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

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April 2005

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STRATEGY FOR ASSESSING AND IMPROVING THE QUALITY OF MANAGED CARE SERVICES OFFERED UNDER RITE CARE

This document describes the State of Rhode Island's strategy for quality assessment and performance improvement for its managed health care programs for low-income populations. First, a brief history of the programs is presented to provide an appropriate context for quality assessment and performance improvement. Second, an overview of Federal requirements for quality improvement and performance assessment is delineated. Third, the components of the State's strategy are described. Finally, the process the State used to obtain the input of recipients and other stakeholders in the development of the strategy and to make the strategy available for public comment.

CHAPTER 1

HISTORY OF RITE CARE AND RITE SHARE

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

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

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

- Family Independence Program (FIP)[1] families
- Pregnant women up to 250 percent of the Federal poverty level (FPL)
- Children up to age 6 in households with incomes up to 250 percent of the FPL who are uninsured

RIte Care has been expanded six times, with Federal approval, as follows:

- Effective March 1, 1996, to expand to children up to age 8 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective May 1, 1997, to expand to children up to age 18 in households with incomes up to 250 percent of the FPL who are uninsured
- Effective November 1, 1998, to expand to families with children under age 18 including parents and relative caretakers with incomes up to 185 of the FPL (expansion under Section 1931 of the Social Security Act)
- Effective July 1, 1999, to expand to children up to age 19 in households with incomes up to 250 percent of the FPL

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

- Effective December 1, 2000, to transition children in temporary foster care placements from fee-for-service Medicaid to RIte Care on a voluntary basis

- Effective January 29, 2003, to enroll the following groups of *children with special health care needs* in RIte Care Health Plans on a mandatory basis:

  - Blind/disabled children (eligible for Supplemental Security Income, or SSI) up to age 21

  - Children eligible under Section 1902(e)(3) of the Social Security Act ("Katie Beckett" children) up to age 18

  - Children up to age 21 receiving subsidized adoption assistance

With respect to the latter groups, the State does not plan to enroll into RIte Care Health Plans children who live in institutional long-term care facilities or children who currently participate in the Department of Mental Health, Retardation and Hospitals (MHRH) *Mental Retardation, Developmental Disabilities* waiver program. The State does plan, however, to offer voluntary enrollment in RIte Care-participating Health Plans to SSI-eligible adults whose children are enrolled in RIte Care.[2]

The May 1997 and July 1, 1999 expansions, because they were implemented after March 15, 1997, qualified as eligible Medicaid expansions under Title XXI (State Child Health Insurance Program, or SCHIP) of the Social Security Act. By a Section 1115 waiver approval, effective January 18, 2001, Section 1931 parents and relative caretakers from 100 to 185 percent and pregnant women between 185 and 250 percent of the FPL were covered under Title XXI. It should be noted that the State received approval on January 5, 1999 to expand SCHIP coverage to children under age 19 in households with income up to 300 percent of the FPL. The State has not yet implemented that approved waiver amendment and has no immediate plans to do so due to budgetary constraints.

Effective April 17, 2003, a separate child health insurance program was approved under a SCHIP State Plan Amendment (SPA) for SCHIP coverage for unborn children from conception to birth with family income up to 250 percent of the FPL. This allows the State to provide comprehensive coverage for pregnant women who are aliens who would not be otherwise eligible for Federal financial participation (FFP).

In addition to these covered populations, the RIte Care Health Plans must make coverage available to certain State-funded or "buy-in" groups who pay 100 percent of the applicable premium; the first group's premiums are supplemented by State-only funds:

- Pregnant women who are uninsured whose household income is between 250 and 350 percent of the FPL

[2] The State believes that if parents and children are covered by the same health care delivery system, it will improve access to needed health care for both parent and child, and will ultimately improve health outcomes.

- Children who are uninsured whose household income is in excess of 250 percent of the FPL

- Licensed family child care providers and their children under age 18

Health Reform Rhode Island 2000 was signed into law on July 1, 2000. The legislation included the following components, each of which advances the larger goal of ensuring that all Rhode Islanders have access to affordable health care:

- **Part 1 –** Directing the Rhode Island Department of Human Services (DHS) to stabilize the RIte Care program by targeting resources to those most in need of coverage – low-wage families without access to affordable coverage, through:

  - Authorizing DHS to establish eligibility requirements for RIte Care to deter substitution (i.e., a waiting period for new applicants who were enrolled in employer-sponsored insurance (ESI) within six months prior to application)

  - Establishing cost-sharing requirements for certain RIte Care-eligible populations to promote both responsible utilization of health care services and development of additional disincentives for substitution

  - Requiring mandatory participation in RIte Share of eligible individuals and families who have access to ESI. RIte Share is the premium assistance program created by the statute to support employees in purchasing or retaining ESI. (This has been implemented under a separate Section 1906 Medicaid State Plan Amendment.)

- **Part 2 –** Reforming the health insurance marketplace to conform with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, stabilize premiums in the small group market by compressing rate bands, and guarantee issue of a basic health plan

- **Part 3 –** Establishing new financial reserve requirements for health insurance, consistent with the recommendations of the National Association of Insurance Commissioners (NAIC)

The passage of Part 1 of the Health Reform Rhode Island 2000 represented a significant and important consensus among the Governor and leaders in the General Assembly – RIte Care must be consistent with its original mission to provide coverage to the truly uninsured and migration from ESI to RIte Care should be deterred. The Governor and General Assembly were also clear that if the RIte Care caseload and cost growth are not controlled by Part 1 of the statute, a State roll-back of eligibility expansions currently in place for working families, particularly the Section 1931 expansion implemented in 1998 for parents and relative caretakers whose incomes are above TANF levels, will be considered.

The Section 1115 SCHIP demonstration waiver noted above enables Rhode Island to receive an enhanced Federal Medical Assistance Percentage (FMAP)[3] for those parents and relative caretakers and pregnant women up to the State's SCHIP allotment.

RIte Share was implemented in February 2001 by signing up "participating employers" on a voluntary basis. Even though active marketing occurred, participation of employers was limited. RIte Share is a premium assistance program that helps families obtain or maintain health insurance coverage through their employer (or spouse's employer). RIte Share pays for all or part of the employee's share of the family premium and also pays for co-payments, deductibles, and Medicaid-covered services not covered by the employer's health plan. In January 2002, DHS began paying participating employees' premium share amounts directly to the employees without employers having to sign up and participate in RIte Share. At the same time, enrollment in RIte Share became mandatory for Medicaid-eligible individuals whose employers offered an approved health plan.

RIte Share has some characteristics that set it apart from other States' employer-subsidy programs. Rhode Island instituted unique features to streamline the administration of the program and maximize enrollment, including qualifying almost all health insurance plans offered in the current Rhode Island market as eligible for participation in the program, providing Medicaid benefits and co-payments not covered in an enrollee's ESI coverage once he or she is enrolled in RIte Share, and using an aggregate cost-effectiveness test (employer-based rather than family-specific). Rhode Island also initiated a Business Advisory Committee and has an active consumer advisory group that provides feedback on key elements of the program.

In addition, since January 1, 2002, all families in RIte Care or RIte Share have been required to pay a portion of the cost of the premiums for their health insurance coverage if their income is above 150 percent of the FPL.

The initial period for the Section 1115 Medicaid waiver for RIte Care was August 1, 1994 to July 31, 1999. On September 17, 1998, the State was notified that its request to extend the waiver period through July 31, 2002 had been granted. On July 29, 2002, the State was notified that its request to extend the waiver period through July 31, 2005 had been granted. The Section 1115 SCHIP waiver period is September 1, 2001 through January 17, 2006.

[3] For Federal Fiscal Year 2005, the FMAP for Rhode Island for SCHIP is 68.77 percent compared to an FMAP for Rhode Island for Medicaid of 55.38 percent.

CHAPTER 2

OVERVIEW OF FEDERAL QUALITY ASSESMENT AND PERFORMANCE IMPROVEMENT REQUIREMENTS

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

- Medicaid Managed Care Final Regulations
- Medicaid External Quality Review Final Regulations
- Waivers and Special Terms and Conditions
- SCHIP Quality Requirements

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

2.1 Medicaid Managed Care Final Regulations

Except for those Federal legal requirements specifically waived in the *approval letter* for the demonstrations, the State must meet all other applicable, Federal legal requirements. Salient requirements include those contained in the June 14, 2002 *Final Rule* implementing the managed care provisions of the Balanced Budget Act of 1997 (BBA)[4]. States had until June 16, 2003 "to bring all aspects of their managed care programs (that is, contracts, waivers, State plan amendments and State operations) into compliance with the final rule provisions."[5]

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

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

- Procedures that:

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

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

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

- Monitor and evaluate Health Plan compliance with the standards regularly

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

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

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

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

2.2 Medicaid External Quality Review Final Regulations

On January 24, 2003, the Centers for Medicare & Medicaid Services (CMS) published an external quality review (EQR) *Final Rule* in the *Federal Register* to implement Section 4705 of the BBA.[6] The effective date of this *Final Rule* is March 25, 2003 and provides[7]:

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

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

- **EQRO Must Perform an Annual EQR of Each Health Plan** – The State must ensure that: "a qualified external quality review organization (EQRO) performs an annual EQR for each contracting MCO."[8]

- **EQR Must Use Protocols** – The January 24, 2003 *Final Rule* stipulates how the EQR must be performed. It should be noted that this includes the requirement[9] that "information be obtained through methods consistent with the protocols established under § 438.352."

