support and services that enable a person to maintain a high quality of life and live independently in the community.
	List any performance measures applicable to this population, as well as the reasons for collecting these performance measures.	This information can be found in pgs. 22-23, 39-46 and Appendix 4 Rhode Island's proposed *Comprehensive*

		Quality Strategy.
	List any performance improvement projects that are tailored to this population. This should include a description of the interventions associated with the performance improvement projects.	Please refer to pg. 38 for a discussion of quality/performance improvement projects.
	Address any assurances required in the State's Special Terms and Conditions (STCs), if applicable.	

QUALITY STRATEGY TOOLKIT FOR STATES

Per **§** 438.202(a), each State contracting with an MCO or PIHP must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The following provides a worksheet for States to use in the development and assessment of their quality strategy.

Instructions: Any time there is a citation under the "regulatory reference" column, this indicates that the item is a regulatory requirement and States must include the information in the quality strategy. If there is no citation under the "regulatory reference" column, this indicates that the item is not a regulatory requirement, but instead, is a component that CMS strongly recommends a State address in its quality strategy.

State Quality Strategy Reference Library

The following provides examples of potential sources of information that States may find helpful in developing the State quality strategy.

State Sources of Information	CMS/Federal Sources of Information

• State-specific Medicaid statutes and regulations, if applicable • Medicaid Management Information Systems (MMIS) data • External Quality Review Organization Technical Reports • State MCO Report Cards • Pay-for-Performance Program Results • Results from Performance Measurement or other Quality Reporting Efforts • Encounter Data • Results of NCQA accreditation reviews • Enrollee and Provider Survey results • Grievance and Appeals reporting • Focused Studies • Contract Compliance reviews • Regional or multi-State Health Information Technology Collaborative • Readiness Reviews • Telemedicine Initiatives • Cross-State Agency Collaborative	• Balanced Budget Act of 1997 and implementing regulations • External Quality Review Protocols, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html • CMS Core Set of Child and Adult Performance Measures, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-–-Performance-Measurement.h • Annual Report on the Quality of Care for Children in Medicaid and CHIP available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html • National Strategy for Quality Improvement in Health Care, available at: http://www.healthcare.gov/law/resources/reports/quality03212011a.hl • HHS Action Plan to Reduce Racial and Ethnic Disparities, available at: http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complet df

Appendix 3: Medicaid Measure Alignment Grid

MEASURE	Age of Population	Data Sources	Steward	All Medicaid	Managed Care Organizations[2] (MCOs)	Connect Care Choice (CCC)	Connect Care Choice Community Partners (4CP)	Chronic Care Sustainability Initiative[3] (CSI)	Electronic Health Records/ Meaningful Use[4] (MU)
CAHPS: Flu Shots for Adults Ages	Adult	Survey	NCQA/ HEDIS		✓				38
Adult Body Mass Index (BMI)	Adult	Admin or hybrid	NCQA/ HEDIS	✓	✓	✓	✓	✓	94
Breast Cancer Screening	Adult	Admin or hybrid	NCQA/ HEDIS	✓	✓				14
Cervical Cancer Screening	Adult	Admin or hybrid	NCQA/ HEDIS	✓	✓				43
Medical Assistance with Smoking and Tobacco Use	Adult	Survey	NCQA/ HEDIS	✓	✓	✓	✓	✓	17
Depression: Screening and Follow-	Adult	Admin	CMS	✓		✓	✓	✓	0
Plan All-Cause Readmission Rate	Adult	Admin	NCQA/ HEDIS	✓					
Diabetes Short-Term Complications Admission Rate	Adult	Admin	AHRQ (PQI 01)						0
Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	Adult	Admin	AHRQ (PQI05)						
Congestive Heart Failure (CHF) Admission Rate	Adult	Admin	AHRQ (PQI08)						
Adult Asthma Admission Rate	Adult	Admin	AHRQ(PQI15)						
Chlamydia Screening in Women Ages 21 to 24	Adult	Admin	NCQA/ HEDIS	✓	✓				23
Follow-Up After Hospitalization for Mental Illness	Adult	Admin	NCQA/ HEDIS	✓	✓				
Elective Delivery	Adult	Hybrid	TJC (PC-01)	✓					0
Antenatal Steroids	Adult	Hybrid	TJC (PC-03)						
Controlling High Blood Pressure	Adult	Hybrid	NCQA/ HEDIS	✓	✓	✓		✓	19
Diabetes Care: LDL-C Screening	Adult	Admin or hybrid	NCQA/ HEDIS	✓	✓		✓		0
Diabetes Care: Hemoglobin A1c Testing	Adult	Admin or hybrid	NCQA/ HEDIS	✓	✓		✓		0
Antidepressant Medication Management	Adult	Admin	NCQA/ HEDIS	✓	✓				0
Adherence to Antipsychotics for Individuals with Schizophrenia	Adult	Admin	CMS-QMHAG	✓					
Annual Monitoring for Patients on Persistent Medications	Adult	Admin	NCQA/ HEDIS	✓	✓				
CAHPS: Health Plan Survey 5.0H -	Adult	Survey	AHRQ, NCQA/ HEDIS		✓	✓	✓		
Care Transition - Transition Record Transmitted to Health Care	Adult	Hybrid	AMA-PCPI	✓					

Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment	Adult	Admin or hybrid	NCQA/ HEDIS	✓	✓				0
Postpartum Care Rate	Adult	Hybrid	NCQA/ HEDIS	✓	✓				
Hypertension BP Measurement: % of patient visits for patients age 18 and older with a diagnosis of hypertension who have been seen for at least 2 office visits in the last 12 months, with blood pressure recorded	Adult	EHR	NQF 0013						94
Tobacco Assessment: % of patients age 18 and older who were queried one or more times about tobacco use during the	Adult	EHR	Based on NQF 0028a			✓		✓	94
DM A1c Poor Control: % diabetic patients (Type 1 or 2) age 18-75 with poorly controlled disease (A1c > 9.0%)	Adult	EHR	Based on NQF 0059			✓		✓	65
Childhood Immunization Status	Child		NQF 0038 PQRS 240						55
Wgt. Assessment & Couns. for Nutrition & Physical Activity for Children/Adol. (WCC): Body Mass Index (BMI) Percentile, Counseling for Nutrition, Counseling for Physical Activity	Child		NQF 0024 PQRS 239 HEDIS		✓				44
Preventive Care and Screening: Influenza Immunization for Patients over 50	All		NQF 0041						
DM LDL Good Control: % of diabetic patients (Type 1 or 2) age 18-75 with well controlled LDL cholesterol (having LDL-C value less than 100 mg/dL)	Adult	EHR	Based on NQF 0064						30
DM LDL Pts w/ Result		EHR							30
DM BP Control (<140/90): % of diabetic patients (Type 1 or 2) age 18-75 who had a blood pressure value < 140/90)	Adult	EHR	Based on NQF 0061			✓		✓	26
Appropriate Testing for Children with Pharyngitis	Child		NQF 0002, PQRS 66, CHIPRA 15, HEDIS		✓				13
Use of Appropriate Medications for Asthma			NQF 0036 PQRS 311						8