[6] Essentially Section 1932(c) of the Social Security Act.
[7] *Federal Register*, 68(16), January 24, 2003, 3586.
[8] 42 CFR 438.350(a).
[9] 42 CFR 438.350(e).

- **EQR(O) Must Produce A Detailed Technical Report** – The January 24, 2003 *Final Rule* requires[10] that the EQR produce a "detailed technical report" that "describes the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP."

- **States Must Perform Mandatory EQR Activities** – The January 24, 2003 *Final Rule* distinguishes between "mandatory" and "optional" EQR-related activities. Apart from the required "detailed technical report", the "mandatory" activities include[11]:

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

  It would appear that, at a minimum, the "detailed technical report" must be prepared by an EQRO. Other "mandatory" EQR activities need not be performed by an EQRO, although enhanced FMAP is not available unless an EQRO performs them[12].

  "Optional" activities[13] include:

  - Validation of encounter data
  - Administration or validation of consumer or provider surveys of quality of care
  - Calculation of additional performance measures[14]
  - Conduct of additional quality improvement projects[15]
  - Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time

Table 2-1 shows these obligations in tabular form.

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

Table 2-1

EXTERNAL QUALITY REVIEW (EQR) ACTIVITIES

Activity	Mandatory Activity[16]	Must Be Performed by EQRO[17]
Prepare detailed technical report	**Yes**[18]	**Yes**
Validation of performance improvement projects	**Yes**	**No**
Validation of MCO performance measures reported	**Yes**	**No**
Review to determine MCO compliance with standards	**Yes**	**No**
Validation of encounter data	**No**	**No**
Administration or validation of consumer or provider surveys of quality of care	**No**	**No**
Calculation of additional performance measures	**No**	**No**
Conduct of additional quality improvement projects	**No**	**No**
Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time	**No**	**No**

2.3 Waivers and Special Terms and Conditions

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

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

The approval of these waivers and Federal matching is contingent upon the State's compliance with Special Terms and Conditions (STCs). These STCs also delineate the "nature, character, and extent of anticipated Federal involvement" in the **demonstration.** Demonstration is highlighted because RIte Care is a "demonstration project," according to the DHHS *approval letter*[19].

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

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

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

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

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

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

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

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

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

    - Require, by contract, that Health Plans meet certain State-specified standards for Internal Quality Assurance Programs (QAPs) as required by

[19] The most recent version of the approval letter with both the waivers and the STCs explicated is April 16, 2003.

42 CFR 438.240 and monitor on a periodic basis each Health Plan's adherence to these standards

- **General Administrative/Reporting Requirements** – The State is required to report quarterly and annually in writing to CMS on[20]:

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

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

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

2.4 SCHIP Quality Requirements

SCHIP, too, has quality requirements. Specifically, 42 CFR 457.495 addresses "access to care and procedures to assure quality and appropriateness of care[21]. The State SCHIP Plan must describe how it will assure:

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

- Access to covered services, including emergency services

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

- That decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after receipt of a request for services, with an extension possible under certain circumstances, and in accordance with State law[22]

[20] Three quarterly and one annual report are required to be submitted to CMS. All reports can be combined Medicaid and SCHIP reports.
[21] *Federal Register*, 66(8), January 11, 2002, 2666-2688.
[22] *Federal Register*, 66(122), June 25, 2001, 33810-33824.

CHAPTER 3

COMPONENTS OF RHODE ISLAND'S QUALITY ASSESMENT AND PERFORMANCE IMPROVEMENT STRATEGY

From the very beginning of RIte Care, the State has taken to heart the fact that it is a *demonstration* initiative. DHS developed a plan for monitoring[23] RIte Care Health Plans early on. The plan included the following mechanisms for monitoring 12 areas of Health Plan operations:

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

This strategy document supersedes the subject plan for monitoring with respect to quality.

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

3.1 Principles Forming The Foundation Of Rhode Island's Quality Strategy

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

[23] The latest version is: Birch & Davis Health Management Corporation. *Plan For Monitoring RIte Care Health Plans*, August 1996.

- **Principle 1: The strategy must embrace the unique features of the program while fulfilling the Federal requirements** – Chapter 2 described the Federal requirements applicable to the *demonstration* with respect to quality assessment and performance improvement. The strategy must incorporate all of the requirements in order to comply fully with the regulations and STCs. Yet, the strategy must make sense given the features of RIte Care[24], what the State has been attempting to accomplish, and how it has been assessing accomplishments.

- **Principle 2: The strategy must build on, not duplicate or supplant, other requirements –** The service delivery system for RIte Care does not exist in isolation. The State made a policy decision[25] in the very beginning that only State-licensed health maintenance organizations (HMOs) would be allowed to participate in RIte Care. HMOs in the State are overseen by the Division of Facility Regulation (DFR) within the Rhode Island Department of Health (DOH) and by the Department of Business Regulation (DBR). In Rhode Island, this also means that the HMOs are accredited by the National Committee for Quality Assurance (NCQA), since this is a requirement of State law[26]. So, the strategy should build on, not duplicate or supplant these requirements.

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

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

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

[25] When Blue Cross and Blue Shield of Rhode Island made a decision to give up its HMO license for CHiP effective January 1, 2005, the State changed its requirements that non-HMO RIte Care Health Plans must meet to include NCQA accreditation and certain HMO requirements that plans must under Rhode Island Department of Health regulations. These requirements are incorporated into the *RIte Care Health Plan Contract* effective January 1, 2005.

[26] All three MCOs participating in RIte Care have full, three-year accreditation from NCQA. All three Health Plans – Coordinated Health Partners (CHiP, or Blue ChiP), Neighborhood Health Plan of Rhode Island (NHPRI), and United HealthCare of New England (UHCNE) – received an "excellent" designation from NCQA. Both Blue CHiP and UHCNE have their Medicaid product lines accredited separately by NCQA and both are Medicare+Choice participating plans (and have their Medicare product lines separately accredited by NCQA).

3.2 The Components Of Rhode Island's Quality Strategy

Using the above principles as a backdrop, the following will constitute the various components of the strategy for quality assessment and performance improvement. Table 3-1 shows how the various components of the State's integrated, unified quality strategy. In order to track compliance with Federal requirements, the table is organized first according to those minimum elements delineated in the June 14, 2002 *Final Rule* and then according to the applicable STCs for the RIte Care waivers. The *mechanisms* in the table are described in detail in Appendix B of this strategy document.

Table 3-1

COMPONENTS OF RHODE ISLAND'S QUALITY ASSESSMENT AND PERFORMACE IMPROVEMENT STRATEGY

QUALITY/PERFORMANCE IMPROVEMENT AREA	MECHANISM	COMMENTS
1. Assess the quality and appropriateness of care and services to enrollees	• Performance incentive program • Encounter Data System • NCQA information • Member Satisfaction Survey • Complaint, grievance and appeals reporting • EQRO studies • Special studies • Contract compliance review	
2. Identify the race, ethnicity, and primary language spoken of each enrollee	• MMIS data	The MCKR 500 reports to the Health Plans on a monthly basis the basic demographics of enrollees.
3. Arrange for annual, external independent reviews of the quality and timeliness of, and access to, the services covered under each Health Plan contract	• Performance incentive program • Encounter Data System • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO studies • Special studies • Contract compliance review	IPRO, the State's EQRO is responsible for preparing an annual, plan-specific detailed technical report that assesses the quality, timeliness, and access to the care furnished by each Health Plan.
4. Appropriate use of intermediate sanctions	• Contract compliance review	Provisions for levying intermediate sanctions have always been a part of the RIte Care Health Plan Contract. Contracts were amended to incorporate Subpart I of the June 14, 2002 *Final Rule* requirements.
6. Standards for Access to Care, Structure and Operations, and Quality Measurement and Improvement		

6.a. Access Standards 6.a.1 Availability of services	• Performance incentive program • Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Special studies • Contract compliance review	As Table 3-2 shows, the State has quantitative access standards and has since 1994
6.a.2 Assurances of adequate capacity and services	• Provider network reporting • NCQA information • Contract compliance review	As Table 3-2 shows, the State has quantitative capacity standards and has since 1994
6.a.3 Coordination and continuity of care	• Complaint, grievance, and appeals reporting • NCQA information • EQRO activities • Special studies • Contract compliance review	The State defers principally to NCQA standards in this area
6.a.4 Coverage and authorization of services	• Encounter Data System • MMIS data • Risk-share reporting • NCQA information • Member Satisfaction Survey • Complaint, grievance, and appeals reporting • EQRO activities • Contract compliance review	The State defers principally to NCQA standards in this area
6.b. Structure and Operation Standards		
6.b.1 Provider selection	• Provider network data • NCQA information • Complaint, grievance, and appeals reporting • Contract compliance review	The State defers principally to NCQA standards in this area
6.b.2 Enrollee information	• Performance incentive program • On-site reviews • NCQA information • Complaint, grievance, and appeals reporting • Special studies • Contract compliance review	The State defers to NCQA standards in this area, except for certain State-specific requirements to be met in the contract

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

	• Special studies • Contract compliance review	since 1998. It is the heart of Rite Care's performance incentive program. It is supplemented by EQRO studies and special studies in areas of access and clinical care interest.
8. Quality Assurance Requirements 8.a. Methodology to monitor performance	• All mechanisms	Previously, the State had a *Plan for Monitoring RIte Care Health Plans*. That plan is superseded by this strategy document with respect to quality.
8.b. Contract with EQRO	• EQRO activities	EQRO contract was reprocured, with a contract effective date ofSeptember 1, 2003..
8.c. Quarterly reports on complaints and grievances	• Complaint, grievance, and appeals reporting • Contract compliance review	Complaint, grievance, and appeals reporting has been in place since 1994
8.d. EQRO focused study of emergency room services	• EQRO study	Study report was submitted to CMS (HCFA) in 1998.
8.e Require that Health Plans meet certain quality assurance requirements	• NCQA information • Contract compliance review	Contracts were amended to conform to the *Final Rule*.
9. General Administrative/Reporting Requirements – quarterly and annual reports	• All mechanisms	

Table 3-2 shows those areas where the State has established quantitative standards for access. Like Table 3-1, the *mechanisms* in Table 3-2 are described in detail in Appendix B of this strategy document.

Table 3-2

Quantitative Standards for Access and Mechanisms for Measuring Them

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

	• No more than 4,000 members FTE network mental health provider • No more than 10,000 members per network psychiatrist • Members may self-refer for up to four GYN/family planning visits annually or for STP services, without obtaining a referral from the PCP	• Encounter Data System
Coverage and authorization of services	• Assignment of a PCP within 20 days of enrollment, if none selected by the enrollee • For children with special health care needs, completion of an Initial Health Screen within 14 days of the effective date of enrollment • For children with special health care needs for whom it is applicable, completion of a Level I Needs Review and Short Term Care Management Plan within 14 days of the effective date of enrollment • Provide initial assessments of RIte Care members within 90 days of enrollment • Provide initial assessments of pregnant women and members with complex and serious medical conditions within 30 days of the date of identification • Allow women direct access to a women's health care specialist within the Health Plan's network for women's routine and preventive services • Resolution of a standard appeal of an adverse decision within 14 days • Resolution of an expedited appeal of an adverse decision within three days	• On-site review • Member Satisfaction Survey • Complaint, grievance, and appeals data

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

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

Table 3-3

Protocols Used/To Be Used for EQR

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

ACS is ACS/Birch & Davis Health Management, the State's management assistance contractor. MCH Evaluation is the State's research and evaluation contractor. IPRO is the State's EQRO. Brown University refers to several components of the university that work with the State under a cooperative agreement.

CHAPTER 4

PROCESS FOR INVOLVING RECIPIENTS AND OTHER STAKEHOLDERS

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

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

The State intends to review the strategy document annually with the Child and Family Consumer Advisory Committee and the Evaluation Studies Workgroup to assess the strategy's effectiveness and to update it, as needed.

APPENDIX A

FEDERAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT REQUIREMENTS

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

- Waivers and Special Terms and Conditions
- Medicaid Managed Care Final Regulations
- Medicaid External Quality Review Final Regulations
- SCHIP Quality Requirements

Each set of requirements is described in separate sections below.

2.1 Waivers And Special Terms And Conditions

The *waivers* approved by Centers for Medicare & Medicaid Services (CMS) of the U. S. Department of Health and Human Services (DHHS), which have allowed the State to operate RIte Care (and, now, RIte Care, in the instance of SCHIP), are actually waivers of specific provisions of the Social Security Act (Act). In Rhode Island's case, these are waivers[27] of the Act pertaining to Medicaid and SCHIP as follows:

- Medicaid Waivers:

  - Amount, Duration, and Scope of Services — Section1902(a)(10)(B)
  - Financial Responsibility — Section 1902(a)(17)(D)
  - Freedom of Choice — Section 1902(a)(23)
  - Payment to Federally Qualified Health Centers — Section 1902(a)(10)
  - Retroactive Eligibility — Section 1902(a)(34)

- SCHIP Waivers

  - General Requirements, Eligibility and Outreach — Section 2102
  - Restrictions on Coverage and Eligibility to Targeted Low Income Children — Sections 2103 & 2110
  - Federal Matching Payment and Family Coverage Limits — Section 2105
  - Annual Reporting Requirements — Section 2108

[27] These are the most recent version of the waivers, as of April 16, 2003.

In addition to the above, these waivers include ones to permit the State to receive Federal funds "not otherwise matchable" except under the authority of Section 1115 of the Act. For Medicaid, this provides Federal matching for the expansion populations. For SCHIP, this provides Federal matching for eligible parents and relative caretakers as well as eligible pregnant women.

The approval of these waivers and Federal matching is contingent upon the State's compliance with Special Terms and Conditions (STCs). These STCs also delineate the "nature, character, and extent of anticipated Federal involvement" in the **demonstration.** Demonstration is highlighted because RIte Care is a "demonstration project," according to the DHHS *approval letter*[28]. The Secretary of DHHS can, under Section 1115 of the Act, authorize "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives" of Medicaid's (and, now, SCHIP's) statutory provisions.[29] In the instance of RIte Care, what needs to be demonstrated is the degree to which the goals shown in Chapter 1 are being accomplished.

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

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

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

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

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

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

[28] The most recent version of the approval letter with both the waivers and the STCs explicated is April 16, 2003.
[29] 42 U.S.C. 1315

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

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

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

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

- **General Administrative/Reporting Requirements** – The State is required to report quarterly and annually in writing to CMS on[30]:

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

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

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

2.2 Medicaid Managed Care Final Regulations

Except for those Federal legal requirements specifically waived in the *approval letter*, the State must meet all other applicable, Federal legal requirements. Salient requirements include those contained in the June 14, 2002 *Final Rule* implementing the managed care provisions of the Balanced Budget Act of 1997 (BBA)[31]. States had until June 16, 2003 "to bring all aspects of their managed care programs (that is, contracts, waivers, State plan amendments and State operations) into compliance with the final rule provisions."[32]

This strategy document is essentially a required element of the June 14, 2002 *Final Rule*. Specifically, Subpart D of the *Final Rule* "implements section 1932(c)(1) of the Act and sets forth specifications for quality assessment and performance improvement strategies that States must implement to ensure the delivery of quality health." It also establishes

[30] Three quarterly and one annual report are required to be submitted to CMS. All reports can be combined Medicaid and SCHIP reports.
[31] *Federal Register*, 67(115), June 14, 2002, 41094-41116. The BBA also created the State Children's Health Insurance Program (SCHIP).
[32] *Ibid.*, 40989.

"standards" that States and Health Plans must meet. Section 438.204 of the *Final Rule* delineates the following minimum elements of the State's quality strategy:

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

- Procedures that:

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

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

    - Monitor and evaluate Health Plan compliance with the standards regularly

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

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

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

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

The remainder of Subpart D of the June 14, 2002 *Final Rule* stipulates the "standards," which encompass the following areas:

- **Access Standards** – This includes the following areas:

    - Availability of services
    - Assurances of adequate capacity and services
    - Coordination and continuity of care
    - Coverage and authorization of services

- **Structure and Operation Standards** – This includes the following areas:

    - Provider selection
    - Enrollee information
    - Confidentiality
    - Enrollment and disenrollment
    - Grievance systems
    - Subcontractual relationships and delegation

- **Measurement and Improvement Standards** – This includes the following areas:

    - Practice guidelines
    - Quality assessment and performance improvement program
    - Health information systems

Although the term "standards" is used, it is important to note that these are not quantitative requirements. To the contrary, they are, with few exceptions[33], more like qualitative guidelines, where the States have reasonable flexibility in tailoring the requirements to meet State exigencies including incorporating quantitative elements. For example, the "access standards" include requirements to maintain an adequate and appropriate network of providers that takes into account such things as geographic location of providers and enrollees. The "standards" do not dictate any distance or travel time requirements, for example[34].