DM A1c Good Control (<8): The percentage of diabetic patients (Type 1 or 2) age 18-75 with controlled disease (having an A1c value less than 8.0%)	Adult	EHR	Based on NQF 0575 HEDIS		✓	✓		✓	5
Pneumonia Vaccination Status for Older Adults	Elderly		NQF 0043 PQRS 111		✓				5
Use of Imaging Studies for Low Back Pain			NQF 0052 PQRS 312 HEDIS		✓				4
Asthma Assessment	All		NQF 0001						3
Colorectal Cancer Screening			NQF 0034 PQRS 113 HEDIS		✓				3
Diabetes: Urine Protein Screening			NQF 0062 PQRS 119						2
Diabetes: Foot Exam			NQF 0056 PQRS 126						1
Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic			NQF 0068 PQRS 204						1
ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range			TBD						0
ADHD: Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	Child		NQF 0108 HEDIS		✓				0
AMI-10 Statin Prescribed at Discharge			CMS/ NQF 0639						0
AMI-2-Aspirin Prescribed at Discharge for AMI			CMS/ NQF 0142						0
AMI-7a Fibrinolytic Therapy Received Within 30 minutes of			CMS/ NQF 0164						0
AMI-8a Primary PCI Received Within 90 Minutes of Hospital Arrival			CMS/ NQF 0163						0
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Child		NQF 0069 PQRS 65						0
Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use			NQF 0110						0
Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer	Adult		NQF 0387 PQRS 71						0
Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery			NQF 0565 PQRS 191						0

Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical			NQF 0564 PQRS 192						0
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Child		NQF 1365						0
Children who have dental decay or cavities	Child		Maternal/CHB HR/Services Admi/TBD						0
Closing the referral loop: receipt of specialist report (A)			TBD						0
Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients			NQF 0385 PQRS 72						0
Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left			NQF 0070 PQRS 7						0
Dementia: Cognitive Assessment			TBD						0
Depression Remission at Twelve Months			NQF 0710						0
Depression Utilization of the PHQ-9 Tool			NQF 0712						0
Depression: Maternal screening			NQF 1401						0
Depressive Disorder, Major (MDD): Suicide Risk Assessment			NQF 0104 PQRS 107						0
Diabetes: Eye Exam			NQF 0055 PQRS 117						0
Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care			NQF 0089 PQRS 19						0
Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of			NQF 0088 PQRS 18						0
Documentation of Current Medications in the Medical Record			NQF 0419 PQRS 130						0
ED-1 Emergency Department Throughput—Median time from ED arrival to ED departure for admitted			Joint Comm NQF 0495						0
ED-2 Emergency Department Throughput—admitted patients—Admit decision time to ED departure			Joint Comm NQF 0497						0

ED-3 Median time from ED arrival to ED departure for discharged ED patients			NQF 0496						0
EHDI-1a Hearing screening before hospital discharge			CDC/ NQF 1354						0
Exclusive Breast Milk Feeding			Joint Comm/NQF 0480						0
Falls: Screening for Future Fall Risk	Elderly	EHR	NQF 0101 PQRS 318			✓	✓	✓	0
Functional status assessment for complex chronic conditions			TBD						0
Functional status assessment for hip replacement			TBD						0
Functional status assessment for knee replacement			TBD						0
Healthy Term Newborn	Child		CA Maternal Quality Care Col./ NQF 0716						0
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)			NQF 0081 PQRS 5						0
Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)			NQF 0083 PQRS 6						0
Hemoglobin A1c Test for Pediatric Patients	Child		NQF 0060						0
HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis			NQF 0405 PQRS 160						0
HIV/AIDS: RNA control for Patients with HIV			TBD						0
Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver			NQF 0338						0
Hypertension: Improvement in blood pressure			TBD						0
Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control			NQF 0075 PQRS 197						0

Oncology: Medical and Radiation—Pain Intensity Quantified			NQF 0384 PQRS 143						0
PN-6 Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patients			CMS/ NQF 0147						0
Pregnant women that had HBsAg testing	Adult		NQF 0608						0
Preventive Care and Screening: Cholesterol—Fasting Low-Density Lipoprotein (LDL-C) Test Performed			TBD						0
Preventive Care and Screening: Risk Stratified Cholesterol—Fasting Low-Density Lipoprotein (LDL-C)			TBD						0
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented			TBD PQRS 235						0
Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists			TBD						0
Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation			NQF 0086						0
Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients			NQF 0389 PQRS 102						0
SCIP-INF-1 Prophylactic Antibiotic Received within 1 Hour Prior to Surgical Incision			Joint Comm/NQF 0572						0
SCIP-INF-2 Prophylactic Antibiotic Selection for Surgical Patients			Joint Comm/ NQF 0528						0
SCIP-INF-9 Urinary catheter removed on Postoperative Day 1 (POD1) or Postoperative Day 2 (POD2) with day			Joint Comm NQF 0453						0
Stroke-10 Ischemic or hemorrhagic stroke—Assessed for Rehabilitation			NQF 0441						0
Stroke-2 Ischemic stroke—Discharged on anti- thrombotic therapy.			NQF 0435						0
Stroke-3 Ischemic stroke—Anticoagulation Therapy for Atrial Fibrillation/Flutter			NQF 0436						0
Stroke-4 Ischemic stroke—Thrombolytic Therapy			NQF 0437						0
Stroke-5 Ischemic stroke—Antithrombotic therapy by end of hospital day two			NQF 0438						0

Stroke-6 Ischemic stroke—Discharged on Statin Medication			NQF 0439						0
Stroke-8 Ischemic or hemorrhagic stroke—Stroke education			NQF 0440						0
Use of High-Risk Medications in the Elderly	Elderly		NQF 0022 PQRS 238						0
Venous Thromboembolism (VTE)-1 VTE prophylaxis			NQF 0371						0
VTE-2 Intensive Care Unit (ICU) VTE prophylaxis			NQF 0372						0
VTE-3 VTE Patients with Anticoagulation Overlap Therapy			NQF 0373						0
VTE-4 VTE Patients Receiving Unfractionated Heparin (UFH) with Dosages/Platelet Count Monitoring by Protocol (or Nomogram)			NQF 0374						0
VTE-5 VTE discharge instructions			NQF 0375						0
VTE-6 Incidence of potentially preventable VTE			NQF 0376						0
Adol. Imm. Before 13th Birthday (IMA)	Child		HEDIS		✓				
Adolescent Well-Care Visits (AWC)	Child		HEDIS		✓				
Adults' Access to Preventive Health Services (AAP): Enrollees 20 - 44 Years Old, Enrollees 45 - 64 Yrs Old	Adult		HEDIS		✓				
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis: % visits w/ diagnosis of acute bronchitis for	Adult	EHR	Based on HEDIS 2013						
Asthma Pharmacologic Therapy	All		NQF 0047						
Childhood Immunization Status (CIS): Childhood Immunization Status - Combo 3, Childhood Immunization Status - Combo 10	Child		HEDIS		✓				
Children & Adolescents' Access to Primary Care Practitioners (CAP): Children 12 - 24 Months, Children 25	Child		HEDIS		✓				