In addition, in most instances the "standards" also do not contain specific measures. It should be noted, however, that 42 CFR 438.240(a)(2) provides that "CMS, in consultation with States and other stakeholders, may specify performance measures and topics for performance improvements projects to be required by States in their contracts" with Health Plans[35].

2.3 Medicaid External Quality Review Final Regulations

On January 24, 2003, CMS published an external quality review (EQR) *Final Rule* in the *Federal Register* to implement Section 4705 of the BBA[36] to apply to managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). Rhode Island only has MCOs, which are State-licensed health maintenance organizations (HMOs, or Health Plans). The effective date of this *Final Rule* was March 25, 2003 and provides[37]:

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

[33] One exception, for example, is that services must be available 24 hours a day, 7 days a week, when medically necessary.
[34] It should be noted that Rhode Island has had quantitative standards in many areas from the beginning of RIte Care that are incorporated into the RIte Care Health Plan Contracts.
[35] Representatives of DHS have been included in the Performance Measurement Partnership Project (PMPP), convened by CMS to consider performance measures that might be reported, some day, by States to CMS. It should be noted that Rhode Island was only one of three States that reported to CMS on **all** PMPP measures in its 2003 SCHIP Annual Report..
[36] Essentially Section 1932(c) of the Social Security Act.
[37] *Federal Register*, 68(16), January 24, 2003, 3586.

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

- **EQR Regulations Are Cross-referenced to Managed Care Regulations** – The *Final Rule* is cross-referenced to the June 14, 2002 *Final Rule* implementing the managed care provisions of the BBA.

- **EQRO Must Perform an Annual EQR of Each Health Plan** – The State must ensure that: "a qualified external quality review organization (EQRO) performs an annual EQR for each contracting MCO."[38] When these regulations became effective, an EQRO needed no longer to be a quality improvement organization (QIO, previously known as a quality control peer review organization or PRO) under Section 1902(a)(30)(C) of the Social Security Act. Under the January 24, 2003 *Final Rule*, any entity may be an EQRO as long as it meets the "competency" and "independence" requirements of 42 CFR 438.354.

- **EQR Must Use Protocols** – The January 24, 2003 *Final Rule* stipulates how the EQR must be performed. It should be noted that this includes the requirement[39] that "information be obtained through methods consistent with the protocols established under § 438.352." In the preamble[40] CMS states its belief that it is providing States with great flexibility in this area: "This regulation provides States with the option to use the protocols developed by us or protocols that are consistent with our protocols." However, the regulations do not define what "consistent with" means.

  The specifications of that section[41] would seemingly require development of detailed protocols, if CMS-provided protocols are not used. It should be noted that the protocols developed for CMS are not actually incorporated into the January 24, 2003 *Final Rule*. These protocols, developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) under contract to CMS, include nine protocols and one appendix in the following areas:

  - Determining MCO/PIHP compliance with Federal Medicaid managed care regulations

  - Performance measurement

  - Validating encounter data

  - Performance improvement projects

[38] 42 CFR 438.350(a).
[39] 42 CFR 438.350(e).
[40] *Federal Register*. *Op. Cit.*, 3592.
[41] 42 CFR 438.352.

- Using surveys

- Assessing MCO/PHP information systems capabilities

- **EQR(O) Must Produce A Detailed Technical Report** – The January 24, 2003 *Final Rule* requires[42] that the EQR produce a "detailed technical report" that "describes the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP." In addition, the "State must provide copies of the information specified . . . ,upon request, through print or electronic media, to interested parties such as participating health care providers, enrollees, and potential enrollees of the MCO or PIHP, recipient advocacy groups, and members of the general public." While not explicit, it appears that CMS' intent[43] is that the EQRO is to produce the subject report.

- **What Constitutes an EQR Is Explicit** – The January 24, 2003 *Final Rule* is explicit[44] about what constitutes EQR: "the analysis and evaluation by an EQRO, of aggregated information on quality, timeliness, and access to the health care services that an MCO or PIHP, or their contractors furnish to Medicaid recipients."

- **States Must Perform Mandatory EQR Activities** – The January 24, 2003 *Final Rule* distinguishes between "mandatory" and "optional" EQR-related activities. Apart from the required "detailed technical report", the "mandatory" activities include[45]:

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

  It would appear that, at a minimum, the "detailed technical report" must be prepared by an EQRO. Other "mandatory" EQR activities need not be performed by an EQRO, although enhanced FMAP is not available unless an EQRO performs them[46].

  "Optional" activities[47] include:

  - Validation of encounter data

[42] 42 CFR 438.364.
[43] *Federal Register*, *Op. Cit*., 3608.
[44] 42 CFR 438.320.
[45] 42 CFR 438.358(b).
[46] *Federal Register*. *Op. Cit.*, 3611.
[47] 42 CFR 438.358(c).

- Administration or validation of consumer or provider surveys of quality of care
- Calculation of additional performance measures[48]
- Conduct of additional quality improvement projects[49]
- Conduct of studies that focus on a particular aspect of clinical or non-clinical services at a point in time

An EQRO may also provide technical assistance to MCOs "to assist them in conducting activities related to the mandatory or optional activities."[50]

- **More Than One EQRO May Be Used** – The January 24, 2003 *Final Rule* specifies[51] that the "State must (1) contract with one EQRO to conduct either EQR alone or other EQR-related activities; and (2) may contract with additional EQROs to conduct EQR-related activities"

The January 24, 2003 *Final Rule* provides[52] for "non-duplication of mandatory activities." The "general rule"[53] is: ". . . the State may use, in place of a Medicaid review by the State, its agent, or EQRO, information about the MCO or PIHP obtained from a Medicare or private accreditation review to provide information otherwise obtained from the mandatory activities. . ." There are, of course, certain conditions that must be met in order for this non-duplication to apply. One such condition is tantamount to incorporating the applicability of this provision into the State's "quality strategy".

However, this is one area where the preamble to the January 24, 2003 *Final Rule* appears to weaken the regulatory provisions. First, the preamble stipulates[54]: "The EQRO must review the reports, findings, and other results of the accreditation review to use in the EQR." Second, the preamble stipulates[55] that validation of performance measures is **not** a candidate activity for non-duplication. This section of the preamble seemingly ignores the fact that there is validation of Medicaid HEDIS® measures, because reference is made only to Medicare and commercial populations. Finally, this section of the preamble stipulates[56] that in order for the non-duplication to apply, the "Medicare or accreditation standards must be comparable to those established by the State." However, CMS has clarified[57] that existing audits will suffice: "Because the protocols were based on quality assessment approaches already in use by public and private quality oversight organizations, we believe that the methods MCOs and PIHPs use to respond to existing private and public sector audits will be able to be used to respond to EQR."

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[48] Any "additional" performance measures must be validated by an EQRO.
[49] Any "additional" performance improvement projects must be validated by an EQRO.
[50] 42 CFR 438.358(d).
[51] 42 CFR 438.356.
[52] 42 CFR 438.360.
[53] 42 CFR 438.360(a).
[54] *Federal Register*. *Op. Cit.*, 3603.
[55] *Ibid.*
[56] *Federal Register*. *Op. Cit.*, 3605.
[57] Centers for Medicare & Medicaid Services. *External Quality Review Regulation Q's and A's, March 25, 2003, 5.*

The January 24, 2003 *Final Rule* also provides[58] that a State may exempt an MCO from EQR under the following conditions:

> "(1) The MCO or PIHP has a current Medicare contract under Part C of title XVIII or under section 1876 of the Act and a current Medicaid contract under section 1903(m) of the Act.
>
> (2) The two contracts cover all or part of the same geographic area within the State.
>
> (3) The Medicaid contract has been in effect for at least 2 consecutive years before the effective date of the exemption and during those 2 years the MCO or PIHP has been subject to EQR under this part, and found to be performing acceptably with respect to quality, timeliness, and access to health care services it provides to Medicaid recipients."

CMS' intent[59] is clear: "This effectively means that no MCO or PIHP could be exempted under § 438.362 until EQR under the January 24, 2003 *Final Rule* is in effect for at least 2 years." This means the earliest an exemption could apply would be **March 25, 2006**.

2.4 SCHIP Quality Requirements

SCHIP, too, has quality requirements. Specifically, 42 CFR 457.495 addresses "access to care and procedures to assure quality and appropriateness of care[60]. The State SCHIP Plan must describe how it will assure:

- Access to well-baby care, well-child care, well-adolescent care, and childhood and adolescent immunizations
- Access to covered services, including emergency services
- Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition
- That decisions related to the prior authorization of health services are completed in accordance with the medical needs of the patient, within 14 days after receipt of a request for services, with an extension possible under certain circumstances, and in accordance with State law[61]

[58] 42 CFR 438.362(a).
[59] *Federal Register*. *Opt. Cit.*, 3607.
[60] *Federal Register*, 66(8), January 11, 2002, 2666-2688.
[61] *Federal Register*, 66(122), June 25, 2001, 33810-33824.

Because Rhode Island is predominantly a *Medicaid expansion State* for SCHIP purposes, SCHIP requirements are subsumed under the Medicaid requirements. Even for the separate child health program for unborn children, enrollment is in RIte Care Health Plans for whom Medicaid requirements prevail.

APPENDIX B

MECHANISMS TO BE USED AS PART OF RHODE ISLAND'S QUALITY STRATEGY

This appendix describes in detail the *mechanisms* referenced in Chapter 3.

1. Performance Incentive Program

In the *RIte Care Health Plan Contract* effective July 1, 1998, the State established a performance incentive program, under which Health Plans can earn payments over and above capitation and SOBRA payments for the attainment of certain administrative, access, and clinical goals. The State did so "to improve care by using available health plan data on access and outcomes" and "to improve the quality of health plan performance data."[62] This was part of an ongoing strategy of partnership with the Health Plans, with both the State and the Health Plans committed to continuous quality improvement for RIte Care. The "approach leverages a comparatively small amount of money in spotlight areas that DHS considers important."[63]

The program began with 21 measures in three areas of focus: 9 for the administrative are, 5 for the access to care area, and 7 for the clinical care area. These measures are in Attachment M of the *RIte Care Health Plan Contract*. Five "pilot measures" were added in 2000 and included the following areas:

- Postpartum visit after delivery
- First outpatient pediatric visit for infants born into RIte Care
- Emergency room visits by child enrollees with asthma
- Outpatient visit after discharge for a mental health diagnosis
- Translation assistance

In the *RIte Care Health Plan Contract* effective January 1, 2005, the program was modified to link more clearly with specific RIte Care programmatic emphases as follows:

- Member Services – 4 goals
- Medical Home/Preventive Care – 14 goals
- Women's Health – 4 goals
- Chronic Care – 3 goals
- Behavioral Health – 1 goal

[62] Dyer, M.B., M. Bailit, and C. Kokenyesi. *Working Paper: Are Incentives Effective in Improving the Performance of Managed Care Plans?*, Center for Health Care Strategies, March 2002.
[63] Rhode Island Department of Human Services. *Rhode Island Medicaid Program: Annual Report Fiscal Year 2001*, 42.

- Resource Maximization – 2 goals

Each measure is clearly defined, has a numeric "standard" to be achieved, and has "scoring guidelines." Current goals are shown in Table B-1 below, with some of the data sources still to be negotiated with the Health Plans. It should be noted that the *RIte Care Health Plan Contract*, effective January 1, 2005, increased the pool of funds potentially available to each Health Plan to $2.50 per member per month.

TABLE B-1			
AREA	**GOAL**	**RITE CARE STANDARD**	**SOURCE OF MEASURE**
MEMBER SERVICES	Identification cards were distributed within 10 days of being notified of enrollment.	98%	Health Plan
	Member handbooks were distributed within 10 days of being notified of enrollment	98%	Health Plan
	New member calls were completed	65%	Health Plan
	Grievances and appeals were resolved within Federal (BBA) time frames	97%	Health Plan
MEDICAL HOME /PREVENTIVE CARE	Members had access to emergency services	90%	CAHPS®
	Members were satisfied with access to urgent care	80%	CAHPS®
	Members had access to urgent care appointments during business hours	95%	To Be Determined with Health Plan Input
	Members had PCP telephone access after business hours	95%	To Be Determined with Health Plan Input
	Adult members had an ambulatory or preventive care visit	90%	HEDIS®
	Child members had an ambulatory or preventive care visit	90%	HEDIS®
	RIte Care members had well-child visits in their first 15 months of life	85%	HEDIS®
	RIte Care members had well-child visits in their 3rd through 6th years of life	80%	HEDIS®

TABLE B-1			
AREA	**GOAL**	**RITE CARE STANDARD**	**SOURCE OF MEASURE**
MEDICAL HOME /PREVENTIVE CARE (Continued)	Adolescents in RIte Care who turned 13 years old received a second dose MMR, three hepatitis B Immunizations prior to their 13th birthday	75%	HEDIS®
	Children enrolled in RIte Care who turned 2 years old received 4 DtaP/DT, 3 IPV, 1 MMR, 3 Hib, 3 hepatitis B and 1 VZV immunizations	75%	HEDIS®
	Children enrolled in RIte Care had a visit with a Health Plan PCP (HEDIS Access)		
	12-24 months)	98%	HEDIS®
	25 months – 6 years	95%	HEDIS®
	7-11 years	95%	HEDIS®
	12-19 years	95%	HEDIS®
	Children received at least one age appropriate blood lead screen prior to their second birthday	85%	To Be Determined With Health Plan Input
	RIte Care members 18 years of age and older received advice to quit smoking (CAHPS)	70%	CAHPS®
	Pregnant RIte Care members received timely prenatal care and timely postpartum care		
	Prenatal	85%	HEDIS®
	Postpartum	90%	HEDIS®

TABLE B-1			
AREA	**GOAL**	**RITE CARE STANDARD**	**SOURCE OF MEASURE**
WOMENS' HEALTH	RIte Care-enrolled women 18-64 years received cervical cancer screening	85%	HEDIS®
	RIte Care-enrolled women 16-25 years of age identified as sexually active received chlamydia screening	50%	HEDIS®
	First time pregnancies for RIte Care-enrolled females <20 years of age decreased	5% Decrease Annually	To Be Determined With Health Plan Input
	Subsequent pregnancies in RIte Care enrolled females <20 years of age with one or more children in household decreased	10% Decrease Annually	To Be Determined With Health Plan Input
CHRONIC CARE	Child RIte Care members with asthma used appropriate medications	70%	HEDIS®
	Adult RIte Care members with diabetes had HbA1c testing	90%	HEDIS®
	New chronic care goal		To Be Determined With Health Plan Input
BEHAVIORAL HEALTH	Members 6 years of age and older received a follow up visit after hospitalization for mental illness up 30 days post discharge	65%	HEDIS®
RESOURCE MAXIMIZATION	Generic Drugs Substitution Rate	1% Improvement Annually	Encounter Data
	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 Plans

Data on the *administrative*-type measures are collected during on-site reviews of each Health Plan. The Encounter Data System had been used to provide the information for the *access*-type and *clinical*-type measures. Data from 1998 established the baseline

against which later performance is compared. DHS offers each Health Plan monetary incentives[64] as a reward for improvements in performance, information accuracy, and the completeness of data submitted.

Because of the requirements of the EQR final regulations, the measures in effect January 1, 2005 moved towards a greater reliance on the Health Plan Employer Data and Information Set (HEDIS®) measures and Consumer Assessment of Health Plan Survey (CAHPS®), which is something that the Health Plans had requested. This was a logical approach[65] since HEDIS® measures are already audited independently and there are national *benchmarks* for them. The State believes that non-duplication is important particularly given the high cost to the Health Plans for NCQA accreditation activities and HEDIS® and CAHPS® reporting.

It should also be noted that in 2001, DHS received a Purchaser Award from the National Health Care Purchasing Institute for the program to recognize DHS' "value purchasing" management philosophy. In January 2003, a report[66] from The Commonwealth Fund highlighted that "Rhode Island's experience illustrates that much can be done to improve quality as well as efficiency through relatively modest quality improvement initiatives."

2. Encounter Data System

The RIte Care Health Plans have worked diligently to implement an encounter data reporting system. Such a reporting system, as noted above, is one of the STCs imposed by the Federal Government in granting the State the waivers necessary to implement RIte Care. An encounter data system is designed to identify services provided to an individual and track utilization over time and across service categories, provider types, and treatment facilities. Unique features and functional components of encounter data include:

- **Episode-specific**: services associated with a particular episode of care are grouped together
- **Person-level**: able to track individuals though the system
- **Standardized**: all Health Plans are reporting using the same definition
- **Longitudinal**: able to track people across reporting period
- **Comprehensive**: able to track people across service and treatment categories

[64] The total incentive pool equals approximately one percent of total capitation payments made to the Health Plans.
[65] The State also recognizes that the Performance Measurement Partnership Project is moving in the direction of using HEDIS® measures, at least on a pilot basis.
[66] Silow-Carroll, S. *Building Quality Into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations: Field Report*, The Commonwealth Fund, January 2003, 21.

Tracking medical encounters from a point of service (e.g., a physician's office) through claim processing by the Health Plans to a data processing component to functional analytical files presents many operational challenges. As the Federal Government, Rhode Island, and the other waiver States have learned, it takes at least three years to achieve a level of consistency in reporting by Heath Plans in order to have usable encounter data.