Chlamydia Screening - Sexual History: % of women 18–24 years of age on the date of visit who were	Adult	EHR	Based on HEDIS 2010		✓	✓		✓	
Depression Screen: % of patients age 18 and older screened one or more times for depression during the measurement period, using a standardized screening tool (PHQ-2 or other validated tool)	Adult	EHR	Based on VHA measure			✓		✓	
DM BP Good Control: % of diabetic patients (Type 1 or 2) age 18-75 with well controlled blood pressure (BP value < 130/80)		EHR	NQF 0061						
DM BP Pts w/Measurement		EHR							
DM HbA1c Pts w/ Result		EHR				✓		✓	
Frequency of On-going Prenatal Care >/= 81% of Expected Visits (FPC)	Adult		HEDIS		✓				
Lead Screening in Children (LSC)	Child		HEDIS		✓				
Pharmacotherapy Management of COPD Exacerbation (PCE): Dispensed a systemic corticosteroid within 14 days of the event (PCE), Dispensed a bronchodilator within 30 days of the event (PCE)			HEDIS		✓				
Prenatal & Postpartum Care (PPC) - Prenatal Care	Adult		HEDIS		✓				
Use of Appropriate Medications for People with Asthma (ASM): Enrollees 5 - 11 Yrs Old, Enrollees 12 - 50 Yrs Old, Enrollees 12 - 18 Yrs Old, Enrollees 19 - 50 Yrs Old, Enrollees 51 - 64 Yrs Old, Total Rate	All		HEDIS		✓				

Well-Child Visits in the 3rd - 6th Yrs. of Life (W34)	Child		HEDIS		✓				
Well-Child Visits in the First 15 Mos. of Life - 6 or More (W15)	Child		HEDIS		✓				

Footnotes:

1. This alignment grid is a working document and only includes measures that have been endorsed by nationally recognized organizations such as National Quality Forum and NCQA and the programs that use such measures. PACE, MFP and HIV do not use these types of measures.
2. MCOs report CAHPS: Flu Shots for Adults Ages 18-64. Adult Quality Grant reports CAHPS: Flu Shots for Adults Ages 50-64.
3. CSI is Rhode Island's all-payer patient centered medical home program.
4. Numbers listed in the MU column refer to the number of providers who have attested to that particular measure. A "0" means it is a MU measure but that no providers have attested to that particular measure.

Appendix 4: MCO Reporting Calendar Template

Month	Name of Report	Reporting Period To Be Covered	Due Date	Report Recipient**
First Quarter of CY 2014				
Jan-14	CAITS: NHPRI	Oct. 2013	1/3/2014	
	CAITS: UHC	Oct. 2013	1/3/2014	
	High Cost (>$25,000) Case Report: NHPRI	Dec. 2013	1/17/2014	
	High Cost (>$25,000) Case Report: UHC	Dec. 2013	1/17/2014	
	Communities of Care: NHPRI (Dashboard)	Dec. 2013	1/24/2014	
	Communities of Care: UHC (Dashboard)	Dec. 2013	1/24/2014	
	Risk Share: Core RIte Care	7/12-11/13 + 7/13-11/13	1/17/2014	
	Risk Share: CSHCN	7/12-11/13 + 7/13-11/13	1/17/2014	
	Risk Share: Substitute Care	7/12-11/13 + 7/13-11/13	1/17/2014	
	Risk Share: RIte Smiles	5/12-11/13 +5/13-11/13	1/17/2014	
	Risk Share: RHP	7/12-11/13 + 7/13-11/13	1/17/2014	
	Risk Share: Medicaid Expansion		1/17/2014	
	Stop Loss: Core RIte Care	CY12FINAL + CY13	1/31/2014	
	Subrogation Report	Dec. 2013	1/31/2014	
Feb-14	Call Center Response Times: RIte Smiles	10/01/13 – 12/31/13	2/7/2014	
	Care Mngt.: CSHCN	10/01/13 – 12/31/13	2/7/2014	
	Care Mngt.: Substitute Care	10/01/13 – 12/31/13	2/7/2014	
	Care Mngt.: RHP	10/01/13 – 12/31/13	2/7/2014	
	Care Mngt: Medicaid Expansion	10/01/13 – 12/31/13	2/7/2014	
	CAITS: NHPRI	Nov. 2013	2/7/2014	
	CAITS: UHC	Nov. 2013	2/7/2014	
	Fraud Investigations: UHC Dental*	10/01/13 – 12/31/13	2/7/2014	
	Fraud Investigations: NHPRI *	10/01/13 – 12/31/13	2/7/2014	
	Fraud Investigations: UHC *	10/01/13 – 12/31/13	2/7/2014	
	Grievance & Appeals: RIte Smiles	10/01/13 – 12/31/13	2/7/2014	
	Grievance & Appeals: Core RIte Care	10/01/13 – 12/31/13	2/7/2014	
	Grievance & Appeals: CSHCN	10/01/13 – 12/31/13	2/7/2014	
	Grievance & Appeals: Substitute Care	10/01/13 – 12/31/13	2/7/2014	
	Grievance & Appeals: RHP	10/01/13 – 12/31/13	2/7/2014	
	Grievance & Appeals: Medicaid Expansion	10/01/13 – 12/31/13	2/7/2014	
	Inf. Complaints: RIte Smiles	10/01/13 – 12/31/13	2/7/2014	
	Inf. Complaints: Core RIte Care	10/01/13 – 12/31/13	2/7/2014	
	Inf. Complaints: CSHCN	10/01/13 – 12/31/13	2/7/2014	
	Inf. Complaints: Substitute Care	10/01/13 – 12/31/13	2/7/2014	
	Inf. Complaints: RHP	10/01/13 – 12/31/13	2/7/2014	
	Inf. Complaints: Medicaid Expansion	10/01/13 – 12/31/13	2/7/2014	
	Compliance Dashboard	10/01/13 – 12/31/13	2/7/2014	
	Provider Network: RIte Smiles	10/01/13 – 12/31/13	2/7/2014	
	Generics First Report: NHPRI	10/01/13 – 12/31/13	2/7/2014	
	Generics First Report: UHC	10/01/13 – 12/31/13	2/7/2014	
	Pharmacy Home Report: NHPRI	10/01/13 – 12/31/13	2/7/2014	
	Pharmacy Home Report: UHC	10/01/13 – 12/31/13	2/7/2014	
	Pain Management Program Dashboard: NHPRI	5/1/13-1/30/14	2/21/2014	
	Pain Management Program Dashboard: UHC	5/1/13-1/30/14	2/21/2014	
	PCMH/CSI Monthly Provider Payment	10/01/13 – 12/31/13	2/14/2014	
	High Cost (>$25,000) Case Report: NHPRI	Jan.2014	2/14/2014	
	High Cost (>$25,000) Case Report: UHC	Jan. 2014	2/14/2014	
	Communities of Care: NHPRI ("Deep-dive")	Jan. 2014	2/28/2014	
	Communities of Care: UHC ("Deep-dive")	Jan. 2014	2/28/2014	
	Risk Share: Core RIte Care	7/12-12/13 + 7/13-12/13	2/14/2014	
	Risk Share: CSHCN	7/12-12/13 + 7/13-12/13	2/14/2014	
	Risk Share: Substitute Care	7/12-12/13 + 7/13-12/13	2/14/2014	
	Risk Share: RIte Smiles	5/12-12/13 +5/13-12/13	2/14/2014	
	Risk Share: RHP	7/12-12/13 + 7/13-12/13	2/14/2014	
	Risk Share: Medicaid Expansion		2/14/2014	
	Subrogation Report	Jan. 2013	2/28/2014	
Mar-14	CAITS: NHPRI	Dec. 2013	3/7/2014	
	CAITS: UHC	Dec. 2013	3/7/2014	
	NAIC Annual filing: NHPRI	2013	3/7/2014	
	NAIC Annual Filing: UHC	2013	3/7/2014	
	NAIC Filing: UHC Dental	2013	3/7/2014	
	High Cost (>$25,000) Case Report: NHPRI	Feb. 2014	3/14/2014	
	High Cost (>$25,000) Case Report: UHC	Feb. 2014	3/14/2014	
	Communities of Care: NHPRI (Dashboard)	Feb. 2014	3/28/2014	
	Communities of Care: UHC (Dashboard)	Feb. 2014	3/28/2014	
	Risk Share: Core RIte Care	7/12-1/14 + 7/13-1/14	3/14/2014	