Information from the Rhode Island Encounter Data System has been reported since 1998, when a level of reporting consistency was reached and data were validated. Besides supporting the performance incentive program, the Encounter Data System is also used to monitor utilization. Monitoring utilization is important in assuring that enrollees have access to needed services. The following measures are produced quarterly in a standard report based on RIte Care utilization from the Encounter Data System:

- Inpatient admissions per 1,000 enrollees
- Inpatient days per 1,000 enrollees
- Average length of inpatient stay
- NICU admissions per 1,000 live births
- NICU days per 1,000 live births
- NICU average length of stay
- Emergency room (ER) visits per 1,000 enrollees
- Outpatient visits to primary care providers (PCPs) per 1,000 enrollees
- Outpatient visits to specialists per 1,000 enrollees
- Fertility rate[67]
- Prescriptions per 1,000 enrollees
- Percentage of prescriptions that are generic

Each report is cumulative so that it shows data not only for the current quarter by Health Plan and for RIte Care overall but for all prior quarters. Data are annualized, which allows for ready comparisons across time.

Since June 2001, encounter data have also been used to prepare *RIte Stats* – a bimonthly publication of the DHS Center for Child and Family Health (which administers RIte Care and RIte Share) to provide information to the public on the health care provided under RIte Care. Table B-2 shows what has been presented in each issue of *RIte Stats*:

[67] Live births per 1,000 female enrollees aged 15 to 44.

Table B-2

Information Presented in Issues of *RIte Stats*

Issue	Topic	Time Periods	Measures Reported
Vol. 1, No. 1	Utilization of hospital and outpatient services	State Fiscal Year (SFY) 1996-2000	• Inpatient admissions/1,000 • Average length of stay (ALOS) • Neonatal intensive care unit (NICU) admissions/1,000 • ER visits/1,000 • Live births/1,000 (fertility rates) • Outpatient visits to PCPs/1,000 • Outpatient visits to specialist/1,000 • Outpatient visits by site of service
Vol. 1, No. 2	Enrollment time and periods of dienrollment (gaps)	1994-2000 and Calendar Year (CY) 2000 for certain analyses	• Monthly enrollment in RIte Care • Distribution of number of months enrolled • Average number of months enrolled • Number of gaps in enrollment • Length of enrollment gaps
Vol. 1, No. 3	Utilization of services provided in emergency Departments (ED)	SFY 1998-2001 and SFY 2001 for certain analyses	• ED rate by treatment category • ED utilization by gender/1,000 • ED utilization by age group/1,000 • Top 20 conditions treated • Average cost for ED visits by treatment category
Vol. 1, No. 4	Utilization of mental health and substance abuse services	SFY 1998-2001 and SFY 2001	• Inpatient admissions/1,000 • ALOS • Residential and day/night treatment utilization/1,000 • Percent of enrollees using outpatient services by age group • Average number of outpatient services used by age group • Utilization of methadone maintenance services • Expenditures
Vol. 2, No. 1	Neonatal Intensive Care Unit (NICU) utilization	July 1998 to March 2002 and CY 2001	• NICU admissions/1,000 live births • Total NICU days/1,000 live births

			• ALOS • ALOS and average cost by DRG • Percentage of NICU stays by DRG • Inpatient readmissions during first year of life for NICU discharges
Vol. 2, No. 2	Utilization of ambulatory professional services	SFY 1997-2002 and SFY 2002 for certain analyses	• Ambulatory visits to PCPs/1,000 • Ambulatory visits to non-PCPs/1000 • Average number of visits to PCPs • Average number of visits to non-PCPs • Ambulatory visits/1,000 by provider type and age group • Ambulatory visits/1,000 by provider type and Health Plan • Expenditures
Vol. 2, No. 3	Asthma surveillance	SFY 1998 – 2002 and SFY 2002 for certain analyses	• Members receiving any astma-related service/1,000 by age group and gender • Ambulatory office visits/1,000 with asthma as a primary vs. any diagnosis • Inpatient admissions/10,000 • ED visits/10,000 • Prescriptions filled for medications used in treatment of asthma • Expenditures
Vol. 3, No. 1	Prescription drugs	July 1999 – March 2003	• Prescription drugs per member by quarter and Health Plan • Prescription drug rates/1,000 by age group and gender • Percentage prescriptions by therapeutic group • Average costs by quarter and prescription type

Whenever possible, encounter data analyses are compared to comparable national benchmarks such as from:

- National Ambulatory Medical Survey

- National Health Interview Survey
- National Hospital Ambulatory Medical Care Survey
- National Medicaid HEDIS® Database/Benchmark Project
- Treatment Episode Data Set

3. Risk-Share Reporting

DHS has entered into risk-share arrangements with all three Health Plans. The purpose of these arrangements is to assure RIte Care-eligible individuals have a choice of Health Plans in which to enroll[68]. Under the risk-sharing methodology, risk is shared according to whether the actual Medical Loss Ratio[69] in any quarter is within agreed-upon ranges or "risk corridors."

The risk-share arrangements require that the Health Plans report monthly to DHS on the following:

- Utilization data, including hospital admissions, length of stay, days per 1,000 enrollees, and maternity stays

- Claims payable and claims statistics, including claims received, claims processed, and average processing time in days

- Financial information

Unlike the encounter data, the risk-share reporting data are already aggregated by the Health Plans. In and of themselves, these data provide a good check on the aggregated encounter data.

These reporting requirements, which are part of the *RIte Care Health Plan Contract* effective January 1, 2005, partition the data into the following categories:

- Institutional Services – Separate reporting for admissions, length of stay, and total days to medical/surgical, obstetrics, behavioral health, and other institutional services. The reports include ambulatory surgery, emergency department visits and other outpatient services that are provided at the hospital.

- Professional services – Separate reporting for primary care, specialty services, emergency department physician services, mental health visits, and mental health intensive outpatient or partial hospital services

- Pharmacy – Reported as number of prescriptions

[68] Federal regulations require that enrollees have a choice of plans in which to enroll.
[69] Medical Loss Ratio means Medical Expenses divided by Premium.

- Other – All other services use
- Actual expenses and per member per month for the categories above
- A specific report that identifies cases where the expense for a member exceeds $50,000 in the reporting period
- Reinsurance expense and recoveries
- Administrative costs
- Other reports the DHS may request to explain certain Medical Expenses as those expenses affect the risk-share agreement.

These data will likely be reported monthly – for the month and year-to-date, and then the risk-shares will be reconciled quarterly and annually.

4. RIte Care Member Satisfaction Survey

Since 1996, ACS/Birch & Davis, under contract to DHS, has conducted RIte Care Member Satisfaction Surveys[70], when sufficient resources are available.. Satisfaction data provide a commentary by enrollees on the services they receive. Each annual survey is comprised of a random sample of RIte Care members, who are selected as representative of the RIte Care enrolled population. The samples are designed to be effective at a 25 percent response rate (plus or minus 5 percent) in measuring member satisfaction at the RIte Care program level at a 95 percent confidence.

Each survey sample member is mailed a survey questionnaire. The questionnaire is developed, in collaboration with the Child and Family Consumer Advisory Committee, for this survey to reflect RIte care-specific program concerns. Questionnaires are pre-tested and modified accordingly. There are adult and child versions of the questionnaire. Adults answer on behalf of child members. Both versions are in English and Spanish. Sample members who did not respond to the initial mailing are sent a replacement mailing of the questionnaire. Responses received after a specified date each year are not included in the data analysis.

Each Member Satisfaction Survey collects information on the following dimensions[71]:

- Regular doctor – other than whether the member has a regular doctor, information about:
  - Doctor's location
  - How long it has been since last seen
  - Ability to talk to or see when sick

[70] It should be noted that the Health Plans also have an annual CAHPS® conducted (see Section 7 below).
[71] It should be noted that dimensions, or questions, may change somewhat from year to year

  - Waiting time for appointment when sick
  - Waiting time for appointment to begin
  - Ability to reach after hours and on holidays and weekends
  - Overall satisfaction

- Prevention services – information about areas discussed by regular doctor, such as the following for adults:

  - Tobacco, alcohol, or drug use
  - Diet, exercise, or seat belt use
  - Stress, depression, or anxiety
  - Family planning

- Pharmacy services – problems getting prescriptions filled

- Specialty services

  - Satisfaction with getting a referral
  - Problems experienced, if dissatisfied

- Emergency services

  - Satisfaction, if ER services were used
  - Problems experienced, if dissatisfied

- Member services – helpfulness of plan staff, if a problem arose

- Member rights

  - Been denied services
  - Know how to appeal coverage decisions
  - Know about RIte Care Consumer Advisory Committee

- Transportation services

  - Satisfaction with RIte Care transportation benefits, if used
  - Availability of car seat for child under 3, if taxi or van used

- Interpreter services – needed one for a visit, but one not offered

- Overall satisfaction

Data from the survey are item-analyzed separately for adult and child versions of the questionnaire. Responses are analyzed by Health Plan and for English-speaking versus Spanish-speaking respondents. Where possible, responses are compared over time to examine trends.

5. Complaint, Grievance, and Appeals Reporting by the Health Plans

Enrollees may file a complaint, grievance, or appeal with their Health Plan[72] at any time. Health Plans have, since RIte Care enrollment began, submitted quarterly reports to DHS summarizing the types of complaints made and whether or not they were resolved. Health Plans have also submitted a Grievance and Appeal Log quarterly from the beginning that itemizes, by enrollee, the nature of the grievance or appeal, how long it took to resolve, how it was resolved, and how long it took to notify the enrollee of the resolution. Data are summarized periodically.

With the enrollment of *children with special health care needs*, Health Plans are reporting complaint, grievance, and appeals quarterly data separately for these children.

In addition to reporting by the Health Plans, complaints from enrollees (or their representatives, providers, advocates, other State agencies, and others can come to DHS directly through the DHS' bilingual information line capability. Complaints may also go the Child and Family Consumer Advisory Committee. In addition, enrollees may avail themselves of the DHS Fair Hearing process at any time or may file complaints with DOH.

6. Provider Network Data

Access to care has multiple dimensions. One dimension, for example, is providing access to care for individuals who had no or limited access due to being uninsured. Another dimension, for example, is improving access for those who had coverage but nonetheless had difficulty obtaining the services they needed.

The State monitors the adequacy of the service delivery system on a continuous basis. Provider network listings are updated monthly, from information submitted by the Health Plans. Among the items of information submitted is whether or not a provider's practice is open to new members. Another item, for example, is language(s) spoken. The listings are matched, as necessary, with enrollee/ applicant listings to assess any network gaps in primary care provider (PCP) availability, for example. Geo-access analyses have also been performed periodically.

Provider network data analysis is also considered in light of the Member Satisfaction Survey data and complaint, grievance, and appeals analyses, to present a broader picture of the adequacy and appropriateness of the provider networks.

7. NCQA Information

[72] Enrollees may also register complaints with the State at any time, including availing themselves of the DHS Fair Hearing process, and may also file complaints with DOH.

As noted in Chapter 3, all RIte Care-participating Health Plans must be accredited by NCQA. Accreditation reviews, of course, follow NCQA standards and use NCQA protocols. NCQA standards[73] include:

- Quality Management and Improvement (QMI)
  - Program Structure
  - Program Operations
  - Health Services Contracting
  - Availability of Practitioners
  - Accessibility of Services
  - Member Satisfaction
  - Health Management Systems
  - Clinical Practice Guidelines
  - Continuity and Coordination of Care
  - Coordination of Medical/Behavioral Health Care
  - Clinical Quality Improvement
  - Service Quality Improvement
  - Medical Record Documentation
  - Delegation of Quality Improvement Activity
- Utilization Management (UM)
  - Utilization Management Structure
  - Clinical Criteria for Utilization Management Decisions
  - Access to Utilization Management Staff
  - Appropriate Professionals
  - Timeliness of Utilization Management Decisions
  - Medical Information
  - Denial Notices
  - Appeal Policies and Procedures
  - Appeal Handling
  - Evaluation of New Technology
  - Satisfaction with Utilization Management Process
  - Emergency Services
  - Procedures for Pharmaceutical Management
  - Ensuring Appropriate Utilization
  - Triage and Referral for Behavioral Health Care
  - Delegation of Utilization Management Authority
- Credentialing and Recredentialing (CR)
  - Credentialing Policies
  - Credentialing Committee

[73] National Committee for Quality Assurance. *Standards for the Accreditation of MCOs: Effective July 1, 2003*, 2002.

- Initial Primary Source Verification
- Application and Attestation
- Initial Sanction Information
- Initial Credentialing Site Visits
- Recredentialing Primary Source Verification
- Recredentialing Sanction Information
- Performance Monitoring
- Ongoing Monitoring of Sanctions and Complaints
- Practitioner Appeal Rights
- Assessment of Organizational Providers
- Delegation of Credentialing

- Members' Rights and Responsibilities (MRR)

  - Statement of Members' Rights and Responsibilities
  - Distribution of Rights Statements to Members and Practitioners
  - Policies for Complaints and Appeals
  - Subscriber Information
  - Privacy and Confidentiality
  - Marketing Information
  - Delegation of Members" Rights and Responsibilities

- Preventive Health Services (PH)

  - Adoption of Preventive Health Guidelines
  - Distribution of Guidelines to Practitioners
  - Health Promotion with Members
  - Delegation of Preventive Health

Accreditation information is provided to DHS by the Health Plans.

HEDIS® data are also provided to DHS by the Health Plans. HEDIS® data encompass the following domains:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care[74]
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choice
- Health Plan Descriptive Information

The Effectiveness of Care domain includes, for example:

[74] This is actually the Consumer Assessment of Health Plans Survey (CAHPS®).

- Childhood immunization status
- Adolescent immunization status
- Breast cancer screening
- Cervical cancer screening
- Chlamydia screening in women
- Prenatal care in the first trimester
- Check-ups after delivery
- Controlling high blood pressure
- Comprehensive diabetes care
- Use of appropriate medications for people with asthma

The Access/Availability of Care domain includes:

- Adult's access to preventive/ambulatory health services
- Children's access to primary care practitioners

HEDIS®/CAHPS® Measures Required for NCQA MCO Medicaid Accreditation:

- Childhood Immunization Status
- Adolescent Immunization Status
- Breast Cancer Screening
- Cervical Cancer Screening
- Prenatal and Postpartum Care
- Medical Assistance with Smoking Cessation
- Comprehensive Diabetes Care
- Follow-Up after Hospitalization for Mental Illness
- Antidepressant Medication Management
- Getting Care Quickly
- Getting Needed Care
- Courteous and Helpful Office Staff
- Customer Service
- Rating of Health Plan
- How Well Doctors Communicate
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

As the text box on the right above shows, HEDIS® and CAHPS® measures are used by NCQA as part of the accreditation process. Taken together, these measures (HM) constitute 30 of the total of 100 points NCQA will use for accreditation in 2003 as the following shows:

QMI	27 points
UM	22 points
CR	10 points
MRR	8 points
PH	3 points
HM	30 points
Total	100 points

It should be noted that NCQA some of the HEDIS® measures may be rotated from one year to the next, to reduce the burden on the Health Plans. NCQA requires an audit of HEDIS® results by an independent agency (certified by NCQA) to ensure that HEDIS® specifications have been met.

The similarity between some of the HEDIS® measures and the RIte Care performance incentive program is not coincidental. Where possible, the performance incentive program used HEDIS® specifications for a given measure since the Health Plans were already collecting information in this manner.

The HEDIS® results reported back to the Health Plans by NCQA (and, in turn, submitted to DHS) show the results not for the Health Plan itself, but in comparison to HEDIS® national percentiles" at the 90^{th}, 75^{th}, 50^{th}, and 25^{th} levels, where available. The results

are also shown for the Health Plan for prior years and in comparison to pre-set Health Plan goals, where applicable. In addition, the Health Plans provide DHS with the *NCQA HEDIS® Data Submission Tool* as well audit reports on the quality of the data.

8. On-Site Reviews

As indicated in Section 1 above, on-site reviews are used partially to collect data on the *administrative*-type measures component of performance improvement program. On-site reviews have also been used since 1994, and will continue to be used under this strategy, to assess Health Plan compliance with contractual and other requirements – at periodic intervals, or as a particular need or concern arises.

Protocols are prepared for each on-site review, tailored to the specific needs of the review that include targeted contract compliance review.

9. External Quality Review Organization (EQRO) Activities

One of the STCs noted earlier was that the State must contract with an EQRO. Prior to the June 14, 2002 *Final Rule*, the State had used its EQRO to validate encounter data[75] as well as to perform clinical focused studies. The clinical focused studies, which were based on detailed review of a sample of medical and other records, included the following clinical areas:

- Neonatal intensive care unit (NICU) utilization
- Emergency room (ER) utilization
- Behavioral health care
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)

Clinical focused studies are undertaken for a reason. While one of the STCs was for the EQRO to perform a study on ER utilization, the State was also interested in this area. This interest was based on the observed decline in ER utilization after RIte Care was implemented. Although reduction in the use of the ER is expected under managed care, there was some concern that the magnitude of the reduction could signify barriers to access to needed care. In addition, there were some reports from enrollees early in RIte Care's history that Health Plans were making access to the ER difficult. Thus, an independent examination by the EQRO of the appropriateness of ER utilization seemed warranted[76].

Effective September 1, 2003, entered into a new EQRO contract with IPRO. Except for the first item below that is mandatory, the specific services IPRO may perform may involve one or more of the following:

[75] Encounter data have also been validated by other than the EQRO.

[76] It should be noted that the ER clinical focused study found that about one-half of the ER use was either inappropriate, clinically, or for an ambulatory-sensitive condition. The study also did not find that the Health Plans were creating barriers to care.