	Risk Share: CSHCN	7/12-1/14 + 7/13-1/14	3/14/2014	
	Risk Share: Substitute Care	7/12-1/14 + 7/13-1/14	3/14/2014	
	Risk Share: RIte Smiles	5/12-1/14 + 5/13-1/14	3/14/2014	
	Risk Share: RHP	7/12-1/14 + 7/13-1/14	3/14/2014	
	Risk Share: Medicaid Expansion	1/14	3/14/2014	
	Subrogation Report	Feb. 2014	3/28/2014	

Month	Name of Report	Reporting Period To Be Covered	Due Date	Report Recipient**
Second Quarter of CY 2014				
Apr-14	CAITS: NHPRI	Jan. 2014	4/4/2014	
	CAITS: UHC	Jan. 2014	4/4/2014	
	High Cost (>$25,000) Case Report: NHPRI	March. 2014	4/18/2014	
	High Cost (>$25,000) Case Report: UHC	March. 2014	4/18/2014	
	Communities of Care: NHPRI (Dashboard)	March. 2014	4/25/2014	
	Communities of Care: UHC (Dashboard)	March. 2014	4/25/2014	
	Risk Share: Core RIte Care	7/12-2/14 + 7/13-2/14	4/18/2014	
	Risk Share: CSHCN	7/12-2/14 + 7/13-2/14	4/18/2014	
	Risk Share: Substitute Care	7/12-2/14 + 7/13-2/14	4/18/2014	
	Risk Share: RIte Smiles	5/12-2/14 + 5/13-2/14	4/18/2014	
	Risk Share: RHP	7/12-2/14 + 7/13-2/14	4/18/2014	
	Risk Share: Medicaid Expansion	1/14 - 2/14	4/18/2014	
	Stop Loss: Core RIte Care	CY13 + CY14	4/30/2014	
	Subrogation Report	Mar.2014	4/30/2014	
May-14	Call Center Response Times: RIte Smiles	01/01/14 – 03/31/14	5/2/2014	
	Annual Report: NHPRI	2013	5/2/2014	
	Annual Report: UHC	2013	5/2/2014	
	Audited Finan. Statements w. Notes: NHPRI	2013	5/2/2014	
	Audited Finan. Statements w. Notes: UHC	2013	5/2/2014	
	Audited Finan. Statements w. Notes: UHC Dental	2013	5/2/2014	
	Care Mngt.: CSHCN	1/1/2014-3/31/2014	5/2/2014	
	Care Mngt.: Substitute Care	1/1/2014-3/31/2014	5/2/2014	
	Care Mngt.: RHP	1/1/2014-3/31/2014	5/2/2014	
	Care Mngt.: Medicaid Expansion	1/1/2014-3/31/2014	5/2/2014	
	CAITS: NHPRI	Feb. 2014	5/2/2014	
	CAITS: UHC	Feb. 2014	5/2/2014	
	Fraud Investigations: UHC Dental*	1/1/2014-3/31/2014	5/2/2014	
	Fraud Investigations: NHPRI *	1/1/2014-3/31/2014	5/2/2014	
	Fraud Investigations: UHC *	1/1/2014-3/31/2014	5/2/2014	
	Grievance & Appeals: RIte Smiles	1/1/2014-3/31/2014	5/2/2014	
	Grievance & Appeals: Core RIte Care	1/1/2014-3/31/2014	5/2/2014	
	Grievance & Appeals: CSHCN	1/1/2014-3/31/2014	5/2/2014	
	Grievance & Appeals: Substitute Care	1/1/2014-3/31/2014	5/2/2014	
	Grievance & Appeals: RHP	1/1/2014-3/31/2014	5/2/2014	
	Grievance & Appeals: Medicaid Expansion	1/1/2014-3/31/2014	5/2/2014	
	Inf. Complaints: RIte Smiles	1/1/2014-3/31/2014	5/2/2014	
	Inf. Complaints: Core RIte Care	1/1/2014-3/31/2014	5/2/2014	
	Inf. Complaints: CSHCN	1/1/2014-3/31/2014	5/2/2014	
	Inf. Complaints: Substitute Care	1/1/2014-3/31/2014	5/2/2014	
	Inf. Complaints: RHP	1/1/2014-3/31/2014	5/2/2014	
	Inf. Complaints: Medicaid Expansion	1/1/2014-3/31/2014	5/2/2014	
	Compliance Dashboard	1/1/2014-3/31/2014	5/2/2014	
	Provider Network: RIte Smiles	1/1/2014-3/31/2014	5/2/2014	
	Generics First Report: NHPRI	1/1/2014-3/31/2014	5/2/2014	
	Generics First Report: UHC	1/1/2014-3/31/2014	5/2/2014	
	Pharmacy Home: NHPRI	1/1/2014-3/31/2014	5/2/2014	
	Pharmacy Home: UHC	1/1/2014-3/31/2014	5/2/2014	
	Pain Management Program Dashboard: NHPRI	5/1/13-3/31/14	5/30/2014	
	Pain Management Program Dashboard: UHC	5/1/13-3/31/14	5/30/2014	
	PCMH/CSI Monthly Provider Payment	1/1/2014 - 3/31/2014	5/16/2014	
	High Cost (>$25,000) Case Report: NHPRI	April. 2014	5/16/2014	
	High Cost (>$25,000) Case Report: UHC	April. 2014	5/16/2014	
	Communities of Care: NHPRI ("Deep-dive")	April. 2014	5/30/2014	
	Communities of Care: UHC ("Deep-dive")	April. 2014	5/30/2014	
	Risk Share: Core RIte Care	7/12-3/14 + 7/13-3/14	5/16/2014	
	Risk Share: CSHCN	7/12-3/14 + 7/13-3/14	5/16/2014	
	Risk Share: Substitute Care	7/12-3/14 + 7/13-3/14	5/16/2014	
	Risk Share: RIte Smiles	5/12-3/14 + 5/13-3/14	5/16/2014	
	Risk Share: RHP	7/12-3/14 + 7/13-3/14	5/16/2014	
	Risk Share: Medicaid Expansion	1/14 - 3/14	5/16/2014	
	Subrogation Report	Apr.2014	5/30/2014	
Jun-14	CAITS: NHPRI	March.2014	6/6/2014	
	CAITS: UHC	March.2014	6/6/2014	
	High Cost (>$25,000) Case Report: NHPRI	May.2014	6/13/2014	
	High Cost (>$25,000) Case Report: UHC	May.2014	6/13/2014	
	Communities of Care: NHPRI (Dashboard)	May.2014	6/27/2014	
	Communities of Care: UHC (Dashboard)	May.2014	6/27/2014	
	Risk Share: Core RIte Care	7/12-4/14 + 7/13-4/14	6/13/2014	
	Risk Share: CSHCN	7/12-4/14 + 7/13-4/14	6/13/2014	
	Risk Share: Substitute Care	7/12-4/14 + 7/13-4/14	6/13/2014	

	Risk Share: RIte Smiles	5/12-4/14 FINAL + 5/13-4/14	6/13/2014	
	Risk Share: RHP	7/12-4/14 + 7/13-4/14	6/13/2014	
	Risk Share: Medicaid Expansion	1/14 - 4/14	6/13/2014	
	Subrogation Report	May.2014	6/27/2014	

Month	Name of Report	Reporting Period To Be Covered	Due Date	Report Recipient**
Third Quarter of CY 2014				
Jul-13	CAITS: NHPRI	April. 2014	7/3/2014	
	CAITS: UHC	April. 2014	7/3/2014	
	High Cost (>$25,000) Case Report: NHPRI	June.2014	7/18/2014	
	High Cost (>$25,000) Case Report: UHC	June.2014	7/18/2014	
	Communities of Care: NHPRI (Dashboard)	June.2014	7/25/2014	
	Communities of Care: UHC (Dashboard)	June.2014	7/25/2014	
	Communities of Care Incentive Payments: NHPRI	11/1/2013-6/30/2014	7/18/2014	
	Communities of Care Incentive Payments: UHC	11/1/2013-6/30/2014	7/18/2014	
	Risk Share: Core RIte Care	7/12-5/14 + 7/13-5/14	7/18/2014	
	Risk Share: CSHCN	7/12-5/14 + 7/13-5/14	7/18/2014	
	Risk Share: Substitute Care	7/12-5/14 + 7/13-5/14	7/18/2014	
	Risk Share: RIte Smiles	5/13-5/14	7/18/2014	
	Risk Share: RHP	7/12-5/14 + 7/13-5/14	7/18/2014	
	Risk Share: Medicaid Expansion	1/14 - 5/14	7/18/2014	
	Stop Loss: Core RIte Care	CY13 + CY14	7/31/2014	
	Subrogation Report	June.2014	7/31/2014	
Aug-14	Call Center Response Times: RIte Smiles	04/01/14 – 06/30/14	8/1/2014	
	Care Mngt.: CSHCN	04/01/14 – 06/30/14	8/1/2014	
	Care Mngt.: Substitute Care	04/01/14 – 06/30/14	8/1/2014	
	Care Mngt.: RHP	04/01/14 – 06/30/14	8/1/2014	
	Care Mngt.: Medicaid Expansion	04/01/14 – 06/30/14	8/1/2014	
	CAITS: NHPRI	May.2014	8/1/2014	
	CAITS: UHC	May.2014	8/1/2014	
	Fraud Investigations: NHPRI *	04/01/14 – 06/30/14	8/1/2014	
	Fraud Investigations: UHC *	04/01/14 – 06/30/14	8/1/2014	
	Fraud Investigations: UHC Dental*	04/01/14 – 06/30/14	8/1/2014	
	Grievance & Appeals: CSHCN	04/01/14 – 06/30/14	8/1/2014	
	Grievance & Appeals: Substitute Care	04/01/14 – 06/30/14	8/1/2014	
	Grievance & Appeals: RHP	04/01/14 – 06/30/14	8/1/2014	
	Grievance & Appeals: Core RIte Care	04/01/14 – 06/30/14	8/1/2014	
	Grievance & Appeals: Medicaid Expansion	04/01/14 – 06/30/14	8/1/2014	
	Inf. Complaints: RIte Smiles	04/01/14 – 06/30/14	8/1/2014	
	Inf. Complaints: Core RIte Care	04/01/14 – 06/30/14	8/1/2014	
	Inf. Complaints: CSHCN	04/01/14 – 06/30/14	8/1/2014	
	Inf. Complaints: Substitute Care	04/01/14 – 06/30/14	8/1/2014	
	Inf. Complaints: RHP	04/01/14 – 06/30/14	8/1/2014	
	Inf. Complaints: Medicaid Expansion	04/01/14 – 06/30/14	8/1/2014	
	Compliance Dashboard	04/01/14 – 06/30/14	8/1/2014	
	Provider Network: RIte Smiles	04/01/14 – 06/30/14	8/1/2014	
	Generics First Report: NHPRI	04/01/14 – 06/30/14	8/1/2014	
	Generics First Report: UHC	04/01/14 – 06/30/14	8/1/2014	
	Pharmacy Home: NHPRI	04/01/14 – 06/30/14	8/1/2014	
	Pharmacy Home: UHC	04/01/14 – 06/30/14	8/1/2014	
	Pain Management Program Dashboard: NHPRI	5/1/13-6/30/14	8/29/2014	
	Pain Management Program Dashboard: UHC	5/1/13-6/30/14	8/29/2014	
	PCMH/CSI Monthly Provider Payment	04/01/14 – 06/30/14	8/1/2014	
	High Cost (>$25,000) Case Report: NHPRI	July. 2014	8/15/2014	
	High Cost (>$25,000) Case Report: UHC	July. 2014	8/15/2014	
	Communities of Care: NHPRI ("Deep-dive")	July. 2014	8/29/2014	
	Communities of Care: UHC ("Deep-dive")	July. 2014	8/29/2014	
	Risk Share: Core RIte Care	7/12-6/14FINAL + 7/13-6/14	8/15/2014	
	Risk Share: CSHCN	7/12-6/14FINAL + 7/13-6/14	8/15/2014	
	Risk Share: Substitute Care	7/12-6/14FINAL + 7/13-6/14	8/15/2014	
	Risk Share: RIte Smiles	5/13-6/14	8/15/2014	
	Risk Share: RHP	7/12-6/14FINAL + 7/13-6/14	8/15/2014	
	Risk Share: Medicaid Expansion	1/14 - 6/14	8/15/2014	
	Subrogation Report	Jul.2014	8/29/2014	
Sept. 2014	CAITS: NHPRI	Jun-14	9/5/2014	
	CAITS: UHC	Jun-14	9/5/2014	
	High Cost (>$25,000) Case Report: NHPRI	Aug-14	9/19/2014	
	High Cost (>$25,000) Case Report: UHC	Aug-14	9/19/2014	
	Communities of Care: NHPRI	Aug-14	9/26/2014	
	Communities of Care: UHC	Aug-14	9/26/2014	
	Risk Share: Core RIte Care	7/13-07/14 + 7/14	9/19/2014	
	Risk Share: CSHCN	7/13-07/14 + 7/14	9/19/2014	
	Risk Share: Substitute Care	7/13-07/14 + 7/14	9/19/2014	
	Risk Share: RIte Smiles	5/13-6/14 + 7/14	9/19/2014	
	Risk Share: RHP	7/13-07/14 + 7/14	9/19/2014	
	Risk Share: Medicaid Expansion	1/14 - 7/14	9/19/2014	
	Annual Report: RIte Smiles	Aug.2014	9/26/2014	
	Subrogation Report	Aug.2014	9/26/2014	