- **Prepare Detailed Technical Report** – IPRO has prepared Health Plan-specific technical reports that meet the requirements of 42 CFR 438.364. These reports were based upon NCQA information and performance incentive program data. IPRO also reviewed Health Plan-specific performance improvement projects. The State anticipates that a consolidated report, across Health Plans, will be completed shortly.

- **Coordinate With Health Plans Regarding Quality Improvement**

- **Review Health Plan Compliance With Standards**

- **Review and Modify Performance Data and Standards for RIte Care**

- **Conduct Focused Patterns of Care Studies**

- **Analyze and/or Validate Encounter Data**

10. Medicaid Management Information System (MMIS) Data

Because RIte Care enrollees are covered by the Medicaid fee-for-service system (FFS) for out-of-plan services (i.e., services not covered by the capitation payments to the Health Plans), *ad hoc* reports from the MMIS are prepared to analyze utilization of these services. In addition, the MMIS provides the basic demographic information on enrollees (e.g., race, ethnicity, and primary language). This latter information is actually imported into the MMIS from the State's eligibility system – InRhodes.

The following enrollment data are produced monthly on RIte Care:

- Number enrolled by Health Plan
- Number enrolled by age group – children vs. adults
- Number of foster children enrolled
- Number of SCHIP parents enrolled
- Number enrolled by Health Plan and primary language
- Number enrolled by town

11. Special Studies

As noted in Chapter 3, the State has implemented an extensive research and evaluation (R&E) program for RIte Care. This program has included a variety of special studies, undertaken as a particular need has arisen or as part of the "planned" R&E effort. Among the studies performed have been:

- **Behavioral Health Care Access Study –** This study[77] was completed and submitted to CMS in 1998 and included intensive, on-site review of Health

[77] Birch & Davis Health Management Corporation. *RIte Care Behavioral Health Access Study*, 1998.

Plan compliance with behavioral health contract provisions established to address concerns related to provider specialization and the multiethnic, multilingual nature of the enrolled RIte Care population.

- **Infant Health Survey** – This survey[78] was conducted to assess the impact of RIte Care on access to and the quality of pediatric primary care in an inner city high-risk population. The study was initiated prior to individuals enrolling in RIte Care Health Plans, so that the effects of RIte Care could be clearly discerned. Specifically, the sample for this study involved two inner city birth cohorts. The first, 1993 Cohort (i.e., pre-RIte Care), consisted of all resident births for Providence inner city census tracts 1 through 7, 12 through 14, 19 and 26 that occurred from March 1, 1993 through July 30, 1993. The second, 1995 Cohort (i.e., post-RIte Care), consisted of all inner city births from the same census tracts and born from March 1, 1995 through July 30, 1995.

- **Prenatal Care and Birth Outcome Study –** This study[79], originally based on data through 1995 and reported in *RIte Care Program Quarterly Report: October 1996 through December 1996*, has been updated using Calendar Year 2001 birth certificate data from the Office of Vital Statistics of the Rhode Island Department of Health. Study results, using the 1995 data, were also published in the *American Journal of Public Health*[80].

  Analyses will continue to be updated as new data become available. The following information will continue to be reported:

  - Percent of women who began prenatal care in the first trimester
  - Percent of women who received adequate or adequate plus prenatal care[81]
  - Percent of women who smoke cigarettes
  - Percent of women with short birth intervals[82]
  - Percent of births that are low birthweight[83]
  - Percent of total births to teenagers

  Analyses compare those on Medicaid versus those commercially insured. These analyses are updated annually, as newer data become available.

In 1998, Rhode Island received a demonstration grant from the Robert Wood Johnson Foundation's Center on Health Care Strategies to develop a *Health Indicator System for*

[78] Griffin, J. *Changes in Access and Quality of Pediatric Health Care in Inner City Providence from 1993 to 1995: Results of the RIte Care Infant Health Survey*, MCH Evaluation, Inc., April 28, 1998.
[79] Griffin, J. The *Impact of RIte Care on Adequacy of Prenatal Care and the Health of Newborns*, MCH Evaluation, Inc., March 2001.
[80] Griffin, J. F., *et. al.* "The Effect of a Medicaid Managed Care Program on the Adequacy of Prenatal Care Utilization in Rhode Island," *American Journal of Public Health*, 89(4), April 1999, 497 – 501.
[81] As measured by the Kotelchuk Index.
[82] Less than 18 months.
[83] Less than 2,500 grams.

Rhode Islanders on Medicaid[84]. This project brought fundamental change through the establishment of the Evaluation Studies Workgroup and the emergence of a partnership between program staff and health services researchers. The Workgroup includes researchers from Brown University, DOH staff, DHS staff, and contracted evaluation services (with MCH Evaluation, Inc.) This project produces and trends health indicators including access, quality, health status, and health outcome measures for the Medicaid population from existing public databases and surveys, and through special studies. The existing databases and surveys include:

- MMIS
- Linked Infant Birth/Death File
- Birth File
- Hospital Discharge File
- Health Interview Survey
- Behavioral Risk Factor Surveillance Survey

Among some of the special studies have been:

- A study[85] of immunization status of 19- to 35-month-old children who had been continuously enrolled in RIte Care for at least one year, based upon medical record reviews

- A study[86] of a documented blood lead screen test of children aged 19 to 35 months who had been continuously enrolled in RIte Care for at least one year had, also based on medical record reviews

Special studies will continue to be performed as part of the state's quality strategy, in collaboration with researchers from Brown and others.

12. Contract Compliance Review

One of the guiding principles for this quality strategy is having properly aligned contract requirements for the Health Plans, obligating them to be active participants in quality assessment and performance improvement. Some of these obligations have been described above (e.g., encounter data reporting and complaints, grievances, and appeals reporting). Two other long-standing contractual obligations have been for each Health Plan to perform at least three quality improvement studies directed at the RIte Care population each year and for each Health Plan to conduct its own member satisfaction survey. Access and other standards are also imbedded in the contract. Thus, targeted, periodic reviews of contract compliance will be undertaken..

[84] For more information on Rhode Islanders indicators, please see: http://dhs.state.ri.us/dhs/reports/dhcresys.htm.
[85] Vivier, P. M., *et.al.* "An Analysis of the immunization status of preschool children enrolled in a statewide Medicaid managed care program," *The Journal of Pediatrics*, 139(5), November 2001, 624-629.
[86] Vivier, P.M., *et.al.* "A Statewide Assessment of Lead Screening Histories of Preschool Children Managed in a Medicaid Managed care Program," *Pediatrics*, 108(2), 2001.

Table B-3 shows the areas in which the Health Plans directed quality improvement studies for the RIte Care population in 2002, as an illustration of the quality activity.

Table B-3

Quality Improvement Studies Undertaken by Health Plans in 2002

Area	ChiP	NHPRI	UHCNE
Adolescent Immunization	**X**		
Childhood Immunization	**X**		**X**
Chlamydia Screening	**X**		
Lead Screening		**X**	**X**
Adult Access to Interpreter Services			**X**
Diabetes Care for Adults		**X**	
Cervical Cancer Screening		**X**	
Use of Antibiotics for Pediatric URI		**X**	
ADHD Diagnosis and Management		**X**	
Improving Customer Service		**X**	
Getting Needed Care		**X**	

It should be noted that the reason NHPRI has so many more projects[87] than the other Health Plans is that NHPRI is a Medicaid-only plan. Blue Cross/Blue Shield and UHCNE undertake many other quality improvement projects but those other projects are directed at their commercial and Medicare enrolled populations.

DHS has amended the *RIte Care Health Plan Contract* multiple times to ensure the Federal requirements and STCs, at least those that can be contractually based, were met. In June 2001, the *RIte Care Health Plan Contract* were amended to conform to what the State believed were the managed care provisions of the BBA. Thus, 16 changes were made to the contracts with the Health Plans at that time.

[87] NHPRI actually has many more initiatives as part of its overall Quality Management Work Plan.

As noted in Chapter 2 above regarding promulgation of the June 14, 2002 *Final Rule*, States were given until June 16, 2003, to bring their contracts into compliance with the *Final Rule* provisions. CMS drafted[88] a *CMS Checklist for Managed Care Contract Approval* (Checklist) to guide both States and CMS in assuring compliance with the *Final Rule*.

In reviewing the details of the *Final Rule* in conjunction with the Checklist, the State found that it needed to make approximately 40 additional changes to the *RIte Care Health Plan Contract*. These changes were due mostly to the *Final Rule*'s language differing somewhat from the actual language in the statute. Thus, one component of the State's quality strategy was to amend the *RIte Care Health Plan Contracts* prior to bring them into compliance with the provisions of the June 14, 2002 *Final Rule*.

As noted in Section 8, on-site reviews are used as needed to determine Health Plan compliance with contract requirements. Compliance is be determined in other ways (e.g., submission of required data and reports).

[88] The draft had a date of September 25, 2002 (or September 30, 2002, depending on where one looks in the document).