Month	Name of Report	Reporting Period To Be Covered	Due Date	Report Recipient**
Fourth Quarter of CY 2014				
Oct-14	CAITS: NHPRI	July.2014	10/3/2014	
	CAITS: UHC	July.2014	10/3/2014	
	High Cost (>$25,000) Case Report: NHPRI	Sept. 2014	10/17/2014	
	High Cost (>$25,000) Case Report: UHC	Sept. 2014	10/17/2014	
	Communities of Care: NHPRI (Dashboard)	Sept. 2014	10/24/2014	
	Communities of Care: UHC (Dashboard)	Sept. 2014	10/24/2014	
	Communities of Care Incentive Payments: NHPRI	7/1/2014-9/30/2014	10/24/2014	
	Communities of Care Incentive Payments: UHC	7/1/2014-9/30/2014	10/17/2014	
	Risk Share: Core RIte Care	7/13-08/14,+7/14-8/14	10/17/2014	
	Risk Share: CSHCN	7/13-08/14,+7/14-8/14	10/17/2014	
	Risk Share: Substitute Care	7/13-08/14,+7/14-8/14	10/17/2014	
	Risk Share: RIte Smiles	5/13-6/14 + 7/14-8/14	10/17/2014	
	Risk Share: RHP	7/13-08/14 + 7/14-8/14	10/17/2014	
	Risk Share: Medicaid Expansion	1/14 - 8/14	10/17/2014	
	Stop Loss: Core RIte Care	CY13 + CY14	10/31/2014	
	Subrogation Report	Sept.2014	10/31/2014	
Nov. 2014	Call Center Response Times: RIte Smiles	07/01/14 – 09/30/14	11/7/2014	
	Care Mngt.: CSHCN	07/01/14 – 09/30/14	11/7/2014	
	Care Mngt.: Substitute Care	07/01/14 – 09/30/14	11/7/2014	
	Care Mngt.: RHP	07/01/14 – 09/30/14	11/7/2014	
	Care Mngt.: Medicaid Expansion	07/01/14 – 09/30/14	11/7/2014	
	CAITS: NHPRI	Aug.2014	11/7/2014	
	CAITS: UHC	Aug.2014	11/7/2014	
	Fraud Investigations: UHC Dental*	07/01/14 – 09/30/14	11/7/2014	
	Fraud Investigations: NHPRI *	07/01/14 – 09/30/14	11/7/2014	
	Fraud Investigations: UHC *	07/01/14 – 09/30/14	11/7/2014	
	Grievance & Appeals: RIte Smiles	07/01/14 – 09/30/14	11/7/2014	
	Grievance & Appeals: Core RIte Care	07/01/14 – 09/30/14	11/7/2014	
	Grievance & Appeals: CSHCN	07/01/14 – 09/30/14	11/7/2014	
	Grievance & Appeals: Substitute Care	07/01/14 – 09/30/14	11/7/2014	
	Grievance & Appeals: RHP	07/01/14 – 09/30/14	11/7/2014	
	Grievance & Appeals: Medicaid Expansion	07/01/14 – 09/30/14	11/7/2014	
	Inf. Complaints: RIte Smiles	07/01/14 – 09/30/14	11/7/2014	
	Inf. Complaints: Core RIte Care	07/01/14 – 09/30/14	11/7/2014	
	Inf. Complaints: CSHCN	07/01/14 – 09/30/14	11/7/2014	
	Inf. Complaints: Substitute Care	07/01/14 – 09/30/14	11/7/2014	
	Inf. Complaints: RHP	07/01/14 – 09/30/14	11/7/2014	
	Inf. Complaints: Medicaid Expansion	07/01/14 – 09/30/14	11/7/2014	
	Compliance Dashboard	07/01/14 – 09/30/14	11/7/2014	
	Provider Network: RIte Smiles	07/01/14 – 09/30/14	11/7/2014	
	Generics First Report: NHPRI	07/01/14 – 09/30/14	11/7/2014	
	Generics First Report: UHC	07/01/14 – 09/30/14	11/7/2014	
	Pharmacy Home: NHPRI	07/01/14 – 09/30/14	11/7/2014	
	Pharmacy Home: UHC	07/01/14 – 09/30/14	11/7/2014	
	Pain Management Program Dashboard: NHPRI	5/1/13-9/30/14	11/28/2014	
	Pain Management Program Dashboard: UHC	5/1/13-9/30/14	11/28/2014	
	PCMH/CSI Monthly Provider Payment	07/01/14 – 09/30/14	11/14/2014	
	High Cost (>$25,000) Case Report: NHPRI	Oct. 2014	11/14/2014	
	High Cost (>$25,000) Case Report: UHC	Oct. 2014	11/14/2014	
	Communities of Care: NHPRI ("Deep-dive")	Oct. 2014	11/28/2014	
	Communities of Care: UHC ("Deep-dive")	Oct. 2014	11/28/2014	
	Risk Share: Core RIte Care	7/13-9/14 + 7/14-9/14	11/14/2014	
	Risk Share: CSHCN	7/13-9/14 + 7/14-9/14	11/14/2014	
	Risk Share: Substitute Care	7/13-9/14 + 7/14-9/14	11/14/2014	
	Risk Share: RIte Smiles	5/13-6/14 + 7/14-9/14	11/14/2014	
	Risk Share: RHP	7/13-9/14 + 7/14-9/14	11/14/2014	
	Risk Share: Medicaid Expansion	1/14 - 9/14	11/14/2014	
	Subrogation Report	Oct. 2014	11/28/2014	
Dec. 2014	CAITS: NHPRI	Sept.2014	12/12/2014	
	CAITS: UHC	Sept.2014	12/12/2014	
	High Cost (>$25,000) Case Report: NHPRI	Nov. 2014	12/12/2014	
	High Cost (>$25,000) Case Report: UHC	Nov. 2014	12/12/2014	
	Communities of Care: NHPRI	Nov. 2014	12/19/2014	

Communities of Care: UHC	Nov. 2014	12/19/2014	
Risk Share: Core RIte Care	7/13-10/14 + 7/14-10/14	12/12/2014	
Risk Share: CSHCN	7/13-10/14 + 7/14-10/14	12/12/2014	
Risk Share: Substitute Care	7/13-10/14 + 7/14-10/14	12/12/2014	
Risk Share: RHP	7/13-10/14 + 7/14-10/14	12/12/2014	
Risk Share: Medicaid Expansion	1/14 - 10/14	12/12/2014	
Risk Share: RIte Smiles	5/13-10/14 + 7/14-10/14	12/12/2014	
Subrogation Report	Nov.2014	12/19/2014	

Appendix 5: Quality Improvement Activity Form Template

Section V: Chart or Graph (Optional)
Attach a chart or graph for any activity having more than two measurement periods that shows the relationship between the timing of the intervention (cause) and the result of the remeasurements (effect). Present one graph for each measure unless the measures are closely correlated, such as average speed of answer and call abandonment rate. Control charts are not required, but are helpful in demonstrating the stability of the measure over time or after the implementation**.**

Section III: Analysis Cycle Complete this section for EACH analysis cycle presented.
A. Time Period and Measures That Analysis Covers.
B. Analysis and Identification of Opportunities for Improvement. Describe the analysis and include the points listed below.
B.1 For the quantitative analysis: ***B.2 For the qualitative analysis:*** • Opportunities identified through the analysis • Impact of interventions • Next steps

Section IV: Interventions Table

Interventions Taken for Improvement as a Result of Analysis. List chronologically the interventions that have had the most impact on improving the measure. Describe only the interventions and provide quantitative details whenever possible (e.g., "hired 4 UM nurses" as opposed to "hired UM nurses"). Do not include intervention planning activities.

Date Implemented (MM / YY)	Check if Ongoing	Interventions	Barriers That Interventions Address

Activity Name:

Section I: Activity Selection and Methodology

A. Rationale. Use objective information (data) to explain your rationale for why this activity is important to members or practitioners *and* why there is an opportunity for improvement.

B. Quantifiable Measures. List and define *all* quantifiable measures used in this activity. Include a goal or benchmark for each measure. If a goal was established,
list it. If you list a benchmark, state the source. Add sections for additional quantifiable measures as needed.

Quantifiable Measure #1:	
Numerator:	
Denominator:	
First measurement period dates:	

Baseline Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #2:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
Quantifiable Measure #3:	
Numerator:	
Denominator:	
First measurement period dates:	
Benchmark:	
Source of benchmark:	
Baseline goal:	
C. Baseline Methodology.	
C.1 Data Sources.	

[ ] Medical/treatment records
[ ] Administrative data:
[ ] Claims/encounter data [ ] Complaints [ ] Appeals [ ] Telephone service data [ ] Appointment/access data
[ ] Hybrid (medical/treatment records and administrative)
[ ] Pharmacy data
[ ] Survey data (attach the survey tool and the complete survey protocol)
[ ] Other (list and describe):

_The Plan also uses a local access database to track all pregnant members as part of our Healthy First Steps Program. Although this database was not used as an administrative database from NCQA perspective, it was used by local Plan team members to identify and outreach to pregnant members. In addition, we used this database to track number of members who participated in our Diaper Reward
Program._____

_____

QUALITY IMPROVEMENT FORM
NCQA Quality Improvement Activity Form

C.2 Data Collection Methodology. Check all that apply and enter the measure number from Section B next to the appropriate methodology.	
If medical/treatment records, check below: [ ] Medical/treatment record abstraction If survey, check all that apply: [ ] Personal interview [ ] Mail [ ] Phone with CATI script [ ] Phone with IVR [ ] Internet	If administrative, check all that apply: [ ] Programmed pull from claims/encounter files of all eligible members [ ] Programmed pull from claims/encounter files of a sample of members [ ] Complaint/appeal data by reason codes [ ] Pharmacy data [ ] Delegated entity data [ ] Vendor file [ ] Automated response time file from call center [ ] Appointment/access data

[ ] Incentive provided [ ] Other (list and describe): _____ _____	[ ] Other (list and describe): _____ _____

C.3 Sampling. If sampling was used, provide the following information.

Measure	**Sample Size**	**Population**	**Method for Determining Size** *(describe)*	**Sampling Method** *(describe)*

C.4 Data Collection Cycle.	**Data Analysis Cycle.**
[ ] Once a year [ ] Twice a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Once a week [ ] Once a day [ ] Continuous [ ] Other (list and describe): _Annual HEDIS data collection in Spring, and interim measure in Summer preceding close of the HEDIS 2008 year (Summer 2007)	[ ] Once a year [ ] Once a season [ ] Once a quarter [ ] Once a month [ ] Continuous [ ] Other (list and describe): _____ ___ _____ ___

C.5 Other Pertinent Methodological Features. Complete only if needed.

D. Changes to Baseline Methodology. Describe any changes in methodology from measurement to measurement.

Include, as appropriate:

- Measure and time period covered
- Type of change
- Rationale for change
- Changes in sampling methodology, including changes in sample size, method for determining size, and sampling method
- Any introduction of bias that could affect the results

Section II: Data/Results Table Complete for each quantifiable measure; add additional sections as needed.							
#1 Quantifiable Measure:							
Time Period Measurement Covers	**Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Comparison Benchmark**	**Comparison Goal**	**Statistical Test and Significance***
	Baseline:						
#2 Quantifiable Measure:							
Time Period Measurement Covers	**Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Comparison Benchmark**	**Comparison Goal**	**Statistical Test and Significance***
	Baseline:						
#3 Quantifiable Measure:							
Time Period Measurement Covers	**Measurement**	**Numerator**	**Denominator**	**Rate or Results**	**Comparison Benchmark**	**Comparison Goal**	**Statistical Test and Significance***
	Baseline:						

***** If used, specify the test, p value, and specific measurements (e.g., baseline to remeasurement #1, remeasurement #1 to remeasurement #2, etc., or baseline to final remeasurement) included in the calculations. NCQA does not require statistical testing

Appendix 6: Medicaid Child and Adult Core Measure Set

[19]Medicaid 2014 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP				
	NQF #	**Measure Steward**	**Measure Name**	**Rhode Island Medicaid Program Source of Data**
Population Health	1959	NCQA	Human Papillomavirus (HPV) Vaccine for Female Adolescents	MCO
	0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents: Body Mass Index for Children/Adolescents*[20]	MCO
Clinical Care	N/A	NCQA	Adolescent Well Care Visit*	MCO
	N/A	NCQA	Children and Adolescent Access to Primary Care Practitioner's*	MCO
	0033	NCQA	Chlamydia Screening in Women*	MCO
	0038	NCQA	Childhood Immunization Status*	MCO
	0471	CMQCC	Cesarean Rate for Nulliparous Singleton Vertex	
	1448	OHSU	Developmental Screening in the First Three Years of Life	
	1391	NCQA	Frequency of Ongoing Prenatal Care*	MCO
	1407	NCQA	Immunization Status for Adolescents*	MCO

[20] The measures marked with an asterisk (*) identify those measures that are also included in Rhode Island Performance Goal Program.

	1382	CDC	Live Births Weighing Less than 2,500 grams	Medicaid Birth File
	1799	NCQA	Medication Management for People with Asthma	MCO
	N/A	CMS	Percentage of Eligibles that Received Preventive Dental Services	CMS 416
	N/A	CMS	Percentage of Eligibles that Received Dental Treatment Services	CMS 416
	1517	NCQA	Timeliness of Prenatal Care*	MCO
	1392	NCQA	Well-Child Visits in the First 15 months of Life*	MCO
	1516	NCQA	Well-Child Visits in the 3rd, 4th, 5th, and 6th years of Life*	MCO
Care Coordination	0108	NCQA	Follow-Up Care for Children Prescribed ADHD Medication*	MCO
	0576	NCQA	Follow-Up After Hospitalization for Mental Illness*	MCO
Safety	0139	CDC	Pediatric Central-line Associated Bloodstream Infections (NICU and PICU)	
Efficiency & Cost Reduction	N/A	NCQA	Ambulatory Care-Emergency Department Visits*	MCO
Person & Caregiver Centered Experience	N/A	NCQA	Consumer Assessment of Healthcare Providers and Systems® CAHPS 5.0	MCO
	N/A	AMA-PCPI	Behavioral Health Risk Assessment (for Pregnant Women)	

Medicaid 2014 Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid				
	NQF #	**Measure Steward**	**Measure Name**	**Rhode Island Medicaid Program Source of Data**
Prevention & Health Promotion	0039	NCQA	Flu Vaccination for Adults (FVA) Ages 50-64 *(Collected as part of HEDIS CAHPS Supplemental Survey)*	NCQA introduced this measure for the Medicaid product line in 2014. Because it is a first-year measure, NCQA will not publically report *FVA* results for the Medicaid product line in HEDIS 2014. Rhode Island does not currently require the State's two MCOs to collect this particular CAHPS® Supplemental Measure.
	N/A	NCQA	Adult Body Mass Index Assessment*¥[21][22]	MCO Connect Care Choice Community Partners
	0031	NCQA	Breast Cancer Screening¥	MCO
	0032	NCQA	Cervical Cancer Screening*¥	MCO
	0027	NCQA	Medical Assistance with Smoking and Tobacco Use Cessation*¥	MCO Connect Care Choice Connect Care Choice Community Partners
	0418	CMS	Screening for Clinical Depression and Follow-up Plan¥	MCO (Rhody Health Options) Connect Care Choice Community Partners
	N/A	NCQA	Plan All-Cause Readmission Rate¥	

[21] The measures marked with a (¥) are those measures quality measures that have been prioritized by the State for analysis across Medicaid delivery systems for the purposes of the Medicaid Adult Quality grant.

[22] The measures marked with an asterisk (*) identify those measures that are also included in Rhode Island Performance Goal Program.

	0272	AHRQ	PQI 01: Diabetes, Short-term Complications Admission Rate	This measure is a population-focused Prevention Quality Indicator which is reported for Rhode Island according to type of health insurance coverage (Medicare, Medicaid, Private, & Uninsured)[23]
	0275	AHRQ	PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate	This measure is a population-focused Prevention Quality Indicator which is reported for Rhode Island according to type of health insurance coverage (Medicare, Medicaid, Private, & Uninsured)
	0277	AHRQ	PQI 08: Congestive Heart Failure Admission Rate	This measure is a population-focused Prevention Quality Indicator which is reported for Rhode Island according to type of health insurance coverage (Medicare, Medicaid, Private, & Uninsured)
	0283	AHRQ	PQI 15: Adult Asthma Admission Rate	This measure is a population-focused Prevention Quality Indicator which is reported for Rhode Island according to type of health insurance coverage (Medicare, Medicaid, Private, & Uninsured)
	0033	NCQA	Chlamydia Screening in Women age 21-24*¥	MCO
Management of Acute Conditions	0576	NCQA	Follow-up After Hospitalization for Mental Illness*¥	MCO
	0469	HCA,TJC	PC-01: Elective Delivery¥	
	0476	Prov/CWISH/NPIC/QAS/TJC	PC-03: Antenatal Steroids	
Management of Chronic Conditions	2082	HRSA	HIV Viral Load Suppression	
	0018	NCQA	Controlling High Blood Pressure*¥	MCO
	0063	NCQA	Comprehensive Diabetes Care: LDL-C Screening¥	MCO

[23] The Prevent Quality Indicators have historically been produced for Medicare by an external contract. In 2013, the director of the organization retired and subsequently the contract was not renewed. The State is currently in the process of pursuing its option and hopes to continue to produce these measures moving forward

	0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c Testing*¥	MCO Connect Care Choice Connect Care Choice Community Partners
	0105	NCQA	Antidepressant Medication Management*¥	MCO Connect Care Choice Connect Care Choice Community Partners RI Medicaid Adult Quality Grant QIP
	N/A	NCQA	Adherence to Antipsychotics for Individuals with Schizophrenia¥	MCO
	0021	NCQA	Annual Monitoring for Patients on Persistent Medications*¥	MCO
Family Experiences of Care	0007	AHRQ & NCQA	CAHPS® Health Plan Survey v 5.0 - Adult Questionnaire	MCO Connect Care Choice Community Partners
Care Coordination	0648	AMA-PCPI	Care Transition - Transition Record Transmitted to Health care Professional	RI Medicaid Adult Quality Grant QIP
Availability	0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment¥	MCO
	1391	NCQA	Postpartum Care Rate*¥	MCO